# COMMONWEALTH OF VIRGINIA

# VIRGINIA BOARD OF NURSING

## Nurse Aide Curriculum

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*Note: The terms "client" and "resident" are used interchangeably through this document.

# UNIT I – THE NURSE AIDE IN LONG-TERM CARE

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Describe the different types of health care. | I. Long-term Care & Acute Care<br>A. Independent living<br>B. Home health care<br>C. Adult day care<br>D. Assisted living facility<br>E. Nursing home<br>F. Hospice<br>G. Continuum of care facility<br>H. Rehabilitation<br>I. Hospital (inpatient & outpatient)<br>J. Dementia/memory care | | |
| 2. Describe comparisons and differences of various methods that residents use to pay for long-term. | 2. Payment Options for Long-term Care Facilities<br>A. Private pay<br>1. resident pays for health care from personal resources<br>B. Group insurance<br>1. resident's health care is paid for by insurance that the resident has previously paid<br>C. Medicaid<br>1. medical assistance program for low-income residents that pays for the resident's healthcare<br>D. Medicare<br>1. health insurance program for residents over the age of 65 pays for resident's healthcare<br>2. funded by Social Security<br>3. Minimum Data Set (MDS) report required for each Medicaid resident | | |
| 3. Describe the role of the nurse aide in long-term care facilities. | 3. Omnibus Budget Reconciliation Act of 1987 (OBRA-87)<br>A. Federal regulation | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | B. Set standards of care for long-term care facilities<br>C. Requires all nurse aides in long-term care facilities to:<br>1. complete training program<br>2. pass certification exam<br>D. Requires each state to have a registry of nurse aides (see Unit XIV)<br>1. available to the public<br>2. contains information on nurse aide's performance, including resident abuse<br>3. information to be kept minimum of five (5) years<br>E. Requires continuing education<br>1. minimum of 12-hours in-service each year for nurse aides<br>F. Requires nurse aide who has not worked for 2 consecutive years to retake the certification exam<br><br>IV. The Health Care Team<br>A. The Nurse<br>1. Registered Nurse (RN)<br>2. Licensed Practical Nurse (LPN)<br>B. The Nurse Aide<br>1. care for residents<br>2. assist the RN and LPN<br>3. supervised by the RN or LPN<br>C. Interdisciplinary Team<br>1. resident<br>2. physician<br>3. registered dietitian/nutritionist<br>4. physical therapist<br>5. occupational therapist<br>6. family member<br>7. social worker<br>8. licensed nurse<br>9. nurse aide | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 10. activities/enrichment | | |
| 4. Describe common tasks for the nurse aide. | V. Common Tasks for the Nurse Aide<br>A. Activities of daily living (ADLs)<br>1. bathing<br>2. dressing<br>3. grooming<br>4. mouth care<br>5. toileting<br>6. eating & hydration<br>7. caring for skin; prevention of pressure ulcers<br>B. Bed making<br>C. Taking/recording vital signs; height & weight<br>D. Observing/reporting resident changes to licensed nurse<br>E. Maintaining safety, including fall prevention<br>F. Caring for equipment<br>G. Infection control | | |
| 5. Discuss professional behaviors of the nurse aide. | VI. Professional Behavior of the Nurse Aide<br>A. Attitude<br>1. outward behavior<br>2. disposition<br>3. positive attitude<br>a. caring<br>b. compassionate<br>c. committed to the job<br>B. Behavior<br>1. neatly dressed following facility uniform policy<br>2. on time to work<br>3. avoid unnecessary absences<br>4. use appropriate language<br>5. do not gossip about co-workers/residents<br>6. keep resident information | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | confidential<br>7. speak politely<br>8. follow facility policies and procedures<br>C. Grooming<br>1. wear clean, neat, unwrinkled uniform<br>2. attend to personal hygiene<br>3. do not use strongly scented fragrances (perfume, lotions, after-shave, body wash, hair spray)<br>4. keep hair away from your face<br>5. long hair should be secured at the back of the head or neck<br>6. keep beards neat and trimmed<br>7. use make-up sparingly<br>8. keep nails short<br>9. do not wear false nails<br>10. keep shoes/laces clean<br>11. jewelry should be minimal<br>D. Work ethic<br>1. attitude toward work<br>2. punctual<br>3. reliable<br>4. accountable<br>5. conscientious<br>6. respectful of others<br>7. honest<br>8. cooperative<br>9. empathetic | | |
| 6. Explain delegation as it relates to the nurse. | VII. Delegation (see Regulations Governing the Practice of Nursing 18VAC90-20-420 to 460)<br>A. Transferring authority to a person for a specific task<br>B. RN may delegate tasks to a nurse aide (NA) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | C. Criteria for delegation<br>1. nurse aide can properly and safely perform task<br>2. resident health, safety and welfare will not be jeopardized<br>3. RN retains responsibility and accountability for care of resident and supervises the NA<br>4. delegated task communicated to NA on a resident-specific basis<br>5. clear, specific instructions for performance, potential complications, expected results are given to NA<br>6. NA is clearly identified with a name tag<br>7. NA may not reassign a task that has been delegated to her/him<br>VIII. Applying for Employment as a Nurse Aide<br>A. Considerations<br>1. type of facility<br>2. adequate transportation<br>3. child care<br>B. Complete resumé and application | | |
| 7. Explain the impact of <u>Guidance Document 90-55</u> on potential employment for a nurse. | C. Guidance Document 90-55<br>1. impact of criminal convictions on potential employment<br>2. certain convictions prohibit employment in long-term care facilities<br>3. review Guidance Document 90-55<br>D. Interview<br>1. arrive on time<br>2. dress appropriately<br>a. professional attire<br>b. neat<br>3. maintain good eye contact | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 4. be prepared to answer questions<br>5. be prepared to ask questions<br>6. thank the interviewer at the end of the interview<br>7. mail short thank-you note the day after interview | | |

# UNIT II – COMMUNICATION AND INTERPERSONAL SKILLS

(18VAC90-26-40.A.1.a)
(18VAC90-26-40.A.5.b)
18VAC90-26-40.A.10)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Identify three aspects of communication. | I. Elements of Communication<br>A. Three components of communication<br>1. message<br>2. sender<br>3. receiver | | |
| 2. Demonstrate the ability to listen. | B. Listening is part of communication<br>1. hear the message<br>2. show an interest in the message<br>3. do not interrupt<br>4. ask appropriate questions for clarification<br>5. be patient allowing resident time to respond<br>6. reduce or eliminate distraction<br>7. use silence appropriately<br>C. Non-verbal communication<br>1. posture<br>2. appearance<br>3. eye contact<br>4. gestures<br>5. facial expressions<br>6. touch<br>7. level of activity | | |
| 3. Recognize barriers to communication. | D. Barriers to communication<br>1. talking too fast or too softly<br>2. avoiding eye contact<br>3. belittling resident's feelings<br>4. physical distance<br>5. false reassurance<br>6. changing subject<br>7. giving advice<br>8. use of slang/medical jargon | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 4. Identify the role of the four senses in communication. | II. Senses in Communication<br>A. Sight<br>1. look for changes in resident<br>2. report changes to licensed nurse<br>B. Hearing<br>1. listen to resident and family<br>C. Touch<br>1. touch and feel for any changes in resident's body<br>2. report any changes to licensed nurse<br>D. Smell<br>1. report any unusual odor | | |
| 5. Describe the documents that are used by the health care team to communicate information and needs of the resident. | III. Communication Among the Health Care Team<br>A. Resident's medical record (chart)<br>1. admission sheet<br>2. health history<br>3. examination results<br>4. physician's orders<br>5. physician's progress notes<br>6. health team notes<br>7. lab test results<br>8. special consents<br>B. Hard copy of health records or electronic health record (EHR)<br>1. condensed version of medical record<br>C. Minimum Data Set (MDS)<br>1. assessment tool<br>2. provides structured, standardized approach to care<br>3. helps identify resident health care problems<br>D. Person-centered care plan<br>1. outlines care that health care team | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | must perform to assist resident to attain optimal level of functioning<br>2. written by the nurse (RN or LPN)<br>3. nurse aide contributes by reporting signs and symptoms he/she observes<br>4. includes objective and subjective information<br>a. objective – information that can be seen, heard, touched, smelled<br>b. subjective – cannot be observed, may be heard or something the resident said | | |
| 6. Demonstrate an understanding of the nursing process. | E. The nursing process<br>1. assessment by the RN<br>a. physical inspection<br>b. medical record<br>c. identifies resident's actual or potential health care problems<br>2. diagnosis<br>3. plan - sets goals and a plan to meet those goals<br>4. implementation - providing care to resident following the plan<br>5. evaluation - look carefully to see if the desired goals have been achieved; if goals are not achieved care plan should be changed<br>6. nurse aide observations and reports are vital to meet resident goals<br>F. Reporting and documentation<br>1. throughout the day report changes in condition to the appropriate staff per facility | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 7. Demonstrate end-of-shift communication. | policy<br>2. shift report<br>a. received at beginning of shift from previous shift<br>b. given to on-coming shift before nurse aide leaves unit at end of shift<br>c. includes observations of changes in resident's condition or behavior<br>3. documentation<br>a. all information is confidential<br>b. document immediately after care is given<br>c. never document before providing care<br>d. document care in designated documentation tool (i.e. resident paper chart or other electronic health record)<br>e. write notes neatly and legibly<br>f. always sign your name and title<br>g. document only facts, not opinions<br>h. use accepted abbreviations<br>i. do not erase or use white-out, draw a single line through and initial any error (follow facility guidelines)<br>4. ADL record (activities of daily living) – check sheet for routine activities | | |
| 8. Demonstrate the correct way to talk on the telephone. | G. Communicating on the telephone<br>1. speak clearly and slowly<br>2. identify your facility and unit<br>3. identify who you are and your title | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. listen carefully<br>5. write any messages<br>6. end call with “thank you” and “good-bye” | | |
| 9. Demonstrate communicating with a hearing-impaired resident. | IV. Communicating with Specific Populations<br>A. Hearing impaired<br>1. identify any assistive devices that resident uses<br>a. hearing aides<br>b. communication boards<br>c. lip reading<br>d. sign language<br>2. reduce distracting noise<br>a. TV<br>b. radio<br>c. noise in adjacent room<br>3. get resident’s attention before speaking<br>4. speak clearly, slowly<br>5. maintain eye contact<br>6. use short, simple words<br>7. use picture cards<br>8. write, if necessary | | |
| 10. Demonstrate communicating with a visually-impaired resident. | B. Visually impaired<br>1. identify any assistive devices that resident uses<br>a. glasses<br>b. special lighting<br>2. knock on door and introduce yourself when entering room<br>3. position resident so they are not looking into bright light or bright window<br>4. position yourself where resident can see you<br>5. have adequate light in room<br>6. encourage resident to wear glasses | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 7. use face of a clock to describe location of items<br>8. only move items with permission | | |
| 11. Describe the characteristics of cognitive impairment. | C. Dementia and cognitive impairment<br>1. recognizing the resident with cognitive impairment<br>a. memory problems, trouble expressing oneself, not finding the right words to say<br>b. trouble with being in new places; not knowing where one is<br>c. trouble making decisions; confusion and inability to use logic<br>d. trouble focusing for long; losing a train of thought easily<br>e. most resident's cognitive condition will change over time | | |
| 12. Identify causes of cognitive impairment in residents. | 2. cognitive impairment may be due to:<br>a. Parkinson's disease<br>b. multiple types of dementia including Alzheimer's<br>c. strokes<br>d. traumatic brain injuries<br>e. alcoholism or drug toxicity (can be reversed)<br>f. depression<br>g. delirium<br>h. urinary tract infection (UTI)<br>3. residents with cognitive impairment may be extremely anxious or frustrated and unable to communicate their needs<br>a. cannot get needs met without | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | communicating<br>b. resident may need pain relief<br>c. rights of resident may be violated<br>d. may be uncooperative with your care if they do not know what you are doing | | |
| 13. Explain why communication challenges need to be overcome and list methods to overcome these challenges. | 4. communication skills must be tailored to meet the needs of cognitively impaired residents<br>a. be sure to have the resident's attention<br>b. explain what you are going to do prior to starting care routine<br>c. allow the resident opportunities to talk<br>d. keep the same routine as much as possible<br>e. be honest and reliable to gain resident's trust<br>f. know resident's likes and dislikes<br>g. speak slowly, softly, and simply | | |
| 14. Discuss communicating with families. | D. Families<br>1. respond to requests and complaints<br>2. answer questions honestly | | |
| 15. Given specific scenarios, demonstrate appropriate communication with members of the health care team. | E. Other members of the health care team<br>1. be tolerant of co-workers<br>2. be respectful of co-workers<br>3. be quiet when others are speaking<br>4. listen to ideas of co-workers<br>5. approach new ideas with an open mind<br>6. use appropriate voice volume | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 7. use appropriate language<br>8. do not curse or use slang<br>9. do not talk about residents in a rude or disrespectful manner | | |
| 16. Discuss important interpersonal skills for the nurse aide. | V. Interpersonal Skills for the Nurse Aide<br>A. Accept every resident<br>1. be tolerant<br>2. be patient<br>3. be understanding<br>4. be sensitive to needs of resident<br>B. Listen to resident<br>C. Be prepared to handle disagreement and criticism | | |
| 17. Given selected scenarios, identify the stressors for the nurse aide and the resources the nurse aide may use to deal with the stress. | VI. Conflict Management<br>A. Signs of stress at work<br>1. anger or abuse displayed toward resident<br>2. arguing with supervisor<br>3. poor working relations with co-workers<br>4. complaining about responsibilities of job<br>5. having difficulty focusing on work<br>6. experiencing “burn out”<br>B. Resources to assist with stress management<br>1. family<br>2. friends<br>3. supervisor<br>4. place of worship<br>5. mental health agency<br>C. Causes of conflict in the workplace<br>1. misunderstanding<br>2. misinterpretation<br>3. stress | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. poor communication<br>D. Who may be involved in conflict<br>1. resident<br>2. family member<br>3. visitor<br>4. staff<br>E. Conflict involving resident<br>1. report to supervisor<br>2. report to ombudsman<br>a. legal advocate for resident<br>b. investigates complaints<br>c. decides action to take if there is a problem<br>d. educates consumers and care providers<br>e. appears in court/legal hearings<br>f. gives information to public | | |
| 18. Demonstrate conflict management strategies. | F. Strategies for nurse aide to manage conflict<br>1. stay calm, do not become emotional<br>2. remove yourself from the area of the conflict<br>3. be aware of your body language<br>4. do not discuss conflict in front of resident<br>5. speak privately with the person involved in the conflict<br>6. focus on the conflict<br>7. use "I" sentences<br>8. listen to the other person<br>9. ask other person for ideas on how to resolve conflict<br>10. be open to a solution<br>11. may be necessary to agree to disagree<br>G. Critical thinking process | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 1. identify the problem<br>2. list alternatives to solve the problem<br>3. list pros and cons to alternative solutions<br>4. mutually decide on a solution<br>5. evaluate the solution together | | |
| 19. Demonstrate an understanding of boundary violations, use and misuse of social media, and use of cell phones, (pictures and texting) as they relate to the care of residents. | VII. Social media and cell phone use<br>A. Definition of social media – a group of internet-based applications that allow the creation and exchange of user-generated content such as pictures and videos<br>B. Some types of social media<br>1. Twitter<br>2. Facebook<br>3. Snapchat<br>4. Instagram<br>5. YouTube | | |
| 20. Demonstrate the importance of protecting the resident's privacy and confidentiality. | C. CNAs must protect the resident's privacy and confidentiality at all times<br>1. breaches in privacy or confidentiality can be<br>a. intentional – i.e. posting a picture on Facebook of a resident lying in bed<br>b. unintentional – posting a picture of self and a resident on Facebook<br>2. Health Insurance and Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH) protect resident's personal health information and privacy<br>3. if you are aware of any | National Council of State Boards of Nursing (NSCBN) Video Library:<br>• Professional Boundaries in Nursing<br>• Social Media Guidelines for Nurses | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | violation it should be reported, whether intentional, or unintentional<br>D. Use and misuse of resident's social media<br>E. Boundary violations<br>1. NEVER post pictures or videos of residents on any type of social media<br>2. may be subject to criminal penalties and civil sanctions – severe violation up to $250,000 fine and 10 years in federal prison<br>3. may lose license<br>4. may be terminated by employer | | |

# UNIT III – INFECTION CONTROL

(18VAC90-26-40.A.1.b)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. List various types of pathogens that cause disease. | I. Overview of Infection<br>A. Microbes that cause disease (pathogens)<br>1. bacteria<br>a. E. coli (urinary tract infections)<br>i. bacteria found throughout the environment<br>b. Staphylococcus aureus (skin infections)<br>c. Group A Streptococcus (strep throat)<br>d. other bacteria<br>2. fungus<br>a. yeast infections<br>b. athlete's foot<br>c. ringworm<br>3. virus<br>a. *Haemophilus influenzae* (Hib)<br>i. flu – can be caused by different strains<br>ii. prevention with flu vaccine<br>b. common cold<br>c. human immunodeficiency virus (HIV)<br>d. hepatitis<br>e. norovirus (gastroenteritis)<br>i. very contagious causing vomiting and diarrhea<br>4. parasite<br>a. giardia (intestinal parasite)<br>b. roundworm<br>c. tapeworm<br>d. pinworm | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | e. scabies | | |
| 2. Describe the relationship of pathogens to the chain of infection. | B. Chain of infection<br>1. microbe (pathogen)<br>2. reservoir<br>a. place for pathogen to accumulate<br>3. means for microbe to leave reservoir<br>4. method of transmission<br>a. how the pathogen spreads<br>5. portal of entry to host<br>a. how the pathogen enters the new host<br>6. susceptible host<br>a. person infected | | |
| 3. Identify factors contributing to the incidence of infection. | C. Factors contributing to incidence of infection<br>1. number of organisms (pathogens) present<br>a. hospital acquired infection – nosocomial<br>2. virulence of organism or pathogen<br>3. susceptibility of the host<br>a. age<br>b. illness<br>c. chronic disease<br>d. poor nutrition<br>e. poor hygiene<br>f. stress<br>g. fatigue<br>4. environmental conditions that foster<br>growth of pathogens<br>a. food – live or dead matter<br>b. moisture<br>c. warm temperature<br>d. darkness | | |
| 4. Describe sources and | D. Sources of infection | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| sites of infection.<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>5. Identify human defenses against infection. | 1. human<br>a. not washing hands after going to the bathroom<br>b. coughing/sneezing into your hands<br>c. poor hygiene<br>2. animal<br>a. fecal contamination<br>b. cat scratch fever<br>c. deer tick (Lyme disease, Rocky Mountain spotted fever)<br>d. mosquito (West Nile virus, malaria)<br>e. meat that is not prepared to the proper temperature<br>3. environment<br>a. contaminated water<br>b. contaminated food<br>c. food that is not properly refrigerated<br>E. Sites of infection<br>1. respiratory system<br>2. urinary system<br>3. blood<br>4. break in the skin<br>5. intestinal tract<br>F. Human body defenses against infection<br>1. external defenses<br>a. the skin<br>b. mucous membranes<br>c. hair in the nose and ears<br>d. keeping the skin clean<br>e. good oral hygiene<br>2. internal defenses<br>a. immune response<br>i. blood goes to area to clean away pathogens (redness, swelling, warmth) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | ii. white blood cells attack pathogen (pus)<br>iii. increased body temperature (fever) helps to destroy pathogens<br>b. antibodies<br>i. special proteins created by previous exposure to a pathogen<br>ii. created by vaccination to a particular pathogen<br>iii. attack newly arrived pathogens | | |
| 6. List early signs of infection and the importance of reporting signs to a licensed nurse. | G. Early signs/symptoms of infection<br>1. feeling "unwell"<br>2. sore throat<br>3. coughing<br>4. fever/chills<br>5. nausea<br>6. diarrhea<br>7. drainage from a skin wound<br>8. report these signs to appropriate licensed nurse | | |
| 7. Explain why the elderly are so susceptible to infection. | H. Why the elderly are so susceptible to infection<br>1. immune system becomes weaker<br>2. skin becomes thinner and tears more easily<br>3. limited mobility increases risk of pressure sores and skin infections<br>4. decreased circulation slows response of the blood to an infection<br>5. decreased circulation slows wound healing<br>6. catheters and feeding tubes are portals of entry for pathogens<br>7. dehydration increases risk of infection | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 8. malnutrition decreases body's defense mechanisms against infection | | |
| 8. Describe Standard Precautions guidelines. | II. Prevention of Infection<br>A. Standard Precautions<br>1. all blood, body fluids, non-intact skin and mucous membranes are considered infected<br>a. blood<br>b. tears<br>c. saliva<br>d. sputum<br>e. vomit<br>f. urine<br>g. feces<br>h. pus or any fluid from a wound<br>i. vaginal secretions<br>j. semen<br>2. always follow Standard Precautions<br>3. established by Centers for Disease Control (CDC)<br>B. Standard Precautions guidelines<br>1. wash hands before putting on gloves<br>2. wash hands after taking off gloves<br>3. do not touch clean objects with contaminated gloves<br>4. immediately wash all skin contaminated with blood and/or body fluids<br>5. wear gloves if you may come in contact with blood or body fluids<br>6. wear a gown if your body may come in contact with blood or body fluids<br>7. wear a mask, goggles and/or face shield if your face may come in | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | contact with blood or body fluids<br>8. place all contaminated supplies in special containers<br>9. dispose of all sharp objects in biohazard containers<br>10. never recap a needle<br>11. clean all surfaces potentially contaminated with infectious waste | | |
| 9. Compare different methods used to achieve medical asepsis. | C. Medical asepsis<br>1. physically removing or killing pathogens<br>2. uses<br>a. soap<br>b. water<br>c. antiseptics<br>d. disinfectants<br>e. heat<br>3. sanitation<br>a. basic cleanliness<br>b. hand washing<br>c. washing the body, clothes, linen, dishes<br>4 antisepsis<br>a. kills pathogens or stops them from growing<br>b. rubbing alcohol<br>c. iodine<br>5. disinfect<br>a. kills pathogen<br>b. cleaning solutions<br>6. sterilization<br>a. uses pressurized steam to kill pathogens | | |
| 10. Demonstrate proper hand washing technique. | D. Hand hygiene<br>1. most important factor in preventing<br>transmission of pathogens<br>2. alcohol-based solutions are not a | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 11. Demonstrate proper donning and removing technique for personal protective equipment. | substitute for proper hand washing<br>a. hand hygiene must include washing with soap and water versus hand sanitizer<br>3. keep fingernails short and clean<br>4. do not wear artificial nails or tips<br>5. rings and bracelets collect pathogens and should not be worn<br>6. use lotion to keep skin soft and intact<br>7. when to wash hands<br>a. arrival at work<br>b. entering resident's room<br>c. leaving resident's room<br>d. before and after feeding resident<br>e. before putting on gloves and after removing gloves<br>f. after contact with blood or body fluids<br>g. before and after handling food<br>h. before and after drinking and eating<br>i. after smoking<br>j. after handling your hair<br>k. after using the bathroom<br>l. after coughing, sneezing or blowing your nose<br>m. before leaving the facility<br>n. when you get home<br>8. hand washing technique<br>a. use technique in most current Virginia Nurse Aide Candidate Handbook<br>E. Personal protective equipment (PPE)<br>1. barrier between a person and disease<br>2. gloves, mask, gown, goggles, face shield | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 12. Identify various types of isolation precautions. | 3. don and remove PPE<br>a. use technique in most current Virginia Nurse Aide Candidate Handbook<br>F. Isolation precautions<br>1. for residents who may be infected or colonized with certain infectious agents (CDC)<br>2. measures taken to contain pathogens<br>3. follow CDC guidelines or facility policy<br>4. protocols to prevent exposure of other residents/staff to pathogens<br>5. Two levels of isolation precautions<br>a. 1st level - Standard Precautions<br>i. For all resident care<br>ii. For protection from blood and body fluids which may contain infectious agents<br>b. 2nd level – Transmission-based<br>6. Three types<br>a. contact – transmitted by touching such as skin, wound infections, feces, respiratory secretions<br>b. droplet – transmitted by droplets from mouth or nose such as influenza, strep throat, pneumonia<br>c. airborne – transmitted through air, like tuberculosis, chicken pox<br>7. infectious agents commonly seen:<br>a. MRSA (Methicillin Resistant Staphlococcus Aureus)<br>b. VRE (Vancomycin Resistant Enterococcus) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | i. multi-drug resistant bacteria<br>ii. indicative of chronic illness<br>c. C. Diff (Clostridium difficile) – a bacterium which causes inflammation of the colon resulting in diarrhea and serious illness<br>G. Personal hygiene<br>1. keep yourself clean<br>2. wear clean uniform each day<br>3. keep yourself well-hydrated and well-nourished<br>4. give yourself adequate rest/sleep<br>5. if you are ill do not come to work<br>6. keep hair pulled back and secured<br>7. follow facility policy for nails and jewelry | | |
| 13. Describe the disposition of infectious waste material in a health care facility. | H. Disposition of contaminated waste<br>1. infectious waste<br>a. contaminated with blood or body fluids<br>2. biohazard bags used to dispose of infectious waste<br>a. red bags<br>3. biohazard bags are not disposed with ordinary trash<br>a. must be incinerated<br>4. improper disposal of biohazard waste is dangerous for everyone | | |

# UNIT IV – SAFETY MEASURES

(18VAC90-26-40.A.1.c)
(18VA 90-26-40.A.7.g)
(18VAC90-26-40.A.9)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Demonstrate an understanding of the OSHA Bloodborne Pathogen Standard. | I. Prevention of Common Accidents<br>A. Occupational Safety and Health Administration (OSHA)<br>1. federal agency<br>2. responsible for safety and health of workers in USA<br>3. establishes workplace rules for safety<br>4. conducts workplace inspections<br>5. mandates workplace training for safety issues<br>6. Bloodborne Pathogen Standard<br>a. requires regular in-service training<br>b. identifies steps to take when exposed to bloodborne pathogens<br>c. requires employers to provide PPE for staff, residents, visitors<br>d. requires each resident room to have biohazard containers to dispose of contaminated equipment/supplies<br>e. requires employers to provide free hepatitis B vaccine for employees<br>f. examples of bloodborne diseases: AIDS, hepatitis | | |
| 2. List risk factors for | B. Risk factors for common accidents | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| common accidents. | 1. environmental risk factors<br>a. floor – wet, cluttered<br>b. equipment not used properly<br>c. equipment not kept in good repair<br>d. special precautions<br>e. arrangement of furnishings/equipment to allow for a clear walkway (med cart, O2 tank, etc.)<br>f. mirrors<br>g. throw rugs<br>h. shadows<br>i. smells/odors<br>j. lighting<br>k. stairs<br>2. resident risk factors<br>a. functional ability/frailty<br>b. impaired vision<br>c. impaired hearing<br>d. impaired sense of smell<br>e. impaired sense of touch<br>f. impaired memory<br>g. altered behavior<br>h. impaired mobility<br>i. medications<br>3. staff risk factors<br>a. use of equipment without proper training<br>b. being in a hurry<br>c. use of poor body mechanics<br>C. Fall prevention<br>1. fall risks for the elderly resident<br>a. impaired vision<br>b. impaired hearing<br>c. decreased balance/unsteady gait<br>d. impaired memory<br>e. disoriented | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | f. confused<br>g. slower reaction time<br>h. slower movements<br>i. tremors<br>j. medications | | |
| 3. Identify safety procedures to prevent falls in health care facilities. | 2. measures to prevent falls<br>a. keep personal items within reach<br>b. keep call bell within reach<br>c. answer call bell promptly<br>d. encourage resident to wear their glasses<br>e. maintain adequate lighting in areas where resident will ambulate<br>f. lock brakes on movable equipment<br>g. wear non-skid footwear when walking<br>h. wear clothing and footwear that fits properly – not too big or too long<br>i. toilet resident on a regular basis<br>j. keep clear walkway in room and halls<br>k. avoid use of throw rugs<br>l. wipe spills on the floor immediately<br>m. only rearrange resident's furnishings with their approval<br>n. report any equipment not in good working order<br>o. report any frayed electrical cords<br>p. report any observations of high risk resident behavior | | |
| 4. Identify the importance of reporting falls to the | 3. report a fall to appropriate licensed nurse immediately – follow health | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| appropriate supervisor.<br><br>5. Discuss measures to prevent various common accidents in health care facilities. | care facility policy for care of resident who has fallen<br>D. Prevention of scalds and burns<br>1. scalds<br>a. burns caused by hot liquid such as water, coffee or tea<br>b. liquid temperature 140° or greater<br>2. burns<br>a. cigarette burns<br>b. liquid burns<br>c. chemical burns<br>d. electrical burns<br>3. measures to prevent scalds or burns<br>a. water temperature should be 110°<br>b. do not have resident use toe to check water temperature<br>c. staff should check temperature of water before giving resident bath or shower<br>d. use low setting on hair dryers<br>e. do not use microwave oven to prepare a warm soak or application<br>f. encourage resident to allow hot drinks to cool before drinking<br>g. if resident has tremors, encourage use of closed cup when drinking hot liquids<br>h. pour hot liquids away from residents<br>i. require to follow facility smoking policy<br>j. frequently check electrical cords for fraying and report any that are frayed; use safety outlet | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| 6. Identify the information contained on a Safety Data Sheet (SDS). | plugs<br>k. avoid keeping cleaning chemicals in areas where have access<br>l. report a scald or burn to appropriate licensed nurse immediately - follow health care facility policy for care of resident who has been scaled or burned<br>4. Safety Data Sheets (SDS)<br>a. an OSHA requirement in all health care facilities for any dangerous chemical on site<br>b. all staff should have access and know where these are kept<br>c. information included on SDS<br>i. chemical ingredient<br>ii. danger of the product<br>5. PPE to be worn when using chemicals<br>6. correct way to use and clean up the chemical<br>7. emergency action to take if the chemical is spilled, splashed or ingested<br>8. safe handling procedures for the chemical<br>E. Prevention of poisoning<br>1. risk factors<br>a. personal care items – nail polish remover, soaps, perfume, hair products<br>b. cleaning supplies<br>c. some plants/flowers<br>2. Poison Control phone number required to be prominently displayed<br>3. measures to prevent poisoning | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. keep cleaning chemicals in locked cabinet<br>b. check drawers for hoarded food that may have spoiled<br>c. keep medications away from the bedside<br>4. report a poisoning to appropriate licensed nurse immediately<br>a. follow health care facility policy for care of a who has been poisoned<br>F. Prevention of choking<br>1. object blocks the trachea (windpipe)<br>2. risk factors<br>a. difficulty swallowing<br>b. disoriented<br>3. measures to prevent choking<br>a. resident in upright position for eating/feeding<br>b. do not rush resident while eating<br>c. cut food into small pieces<br>d. use thickening for liquids if resident has difficulty with thin liquids<br>e. make sure dentures fit correctly<br>f. report any problems with swallowing or choking to appropriate licensed nurse | | |
| 7. Demonstrate the procedure for dealing with an obstructed airway. | 4. demonstrate how to deal with an obstructed airway<br>a. follow health care facility guidelines for obstructed airway<br>G. Prevention of suffocation<br>1. risk factors<br>a. improperly fitting dentures<br>b. poor feeding technique<br>c. unattended baths | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. use of restraints<br>2. measures to prevent suffocation<br>a. report to appropriate licensed nurse any dentures that do not fit properly<br>b. always have resident in upright position when eating<br>c. never leave resident unattended in a bath tub, whirlpool or shower<br>d. avoid use of physical or chemical restraints | | |
| 8. Discuss the use of restraints, including the reasons to avoid their use. | H. Avoiding the need for restraints<br>1. restraints<br>a. restrict voluntary movement or behavior<br>b. may be physical or chemical<br>2. physical restraints/protective devices<br>a. examples – vest, wrist/ankle restraints, waist/belt restraint, mitt<br>b. bed side rails<br>c. any chair that prevents resident from rising (geriatric table chair; recliner)<br>3. chemical restraints - medication that controls resident's behavior<br>4. problems with restraints/protective devices<br>a. bruising<br>b. decreased mobility<br>i. pressure sores<br>ii. pneumonia<br>iii. incontinence<br>iv. constipation<br>c. social isolation<br>d. stress and anxiety | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | e. increased agitation<br>f. loss of independence<br>g. loss of dignity<br>h. loss of self-esteem<br>i. risk of suffocation | | |
| 9. Explain the importance of and frequency of monitoring the resident while restraints/protective devices are in use. | 5. use of restraints/protective devices<br>a. requires health care provider order<br>b. illegal to use for convenience of the staff<br>c. resident must be continually monitored, at least every 15 minutes<br>d. restraint must be released every 2 hours<br>e. know how to use | | |
| 10. Identify alternatives to restraints/protective devices. | 6. restraint alternatives (restraint-free care) - evaluate situation for cause of behavior or problem by anticipating resident's needs:<br>a. is resident wet?<br>b. is resident soiled?<br>c. is resident tired?<br>d. is resident thirsty?<br>e. is resident hungry?<br>f. is resident bored?<br>7. observe for emotional status<br>8. observe for pain<br>9. is resident confused/disoriented?<br>a. encourage resident independence<br>i. provide meaningful activities<br>ii. encourage to participate in activities to the best of resident's ability<br>iii. redirect the resident's interests<br>b. reduce boredom - encourage | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | resident's engagement<br>i. involve in activities/life enrichment appropriate for resident<br>ii. take resident for walk<br>iii. encourage participation in social activities that are meaningful to the resident<br>iv. provide reading materials<br>v. read to resident if desired<br>10. provide a safe area for resident to ambulate<br>a. well-lighted<br>b. free of clutter<br>c. make sure resident wears non-skid footwear<br>d. provide activity for resident who wanders at night<br>11. reduce tension and anxiety<br>a. toilet every 2 hours<br>b. escort resident to social activities<br>c. provide backrub<br>d. offer snack or drink<br>e. reduce noise level around resident<br>f. play soothing music<br>12. involve family in resident's care<br>a. encourage visits<br>b. encourage participation in care of resident<br>13. other alternatives to restraints<br>a. bed/chair alarms<br>b. specially shaped cushions<br>14. report any changes in resident's behavior | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | or mental status to appropriate licensed nurse<br>15. answer call bells immediately | | |
| 11. Demonstrate the use of good body mechanics. | II. Workplace Safety<br>A. Body mechanics<br>1. definitions<br>a. alignment – keeping muscles and joints in proper position to prevent unnecessary stress on them<br>b. balance – keeping center of gravity close to base of support<br>c. coordinated body movement – using your body weight to help move the object<br>2. lifting<br>a. feet hip distance apart<br>b. back straight<br>c. knees bent<br>d. object close to you<br>e. tighten abdominal muscles<br>f. lift with leg muscles<br>g. keep object close to your body<br>h. keep your back straight<br>3. resident care<br>a. if resident is in bed, raise bed to waist height. Remember to lower bed when you are finished<br>b. push, slide or pull rather than lifting, if possible<br>c. avoid twisting when lifting by pivoting your feet<br>d. do not try to lift with one hand<br>e. ask for help from co-workers<br>f. tell resident what you are planning to do so they can help you, if possible | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| 12. Demonstrate the correct way to assist a falling resident. | 4. assisting the falling resident<br>a. do not try to prevent the fall<br>b. stand behind the resident with arms around his torso<br>c. slide resident down your body and leg, as a sliding board<br>d. ease resident to the floor<br>e. protect the head<br>f. stay with resident and call for help<br>g. report the incident to the appropriate licensed nurse as soon as possible | | |
| 13. Discuss the importance of and methods for reporting incidents/accidents to the appropriate supervisor. | B. Incident/Accident reports<br>1. incident – accident, problem or unexpected event that occurs while providing resident care<br>a. may involve staff, resident and/or visitor<br>2. report should be written as soon as possible after the event<br>a. document exactly what happened<br>b. give time and condition of person involved<br>c. only use facts, not opinions<br>3. information is confidential<br>4. report is given to the charge nurse<br>5. always file an incident report if you are injured on the job<br>a. provides protection for you<br>b. identifies that injury occurred at work<br>C. Fire safety<br>1. fire requires<br>a. object that will burn<br>b. fuel – oxygen<br>c. heat to make the flame | | |
| 14. Identify potential causes | 2. potential causes of fire | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| of a fire in a health care facility. | a. smoking<br>b. frayed/damaged electrical cord/wires<br>c. electrical equipment in need of repair<br>d. space heaters<br>e. overloaded electrical plugs/outlets<br>f. oxygen use<br>g. careless cooking<br>h. oily cleaning rags<br>i. newspapers and paper clutter | | |
| 15. Identify ways to prevent a fire in a health care facility. | 3. ways to prevent fire in a health care facility<br>a. stay with resident who is smoking<br>b. make sure cigarettes and ash are in ashtray<br>c. only empty an ashtray if cigarette and ash are not hot<br>d. report frayed/damaged cords/outlets immediately<br>e. keep fire doors closed and accessible<br>f. keep halls clear and accessible<br>4. RACE<br>a. if fire occurs<br>b. R – remove resident from danger<br>c. A – activate alarm<br>d. C – contain fire by closing doors and windows<br>e. E – extinguish fire if possible or evacuate the area | | |
| 16. Demonstrate the proper use of a fire extinguisher. | 5. use of a fire extinguisher - PASS<br>a. P – pull the pin<br>b. A – aim at the base of the fire<br>c. S – squeeze the handle<br>d. S – sweep back and forth at the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 17. Discuss the sequence of events to be taken if fire is discovered in a health care facility. | base of the fire<br>5. know facility policy/procedure for a fire<br>a. call for help immediately<br>b. know location of fire evacuation plan<br>c. remain calm and do not panic<br>d. remove all persons in the immediate area of the fire (RACE)<br>e. if a door is close, always check it for heat before opening it<br>f. stay low in room when trying to escape fire to avoid the smoke<br>g. use wet towels to block doorways to prevent smoke from entering a room<br>h. use covering over face to reduce smoke inhalation<br>i. if clothing is on fire…Stop…Drop…Roll<br>j. never get into an elevator during a fire; use the stairs | | |
| 18. Discuss the sequence of events to be taken in the event of a disaster. | D. Safety in a disaster<br>1. definition<br>a. sudden unexpected event<br>b. hurricane<br>c. ice/snow storm<br>d. flood<br>e. tornado<br>f. earthquake<br>g. acts of terrorism | | |
| 19. Explain the importance of the facility policy/procedure manual for fire and disaster, including its location. | 2. know where facility disaster policy/procedure manual is located<br>3. know your responsibilities during a disaster<br>a. listen carefully to directions<br>b. follow instructions<br>c. know location of all exits and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 20. Discuss the role of the nurse aide and oxygen use in a health care facility. | stairways<br>d. know where fire alarms and extinguishers are located<br>e. resident safety comes first<br>f. keep calm<br>4. know facility evacuation plan<br>E. Safety precautions for oxygen use<br>1. oxygen use<br>a. resident with difficulty breathing<br>b. prescribed by health care provider<br>2. role of the nurse aide<br>a. observation only<br>b. only licensed person (RN or LPN) can adjust the flow rate<br>3. special safety precautions<br>a. post “No Smoking” and “Oxygen in Use” signs in room and on the door to the room<br>b. smoking is not permitted in the resident’s room or around oxygen equipment<br>c. remove fire hazards from the room such as electrical equipment: razors, hair dryers, radios<br>d. remove flammable liquids from resident’s room: nail polish remover, alcohol<br>e. do not permit candles, lighters or matches around oxygen equipment<br>f. synthetic (man-made fibers), nylon and wool material should not be used around oxygen equipment because they create static electricity which can create a spark and start a fire | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | g. check resident's nose and behind their ears for irritation caused by oxygen tubing and report irritation to appropriate licensed nurse<br>h. learn how to turn off oxygen equipment in case of a fire<br>4. report any changes in the resident's condition to the appropriate licensed nurse<br>5. report any problems with the oxygen equipment immediately to the appropriate licensed nurse | | |

# UNIT V – EMERGENCY MEASURES

(18VAC90-26-40.A.1.c)
(18VAC 90-26-40.A.2.f)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | I. Life-threatening Emergency Measures<br>A. Emergency<br>1. definition<br>a. condition requiring immediate medical or surgical treatment to prevent the resident from having a permanent disability or from dying | | |
| 1. Identify the basic steps a nurse aide should take in any emergency situation. | 2. basic steps for nurse aide in an emergency<br>a. collect information from resident or situation<br>b. call or send for help<br>c. use gloves and a breathing barrier<br>d. remain calm<br>e. know your limitations<br>f. assist medical personnel after help arrives | | |
| 2. Identify symptoms a resident may display when experiencing an emergency. | 3. emergency situations<br>a. change in level of consciousness<br>b. irregular breathing or not breathing<br>c. has no pulse<br>d. severely bleeding<br>e. unusual color or feel to the skin<br>f. choking<br>g. poisoning<br>h. severe pain<br>i. shock<br>j. allergic reaction<br>B. Responding to change in level of consciousness | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 1. definitions<br>a. conscious – mentally alert and aware of surroundings, sensations and thoughts<br>b. confused – disoriented to time, place, and/or person<br>c. unconscious – resident is unable to respond to touch or speech | | |
| 3. Demonstrate the appropriate response to a conscious or unconscious resident in an emergency situation. | 2. responding to conscious resident<br>a. has a pulse and is breathing<br>b. observe skin color, warmth, moisture<br>c. call for help<br>d. question resident regarding pain, illnesses, current medical issues<br>e. take vital signs (VS)<br>f. remain calm<br>g. reassure resident<br>h. stay with resident until help arrives<br>i. document what occurred, the time, and VS<br>3. responding to an unconscious resident<br>a. this is an emergency<br>b. know resident's DNR status<br>c. know facility policy/procedure for activating the EMS or 911<br>d. activate emergency medical system by calling for help or have someone call immediately<br>e. initiate CPR (if facility policy permits) or first aid until EMS or medical personnel arrive | | |
| 4. Demonstrate CPR, including the use of an AED, on an adult manikin (not required by regulation). | 4. responding to resident who has no pulse and is not breathing (if facility policy permits a Nurse Aide to perform CPR and resident is not a DNR) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. follow the most current national guidelines for performing CPR | | |
| 5. Discuss appropriate nurse aide actions for a resident who is bleeding. | II. Basic Emergency Measures<br>A. Bleeding<br>1. call nurse immediately<br>2. put on gloves<br>3. have resident lie down<br>4. apply pressure to source of bleeding with a clean cloth<br>5. elevate source of bleeding above level of the heart, if possible<br>6. place another cloth on top of original cloth if the 1st one becomes saturated<br>7. when help arrives, remove gloves, wash hands and document what occurred | | |
| 6. Discuss appropriate nurse aide actions for a resident who is having a nose bleed. | B. Nose bleed (Epistaxis)<br>1. may be caused by dry air, medical condition, medications<br>2. notify nurse immediately<br>3. put on gloves<br>4. have resident tilt head slightly forward and squeeze bridge of the nose with your fingers<br>5. apply pressure until bleeding stops<br>6. apply ice pack or cool cloth to back of the neck, forehead or upper lip to help slow the bleeding<br>7. stay with resident until bleeding stops<br>8. remove gloves and document what occurred | | |
| 7. Demonstrate appropriate nurse aide actions for a resident who has fainted. | C. Fainting (syncope)<br>1. caused by decreased blood flow to the brain<br>2. notify nurse immediately<br>3. assist resident to floor<br>4. if resident is in chair, have him/her | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | place head between his/her knees<br>5. elevate feet about 12 inches above level of the heart<br>6. take VS<br>7. loosen any tight clothing<br>8. do not leave resident unattended<br>9. if resident vomits, turn on side in recovery position<br>10. after symptoms disappear have resident remain lying down for 5 minutes<br>11. slowly assist resident to seated position<br>12. document what occurred, the time and VS | | |
| 8. Discuss appropriate nurse aide actions for a resident who has vomited. | D. Vomiting (emesis)<br>1. notify nurse immediately<br>2. put on gloves<br>3. use emesis basin, wash basin or trash can<br>4. wipe resident's mouth and nose<br>5. be calm and reassuring to the resident<br>6. when resident is finished offer water or mouthwash to rinse the mouth<br>7. encourage resident to brush teeth or provide oral care to dependent resident<br>8. provide resident with clean clothes and/or clean linen as necessary<br>9. flush vomit down the toilet after showing it to the nurse and wash the basin<br>10. place soiled linen in proper containers<br>11. remove gloves and wash hands<br>12. document time, amount, color, odor and consistency of vomitus | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 9. Discuss appropriate nurse aide actions for a resident who has been burned.<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>10. Explain the signs/symptoms of a heart attack. | E. Burns (1st, 2nd, & 3rd degree)<br>1. notify nurse immediately – assist only as directed by licensed health professional (i.e.-nurse, N.P., physician, P.A.)<br>2. put on gloves to protect resident and self<br>3. lightly cover with dry, sterile gauze, if directed<br>4. never apply butter, oil, or ointment, water or any other solution to a burn<br>5. have resident lie down and wait for EMS to arrive<br>6. stay with resident until help arrives<br>7. remove gloves, wash hands and document what occurred per facility policy<br>F. Heart attack - myocardial infarction (MI)<br>1. Signs - (may differ in males and females)<br>a. c/o "heaviness" or pain in the chest<br>b. female may feel tight discomfort described as a full feeling across entire chest<br>c. c/o pain radiating down left arm (either male or female)<br>d. c/o sharp upper body pain (female)<br>e. difficulty breathing or SOB<br>f. sweating – may be mistaken for hot flash in females<br>g. skin looks pale or bluish<br>h. complaint of nausea or indigestion<br>i. stomach cramps (female)<br>j. jaw pain (female) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 11. Discuss appropriate nurse aide actions for a resident who has signs/symptom of a heart attack. | G. Heart attack - actions<br>1. have resident lie down<br>2. notify nurse immediately<br>3. this is medical emergency<br>4. elevate resident's head to help him/her breathe better<br>5. initiate CPR if necessary<br>6. stay with resident until help arrives<br>7. document what occurred and the time per facility policy | | |
| 12. Discuss appropriate nurse aide actions for a resident who is having a seizure. | H. Seizure<br>1. clear the immediate area of objects that may cause harm<br>2. assist resident to the floor<br>3. notify nurse immediately<br>4. protect the head, but allow remainder of body to move<br>5. note time seizure began<br>6. do not try to put anything in resident's mouth<br>7. after seizure, turn resident on side in recovery position<br>8. document time seizure began, what occurred per facility policy | | |
| 13. Explain the signs/symptoms of a stroke. | I. Signs of a cerebral vascular accident (CVA) such as stroke; remember to act FAST and report to nursing supervisor or appropriate licensed staff immediately<br>1. change in level of consciousness<br>2. complaint of severe headache<br>3. drooping on one side of the face<br>4. weakness on one side of the body<br>5. sudden on-set of slurred speech | | |
| 14. Discuss appropriate nurse aide actions for a resident who is having a stroke. | J. Stroke - actions<br>1. notify nurse immediately<br>2. this is medical emergency<br>3. have resident lie down<br>4. note time of on-set of symptoms | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 5. stay with resident until EMS arrives<br>6. document time of on-set of symptoms and what occurred<br>7. Observe and Report - FAST<br>a. FACE: Does one side of the face droop?<br>b. ARMS: Does one arm drift downward when both arms are raised?<br>c. SPEECH: Is speech slurred or strange?<br>d. TIME: If you observe any of these signs, report to appropriate staff member immediately. This is a medical emergency; follow facility policy for activating 9-1-1<br>K. Shock | | |
| 15. Discuss definition of and causes of shock. | 1. definition<br>a. lack of adequate blood supply to body organs<br>b. medical emergency<br>2. causes<br>a. bleeding<br>b. heart attack<br>c. severe infection<br>d. low blood pressure<br>e. exposure to environmental changes | | |
| 16. Identify the signs/symptoms of shock. | 3. signs/symptoms<br>a. pale or bluish skin<br>b. staring<br>c. increased pulse and respirations<br>d. decreased blood pressure<br>e. extreme thirst | | |
| 17. Discuss appropriate nurse aide actions for a resident who is in shock. | 4. care of resident experiencing shock<br>a. notify nurse immediately<br>b. have resident lie down | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. control any bleeding that you can see<br>d. check VS<br>e. if no respirations or pulse begin CPR<br>f. cover resident with blanket to maintain temperature<br>g. elevate feet about 12 inches<br>h. do not give resident anything to eat or drink<br>i. remain with resident until EMS arrives<br>j. document what occurred<br>L. Diabetic reactions<br>1. mnemonic - hot and dry, sugar high; cold and clammy, need some candy<br>2. low blood sugar (hypoglycemia) | | |
| 18. Explain the signs/symptoms of hypoglycemia. | a. signs/symptoms<br>i. nervous<br>ii. dizzy<br>iii. hungry<br>iv. headache<br>v. rapid pulse<br>vi. disoriented<br>vii. cool, clammy skin<br>viii. unconscious | | |
| 19. Discuss appropriate nurse aide actions for a resident/resident who is hypoglycemic. | b. care of resident with low blood sugar<br>i. notify the nurse immediately<br>ii. if conscious, give glass of orange juice or something to eat that has sugar or complex carbohydrates<br>iii. know facility policy for low blood sugar<br>iv. stay with resident until feels better<br>v. document what symptoms | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | you saw, when they occurred and what you did | | |
| | 3. high blood sugar (hyperglycemia) | | |
| 20. Explain the signs/symptoms of hyperglycemia. | a. signs/symptoms<br>i. increased thirst<br>ii. increased urination<br>iii. increased hunger<br>iv. flushed, dry skin<br>v. drowsy<br>vi. nausea, vomiting<br>vii. unconscious | | |
| 21. Discuss appropriate nurse aide actions for a resident who is hyperglycemic. | b. care of resident with high blood sugar<br>i. notify nurse immediately<br>ii. follow nurse's instructions<br>iii. document what symptoms you saw, when they occurred and what you did | | |

# UNIT VI – CLIENT RIGHTS

(18VAC90-26-40.A.1.d)
(18VAC 90-26-40.A.1.e)
(18VAC 90-26-40.A.4.b)
(18VAC 90-26-40.A.4.h)
(18VAC 90-26-40.A.7.a,b,c,d,e,f)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Identify the four (4) basic rights of all clients/residents. | I. Basic Rights of All Clients/Residents<br>A. Right to be treated fairly and with respect<br>B. Right to live in dignity<br>C. Right to be free from fear<br>D. Right to pursue a meaningful life | | |
| 2. Explain client/resident rights identified in the Omnibus Budget Reconciliation Act (OBRA) and the Health Insurance Portability and Accountability Act (HIPAA). | II. Rights of Clients/Residents of Long-term Care Facilities<br>A. Part of Omnibus Budget Reconciliation Act (OBRA)<br>B. Client/resident has right to:<br>1. make decisions regarding care<br>2. privacy<br>3. be free from physical or psychological abuse, including improper use of restraints<br>4. receive visitors and to share room with a spouse if both partners are clients/residents in the same facility<br>5. use personal possessions<br>6. control own finances<br>7. confidentiality of his/her personal and clinical records<br>8. information about eligibility for Medicare or Medicaid funds<br>9. information about facility's compliance with regulations, planned changes in living | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | arrangement and available services<br>10. voice grievances without discrimination or reprisal<br>11. examine results of recent survey<br>12. exercise his/her rights as a citizen or resident of the U.S.<br>13. remain in facility unless transfer or discharge is required by change in client's/resident's health, ability to pay, or the facility closes<br>14. organize and participate in groups organized by other clients/residents or families of residents including social, religious and community activities<br>15. choose to work at the facility either as a volunteer or a paid employee, but cannot be obligated to work | | |
| 3. Identify nurse aide actions that maintain client/resident privacy and confidentiality. | C. HIPAA (Health Insurance Portability and Accountability Act)<br>i. Federal law since 1996 (Privacy Rule 2000 & Security Rule 2003, Enforcement)<br>b. identifies protected health information that must remain confidential<br>c. only those who must have information for care or to process records can have access to this information<br>d. nurse aide must never share protected health information with anyone not directly involved in care of client/resident (including family members or other clients/residents)<br>e. do not give information over the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | telephone unless you know you are speaking with an approved staff member<br>6. do not share client/resident information on any social media, including photos, videos, texts, and emails<br>7. do not discuss client/resident in public area<br>8. set standards for use of individually identifiable health information use, and electronic records<br>9. set standards for reporting violations | | |
| 4. Identify nurse aide actions that promote the client's/resident's right to make personal choices to accommodate their individual needs. | D. Actions of the nurse aide to promote client/resident rights<br>1. right to privacy and confidentiality<br>a. pull curtain or close door when providing personal care<br>b. cover lap of client/resident sitting in chair/wheelchair<br>c. allow client/resident to use bathroom in private<br>d. allow alone-time with family and visitors<br>e. allow client/resident to have personal alone-time<br>f. only discuss client/resident information with other health care team members when there is a need to know; do not share information with unauthorized family members or with other clients/residents<br>g. do not share client/resident information on any form of social media, including photos, videos, texts and emails | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 5. Identify nurse aide actions that assist the client/resident with their right to receive assistance | 2. right to make personal choices to accommodate individual needs<br>a. client/resident has right to make choices about their care<br>i. may choose own physician<br>ii. participate in planning their therapies, treatments and medications<br>3. right to refuse care, medication<br>a. encourage client/resident to make choices during personal care<br>i. when to bathe/shower<br>ii. what to wear<br>iii. how to style hair<br>b. encourage client/resident to make choices at mealtime<br>i. filling out menu<br>ii. order in which food is eaten<br>iii. what fluids offered<br>c. encourage client/resident to choose activities and schedules<br>d. honor client/resident choices regarding when to get up and when to go to bed<br>e. permit client/resident enough time to make choices<br>f. make offering client/resident choices a habit of providing care<br>g. offer input to Interdisciplinary Care Team regarding client/resident choices<br>h. freedom of sexual expression/gender identity<br>4. assistance resolving grievances and disputes<br>a. listen to client/resident<br>b. obtain all the facts | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| resolving grievances and disputes. | c. report facts to charge nurse<br>d. follow up with the client/resident<br>e. avoid involvement in family matters<br>f. do not take sides<br>g. do not give confidential information to family members<br>h. report disagreements to charge nurse<br>i. remember the nurse aide is the client/resident advocate | | |
| 6. Describe the role of the ombudsman in a long-term care facility. | j. involve the ombudsman of the facility<br>i. legal problem solver on behalf of client/resident<br>ii. listens to client/resident and decides what action to take<br>iii. telephone number is listed in the facility<br>k. client/resident may not be punished or fear retaliation for voicing concerns or complaints | | |
| 7. Identify nurse aide actions that provide the client/resident with assistance necessary to participate in client/resident and family groups and other activities. | 5. provide assistance necessary to participate in client/resident and family groups and other activities<br>a. provide client/resident with calendar of daily activities<br>b. allow time to make choices<br>c. be flexible with client/resident schedule to permit participation in activities<br>d. encourage client/resident to participate in activities<br>e. encourage family to visit<br>f. procure appropriate assistive devices to be able to attend activities<br>i. wheelchair | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | ii. walker<br>iii. cane<br>g. assist client/resident to dress appropriately to attend activities<br>i. glasses<br>ii. hearing aid<br>iii. attractive, clean, appropriate clothing<br>iv. hair care and grooming<br>h. assist client/resident to toilet before attending activities<br>i. provide means to attend activities in facility<br>i. escort or take client/resident to activities in facility<br>ii. return client/resident to room after activities in facility<br>j. families have right to meet with other families to discuss concerns, suggestions and plan activities | | |
| 8. Identify nurse aide actions that maintain the care and security of the client's/resident's personal possessions. | 6. maintaining care and security of client's/resident's personal possessions<br>a. mark all clothing with name and room number<br>b. encourage family to take valuable items and money home<br>c. if client/resident wants to keep valuables, encourage use of lock<br>box or facility safe<br>d. honor privacy of client/resident regarding their possessions<br>e. assist client/resident to keep personal possessions neat and clean | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | f. permit client/resident right to decide where personal items are kept, if possible<br>g. be careful when working around client/resident personal items<br>h. complaint of stolen, lost or damaged property must immediately be reported and investigated<br>i. avoid placing client/resident personal possessions in areas where nursing care is performed | | |
| 9. Identify nurse aide actions that promote client's/resident's right to be free from mistreatment, including abuse, neglect and exploitation. | 7. promoting client's/resident's (vulnerable adults) right to be free from mistreatment, including abuse, neglect, exploitation including misappropriation of resident/resident property and the need to report any instances of such treatment to appropriate staff and/or Adult Protective Services (APS)<br>a. vulnerable adults (clients/residents) have the right (APS philosophy) to:<br>i. to be treated with dignity<br>ii. refuse assistance if they are capable of making decisions<br>iii. make their own choices regarding how and where they live<br>iv. privacy<br>b. vulnerable adults are persons 18 years of age or older who are incapacitated, or persons 60 years of age or older<br>c. mandatory reporting of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | suspicion of willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm or mental anguish – Elder Justice Act<br>d. mandatory reporters include, but are not limited to:<br>i. any person licensed, certified or registered, by health regulatory boards (except veterinarians), any mental health service provider, any person employed by or contracted with a facility working with adults in an administrative, supportive, or direct care capacity, any law enforcement officer<br>e. reports should be made immediately to the local Department of Social Services or toll-free 24-hour APS hotline 1-888-832-3858. As a caregiver, you are uniquely suited to observe mistreatment<br>i. if there is harm/injury, reporting must be immediate<br>ii. if there is harm/injury local law enforcement must be notified | | |
| 10. Define the types of adult abuse recognized in Virginia. | 8. define abuse<br>a. abuse – the intentional infliction<br>of physical pain or injury<br>i. also includes mental anguish and extends to unreasonable confinement – physical or chemical restraints, isolation, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | or other means of confinement without medical orders, when such confinement is used for purposes other than providing safety and well-being of client/resident or those around the individual<br>b. mental (psychological) anguish indicated by a state of emotional pain or distress resulting from activity (verbal or behavioral) or a perpetrator. The intent of the activity is to threaten or intimidate, to cause sorrow, or fear, to humiliate, change behavior or ridicule. Evidence must show that the mental anguish was caused by the perpetrator's activity | | |
| 11. Recognize the indicators of sexual abuse of older or incapacitated adult. | c. sexual abuse – unwanted sexual activity including, but not limited to, an act committed with the intent to sexually molest, arouse, or gratify another person against that person's will, that occurs by force, threat, intimidation, or advantage | | |
| 12. Recognize the indicators of physical abuse of older or incapacitated adult. | d. indicators of physical abuse<br>i. multiple and/or severe bruises, burns, and welts<br>ii. unexplained injuries<br>iii. a mix of old and new bruises (may indicate abuse over time)<br>iv. signs of broken bones and fractures (may complain of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | pain or weakness) | | |
| 13. Recognize the indicators of unreasonable confinement of older or incapacitated adult (client/resident). | e. indicators of unreasonable confinement<br>i. restraints used on chairs or bed<br>ii. an adult who is placed or locked in a room<br>iii. social isolation<br>iv. pressure sores from prolong stays in a restrained position<br>f. indicators of mental of psychological abuse<br>i. verbal assaults, threats, or intimidation by a caregiver<br>ii. the client/resident demonstrates fear of the caregiver<br>iii. the caregiver doesn't allow anyone to visit with the adult alone<br>iv. adult is withdrawn/doesn't communicate in the presence of the caregiver | | |
| 14. Discuss the definition of neglect of vulnerable or incapacitated adults (clients/residents). | 9. define neglect<br>a. any condition that threatens the client's/resident's physical and mental health and well-being. Neglect can include medical neglect in the form of a caregiver withholding medications or aids such as hearing aids, glasses, walkers, or failure to obtain needed medical treatment | | |
| 15. Recognize the indicators of neglect of older or incapacitated adult (client/resident). | b. indicators of neglect<br>i. untreated medical or mental health problems<br>ii. medication not taken or administered as prescribed<br>iii. dehydration and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | malnourishment, including not providing adults with necessary special dietary needs | | |
| 16. Discuss the definition of exploitation of incapacitated adults (clients/residents). | 10. define exploitation<br>a. the illegal use of an adult's resources for profit or advantage. Typically relates to financial exploitation and includes misuse or theft of funds, inappropriate use of property, or the threat to withhold services or care unless financial resources are made available to the other person | | |
| 17. Recognize the indicators of exploitation of older or incapacitated adult (client/resident). | b. indicators of exploitation<br>i. misappropriation of client's/resident's possessions; taking money or personal items that belong to the client/resident<br>ii. deceiving client/resident into signing documents that benefit nurse aide (titles of possessions, bank signature cards, credit card applications)<br>iii. personal belongings, especially those of value are missing after a visit with family or friends<br>iv. if the nurse aide is aware that anyone is attempting to exploit a client/resident (e.g. client/resident tells a nurse aide that a relative made him/her sign papers but he/she doesn't know what | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | was signed), the nurse aide should report it. | | |
| 18. Discuss the definition of negligence of vulnerable or incapacitated adults (clients/residents). | 11. define negligence<br>a. causing harm or injury to another person without the intent to cause harm<br>i. client/resident falls and breaks a hip when transferring from wheelchair to bed because nurse aide forgot to lock brakes on the wheelchair | | |
| 19. Identify actions of the nurse aide that constitute client/resident mistreatment including adult abuse, neglect and/or exploitation. | 12. actions of the nurse aide that constitute abuse<br>a. yelling at client/resident<br>b. directing obscenities toward client/resident<br>c. threatening client/resident with physical injury<br>d. false imprisonment<br>e. withdrawal of food or fluids<br>f. withdrawal of physical assistance<br>g. hitting<br>h. shaking<br>i. biting<br>j. forced isolation<br>k. teasing in a cruel manner<br>l. inappropriate sexual comments or acts<br>13. actions of the nurse aide that constitute neglect<br>a. inadequate personal care<br>b. inadequate nutrition<br>c. inadequate hydration<br>d. failure to turn and reposition a bed ridden client/resident<br>e. living areas not kept neat and clean | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 14. actions of the nurse aide that constitute exploitation<br>a. taking client/resident possessions<br>b. forcing client/resident to perform activities in exchange for care<br>c. asking for or borrowing money from a client/resident<br>d. forging client/resident's signature for personal gain<br>e. unauthorized receipt of gifts or gratuities<br>f. accepting money beyond normal compensation | | |
| 20. Identify signs and symptoms that indicate client/resident abuse, neglect or exploitation. | 15. signs and symptoms that client/resident has been abused, neglected or exploited<br>a. unexplained bruising<br>b. unexplained broken bones<br>c. bruising/broken bones that occur repeatedly<br>d. burns shaped like the end of a cigarette<br>e. bite or scratch marks<br>f. unexplained weight loss<br>g. signs of dehydration such as extremely dry and cracked skin or mucous membranes<br>h. missing hair<br>i. broken or missing teeth<br>j. blood in underwear<br>k. bruising in the genital area<br>l. unclean body and/or clothes<br>m. strong smell of urine<br>n. poor grooming and hygiene<br>o. depression or withdrawal<br>p. mood swings<br>q. fear or anxiety when a | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | particular caregiver is present<br>r. fear of being left alone | | |
| 21. Describe the nurse aide's role as a mandated reporter. | 16. nurse aide is a mandated reporter<br>a. definition<br>i. required by law to report suspected or observed abuse or neglect or exploitation<br>ii. immediately report suspected or observed adult abuse or neglect to appropriate supervisor and/or Adult Protective Services | | |
| 22. Describe the consequences of a report of abuse, or neglect against a nurse aide. | b. civil penalty may be imposed for failure to report<br>c. immunity from criminal or civil liability for making a report in good faith<br>d. protection from employer retaliation from reporting. Employers cannot prevent an employee from reporting directly to APS<br>e. know your facility policy/procedure for reporting suspected or observed abuse, neglect, and/or exploitation<br>f. if the perpetrator is registered, certified or licensed by the Virginia Board of Nursing an investigation will be initiated<br>g. 18VAC90-25-100(2)(e) Virginia Board of Nursing Regulations Governing Nurse Aides identifies disciplinary provisions for nurse aides (abuse, neglect, and abandoning residents)<br>h. 18VAC90-25-100(2)(h) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 23. Explain how the nurse aide can help the client/resident meet their basic needs described by Maslow. | Virginia Board of Nursing Regulations Governing Nurse Aides identifies disciplinary provisions for nurse aides (obtaining money or property of a resident/resident by fraud, misrepresentation or duress)<br>i. 18VAC90-25-81identifies actions nurse aide may take to remove a finding of neglect from certification based on a single occurrence<br><br>III. Holistic Needs of Residents in Long-term Care Facilities<br>A. Maslow's Hierarchy of Needs<br>1. physical needs<br>a. oxygen<br>b. water<br>c. food<br>d. elimination<br>e. rest<br>f. nurse aide helps client/resident meet these needs by encouraging eating, drinking and adequate rest and assisting with toileting, if necessary<br>2. safety and security<br>a. shelter<br>b. clothing<br>c. protection from harm<br>d. stability<br>e. nurse aide helps client/resident meet these needs by listening, being compassionate and caring<br>3. need for love<br>a. feeling loved<br>b. feeling accepted<br>c. feeling of belonging | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. nurse aide helps client/resident meet these needs by welcoming client/resident to facility, encourage interaction with other client/residents<br>4. need for self-esteem<br>a. achievement<br>b. belief in one's own worth and value<br>c. nurse aide helps client/resident meet these needs by encourage client/resident independence, praise, success, promote dignity<br>5. need for self-actualization<br>a. need to learn<br>b. need to create<br>c. need to realize one's own potential<br>d. nurse aide helps client/resident meet these needs by accepting client's/resident's wishes regarding their activities<br>6. each level of need must be accomplished before person can move on to the next level<br>B. Promote client/resident independence<br>1. person-centered care<br>a. values each unique person<br>b. respects personal preferences<br>c. encourages client/resident to direct his/her care<br>d. encourages meaningful engagement<br>e. helps client/resident feel at home<br>f. encourages friendships and relationships<br>2. individualized person-centered multidisciplinary care plan | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. written by nurses and other members of the team<br>b. based on MDS (Minimum Data Set) and other important client/resident data<br>c. nurse aides are important members of the team<br>d. care plan includes<br>i. client/resident strengths and routines<br>ii. eating skills<br>iii. incontinence management<br>iv. skin care<br>v. cognition<br>vi. assistive devices | | |
| 24. Discuss strategies the nurse aide can use to promote client/resident independence. | 3. strategies nurse aide can utilize to promote client independence<br>a. praise every attempt at independence<br>b. overlook failures<br>c. tell client/resident that nurse aide has confidence in his/her ability<br>d. allow client/resident time to do for self<br>e. develop the patience to wait for client/resident to do for self<br>f. attend to other tasks while waiting for client/resident to attempt to do for self<br>g. encourage progressive mobility<br>h. assist with active and passive range of motion<br>i. promote social interaction<br>j. encourage activity<br>k. report progress and/or needs of independence to the appropriate licensed nurse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 25. Define culture, and what represents culture. | C. Provide culturally sensitive care<br>1. culture definition – the arts, beliefs, customs, and institutions of a certain group of people at a particular time<br>a. culture represents the ideas, learned beliefs, values, behaviors, and attitudes groups possess<br>i. gender<br>ii. faith<br>iii. sexual orientation<br>iv. socioeconomic status<br>v. race<br>vi. ethnicity | | |
| 26. Describe cultural sensitivity awareness, ethnic cultures, and national cultures. | 2. cultural sensitivity awareness – the knowledge and interpersonal skills that allow you to understand, appreciate, and embrace individuals from cultures and ethnicity other than your own<br>3. ethnic cultures in the United States<br>a. numerous ethnic cultures<br>b. some ethnic groups may live in the same area<br>c. value and respect each unique person<br>d. learn to embrace cultural differences<br>4. national cultures - various cultures from different parts of the world<br>a. ethnicity is usually by country of origin | | |
| 27. Recognize cultural differences as they relate to clients/residents and their family members. | 5. cultural differences that impact nursing care<br>a. religious differences – respect client's/resident's beliefs<br>b. ethnicity – you will encounter people from different | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | backgrounds<br>c. language barrier – provide available interpreter services per facility policy<br>d. cultural and religious diets – clients/residents may not eat foods that are unfamiliar; family may bring traditional meals; know cultural diet restrictions<br>e. spatial distance – some cultures are uncomfortable when you are in their personal space<br>f. interaction of genders – approach client/resident according to his/her preferred gender identification<br>g. generational interaction – each generation has its own set of values, beliefs, and life experiences; take time to learn from others<br>h. fear of the unknown or what is different<br>i. death and dying<br>j. post mortem care | | |
| 28. Identify strategies to provide culturally sensitive care. | f. strategies to provide culturally sensitive care<br>a. always respect client/resident<br>b. honor resident/family requests to follow cultural guidelines<br>c. provide resident/family privacy<br>d. ask resident/family if they have specific ways of celebrating holidays<br>e. ask if resident/resident has special dietary guidelines to follow<br>f. respect differences in cultural | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | values<br>g. self-awareness of your own culture<br>h. do not stereotype – do not assume because a client/resident is from a certain culture that he/she will behave in a certain way<br>i. do not engage in gossip about clients/residents because of gender preferences or any differences | | |
| 29. Identify developmental tasks for each age group described by Erikson. | D. Stages of human growth and development<br>1. Eric Erikson's Development Tasks<br>a. birth to 1 year<br>i. receives care and develops trust<br>ii. sense of security<br>b. toddler (1-3 years)<br>i. learns self-control (bowel and bladder control) and develops autonomy (self-identity)<br>c. preschool (3-6 years)<br>i. explores the world<br>ii. develops initiative, ambition<br>d. school age (6–9 years)<br>i. gains skills, learns to get along with others<br>ii. develops industry (work)<br>e. late childhood (9-12 years)<br>i. gains confidence<br>ii. develops moral behavior<br>f. teenage or adolescence (13-18)<br>i. changes in the body<br>ii. develops identity (individuality and sexuality)<br>g. young adult (18-40) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | i. starts family<br>ii. develops close relationships and intimacy<br>h. middle adulthood (40-65)<br>i. pursues career<br>ii. physical changes<br>iii. develops generatively (productivity)<br>i. late adulthood (65 and older)<br>i. reviews own life<br>ii. resolves remaining life conflicts<br>iii. accepts own mortality without despair or fear<br>iv. represents major change of focus from previous life tasks | | |
| 30. List psychosocial changes occurring in late adulthood.<br><br>31. Discuss how the changes of late adulthood affect the psychosocial and physical care of the client/resident in long-term care. | E. Psychosocial changes in late adulthood<br>1. self-esteem threatened by physical changes<br>a. graying hair or loss of hair<br>b. wrinkles<br>c. slow movement<br>d. weight<br>e. loss of sex drive and/or decreased libido<br>2. autonomy threatened by<br>a. change in income<br>b. decreased ability to care for self<br>3. relationships and intimacy are threatened by<br>a. death of spouse<br>b. death of family and friends<br>4. coping with aging depends on<br>a. health status<br>b. life experiences<br>c. finances<br>d. education | | |

# UNIT VII – BASIC SKILLS

(18VAC90-26-40.A.2.a,b,c,d,e)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Explain the beginning and ending steps for the nurse aide when providing care to the resident. | I. How to Begin and End Resident Care<br>A. Beginning steps<br>1. before entering resident's room, knock on the door<br>a. resident's room is his home<br>2. identify yourself<br>a. resident has right to know who is going to be caring for them<br>3. identify resident<br>a. shows respect<br>b. use resident's name, not "honey," "sugar," "Bubba"<br>c. assures you have the correct resident<br>4. wash your hands<br>a. Standard Precautions<br>b. prevent spread of infections<br>5. explain what you are going to do<br>a. speak clearly, slowly and directly to the resident<br>b. resident has right to know what to expect<br>c. encourages resident independence and cooperation<br>6. provide for privacy<br>a. resident has right to privacy<br>b. promotes resident dignity<br>c. pull privacy curtain or close the door<br>7. use good body mechanics<br>a. raise bed to waist height<br>b. lock wheels on the bed<br>c. if using a wheelchair, lock the wheels | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 2. Identify changes in mental status that the nurse | d. only use side rails if specifically ordered<br>B. Ending steps<br>1. ensure resident is comfortable<br>a. sheets are wrinkle-free and crumb-free<br>b. helps to prevent pressure sores<br>c. replace pillows and blankets<br>d. resident's body should be in good alignment<br>2. put bed in low position<br>a. promotes resident safety<br>3. if side rails were used as part of the procedure, return them to the position ordered for the resident<br>4. remove privacy measures<br>a. open privacy curtain<br>b. open door<br>c. bath blanket<br>5. place call bell within reach of resident<br>a. permits resident to communicate with staff as needed<br>6. announce to resident when you are leaving the room<br>7. wash your hands before leaving resident room<br>a. prevents spread of micro-organisms<br>b. Standard Precautions<br>8. report any changes to licensed nurse of physical or mental changes observed while providing care<br><br>II. Recognizing Changes in Body Functioning and the Importance of Reporting these Changes to the Appropriate Licensed Nurse<br>A. Changes in mental status | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| aide might observe. | 1. confusion<br>2. combativeness<br>3. agitation<br>4. restlessness<br>5. extreme or unusual verbalization<br>6. expression of fear<br>7. complaints of hallucinations<br>8. being very quiet or withdrawn<br>9. report changes to appropriate licensed nurse | | |
| 3. Identify changes in physical appearance that the nurse aide might observe. | B. Change in physical appearance<br>1. swelling/edema (i.e. hands, or feet, face, abdomen, or any body part)<br>2. pallor, pale skin, yellow skin<br>3. blue lips, hands or feet<br>4. an expression of pain<br>5. change in a mole or wart<br>6. any change in bowel or bladder contents<br>7. any change in breast such as dimple or lump<br>8. any change in genitalia such as discharge<br>9. unusual grimace or drooling of saliva | | |
| 4. Identify changes in appetite that the nurse aide might. | 10. report changes to appropriate licensed nurse<br>C. Change in appetite<br>1. increase in appetite<br>2. decrease in appetite<br>3. report changes to appropriate licensed nurse | | |
| 5. Identify signs of infection that the nurse aide might observe. | D. Signs of infection<br>1. elevated temperature<br>2. chills and/or sweating<br>3. skin hot or cold, flushed or bluish<br>4. area of skin that is inflamed (warm, red, swollen)<br>5. delirium/confusion/change in | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | mental status | | |
| 6. Discuss changes to the skin and hair that occurs in geriatric residents. | E. Age-related changes to skin and hair<br>1. wrinkles (due to less elasticity)<br>2. hair – grey/white, balding<br>3. age spots<br>4. fragile, thinner skin<br>5. dry, itchy skin – due to less oil production<br>6. nails – harder, thicker, brittle, fungus, discoloration | | |
| 7. Identify signs and symptoms that should be reported to the appropriate supervisor or the appropriate licensed nurse during daily care. | 7. what to report to the appropriate licensed nurse<br>a. skin that is abnormally pale, bluish, yellowish, or flushed<br>b. rash, abrasion, bruising<br>c. mole that has changed in appearance<br>d. redness over a pressure point that does not go away within 5 minutes<br>e. area over a pressure point that has become pale or white<br>f. drainage from a wound<br>g. wound that does not heal<br>h. blisters<br>i. swelling<br>j. c/o pain, tingling, numbness, burning<br>k. weight changes | | |
| 8. Describe changes to the musculoskeletal system that may occur in geriatric residents and what to report to the licensed nurse. | F. Age-related changes to the musculoskeletal system<br>1. osteoporosis<br>2. loss of muscle mass<br>3. arthritis<br>4. what to report to the appropriate licensed nurse<br>a. resident has fallen<br>b. area of body that is swollen, red, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | bruised or painful to touch<br>c. complaints of pain when moving a joint<br>d. range of motion for a joint that has decreased movement<br>e. resident limps or has pain when walking or repositioning | | |
| 9. Identify changes to the respiratory system that may occur in geriatric residents and what to report to the licensed nurse. | G. Age-related changes to the respiratory system and what to report to appropriate licensed nurse<br>1. short of breath - lung strength and capacity decrease, voice weakens<br>2. more susceptible to respiratory infections (cold, pneumonia, influenza)<br>3. what to report to the appropriate licensed nurse<br>a. persistent cough, nasal congestion<br>b. changes in respiration<br>c. cough produces sputum that is yellowish, greenish or pinkish<br>d. sudden onset of difficulty breathing<br>e. resident experiences wheezing or gurgling respirations<br>f. skin has blue or gray tinge | | |
| 10. Discuss changes to the cardiovascular system that may occur in geriatric residents and what to report to the licensed nurse. | H. Age-related changes to the cardiovascular system and what to report to appropriate licensed nurse<br>1. heart beats less effectively<br>2. heart rate slows or speeds up<br>3. fluid may accumulate in hands and feet<br>4. orthostatic hypotension<br>5. chest pain due to lack of oxygen to the heart muscle<br>6. high blood pressure or low blood pressure | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 7. what to report<br>a. complaints of chest pain or pressure<br>b. difficulty breathing<br>c. rapid, slow or erratic pulse<br>d. blood pressure that is unusually low or high<br>e. face, lips or fingers are bluish<br>f. shortness of breath on exertion<br>g. complaints of chest or leg pain on exertion<br>h. unusual pain, swelling or redness in legs<br>i. bluish or cool/cold areas on the legs or feet | | |
| 11. Describe changes to the nervous system that may occur in geriatric residents and what to report to the licensed nurse. | I. Age-related changes to the nervous system and what to report to appropriate licensed nurse<br>1. slowed reaction time<br>2. poor balance<br>3. difficulty remembering recent events<br>4. loss of sensation in hands and feet<br>5. reduced grip strength<br>6. what to report<br>a. changes in level of consciousness<br>b. suddenly becomes confused or disoriented<br>c. speech becomes slurred<br>d. eyelid or corner of the mouth begins to droop<br>e. sudden onset of severe headache<br>f. sudden onset of numbness, tingling, loss of sensation in arm, leg or face | | |
| 12. Discuss changes to the eyes and ears that may occur in geriatric residents | J. Age-related changes to the eyes and ears and what to report to appropriate licensed nurse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| and what to report to the licensed nurse. | 1. eyes adjust more slowly to change in light<br>2. becomes more difficult to read small print<br>3. lens becomes cloudy and cataracts form decreasing ability to see<br>4. less tears are produced causing eye to become dry and irritated<br>5. what to report about the eyes<br>a. drainage from eyes<br>b. complaints of dryness<br>c. redness in or around the eyes<br>d. glasses that are broken or do not fit<br>6. outer ear continues to grow<br>7. hearing decreases<br>8. what to report about the ears<br>a. drainage from the ears<br>b. changes in ability to hear<br>c. hearing aid not functioning properly (batteries, wax filters or other maintenance) | | |
| 13. Describe changes to the digestive system that may occur in geriatric residents and what to report to the licensed nurse. | K. Age-related changes to the digestive system and what to report to appropriate licensed nurse<br>1. poor teeth cause less efficient chewing<br>2. decrease in saliva and stomach acids causes poor breakdown of food<br>3. decrease motility in intestinal tract causes constipation<br>4. what to report<br>a. teeth that are loose or painful<br>b. dentures that do not fit or are broken<br>c. choking while eating<br>d. complaints of constipation or abdominal pain | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | e. changes in bowel patterns<br>f. blood in stool | | |
| 14. Identify changes to the urinary system that may occur in geriatric residents and what to report to the licensed nurse. | L. Age-related changes to the urinary system and what to report to appropriate licensed nurse<br>1. kidneys less efficient at filtering waste from the blood<br>2. loss of muscle tone increases risk of urinary incontinence (particularly in women)<br>3. enlarged prostate in men causes<br>a. difficulty starting urine stream<br>b. dribbling between voids<br>c. increased risk of urinary tract infections<br>4. what to report<br>a. complaint of pain or burning upon urination<br>b. frequent complaints of urgency and then unable to void or voids small amount<br>c. urine with a strong or unusual odor<br>d. episodes of dribbling before getting to the toilet<br>e. presence of blood in urine | | |
| 15. Discuss changes to the endocrine system that may occur in geriatric residents and what to report to the licensed nurse. | M. Age-related changes to the endocrine system and what to report to appropriate licensed nurse<br>1. adult onset diabetes mellitus<br>2. what to report<br>a. increased thirst<br>b. increased urination<br>c. increased appetite<br>d. drowsiness and confusion<br>e. cold, clammy skin<br>f. shaky with increased perspiration<br>g. complaint of headache<br>h. sweet smelling breath | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 16. Describe changes to the reproductive system that may occur in geriatric residents and what to report to the licensed nurse. | i. seizure<br>j. loss of consciousness<br>N. Age-related changes to the reproductive system and what to report to appropriate licensed nurse<br>1. menopause<br>2. breast cancer<br>3. prostate cancer<br>4. what to report<br>a. unusual vaginal discharge<br>b. changes in breast tissue<br>i. dimpling, lump, thickening of skin<br>ii. discharge from breast or nipple<br>c. discharge from penis<br>d. pain or burning with urination for male resident<br>e. change in skin of the scrotum<br>f. lump in scrotum | | |
| 17. Discuss six (6) conditions that effect the resident's environment. | III. Caring for the Resident's Environment<br>A. Conditions that affect resident's environment<br>1. cleanliness<br>a. reflection of quality of care<br>b. this is resident's home<br>c. impedes spread of micro-organisms<br>d. everyone's responsibility, not just housekeeping<br>2. odor control<br>a. follow facility policy for handling of waste and soiled linens<br>b. close laundry and waste receptacle lids<br>c. empty urinals, bedside commodes and bedpans promptly<br>d. flush toilets promptly | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | e. use air fresheners as appropriate, per facility policy<br>f. assist resident to maintain personal care and good oral hygiene<br>g. be aware of your personal hygiene, particularly if you are a smoker<br>3. ventilation<br>a. may create drafts<br>b. position resident away from draft<br>c. provide sweaters, blankets and/or lap covers if needed to keep resident warm<br>4. room temperature<br>a. 71° to 81° is OBRA regulation for temperature in long-term care facility<br>5. lighting<br>a. general lighting<br>i. light from the window<br>ii. ceiling lights<br>iii. ask resident for preference<br>iv. encourage light from windows during the day and closed curtains at night<br>b. task lighting<br>i. overbed light<br>ii. light focused on a chair for reading<br>c. night light<br>6. noise control<br>a. provide quiet times for nap or at night time for restful sleep<br>b. answer call bells and telephones promptly | | |
| 18. Identify the six (6) OBRA requirements for a resident room in a long-term | B. Features of a long-term care room<br>1. OBRA requirements for room in long-term care facility | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| care facility. | a. one window<br>b. call system<br>c. odor free<br>d. pest free<br>e. bed wheels lock<br>f. personal supplies are labeled and stored appropriately | | |
| 19. Describe the furnishings located in a typical resident room in a long-term care facility. | 2. bed<br>a. when resident is unattended always keep bed in low position with the wheels locked<br>b. adjustable height, positioning of head and feet<br>c. basic bed positions<br>i. Fowler's<br>ii. semi-fowler's<br>iii. Trendelenburg<br>iv. reverse Trendelenburg<br>d. practice how to use bed<br>i. raise and lower bed<br>ii. lock the wheels<br>iii. raise and lower head<br>iv. raise and lower feet<br>e. siderails (see facility policy)<br>3. overbed table<br>a. fits over bed or chair<br>b. height can be adjusted<br>c. holds personal care items and/or meal tray<br>d. considered a "clean" area<br>e. do not put used urinal or bedpan on overbed table<br>4. bedside table<br>a. stores personal care items, basins, bedpans<br>b. surface area should be kept neat and tidy<br>5. personal furniture<br>a. residents encouraged to bring | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | own furniture to make the room more like home (chairs, chest of drawers, tables, wardrobes)<br>a. keep personal furniture well cared for, dusted and clean<br>6. call bell/intercom system<br>a. communication link between resident and staff<br>b. call bell should always be kept within easy reach of resident<br>c. educate resident on use of call bell<br>7. privacy curtain/room dividers<br>a. divide one room into multiple resident areas<br>b. use to provide privacy when giving resident personal care<br>C. Nurse aide's responsibilities for care of the resident's environment | | |
| 20. Demonstrate the nurse aide's responsibilities for care of the resident's environment. | 1. always knock before entering resident's room<br>2. assist resident to keep room neat and clean<br>3. clean up spills immediately<br>4. assist resident to keep personal Items in good condition<br>5. label all items upon admission<br>6. keep clutter to a minimum<br>7. always straighten up the resident's area after meals and procedures<br>8. assist resident to keep room at comfortable temperature<br>9. do not place urinals on tables used for eating<br>10. flush toilets and empty beside commodes and urinals as soon as they have been used<br>11. use lighting to provide good illumination so resident can see to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | get around the room<br>12. keep noise in hallways to minimum especially at rest times to promote resident's ability to sleep/rest<br>13. always have call bell within easy reach of the resident<br>14. use care when dealing with resident's clothing and personal items so damage, loss or misplacement does not occur<br>15. re-stock resident's supplies every day and prn<br>16. refill water pitcher every shift unless the resident has a fluid restriction | | |
| 21. Describe what the nurse aide should report to the supervisor or licensed nurse regarding the resident's room. | D. What nurse aide should report to the licensed nurse<br>1. piece of equipment or furniture that is not working properly<br>2. resident injured by piece of equipment or furniture in the room<br>3. staff injured by a piece of equipment or furniture in the room<br>4. suspicion that resident is storing unwrapped food in his room<br>5. signs of pests or insects<br>6. resident or family member complains that personal items are missing<br>7. belongings from other residents found in room<br>8. personal item belonging to resident is accidentally broken<br>9. room and/or bathroom is not properly cleaned<br>10. waste receptacles are not consistently emptied<br>11. there is an odor in the room that will not go away | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| 22. Discuss the difference between an unoccupied, closed and open bed and an occupied bed. | E. Making the bed<br>1. unoccupied bed<br>a. no one is in the bed<br>2. closed bed<br>a. when resident is out of bed all day<br>b. completely made with bedspread, blankets and pillows in place<br>3. open bed<br>a. linen is folded down to the foot of the bed<br>b. makes it easier for resident to get into bed by himself<br>4. occupied bed<br>a. made while the resident is in the bed | | |
| 23. Describe the different types of linen the nurse aide uses to make a bed in a long-term care facility. | 5. linen required to make a bed<br>a. mattress pad<br>i. makes mattress more comfortable<br>ii. protects mattress from liquid spills<br>b. top and bottom sheets<br>i. bottom sheet is often fitted<br>ii. top sheet is flat<br>c. draw sheet<br>i. small, flat sheet placed over the middle of the bed<br>ii. goes from resident's shoulders to below buttocks<br>ii. used to help lift or turn resident<br>iii. sides are tucked under the mattress<br>d. bed protector<br>i. absorbent fabric-backed waterproof material<br>ii. used with residents who are | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | incontinent<br>e. blankets<br>i. may be personal or provided by facility<br>f. bedspread<br>i. adds decorative look to room<br>ii. may be personal or provided by facility<br>g. pillow and pillowcases<br>i. for comfort and for positioning resident<br>ii. pillows always covered with pillowcase<br>h. bath blanket<br>i. keep resident warm during bed bath or linen change | | |
| 24. Identify various devices used on the bed in a long-term care facility. | 6. other bed equipment<br>a. pressure-relieving mattresses<br>i. egg-crate mattress<br>ii. alternating air mattress<br>b. bed board<br>i. wood board placed under the mattress to make bed more firm<br>c. bed cradle<br>i. metal frame that prevents top linen from placing pressure on the feet and causing foot drop<br>d. foot board<br>i. piece of wood placed at foot end of mattress to keep the feet in proper anatomical alignment<br>e. fall mats | | |
| 25. Demonstrate correct handling of linen. | 7. how to handle linen<br>a. wash hands<br>b. collect linen in order they will be used on the bed<br>c. do not take linen from one | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | resident room to another<br>d. when carrying linen, take care not to touch linen to your uniform<br>e. wear gloves to remove soiled linen<br>f. when removing linen from the bed turn it from the ends of the bed toward the center of the bed<br>g. NEVER place used linen on the floor<br>h. do not have used linen come in contact with your uniform<br>i. place used linen in receptacle per facility policy<br>j. wash hands | | |
| 26. Demonstrate how to make a closed bed. | 8. make a closed bed<br>a. wash hands<br>b. obtain linen and place on chair or table in resident's room<br>c. flatten bed and raise to waist level<br>d. loosen used linen and place in hamper or linen bag<br>e. remake the bed starting with the bottom sheet with the seams down<br>f. place end of bottom sheet flush with bottom end of mattress, tuck in at top of mattress and make mitered corners at top of mattress<br>g. place draw sheet if appropriate<br>h. place top sheet, seams up, with end of sheet flush with head of mattress, tuck in bottom of sheet, make mitered corners at foot of mattress<br>i. place blanket on bed, flush with | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | top of sheet, fold down blanket and sheet as one at head of bed about 6 inches, tuck blanket under mattress at foot of bed, make mitered corners at foot of bed<br>j. place clean pillowcase on pillow, and pillow at head of bed<br>k. cover pillow and blanket with bedspread and tuck under the pillow<br>l. return bed to low position<br>m. place call bell where resident can reach it<br>n. dispose of used linen<br>o. wash hands | | |
| 27. Demonstrate how to make an open bed. | 9. make an open bed<br>a. follow steps a-j for closed bed above<br>b. standing at head of bed, grasp top sheet, blanket, bedspread and fold down to foot of bed and then bring them back up the bed to make a large cuff<br>c. place clean pillowcase on pillow, and pillow at head of bed<br>d. return bed to low position<br>e. place call bell where resident can reach it<br>f. dispose of used linen<br>g. wash hands | | |
| 28. Demonstrate how to make an occupied bed. | 10. make an occupied bed<br>a. identify yourself by name<br>b. wash hands<br>c. explain procedure to resident<br>d. provide for resident privacy<br>e. place clean linen on clean surface within reach<br>f. adjust bed to waist height | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | g. put on gloves<br>h. loosen top linen from end of bed on side you will work on first<br>i. unfold bath blanket over top sheet to cover resident and remove top sheet keeping resident covered at all times<br>j. raise side rail on far side of bed to protect resident from falling out of bed while you are making it<br>k. after raising side rail, go to other side of bed and assist resident to turn onto side away from you toward the raised siderail<br>l. loosen bottom soiled linen, mattress pad, and protector on the working side<br>m. roll bottom soiled linen toward resident, soiled side inside and tuck it snugly against resident's back<br>n. place mattress pad on bed, attaching elastic corners on working side<br>o. place and tuck in clean bottom linen; finish with bottom sheet free of wrinkles<br>p. smooth bottom sheet out toward resident; roll extra material toward resident; tuck it under resident's body<br>q. if using a draw sheet, place it on the bed and tuck in on your side, smooth it and tuck as you did with the other bedding<br>r. raise side rail nearest you; go to the other side of bed, lower side rail on that side and help resident turn onto clean bottom sheet | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | s. loosen soiled linen; roll linen from head to foot of bed avoiding contact with your skin or uniform; place in laundry hamper or bag; NEVER place linen on the floor<br>t. pull clean linen through as quickly as possible starting with mattress pad; pull and tuck in clean bottom linen just like the other side; finish with bottom sheet free of wrinkles<br>u. assist resident to turn onto back; keep resident covered and comfortable with pillow under head; raise side rail<br>v. unfold top sheet and place over resident, centering it; slip bath blanket or old sheet out from underneath and put in hamper or bag<br>w. place blanket over top sheet, matching top edges; tuck bottom edges of top sheet and blanket under bottom of mattress; miter corners and loosen top linens over resident's feet; fold top sheet over blanket at top of bed by about 6 inches<br>x. remove pillow and change pillowcase placing soiled one in hamper or bag<br>y. remove and discard gloves<br>z. position resident in comfortable position; return bed to low position; return side rails to appropriate position and place call light within resident's reach.<br>aa. take laundry hamper/bag to proper area<br>bb. wash hands | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 29. Discuss the importance of measuring and recording routine vital signs on geriatric residents.<br><br>30. Demonstrate the knowledge of types and use of thermometers to accurately measure and record resident's temperature. | cc. report any resident changes to nurse<br>dd. document procedure using facility guidelines<br><br>IV. Vital Signs (VS)<br>A. Purpose of VS<br>1. measurement of body functions that are automatically regulated<br>2. change may indicate body is out of balance<br>3. indicate if the body is healthy or not<br>healthy<br>B. When are VS measured?<br>1. upon admission to long-term care facility (baseline VS)<br>2. weekly, monthly according to facility policy<br>3. before and after certain medications as ordered by the health care provider<br>4. after diagnostic procedure or surgery<br>5. after a fall<br>6. during an emergency<br>C. Temperature<br>1. types of thermometers and/or methods of taking temperature<br>a. oral – by mouth<br>b. tympanic - in the ear<br>c. NCIT (no contact infrared thermometer) - forehead<br>d. rectal - by rectum (usually distinguished by red to deter use in mouth)<br>e. axillary - under the armpit (axilla)<br>f. most facilities use digital | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | thermometers<br>2. measures the warmth of the body<br>a. adult oral temperature 97.6° - 99.6°<br>b. adult tympanic temp 96.6° - 99.7°<br>c. adult NCIT (forehead) 97.2° - 100.1°<br>d. adult rectal temp. 98.6° – 100.6°<br>e. adult axillary temp. 96.6° - 98.6°<br>3. may be affected by<br>a. age - less fat and decreased circulation lowers the temperature<br>b. exercise - exercise increases body temp.<br>c. circadian rhythm - resident has higher temp. during active times of the day<br>d. stress - increases body temperature<br>e. illness - increases body temperature<br>f. environment - cold environment lowers body temp. (hypothermia), hot environment raises body temperature (hyperthermia)<br>4. signs of hypothermia<br>a. shivering<br>b. numbness<br>c. quick, shallow breathing<br>d. slow movements<br>e. mild confusion<br>f. changes in mental status<br>g. pale/bluish skin<br>5. signs of hyperthermia | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. perspiration<br>b. excessive thirst<br>c. changes in mental status<br>6. signs of elevated temperature due to infection<br>a. headache<br>b. fatigue<br>c. muscle aches<br>d. chills<br>e. skin warm and flushed<br>7. measure, record, and report temperature<br>a. follow facility policy for taking temperature<br>b. follow facility policy for recording<br>c. report changes to licensed nurse | | |
| 31. Report abnormal readings or changes to the appropriate supervisor or licensed nurse. | | | |
| 32. Identify specific factors that may affect the accuracy of the temperature reading. | 8. factors that can affect temperature<br>a. raise the temperature<br>i. eating/drinking something hot<br>ii. smoking<br>iii. wait 10-15 minutes to take temp.<br>iv. physical activity<br>v. heavy clothing or blankets<br>b. lower the temperature<br>i. eating/drinking something cold (wait 10-15 minutes to take temp.)<br>ii. incorrect placement of thermometer<br>iii. not waiting long enough for thermometer to read temperature<br>9. special considerations for taking temperatures<br>a. do not force a rectal thermometer<br>b. do not force tympanic | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | thermometer<br>c. if the temperature seems questionable repeat the process; you may need to use a different thermometer | | |
| 33. Describe the circulation of blood from the heart, to the periphery of the body and back to the heart. | D. Anatomy of the cardiovascular system<br>1. heart<br>a. muscle<br>b. pumps blood throughout the body<br>2. arteries<br>a. blood vessels that carry blood from heart to every part of the body<br>b. transport oxygen to cells of the body<br>3. veins<br>a. blood vessels that carry blood from the cells of the body back to the heart<br>b. transport carbon dioxide from cells back to the lungs<br>4. capillaries<br>a. tiny vessels that connect arteries to veins<br>5. blood<br>a. red blood cells carry oxygen to the cells<br>b. white blood cells fight infection<br>c. platelets form clots to stop bleeding | | |
| 34. Explain what the pulse measures. | E. Pulse<br>1. description<br>a. heart contracts pushing blood out of heart<br>b. that push is the pulse or beat of the heart<br>c. can be felt by applying pressure over an artery | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. tells how many times the heart is contracting or beating in 1 minute<br>e. normal adult rate 60-100 beats/min<br>f. tachycardia > 100 beats/min<br>g. bradycardia < 60 beats/min<br>2. location of pulse points<br>a. radial pulse is on thumb-side of the wrist<br>b. brachial pulse on little finger side of the elbow space<br>c. carotid – either side of the windpipe in the neck<br>d. apical – left ventricle of heart, 5th intercostal space on left side of chest<br>e. femoral - in groin where leg attaches to torso<br>f. popliteal - in space behind the knee<br>3. measure, record, and report pulse | | |
| 35. Demonstrate how to count and record radial pulse. | a. follow the procedure for "Counts and Records Radial Pulse" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>b. use stethoscope to listen to, then count and record apical pulse | | |
| 36. Report any changes or abnormal pulse rates to the appropriate licensed nurse. | c. report any changes or abnormal rate to appropriate licensed nurse<br>4. factors that affect pulse rate<br>a. age - decreases pulse | | |
| 37. Identify specific factors that may affect the accuracy of the pulse rate. | b. sex - males have lower pulse than females<br>c. exercise - increases pulse<br>d. stress - increases pulse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 38. Explain what the blood pressure measures. | e. hemorrhage (bleeding) - increases pulse<br>f. medications - depending on medication may increase or decrease pulse rate<br>g. fever/illness - increases pulse rate<br>F. Blood pressure (BP)<br>1. definitions<br>a. measures force applied to walls of arteries as the heart contracts pushing blood away from the heart<br>b. measured in mm Hg (mercury)<br>c. systolic - top number when BP is reported and recorded<br>i. measures force applied to walls of arteries as the left ventricle contracts pushing blood away from the heart<br>ii. normal adult range less than 120 mm Hg<br>d. diastolic - bottom number when BP is reported and recorded<br>i. measures pressure in the arteries when the heart is resting between contractions<br>ii. normal range less than 80 mm Hg<br>e. hypertension (elevated)<br>i. high blood pressure<br>ii. > 130/80 of higher<br>f. hypotension<br>i. low blood pressure<br>ii. < 90/60<br>g. orthostatic hypotension<br>i. when resident changes position from lying to sitting, or sitting to standing the BP | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | drops<br>ii. when BP drops, resident becomes dizzy, lightheaded and may faint<br>2. equipment needed to take BP | | |
| 39. Identify equipment needed to take a blood pressure. | a. stethoscope<br>b. blood pressure cuff (sphygmomanometer)<br>i. size of cuff should match size of resident's arm<br>ii. electronic<br>iii. aneroid<br>c. alcohol wipes<br>3. measure and record blood pressure | | |
| 40. Demonstrate how to measure and record blood pressure. | a. follow the procedure for "Measures and Records Blood Pressure" per facility policy | | |
| 41. Report any changes or abnormal blood pressure to the appropriate licensed nurse. | b. report any changes or abnormal blood pressure to appropriate licensed nurse<br>4. considerations for where to take BP<br>a. do not take BP in arm with an IV (intravenous line) present<br>b. do not take BP in arm with a shunt used for dialysis<br>c. do not take BP in arm on same side as mastectomy surgery for breast cancer<br>d. do not take BP in arm paralyzed due to stroke (CVA)<br>e. do not take BP in extremity with an amputation<br>f. do not take BP in an arm with a cast<br>g. if both arms have a dialysis shunt or resident has had double mastectomy take BP in thigh using the popliteal pulse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 42. Identify specific factors that may affect the BP reading. | 5. factors affecting BP<br>a. age - increases BP<br>b. exercise - decrease or increase<br>c. stress - increases<br>d. race - ethnicity may affect BP (i.e. -African-Americans more likely to have high BP than Caucasians)<br>e. heredity - familial tendency to high BP<br>f. obesity - increases BP<br>g. alcohol - high intake may increase BP<br>h. tobacco - may increase BP<br>i. time of day - BP lower in morning and higher in the evening<br>j. illness - diabetics and residents with kidney disease may have high BP<br>k. medications | | |
| 43. Identify specific factors that may affect the accuracy of BP reading. | 6. factors affecting accuracy of BP reading<br>a. wrong size cuff<br>b. not inflating cuff sufficiently<br>c. releasing cuff pressure too quickly<br>d. taking BP multiple times in rapid succession in same arm<br>e. cuff placement<br>f. using cuff over clothing<br>g. resident talking<br>h. most recent physical activity | | |
| 44. Define the physiology of respirations, how respirations are measured and terminology related to respirations. | G. Respirations<br>1. definitions<br>a. inspiration – taking air and oxygen into the lungs (inhale), chest rises<br>b. expiration - letting air and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | carbon dioxide out of the lungs (exhale), chest falls<br>c. respiration - 1 complete inhalation and exhalation<br>d. measured in breaths/minute<br>e. normal adult respiratory rate 12-20 breaths/min<br>f. apnea - absence of breathing<br>g. dyspnea - difficulty breathing | | |
| 45. Demonstrate how to count and record respirations. | 2. measure and record respirations<br>a. follow the procedure for "Counts and Records Respirations" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 46. Report any changes or abnormal respirations to the appropriate licensed nurse. | b. report any changes or abnormal respiratory rate to appropriate licensed nurse<br>H. Pain management<br>1. definitions<br>a. fifth vital sign<br>b. different for every person (some residents have higher pain tolerance than others) | | |
| 47. Discuss pain management, the pain scale, and questions the nurse aide may asked to understand the resident's pain level. | c. pain scale<br>i. know facility's pain scale<br>ii. some pain scales are 0-10 and some are 1-10<br>iii. objective value to sensation of pain<br>2. questions to ask to understand resident's pain<br>a. where is the pain?<br>b. when did pain start?<br>c. does the pain go away with rest?<br>d. how long does pain last?<br>e. describe the pain…sharp, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | shooting, dull, ache, burning, electric-like, constant, comes and goes | | |
| 48. Describe observations that the nurse aide can make to understand the resident's pain level. | 3. observations nurse aide may make that indicate resident is experiencing pain<br>a. increased P, R, BP<br>b. sweating<br>c. nausea<br>d. vomiting<br>e. tightening of the jaw<br>f. frowning<br>g. groaning on movement<br>h. grinding teeth<br>i. increased restlessness<br>j. agitation<br>k. changes in behavior<br>l. crying<br>m. difficulty moving<br>n. guarding/protecting an area<br>4. report any complaints or observations of pain to appropriate licensed nurse | | |
| 49. Describe comfort measures the nurse aide can perform in response to the resident's pain. | 5. actions nurse aide can take to alleviate pain<br>a. offer back rub<br>b. assist to change position<br>c. offer warm bath or shower<br>d. encourage slow, deep breaths<br>e. be patient, caring and gentle | | |
| 50. Demonstrate how to measure and record height of a resident. | V. Height and Weight<br>A. Height (per facility policy)<br>1. usually performed on admission<br>2. assist to step onto the scale and measure height by extending height rod<br>3. if unable to stand, may use tape measure while resident is lying on bed | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. record accurately in feet and inches<br>B. Weight<br>1. performed on admission and at regular intervals afterwards (per facility policy)<br>2. ambulatory resident uses standing scale<br>3. portable wheelchair scale, lift & tub scales, and/or bed scale may be available<br>4. measured in pounds or kilograms, per facility policy<br>5. uses<br>a. data on nutritional status of resident<br>b. calculate correct medication dosage | | |
| 51. Demonstrate how to measure and record weight of ambulatory resident. | 6. measure and record weight<br>a. follow the procedure for "Measures and Records Weight of Ambulatory Resident" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 52. Report any changes in weight to the appropriate licensed nurse. | b. report any changes in weight to appropriate licensed nurse | | |
| | VI. Measure and Record Fluid Intake and Output<br>A. Measure and record fluid intake<br>1. fluid taken into the body<br>a. fluid that resident drinks<br>b. liquids that are eaten: soup, jello, pudding, ice cream, popsicles<br>2. measurement<br>a. milliliter (ml)<br>b. ounce (oz) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. 1 oz = 30 ml | | |
| 53. Measure and record fluid intake. | 3. measure and record fluid intake<br>a. convert all fluid measurements into milliliters<br>b. add together all fluid taken into the body<br>c. at end of shift record all fluid intake per facility policy<br>d. fluid taken into the body should be approximately equal to the amount of fluid that the body eliminated | | |
| 54. Identify the major anatomical structures of the urinary system. | B. Urinary system<br>1. kidneys - filter waste products and water out of blood to make urine<br>2. urethra - carry urine from kidneys to bladder<br>3. bladder - collects and holds urine<br>4. ureters - carries urine from bladder to the outside of body<br>5. urine - water and waste products that kidneys filtered out of the blood | | |
| 55. Describe the fluids that can be recorded as fluid output. | C. Fluid output<br>1. fluid that is eliminated by the body<br>a. urine<br>b. vomit (emesis)<br>c. blood<br>d. wound drainage<br>e. diarrhea<br>2. measured in ml or cc<br>3. at end of shift record all fluid output per facility policy<br>4. fluid taken into the body should be approximately equal to the amount of fluid that the body eliminated | | |
| 56. Identify equipment used to measure fluid output. | D. Measure and record urinary output<br>1. equipment<br>a. graduate | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | b. commode hat<br>c. urinal<br>d. catheter drainage bag<br>2. measuring output<br>a. 1ml = 1cc (cc = cubic centimeter)<br>b. 30 ml = 1 oz<br>c. always measure fluid output in graduate, not in urinal, commode hat or catheter drainage bag<br>d. urinary output should not be less than 30ml per hour | | |
| 57. Demonstrate accurate measurement and recording of urinary output. | e. always wear gloves to measure output<br>3. measure and record urinary output<br>a. follow the procedure for "Measures and Records Urinary Output" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 58. Report any changes in urinary output to the appropriate licensed nurse. | b. report unusually low or high urinary output to appropriate licensed nurse | | |
| 59. Identify factors that may affect the resident's urinary output. | 4. factors affecting urinary output<br>a. decreased intake of fluids<br>b. fever (increased temperature)<br>c. increased salt in diet<br>d. excessive perspiration<br>e. medical condition<br>f. medications | | |
| 60. Demonstrate accurate measurement and recording of food intake. | E. Measure and record food intake<br>1. know facility policy<br>a. percentage methods – percentage of each food item<br>i. calculated by dietician<br>ii. record percentage (%) of each item on meal tray eaten<br>iii. add together all the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 61. Report any changes in food intake to the appropriate licensed nurse. | percentages and record total percent of meal eaten<br>iv. some facilities use percentage of entire meal rather than percentage of each item on meal tray<br>b. be accurate and consistent<br>c. at end of shift record all food intake per facility policy<br>d. report unusually small or large food intake to appropriate licensed nurse | | |

# UNIT VIII – PERSONAL CARE SKILLS

(18VAC90-26-40.A.3.a, b, c, d, e, f, g)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | I. Guidelines for Assisting with Personal Care<br>A. Definitions<br>1. hygiene<br>a. methods of keeping the body clean<br>2. grooming<br>a. hair, nail and foot care<br>b. shaving facial hair<br>3. diaphoretic<br>a. perspired, sweaty | | |
| 1. Identify the components of personal care. | B. Components of personal care<br>1. bathing<br>2. oral hygiene<br>3. shaving<br>4. back rub<br>5. dressing and undressing<br>6. hair care<br>7. nail care<br>8. elimination<br>9. bed-making | | |
| 2. Explain routine personal care for both morning and bedtime. | C. Routine personal care (with attention to resident preference)<br>1. early AM care<br>a. after waking and before breakfast<br>b. going to the bathroom<br>c. washing hands, face<br>d. mouth care<br>2. morning (AM) care – preparing for the day<br>a. take resident to bathroom or assist with elimination<br>b. assist to wash hands<br>c. before or after breakfast | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | (resident preference) assist with mouth care/denture care<br>d. assist with bathing<br>e. provide a back rub<br>f. helping resident to dress in day-time clothes<br>g. assisting resident with hair care, shaving, hand care, foot care, make-up<br>h. make bed<br>i. tidy room<br>3. evening (PM) care – preparing for bedtime<br>a. offer bedtime snack and fluid, if appropriate<br>b. take resident to bathroom or assist with elimination<br>c. assist with bathing, if resident preference; otherwise assist to remove make-up, if appropriate, wash hands and face<br>d. help with mouth care/denture care<br>e. help with hair care<br>f. assist to put on night clothes<br>g. provide back rub<br>h. prepare bed for resident<br>i. tidy room | | |
| 3. Describe person-centered care (PCC).<br><br>4. Explain why it is important to provide PCC in the long-term care environment. | D. Person-centered care (PCC) - promotes choice, purpose and meaning in daily life<br>1. resident can direct care and services<br>2. resident choice fosters engagement and improves quality of life<br>3. resident lives in an environment of trust and respect<br>4. resident is in a close | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | relationship with staff that are attuned to his/her changes and can respond appropriately<br>5. resident continues to live in a way that is meaningful to him/her | | |
| 5. Describe the guidelines for assisting the resident with person-centered personal care. | E. Guidelines for assisting with personal care in a person-centered home-like environment<br>1. promote resident dignity<br>a. address by name<br>b. treat as an adult<br>c. explain what you will be doing<br>d. provide privacy during personal care<br>2. promote resident independence<br>a. encourage resident to perform tasks<br>b. provide time for resident to perform tasks<br>3. respect resident preferences<br>a. permit resident to make choices regarding clothing, hair style, make-up<br>b. allow resident to choose when to take bath or perform mouth care<br>4. follow resident's routine<br>a. routine may be comforting<br>b. allows resident choice in care<br>5. follow care plan instructions<br>a. consistency among staff helps to prevent behavior problems<br>b. assures that resident receives all the care and assistance they require | | |
| 6. Explain what the nurse aide is able to observe while assisting the resident with personal care. | F. Observation during personal care<br>1. skin<br>a. areas that are red, white, bluish<br>b. areas of broken skin<br>c. bruises | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. edema<br>e. condition of fingernails and toenails<br>f. blisters<br>g. odors<br>2. mobility<br>a. difficulty walking<br>b. difficulty raising arms to dress<br>c. difficulty repositioning<br>3. flexibility<br>a. difficulty bending a joint | | |
| 7. Identify different pain scales (per facility policy). | 4. complaint of pain (verbal or nonverbal)<br>a. location of pain<br>b. cause of pain<br>c. description of pain<br>d. duration of pain<br>e. what causes pain to cease<br>5. change in level of consciousness<br>a. drowsy<br>b. confused<br>c. disoriented to person, place, time<br>d. not able to arouse<br>II. Bathing | | |
| 8. Identify the purpose of bathing. | A. Purpose<br>1. clean the skin<br>2. eliminate body odor<br>3. relax and refresh resident<br>4. exercise muscles<br>5. stimulate blood flow to skin<br>6. improve resident self-esteem<br>7. nurse aide can observe skin | | |
| 9. Identify the supplies required for bathing. | B. Supplies<br>1. soap (resident may have personal preference for type of soap used)<br>2. wash clothes<br>3. bath towels<br>4. clean clothes<br>5. non-skid footwear | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 6. gloves<br>7. lotion/cream/oil<br>8. deodorant<br>9. shampoo<br>C. Types of baths<br>1. shower<br>2. tub bath<br>a. uses a whirlpool or bath tub<br>3. partial<br>a. face, underarms, hands, perineal area, feet<br>b. can be performed in bathroom or while resident is in bed<br>4. bed bath<br>a. resident unable to leave bed<br>b. entire body washed while resident in bed | | |
| 10. Describe the safety guidelines the nurse aide should follow when assisting the resident to bathe. | D. Safety guidelines during bathing<br>1. follow nursing care plan for special instructions<br>2. if nurse aide cannot handle resident alone, ask for help<br>3. gather all supplies before entering the bathing area and put them where they are easily accessible<br>4. resident should wear non-skid shoes to and from the bathing area<br>5. keep resident covered on way from room to bathing room<br>6. have bathing room warm before bringing resident to room<br>7. follow facility policy for cleaning bathing area before and after resident use<br>8. make sure floor in bathing area is dry before resident walks on it<br>9. use non-slip mats in tub<br>10. hand rails and grab bars should be sturdy and secured to the walls | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 11. do not leave resident unattended in bathing area<br>12. check water temperature before resident tests water (should not be greater than 105°F.); test on inside of wrist or elbow<br>13. have resident check water temperature (not too hot; not too cold)<br>14. wear gloves to bathe resident<br>15. do not have electrical items (razors, hair dryers) near water source | | |
| 11. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor/licensed nurse. | 16. remember to report any observations of changes in resident's condition or behavior to appropriate supervisor | | |
| 12. Explain the importance of following the correct sequence of bathing. | E. Order of bathing<br>1. clean to dirty to prevent transferring micro-organisms from one part of the body to another<br>2. eyes first – nose to temple (no soap)<br>3. face (no soap)<br>4. ears<br>5. neck<br>6. arms, underarms (axilla), hands – from torso outward<br>7. chest<br>8. abdomen<br>9. legs, feet – from torso downward<br>10. back<br>11. perineum<br>12. buttocks | | |
| 13. Demonstrate how to give a shower. | F. Giving a shower<br>1. Supplies<br>a. soap (resident may have personal preference for type of soap used<br>b. washcloths<br>c. towels<br>d. clean clothes | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | e. non-skid footwear<br>f. gloves<br>g. lotion/cream/oil<br>h. deodorant<br>i. shampoo<br>2. make sure shower room is clean, including shower chair<br>3. explain procedure to resident<br>4. with resident's input gather clean clothing, personal toiletries<br>5. have resident wear non-skid footwear<br>6. transport resident to shower room, making sure resident is fully covered and warm<br>7. lock wheels of shower chair when resident has been transported to shower<br>8. test temperature of water before running water on resident<br>9. put on gloves<br>10. assist resident to undress, removing non-skid footwear last<br>11. encourage resident to wash face, arms, chest, abdomen, and hands<br>12. wash resident's back, legs, feet and perineum<br>13. rinse, being careful to remove all soap residue<br>14. cover resident's back with towel after washing and rinsing to keep resident warm<br>15. unlock shower chair wheels, roll resident to dressing area and dry with bath towels, including under breasts and between the toes<br>16. place bath blanket around shoulders to keep resident warm<br>17. apply deodorant and lotion per | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 14. Accurately document performance of a shower on facility ADL Form.<br><br>15. Demonstrate how to give a tub bath. | resident's request and as needed<br>18. remove gloves and wash hands<br>19. assist resident to put on clean clothes, including non-skid footwear<br>20. return resident to room<br>21. assist with remainder of grooming: hair care, shaving, nail care<br>22. help resident to comfortable position<br>23. place call bell within reach<br>24. wash hands<br>25. be courteous and respectful to resident at all times<br>26. report any observations of changes in resident's condition or behavior to appropriate supervisor<br>27. document on ADL (Activities of Daily Living) form or designated documentation tool per facility policy<br>G. Giving a tub bath<br>1. equipment is the same as shower<br>2. make sure tub room is clean, including the bathtub<br>3. explain procedure to resident<br>4. with resident's input gather clean clothing, personal toiletries<br>5. have resident wear non-skid footwear<br>6. ambulate or transport resident to tub room, making sure resident is fully covered and warm<br>7. lock wheels of tub chair or tub lift when resident has been safely transferred to chair or lift<br>8. test temperature of water and fill tub half-full with warm water<br>9. put on gloves | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 10. assist resident to undress, removing non-skid footwear last<br>11. encourage resident to wash face, arms, chest, abdomen, and hands<br>12. wash resident's back, legs, feet and perineum<br>13. rinse, being careful to remove all soap residue<br>14. cover resident's back with towel after washing and rinsing to keep resident warm<br>15. remove resident from tub and dry with bath towels, including under breasts and between the toes<br>16. place bath blanket around shoulders to keep resident warm<br>17. apply deodorant and lotion per resident's request and as needed<br>18. remove gloves and wash hands<br>19. assist resident to put on clean clothes, including non-skid footwear<br>20. return resident to room<br>21. assist with remainder of grooming: hair care, shaving, nail care<br>22. help resident to comfortable position<br>23. place call bell within reach<br>24. wash hands<br>25. be courteous and respectful to resident at all times<br>26. report any observations of changes in resident's condition or behavior to appropriate supervisor | | |
| 16. Accurately document performance of a tub bath on facility ADL Form. | 27. document on ADL (Activities of Daily Living) Form or designated documentation tool per facility policy | | |
| 17. Demonstrate how to | H. Giving a partial bath | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| give a partial bed bath. | 1. used on days resident does not receive complete bath or shower<br>2. explain procedure to resident<br>3. with resident's input gather clean clothing, personal toiletries<br>4. have resident wear non-skid footwear<br>5. transport resident to bathroom, making sure resident is fully covered and warm<br>6. lock wheels of chair when resident has been transported to bathroom<br>7. if giving a partial bed bath, raise level of bed to waist-height of the nurse aide (lock bed wheels)<br>8. test temperature of water at sink or before filling bath basin about half-full<br>9. Have resident test water temperature (not too hot; not too cold)<br>10. put on gloves<br>11. assist resident to undress, removing non-skid footwear last<br>12. encourage resident to wash face, underarms, and hands<br>13. assist resident to wash perineum remembering to wash front to back, rinse front to back and dry front to back<br>14. help resident to rinse being careful to remove all soap residue<br>15. apply deodorant and lotion per resident's request and as needed<br>16. remove any wet bed linens<br>17. remove gloves and wash hands<br>18. assist resident to put on clean clothes, including non-skid footwear | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 18. Accurately document performance of a partial bed bath on facility ADL Form.<br><br>19. Demonstrate how to give a complete bed bath. | 19. remake bed, if needed<br>20. assist with remainder of grooming: hair care, shaving, nail care<br>21. help resident to comfortable position chair or bed)<br>22. place call bell within reach<br>23. if partial bed bath was given, return bed to low position<br>24. wash hands<br>25. be courteous and respectful to resident at all times<br>26. report any observations of changes in resident's condition or behavior to appropriate supervisor<br>27. document on ADL (Activities of Daily Living) Form, or designated documentation tool per facility policy<br>I. Giving a complete bed bath<br>1. supplies are the same as above with addition of bath basin<br>2. explain procedure to resident<br>3. provide resident privacy be pulling privacy curtain or closing resident's door<br>4. with resident's input gather clean clothing, personal toiletries<br>5. test temperature of water at sink before filling bath basin about half-full and taking to bedside<br>6. have resident verify water temperature is OK<br>7. raise level of bed to waist-height of the nurse aide and lock wheels of bed<br>8. cover resident with bath blanket to maintain warmth and remove night clothing<br>9. put on gloves | | |

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| | 10. beginning with eyes, wash eyes with wet washcloth (no soap) using different area of washcloth for each eye, washing from the nose toward the temple<br>11. wash remainder of face<br>12. dry face with towel<br>13. keeping resident covered with bath blanket, expose one (1) arm placing a clean, dry towel under the exposed arm<br>14. with soap on the washcloth, wash arm, hand and underarm<br>15. rinse arm, hand, underarm and pat dry with towel and place under bath blanket<br>16. repeat process for 2nd arm<br>17. expose resident's chest and abdomen and with soap on washcloth wash chest (including under the breasts) and abdomen<br>18. rinse and dry chest and abdomen and cover with bath blanket<br>19. expose one leg and foot and place clean, dry towel under leg<br>20. with soap on the washcloth, wash leg and foot (including between the toes) and rinse<br>21. dry leg and foot with towel that is underneath leg<br>22. cover leg and foot with bath blanket<br>23. repeat process for 2nd leg and foot<br>24. wash front of perineum, front to back<br>a. use clean area of washcloth for each stroke<br>b. using clean washcloth, rinse soap from perineum, front to back using clean area of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 20. Accurately document performance of a | washcloth for each stroke<br>25. dry perineum, front to back with towel<br>26. return bed to low position<br>27. empty bath basin and refill with clean, warm water<br>28. raise bed to comfortable level for the nurse aide and raise side rail on opposite side of bed<br>29. turn resident on side toward raised side rail and wash rectal area with clean washcloth and soap front to back with clean area of washcloth for each stroke<br>30. dry with towel<br>31. reposition resident<br>32. apply deodorant and lotion per resident's request and as needed<br>33. remove gloves and wash hands<br>34. assist resident to put on clean clothes, including non-skid footwear, if appropriate<br>35. assist with remainder of grooming: hair care, shaving, nail care<br>36. help resident to comfortable position<br>37. place call bell within reach<br>38. return bed to low position<br>39. empty, rinse, dry basin and store per facility policy<br>40. dispose of soiled washcloths, towels and linen per facility policy<br>41. be courteous and respectful to resident at all times<br>42. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>43. document on ADL (Activities of Daily Living) Form, or designated | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| complete bed bath on facility ADL Form.<br><br>21. Demonstrate how to give modified bed bath (face, 1 arm, hand and underarm).<br><br><br><br>22. Identify terms associated with oral hygiene. | documentation tool per facility policy<br>J. Give a modified bed bath<br>1. skill required for NNAAP testing<br>a. follow the procedure for "Gives Modified Bed Bath" in the most current edition of Virginia Nurse Aide Candidate Handbook<br><br>III. Oral Hygiene<br>A. Definitions<br>1. oral hygiene<br>a. teeth<br>b. gums<br>c. tongue<br>d. bridge<br>e. dentures<br>2. periodontal disease - diseases of the gums<br>3. plaque<br>a. sticky, colorless deposit that forms on teeth<br>b. develops when food containing carbohydrates is left on the teeth<br>c. bacteria live in plaque and destroy the tooth enamel causing tooth decay<br>4. tartar<br>a. plaque left on teeth more than 24 hours hardens into tartar<br>b. promotes tooth decay and gum disease, gingivitis<br>5. gingivitis<br>a. inflammation of gums caused by bacteria and plaque that remain on teeth<br>b. can be prevented with regular brushing, flossing and cleaning by a dentist | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 6. periodontitis<br>a. inflammation of gums becomes more severe<br>b. gums pull away from teeth allowing bacteria and food to accumulate<br>c. gums become infected<br>d. teeth become loose and fall out or must be removed<br>7. halitosis<br>a. bad breath<br>b. caused by poor oral hygiene<br>c. bacteria and plaque build-up around un-brushed teeth producing odor<br>8. bridge<br>a. may be permanent or removable<br>b. bridge a gap between resident's own teeth with a false tooth/teeth<br>c. attach to resident's own teeth<br>9. edentulous - toothless<br>10. dentures<br>a. removable replacement for teeth and gums<br>b. all resident's teeth are removed<br>c. may have upper – replaces teeth in upper jaw<br>d. lower denture – replaces teeth in lower jaw | | |
| 23. Demonstrate an understanding of the importance of oral hygiene. | B. Purpose of oral hygiene<br>1. Keep mouth clean<br>2. remove food and bacteria from teeth, tongue, gums, cheeks<br>3. prevent tooth decay and gum disease<br>4. prevent bad breath | | |
| 24. Describe observations that the nurse aide may make while providing oral | C. Observations to make while assisting with oral care<br>1. lips | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| hygiene to a resident.<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>25. Identify the guidelines for good oral hygiene. | a. dry<br>b. cracked<br>c. bleeding<br>d. chapped<br>e. cold sores (fever blisters)<br>2. tongue, gums, and cheeks<br>a. red, white or swollen areas<br>b. sores or white spots<br>c. bleeding<br>3. teeth<br>a. loose<br>b. cracked<br>c. chipped<br>d. broken<br>e. discolored<br>f. missing<br>4. dentures (partial, upper, lower)<br>a. chipped<br>b. cracked<br>c. fit poorly<br>5. breath<br>a. bad breath that does not go away with brushing<br>b. fruity aroma to breath<br>6. difficulty swallowing<br>a. gagging<br>b. choking<br>7. resident complains of pain in mouth<br>D. Guidelines for good oral hygiene<br>1. brush teeth after each meal and at bedtime<br>2. floss once a day<br>3. rinse dentures after each meal<br>4. remove dentures at bedtime and soak overnight in soaking solution<br>E. Supplies to provide oral care<br>1. toothbrush<br>2. toothpaste<br>3. emesis basin | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. gloves<br>5. towel<br>6. glass of water<br>7. denture cup for resident with dentures<br>8. floss<br>9. mouthwash<br>F. Provide mouth care | | |
| 26. Demonstrate how to provide mouth care. | 1. consider the toothbrush as a "clean" instrument throughout procedure<br>2. encourage resident to be as independent as he can<br>3. independent resident may only need assistance gathering supplies or transport to the bathroom<br>4. follow the procedure for "Provides Mouth Care" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 27. Accurately document performance of mouth care on facility ADL form. | 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility policy | | |
| 28. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>G. Provide mouth care for edentulous resident | | |
| 29. Demonstrate how to provide mouth care for an edentulous resident. | 1. even though teeth are absent, mouth care is important<br>2. use foam-tipped applicators moistened with mouthwash or half-strength mouthwash/hydrogen peroxide to clean gums<br>3. use applicators to clean tongue<br>4. rinse mouth with mouthwash | | |
| 30. Accurately document performance of mouth care on facility ADL form. | 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 31. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | policy<br>6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>H. Flossing teeth<br>1. purpose<br>a. cleans food and bacteria from between teeth where toothbrush cannot reach<br>2. equipment<br>a. dental floss<br>b. gloves<br>c. towel<br>d. water for resident to drink<br>e. emesis basin | | |
| 32. Demonstrate how to floss a resident's teeth. | 3. procedure<br>a. identify yourself to resident<br>b. explain what you will be doing<br>c. provide privacy<br>d. wash hands<br>e. gather supplies<br>f. place resident in upright sitting position with towel over chest<br>i. if resident in bed, raise bed to waist-height and lower side rail closest to you<br>g. put on gloves<br>h. wrap ends of floss securely around each of your index fingers<br>i. beginning with back teeth, using a sawing motion, move floss up and down between teeth<br>j. gently slip floss into space between gum and tooth<br>k. repeat on each side of the tooth<br>l. after every 2 teeth, unwind floss and use a new area of floss<br>m. offer resident water to drink and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | provide emesis basin to spit the water into<br>n. clean resident's mouth with towel<br>o. return bed to low position, replace side rail as appropriate<br>p. place call bell within reach of resident<br>q. clean and return supplies to appropriate storage area<br>r. remove and dispose of gloves and used floss | | |
| 33. Accurately document performance of flossing teeth on facility ADL form. | s. wash hands<br>t. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy | | |
| 34. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | u. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>I. Provide denture care | | |
| 35. Demonstrate how to provide denture care. | 1. always wear gloves when handling dentures<br>2. dentures are very expensive, handle with care<br>3. always store in water<br>a. prevents cracking<br>4. follow the procedure for "Cleans Upper or Lower Denture" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 36. Accurately document performance of denture care on facility ADL form. | 5. document procedure on Activities of Daily Living form or designated documentation tool, per facility policy | | |
| 37. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse | | |

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| 38. Demonstrate how to provide mouth care for an unconscious resident. | J. Provide oral care for unconscious resident<br>1. require frequent mouth care<br>a. prevent mucous membranes from drying<br>b. keep teeth and gums moist<br>c. keeps lips moist to prevent cracking<br>2. supplies<br>a. toothbrush or foam-tipped applicator<br>b. toothpaste or cleaning solution<br>c. gloves<br>d. towel<br>e. emesis basin<br>f. lip lubricant<br>3. procedure<br>a. identify yourself to resident and explain what you will do, even though resident is unconscious<br>b. provide resident privacy<br>c. wash hands<br>d. gather supplies<br>e. raise bed to waist-height and lock wheels of bed<br>f. lower side rail closest to you<br>g. turn resident on side, facing you<br>h. put on gloves<br>i. place towel under resident cheek and chin<br>j. place emesis basin next to cheek and chin to catch fluid from mouth<br>k. using moistened toothbrush or foam-tipped applicator gently clean teeth, gums, tongue<br>l. rinse and remoisten brush or applicator as needed<br>m. when finished use towel to dry | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | resident's face<br>n. remove towel and basin<br>o. apply lip lubricant<br>p. reposition resident<br>q. replace side rail to appropriate position<br>r. return bed to low position<br>s. place call bell within resident's reach<br>t. clean and store equipment<br>u. dispose of linen<br>v. remove gloves and wash hands | | |
| 39. Accurately document performance of mouth care for the unconscious resident on facility ADL form. | w. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy | | |
| 40. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | x. report any observations of changes in resident's condition or behavior to appropriate licensed nurse | | |
| 41. Identify the components of personal grooming. | IV. Grooming<br>A. Maintaining neat, clean, and well-groomed appearance<br>1. hair care<br>2. shaving<br>3. make-up<br>4. fingernail care<br>5. foot care | | |
| 42. Explain how to shampoo a resident's hair. | B. Hair care<br>1. shampooing resident's hair<br>a. always ask resident if he/she wants hair shampooed<br>b. many facilities have beauty shop for resident to use weekly or bi-weekly<br>c. easiest to perform during shower<br>i. provide resident cloth to cover/protect eyes | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | ii. with hand-held shower head, wet hair with warm water<br>iii. apply resident's preferred shampoo and lather, gently massaging scalp<br>iv. thoroughly rinse shampoo from hair<br>v. towel dry hair and wrap hair in towel to transport resident back to room<br>vi. document procedure on Activities of Daily Living form, per facility policy<br>vii. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>d. shampoo in bed (some facilities have shampoo basin for use in bed)<br>e. dry, powder shampoo may be used for bed-ridden resident | | |
| 43. Demonstrate how to provide hair care. | 2. daily hair care<br>a. improves self-esteem<br>b. resident chooses how to style his/her hair<br>c. brushing hair massages scalp<br>d. prevents tangles<br>3. equipment<br>a. resident's own comb and/or brush<br>b. mirror<br>c. towel<br>d. hair care items requested by resident<br>4. procedure to provide hair care<br>a. identify yourself to resident and explain what you will be doing<br>b. gather supplies | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. wash hands<br>d. provide for resident privacy<br>e. place towel over shoulders to collect hair that comes out while combing/brushing<br>f. gently comb/brush hair starting at the ends and working toward the scalp<br>g. remove tangles first<br>h. then brush hair from scalp to ends of hair<br>i. style as resident prefers<br>j. clean hair from comb and/or brush and return equipment to appropriate storage<br>k. dispose of towel per facility policy<br>l. position resident comfortably<br>m. place call bell within resident's reach | | |
| 44. Accurately document performance of hair care on facility ADL form. | n. wash hands<br>o. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy | | |
| 45. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | p. report any observations of changes in resident's condition or behavior to appropriate licensed nurse | | |
| 46. Explain guidelines for nurse aide when shaving a resident. | C. Shaving<br>1. guidelines for shaving men facial hair<br>a. respect resident preference<br>b. follow the facility policy for shaving<br>c. some residents do not wish to shave daily<br>d. always wear gloves when shaving | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | e. before shaving with safety or disposable razor, soften facial hair with warm, moist cloth<br>f. always shave in same direction as the hair grows<br>g. follow resident preference for shaving and after-shave products<br>h. discard disposable razors in the biohazard container<br>i. never cut or trim resident's facial hair without their permission | | |
| 47. Describe the different types of razors including how the nurse aide would use each type. | 2. supplies<br>a. electric razor<br>i. safest<br>ii. does not require shaving cream or soap<br>iii. prevents nicks and cuts<br>iv. should be used if resident receiving anti-coagulant medications<br>v. do not use near water source or when oxygen is in use<br>b. disposable razor<br>i. requires shaving cream or soap<br>ii. may make nicks or cuts because they are very sharp<br>c. safety razor<br>i. requires shaving cream or soap<br>ii. blades need to be changed when become dull<br>iii. dispose of old blades in biohazard container<br>iv. may make nicks or cuts because they are very sharp<br>d. towels<br>e. washcloth<br>f. mirror | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 48. Demonstrate how to shave a resident. | g. shaving cream or soap<br>h. gloves<br>3. procedure for shaving male resident<br>a. identify yourself and explain what you will be doing<br>b. gather supplies<br>c. fill basin half-full of warm water for use with resident in bed<br>d. provide for resident privacy<br>e. if resident is in bathroom, position him in front of mirror<br>f. if resident is in bed, raise bed to waist-height, lower side rail closest to you and raise head of bed to sitting position<br>g. put on gloves<br>h. for safety or disposable razor<br>i. drape towel over resident's chest<br>ii. moisten beard with warm, moist cloth<br>iii. apply shaving cream or lathered soap to cheeks, chin and front of neck<br>iv. holding skin taut shave in direction hair grows (downward on face, upward on neck)<br>v. rinse razor frequently to get rid of excess cream/soap/whiskers<br>vi. offer mirror to resident for approval<br>vii. wash, rinse and dry face and neck<br>viii. apply after-shave per resident preference<br>ix. remove and dispose of towel<br>x. remove gloves and wash hands<br>i. for electric razor | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 49. Accurately document shaving on facility ADL form.<br><br>50. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>51. Discuss procedure for shaving a female resident. | i. do not use near the sink<br>ii. place towel on resident's chest<br>iii. put on gloves<br>iv. apply pre-shave lotion per resident preference<br>v. holding skin taut shave with smooth, even, circular motions if razor has 3 heads, otherwise go back and forth in direction of hair growth (downward on face and upward on neck)<br>vi. offer mirror to resident for approval<br>vii. apply after-shave per resident preference<br>viii. remove and dispose of towel<br>ix. remove gloves and wash hands<br>x. remove any loose hairs from resident<br>xi. position resident comfortably<br>j. if in bed, return bed to low position<br>k. place call bell within resident's reach<br>l. clean razor of hair and/or soap<br>m. return equipment to appropriate storage<br>n. document procedure on Activities of Daily Living form, per facility policy<br>o. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>4. procedure for shaving a female resident<br>a. always obtain resident consent<br>b. some women want to shave unwanted facial | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | c. hair, underarm hair and/or leg hair follow same procedure as for male resident<br>D. Make-up | | |
| 52. Explain why make-up may be important for the resident. | 1. important for sense of well-being and self-esteem<br>2. follow resident's wishes regarding make-up<br>3. encourage independence but assist as required<br>4. many residents also like to wear jewelry during the day: necklace, pin, etc.<br>5. take time to follow resident's preferences | | |
| 53. Identify the importance of fingernail care. | E. Fingernail care<br>1. purpose of nail care<br>a. nails collect micro-organisms<br>b. long, jagged nails can scratch resident, care giver or another resident<br>c. improves self-esteem | | |
| 54. Describe guidelines the nurse aide should follow when providing nail care. | 2. guidelines for nail care<br>a. do not cut with scissors or trim with nail clippers<br>b. file nails straight across using emery board and shape the nail<br>c. no shorter than the end of the finger<br>d. never share nail equipment between residents | | |
| 55. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 3. observations nurse aide may make<br>a. pain or tenderness in hands/fingers<br>b. dry, cracked skin<br>c. bruising<br>d. discolored nail beds<br>4. supplies<br>a. orangewood stick | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| . <br><br><br><br><br>56. Demonstrate how to provide fingernail care. | b. emery board (nail file)<br>c. lotion<br>d. basin with warm water<br>e. soap<br>f. gloves<br>g. towel<br>5. provide fingernail care<br>a. identify yourself by name<br>b. wash your hands<br>c. explain procedure to resident<br>d. provide for privacy with curtain, screen or door<br>e. if resident is in bed, adjust bed to safe level, usually waist high and lock the wheels<br>f. fill basin halfway with warm water, no warmer than 105° and place basin at comfortable level for resident (have resident check water temperature)<br>g. put on gloves<br>h. soak resident's hands and nails in water at least 5 minutes<br>i. remove one hand from water, wash with soapy wash cloth; rinse; pat dry with towel, including between fingers<br>j. place hand on towel<br>k. gently clean under each fingernail with the orangewood stick, wiping orangewood stick on towel after cleaning under each nail<br>l. repeat steps i-k for the second hand<br>m. wash and rinse both hands again and dry thoroughly between fingers<br>n. shape fingernails with emery | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | board or nail file<br>o. finish with nail smooth and free of rough edges<br>p. apply lotion from fingertips to wrists<br>q. empty, rinse and dry basin before placing in designated dirty supply area or returning to storage per facility policy<br>r. place soiled clothing and linens in proper containers<br>s. remove and discard gloves before washing your hands<br>t. make resident comfortable<br>u. return bed to low position and remove privacy measures<br>v. place call bell within reach of resident<br>w. wash hands | | |
| 57. Accurately document performance of fingernail care on facility ADL form. | x. document procedure on Activities of Daily Living form, per facility policy<br>y. report any observations of changes in resident's condition or behavior to appropriate licensed nurse | | |
| 58. Discuss the importance of foot care. | F. Foot care<br>1. purpose<br>a. prevent foot odor<br>b. prevent infection<br>c. prevent pressure ulcer<br>d. prevent complications of diabetes mellitus<br>e. provides nurse aide opportunity to observe feet and toes<br>f. long toenails make wearing shoes uncomfortable | | |
| 59. Identify guidelines for foot care. | 2. guidelines of foot care<br>a. nurse aide may not cut toenails, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | corns or calluses<br>b. always dry feet thoroughly, including between the toes<br>c. put on clean socks every day | | |
| 60. Discuss observations that the nurse aide may make while providing foot care. | 3. observations the nurse aide may make during foot care<br>a. dry skin<br>b. breaks or tears in the skin (including between toes)<br>c. ingrown nails<br>d. red areas on the feet, heels, or toes<br>e. drainage or bleeding<br>f. change in color of skin or nails<br>g. heels that are soft or whitish or discolored<br>h. corns, blisters, calluses, warts<br>i. complaints of pain, burning or tenderness in feet, heels, or toes<br>j. rash<br>k. unusual odor<br>4. supplies<br>a. basin<br>b. towels<br>c. soap<br>d. lotion<br>e. gloves<br>f. washcloth<br>g. clean socks | | |
| 61. Demonstrate how to provide foot care. | 5. provide foot care<br>a. follow the procedure for “Provides Foot Care on One Foot” in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 62. Accurately document performance of foot care on facility ADL form. | b. document procedure on Activities of Daily Living form, per facility policy<br>c. report any observations of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 63. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>64. Describe the importance of daily dressing.<br><br>65. Discuss guidelines the nurse aide should follow when helping a resident to dress | changes in resident's condition or behavior to appropriate licensed nurse<br><br>V. Dressing<br>A. Purpose<br>1. everyone should dress in clean clothes every day<br>2. promotes self-esteem<br>3. cleanliness helps to prevent odors<br>B. Guidelines for dressing resident (explain procedure and provide privacy)<br>1. encourage resident to be as independent as possible within their capabilities<br>2. provide resident opportunity to make choices regarding what clothing to wear<br>3. allow resident time to make decisions and choices<br>4. clothing should be appropriate to time of year, temperature of surroundings<br>5. all of resident's clothing should be labeled with name and room number<br>6. handle resident's clothing with care<br>7. report to supervisor any clothing that needs to be repaired in any way<br>8. provide resident privacy when dressing or undressing<br>9. report to supervisor or family clothing and shoes that are too big or too small<br>10. begin dressing on the weak side<br>11. begin undressing on the strong side<br>12. dresses that open in the front are easier to put on than ones that open | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | in the back<br>13. slacks, skirts and pants with elastic waistbands are preferable<br>14. shoes should have non-skid soles | | |
| 66. Identify assistive devices that are useful for residents when they are dressing themselves. | 15. to promote resident independence, assistive clothing devices may be required<br>a. zipper-pull<br>b. extended shoe horn<br>c. button hole helper<br>d. long handled graspers<br>e. Velcro openings | | |
| 67. Explain observations the nurse aide may make when assisting the resident to dress. | C. Observations nurse aide may make when assisting resident to dress<br>1. change in flexibility of joints<br>2. weakness of one side of body<br>3. loss of weight if clothing becomes loose<br>4. gaining weight if clothing becomes tight | | |
| 68. Identify safety measures and precautions the nurse aide should be aware of when assisting the resident to dress. | D. Safety measures and precautions when assisting resident to dress and undress<br>1. clothing should fit properly<br>a. not too long<br>b. not too tight<br>c. not too loose<br>2. shoes should have non-skid soles<br>3. encourage resident to sit when putting on socks/stockings and shoes<br>4. provide sweaters and long-sleeved tops if resident complains of feeling cool or cold | | |
| 69. Demonstrate how to dress resident with affected (weak) right arm. | E. Dress resident<br>1. if resident is independent, provide assistance as requested<br>2. if resident needs assistance follow the procedure for "Dresses Resident with Affected (weak) Right Arm" | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 70. Accurately document dressing on facility ADL form.<br><br>71. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | in the most current edition of Virginia<br>Nurse Aide Candidate Handbook<br>a. document procedure on Activities of Daily Living form, per facility policy<br>b. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>3. Care of resident's personal clothing<br>a. labeled with name and room number<br>b. place in hamper for laundry when soiled or when removed at end of the day<br>c. store clean clothes per facility policy<br>d. report to supervisor and/or family clothing that needs to be mended<br>e. report to supervisor and/or family clothing/shoes that no longer fit | | |
| 72. Explain the anatomy and physiology of the urinary system. | VI. Toileting<br>A. Anatomy and physiology of urinary system<br>1. kidneys<br>a. most people have 2 kidneys, one on each side of the small of the back<br>b. cleanse and filter the blood<br>c. regulate the balance of water, sodium, potassium<br>d. remove toxins and waste products from blood<br>e. assist to regulate blood pressure<br>2. urine - fluid created by kidneys | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | from the water and waste products filtered from the blood<br>3. ureters - thin tube that carries urine from each kidney to the bladder<br>4. bladder - collects urine<br>5. internal urethral sphincter - muscle that holds the neck of the bladder closed, keeping the urine in the bladder<br>6. urethra - tube that carries urine from bladder to the outside of the body<br>a. about 3- 4 inches long in females<br>b. about 7 – 8 inches long in males<br>7. external urethral sphincter - muscle that contracts to prevent urine from exiting the urethra<br>8. urethral meatus - opening to the outside of the body at the end of the urethra<br>B. Process of passing urine from the body<br>1. voiding<br>2. micturating<br>3. urinating<br>C. Urinary incontinence<br>1. unable to control the internal sphincter<br>2. involuntary passing of urine | | |
| 73. Define the terms used in the urinary system. | D. Definitions<br>1. hematuria - blood in the urine<br>2. anuria – no urine<br>3. dysuria – painful urination<br>4. nocturia – urinating at night<br>5. polyuria – excessive urination | | |
| 74. Describe age-related changes seen in the urinary system. | E. Age-related changes to the urinary system<br>1. kidneys do not filter the blood as efficiently<br>a. increase in blood pressure<br>b. urethral sphincter muscle tone | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | decreases<br>i. increases risk of urinary incontinence<br>2. bladder is not able to hold as much urine before the sensation that it needs to empty<br>a. more frequent urination<br>3. bladder does not empty completely<br>i. increased risk of urinary tract infection | | |
| 75. Identify normal characteristics of urine. | F. Urine<br>1. color<br>a. pale yellow – normal<br>b. dark yellow to amber – dehydrated<br>c. can be affected by food, medications and/or illnesses<br>2. clarity<br>a. should be clear<br>b. cloudy – sign of infection<br>3. odor<br>a. smells of ammonia<br>b. foods can affect smell – asparagus<br>4. amount<br>a. adults produce 1200-1500 ml/24 hours<br>b. minimum is 30ml/hour<br>5. should not contain<br>a. blood<br>b. pus<br>c. mucus<br>d. bacteria<br>e. glucose<br>f. sediment | | |
| 76. Identify abnormal characteristics of urine | 6. report the following to the appropriate licensed nurse<br>a. cloudy urine | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| that the nurse aide should report to the appropriate supervisor. | b. dark or rust-colored urine<br>c. strong, offensive smelling urine<br>d. fruity-smelling urine<br>e. blood, pus, mucus in urine<br>f. bacteria or glucose in urine<br>g. sediment<br>h. complaints of pain or burning on urination<br>i. frequent urinary incontinence<br>j. resident wakes up frequently during the night to urinate | | |
| 77. Explain the guidelines the nurse aide should follow to promote normal urination patterns. | G. Guidelines to promote normal urination<br>1. provide privacy<br>2. take to the bathroom as needed<br>3. assist male residents to stand to void, if possible<br>4. if resident must use bedpan, raise head of bed to sitting position<br>5. encourage adequate fluid intake<br>6. provide fresh water in easy reach of resident<br>7. frequently offer residents fluids to drink<br>8. encourage activity and exercise<br>9. teach Kegel exercises to female residents<br>10. answer call bells promptly<br>11. take resident to bathroom every 2 hours to avoid incontinence | | |
| 78. Discuss common disorders of the urinary system, including their signs and symptoms. | H. Common disorders of the urinary system<br>1. urinary tract infection (UTI)<br>a. usually a bacterial infection<br>b. causes<br>i. wiping incorrectly and contaminating urethra with bowel movement<br>ii. not emptying the bladder | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | completely<br>iii. indwelling urinary catheter<br>c. symptoms<br>i. urgency<br>ii. complaints of pain or burning with urination<br>iii. urinating frequently in small amounts<br>iv. blood in urine<br>v. lower abdominal pain<br>vi. flank pain<br>vii. change in mental status or behavior<br>viii. nausea<br>d. measures to avoid UTI<br>i. wipe perineum front to back<br>ii. drink plenty of fluids<br>iii. Vitamin C helps to prevent UTI<br>a) orange juice<br>b) cranberry juice<br>iv. take shower rather than tub bath<br>e. report to nurse<br>i. complaints of pain or burning on urination<br>ii. foul-smelling urine<br>iii. dark-colored urine<br>iv. blood in urine<br>v. resident voids frequently in small amounts<br>vi. urine that looks cloudy<br>vii. sediment in urine<br>2. urinary retention<br>a. possible causes<br>i. in men – commonly caused by enlarged prostate - benign prostatic hypertrophy (BPH) | | |

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| | ii. in women – may be caused by cystocele (sagging of the bladder) and rectocele (sagging of the lower part of the colon)<br>b. symptoms<br>i. unable to empty bladder completely<br>ii. frequent urge to void<br>iii. difficulty starting urine stream<br>iv. weak flow of urine stream<br>v. dribbling after finished voiding<br>vi. distended lower abdomen<br>c. report any of the above 6 symptoms to the appropriate licensed nurse<br>3. urinary incontinence<br>a. involuntary loss of urine from the bladder<br>b. decreased muscle tone at internal or external sphincter allows urine to "leak"<br>c. symptoms<br>i. urine leaks when resident coughs, sneezes, laughs<br>ii. resident cannot "make it to the bathroom in time"<br>4. chronic renal failure<br>a. kidneys do not function correctly<br>b. unable to filter waste products and toxins from blood<br>c. unable to regulate water balance and blood pressure<br>d. life-threatening<br>e. most frequent causes<br>i. high blood pressure<br>ii. diabetes mellitus<br>f. symptoms | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | i. unexplained weight gain<br>ii. itching<br>iii. fatigue<br>5. end-stage renal disease (ESRD)<br>a. kidneys stop functioning<br>b. resident requires dialysis or kidney<br>transplant<br>i. dialysis - resident's blood flows through a machine that filters out waste products, toxins and extra water<br>a) usually performed 3 times per week<br>b) required to keep resident alive | | |
| 79. Identify equipment used with the urinary system. | I. Equipment used with the urinary system<br>1. urinal<br>a. mostly used by male residents but there are female urinals (ask if your facility uses them)<br>b. placed between resident's leg with penis in the urinal<br>c. can be used standing, sitting or lying down<br>d. do not store on same table used to serve meal tray<br>e. provide privacy for use<br>2. bedpan (can be used by both male and female)<br>a. used when resident is unable to get out of bed<br>b. two types<br>i. regular - wide, rounded end placed under resident's buttocks<br>ii. fracture pan – used when resident has had hip surgery; | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | thin end is placed under resident's/resident's buttocks<br>c. may be very uncomfortable and may damage the resident's/resident's skin<br>3. bedside commode<br>a. chair frame with a toilet seat and collection bucket<br>b. kept at bedside for residents unable to walk into bathroom<br>4. catheter<br>a. tube inserted through the urinary meatus into the bladder<br>b. drains urine from the bladder<br>c. 3 types<br>i. straight – temporary – removed as soon as bladder is emptied<br>ii. indwelling – remains in bladder to continuously drain urine into a collection bag<br>iii. condom – fits over the penis and drains urine into a drainage bag<br>a) Texas catheter is another name<br>5. urinary drainage bags<br>J. Care for resident with urinary incontinence | | |
| 80. Discuss how to provide care to the resident/resident with urinary incontinence.<br><br>81. Demonstrate how to provide perineal care. | 1. can be emotionally traumatic for resident and family<br>2. treat with respect and dignity<br>3. follow the procedure for "Provides Perineal Care (Peri-Care) for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>4. adaptations of peri-care for male resident | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 82. Accurately document performance of perineal care on facility ADL form.<br><br>83. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | a. if resident is not circumcised retract foreskin of penis<br>b. hold penis by the shaft<br>c. wash in circular motion from tip of penis down toward the body<br>d. use clean area of washcloth for each stroke<br>e. wash scrotum, then the groin<br>f. rinse and dry<br>g. turn resident on side<br>h. wash, rinse, dry rectal area<br>i. document procedure on Activities of Daily Living form, per facility policy<br>j. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>5. management of urinary incontinence<br>a. answer call bell promptly<br>b. encourage fluids<br>c. encourage resident to walk or exercise<br>d. toilet resident q2h<br>e. resident wears incontinent pad or brief<br>f. check pad or brief q2h for dryness and change if wet<br>g. keep perineum clean and dry to prevent odor and skin breakdown<br>h. change wet clothing immediately<br>i. treat resident with respect and dignity<br>j. anticipate need to toilet<br>k. resident may need a catheter<br>K. Care of resident with a catheter<br>1. Guidelines for the indwelling | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | catheter<br>a. always wear gloves when emptying catheter drainage bag<br>b. do not touch tip of the clamp to any object when draining the bag<br>c. do not touch the drainage spout to the graduate<br>d. drainage bag should always be lower than the level of the hips or bladder to prevent urine flowing back into the bladder<br>e. never hang the drainage bag from the side rail of the bed<br>f. hang drainage bag from bed frame<br>g. do not have the drainage bag on the floor<br>h. catheter tubing should not touch the floor<br>i. check catheter tubing frequently to assure it is not kinked<br>k. catheter tubing should drape over the thigh, not be under the leg<br>l. use catheter strap to position catheter over the thigh<br>m. do not place tubing over the side rail<br>n. always clean perineum front to back to prevent infection<br>o. keep perineum clean and dry to prevent infection<br>p. do not disconnect drainage tubing from the catheter<br>q. notify appropriate licensed nurse immediately if drainage tubing becomes disconnected | | |
| 84. Demonstrate how to provide catheter care. | 2. Care of the resident with an indwelling catheter | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 85. Accurately document performance of catheter care on facility ADL form. | a. follow the procedure for "Provides Catheter Care for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>b. document procedure on Activities of Daily Living form, per facility policy<br>c. report any observation of changes in resident's condition or behavior to appropriate licensed nurse | | |
| 86. Demonstrate how to empty a urinary drainage bag. | 3. measuring urinary output<br>a. always wear gloves<br>b. always measure with a graduate<br>i. do not use lines on urinal or drainage bag to measure urine output<br>c. place graduate on counter top and bend knees to have urine level at your eye level to measure<br>d. measure in milliliters (ml)<br>i. 1ml=1cc (cc= centimeter)<br>ii. 30 ml = 1 ounce (oz)<br>4. how to empty a drainage bag<br>a. identify yourself and explain what you will be doing<br>b. wash hands and put on gloves<br>c. provide for privacy<br>d. obtain graduate<br>e. place paper towel on floor under graduate<br>f. open clamp on drainage bag and allow urine to empty into graduate<br>g. empty entire content of drainage bag<br>h. close clamp and return to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 87. Accurately document urinary output.<br><br>88. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>89. Discuss how to collect routine urine specimen. | housing on drainage bag<br>i. measure urine in bathroom by placing graduate on counter top and reading at eye level<br>j. empty urine into toilet and flush<br>k. rinse and dry graduate and store per facility policy<br>l. remove gloves and wash hands<br>m. document output per facility policy<br>n. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse<br>L. Urinary specimens<br>1. routine urine specimen<br>a. not a sterile specimen<br>b. can be obtained from bedpan, urinal or speci-hat (collector that fits over the porcelain bowl of the toilet and under the seat)<br>c. equipment needed<br>i. specimen container and lid<br>ii. completed label and lab slip<br>iii. gloves<br>iv. means to collect urine<br>v. supplies for perineal care<br>d. procedure<br>i. identify yourself and explain what you need the resident to do<br>ii. provide for privacy<br>iii. wash hands and put on gloves<br>iv. assist resident to toilet with speci-hat, bedside commode (BSC), or provide urinal or bedpan<br>v. instruct resident to urinate | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 90. Accurately document specimen collection.<br>91. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>92. Discuss how to collect clean-catch urine specimen. | but put toilet paper in trash for disposal<br>vi. remove gloves and wash hands<br>vii. assist resident to return to comfortable position in room<br>viii. put on clean gloves<br>ix. in bathroom, pour urine into specimen cup until cup is half full, keeping outside of cup clean<br>x. place lid on cup and label immediately<br>xi. rinse and dry any equipment used to collect urine<br>xii. remove gloves and wash hands<br>xiii. place call bell within easy reach of resident<br>xiv. document specimen collection per facility policy<br>xv. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse<br>2. clean-catch urine specimen (mid-stream specimen)<br>a. used to determine the presence of bacteria in the urine<br>b. resident urinates a small amount to clear the urethra, stops, if possible, then collects sample<br>c. procedure for collecting clean-catch specimen<br>i. identify yourself and explain what you need the resident to do<br>ii. provide for privacy | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | iii. wash hands and put on gloves<br>iv. assist resident to bathroom<br>v. open specimen kit keeping inside of specimen cup from touching anything<br>vi. instruct resident to clean perineum prior to obtaining specimen<br>a) female – separate labia and clean front to back in 3 separate strokes with a clean towelette or wipe each time<br>- down the left side<br>- down the right side<br>- down the middle<br>b) male – clean head of penis with circular strokes using clean towelette for each stroke<br>- if uncircumcised, pull back foreskin and clean as above<br>c) return foreskin to un-retracted position after urinating<br>vii. ask resident to urinate a small amount and then stop, if possible<br>viii. place container and ask resident to continue urinating, collecting until cup is about half full<br>ix. instruct resident to finish urinating and wipe with toilet paper as usual<br>x. place lid on specimen cup and clean outside of cup with paper towel | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | xi. apply label and place cup in plastic bag provided<br>xii. remove gloves and wash hands<br>xiii. assist resident to comfortable position in room<br>xiv. place call bell within easy reach of resident | | |
| 93. Accurately document specimen collection. | xv. document specimen collection per facility policy | | |
| 94. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | xvi. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse<br>M. Anatomy and physiology of the gastrointestinal system (GI) – digestive system | | |
| 95. Explain the anatomy and physiology of the gastrointestinal system. | 1. begins at the mouth and ends at the rectum<br>2. tongue moves food around the mouth<br>3. salivary glands – secrete saliva which begins the breakdown of food<br>4. teeth – break up food<br>5. esophagus – carries food to stomach<br>6. stomach – contains acid to break down food into chyme (semifluid mass of partly digested food)<br>7. chyme enters small intestines where it is propelled via peristalsis (wavelike motion that moves contents through small and large intestines)<br>a. continues to be digested by bile from liver enzymes<br>b. about 90% of absorption of nutrients from food occurs in small intestines | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 8. large intestines – help regulate water balance<br>a. chyme takes 3-10 hours to become feces<br>b. feces water, sold waste material, bacteria and mucus<br>c. defecation – eliminating feces from the body<br>9. functions of the GI system<br>a. ingestion – taking food/fluid into the body<br>b. digestion – breakdown of food into nutrients to be absorbed<br>c. elimination of waste products from the body | | |
| 96. Describe age-related changes seen in the gastrointestinal. | N. Age-related changes to the GI system<br>1. decreased taste (sweet is last taste to remain)<br>2. loss of teeth affects ability to chew<br>3. decreased saliva and digestive fluids slow digestion of food<br>4. medical conditions may cause difficulty swallowing<br>5. decreased absorption of vitamins and minerals<br>6. decreased rate of digestion leads to constipation<br>7. age related changes and behaviors<br>a. inactivity<br>b. drinking less fluids<br>c. some chronic or acute illnesses<br>d. medications | | |
| | O. Bowel elimination | | |
| 97. Identify normal characteristics of stool. | 1. called stool, feces, bowel movement (BM)<br>2. frequency<br>a. varies by individual<br>b. regularity prevents complications | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 3. color<br>a. brown<br>b. foods can cause color to change<br>c. iron medication changes color to black<br>d. illness<br>4. consistency<br>a. soft, moist, formed<br>b. foods can cause change to consistency<br>5. illness<br>6. not normally found in feces<br>a. blood<br>b. mucus<br>c. pus<br>d. worms | | |
| 98. Discuss the importance of identifying abnormal characteristics of stool that the nurse aide should report to the appropriate supervisor. | 7. report the following to the appropriate licensed nurse<br>a. abnormally colored feces (white, black, bloody)<br>b. hard, dry feces<br>c. liquid stool (diarrhea)<br>d. inability to have bowel movement (constipation)<br>e. pain with bowel movement<br>f. stool that contains blood, mucus, pus<br>g. stool incontinence | | |
| 99. Explain the guidelines the nurse aide should follow to promote normal bowel elimination patterns. | P. Guidelines to promote normal bowel elimination<br>1. encourage adequate fluid intake<br>2. warm fluids stimulate peristalsis<br>3. diet with adequate fiber/roughage<br>4. promote regular exercise<br>5. provide good oral care to keep mouth and teeth healthy<br>6. provide privacy when using the bathroom<br>7. allow plenty of time for resident to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 100. Demonstrate how to help a resident use a bedpan.<br><br>101. Accurately document use of a bedpan and the outcome on facility ADL form.<br><br>102. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>103. Discuss common disorders of the GI system, including their signs and symptoms. | use bathroom<br>8. follow resident's pattern for bowel elimination<br>9. laxatives may be ordered to stimulate bowel activity<br>Q. Care of the resident needing to use a bedpan<br>1. used by residents unable to get to the bathroom<br>2. not comfortable and can cause damage to the skin<br>3. follow the procedure for "Assists with use of Bedpan" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>4. document procedure on Activities of Daily Living form, per facility policy<br>5. report any observations of changes in resident's condition, skin changes, and/or behavior to appropriate licensed nurse<br>R. Common disorders of the GI system<br>1. heartburn<br>a. acid reflux<br>b. sphincter muscle where esophagus enters stomach has poor muscle tone allowing gastric acid to enter the esophagus<br>c. causes pain in chest<br>d. burning in esophagus<br>e. bitter taste in mouth<br>f. usually after meals<br>2. flatulence<br>a. gas or flatus<br>b. too much air in GI tract<br>c. caused by certain foods<br>i. beans | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | ii. broccoli<br>iii. high fiber<br>iv. dairy products (lactose intolerance)<br>d. exercise may provide relief<br>e. lying on left side may be helpful<br>3. constipation<br>a. difficult, painful elimination of stool<br>b. stool is usually hard and dry<br>c. symptoms<br>i. abdominal swelling<br>ii. gas<br>iii. irritability<br>iv. straining during bowel movement<br>d. treatment<br>i. increase fluid intake<br>ii. increase exercise<br>iii. increase fiber<br>iv. laxative, enema, suppository may be ordered<br>4. diarrhea<br>a. frequent liquid or semi-liquid stool<br>b. causes<br>i. infections<br>ii. irritating foods<br>iii. medications<br>iv. stress/anxiety<br>v. illness or disease process<br>c. treatment<br>i. BRAT diet (bananas, rice, apples, tea)<br>ii. diet may be changed<br>iii. medications may be ordered<br>iv. probiotics may be ordered<br>5. fecal incontinence<br>a. involuntary passage or oozing of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | stool<br>b. causes<br>i. loss of muscle tone at anal sphincter<br>ii. loss of nerve control at anal sphincter<br>iii. fecal impaction<br>c. treatment by changing diet and/or medication as ordered<br>i. bowel training<br>6. fecal impaction<br>a. hard, dry feces accumulate in rectum and resident cannot expel<br>b. symptoms<br>i. no stool for several days<br>ii. complaints abdominal pain<br>iii. abdominal distension<br>iv. nausea and vomiting<br>v. oozing liquid stool<br>c. must be manually removed by nurse (RN or LPN)<br>d. prevention<br>i. encourage adequate fluid intake<br>ii. diet high in fiber<br>iii. adequate exercise<br>iv. regular toileting schedule | | |
| 104. Explain the different types of enemas and when a nurse aide is permitted to give an enema. | S. Enemas<br>1. nurse aides may only give enemas that contain no additives<br>2. know and follow your facility policy regarding nurse aides administering enemas<br>3. types of enemas<br>a. tap water – 500-1000ml tap water<br>b. soapsuds – 500-1000ml tap water with castile soap added<br>c. saline - 500-1000ml water with | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | salt added<br>d. pre-packaged (Fleets) – 120ml saline or oil | | |
| 105. Discuss how to collect routine stool specimen. | T. Stool specimens<br>1. stool specimen<br>2. purpose<br>a. identify parasites, microorganisms, or blood<br>3. procedure<br>a. identify yourself and explain what you are going to do<br>b. wash hands<br>c. put on gloves<br>d. place speci-hat in toilet or bedside commode<br>e. have resident defecate in speci-hat<br>f. assist with perineal care<br>g. using 2 tongue blades place stool in specimen cup and close lid<br>h. attach label immediately<br>i. dispose of tongue blades per facility policy<br>j. remove gloves and wash hands<br>k. position resident comfortably in room<br>l. place call bell within reach of resident<br>m. dispose of tongue blades per facility policy | | |
| 106. Accurately document specimen collection. | n. document procedure on Activities of Daily Living form, per facility policy | | |
| 107. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | o. report any observations of changes in resident's condition or behavior to appropriate license nurse<br>U. Ostomies<br>1. ostomy - opening from an area | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | inside the body to the outside of the body<br>2. colostomy – intestine is brought to outside of abdomen<br>a. stoma - opening in abdomen<br>b. colostomy bag – appliance that covers the stoma and into which the stool drains<br>c. no stool will be eliminated via the rectum | | |
| 108. Explain why a resident might have a colostomy. | 3. some causes<br>a. cancer of colon, rectum<br>b. trauma – gunshot<br>c. diverticulitis<br>d. Crohn's disease | | |
| 109. Describe care issues for a resident with a colostomy including what observations the nurse aide should make.<br><br>110. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 4. care for resident with ostomy<br>i. treat resident with respect<br>ii. be sensitive and supportive<br>iii. provide privacy for resident or nurse to change bag<br>5. observations nurse aide should report to the appropriate licensed nurse<br>a. color and consistency of stool<br>b. unusual odor<br>c. blood, pus, mucus in stool in bag<br>d. leaking around the seal of the bag<br>e. flatus accumulating in the ostomy bag<br>f. complaints of pain in abdomen<br>g. distended abdomen | | |
| 111. Discuss the importance of nutrition, hydration, and elimination as it relates to the client/resident. | VII. Eating and Hydration<br>A. Basic nutrition<br>1. purpose of GI (gastrointestinal) system<br>a. ingestion – take in food<br>b. digestion – breakdown food into | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 112. Describe the six (6) main nutrients in a healthy diet. | nutrients the body can absorb and use<br>c. elimination – eliminate parts of food not absorbed<br>2. types of nutrients<br>a. water<br>i. most important nutrient<br>ii. essential for life<br>iii. ingested as liquid but also as part of foods<br>iv. 50-60% of body weight<br>v. transports waste products out of body<br>vi. keeps us cool – perspiration<br>vii. keeps mucous membranes moist<br>viii. helps joints to move smoothly<br>b. carbohydrates<br>i. source of glucose – food for the cells of the body<br>ii. if not used for energy (food) for the body they are stored as fat<br>iii. 1 gram carbohydrate = 4 calories<br>iv. grains, cereals, fruit, some vegetables<br>c. protein<br>i. contain the "building blocks" for the cells<br>ii. found in fish, meat, nuts, bean, legumes, eggs and dairy products<br>iii. helps body to build new tissue and to rebuild tissue that is damaged<br>iv. 1 gram = 4 calories<br>d. vitamins<br>i. fat soluble – only dissolve in | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | presence of fat – vitamins D, E, A, K<br>ii. water soluble – dissolve in water – B vitamins, vitamin C<br>iii. essential for the body to function correctly<br>e. minerals<br>i. help provide structure to the body<br>ii. calcium – builds bones and teeth<br>iii. iron – required to transport oxygen throughout the body<br>f. fat (lipids)<br>i. found in meat and oils, milk, cheese, nuts<br>ii. make food taste good<br>iii. take long time to breakdown giving the sensation of being "full" longer<br>iv. most be present in the body to use Vitamin D, E, A, K<br>v. 1 gram = 9 calories | | |
| 113. Explain how to use My Plate as a guide for a healthy diet. | 3. USDA My Plate<br>a. general guide for types and quantities of foods to eat each day<br>b. fruits and vegetables<br>i. half of plate<br>ii. vegetables - fresh, frozen, dried, canned, juice, dark green vegetables, red and orange vegetables, dry beans and peas, starchy vegetables<br>iii. fruits – fresh, frozen, dried, canned, juice<br>c. grains<br>i. one quarter of plate<br>ii. half should be whole grain | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 114. Identify various special diets that residents may receive. | d. protein<br>i. one quarter of plate<br>ii. meat, poultry, seafood, eggs<br>iii. beans, peas, soy products, nuts, seeds<br>e. dairy<br>i. 3 cups each day<br>ii. milk, yogurt, cheese, anything made with milk<br>4. Special diets<br>a. regular diet - well-balanced diet without restrictions<br>b. soft diet<br>i. restricts foods hard to chew or swallow<br>ii. restricts raw fruits and vegetables<br>iii. restricts high fiber and spicy foods<br>c. mechanical soft diet<br>i. foods are chopped or blended to make them easier to chew<br>ii. does not restrict spices, fat or fiber<br>d. pureed diet<br>i. consistency of baby food<br>ii. for resident with difficulty chewing and/or swallowing<br>e. clear liquid diet<br>i. only includes liquids you can see through<br>ii. jello, apple juice, bouillon, water, coffee or tea without cream<br>iii. does not provide enough nutrients to maintain health for prolonged period of time<br>f. full liquid diet<br>i. clear liquids and any food that | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | can be poured at room or body temperature<br>ii. puddings, cream soups, yogurt, breakfast drinks<br>g. bland diet<br>i. restricts spicy and acidic foods<br>h. fiber-specific diet<br>i. may be high or low fiber depending on medical needs of resident<br>i. low sodium diet (low NA diet)<br>i. restrict amount of salt resident may use<br>ii. ordered for resident with high blood pressure<br>iii. may be "no added salt: diet (NAS)<br>j. diabetic diet<br>i. ordered for residents with diabetes mellitus<br>ii. may restrict caloric intake<br>iii. restricts amount of sugar and carbohydrates<br>k. fluid restricted diet<br>i. ordered for resident with heart or kidney disease<br>ii. identifies specific quantity of fluid resident may have in 24-hour period<br>l. gluten-free diet<br>i. may be resident choice or due to intolerance to gluten<br>ii. gluten is a general term for proteins found in wheat<br>iii. residents/residents with celiac disease cannot tolerate gluten<br>m. NPO<br>i. nothing by mouth | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 115. Describe the three (3) consistencies of thickening that may be ordered for residents with swallowing difficulties. | n. liquid modifications<br>i. may be required for residents with difficulty swallowing "thin" fluid like water<br>ii. Thick-It – works like corn starch to thicken the liquid<br>iii. nectar thick (consistency of thick fruit juice)<br>iv. honey thick (consistency of honey)<br>v. pudding thick (consistency of pudding)<br>vi. know facility policy and procedures for who can thicken fluids | | |
| 116. Identify age-related changes that affect eating and nutrition. | B. Age-related changes to eating and nutrition<br>1. physical changes<br>a. dysphagia – difficulty swallowing<br>b. loss of teeth – difficulty chewing<br>c. decrease saliva – difficulty swallowing<br>d. decrease sensations of taste and smell – food is less appealing<br>e. decreased ability to see – makes it difficult to feed oneself and food appears less appealing<br>2. decreased activity level<br>a. less appetite<br>b. increases risk of constipation<br>3. special diets<br>a. foods not prepared with spices have less flavor<br>b. pureed diets not very appealing to the eye<br>4. psychosocial<br>a. decreased income makes it difficult to buy foods that | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | resident<br>purchased earlier in life<br>b. lack of social interaction may decrease appetite<br>c. depression may decrease appetite<br>5. physical ailments<br>a. medical conditions can make eating/cooking difficult<br>b. Parkinson's Disease, stroke, certain cancers, Alzheimer's Disease (AD)<br>6. medications<br>a. can alter the taste of food<br>b. can leave bad taste in the mouth<br>c. can decrease appetite<br>d. may cause nausea, diarrhea, constipation | | |
| 117. Identify cultural considerations that affect eating and nutrition. | C. Cultural considerations for eating and nutrition<br>1. religious considerations<br>a. Jewish religion<br>i. may not eat pork<br>ii. may require Kosher diet<br>iii. food specially prepared to religious specifications<br>b. Muslim (Islam)<br>i. will not eat pork<br>ii. may require halal diet (foods allowed under Islamic dietary guidelines)<br>iii. food specially prepared to religious specifications<br>c. Hindu (may not eat beef)<br>d. Buddhist (many are vegetarian)<br>e. Mormon<br>i. may not drink caffeine – coffee, tea, cola<br>ii. may not drink alcohol | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 2. social considerations<br>a. vegan<br>i. will may not eat any animal products<br>ii. restricts eggs, dairy products, meat<br>b. vegetarian (restrict meat, fish and poultry)<br>c. fasting (voluntarily gives up eating for a period of time)<br>3. ethnic considerations<br>a. some ethnic groups like food that is cooked with specific spices (e.g. Asian residents may prefer rice to potatoes | | |
| 118. Identify specific observations concerning eating and nutrition that the nurse aide should report to the appropriate supervisor. | D. Observations nurse aide should report concerning eating and nutrition<br>1. eats less than 70% of meals<br>2. complains of mouth pain<br>3. dentures do not fit<br>4. teeth are loose<br>5. difficulty chewing or swallowing<br>6. frequent coughing/choking while eating<br>7. needs help eating or drinking<br>8. weight loss – clothes become loose-fitting<br>9. weight gain – clothes become tight<br>10. complaints of constipation<br>11. edema (fluid accumulation) in hands/feet | | |
| 119. Explain guidelines for the nurse aide concerning eating and nutrition as. | E. Guidelines for nurse aide concerning eating and nutrition<br>1. check diet card on resident's tray to make sure it is the correct tray for the correct resident<br>2. season food following resident's choices<br>3. assist resident to fill out menu | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. if resident does not like food on tray try to replace with food of his choice<br>5. encourage resident to eat by making mealtime a pleasant experience<br>6. assist resident to rinse mouth if resident receives medication immediately before mealtime<br>7. assist resident with adaptive devices to help him maintain his independence and feed himself<br>8. accurately record food and fluid intake for each meal<br>9. follow nursing care plan to assist resident to maintain independence at mealtime | | |
| 120. Describe actions the nurse aide should take to prepare the resident for mealtime. | F. Preparing for mealtime<br>1. encourage resident to toilet before going to the dining room<br>2. assist to wash hands and face, brush teeth<br>3. encourage resident to wear glasses, hearing aides<br>4. provide pleasant area for eating<br>a. encourage resident to eat in dining room with other residents to promote social interaction<br>5. if eating in his room, clear a clean area for resident's tray<br>a. remove urinal/bedpan from view<br>b. position in an upright position<br>c. if positioned in a wheelchair, lock the wheels | | |
| 121. Demonstrate how to serve resident trays. | G. Serving the tray<br>1. wash hands<br>2. offer/provide clothing protector or napkin<br>3. check diet card of tray | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. correct resident<br>b. correct diet<br>4. assist resident to prepare food<br>a. season food per resident choice<br>b. if resident requests, cut food into bite-sized pieces<br>c. open cartons, containers at resident's request<br>5. provide resident with appropriate assistive devices to promote resident independence<br>a. plate guard<br>b. silverware with built-up handles<br>c. sippy cup<br>6. decrease distractions by lowering TV/radio volume<br>7. allow resident sufficient time to eat, do not rush<br>8. talk with resident respectfully<br>9. for a visually impaired resident identify the location of foods on the plate using the numbers on a clock-face<br>H. Guidelines for feeding resident<br>1. assist resident to wash hands<br>2. place a clothing protector over the resident's chest<br>3. sit at the same level as resident, facing the resident<br>4. identify foods for the resident<br>5. ask resident in what order he/she would like to have his/her food<br>6. do not mix foods unless requested by resident<br>7. offer liquids between bites of food<br>8. do not touch food to test for hotness, place hand above food<br>9. do not force resident to eat<br>10. provide resident ample time to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | chew and swallow food before offering another bite<br>11. do not rush resident | | |
| 122. Demonstrate how to feed a resident who cannot feed self. | I. Feed a resident who cannot feed himself<br>1. follow the procedure for "Feeds Resident who Cannot Feed Self" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 123. Accurately document food and fluid intake. | 2. document procedure on Activities of Daily Living form, per facility policy | | |
| 124. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 3. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>J. Calculate food intake<br>1. know facility procedure for calculating food intake<br>2. some facilities use a percentage eaten of the entire plate of food<br>3. some facilities calculate percentage based on type of food eaten, for example:<br>a. all of protein eaten = 30%<br>b. all of carbohydrates eaten = 50%<br>c. all of vegetable eaten = 20%<br>4. document and report food intake and fluid intake per facility policy | | |
| 125. Describe actions to help prevent aspiration. | K. Guidelines to help prevent aspiration<br>1. aspiration – taking food/liquid into the lungs<br>2. resident should be in up-right position (90°) to eat<br>3. feed resident slowly<br>4. reduce distractions<br>5. use thickener in liquids per nursing care plan | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 6. cut food into small bites<br>7. alternate liquids and solid food<br>8. if resident has paralysis, place food in non-paralyzed (non-affected) side of mouth<br>9. provide mouth care after resident has finished eating<br>10. have resident remain in up-right position about 30 minutes after finishing meal<br>11. report choking or gagging during meal to appropriate licensed nurse<br>L. Supplemental nutrition<br>1. used to increase caloric intake<br>a. Ensure<br>b. Sustacal<br>c. Instant Breakfast<br>2. served between meals, or as ordered by health care provider<br>3. include in daily intake and output | | |
| 126. Define hydration, including actual amount of fluid required per day. | M. Hydration<br>1. man cannot live without water<br>2. recommend 8-8oz glasses (2000-2500 ml) of fluid every day, unless restricted by health care provider<br>3. dehydration<br>a. lack of sufficient fluid intake<br>b. may cause<br>i. constipation<br>ii. UTI<br>iii. change in level of consciousness<br>c. most common fluid and electrolyte problem in the elderly | | |
| 127. Describe signs and symptoms of dehydration. | N. Signs of dehydration the nurse aide should report to the appropriate licensed nurse<br>1. drinking less that 6-8oz glasses | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | (1400ml) of fluid/day<br>2. complaints of thirst<br>3. dry, cracked lips<br>4. dry mucous membranes<br>5. sunken eyes<br>6. decrease urine output<br>7. urine is dark and strong smelling<br>8. complaints of constipation<br>9. loss of weight<br>10. weak, dizzy, light-headed<br>11. low blood pressure<br>12. complaints of headache<br>13. irritable<br>14. confusion<br>15. weak, rapid heartbeat | | |
| 128. Accurately describe actions of the nurse aide to prevent resident dehydration. | O. Actions the nurse aide can take to prevent dehydration<br>1. provide resident with fresh water every shift and place pitcher where resident can easily reach it<br>2. frequently ask resident if they would like something to drink<br>3. offer fluids that resident likes to drink<br>4. provide fluids at temperature resident prefers<br>5. provide resident with assistive devices if needed<br>6. keep accurate I/O records<br>7. follow nursing care plan and specific fluid<br>8. report to appropriate licensed nurse any signs of dehydration | | |
| 129. Identify signs and symptoms of fluid overload to report to the appropriate supervisor. | P. Signs of too much fluid (fluid overload) that the nurse aide should report to the appropriate licensed nurse<br>1. edema<br>a. body retains fluid<br>b. hands and feet swell | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. rings and shoes become tight<br>2. weight gain<br>3. moist cough<br>4. shortness of breath on exertion<br>5. increased heart rate<br>6. skin on legs and feet becomes tight and shiny | | |
| 130. Explain the anatomy and physiology of the skin. | VIII. Care of the Skin (Integumentary System)<br>A. Anatomy and physiology of the skin<br>1. layers of the skin<br>a. epidermis<br>i. outer layer<br>ii. made up of dead cells<br>iii. has no blood vessels<br>iv. contains melanin – pigment that gives color to the skin<br>b. dermis<br>i. inner layer<br>ii. contains oil glands, sweat glands, hair follicles, blood vessels<br>iii. protects internal organs from injury<br>iv. produces Vitamin D when exposed to the sun<br>2. subcutaneous tissue<br>a. layer of fat under the dermis<br>b. blood vessels and nerve of the skin originate here<br>c. nerves provide sense of touch<br>3. glands in the dermis<br>a. oil glands (sebaceous glands)<br>i. secrete oily substance to prevent skin from drying and from harmful bacteria<br>b. sweat glands<br>i. produce sweat<br>a) excrete waste products | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | b) help to cool the body<br>4. hair - helps to keep body warm<br>5. nails - protects the ends of fingers and toes | | |
| 131. Describe age-related changes seen in the skin. | B. Age-related changes of the skin that may occur in geriatric residents/residents<br>1. decrease in fat in subcutaneous layer<br>a. wrinkles<br>b. sagging skin<br>c. resident feels cooler<br>2. decrease in amount of melatonin<br>a. gray hair<br>b. age spots<br>3. decreased production of oil and sweat<br>a. skin becomes drier<br>b. becomes thinner<br>c. becomes fragile<br>d. more prone to infections and tearing<br>4. nails thicken and may become yellow<br>C. Factors promoting healthy skin<br>1. good nutrition<br>2. adequate hydration<br>3. adequate sleep<br>4. adequate exercise | | |
| 132. Discuss common disorders of the skin, including signs and symptoms. | D. Common disorders of the skin<br>1. burns<br>a. first degree<br>i. involves epidermis<br>ii. redness and pain<br>b. second degree<br>i. involves dermis<br>ii. red, painful, swelling, blistering<br>c. third degree | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | i. dermis and underlying tissue<br>ii. scarring<br>iii. muscle and bone may be involved<br>d. pain, swelling, peeling<br>e. causes<br>i. hot liquid<br>ii. electrical equipment<br>iii. hair dryer<br>iv. heating pad<br>v. chemicals<br>f. never put oil, lotion or butter on a burn<br>g. cool and cover loosely<br>h. notify appropriate licensed nurse immediately<br>2. shingles<br>a. related to chicken pox reactivation<br>b. viral infection that follow path of a nerve<br>c. blistery rash that appears as a single line on one side of the body<br>d. very painful<br>e. contagious for someone who has never had chicken pox<br>f. keep rash covered<br>g. wash hands frequently<br>3. wounds<br>a. two types<br>i. open wound<br>a) abrasion<br>b) puncture wound<br>c) gunshot wound<br>d) laceration<br>ii. closed would<br>a) bruise<br>b) hematoma | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | b. symptoms<br>i. pain<br>ii. damage to the skin<br>iii. discoloration of the skin<br>iv. bleeding<br>v. fever, chills<br>vi. difficulty breathing<br>c. report any wounds to the appropriate licensed nurse immediately<br>E. Pressure Sores (decubitus ulcers)<br>1. pressure points<br>a. bony prominences<br>b. heels<br>c. shoulder blades<br>d. elbows<br>e. sacrum<br>f. areas with very little fat between bone and skin<br>2. pressure sores<br>a. breakdown of skin over a bony prominence<br>b. harder to cure than to prevent<br>c. caused by<br>i. immobility – lying, or sitting on same area for a prolonged period of time<br>a) weight of body prevents blood flow to tissue and body tissue begins to die after 2 – 3 hours<br>ii. lying on wrinkled linen<br>iii. lying on an object in the bed<br>iv. sitting on bedpan for prolonged time<br>v. wearing splint or brace that does not fit properly | | |
| 133. Identify risk factors for developing pressure | 3. risk factors for developing pressure sores | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| sores. | a. aging – skin becomes more fragile<br>b. poor nutrition and hydration<br>c. skin that has prolonged contact with water or moisture – causes epidermis to breakdown<br>d. cardiovascular and respiratory problems – decreases amount of oxygen reaching cells<br>e. skin exposed to friction and shearing - during turning and positioning<br>4. signs of developing pressure sores<br>a. skin becomes whitish or reddened<br>b. skin is dry, cracked and/or torn<br>c. blisters, bruises | | |
| 134. Describe the staging of pressure sores. | 5. staging of pressure sores – *performed by a licensed nurse, not a nurse aide<br>a. Stage 1<br>i. skin intact, but red, blue or grey non-blanchable<br>ii. relieving pressure for 15-30 minutes does not return skin to normal coloration<br>iii. can be reversed if treated early<br>b. stage 2<br>i. involves both epidermis and dermis<br>ii. looks like clear fluid filled blister or shallow crater<br>iii. epidermis cracks or peels away<br>iv. open area is portal of microorganism to enter<br>v. no dead tissue yet<br>c. stage 3<br>i. both epidermis and dermis are gone | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 135. Describe actions the nurse aide can take to prevent pressure sores. | ii. looks like a deep crater<br>iii. drainage is present<br>iv. necrotic (dead) tissue may be visible but doesn't obscure depth of tissue loss<br>v. takes weeks or months to completely heal<br>d. stage 4<br>i. crater of damaged tissue extends down to the muscle or bone<br>ii. often becomes seriously infected<br>iii. takes months to heal<br>iv. may require skin graft<br>6. deep tissue injury (DTI)<br>a. purple or discolored area with intact skin<br>b. firm, mushy, boggy, or warmer or cooler than adjacent tissue<br>c. unstageable<br>i. unable to see wound bed<br>ii. eschar or slough in wound<br>iii. can be yellow, tan, brown, black<br>iv. can be firm, soft, or draining<br>7. actions to prevent pressure sores<br>a. prevention is easier than treating and healing<br>b. perform skin care and skin checks on regular basis<br>i. during routine personal care<br>ii. throughout the day as needed<br>iii. use moisturizer on unbroken skin<br>iv. keep skin clean and dry<br>v. where skin comes in contact with skin<br>a) under pendulous breasts | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | b) between scrotum and legs<br>c) between abdominal folds<br>vi. clean and dry immediately after urinary or bowel incontinence<br>a) replace soiled linen protectors and clothing with clean, dry linen and clothing<br>b) assist resident to wipe well, drying perineum<br>c) toilet q2hrs. to avoid incontinence<br>d) keep linen clean, dry and free of wrinkles (if resident eats in bed remove any crumbs from linen)<br>c. turn and reposition immobile residents at least q2h<br>d. encourage mobile residents to change position frequently<br>e. during transfer and repositioning resident<br>i. avoid dragging resident across the linen by using draw sheet to turn and reposition resident<br>ii. use mechanical lift to transfer from bed to chair<br>iii. use transfer board to transfer bedridden resident from bed to stretcher<br>iv. avoid bumping resident against side rails or wheelchair leg rests<br>f. use positioning devices to keep pressure off areas at risk<br>i. foot boards<br>ii. bed cradles<br>iii. heel/elbow protectors | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | iv. sheepskin pads to protect the back<br>g. perform range of motion exercises on regular basis<br>h. massage healthy skin to increase circulation (do not massage skin that is white, red, purplish)<br>i. encourage healthy diet and adequate hydration | | |
| 136. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | 8. observations to report to the appropriate licensed nurse<br>a. change in skin coloration over a bony prominence or in a skin fold (whitish, red, grey, purplish)<br>b. dry, cracked, flaking skin, particularly on heels or elbows<br>c. torn skin<br>d. blisters, bruises, cuts<br>e. resident itches or scratches skin frequently<br>f. broken skin anywhere on the body, including between the toes<br>g. any change in an existing pressure sore<br>i. drainage<br>ii. odor<br>iii. peeling skin<br>iv. change in color of skin<br>v. change in size of crater | | |
| 137. Demonstrate how to perform a back massage. | F. Back massage (back rub)<br>1. relaxes tired, tense muscles<br>2. improves circulation<br>3. check nursing care plan for instructions on when to perform<br>4. procedure for performing back rub<br>a. identify yourself and explain what you are going to do<br>b. wash hands<br>c. put on gloves if there is an area | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | of broken skin<br>d. provide for privacy<br>e. adjust bed to waist-height and lock bed wheels<br>f. lower side rail closest to you<br>g. position resident on his side or back, if tolerated<br>h. pour lotion on hands and rub hands together<br>i. using full palm of your hand, start at base of spine and with firm, even stroke gently massage upward toward the shoulders<br>j. at shoulders, circle hands outward and stroke along outside of back, down toward base of spine<br>k. repeat circular motion for 3-5 minutes<br>l. using circular motion, gently massage bony prominences<br>m. if bony prominences are red, massage around them, not over them<br>n. if there is extra lotion, remove it<br>o. redress and reposition resident<br>p. raise side rail, if appropriate<br>q. return bed to low position<br>r. place call bell in easy reach of resident<br>s. store lotion per facility policy and resident request | | |
| 138. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | t. wash hands<br>u. report to appropriate licensed nurse any changes in resident or skin that you observed | | |
| | IX. Transfer, Positioning and Turning | | |
| 139. Identify the structure | A. Anatomy and physiology of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| and function of the skeletal system.<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>140. Identify the structure and function of the muscular system. | musculoskeletal system<br>1. skeleton<br>a. long bones (arms and legs)<br>b. short bones (wrists and ankles)<br>c. flat bones<br>i. thin and often curved<br>2. skull and ribs<br>a. irregular bones<br>i. oddly shaped<br>ii. spine and face<br>3. joints (where 2 bones join together)<br>4. cartilage<br>a. fibers that permit limited movement between bone acts as shock absorber between bones<br>b. ligaments<br>i. strong fibrous bands attaching one bone to another<br>ii. stabilize joint<br>5. muscles<br>a. skeletal muscles<br>i. attach to bones<br>ii. allow for movement<br>iii. resident controls these muscles<br>b. smooth muscles<br>i. line walls of blood vessels, stomach, bladder and hollow organs<br>ii. controlled involuntarily<br>c. cardiac muscle<br>i. forms the heart<br>ii. cause heart to contract and relax<br>iii. controlled involuntarily<br>d. purpose of muscles<br>i. enables body to move, internally and externally<br>6. purpose of skeletal system | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | a. support the body<br>b. protect the body | | |
| 141. Describe age-related changes seen in the musculoskeletal system. | B. Age-related changes to musculoskeletal system<br>1. bones lose calcium<br>a. become weak<br>b. break easily<br>c. osteoporosis<br>2. muscles weaken<br>a. lose tone<br>b. cannot support the body or move bones<br>3. lose muscle mass<br>a. causes weight loss<br>4. joints become less flexible<br>a. decreases range of motion<br>b. slows body movements<br>5. lose height<br>a. space between vertebrae decreases | | |
| 142. Discuss common disorders of the musculoskeletal system, including their signs and symptoms and guidelines for the nurse aide. | C. Common disorders of musculoskeletal system<br>1. Osteoporosis<br>a. bones break easily due to loss of bone tissue<br>b. caused by<br>i. lack of calcium in diet<br>ii. loss of estrogen<br>iii. reduced mobility<br>c. bones most commonly affected<br>i. vertebrae<br>ii. pelvic bones<br>iii. arm and leg bones<br>d. signs and symptoms<br>i. low back pain<br>ii. loss of height<br>iii. stooped posture<br>e. treatment<br>i. medication | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | ii. exercise<br>f. considerations for the nurse aide providing care<br>i. allow time for resident to move<br>ii. turn and reposition very carefully<br>iii. follow special dietary orders<br>iv. encourage and assist with mobility<br>v. report to appropriate licensed nurse any changes in resident's ability to be active or to move<br>2. Arthritis<br>a. painful inflammation of joints<br>i. stiff, swollen joints<br>ii. decreases mobility of joints<br>b. two types of arthritis<br>i. osteoarthritis<br>a) DJD – degenerative joint disease<br>b) cartilage between joints decreases<br>c) causes pain when bones rub together<br>ii. rheumatoid<br>i. considered an auto-immune disease<br>ii. causes deformity which can be disabling<br>c. signs and symptoms<br>i. swollen and stiff joints<br>ii. joints deformed<br>d. treatment<br>i. rest<br>ii. range of motion exercises<br>iii. anti-inflammatory medications | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | iv. weight loss<br>v. heat<br>vi. total joint replacement surgery<br>e. considerations for the nurse aide providing care<br>i. encourage activity per nursing care plan<br>ii. range of motion exercises as ordered<br>iii. assist with ADLs<br>iv. encourage use of assistive devices to promote resident independence<br>f. report the following to the appropriate licensed nurse<br>i. unusual stiffness of joints<br>ii. swelling of joints<br>iii. resident complaint of pain in joints<br>iv. decreased ability to perform range of motion exercises<br>v. decreased ability of resident to perform daily activities | | |
| 143. Identify complications of immobility. | D. Complications of immobility<br>1. physical discomfort<br>2. pressure sores<br>3. contractures<br>4. bones become brittle due to loss of calcium<br>5. pneumonia<br>6. blood clots, especially in the legs | | |
| 144. Demonstrate the various positions for the resident in bed. | E. Proper body alignment<br>1. positioned so spine is straight and not twisted<br>2. promotes comfort and good health<br>3. supine<br>a. flat on back<br>b. support head and shoulders with a pillow | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. support arms and hands with pillow or rolled washcloth<br>d. place pillow under calves so heels are elevated off bed to prevent pressure sores<br>e. use footboard to keep ankles flexed to promote anatomical position of feet and ankles<br>4. lateral<br>a. lying on side<br>b. pillow to support the head and neck<br>c. pillow to the back to maintain side-lying position<br>d. flex top knee and place pillow under the knee and lower leg for support<br>e. pillow under bottom foot to keep toes from touch the bed<br>5. prone<br>a. lying on the abdomen<br>b. many residents do not like this position<br>c. head turned to the side and placed on small pillow<br>d. place pillow under abdomen to allow room for breasts and to allow chest to expand during inhalation<br>e. do not leave resident prone for a long period of time<br>6. Fowler's<br>a. resident on back with head of bed (HOB) elevated 45 - 60°<br>b. semi-Fowler's – HOB elevated 30 - 45°<br>c. high Fowler's – HOB elevated 60 - 90°<br>d. raise knee gatch or place pillow | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | under knees to help prevent resident from sliding down the mattress<br>7. Sims'<br>a. extreme side-lying position, almost prone<br>b. head turned to side and supported with pillow<br>c. lower arm positioned behind the back<br>d. upper knee is flexed and supported with pillow<br>e. pillow under each foot to prevent toes from touching bed<br>8. Trendelenburg<br>a. head is lower than the rest of the body<br>b. used to increase blood flow to the brain if resident is in shock<br>9. reverse Trendelenburg<br>a. mattress placed at an angle with the head higher than the foot of the mattress<br>b. used for residents with digestive disorders<br>10. logrolling<br>a. turning resident onto side while keeping spine straight<br>b. use a draw sheet and a helper<br>F. Repositioning resident | | |
| 145. Demonstrate how to raise a resident's head and shoulders. | 1. raising resident's head and shoulders<br>a. use good body mechanics<br>b. raise bed to waist-height and lower side rail<br>c. place closest hand and arm under resident back to the far shoulder<br>d. place other hand and arm under | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | resident's closest shoulder<br>e. gently raise head and shoulders on the count of three<br>f. re-fluff, turn, and replace pillow<br>g. make resident comfortable, provide with call bell<br>h. lower bed and replace side rail, as appropriate<br>i. document procedure and report any resident changes to appropriate licensed nurse | | |
| 146. Demonstrate how to move a resident up in bed. | 2. assisting resident to move up in bed<br>a. practice good body mechanics<br>b. raise bed to waist-height and lower side rail and head of bed<br>c. place 1 arm under resident's shoulders<br>d. place other arm under resident's knees and turn your feet toward the HOB<br>e. have resident bend knees<br>f. on count of 3, have resident push with feet while you lift body up in bed<br>g. make resident comfortable, raise HOB, return<br>h. document procedure and report any resident changes to appropriate licensed nurse | | |
| 147. Demonstrate how to move a resident up in bed using a draw sheet. | 3. assisting resident to move up in bed with a draw sheet<br>a. practice good body mechanics<br>b. raise bed to waist-height and lower side rail and head of bed<br>c. have one nurse aide on each side of bed turned slightly toward HOB<br>d. with 1 hand at the shoulder and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 148. Accurately document moving resident up in bed on facility ADL form.<br><br>149. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.<br><br>150. Demonstrate how to position resident on side.<br><br>151. Accurately document positioning resident on side on facility ADL form. | 1 hand at the hips, roll draw sheet toward resident<br>e. grasp roll of draw sheet with palms up<br>f. on count of 3 both nurse aides lift the draw sheet and resident toward the HOB<br>g. unroll draw sheet and tuck edges under mattress<br>h. make resident comfortable, raise HOB, return bed to low position<br>i. place call bell in resident's reach<br>j. wash hands<br>k. document procedure and report any resident changes to appropriate licensed nurse<br>4. position resident on side<br>a. follow the procedure for "Position Resident on Side" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>b. document procedure on Activities of Daily Living form, per facility policy<br>c. report any observations of changes in resident's condition or behavior to appropriate licensed nurse<br>G. Transferring Resident<br>1. assisting resident to move from one location to another<br>2. weight-bearing<br>a. resident's ability to stand on one or both legs<br>3. gait belt or transfer belt<br>a. device nurse aide uses to assist unsteady or weak resident to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | transfer or ambulate | | |
| 152. Demonstrate how to transfer resident from bed to wheelchair using a transfer belt. | 4. transfer resident from bed to wheelchair using transfer belt<br>a. follow the procedure for "Transfer Resident from Bed to Wheelchair Using Transfer Belt" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>b. document procedure on Activities of Daily Living form, per facility policy | | |
| 153. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | c. report any observations of changes in resident's condition or behavior to appropriate licensed nurse | | |
| 154. Demonstrate how to transfer resident from bed to wheelchair using a mechanical lift. | 5. mechanical lifts<br>a. equipment used to lift and move residents<br>b. Fair Labor Standards Act, Hazardous Occupation Order Number 7<br>i. prohibits minors under 18 from operating or assisting in the operation of most power-driven hoists, including those designed to lift and move patients<br>c. should only be used by nurse aides 18 years of age and older<br>d. nurse aide should receive training to use the specific lift in the facility<br>e. at least 2 nurse aides should be present when a mechanical lift is used to move a resident<br>f. practice good body mechanics<br>g. raise bed to waist-height and lower side rail and head of bed | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | h. position wheelchair next to bed with footrests removed and wheels locked<br>i. lower side rail on side nearest nurse aide<br>j. assist resident to turn on side and place lift pad under resident<br>k. assist resident to turn to opposite side and position lift pad under resident without wrinkles<br>l. roll mechanical lift to bedside with base at its widest point, the wheels locked and the overhead bar directly over the resident<br>m. with resident on his back attach the straps to each side of the lift pad and the overhead bar<br>n. fold resident arms over chest to protect arms and elbows<br>o. raise resident about 2 inches off bed<br>p. with assistance of 2nd nurse aide, guide resident to the wheelchair<br>q. slowly lower resident into chair, taking care with arms and legs and making sure the resident's hips are against the back of the wheelchair<br>r. replace footrests and support resident's feet on wheelchair footrests<br>s. remove straps from overhead bar and lift pad<br>t. make sure resident is comfortable and is wearing non-skid footwear<br>u. cover resident's lap and legs with blanket or robe | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | v. place call bell in resident's reach | | |
| 155. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. | w. wash hands<br>x. document procedure and report any resident changes to appropriate licensed nurse | | |
| | H. Ambulating a resident<br>1. walking a resident | | |
| 156. Demonstrate how to ambulate resident using transfer/gait belt. | 2. assistive devices<br>a. transfer or gait belt<br>b. walker<br>c. cane<br>d. crutches | | |
| 157. Identify complaints and concerns the nurse aide should report to the appropriate supervisor related to ambulation. | 3. report to the appropriate licensed nurse<br>a. complaints of dizziness<br>b. shortness of breath<br>c. chest pain<br>d. rapid heart beat<br>e. sudden complaints of head pain<br>f. unusual pain on weight bearing<br>g. changes in resident's strength or ability to walk<br>h. change in resident attitude toward walking<br>i. assistive equipment that is broken or not working correctly<br>4. assist resident to ambulate using transfer belt<br>a. follow the procedure for "Assists to Ambulate Using Transfer Belt" in the most | | |
| 158. Accurately document ambulating resident on facility ADL form. | current edition of Virginia Nurse Aide Candidate Handbook<br>b. document procedure on Activities of Daily Living form, per facility policy | | |
| 159. Discuss the importance of reporting abnormal observations or | c. report any observations of changes in resident's condition | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| changes to the appropriate supervisor. | or behavior to appropriate licensed nurse | | |

# UNIT IX – INDIVIDUAL CLIENT'S NEEDS, INCLUDING MENTAL HEALTH AND SOCIAL SERVICE NEEDS

(18VAC90-26-40.A.4.a,c,d,e,f,g)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Identify basic physical needs of the client/resident. | I. Basic Psychosocial Needs<br>A. Physical needs<br>1. food and water<br>2. protection<br>3. activity<br>4. rest and sleep<br>5. safety<br>6. comfort | | |
| 2. Identify basic psychosocial needs of the client/resident. | B. Psychosocial needs<br>1. recognition as a unique individual<br>a. love and affection<br>b. supportive environment<br>c. acceptance by others<br>d. independence<br>e. social interaction<br>f. security<br>g. success and self-esteem<br>h. spiritual expression<br>i. sexual expression<br>C. Problems meeting these needs<br>1. physical loss of body functions and/or body parts<br>2. social losses<br>a. spouse<br>b. relatives<br>c. friends<br>3. economic losses<br>a. retirement<br>b. health costs<br>4. loss of personal control over decision-making<br>a. loss of driver's license<br>b. loss of personal dwelling when moving to a long-term care | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 3. Demonstrate guidelines for the nurse aide to assist the client/resident to meet his psychosocial needs. | facility<br>D. Guidelines for the nurse aide to assist client/resident in meeting psychosocial needs<br>1. demonstrate caring, personal feeling for each client/resident<br>2. communicate a caring, personal feeling for each client/resident<br>3. promote client/resident independence and personal control as much as possible<br>a. allow to follow habits and make personal choices<br>b. adjust client/resident care to permit continuation of lifestyle as much as possible<br>c. encourage use of personal belongings<br>d. encourage self-care as appropriate<br>e. encourage client/resident to continue religious practices<br>f. provide personal time for sexual expression<br>4. provide client/resident with explanations when providing care<br>a. promote right to dignity<br>b. respect right to refuse care<br>E. Common reactions when client/resident is unable to meet psychosocial needs<br>1. anxiety<br>2. depression<br>3. anger or aggression<br>4. confusion or disorientation<br><br>II. Mental health<br>A. Client/resident is able to make adjustments to maintain state of | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 4. Identify defense mechanisms. | emotional balance<br>1. stress<br>a. anxiety, burden, pressure, worry<br>b. causes<br>i. loss of independence<br>ii. loss of significant other/s<br>iii. loss of economic resources<br>iv. loss of body part/function<br>v. many other causes<br>2. defense mechanisms<br>a. compensation<br>i. substituting for the loss<br>b. conversion<br>i. may have physical symptoms that cannot be explained medically<br>ii. may use physical problem to avoid participating in an activity<br>iii. "changes" the real reason into something else<br>c. denial<br>i. refuses to believe<br>d. displacement<br>i. shifting an emotion from one person to another less threatening person<br>e. projection<br>i. blaming someone else for own actions or feelings<br>f. rationalization<br>i. creating acceptable reasons for behavior or action<br>g. regression<br>i. demonstrate behaviors from an earlier time in life<br>h. repression<br>i. refusing to remember frightening or unpleasant | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | memory | | |
| 5. Describe the signs and symptoms of anxiety. | III. Mental Illness<br>A. Anxiety<br>1. feeling of uneasiness, dread, worry can be helpful response unless it persists and effects ability to cope with everyday life signs and symptoms<br>a. rapid pulse<br>b. dry mouth<br>c. sweating<br>d. nausea<br>e. difficulty sleeping<br>f. loss of appetite<br>g. restless<br>h. irritable | | |
| 6. Identify the behaviors associated with obsessive-compulsive disorder. | B. Obsessive-Compulsive Disorder (OCD)<br>1. obsession<br>a. recurring unwanted thoughts<br>2. compulsion<br>a. rituals that client/resident cannot control<br>b. hand-washing frequently<br>c. repeatedly checking door to make certain it is locked, for example<br>3. prohibiting the ritual increases the level of anxiety<br>C. Phobias<br>1. excessive, abnormal fear<br>a. fear of heights<br>b. fear of water<br>c. fear of flying<br>d. fear of dogs<br>e. fear of closed in spaces<br>2. can be very debilitating | | |
| 7. Identify the signs and | D. Depression | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| symptoms of depression. | 1. overwhelming sadness prohibits client/resident from functioning<br>2. signs and symptoms<br>a. lack of interest<br>b. frequent crying<br>c. fatigue<br>d. weight loss<br>e. sleep disturbances<br>f. irritability<br>g. frequent physical complaints<br>h. feelings of worthlessness<br>i. feelings of hopelessness | | |
| 8. Describe the behavior associated with bipolar disorder. | E. Bipolar Disorder<br>1. severe mood swings<br>a. manic phase<br>i. everything is wonderful<br>ii. hyperactive<br>b. depression phase<br>i. excessive sadness<br>ii. not enough energy to participate in ADLs<br>2. caused by chemical imbalance in brain | | |
| 9. Describe the signs and symptoms associated with schizophrenia. | F. Schizophrenia<br>1. loss of contact with reality<br>2. signs and symptoms<br>a. delusions<br>i. false ideas of who or what is around client/resident<br>ii. delusions of grandeur<br>iii. delusions of persecution<br>iv. paranoia<br>b. hallucinations<br>i. false sensations that are real to client/resident<br>ii. hearing voices<br>iii. seeing things that are not really there<br>iv. may involve any of the 5 | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | senses<br>c. disorganized speech<br>i. flight of ideas<br>d. catatonic behavior - may stop in mid-sentence and stare | | |
| 10. Describe types of drugs that may lead to substance abuse disorder | IV. Substance abuse disorder<br>A. Types of drugs<br>1. Alcohol<br>2. Marijuana<br>3. Nicotine<br>4. Opioids<br>5. Other | | |
| 11. Causes of substance abuse disorder and opiate misuse | B. Contributing Factors<br>1. Environment<br>2. Genetics<br>3. Other | | |
| 12. Identify signs/symptoms of substance abuse and opiate misuse disorder | C. Signs/Symptoms<br>1. Exhibiting physical or psychological changes<br>2. Other | | |
| 13. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse or supervisor. | D. Report physical or psychological changes to appropriate licensed nurse | | |
| 14. Demonstrate ways the nurse aide can modify his behavior in response to the behavior of the client/resident. | V. Guidelines to Modify the Nurse Aide's Behavior in Response to the Behavior of Clients/Residents<br>A. Know the client/resident<br>1. greet client/resident when entering the room<br>2. encourage self-care as appropriate<br>3. encourage independence with ADLs and activities<br>4. allow client/resident to make choices<br>5. offer to come back at a later time<br>6. remember the aide is not the cause of the client's/resident's behavior<br>7. do not take client's/resident's | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | actions and behavior personally<br>8. stop when client/resident resists what you are doing<br>B. Be aware of your actions<br>1. monitor your body language<br>2. stay calm<br>3. do not yell at or argue with client/resident<br>4. use silence appropriately<br>5. treat client/resident like an adult, not a child<br>6. use appropriate eye contact<br>7. be respectful of resident<br>8. provide privacy, if appropriate for resident<br>9. review reality with resident<br>10. answer questions about time, place, people honestly | | |
| 15. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | C. Report unusual behavior to appropriate licensed nurse<br>1. change in ability to perform ADLs<br>2. change in mood<br>3. behavior that is extreme, dangerous or frightening to other clients/residents<br>4. hallucinations or delusions<br>5. comments about suicide<br>6. client/resident not taking medications or hiding medications<br>7. any activity that causes a change in client's/resident's behavior | | |
| | VI. Behavior Management Techniques | | |
| 16. Demonstrate principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated. | A. Principles of behavior management<br>1. ABCs<br>a. antecedent – what precedes the behavior<br>b. behavior – an action, activity, or process which can be observed | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | and measured<br>c. consequence – how people in the environment react to the behavior<br>d. to change the behavior, change either the antecedent or the consequence<br>2. speak with the 3 s's<br>a. slowly<br>b. softly<br>c. simply – avoid medical terminology<br>3. cueing – graduated guidance<br>a. provide guidance to perform a skill and then gradually let client/resident perform task on his own<br>4. mirroring - modeling<br>a. have client/resident mirror or copy what you are doing<br>5. directing<br>a. instructing the client/resident to do a specific behavior<br>6. redirecting<br>a. change client/resident focus from one behavior to another more appropriate behavior<br>7. schedule care when client/resident is least agitated<br>B. Reward steps that lead to final desired behavior<br>1. plan what behavior is to be addressed<br>2. behavior is broken down into small steps<br>3. each step completed is rewarded<br>C. Three (3) types of rewards<br>1. primary rewards<br>a. food | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 2. social rewards<br>a. smile<br>b. words of praise<br>3. physical rewards<br>a. touch<br>b. hug<br>c. pat on the arm<br>4. rewards must be given in a way that would normally occur in the environment<br>5. rewards should suit the preferences of the client/resident receiving the reward | | |
| 17. Demonstrate strategies to reinforce appropriate behavior. | D. Strategies to reinforce appropriate behavior<br>1. remain calm<br>2. maintain client's/resident's routine<br>3. maintain client's/resident's toileting schedule<br>4. encourage independence<br>5. provide privacy<br>6. encourage socialization<br>7. respond positively to appropriate behavior | | |
| 18. Demonstrate strategies to reduce inappropriate behavior. | E. Strategies to reduce client's/resident's inappropriate behavior<br>1. ignore behavior if it is safe to do so<br>2. remove behavior triggers<br>3. focus on the familiar<br>4. avoid caffeine<br>5. allow to pace in a safe place<br>6. do not argue with client/resident<br>7. try distraction – redirect behavior<br>8. do not take behavior personally<br>9. continue to reinforce appropriate behavior | | |
| 19. Identify age- | VII. Supporting Age-appropriate Behavior<br>A. Age-appropriate strategies | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| appropriate strategies to reinforce client/resident dignity. | 1. participate in planning own care<br>2. encourage to make independent choices<br>3. maintain privacy<br>4. maintain confidentiality<br>5. encourage client/resident to have own possessions<br>6. encourage participation in social activities<br>7. encourage participation in recreational activities<br>8. respect client's/resident's decisions and choices | | |
| 20. Identify guidelines for nurse aide to reinforce client/resident dignity. | B. Guidelines for nurse aide to reinforce client/resident dignity<br>1. address resident in a dignified manner<br>2. take time to listen to what client/resident has to say<br>3. converse with client/resident as with an adult<br>4. do not ignore or humor client/resident<br>5. respect client's/resident's privacy<br>6. explain what you are going to do<br>7. treat client/resident as you would want to be treated<br>8. encourage client/resident to make choices<br>9. client/resident has right to refuse treatment, medications, activities<br><br>VIII. Responding Appropriately to Client's/Resident's Behavior<br>A. Aggressive behavior<br>1. common causes<br>a. pain<br>b. lack of sleep<br>c. fear | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. medication side effects<br>e. too hot or too cold<br>f. hunger<br>g. unable to communicate<br>h. forgetting<br>i. infection and/or illness<br>j. being approached by unknown residents and/or staff | | |
| 21. Identify warning signs that frequently precede aggressive behavior. | 2. warning signs preceding aggressive behavior<br>a. fear<br>b. restlessness<br>c. pacing<br>d. clenching fists<br>e. clenching jaw<br>f. yelling<br>g. trying to leave facility<br>h. throwing things | | |
| 22. Demonstrate strategies to respond to aggressive behavior. | 3. strategies to respond to aggressive behavior<br>a. stay calm<br>b. avoid touching client/resident<br>c. try to identify the trigger for the behavior<br>d. take threats seriously<br>e. get help | | |
| 23. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | f. do not argue with client/resident<br>g. protect yourself and others from harm<br>h. report observations to appropriate licensed nurse<br>B. Angry behavior<br>1. common causes<br>a. disease<br>b. fear<br>c. pain<br>d grief<br>e. loneliness<br>f. loss of independence | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 24. Identify warning signs that frequently precede angry behavior. | g. changes in daily routine<br>2. warning signs preceding angry behavior<br>a. yelling<br>b. throwing things<br>c. threatening<br>d. sarcasm<br>e. pacing<br>f. narrowed eyes<br>g. clenched, raised fists<br>h. withdrawal<br>i. silent, sulking | | |
| 25. Demonstrate strategies to respond to angry behavior. | 3. strategies to respond to angry behavior<br>a. be pleasant and supportive<br>b. try to find cause of anger<br>c. listen to client/resident<br>d. observe body language<br>e. think before speaking<br>f. do not argue with client/resident<br>g. speak in a normal tone of voice<br>h. treat client/resident with respect<br>i. respond promptly to requests<br>j. report behavior to licensed nurse<br>4. strategies if anger escalates<br>a. stay a safe distance away from client/resident<br>b. provide for safety of other clients/residents<br>c. leave client/resident alone if it is safe to do so<br>d. summon help | | |
| 26. Identify signs of combative behavior. | C. Combative behavior<br>1. common causes<br>a. disease affecting the brain<br>b. escalating anger or frustration<br>c. medication side effects<br>2. combative behavior<br>a. hitting | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | b. shoving<br>c. kicking<br>d. throwing things<br>e. insulting others | | |
| 27. Demonstrate strategies to respond to combative behavior. | 3. strategies to respond to combative behavior<br>a. immediately call for help<br>b. keep yourself and others at a safe distance from the client/resident<br>c. stay calm<br>d. be reassuring, speak calmly<br>e. try to find the trigger for the behavior<br>f. do not respond to insults<br>g. do not hit back<br>h. follow the direction of the licensed nurse<br>i. when behavior is under control sit with client/resident to provide comfort, if instructed by licensed nurse<br>j. report behavior to licensed nurse | | |
| 28. Demonstrate strategies to respond to inappropriate language. | D. Inappropriate language<br>1. examples<br>a. cursing<br>b. name calling<br>c. yelling<br>d. sexually suggestive language<br>2. strategies to respond to inappropriate language<br>a. remain calm<br>b. do not take the language personally<br>c. do not argue with the client/resident<br>d. politely tell client/resident that language is inappropriate<br>e. do not respond emotionally to the language | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | f. if appropriate, permit client/resident to have private time<br>g. tell client/resident you will return when he has had opportunity to calm down<br>h. report behavior to licensed nurse | | |
| 29. Identify common causes of confusion and/or disorientation. | E. Confused/disoriented behavior<br>1. inability to think clearly<br>a. disoriented to time, place and/or person<br>b. unable to focus on a task<br>c. temporary or permanent<br>2. common causes<br>a. low blood sugar<br>b. stroke<br>c. head trauma/injury<br>d. dehydration<br>e. nutritional problems<br>f. fever<br>g. sudden drop in body temperature<br>h. lack of oxygen<br>i. medication side effects<br>j. infection<br>k. illness<br>l. loss of sleep<br>m. seizure<br>n. constipation<br>o. difficulty hearing | | |
| 30. Demonstrate strategies to respond to confused and/or disoriented behavior. | 3. strategies to respond to confusion/disorientation<br>a. do not leave client/resident alone<br>b. stay calm<br>c. provide quiet environment<br>c. speak slowly, softly, simply<br>d. introduce yourself every time you encounter client/resident<br>e. reality orientation<br>f. repeat directions as needed | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | g. break ADL tasks into simple steps<br>h. do not rush client/resident to complete tasks<br>i. keep client's/resident's routine<br>j. observe client's/resident's body language as well as listen to what client/resident is saying<br>k. tell client/resident when you are leaving room<br>l. encourage use of glasses and hearing aides<br>m. allow client/resident to make choices<br>n. encourage independence as appropriate<br>o. report observations to the appropriate licensed nurse<br>F. Inappropriate sexual behavior<br>1. examples<br>a. sexual advances or comments<br>b. inappropriate touching of staff<br>c. inappropriate touching of themselves<br>d. removing clothing in public<br>e. masturbation in public<br>2. common causes<br>a. illness<br>b. dementia<br>c. confusion<br>d. medication side effects | | |
| 31. Demonstrate strategies to respond to inappropriate sexual behavior. | 3. strategies to respond to inappropriate sexual behavior<br>a. do not over-react<br>b. be matter-of-fact<br>c. distract the client/resident<br>d. do not judge behavior<br>e. if client/resident wants to talk, listen | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | f. client/resident has right to express sexuality, provide privacy<br>g. report inappropriate behavior to licensed nurse | | |
| 32. Identify the role of family/concerned others as a source of emotional support for the client/resident. | IX. Family/Concerned Others as Source of Emotional Support<br>A. Role of family/concerned others on the health care team<br>1. provide love, support, self-esteem for client/resident<br>2. lessen loneliness of client/resident<br>3. participate in care planning, if desired by client/resident<br>4. participate in care decisions on behalf of client/resident<br>5. provide vital information to assist staff in planning appropriate behavior management plan as needed | | |
| 33. Demonstrate strategies to meet the emotional needs of the client/resident and the family/concerned others. | B. Strategies to meet emotional needs of client/resident and family/concerned others<br>1. be kind and respectful<br>2. ask appropriate questions<br>3. answer questions from client/resident and family/concerned others promptly and appropriately<br>4. listen<br>5. provide competent care to gain confidence of family/concerned others and client/resident<br>6. create permanent assignments so client/resident and family/concerned others can develop relationship with caregiver | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 7. allow client/resident to contact family/concerned others as desired | | |
| 34. Demonstrate strategies to encourage family/concerned others to provide emotional support to the client/resident. | C. Strategies to encourage family/concerned others to provide emotional support to client/resident<br>1. invite family to care conferences as appropriate<br>2. send newsletters informing of up-coming events and special occasions<br>3. make space for family/concerned others to celebrate private events (birthday, anniversary, etc.)<br>4. be friendly and respectful to visiting family/concerned others<br>5. keep facility welcoming, clean and odor-free | | |
| | X. Providing Appropriate Clinical Care to the Aged and Disabled | | |
| 35. Demonstrate appropriate clinical care of the aged. | A. Clinical care for the aged<br>1. respect client/resident rights at all times<br>2. provide for privacy<br>3. maintain confidentiality<br>4. know each client/resident as an individual<br>5. provide care within the nurse aide scope of practice, as assigned<br>6. promote client/resident independence<br>7. keep client/resident free from pain and discomfort<br>8. follow nursing care plan<br>9. observe and report physical and/or behavioral changes to appropriate licensed nurse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | B. Developmental disabilities<br>1. definition<br>a. present from birth<br>b. restricts physical and/or mental ability<br>c. client/resident has difficulty with language, mobility and/or learning<br>2. examples<br>a. cerebral palsy – caused by oxygen deficit at birth<br>b. autism<br>c. mental retardation | | |
| 36. Describe the effects developmental disabilities may have on the client/resident. | 3. functions limited by developmental disabilities<br>a. affect<br>b. self-care<br>c. learning<br>d. mobility<br>e. self-direction<br>f. expressing language<br>g. expressing understanding | | |
| 37. Identify various physical disabilities the nurse aide may find in a long-term care facility. | C. Physical disabilities<br>1. examples<br>a. visual impairment<br>b. hearing impairment<br>c. amputee<br>d. cerebral vascular accident (CVA/stroke)<br>2. functions limited by physical disability<br>a. depends on part of the body affected | | |
| 38. Demonstrate appropriate clinical care of the disabled. | D. Guidelines for clinical care for the disabled<br>1. treat as adults regardless of behavior<br>2. praise and encourage<br>3. be patient | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 4. maintain privacy<br>5. maintain confidentiality<br>6. keep free from pain and discomfort<br>7. encourage client/resident independence<br>8. encourage client/resident to make personal choices<br>9. help teach ADLs as appropriate<br>10. repeat words and directions as needed<br>11. allow time to process what you have said<br>12. encourage participation in restorative care<br>13. follow nursing care plan<br>14. observe and report any physical and/or behavioral changes to appropriate licensed nurse | | |

# UNIT X – SPECIAL NEEDS CLIENTS

(18VAC90-26-40.A.5.a,b,c,d)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Explain the anatomy and physiology of the nervous system. | I. Nervous System<br>A. Anatomy and Physiology<br>1. neuron<br>a. cell that sends and receives information<br>b. dendrite – short extension from the neuron cell body that receives information<br>c. axon – long extension from the cell body that sends information<br>d. synapse – space between axon of one neuron and the dendrite of the next<br>e. myelin – covering of some of the axons<br>2. two (2) divisions of the nervous system<br>a. central nervous system (CNS) - brain and spinal cord<br>b. peripheral nervous system (PNS) - nerves outside of brain and spinal cord<br>3. CNS<br>a. brain<br>i. cerebrum – largest part of brain<br>a) controls voluntary muscle movement<br>b) processes information received from sensory organs<br>c) allows us to speak, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | remember, think and feel emotions<br>ii. cerebellum<br>a) helps coordinate brain's commands to muscles<br>b) assists with balance<br>iii. brain stem<br>a) connects spinal cord to brain<br>b) regulates body temperature, blood pressure, respirations and heartbeat<br>iv. spinal cord<br>a) extends from base of brain to about the level of the naval<br>b) surrounded and protected by the vertebrae<br>c) carries messages from the brain to and from the body<br>4. PNS<br>a. sensory nerves – carry information from the internal organs and the outside world to the spinal cord and into the brain<br>b. motor nerves - carry commands from brain down spinal cord and to the muscles and organs of the body<br>5. function of the nervous system<br>a. regulates what goes on inside the body in response to external stimuli<br>b. allows body to interact with the world around us<br>i. senses – touch, hearing, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 2. Describe age-related changes seen in the nervous system.<br><br><br><br><br><br><br><br><br><br>3. Discuss common disorders of the nervous system, including their signs and symptoms. | sight, smell, taste<br>B. Effects of aging on the nervous system<br>1. slower conduction time<br>a. slower reflexes<br>b. increased risk of falling<br>c. short-term memory loss<br>d. decreased sense of touch<br>e. some hearing loss<br>f. decreased vision, sense of smell and sense of taste<br>C. Common disorders of the nervous system<br>1. cerebrovascular accident (CVA, stroke, brain attack)<br>a. caused by blocked blood vessel or a ruptured blood vessel in the brain<br>b. signs and symptoms<br>i. dizziness<br>ii. confusion<br>iii. loss of consciousness<br>iv. seizure<br>v. facial droop on one side<br>vi. drooping of one eyelid<br>vii. blurred vision<br>viii. sudden, intense headache<br>ix. loss of bowel and/or bladder control<br>x. numbness, tingling on one side of the body<br>xi. weakness and/or paralysis on one side of the body<br>xii. inability to speak<br>xiii. elevated blood pressure<br>c. guidelines for caring for client/resident recovering from a CVA<br>i. encourage independence by | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | using assistive devices as appropriate<br>ii. promote self-esteem<br>iii. allow client/resident time to respond by providing ample time for tasks<br>iv. assist with range of motion to maintain muscle tone and joint mobility<br>v. be aware of changes in or loss of sensation when providing or assisting with personal care<br>vi. assist with nutrition and fluid intake as appropriate to maintain weight and avoid constipation<br>vii. do not refer to a “bad” body part<br>viii. place food in the strong or unaffected side of the mouth when feeding client/resident<br>ix. keep communication simple and use a communication board if appropriate<br>x. if client/resident forgets about paralyzed body part, gently remind him when transferring or repositioning client/resident<br>xi. reposition client/resident q2hrs to prevent pressure sores and contractures<br>xii. be aware client/resident emotions can suddenly change<br>xiii. encourage client/resident progress<br>xiv. encourage client/resident to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 4. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | socialize and participate in activities<br>d. notify appropriate licensed nurse of the following<br>i. change in level of consciousness<br>ii. change in ability to use a body part<br>iii. change in degree of sensation<br>iv. signs of dehydration<br>v. weight loss<br>vi. signs of depression<br>2. Parkinson's Disease<br>a. resident progressively deteriorates<br>b. signs and symptoms<br>i. uncontrollable tremors<br>ii. mask-like facial expression<br>iii. drooling<br>iv. pill-rolling<br>v. rigid muscles<br>vi. shuffling gait<br>vii. stooped posture<br>c. guidelines for caring for client/resident with Parkinson's Disease<br>i. assist with ambulation to prevent falls<br>ii. when ambulating, encourage resident to stand as straight as possible and to pick up his feet<br>iii. allow client/resident ample time to complete simple tasks<br>iv. assist with ADLs as appropriate<br>v. provide assistive devices to help with eating<br>vi. encourage socialization and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 5. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | participation in activities to prevent depression<br>d. notify the appropriate licensed nurse of the following<br>i. severe trembling<br>ii. severe muscle rigidity<br>iii. mood swings<br>iv. sudden incontinence<br>v. dehydration<br>vi. signs of depression<br>3. seizures<br>a. caused by a short-circuit in brain's electrical pathways<br>i. head trauma<br>ii. tumor in the brain<br>iii. high fever<br>iv. alcohol and/or drug abuse<br>v. deficiency of oxygen to the brain at birth<br>b. signs and symptoms<br>i. change in level of consciousness<br>ii. tonic-clonic muscle movements<br>iii. staring<br>c. guidelines for care of the client/resident having a seizure<br>i. lower client/resident to floor and protect the head from injury<br>ii. watch breathing, turn client/resident on his/her side to help keep airway open if needed<br>iii. allow the rest of the body to move<br>iv. do not attempt to put anything in resident's mouth<br>v. when seizure is finished | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse<br>. | position resident on side in the recovery position<br>vi. when resident recovers assist into clean, dry clothes if appropriate<br>vii. be supportive of resident to promote self-esteem<br>viii. notify licensed nurse immediately<br>a) report time seizure began<br>b) how long it lasted<br>c) describe seizure<br>4. multiple sclerosis (MS)<br>a. progressive disorder that affects the nervous system's ability to communicate with muscles and control movement<br>b. occurs in young adults most often<br>c. signs and symptoms<br>i. numbness and tingling<br>ii. muscle weakness<br>iii. extreme fatigue<br>iv. tremors<br>v. decreased sensation in extremities<br>vi. blurred or double vision<br>vii. poor balance<br>viii. difficulty walking because the feet drag<br>ix. bowel and/or bladder incontinence<br>x. paralysis in late stages of disease<br>d. guidelines for caring for the resident with MS<br>i. assist with ambulation to prevent falls<br>ii. allow resident ample time to | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 7. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | complete tasks and ADLs<br>iii. offer frequent rest periods during tasks and ADLs<br>iv. turn, reposition, and provide skin care q2h to prevent pressure sores<br>v. assist with range of motion to maintain muscle tone and joint mobility<br>vi. encourage socialization and participation in activities to prevent depression<br>e. notify the appropriate licensed nurse of the following<br>i. skin that is red, pale or looks like the beginning of a pressure sore<br>ii. joints that do not move as easily as they did<br>iii. complaints of burning on urination, frequency of urination, urine that is concentrated or foul-smelling<br>iv. change in level of consciousness<br>v. signs of depression<br>5. head and spinal cord injuries<br>a. causes<br>i. concussion – banging injury to the brain<br>ii. accidents<br>b. sign and symptoms<br>i. headache<br>ii. unequal pupils<br>iii. drowsy<br>iv. seizure<br>v. change in level of consciousness<br>c. guidelines for care of the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | client/resident with a head or spinal cord injury<br>i. turn, reposition and give skin care q2h to maintain skin and prevent pressure sores and contractures<br>ii. perform range of motion exercises on a regular basis<br>iii. encourage as much independence with ADLs as appropriate<br>iv. encourage hydration<br>v. provide assistive devices as necessary to promote independence and self-esteem<br>vi. follow bowel and bladder schedule<br>vii. encourage client/resident to socialize and participate in activities to prevent depression | | |
| 8. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | d. report to the appropriate licensed nurse the following<br>i. skin that looks as though a pressure sore is forming<br>ii. joints that do not move as easily as they did<br>iii. complaints of burning on urination, frequency of urination, urine that is concentrated or foul smelling<br>iv. change in level of consciousness<br>v. signs of depression | | |
| | D. The eye | | |
| 9. Explain the anatomy and physiology of the eye. | 1. organ of sight<br>a. sclera – white of the eye<br>b. cornea – clear part of sclera that allows light to enter into the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | eyeball<br>c. lens – clear structure that refracts (bends) the light to focus on the retina<br>d. retina – inner-most part of the eyeball<br>i. contains receptors (rods and cones) that convert light into nerve impulses that travel to the brain where the impulses are processed | | |
| 10. Describe age-related changes seen in the eye. | 2. effects of aging on the eye<br>a. decreased number of receptors in the retina<br>b. lens becomes cloudy and opaque<br>c. lens becomes less flexible, unable to properly focus the light on the retina<br>d. decrease in tear production<br>3. common disorders of the eye<br>a. conjunctivitis (pink eye)<br>i. infection and inflammation of the eyelid<br>ii. signs and symptoms<br>a) eye is red, itchy<br>b) eye tears a lot<br>c) white or yellow discharge from the eye<br>iii. guidelines for caring for the client/resident with pink eye<br>a) wash hands before and after caring for the client/resident<br>b) keep your hands away from your face and eyes<br>c) encourage client/resident to avoid touching or rubbing his eyes and to use a tissue | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 11. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | if he must<br>iv. report the following to the appropriate licensed nurse<br>a) discharge from eyes<br>b) complaint of burning or itching in the eyes<br>b. cataracts<br>i. lens becomes cloudy preventing light from entering into the eye and decreasing vision<br>ii. treated by surgery to remove the lens and replace it with an artificial lens<br>iii. guidelines for caring for the client/resident with a cataract<br>a) provide extra light in room or when performing tasks such as reading<br>b) do not sit facing a bright window, turn and sit with back toward window<br>c) encourage independence<br>d) assist with ADLs as appropriate<br>c. glaucoma<br>i. increased pressure inside the eye<br>a) can lead to blindness if not treated<br>ii. signs and symptoms<br>a) decreased vision<br>b) nausea/vomiting<br>c) seeing "halo" around lights<br>d) blurred vision<br>d. age-related macular degeneration (AMD)<br>i. receptors in center of retina are destroyed | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 12. Demonstrate an understanding of the visually impaired client/resident.<br><br>13. Respond appropriately to the behavior of the visually impaired client/resident.<br><br>14. Explain the anatomy and physiology of the ear. | a) resident can only see the periphery of the field of sight<br>4. guidelines for caring for the client/resident with vision impairment<br>a. encourage use of their glasses<br>b. check glasses daily to assure they are clean<br>i. wash glasses with warm water and dry with soft towel; never dry with a paper towel<br>c. knock before entering client's/resident's room<br>d. identify yourself whenever enter client's/resident's room<br>e. announce to client/resident when you are leaving client's/resident's room<br>f. leave furniture where client/resident knows where it is<br>g. use numbers of a clock to tell client/resident where an item or food is located on the plate<br>h. when assisting client/resident to ambulate, walk slightly ahead of client/resident and allow client/resident to hold your arm or elbow<br>i. report to appropriate licensed nurse glasses that need to be repaired<br>E. The ear<br>1. anatomy and physiology of the ear<br>a. outer ear<br>i. tympanic membrane – ear drum<br>ii. cerumen – ear wax<br>b. middle ear | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | i. equalizes air pressure<br>ii. 3 small bones – malleus, incus and stapes<br>c. inner ear<br>i. cochlea – contains receptors for hearing<br>ii. vestibule<br>iii. semicircular canals – help keep our balance<br>2. function of the ear<br>a. hearing<br>b. balance | | |
| 15. Describe age-related changes seen in the ear. | 3. effects of aging on the ear<br>a. tympanic membrane becomes stiff<br>b. 3 small bones don't vibrate as easily<br>c. sensory receptors in cochlea decrease<br>d. decreased hearing<br>4. common disorders of the ear<br>a. otitis media<br>i. infection of the middle ear<br>ii. signs and symptoms<br>a) ear pain<br>b) fever<br>c) discharge from the ear<br>d) difficulty hearing | | |
| 16. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | iii. report to appropriate licensed nurse the following<br>a) discharge from the ear<br>b) complaints of ear pain<br>c) complaints of difficulty hearing<br>d) fever<br>b. Meniere's Disease<br>i. disease of the inner ear<br>ii. signs and symptoms<br>a) dizzy | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| | b) tinnitus – ringing in the ears<br>c) temporary hearing loss<br>d) nausea/vomiting<br>iii. guidelines for care of client/resident with Meniere's Disease<br>a) lie down<br>b) keep eyes from moving<br>c) allow resident ample time to complete ADLs<br>c. deafness<br>i. conductive hearing loss – sound waves prevented from reaching receptors in cochlea<br>ii. sensorineural hearing loss – receptors unable to transmit nerve impulses or to receive stimuli<br>5. hearing aids<br>a. battery operated device to amplify sound<br>b. very expensive, handle with care<br>c. guidelines for caring for hearing aids<br>i. treat with care<br>ii. turn off when not in use<br>iii. store in labeled container in a cool, dry place<br>iv. check batteries frequently to ensure they are in working order<br>v. do not get batteries wet<br>vi. remove hearing aid before bathing, showering or shampooing hair<br>vii. report to licensed nurse dead batteries, hearing aid that need repair | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| 17. Demonstrate an understanding of the hearing impaired client/resident.<br><br>18. Respond appropriately to the behavior of the hearing impaired resident. | 6. guidelines for caring for the client/resident with hearing impairment<br>a. reduce or eliminate background noise<br>b. encourage client/resident to wear hearing aid and verify that hearing aid is turned on<br>c. check that batteries for hearing aid are functional<br>d. face client/resident when speaking<br>e. use note pad to write important directions<br>f. consider learning sign language<br><br>II. Cognitive Impairment – Memory Care<br>A. Introduction | | |
| 19. Define the terms used with cognitive impairment. | 1. inability to think, to remember or to reason<br>2. causes<br>a. delirium – temporary confusion<br>b. depression<br>c. dementia<br>3. dementia in long-term care<br>a. brain atrophies, nerve fibers become tangled and covered with a sticky protein<br>b. progressive<br>c. not reversible<br>d. there is no cure<br>e. many causes<br>i. brain injury<br>ii. AIDS<br>iii. prolonged substance abuse<br>iv. CVA<br>v. Parkinson's Disease<br>vi. Alzheimer's Disease (AD) | | |
| 20. Define the various types | 4. types of dementia | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| of dementia. | a. over 100 different types<br>b. vascular dementia – may occur after a stroke due to interruption of blood supply<br>i. symptoms of impaired judgment and problems planning, concentrating and thinking<br>c. dementia with Lewy bodies – less common<br>i. symptoms of memory loss, thinking problems, visual hallucinations, muscle rigidity<br>d. Alzheimer's Disease - most common type | | |
| 21. Discuss the three stages of Alzheimer's Disease. | B. Alzheimer's Disease (AD)<br>1. three (3) stages<br>a. stage 1- early/mild<br>i. short-term memory loss<br>ii. disorientated to time<br>iii. loses interest in work and hobbies<br>iv. unable to concentrate<br>v. decreased attention span<br>vi. mood swings<br>vii. rude behavior<br>viii. tends to blame others<br>ix. poor judgment<br>x. poor personal hygiene and safety awareness<br>b. stage 2 - middle/moderate<br>i. increased disorientation<br>ii. increased memory loss – may forget family and friends<br>iii. slurred speech<br>iv. difficulty finding the right words<br>v. difficulty following directions<br>vi. loses ability to read, write or | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | do math<br>vii. unable to perform own ADLs without assistance<br>viii. unable to recognize common items like a comb or eating utensils<br>ix. becomes incontinent<br>x. restless, wanders, paces, sundown syndrome<br>xi. difficulty sleeping<br>xii. poor impulse control – inappropriate language, sexually aggressive<br>xiii. hallucinations (experiences sensations that are not real) and/or delusions (false ideas about who one is or what is going on around them)<br>c. stage 3 – late/severe<br>i. total disorientation to time, place and person<br>ii. total dependence on others for care<br>iii. completely incontinent<br>iv. verbally unresponsive<br>v. confined to bed, unable to walk<br>vi. unable to recognize family or self<br>vii. difficulty swallowing and eating<br>viii. seizures<br>ix. coma<br>x. death | | |
| 22. Demonstrate an understanding of the behavior of the cognitively impaired client/resident. | C. Behaviors associated with dementia<br>1. wandering or pacing<br>a. causes<br>i. over-stimulating environment<br>ii. feeling scared or lost | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 23. Respond appropriately to the behavior of the cognitively impaired client/resident . | iii. looking for someone or something<br>iv. need to go to the bathroom<br>v. hunger<br>vi. forgetting how or where to sit<br>b. appropriate responses to wandering or pacing<br>i. provide safe place for wandering/pacing<br>ii. maintain toileting schedule<br>iii. offer snacks<br>iv. redirect to other activities<br>v. redirect to other exercise<br>vi. for nighttime wandering, minimize daytime napping<br>vii. provide reassurance<br>2. agitation<br>a. causes<br>i. frustration<br>ii. insecurity<br>iii. new people or new places<br>iv. changes in routine<br>v. over-stimulating environment<br>b. appropriate responses to agitation<br>i. eliminate triggering behavior<br>ii. keep calm<br>iii. speak slowly and simply<br>iv. reduce noise and stimulation in environment<br>v. redirect to a familiar activity<br>vi. reassure client/resident that he is safe<br>3. hallucinations and delusions<br>a. hallucinations – hearing/seeing things that are not there<br>b. delusions – false ideas about who one is or what is going on around one | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 24. Demonstrate Appropriate responses to a client/resident experiencing hallucinations/delusions.<br><br><br><br><br><br>25. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | c. appropriate responses to hallucinations/delusions<br>i. if they are harmless, ignore them<br>ii. do not argue because they are real to the client/resident<br>iii. redirect client/resident to other activities<br>iv. report violent behavior to appropriate nurse, such as hitting, attacking, threatening to self and/or others<br>a) causes<br>1) frustration<br>2) over-stimulation<br>3) change in routine<br>b) appropriate responses to violent behavior<br>1) notify licensed nurse immediately<br>2) decrease environmental stimulation<br>3) step out of reach and remain calm<br>4) protect yourself and others<br>5) never hit back<br>6) speak slowly and simply<br>4. catastrophic reactions<br>a. unreasonable, exaggerated reaction<br>i. may be inappropriate language<br>b. causes<br>i. fatigue<br>ii. change of routine<br>iii. over-stimulation in environment | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | iv. pain or discomfort<br>v. hunger or need to toilet | | |
| 26. Demonstrate appropriate responses to a client/resident experiencing catastrophic reactions. | c. appropriate responses to catastrophic reactions<br>i. remove triggers<br>ii. use calming techniques<br>iii. do not leave the client/resident alone<br>iv. block blows | | |
| 27. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | v. never hit back<br>vi. stay out of reach<br>vii. protect yourself and others<br>viii. call for help<br>ix. notify licensed nurse immediately | | |
| 28. Define pillaging, rummaging, and hoarding. | 5. pillaging, rummaging and/or hoarding<br>a. pillaging – taking items that belong to someone else<br>b. rummaging – going through drawers, closets, personal items that belong to oneself or to others<br>c. hoarding – collecting more items than one needs and never throwing anything away | | |
| 29. Demonstrate appropriate responses to a client/resident experiencing pillaging, rummaging and/or hoarding. | d. appropriate responses to pillaging, rummaging and/or hoarding<br>i. do not judge clients/residents – these behaviors are out of their control<br>ii. label all of client/resident belongings<br>iii. check hiding places periodically<br>iv. notify family so they are aware of behavior | | |
| 30. Discuss the importance of reporting abnormal | v. set aside special drawer for | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| observations or changes to the appropriate licensed nurse. | rummaging or hoarding<br>vi. notify licensed nurse immediately<br>6. sundown syndrome<br>a. client/resident becomes restless and agitated in late afternoon, evening or night<br>b. causes<br>i. hunger<br>ii. fatigue<br>iii. change in routine<br>iv. new situation | | |
| 31. Demonstrate appropriate responses to a client/resident experiencing sundowning. | c. appropriate responses to sundowning<br>i. provide adequate lighting before it gets dark<br>ii. avoid stressful situations in afternoon or evening<br>iii. discourage daytime naps<br>iv. follow a bedtime routine<br>v. plan calming activity just before bedtime<br>vi. eliminate caffeine from diet<br>vii. give soothing back rub<br>viii. redirect behavior to a calm activity | | |
| 32. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | ix. maintain daily exercise routine<br>x. notify licensed nurse of behavior<br>7. perseveration<br>a. repeat words, phrases or questions over and over again<br>b. may repeat same activity over and over again<br>c. appropriate responses to perseveration | | |
| 33. Demonstrate appropriate responses to a | i. remember that client/resident is unaware of behavior | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| client/resident experiencing perseveration.<br><br>34. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.<br><br>35. Demonstrate appropriate responses to a client/resident experiencing inappropriate social behavior.<br><br>36. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.<br><br>37. Demonstrate appropriate responses to a client/resident displaying | ii. respond each time to a question<br>iii. remain calm<br>iv. do not attempt to silence or stop client/resident<br>v. redirect client/resident to another activity<br>vi. notify licensed nurse of behavior<br>8. inappropriate social behavior<br>a. cursing, yelling<br>b. banging on furniture, slamming doors, etc.<br>c. causes<br>i. pain<br>ii. constipation<br>iii. frustration<br>iv. desire for attention<br>d. appropriate responses to inappropriate social behavior<br>i. remain calm<br>ii. speak slowly, simply, softly<br>iii. try to determine cause of the behavior<br>iv. report behavior to licensed nurse<br>9. inappropriate sexual behavior<br>a. removing clothing, inappropriate touching of self or others<br>b. causes<br>i. client/resident is hot<br>ii. need to toilet<br>iii. attempting to remove soiled clothing<br>iv. pleasant sensation<br>c. appropriate responses to inappropriate sexual behavior<br>i. stay calm and professional | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| inappropriate sexual behavior.<br><br>38. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.<br><br>39. Demonstrate strategies for communicating with the cognitively impaired client/resident. | ii. try to find reason for behavior<br>iii. direct client/resident to private area<br>iv. distract client/resident<br>v. report behavior to licensed nurse<br>D. Strategies for communicating with the cognitively impaired client/resident<br>1. always introduce yourself to Client/resident<br>2. be careful with touching client/resident, as this may frighten or upset client/resident<br>3. maintain eye contact when speaking with client/resident<br>4. allow client/resident ample time to respond<br>5. speak slowly, simply, softly<br>6. reduce environmental noise<br>7. give directions one at a time, not a list of directions<br>8. repeat directions and answers as often as needed<br>9. if client/resident does not seem to understand what you are saying, try using different words<br>10. watch for body-language clues that indicate what client/resident needs or is trying to say<br>11. always describe what you are doing<br>12. break tasks into simple steps<br>13. use pictures or a communication board<br>14. post reminders such as calendars, signs, activity boards, pictures<br>15. frequently offer praise<br>16. if language is offensive, ignore it or gently try to redirect | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | client/resident to another activity<br>17. do not talk to or about client/resident as though he is a child<br>18. use validation therapy<br>a. acknowledge the client's/resident's reality<br>b. do not argue with client/resident<br>c. attempt to distract client/resident and redirect attention to another, more appropriate activity | | |
| 40. Demonstrate techniques for addressing the unique needs and behaviors of clients/residents with cognitive impairment. | E. Techniques to address unique needs of the cognitively impaired client/resident<br>1. bathing<br>a. schedule bathing when client/resident is least agitated<br>b. adhere to the schedule<br>c. gather all supplies before beginning procedure<br>d. use sponge bath if client/resident becomes upset with tub bath or shower<br>e. have bathroom warm and well-lit<br>f. make sure water is warm<br>g. provide for privacy and safety<br>h. encourage independence by giving client/resident washcloth<br>i. explain everything you are doing<br>j. be calm and reassuring throughout procedure<br>2. grooming and dressing<br>a. assist with grooming to maintain self-esteem and dignity<br>b. use clothing that opens in the front, has elastic waistbands, Velcro instead of buttons<br>c. choices may agitate | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | client/resident; therefore, do not give client/resident too many choices when selecting clothes; may be best to offer only one outfit to wear<br>3. toileting<br>a. establish toileting schedule and adhere to it<br>b. toilet q2h or more often if necessary<br>c. toilet before meals and before bedtime<br>d. place sign on bathroom door so client/resident will recognize it<br>e. keep bathroom lit<br>f. assist client/resident to clean self after toileting<br>g. change client's/resident's clothing if they become soiled<br>h. keep skin clean and dry<br>i. document bowel movements<br>j. reassure family and friends if they are upset by client's/resident's incontinence<br>k. encourage fluid intake to avoid dehydration<br>4. eating<br>a. establish a meal schedule and adhere to it<br>b. encourage independence at mealtime with the use of assistive devices<br>c. dining area should be well-lit, pleasant, with a minimum of background noise (turn off TV)<br>d. seat client/resident with others to promote socialization<br>e. food should look pleasant and appealing | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 41. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | f. food and drink should not be too hot or too cold<br>g. keep table setting simple<br>i. no patterns on the tablecloth or plates<br>ii. do not put unnecessary plates, glasses or silverware on the table<br>h. finger foods are acceptable<br>i. offer plenty of fluids<br>j. give simple directions<br>k. use cueing to give client/resident idea of how to feed self<br>l. allow ample time for client/resident to feed self<br>m. give resident smaller meals at more frequent intervals if wandering interferes with meals<br>n. report to appropriate licensed nurse<br>i. choking or difficulty swallowing<br>ii. changes in intake and/or output<br>5. general health issues<br>a. assist to wash hands at frequent intervals<br>b. be alert to risk for falls and reduce risks for client/resident<br>c. be diligent with skin care<br>d. observe for non-verbal cues regarding pain or discomfort and report to appropriate licensed nurse<br>e. promote self-esteem by encouraging independence in activities where possible<br>f. provide daily/weekly calendar<br>g. encourage participation in | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | activities and socialization<br>h. reward behavior with smiles, hugs and praise | | |
| 42. Demonstrate methods to reduce the effects of cognitive impairment. | 6. therapies used with cognitively impaired clients/residents<br>a. reality orientation<br>i. calendars<br>ii. clocks<br>iii. signs<br>iv. lists<br>b. validation therapy<br>i. acknowledge client's/resident's reality<br>ii. do not argue<br>iii. redirect activity to more appropriate behavior<br>c. reminiscence therapy<br>i. reminds resident of past experiences and people<br>d. re-motivation therapy<br>i. promote self-esteem, socialization<br>ii. groups to focus on specific topic | | |
| 43. Identify strategies the nurse aide can use to keep a positive, empathetic attitude when caring for clients/residents with cognitive impairment. | F. Care for the caregiver<br>1. do not take behavior personally<br>2. consider what client/resident is feeling<br>3. work with client/resident as they are today<br>4. work as a team making sure everyone follows the person-centered care plan<br>5. work with and support family members<br>6. take care of yourself<br><br>III. Diabetes Mellitus | | |
| 44. Define the anatomy of | A. The endocrine system | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| the endocrine system. | 1. regulates many body functions<br>2. made up of glands that secrete hormones directly into the bloodstream<br>3. glands<br>a. pituitary gland – 7 hormones including growth-stimulating hormone<br>b. thyroid –controls metabolism<br>c. parathryoids – regulates body's use of calcium<br>d. thymus – regulates immune system<br>e. adrenals – regulate BP and fight vs. flight<br>f. pancreas – produces insulin to regulate blood sugar<br>g. ovaries – female sex hormones<br>h. testes – male sex hormones | | |
| 45. Describe age-related changes seen in the endocrine system. | 4. age-related changes in the endocrine system<br>a. levels of hormones decrease<br>i. menopause in women<br>b. levels of insulin decrease<br>c. body handles stress less efficiently | | |
| 46. Discuss common disorders of the endocrine system, including their signs and symptoms. | 5. common disorders of the endocrine system<br>a. diabetes mellitus<br>b. hypothyroidism<br>B. Diabetes mellitus (DM)<br>1. insulin<br>a. the key that opens the door to allow glucose to enter the cell<br>b. cells use glucose for energy/food<br>c. without glucose, cells will die<br>d. without insulin, glucose stays in the blood and cannot get into the | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | cells | | |
| 47. Describe the difference between Type 1 and Type 2 diabetes mellitus. | 2. type 1 – insulin dependent diabetes mellitus (IDDM)<br>a. pancreas produces little or no insulin<br>b. must have outside source of insulin (injection)<br>3. type 2 – non-insulin dependent diabetes mellitus (NIDDM)<br>a. pancreas produces insulin but the body has become resistant to its own insulin<br>b. may take oral hypoglycemic tablet<br>c. may be treated with diet and exercise<br>d. may require injection of insulin | | |
| 48. Identify signs and symptoms of diabetes mellitus. | 4. signs and symptoms of DM<br>a. increased thirst<br>b. increased urination<br>c. increased hunger<br>d. fatigue<br>e. elevated blood sugar<br>f. blurred vision<br>g. slow-healing cuts or sores<br>h. numbness/tingling in hands/feet<br>i. increased number of infections<br>5. complications of DM | | |
| 49. Discuss hypoglycemia, including the signs and symptoms and the care of the client/resident experiencing hypoglycemia. | a. hypoglycemia<br>i. signs<br>a) change in level of consciousness<br>b) skin cool and clammy<br>c) complaint of headache<br>d) shaky<br>e) nauseated<br>ii. causes<br>a) skipped a meal<br>b) too much exercise | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 50. Discuss hyperglycemia, including the signs and symptoms and the care of the client/resident experiencing hyperglycemia.<br><br>51. Describe long-term complications of diabetes mellitus.<br><br>52. Discuss guidelines for the nurse aide caring for the client/resident with diabetes mellitus. | c) received too much insulin<br>iii. notify licensed nurse immediately<br>iv. if conscious, give orange juice or peanut butter crackers or follow facility policy<br>b. hyperglycemia<br>i. signs<br>a) skin warm and flushed<br>b) breath has fruity smell<br>c) blood sugar is elevated<br>ii. causes<br>a) over-eating<br>b) not enough exercise<br>c) did not receive enough insulin<br>iii. notify licensed nurse immediately<br>c. damage to blood vessels<br>i. damage to blood vessels in the retina leads to blindness<br>ii. damage to blood vessels in the kidneys leads to kidney failure and dialysis<br>iii. damage to blood vessels in the feet and legs leads to amputation<br>d. damage to nerves<br>i. numbness and tingling in hands and feet<br>ii. loss of sensation in fingers and toes<br>6. guidelines for the care of the client/resident with DM<br>a. maintain meal schedule<br>b. encourage client/resident to follow diet and not eat concentrated sweets<br>c. monitor blood sugar per facility | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | policy<br>d. inspect client's/resident's feet and toes every day for blisters, reddened areas<br>e. client/resident should always wear well-fitting shoes when ambulating<br>f. if client/resident has loss of sensation in hands, assist with activities such as eating, writing or holding objects<br>g. if client/resident has loss of sensation in feet, assist with ambulation<br>h. never cut client's/resident's toenails; only a podiatrist can do this<br>i. always dry between client's/resident's toes after washing feet | | |
| 53. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | 7. what to report to the appropriate licensed nurse<br>a. a missed meal<br>b. complaints of increased thirst<br>c. complaints of increased urination, particularly at night<br>d. complaints of blurred vision<br>e. change in level of consciousness<br>f. skin that is cool and clammy<br>g. skin that is warm and flushed<br>h. observing client/resident eating concentrated sweets between meals<br>i. cuts, bruises, sores that do not seem to be healing<br>j. blisters, sores, redness, cracks on/between toes or on feet<br>k. increased incidence of infections<br>C. Hypothyroidism | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 1. description<br>a. lack of thyroid hormone<br>b. causes body metabolism to slow down | | |
| 54. Identify signs and symptoms of hypothyroidism. | 2. signs and symptoms<br>a. fatigue<br>b. weakness<br>c. weight gain<br>d. constipation<br>e. intolerant of the cold<br>f. dry skin<br>g. hair thins and/or begins to fall out<br>h. brittle hair and fingernails<br>i. pulse slows<br>j. blood pressure decreases<br>k. temperature is lower<br>l. goiter (enlarged thyroid)<br>m. voice becomes hoarse<br>n. depression | | |
| 55. Discuss guidelines for the nurse aide caring for the client/resident with hypothyroidism. | 3. guidelines for care of the client/resident with hypothyroidism<br>a. offer sweater, blanket to keep client/resident comfortable when complains of being cold<br>b. set room thermostat a little higher to provide warmth<br>c. be extra careful when grooming hair and nails<br>d. provide frequent rest periods, as necessary, during ADLs<br>e. encourage fluid intake | | |
| 56. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | 4. report the following to the appropriate licensed nurse<br>a. unusual complaints of coldness<br>b. unusual complaints of fatigue<br>c. hair that breaks or appears to be falling out<br>d. complaints of constipation | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 57. Identify signs and symptoms of hyperthyroidism.<br><br>58. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | e. changes in voice<br>f. neck becoming larger<br>g. decrease in vital signs from baseline<br>h. increase in weight<br>D. Hyperthyroidism<br>1. thyroid gland produces too much thyroid hormone<br>2. body processes speed up<br>3. body metabolism increases<br>4. signs and symptoms<br>a. nervousness<br>b. restlessness<br>c. fatigue<br>d. bulging or protruding eyes<br>e. tremors of the hands<br>f. intolerance to heat<br>g. excessive perspiration<br>h. rapid pulse<br>i. high BP<br>j. increased appetite with weight loss<br>k. enlarged neck (goiter)<br>5. guidelines for care of the client/resident with hyperthyroidism<br>a. assist to dress in cooler clothing<br>b. lower thermostat in room<br>c. assist at mealtime if appropriate<br>6. what to report to appropriate licensed nurse<br>a. unusual complaints of being warm/hot<br>b. nervousness<br>c. unusual tremors of hands<br>d. eyes that appear to be bulging<br>e. excessive perspiration<br>f. increase in vital signs<br>g. weight loss | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | h. change in appetite<br>i. change in size of neck | | |

# UNIT XI – BASIC RESTORATIVE SERVICES

(18VAC90-26-40.A.6.a,b,c,d,e,f)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | I. Definitions<br>A. Disability<br>1. impaired function<br>a. physical<br>b. emotional<br>c. both at the same time<br>2. may be permanent or temporary<br>3. goal of care<br>a. assist resident to learn to manage disability<br>b. gain as much independence as possible | | |
| 1. Describe the purpose of rehabilitation. | B. Rehabilitation<br>1. occurs after accident, illness or injury<br>2. assist resident with disability to achieve highest possible level of functioning<br>a. physical<br>b. emotional<br>c. economic<br>3. holistic care<br>a. treating the entire person<br>b. physical and psychological | | |
| 2. Identify members of the rehabilitation team. | C. Members of the rehabilitation team<br>1. physiatrist – physician specializing in rehabilitation<br>2. other physicians<br>3. therapists<br>a. speech therapy<br>b. physical therapy<br>c. occupational therapy<br>4. social workers | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 5. discharge planners<br>6. nurses<br>7. nurse aides<br>8. resident<br>9. resident’s family<br>D. Goals of rehabilitation team<br>1. assist resident to maintain and/or regain ability to perform ADLs<br>2. promote resident independence<br>3. assist resident adaptation to disability<br>4. prevent complications of disability<br>E. Restorative care<br>1. actions of health care workers<br>2. goals<br>a. assist resident to maintain health, strength, function<br>b. increase independence<br>3. includes<br>a. treatment<br>b. education<br>c. prevention of complications<br><br>II. Guidelines of Rehabilitation and Restorative Care | | |
| 3. Describe restorative care. | A. Understand diagnosis and disability<br>1. be aware of resident’s limitations<br>2. know resident’s abilities and strengths<br>3. follow person-centered care plan<br>B. Display patience with resident and significant others<br>1. small improvements may be significant<br>2. respond appropriately and offer praise | | |
| 4. Discuss the role of the nurse aide in rehabilitation and restorative care. | C. Display positive attitude<br>1. staff sets the tone for the day<br>2. show support, encouragement, and | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 5. Describe ways to teach, with supervision, a resident to participate in self-care.<br><br>6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | patience<br>D. Listen to resident's thoughts and feelings - emotional needs are important<br>E. Provide for resident privacy<br>1. avoids distractions<br>2. allows resident to practice new skills without an audience<br>3. promote resident independence within the resident's level of functioning - accomplishing a task by himself improves resident self-esteem<br>F. Promote personal choice - supports self-esteem<br>G. Encourage physical activity<br>1. helps prevent complications of disability<br>2. encourages social interaction<br>H. Be aware resident may have setbacks<br>I. Report the following to appropriate licensed nurse<br>1. lack of motivation<br>2. signs of withdrawal or depression<br>3. change in ability, both increased or decreased<br>4. change in resident strength, both increased and decreased<br>5. change in ability to perform range of motion<br>6. changes in pain level, or signs that resident is in pain<br><br>III. Methods to Teach Resident to Participate in Self-Care Program<br>A. Nurse aide project positive attitude<br>1. be enthusiastic<br>2. nurse aide's attitude will encourage resident | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | B. Establish reasonable goals with resident's participation<br>1. what does resident want to achieve?<br>2. how will resident work toward goal?<br>3. how will resident know when goal has been achieved?<br>4. begin at resident's current level of function<br>5. use cueing, mirroring, behavior reinforcement | | |
| 7. Describe reasons why resident may not want to participate in self-care. | C. Reasons resident may refuse<br>1. fear of hurting themselves<br>2. fear of failure<br>3. feeling of hopelessness<br>4. not understanding why self-care is helpful<br>5. not understanding why self-care is necessary | | |
| 8. Identify assistive devices the nurse aide may use for transferring residents, including bed to chair and bed to stretcher. | IV. Assistive Devices<br>A. Definition<br>1. devices to make specific tasks easier<br>2. promote independence<br>B. Transferring resident<br>1. transfer belt (gait belt) for ambulation and transfer bed to wheelchair<br>2. slide board to transfer resident from bed to stretcher<br>3. mechanical lift (manual or electronic) to transfer resident from bed to chair<br>4. U.S. Department of Labor Fair Labor Standards Act (FLSA) Hazardous Occupation Order No. 7<br>a. prohibits minors under 18 from | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | operating or assisting in the operation of most power-driven hoists, including those designed to lift and move residents<br>b. US Department of Labor Wage and Hour division website, pages 3, 4 | | |
| 9. Identify assistive devices the nurse aide may use to assist the resident to ambulate. | C. Ambulating resident – ambulatory assistive devices<br>1. transfer belt (gait belt)<br>2. cane<br>a. C-cane: handle in shape of a "C"<br>b. quad cane: has 4 rubber-tipped feet<br>3. walker- provides more support than cane<br>4. crutches - used when resident has limited weight bearing on one leg | | |
| 10. Demonstrate how to assist the resident to ambulate with assistive devices. | D. Guidelines for ambulatory assistive devices<br>1. check assistive device for any defect or damage prior to use<br>2. resident should always wear non-skid shoes that fit correctly when ambulating<br>3. clothing should fit properly, not be too long or too loose-fitting<br>4. promptly clean spills and clutter from floors where resident will be walking<br>5. encourage resident to stand as straight as possible when walking<br>6. do not rush resident<br>7. do not use walker to hang items<br>8. resident should use cane in strong hand<br>9. when assisting resident to walk, | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | stay near resident on the weak side<br>10. have chair available for resident to use if he experiences pain or discomfort while ambulating<br>11. after walking, return resident to chair or bed, in the low position, with call bell within reach | | |
| 11. Identify assistive devices the nurse aide may use to assist the resident to eat. | E. Assistive devices for eating<br>1. plate guard<br>2. utensils with built-up handles<br>3. utensils with curved handles<br>4. utensils that have a Velcro strap to hold utensil in resident's hand<br>5. sippy cup<br>6. cup holders | | |
| 12. Identify assistive devices the nurse aide may use to assist the resident to dress. | F. Assistive devices for dressing/grooming<br>1. zipper pulls<br>2. Velcro fasteners instead of buttons<br>3. long handled shoe horn<br>4. long-handled graspers<br>5. button hole hooks<br>6. elastic shoelaces<br>7. denture brush<br>8. long handled bathing sponge | | |
| 13. Define terms associated with range of motion. | V. Range of Motion Exercises<br>A. Definitions<br>1. abduction - move away from the body's midline<br>2. adduction - move toward the body's midline<br>3. extension - straighten the body part<br>4. flexion - bend the body part<br>5. dorsiflexion - bend body part backward<br>6. pronation - turn body part downward | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 7. rotation - turn the joint<br>8. supination - turn body part upward<br>9. contraction<br>a. joint remains in permanently bent position<br>b. caused by lack of movement<br>c. prevented by<br>i. proper positioning<br>ii. range of motion (ROM) exercises to joint | | |
| 14. Describe benefits of exercise. | B. Benefits of exercise<br>1. increase muscle strength<br>2. maintain joint mobility<br>3. prevent contractures<br>4. improve coordination to help prevent falls<br>5. improve self-image to prevent depression<br>6. maintain/reduce weight<br>7. improve circulation to prevent leg ulcers<br>C. Range of motion exercises<br>1. active range of motion exercise (AROM) - resident exercises own joints without assistance<br>2. passive range of motion exercise (PROM) – staff exercises resident's joints without assistance from the resident<br>3. promotes self-care and resident independence | | |
| 15. Demonstrate passive range of motion (PROM) to lower extremity. | D. Perform passive range of motion (PROM) for lower extremity - follow the procedure for "Performs Modified Passive Range of Motion (PROM) for One Knee and One Ankle" in the most current edition of Virginia Nurse Aide Candidate Handbook | | |
| 16. Demonstrate passive | E. Perform passive range of motion | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| range of motion (PROM) to upper extremity. | (PROM) for upper extremity - follow the procedure for "Performs Modified Passive Range of Motion (PROM) for One Shoulder" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>F. Signs to stop or withhold range of motion exercises<br>1. pain in the joint<br>2. red, swollen joint<br>G. Ways to maintain range of motion<br>1. therapeutic positioning to maintain good body alignment<br>2. use of positioning devices<br>3. range of motion exercises on a<br>4. regular schedule | | |
| 17. Discuss the guidelines for range of motion exercises. | H. Guidelines for range of motion exercises<br>1. follow person-centered care plan<br>2. use proper body mechanics when performing range of motion exercises to protect your body<br>3. provide range of motion exercises to both sides of resident's body beginning at the head and working down the body (head and neck are usually not exercised unless specifically ordered)<br>4. support the extremity above and below the joint during range of motion<br>5. do not exercise joint that is bandaged or has dressing, cast, IV tubing<br>6. never exercise a joint that is red, bruised, has open sore, draining fluid<br>7. provide for privacy when doing range of motion exercises | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 8. do not exercise joint to point of discomfort -hyperextension can cause damage to joint<br>9. maintain resident in good body alignment<br>10. talk with resident while performing range of motion | | |
| 18. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | I. Report the following to the appropriate licensed nurse<br>1. joint that is red, swollen, painful, draining<br>2. complaints of pain during range of motion exercise<br>3. lack of motivation<br>4. signs of withdrawal or depression<br>5. change in ability, both increased or decreased<br>6. change in resident strength, both increased and decreased<br>7. change in ability to perform range of motion | | |
| 19. Identify positioning devices the nurse aide may use when turning and position residents in bed and in the chair. | VI. Turning and Positioning in Bed and Chair<br>A. Positioning devices<br>1. backrests<br>a. pillow<br>b. special wedge-shaped foam pillows<br>c. provide support, comfort<br>d. maintain proper body alignment<br>2. bed cradles/foot cradles<br>a. keep sheets/blankets from pushing down on the resident's toes and feet<br>3. footboards<br>a. padded boards or device placed against resident's feet to keep ankles and foot in proper alignment<br>b. prevent foot drop | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | 4. heel/elbow protectors<br>a. padded protectors wrapped around foot and ankle (heel) or elbow and arm (elbow)<br>b. prevents rubbing, irritation and pressure on the heel or elbow<br>c. heel protector maintains proper body alignment for ankle<br>d. heel protector prevents foot drop<br>5. abduction wedges - keep hips in proper position after hip surgery<br>6. trochanter roll<br>a. rolled blanket or towel placed on outside of leg<br>b. prevent hip and leg from turning outward<br>7. handroll<br>a. rolled washcloths placed in palm of hand<br>b. keep hand and/or fingers in proper alignment<br>c. prevents contractures of finger, hand or wrist<br>B. Turning resident in bed<br>1. protects against problems of immobility<br>a. blood clots in the legs<br>b. pneumonia<br>c. contractures<br>d. depression<br>e. urinary tract infection<br>2. prevents pressure sores - turn and reposition q2h around the clock<br>3. comfort | | |
| 20. Demonstrate positioning resident on his side. | 4. position resident on side - follow the procedure for “Positions on Side” in the most current edition of Virginia Nurse Aide Candidate | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | Handbook<br>5. use positioning devices for proper body alignment and comfort | | |
| 21. Demonstrate positioning resident in a chair. | C. Position resident in chair<br>1. feet on floor<br>2. hips touching back of chair<br>3. use positioning devices to maintain body alignment and comfort<br>4. place call bell within resident's reach<br><br>VII. Prosthetic and Orthotic Devices<br>A. Prosthetic devices<br>1. definition - artificial replacement for legs, feet, arms or other body parts<br>2. examples<br>a. artificial arm or leg<br>b. artificial eye | | |
| 22. Describe caring for and using prosthetic devices. | 3. caring for and using prosthetic devices<br>a. handle with extreme care – they are very expensive<br>b. follow instructions when applying and removing prosthesis<br>c. assist resident as needed to apply or remove prosthesis<br>d. follow person-centered care plan and manufacturer's instructions<br>e. make sure skin is always clean and dry under prosthesis<br>f. use special stockings under an artificial leg or arm<br>g. if resident experiences phantom pain, be supportive<br>h. do not react negatively to sight of anatomical stump or | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 23. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | prosthesis<br>4. report the following to the appropriate licensed nurse<br>a. redness, swelling of stump or extremity<br>b. drainage, bleeding or sores of any kind on the stump or extremity<br>c. phantom pain, phantom sensation, stump pain<br>d. decreased ability to move extremity<br>e. cyanosis of any part of the extremity<br>f. any difficulty applying or using prosthesis<br>g. need repair or need to be changed<br>B. Orthotic devices<br>1. definition<br>a. device applied over a body part for support and protection<br>b. keep joint in correct alignment<br>c. improve function of body part<br>d. prevent contractures of body part<br>e. splints and braces<br>2. examples<br>a. splints<br>b. shoe inserts<br>c. knee/leg braces<br>d. surgical shoes<br>e. elastic stockings | | |
| 24. Describe caring for and using orthotic devices. | 3. caring for and using orthotic devices<br>a. do not immerse in water<br>b. do not use hot water to clean<br>c. clean with warm, damp cloth<br>d. check braces and splints for | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | wear and tear<br>e. after removal wash elastic stocking in warm, soapy water every day<br>f. gradually increase wearing time of device<br>g. if device causes pain remove and notify licensed nurse<br>h. observe area around, under device | | |
| 25. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | 4. report the following to the appropriate licensed nurse<br>a redness, swelling of body part, or foul odor<br>b. drainage, bleeding or sores of any kind on the body part<br>c. complaints of pain<br>d. decreased ability to move body part<br>e. cyanosis of the body part<br>f. any difficulty applying or using orthotic device<br>g. orthotic device that needs repair or need to be changed<br>C. Anti-embolic (elastic) stockings – requires a prescriber's order | | |
| 26. Describe the purpose of elastic stockings. | 1. purpose<br>a. cause smooth, even compression of the leg<br>b. allows blood to move through the arteries and veins<br>c. improves blood circulation in lower extremities<br>d. prevent swelling of legs and feet<br>e. reduce fluid retention<br>f. reduce blood clots in legs<br>2. sized to fit resident<br>a. measure length of leg | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 27. Demonstrate correct application of elastic stockings. | b. measure girth of leg<br>3. apply elastic stocking<br>a. follow the procedure for "Applies One Knee-High Elastic Stocking" in the most current edition of Virginia Nurse Aide Candidate Handbook<br>4. daily observations<br>a. use open area at toes to observe resident's toes<br>b. look for cyanosis, bluing of toes/nailbeds<br>c. document application of stocking and observations per facility policy<br>5. risks of elastic stocking<br>a. turning down the top of the stocking may impede circulation<br>b. stockings should be applied first thing in the morning when legs are smallest<br>c. apply stockings while legs are elevated, before resident gets out of bed<br>d. make sure there are no wrinkles or twists in stocking after it is applied | | |
| 28. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | 6. report the following to the appropriate licensed nurse<br>a. toes or feet that are bluish and/or cool to touch<br>b. complaints of pain or discomfort in the feet or legs<br>c. red areas on heels, toes, calf of the leg | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| <br><br><br><br><br><br>29. Describe the process for bladder training. | VIII. Bladder and Bowel Training<br>A. Goal<br>1. relearn control of urinary elimination pattern<br>2. control involuntary urination (incontinence)<br>B. Guidelines for bladder training<br>1. identify pattern of elimination<br>2. establish schedule for use of bathroom, at least q2h<br>3. explain training schedule to resident<br>4. follow schedule consistently<br>5. keep accurate record of elimination to help establish a routine<br>6. toilet resident before beginning long procedures and after procedures are complete<br>7. toilet resident before meals and before bedtime<br>8. answer call bell promptly<br>9. provide privacy when resident emptying bladder<br>10. do not rush resident<br>11. assist resident to maintain good perineal hygiene<br>12. encourage or increase fluid intake, if permitted<br>13. toilet about 30 minutes after fluid intake<br>14. if resident has difficulty urinating try running water in the sink, leaning resident forward slightly to place additional pressure on the bladder<br>15. assist with change of clothing if accident occurs<br>16. be positive with success and understanding of accidents | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 30. Describe the process for bowel training. | C. Guidelines for bowel training<br>1. identify pattern of elimination<br>2. establish schedule for use of bathroom<br>3. explain training schedule to resident<br>4. follow schedule consistently<br>5. provide diet that stimulates the bowels<br>a. high in fiber<br>b. fresh fruits and vegetables<br>c. adequate hydration<br>6. provide exercise as tolerated<br>7. provide privacy when in the bathroom<br>8. provide encouragement<br>9. answer call bell promptly<br>10. do not rush resident<br>11. assist with change of clothing if accident occurs<br>12. be positive with success and understanding of accidents | | |
| 31. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | D. Report anything that interferes with bladder and/or bowel training and any unusual occurrences to the appropriate licensed nurse | | |

# UNIT XII – RESPIRATORY SYSTEM, CARDIOVASCULAR SYSTEM, HIV/AIDS, CANCER, AND CARE OF THE RESIDENT WHEN DEATH IS IMMINENT

(18VAC90-26-40.A.2.g)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 1. Explain the anatomy and physiology of the respiratory system. | I. Respiratory System<br>A. Anatomy<br>1. airway<br>a. mouth<br>b. nasal cavities<br>c. throat – pharynx<br>d. voice box – larynx<br>e. epiglottis – flap that closes off opening to trachea when resident swallows<br>f. trachea – windpipe<br>g. bronchi – 2 branches of the trachea<br>i. one to right lung, one to left lung<br>h. lungs<br>i. where respiration occurs<br>ii. exchanges carbon dioxide from the body for oxygen from the environment<br>i. bronchioles<br>j. alveoli – where gas exchange actually occurs<br>k. inhalation – breathe air and oxygen into the lungs<br>l. exhale – breathe out carbon dioxide<br>B. Ventilation<br>1. diaphragm<br>a. muscle separating chest from abdomen | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 2. Describe age-related changes seen in the respiratory system. | b. during inhalation diaphragm contracts making room for lungs to expand and negative pressure to pull air from environment into the lungs<br>c. during exhalation diaphragm relaxes and causes positive pressure in the lungs to push the air out of the lungs<br>2. respiratory rate<br>a. controlled by central nervous system<br>b. medulla oblongata of the brain has control<br>C. Function of respiratory system<br>1. cleanse inhaled air<br>2. supply oxygen to body cells<br>3. remove carbon dioxide from cells<br>4. produce sound associated with speech<br>D. Effects of aging on the respiratory system<br>1. less efficient ventilation<br>a. lung strength decreases (do not expand and contract as easily)<br>b. alveoli become less elastic (do not empty on exhalation)<br>c. alveoli decrease in number<br>d. diaphragm becomes weaker<br>e. airways become less elastic<br>2. lung capacity decreases<br>3. muscles of the rib cage become weaker making it harder to expand the chest during inhalation<br>4. cough reflex becomes less effective making the cough weaker<br>5. decrease in effectiveness of ventilation causes less oxygen in the blood | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 3. Discuss common disorders of the respiratory system, including their signs and symptoms. | 6. decreased lung capacity may cause voice to weaken<br>E. Common disorders of the respiratory system<br>1. chronic obstructed pulmonary disease (COPD)<br>a. resident becomes progressively worse with time<br>b. no cure<br>c. acute bronchitis – inflammation of lining of bronchi<br>i. cause – infection<br>ii. symptoms<br>a) production of yellow or green sputum and mucus<br>b) difficulty breathing and wheezing may occur<br>c) lasts a short time<br>d. chronic bronchitis<br>i. cause – inflammation of bronchial lining<br>ii. cigarette smoking<br>iii. environmental air pollution<br>iv. symptoms<br>a) chronic cough producing thick, whitish sputum<br>b) restricts air flow<br>c) scars lungs<br>e. emphysema<br>i. alveoli become over-stretched<br>ii. carbon dioxide remains trapped in the alveoli<br>iii. causes<br>a) cigarette smoking<br>b) chronic bronchitis<br>iv. symptoms<br>a) short of breath<br>b) coughing<br>c) difficulty breathing | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 4. Discuss the importance of reporting abnormal observations or changes to | f. signs and symptoms of COPD<br>i. coughing/wheezing<br>ii. difficulty breathing (dyspnea)<br>iii. short of breath especially during exercise<br>iv. cyanosis<br>v. complaints of chest tightness or pain<br>vi. confusion<br>vii. weakness<br>viii. loss of appetite and weight<br>ix. fear and anxiety<br>g. guidelines for COPD<br>i. use pillows to assist resident to sit up and lean slightly forward to facilitate breathing<br>ii. plan periods of rest during ADLs to prevent resident from getting overly tired<br>iii. practice good hand washing to protect resident from infections<br>iv. encourage a healthy diet<br>v. provide plenty of fluids to help keep resident well-hydrated<br>vi. be supportive and calm if resident is anxious and fearful<br>vii. provide trash can close to resident to help with appropriate disposal of used tissues<br>viii. if resident is receiving oxygen, follow instructions on use of oxygen<br>h. report the following to the appropriate licensed nurse<br>i. signs and symptoms of colds | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| the appropriate licensed nurse.<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>5. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | or the flu<br>a) fever<br>b) chills<br>c) complaints of feeling achy<br>ii. confusion<br>iii. change in breathing patterns<br>iv. shortness of breath on exertion<br>v. change in color or consistency of sputum<br>vi. complaints of chest pain or tightness<br>vii. insomnia due to anxiety or fear<br>2. asthma<br>a. chronic<br>b. causes<br>i. allergens<br>ii. infection<br>iii. cold air<br>iv. environmental irritants or pollution<br>v. obesity<br>c. signs and symptoms<br>i. wheezing<br>ii. coughing<br>iii. complaints of tightness in the chest<br>iv. difficulty breathing<br>d. report the following to the appropriate licensed nurse<br>i. changes in respirations and/or pulse<br>ii. wheezing<br>iii. shortness of breath<br>iv. cyanosis<br>v. complaints of chest pain or chest tightness<br>3. pneumonia | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.<br><br>7. Describe the use of various types of oxygen therapy equipment. | a. acute inflammation of lungs<br>b. cause<br>i. infection – viral, bacterial or fungal<br>ii. chemical irritant<br>c. signs and symptoms<br>i. high fever<br>ii. chest pain during inhalation<br>iii. coughing<br>iv. difficulty breathing<br>v. shortness of breath<br>vi. chills<br>vii. increased pulse<br>viii. thick, colored sputum<br>d. report the following to the appropriate licensed nurse<br>i. changes in vital signs<br>ii. complaints of difficulty breathing<br>iii. complaints of chest pain or discomfort<br>iv. unusual sputum production<br>v. sputum that has a distinct color<br>F. Oxygen therapy<br>1. administration of oxygen to improve oxygen levels in the body<br>a. normal blood oxygen level is 95-100%<br>b. residents with certain disease processes have different optimal blood oxygen levels<br>2. methods of delivery<br>a. compressed air – green oxygen tank or in wall unit<br>b. air condenser – connects to electrical outlet and pulls oxygen out of room air<br>c. appliance | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | i. nasal cannula – 2 nasal prongs and tubing that goes around the ears and cinches under the chin; tubing is attached to oxygen source<br>ii. mask – mask fits over nose and mouth and attaches to tubing attached to oxygen source<br>3. oxygen is a medication<br>a. requires physician's order<br>b. ordered in liters/minute<br>c. nurse aide may only observe and report administration of oxygen | | |
| 8. Discuss the guidelines for caring for the resident receiving oxygen therapy. | 4. guidelines for oxygen delivery<br>a. ensure oxygen tubing is not on the floor<br>b. no smoking can take place in same room as oxygen administration<br>c. post "No Smoking" signs outside of room and in resident's room<br>d. any spark can cause a fire in presence of oxygen, including static electricity from wool, and from dry air in winter<br>e. perform frequent skin care to areas in contact with oxygen equipment (under the nose, behind the ears)<br>f. observe these areas for redness and drainage<br>g. use water-based lubricant to keep nostrils and lips moist and to prevent skin cracking<br>h. monitor oxygen delivery device | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 9. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.<br><br>10. Explain the anatomy and physiology of the circulatory system. | frequently to assure resident is receiving correct amount of oxygen<br>i. encourage activity as tolerated by resident<br>j. provide emotional support to resident<br>k. know where fire alarms and extinguishers are located<br>l. report the following to the appropriate licensed nurse<br>i. sores or crusty areas on or under resident's nose or ears<br>ii. dry, red areas on skin in contact with oxygen tubing<br>iii. shortness of breath<br>iv. changes in respirations and/or pulse<br>v. changes in respiratory patterns<br>vi. changes in character or color of sputum<br>vii. cyanosis<br>viii. complaints of chest pain or tightness<br><br>II. Cardiovascular System<br>A. Anatomy<br>1. blood<br>a. red blood cells<br>i. carry oxygen to the individual cells and carbon dioxide to the lungs<br>b. white blood cells<br>i. part of immune system<br>ii. attack invading micro-organisms (infection)<br>c. platelets - assist the blood to clot | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | d. plasma- fluid portion of blood<br>2. heart<br>a. pump that circulates blood throughout the body<br>b. has 4 chambers<br>i. right atrium – blood from the body enters heart through right atrium and flows into the right ventricle<br>ii. right ventricle – blood goes from right ventricle to the lungs where carbon dioxide leaves the blood and is replaced with oxygen<br>iii. left atrium – blood returns to the heart from the lungs and enters the left atrium<br>iv. left ventricle – blood flows from the left atrium into left ventricle which pumps oxygen-rich blood to the body<br>3. arteries<br>a. arteries carry oxygen-rich blood to the cells<br>b. exception is pulmonary arteries which carry deoxygenated blood from right ventricle to lungs<br>4. veins - carry deoxygenated blood from the cells back to the heart (right atrium)<br>5. capillaries<br>a. connect arteries to veins at the cellular level<br>b. where actual exchange of oxygen from the arteries to the cells and pick-up of carbon dioxide to return to the heart | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| | B. Functions of the circulatory system<br>1. blood<br>a. carries oxygen, nutrients and chemicals to cells<br>b. removes carbon dioxide and waste products from cells<br>c. controls acidity of body<br>d. controls body temperature<br>e. fights infection and foreign bodies within the body<br>2. heart<br>a. pumps blood to every cell in the body | | |
| 11. Describe age-related changes seen in the circulatory system. | C. Effects of aging on the circulatory system<br>1. heart muscle weakens and pumps less effectively<br>2. blood vessels become clogged with cholesterol and clots and become less efficient at circulating blood<br>3. blood vessels become less elastic<br>4. blood flow decreases | | |
| 12. Discuss common disorders of the circulatory system, including their signs and symptoms. | D. Common disorders of the circulatory system<br>1. hypertension – high blood pressure<br>a. follow current guidelines<br>b. causes<br>i. arteries become less elastic (hardening of the arteries)<br>ii. arteries become more narrow<br>iii. kidney disease<br>iv. stress and/or pain<br>v. side effect of medication<br>c. signs and symptoms<br>i. headache<br>ii. blurred vision<br>iii. dizziness<br>d. if untreated<br>i. may cause kidney damage | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 13. Discuss the guidelines for caring for the resident experiencing angina. | ii. may cause rupture of blood vessel in the brain (cerebrovascular accident – CVA– stroke)<br>e. treatment<br>i. medication<br>ii. diet with controlled sodium (salt) and/or fat intake<br>2. coronary artery disease (CAD)<br>a. arteries that provide blood to heart muscle become blocked with fatty deposits or blood clots and the heart muscle does not receive enough oxygen<br>b. heart muscle deprived of oxygen causes chest pain – angina<br>i. may occur with activity or at rest<br>ii. described<br>a) pressure/tightness in chest<br>b) pain radiating down left arm<br>c) pain in back, neck, jaw, shoulder<br>iii. symptoms<br>a) sweaty<br>b) trouble breathing<br>c) complexion pales<br>d) cyanosis of lips, nail beds<br>e) complaints of dizziness<br>iv. guidelines for resident experiencing angina<br>a) have resident lie down and rest<br>b) notify licensed nurse immediately<br>c) reduce stressors<br>d) encourage rest periods | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| 14. Discuss the guidelines for caring for the resident experiencing possible cardiac event. | during ADLs<br>e) avoid large meals close to bedtime<br>f) avoid exposure to weather extremes<br>g) report to licensed nurse complaints of chest pain, shortness of breath that occurs with activity or at rest<br>c. when muscle cells begin to die – myocardial infarction (MI or heart attack)<br>i. area of the heart is permanently damaged<br>ii. signs and symptoms are same as angina<br>iii. guidelines for resident experiencing a possible cardiac event<br>a) a medical emergency<br>b) notify licensed nurse immediately<br>c) have resident lie down<br>d) remain calm and stay with resident<br>e) remove constrictive clothing<br>f) if resident becomes unresponsive, begin CPR<br>g) report to licensed nurse complaints of chest pain, shortness of breath that occurs with activity or at rest<br>3. peripheral vascular disease (PVD)<br>a. decreased blood supply to extremities (arms, hands, legs, feet) | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | b. causes<br>i. narrowed blood vessels<br>ii. blood vessels less elastic<br>iii. blockages in blood vessels<br>iv. decreased amount of blood being pumped by heart<br>v. inflammation of veins in legs<br>c. signs and symptoms<br>i. pain in legs when walking or during activity<br>ii. pain in legs that remains after activity is stopped<br>iii. cyanosis in hands and/or feet<br>iv. cyanotic nail beds<br>v. extremities that are cool to touch<br>vi. swelling of the hands and/or feet<br>vii. sores on arms, hands, legs, feet that do not heal in expected time-frame | | |
| 15. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | d. report the following to the appropriate licensed nurse<br>i. complaints of pain or discomfort in extremities with activity or at rest<br>ii. change in skin color of extremities<br>iii. change in temperature of extremities<br>iv. change in pulse or blood pressure<br>v. edema in feet and/or hands<br>vi. increase in weight<br>vii. urine output that is significantly less than intake<br>viii. complaints of headache<br>ix. complaints of blurred vision<br>x. complaints of chest pain | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | xi. change in level of consciousness<br>4. congestive heart failure (CHF)<br>a. when one or both sides of heart pumps ineffectively and blood begins to back up in the heart and in the arteries and veins<br>b. signs and symptoms<br>i. fatigue<br>ii. swelling (edema) in hands and feet<br>iii. difficulty breathing<br>iv. shortness of breath not relieved by rest<br>v. persistent cough<br>vi. decreased activity tolerance<br>vii. increased pulse<br>viii. irregular pulse<br>ix. chest pain<br>x. dizziness<br>xi. change in level of consciousness<br>xii. weight gain<br>xiii. increased urination<br>xiv. swelling of the abdomen | | |
| 16. Discuss the guidelines for caring for the resident experiencing CHF. | c. guidelines for caring for the resident with CHF<br>i. include rest periods during ADLs<br>ii. daily weights<br>iii. record intake and output daily<br>iv. follow care plan for diet and fluid intake<br>v. use elastic stockings as ordered<br>vi. position resident so breathing is comfortable | | |
| 17. Discuss the importance of reporting abnormal | d. report the following to the appropriate licensed nurse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
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| observations or changes to the appropriate licensed nurse. | i. change in level of consciousness<br>ii. change in activity tolerance<br>iii. change in vital signs<br>iv. shortness of breath with activity or at rest<br>v. coughing and/or wheezing<br>vi. weight gain<br>vii. increase in urination<br>viii. unusual swelling in hands, feet, legs<br><br>III. Resident with AIDS (Acquired Immune Deficiency Syndrome)<br>A. Description<br>1. human immunodeficiency virus (HIV) attacks immune system<br>2. damages or destroys cells of immune system<br>3. weakens and disables immune system<br>B. Causes - exposure to HIV infected blood and/or body fluids | | |
| 18. Discuss HIV/AIDS, including signs and symptoms and guidelines for care. | C. Possible signs and symptoms<br>1. flu-like symptoms<br>2. swollen glands<br>3. headache<br>4. fever<br>5. weight loss<br>6. night sweats<br>7. difficulty breathing<br>8. cold sores<br>9. frequent infections of skin, respiratory system and mouth<br>10. change in mental status | | |
| 19. Discuss the guidelines for caring for the resident with HIV/AIDS. | D. Guidelines for care of resident with HIV/AIDS<br>1. practice Standard Precautions and encourage resident and significant | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | others to practice Standard Precautions<br>2. disinfect surfaces in resident's room and bathroom on a regular basis<br>3. discourage visitors who have infections or colds from visiting<br>4. observe resident's skin on regular basis<br>5. keep skin clean and dry<br>6. turn and reposition q2h<br>7. provide rest periods during ADLs<br>8. provide mouth care at frequent intervals<br>9. monitor vital signs<br>10. measure and record weight, intake and output<br>11. follow person-centered care plan<br>12. encourage independence as much as possible<br>13. provide emotional support | | |
| 20. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | E. Report the following to the appropriate licensed nurse<br>1. change in appetite<br>2. weight loss<br>3. mouth sores<br>4. difficulty swallowing<br>5. changes in the skin<br>6. changes in vital signs<br>7. bleeding from any opening on the body<br>8. unusual behavior – anxiety, depression, mood swings, suicidal thoughts | | |
| 21. Discuss cancer, including signs and symptoms and guidelines for care. | IV. The Resident with Cancer<br>A. Definitions<br>1. tumor - abnormal growth of tissue<br>2. benign - slowly growing tumor that | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | is easily treated; not malignant<br>3. malignant<br>a. abnormal cells that do not function properly<br>b. divide rapidly<br>c. invade nearby tissue<br>4. cancer - abnormal cells growing in an uncontrolled manner<br>5. metastasis - cancer cells spread from their original location to a new location<br>6. biopsy - removal of a sample of tissue to test for cancer cells<br>B. Risk factors for cancer<br>1. inheritance<br>a. race<br>b. gender<br>c. family history<br>2. environmental factors<br>a. history of smoking<br>b. alcohol use<br>c. exposure to chemical and food additives<br>3. lifestyle factors<br>a. diet/obesity<br>b. lack of exercise<br>c. exposure to sun | | |
| 22. Identify the American Cancer Society signs of cancer. | C. American Cancer Society signs of cancer<br>1. fever<br>2. fatigue<br>3. unexplained weight loss<br>4. pain<br>5. skin changes<br>6. new mole or change in existing mole/wart<br>7. change in bowel/bladder function<br>8. sore that does not heal/unusual bleeding/discharge | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 23. Discuss the guidelines for caring for the resident with cancer. | 9. thickening in breast, scrotum<br>10. indigestion, difficulty swallowing<br>11. nagging cough or hoarseness<br>D. Guidelines for care of resident with cancer<br>1. manage pain<br>a. reposition at frequent intervals<br>b. offer back rubs<br>c. provide rest periods during ADLS<br>d. report pain to licensed nurse for medication<br>2. skin care<br>a. observe skin on regular basis<br>b. keep skin clean and dry<br>c. turn and reposition q2h<br>3. oral care<br>a. provide mouth care at regular intervals<br>b. use soft toothbrush or swabs, as needed<br>4. schedule rest periods<br>5. provide small, frequent meals<br>6. encourage fluid intake<br>7. weigh resident on regular basis<br>8. provide nutritional supplements as ordered<br>9. monitor vital signs<br>10. provide emotional support for changes in self-image<br>11. encourage participation in activities to promote socialization<br>12. encourage participation in support groups<br>13. monitor side effects of the treatments such as chemo and radiation | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 24. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. | E. Report the following to the appropriate licensed nurse<br>1. pain or increase in pain<br>2. changes in vital signs<br>3. any changes to the skin<br>a. new lesions<br>b. rashes<br>c. red areas<br>4. odors<br>5. changes in ability to ambulate<br>6. chest pain<br>7. difficulty breathing<br>8. change in appetite or weight loss<br>9. sores or pain in mouth<br>10. bleeding from any opening in the body<br>11. nausea or vomiting<br>12. change in bowel or bowel patterns<br>13. change in urine or urinary patterns<br>14. change in level of consciousness | | |
| | V. Care of the Resident When Death is Imminent | | |
| 25. Identify an understanding of the student's own feelings about death and dying. | A. Feelings about death and dying<br>1. cultural<br>a. fear of unknown<br>b. anticipation of what has been promised<br>2. religious beliefs<br>a. anticipate after-life<br>b. no after-life<br>c. reincarnation<br>d. punishment<br>3. personal experience | | |
| 26. Describe the stages of grief. | B. Stages of grief<br>1. denial - refuse to accept diagnosis | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 2. anger<br>a. occurs when realize they are going to die<br>b. may be expressed at self, family, staff<br>3. bargaining - bargain with God or a higher power<br>4. depression<br>5. acceptance - may appear detached from situation<br>6. not everyone passes through all the stages of grief before they die<br>7. nurse aide must remember not to take resident's behavior personally<br>C. Rights of the dying resident<br>1. to have visitors<br>2. to privacy<br>3. to be free of pain<br>4. to honest, accurate information<br>5. to refuse treatment | | |
| 27. List physical changes that occur when death is imminent. | D. Physical changes of the dying resident<br>1. changes in vital signs<br>a. increased pulse<br>b. shallow, irregular respirations<br>c. gurgling, rattling sound to respirations<br>d. decreased BP<br>2. changes in skin<br>a. bluish<br>b. mottled<br>c. sweaty<br>d. becomes cool to touch<br>3. urine production decreases<br>4. incontinent of urine and/or stool<br>5. resident may not want to eat or drink<br>6. difficulty swallowing<br>7. decreased muscle tone<br>8. decreased vision | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 28. Discuss care measures for the resident when death is imminent. | 9. change in level of consciousness<br>10. hallucinations<br>11. hearing is the last sense to decline<br>E. Guidelines for meeting the physical needs of the dying resident<br>1. care of the skin<br>a. turn and reposition q2hrs.<br>b. keep skin clean and dry<br>c. change soiled clothing and linen immediately<br>2. care of mucous membranes<br>a. oral care q2h if needed<br>b. moisten lips and mucous membranes as needed<br>c. using warm, wet washcloth gently clean eyes of any accumulated crust<br>d. apply water-based lubricant to nostrils if resident is receiving oxygen therapy<br>3. positioning<br>a. use positioning devices to assure proper body alignment<br>b. turn and reposition q2h<br>c. notify licensed nurse of pain<br>d. elevate head of bed if resident having difficulty breathing<br>4. comfort measures<br>a. back rub<br>b. soft music<br>c. keep room well ventilated<br>d. use soft lighting, adequate to see but not glaring<br>e. remove soiled linens and bedpans immediately<br>f. encourage and assist family/significant others to visit<br>g. do not leave resident alone<br>h. remember that dying resident | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | may still have intact sense of hearing | | |
| 29. Discuss psychosocial and spiritual care measures for the resident when death is imminent. | F. Guidelines for meeting the psychosocial and spiritual needs of the dying resident<br>1. do not isolate or avoid the dying resident<br>2. provide opportunity for dying resident to talk<br>3. be non-judgmental about resident and anything he tells you<br>4. allow resident to express his views on death and dying<br>5. respect resident's wishes for visits from spiritual leaders<br>6. provide privacy for resident and family/friends<br>7. maintain confidentially regarding anything resident and/or family shares<br>8. provide care with compassion, understanding, patience, empathy | | |
| 30. Discuss care measures for the family when death of the resident is imminent. | G. Care for the family of the dying resident<br>1. communicate what is happening to the resident<br>2. provide space for family members to be by themselves<br>3. provide time for family members to be with the resident<br>4. permit family members to care for dying resident, if they so desire<br>5. allow family members to verbalize feelings in a non-judgmental environment<br>6. permit family to follow religious rituals of their choice<br>7. do not be afraid to show your own emotions | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 31. Demonstrate proper procedure for postmortem care. | H. Postmortem care<br>1. provide for privacy<br>2. explain procedure to family and request they leave the room<br>3. gently close the eyes<br>4. bathe body and comb hair<br>5. place in clean gown or pajamas<br>6. place in proper body alignment<br>7. elevate head slightly<br>8. make resident's room neat and tidy for the family<br>9. turn lights down for family<br>10. provide privacy and time for family to grieve<br>11. prepare body for funeral home to transport<br>12. follow facility policy for handling and removal of personal items<br>13. have a witness for any personal items that is given to a family member<br>14. document procedure following facility policy | | |

# UNIT XIII – ADMISSION, TRANSFER AND DISCHARGE

(18VAC90-26-40.A.7.e.)
(18VAC90-26-40.A.2.d.)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Describe preparation of resident room prior to admission. | I. Admission to the Long-Term Care Facility<br>A. Prepare the room<br>1. admission pack<br>a. wash basin<br>b. bedpan/urinal<br>c. toiletry items<br>d. water pitcher/cup<br>2. assemble vital sign equipment<br>a. stethoscope<br>b. BP cuff<br>c. thermometer<br>3. open curtains/blinds<br>4. adjust room temperature<br>5. bed in low position with wheels locked | | |
| 2. Identify areas of orientation that must be provided to the resident during admission. | B. Orientation to facility<br>1. introduce yourself, including your title<br>2. identify how you will work with resident providing care<br>3. introduce roommate, if there is one<br>4. be friendly, polite<br>5. include family and significant others<br>6. review resident rights<br>7. review facility rules<br>a. meal times<br>b. smoking policy<br>c. visitation policy<br>d. how to complete menu<br>8. tour facility<br>a. dining area<br>b. bathing area | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. activity room and schedule<br>d. chapel<br>C. Orientation to resident's room<br>a. how to use the bed<br>b. call bell<br>c. bathroom/emergency light<br>d. lights<br>e. TV<br>f. how to use telephone | | |
| 3. Describe how to care for resident's personal belongings. | D. Care of personal belongings<br>1. complete resident inventory sheet – describe all belongings completely and accurately<br>2. assist to label all personal items, including clothing<br>3. assist to unpack personal items<br>E. Admission process<br>1. wash hands<br>2. explain to resident what you will be doing<br>3. provide for privacy<br>4. if appropriate, ask family to wait outside the room<br>5. obtain baseline vital signs, height, weight | | |
| 4. Discuss the observations that the nurse aide should make during the admission process. | 6. observe<br>a. condition of skin<br>b. mobility<br>c. behavior<br>d. ability to communicate | | |
| 5. Document the admissions process, including care of resident's personal belongings, observations and vital signs. | 7. fill water pitcher with fresh water<br>8. have family return to room<br>9. make resident comfortable<br>10. place call bell within reach and demonstrate how to use it<br>11. wash hands | | |
| 6. Discuss the importance of reporting abnormal observations or findings to | 12. document vital signs, height, weight<br>13. report any abnormal findings to appropriate licensed nurse | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| the appropriate licensed nurse.<br><br>7. Discuss important factors in preparing resident for transfer from his room and/or facility.<br><br>8. Demonstrate preparing resident for transfer. | II. Transfer of resident<br>A. Prepare resident<br>1. inform resident of transfer as soon as you know<br>2. assist resident to prepare for moving belongings<br>3. accompany resident to new unit<br>4. provide report to new unit personal<br>a. vital signs<br>b. condition of skin<br>c. mobility<br>d. ability to communicate<br>5. introduce resident to new unit staff<br>6. assist resident to unpack belongings on new unit<br>7. make resident comfortable<br>8. have call bell in easy reach<br>9. wash hands<br>10. document procedure<br>11. report any changes in the resident to the appropriate licensed nurse | | |
| 9. Discuss care of the resident room after transfer has occurred. | B. Care of room after transfer in accordance with facility policy<br>1. strip bed<br>2. place all linen, used and unused in laundry hamper<br>3. inform housekeeping service that room is empty and ready for terminal cleaning | | |
| 10. Identify responsibilities of nurse aide during the discharge of the resident. | III. Discharge<br>A. Responsibilities of nurse aide<br>1. explain what you will be doing to resident<br>2. provide for privacy<br>3. compare admission resident inventory sheet to items being packed for discharge | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 11. Demonstrate discharge of the resident, including care of personal belongings and assisting to transport to the pick-up area. | 4. carefully assist resident/family to pack belongings<br>5. assist resident to dress in personal clothing<br>6. assist resident to say "Good-byes" to staff<br>7. using wheelchair, take resident to area where family vehicle is waiting<br>8. lock wheels on wheelchair<br>9. assist resident into vehicle, engage seatbelt and close door<br>10. return to unit with wheelchair<br>11. wash hands<br>12. document procedure<br>B. Care of room after discharge<br>1. strip bed<br>2. place all linen, used and unused in laundry hamper<br>3. inform housekeeping service that room is empty and ready for terminal cleaning | | |

# UNIT XIV – LEGAL AND REGULATORY ASPECTS OF PRACTICE FOR THE CERTIFIED NURSE AIDE

(18VAC90-26-40.A.8)
(18VAC90-26-40.A.10)
(18VAC90-26-40.A.7.f)

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 1. Discuss professional behaviors of the nurse aide. | I. Professional Behaviors of a Nurse Aide<br>A. Positive attitude<br>B. Maintain confidentiality and privacy<br>1. resident information<br>2. staff information<br>C. Be polite and cheerful<br>D. Listen to residents<br>E. Perform assigned duties<br>1. in timely manner<br>2. to the best of your ability<br>F. Do not give or accept money or gifts from residents<br>G. Follow facility policies and procedures<br>H. Take directions and constructive criticism<br>I. Practice good personal hygiene<br>J. Dress neatly and appropriately<br>K. Be punctual to work<br>L. Be respectful<br>1. to residents<br>2. to staff<br>3. to visitors<br>M. Be dependable<br>1. report to work on assigned shifts<br>2. call in following facility policy if you will be late or are sick<br>3. complete assignments without having to be prompted<br>4. if you volunteer to perform a task, do it | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | N. Be dedicated to your position - take pride in your work<br>O. Treat residents the way you would want to be treated<br>1. regardless of diagnosis<br>2. regardless of race<br>3. regardless of gender<br>4. regardless of ethnicity<br>P. Always use appropriate language<br>1. do not curse<br>2. do not use slang<br>3. do not use medical terminology that resident does not understand | | |
| 2. Discuss the Code of Ethics for the nurse aide. | II. Nurse Aide Code of Ethics<br>A. Preserve life, ease suffering and work to restore resident's health<br>B. Consider resident's physical, mental, emotional and spiritual needs<br>C. Loyalty to employer, residents and co-workers<br>D. Provide quality care regardless of resident's religious beliefs<br>E. Demonstrate equal courtesy and respect to everyone<br>F. Respect resident confidentiality and dignity<br>G. Perform only those procedures that you have been trained to perform<br>H. Be willing to learn new skills and keep old skills current<br>I. Care for resident as you were taught<br>J. Always be clean and professional in appearance<br>K. Legal and ethical behaviors for nurse aides<br>1. be honest at all times<br>2. protect resident's/resident's privacy | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 3. keep staff information confidential<br>4. report abuse or suspected abuse of residents<br>5. follow the care plan and your assignments<br>6. report mistakes you make immediately<br>7. do not perform tasks outside your scope of practice<br>8. report all resident observations and incidents to the licensed nurse<br>9. document accurately and promptly according to your facility policy<br>10. follow rules about safety and infection prevention<br>11. do not get personally or sexually involved with residents or their family members or friends | | |
| 3. Review methods of conflict management. | III. Conflict Management<br>A. Report conflicts to appropriate licensed nurse<br>1. conflicts between residents<br>2. conflicts between resident and staff<br>3. conflicts among staff<br>B. Respect resident's rights<br>1. right to complain without fear for their safety or care<br>2. right to have assistance in resolving grievances and disputes<br>3. right to contact the Ombudsman<br>C. Resolve conflict in professional manner<br>1. remain calm<br>2. do not be aggressive or argumentative<br>3. do not use inappropriate language<br>4. do not take resident's behavior personally | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | 5. do not act inappropriately | | |
| 4. List two (2) regulatory agencies that are involved with nurse aides. | IV. Regulatory Agencies for Nurse Aides<br>A. Nurse Aide Training and Competency Evaluation Program (NATCEP)<br>1. makes rules for training and testing<br>2. Federal Government Omnibus Budget Reconciliation Act (OBRA) 1987<br>3. individual state programs assure federal rules are followed in facilities receiving Medicare/Medicaid funds<br>4. establishes registry to track nurse aides working in that individual state | | |
| 5. Discuss the role of the Virginia Board of Nursing. | B. Virginia Board of Nursing (VBON)<br>1. Health regulatory board of the Department of Health Professions<br>2. protects the welfare of the public<br>3. enforces the Virginia Nurse Practice Act<br>4. establishes and enforces Regulations for Nurse Aide Education Programs (18VAC90-26-10 et seq.)<br>a. approves nurse aide education programs<br>b. establishes curriculum requirements for nurse aide education programs<br>5. establishes and enforces Regulations Governing Certified Nurse Aides in Virginia (18VAC90-25-10 et seq.)<br>a. establishes certification process for nurse aides<br>b. establishes nurse aide competency standards | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | c. maintains the Nurse Aide Registry<br>d. denies, revokes, suspends or reinstates certification for nurse aides<br>e. otherwise discipline nurse aide certificate holders in Virginia | | |
| | V. Inappropriate Behavior for the Nurse Aide<br>A. Abuse | | |
| 6. Describe abuse, including the signs of abuse that the nurse aide might observe. | 1. causing physical, mental or emotional pain to resident<br>2. failure to provide food, water, care and/or medications<br>3. involuntary confinement or seclusion<br>4. withholding Social Security checks and/or other sources of income<br>5. intentional or unintentional misappropriation of resident's money<br>6. intentional or unintentional posting pictures of residents on any type of social media or texting pictures of residents<br>7. types of abuse<br>a. verbal<br>b. financial<br>c. assault – threatening to harm resident<br>d. battery – touching resident without their permission<br>e. domestic abuse – within the family<br>f. sexual abuse<br>8. signs of abuse<br>a. bruising, swelling, pain or other injuries | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 7. Give examples of inappropriate nurse aide behavior, including neglect and misappropriation of resident property.<br><br>8. Describe strategies the nurse aide can use to avoid inappropriate behavior.<br><br>9. Discuss the role of the mandated reporter as described in the Code of Virginia, including who is | b. fear and anxiety<br>c. sudden changes in resident's personality or behavior<br>B. Neglect<br>1. harming resident physically, mentally, emotionally by failing to provide care<br>C. Misappropriation of resident's property<br>1. deliberate misappropriation, exploitation, or wrongful use of resident's belongings or money without the resident's consent<br>2. may be temporary or permanent<br>D. How to avoid inappropriate behavior<br>1. remain calm<br>2. do not take resident's behavior personally<br>3. always remember there is no excuse for abusing a resident<br>4. if nurse aide is feeling overwhelmed with assigned duties or a certain resident<br>a. discuss it with supervisor<br>b. get help from co-workers<br>c. make arrangements to take a break and compose self<br>5. if nurse aide sees a co-worker who appears overwhelmed<br>a. offer support and assistance<br>b. encourage co-worker to report situation<br>c. report situation to supervisor<br><br>VI. Mandated Reporter Authority (§63.2-1606 of Virginia Code)<br>A. Who is a mandated reporter?<br>1. any person licensed, certified, or registered by health regulatory | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
| --- | --- | --- | --- |
| a mandated reporter, what must be reported, to whom it must be reported, and the penalty for not reporting. | boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine<br>2. any mental health services provider as defined in §54.1-2400.1<br>3. any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5<br>4. any guardian or conservator of an adult<br>5. any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity<br>6. any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker and personal care workers<br>7. any law-enforcement officer<br>B. What to report<br>1. required to report suspected abuse, neglect, or exploitation of adults 60 years or older or incapacitated adults 18 years or older<br>2. name, age, address or location of the person suspected of being abused and as much about the suspected situation as possible<br>3. to be reported immediately<br>C. Where to report<br>1. report suspected finding to supervisor<br>2. local departments of social services in the city or county where the adult resides or the Virginia Department of Social Services | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| 10. List reasons why the Virginia Board of Nursing would begin disciplinary proceedings for a Certified Nurse Aide. | APS hotline at 1 (888) 832-3858<br>D. Rights of mandated reporters<br>1. a person who makes a report is immune from civil and criminal liability unless the reporter acted in bad faith or with a malicious purpose.<br>2. a person who reports has a right to have his/her identity kept confidential unless consent to reveal his/her identity is given or unless the court orders that the identity of the reporter be revealed<br>3. a person who reports has a right to hear from the investigating local department of social services confirming that the report was investigated<br>E. Failure to report suspected abuse<br>1. punishable by a civil money penalty of not more than $500 for the first failure and not less than $100 nor more than $1,000 for subsequent failures<br>2. failure to report may also subject a mandated reporter to administrative action by the appropriate licensing authority<br>3. not obligated to report if mandated reporter has actual knowledge the same matter has been already reported to APS hotline<br><br>VII. Disciplinary Proceedings Against a Certified Nurse Aide<br>A. Regulation 18VAC90-25-100<br>1. disciplinary provisions for nurse aides<br>2. examples of allegations | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | investigated by VBON<br>a. unprofessional conduct<br>i. abuse<br>ii. neglect<br>iii. abandoning resident<br>iv. falsifying documentation<br>v. obtaining money or property of a resident by fraud, misrepresentation or duress<br>vi. entering into an unprofessional relationship with a resident<br>vii. violating privacy of resident information<br>viii. taking supplies or equipment or drugs for personal or other unauthorized use<br>b. performing acts outside the scope of practice for a nurse aide in Virginia<br>c. providing false information during a Virginia Board of Nursing investigation | | |
| 11. Identify the consequences of abuse, neglect, and exploitation conviction. | B. Consequences of abuse (including texting or posting pictures to social media), neglect, exploitation conviction<br>1. permanent bar to employment in health care<br>2. revocation of certification<br>3. possible legal action | | |
| 12. Discuss responsibilities and requirements of certified nurse aides per Virginia Board of Nursing regulations. | VIII. Responsibilities of Certified Nurse Aide to the Virginia Board of Nursing (BON) (18VAC90-25-10 et seq)<br>A. Requirements of approved nurse aide education program<br>B. Notify Board of Nursing of name | | |

| OBJECTIVES | CONTENT OUTLINE | TEACHING TOOLS/RESOURCES | STUDENT EVALUATION |
|---|---|---|---|
| | change<br>C. Notify Board of Nursing of address change<br>D. Renew certification every year<br>E. Disciplinary provisions | | |
| 13. Discuss responsibilities of employers of nurse aides to the Virginia Board of Nursing. | IX. Responsibilities of Employers of Certified Nurse Aides to the Board of Nursing<br>A. Board of Nursing may be notified of certified nurse aide's unprofessional/unethical conduct<br>B. Notify the Board of Nursing of disciplinary actions taken against a certified nurse aide | | |

# TERMINOLOGY & ABBREVIATIONS

## *Infection Control Definitions*

1. **MDRO** (multidrug-resistant organism) – microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents
2. **MRSA –** methicillin-resistant *Staphylococcus aureus*
3. **VRE –** vancomycin-resistant *Enterococcus*
4. **MDR-GNB –** multidrug resistant gram-negative bacilli
5. **MDRSP –** multidrug-resistant *Streptococcus pneumoniae*
6. **contact precautions -** are a set of practices used to prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment
7. **asepsis –** free from germs
8. **infection –** invasion of a body part by disease-causing microorganisms (pathogens)
9. **infectious disease –** disease caused by some parasitic organisms and transmitted from one person to another by transfer of the organism
10. **contagious disease –** disease readily transmitted by direct or indirect contact
11. **HAI – (hospital acquired infection)** any infection acquired while in the hospital or a facility
12. **CAI – (community acquired infection) –** any infection acquired in the community
13. **isolation –** the act of separating or setting residents/patients apart from others; it is now known as **Precautions**
14. **microorganisms –** small living body not visible to the naked eye
15. **contamination –** to make something unclean or unsterile
16. **disinfection –** destroying ***MOST*** disease-carrying organisms

## *Frequently Used Abbreviations*

| | |
|---|---|
| a.c. | before meals |
| Abd | abdomen |
| ad lib | as desired |
| ADLs | activities of daily living |
| Amb | ambulate (to walk) |
| AROM | active range of motion |
| B&B | bowel and bladder |
| BID | twice a day |
| BM | bowel movement, bone marrow, breast milk |
| BP | blood pressure |
| BRP | bathroom privileges |
| $\bar{c}$ | with |
| cc | cubic centimeters |
| C/O or c/o | complains of |
| CVA | cerebral vascular accident (stroke) |
| D/C | discontinue or discharge |
| DNR | do not resuscitate |
| DOB | date of birth |
| Dx | diagnosis |
| FF | force fluids |
| Fx | fracture |

| | |
|---|---|
| h.s. or hs | hours of sleep (bedtime) |
| HOB | head of bed |
| I&O | intake and output |
| IV | intravenous |
| N&V or n/v | nausea and vomiting |
| NPO | nothing by mouth |
| $O_2$ | oxygen |
| OOB | out of bed |
| PO | by mouth |
| p.c. | after meals |
| PRN or prn | as necessary or when needed |
| PROM | passive range of motion |
| PT | physical therapy |
| q | every |
| q.d. | every day |
| q.i.d. | four times each day |
| q,o,d, | every other day |
| q.h. | every hour |
| q2h | every two hours |
| Rx | prescription |
| $\overline{s}$ | without |
| SOB | shortness of breath |

| | |
|---|---|
| stat | immediately |
| TID | three times a day |
| UA | urinalysis |
| URI | upper respiratory infection |
| UTI | urinary tract infection |
| VS | vital signs |
| W/C | wheelchair |
| wt | weight |