Virginia Department of Health Professions

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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Describe the different types of health care. 2. Describe comparisons and differences of various methods that residents use to pay for long-term.	I. Long-term Care & Acute Care A. Independent living B. Home health care C. Adult day care D. Assisted living facility E. Nursing home F. Hospice G. Continuum of care facility H. Rehabilitation I. Hospital (inpatient & outpatient) J. Dementia/memory care II. Payment Options for Long-term Care Facilities A. Private pay 1. resident pays for health care from personal resources B. Group insurance 1. resident’s health care is paid for by insurance that the resident has previously paid C. Medicaid 1. medical assistance program for low-income residents that pays for the resident’s healthcare D. Medicare 1. health insurance program for residents over the age of 65 pays for resident’s healthcare 2. funded by Social Security 3. Minimum Data Set (MDS) report required for each Medicaid resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
3. Describe the role of the nurse aide in long-term care facilities.	III. Omnibus Budget Reconciliation Act of 1987 (OBRA-87) A. Federal regulation B. Set standards of care for long-term care facilities C. Requires all nurse aides in long-term care facilities to: 1. complete training program 2. pass certification exam D. Requires each state to have a registry of nurse aides (see Unit XIV) 1. available to the public 2. contains information on nurse aide's performance, including resident abuse 3. information to be kept minimum of five (5) years E. Requires continuing education 1. minimum of 12-hours in-service each year for nurse aides F. Requires nurse aide who has not worked for 2 consecutive years to retake the certification exam IV. The Health Care Team A. The Nurse 1. Registered Nurse (RN) 2. Licensed Practical Nurse (LPN) B. The Nurse Aide 1. care for residents 2. assist the RN and LPN 3. supervised by the RN or LPN C. Interdisciplinary Team 1. resident 2. physician 3. registered dietitian/nutritionist 4. physical therapist			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	5. occupational therapist 6. family member 7. social worker 8. licensed nurse 9. nurse aide 10. activities/enrichment			
4. Describe common tasks for the nurse aide.	V. Common Tasks for the Nurse Aide A. Activities of daily living (ADLs) 1. bathing 2. dressing 3. grooming 4. mouth care 5. toileting 6. eating & hydration 7. caring for skin; prevention of pressure ulcers B. Bed making C. Taking/recording vital signs; height & weight D. Observing/reporting resident changes to licensed nurse E. Maintaining safety, including fall prevention F. Caring for equipment G. Infection control			
5. Discuss professional behaviors of the nurse aide.	VI. Professional Behavior of the Nurse Aide A. Attitude 1. outward behavior 2. disposition 3. positive attitude a. caring b. compassionate c. committed to the job			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	B. Behavior 1. neatly dressed following facility uniform policy 2. on time to work 3. avoid unnecessary absences 4. use appropriate language 5. do not gossip about co-workers/residents 6. keep resident information confidential 7. speak politely 8. follow facility policies and procedures C. Grooming 1. wear clean, neat, unwrinkled uniform 2. attend to personal hygiene 3. do not use strongly scented fragrances (perfume, lotions, after-shave, body wash, hair spray) 4. keep hair away from your face 5. long hair should be secured at the back of the head or neck 6. keep beards neat and trimmed 7. use make-up sparingly 8. keep nails short 9. do not wear false nails 10. keep shoes/laces clean 11. jewelry should be minimal D. Work ethic 1. attitude toward work 2. punctual 3. reliable 4. accountable 5. conscientious 6. respectful of others			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	7. honest 8. cooperative 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) A. Transferring authority to a person for a specific task B. RN may delegate tasks to a nurse aide (NA) C. Criteria for delegation 1. nurse aide can properly and safely perform task 2. resident health, safety and welfare will not be jeopardized 3. RN retains responsibility and accountability for care of resident and supervises the NA 4. delegated task communicated to NA on a resident-specific basis 5. clear, specific instructions for performance, potential complications, expected results are given to NA 6. NA is clearly identified with a name tag 7. NA may not reassign a task that has been delegated to her/him			
7. Explain the impact of Guidance Document 90-55 on potential employment for a nurse.	VIII. Applying for Employment as a Nurse Aide A. Considerations 1. type of facility 2. adequate transportation 3. child care B. Complete resumé and application C. Guidance Document 90-55			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	1. impact of criminal convictions on potential employment 2. certain convictions prohibit employment in long-term care facilities 3. review Guidance Document 90-55 D. Interview 1. arrive on time 2. dress appropriately a. professional attire b. neat 3. maintain good eye contact 4. be prepared to answer questions 5. be prepared to ask questions 6. thank the interviewer at the end of the interview 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Identify three aspects of communication. 2. Demonstrate the ability to listen. 3. Recognize barriers to communication.	I. Elements of Communication A. Three components of communication 1. message 2. sender 3. receiver B. Listening is part of communication 1. hear the message 2. show an interest in the message 3. do not interrupt 4. ask appropriate questions for clarification 5. be patient allowing resident time to respond 6. reduce or eliminate distraction 7. use silence appropriately C. Non-verbal communication 1. posture 2. appearance 3. eye contact 4. gestures 5. facial expressions 6. touch 7. level of activity D. Barriers to communication 1. talking too fast or too softly 2. avoiding eye contact 3. belittling resident's feelings 4. physical distance 5. false reassurance 6. changing subject 7. giving advice			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	8. use of slang/medical jargon II. Senses in Communication A. Sight 1. look for changes in resident 2. report changes to licensed nurse B. Hearing 1. listen to resident and family C. Touch 1. touch and feel for any changes in resident's body 2. report any changes to licensed nurse D. Smell 1. report any unusual odor			
4. Identify the role of the four senses in communication. 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 A. Resident's medical record (chart) 1. admission sheet 2. health history 3. examination results 4. physician's orders 5. physician's progress notes 6. health team notes 7. lab test results 8. special consents B. Hard copy of health records or electronic health record (EHR) 1. condensed version of medical record C. Minimum Data Set (MDS) 1. assessment tool 2. provides structured, standardized approach to care 3. helps identify resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Demonstrate an understanding of the nursing process.	health care problems D. Person-centered care plan 1. outlines care that health care team must perform to assist resident to attain optimal level of functioning 2. written by the nurse (RN or LPN) 3. nurse aide contributes by reporting signs and symptoms he/she observes 4. includes objective and subjective information a. objective – information that can be seen, heard, touched, smelled b. subjective – cannot be observed, may be heard or something the resident said E. The nursing process 1. assessment by the RN a. physical inspection b. medical record c. identifies resident's actual or potential health care problems 2. diagnosis 3. plan - sets goals and a plan to meet those goals 4. implementation - providing care to resident following the plan 5. evaluation - look carefully to see if the desired goals have been achieved; if goals are not achieved care plan should be changed 6. nurse aide observations and			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
7. Demonstrate end-of-shift communication.	reports are vital to meet resident goals F. Reporting and documentation 1. throughout the day report changes in condition to the appropriate staff per facility policy 2. shift report a. received at beginning of shift from previous shift b. given to on-coming shift before nurse aide leaves unit at end of shift c. includes observations of changes in resident's condition or behavior 3. documentation a. all information is confidential b. document immediately after care is given c. never document before providing care d. document care in designated documentation tool (i.e. resident paper chart or other electronic health record) e. write notes neatly and legibly f. always sign your name and title g. document only facts, not opinions h. use accepted abbreviations i. do not erase or use white-out, draw a single line through and initial any error (follow facility guidelines)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
8. Demonstrate the correct way to talk on the telephone. 9. Demonstrate communicating with a hearing-impaired resident.	4. ADL record (activities of daily living) – check sheet for routine activities G. Communicating on the telephone 1. speak clearly and slowly 2. identify your facility and unit 3. identify who you are and your title 4. listen carefully 5. write any messages 6. end call with "thank you" and "good-bye" IV. Communicating with Specific Populations A. Hearing impaired 1. identify any assistive devices that resident uses a. hearing aides b. communication boards c. lip reading d. sign language 2. reduce distracting noise a. TV b. radio c. noise in adjacent room 3. get resident's attention before speaking 4. speak clearly, slowly 5. maintain eye contact 6. use short, simple words 7. use picture cards 8. write, if necessary			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Demonstrate communicating with a visually-impaired resident. 11. Describe the characteristics of cognitive impairment.	B. Visually impaired 1. identify any assistive devices that resident uses a. glasses b. special lighting 2. knock on door and introduce yourself when entering room 3. position resident so they are not looking into bright light or bright window 4. position yourself where resident can see you 5. have adequate light in room 6. encourage resident to wear glasses 7. use face of a clock to describe location of items 8. only move items with permission C. Dementia and cognitive impairment 1. recognizing the resident with cognitive impairment a. memory problems, trouble expressing oneself, not finding the right words to say b. trouble with being in new places; not knowing where one is c. trouble making decisions; confusion and inability to use logic d. trouble focusing for long; losing a train of thought easily e. most resident's cognitive condition will change over time			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
12. Identify causes of cognitive impairment in residents. 13. Explain why communication challenges need to be overcome and list methods to overcome these challenges.	2. cognitive impairment may be due to: a. Parkinson's disease b. multiple types of dementia including Alzheimer's c. strokes d. traumatic brain injuries e. alcoholism or drug toxicity (can be reversed) f. depression g. delirium h. urinary tract infection (UTI) 3. residents with cognitive impairment may be extremely anxious or frustrated and unable to communicate their needs a. cannot get needs met without communicating b. resident may need pain relief c. rights of resident may be violated d. may be uncooperative with your care if they do not know what you are doing 4. communication skills must be tailored to meet the needs of cognitively impaired residents a. be sure to have the resident's attention b. explain what you are going to do prior to starting care routine c. allow the resident opportunities to talk d. keep the same routine as much as possible			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	e. be honest and reliable to gain resident's trust f. know resident's likes and dislikes g. speak slowly, softly, and simply			
14. Discuss communicating with families.	D. Families 1. respond to requests and complaints 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 1. be tolerant of co-workers 2. be respectful of co-workers 3. be quiet when others are speaking 4. listen to ideas of co-workers 5. approach new ideas with an open mind 6. use appropriate voice volume 7. use appropriate language 8. do not curse or use slang 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 A. Accept every resident 1. be tolerant 2. be patient 3. be understanding 4. be sensitive to needs of resident B. Listen to resident C. Be prepared to handle disagreement and criticism			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
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 A. Signs of stress at work 1. anger or abuse displayed toward resident 2. arguing with supervisor 3. poor working relations with co-workers 4. complaining about responsibilities of job 5. having difficulty focusing on work 6. experiencing "burn out" B. Resources to assist with stress management 1. family 2. friends 3. supervisor 4. place of worship 5. mental health agency C. Causes of conflict in the workplace 1. misunderstanding 2. misinterpretation 3. stress 4. poor communication D. Who may be involved in conflict 1. resident 2. family member 3. visitor 4. staff E. Conflict involving resident 1. report to supervisor 2. report to ombudsman a. legal advocate for resident b. investigates complaints c. decides action to take if there is a problem			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
18. Demonstrate conflict management strategies.	d. educates consumers and care providers e. appears in court/legal hearings f. gives information to public F. Strategies for nurse aide to manage conflict 1. stay calm, do not become emotional 2. remove yourself from the area of the conflict 3. be aware of your body language 4. do not discuss conflict in front of resident 5. speak privately with the person involved in the conflict 6. focus on the conflict 7. use "I" sentences 8. listen to the other person 9. ask other person for ideas on how to resolve conflict 10. be open to a solution 11. may be necessary to agree to disagree G. Critical thinking process 1. identify the problem 2. list alternatives to solve the problem 3. list pros and cons to alternative solutions 4. mutually decide on a solution 5. evaluate the solution together			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
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. 20. Demonstrate the importance of protecting the resident's privacy and confidentiality.	VII. Social media and cell phone use 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 B. Some types of social media 1. Twitter 2. Facebook 3. Snapchat 4. Instagram 5. YouTube C. CNAs must protect the resident's privacy and confidentiality at all times 1. breaches in privacy or confidentiality can be a. intentional – i.e. posting a picture on Facebook of a resident lying in bed b. unintentional – posting a picture of self and a resident on Facebook 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 3. if you are aware of any violation it should be reported, whether intentional, or unintentional D. Use and misuse of resident's social media	National Council of State Boards of Nursing (NSCBN) Video Library: • Professional Boundaries in Nursing • Social Media Guidelines for Nurses		

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	E. Boundary violations 1. NEVER post pictures or videos of residents on any type of social media 2. may be subject to criminal penalties and civil sanctions – severe violation up to $250,000 fine and 10 years in federal prison 3. may lose license 4. may be terminated by employer			

UNIT III – INFECTION CONTROL

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

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	away pathogens (redness, swelling, warmth) ii. white blood cells attack pathogen (pus) iii. increased body temperature (fever) helps to destroy pathogens b. antibodies i. special proteins created by previous exposure to a pathogen ii. created by vaccination to a particular pathogen 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 1. feeling "unwell" 2. sore throat 3. coughing 4. fever/chills 5. nausea 6. diarrhea 7. drainage from a skin wound 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 1. immune system becomes weaker 2. skin becomes thinner and tears more easily 3. limited mobility increases risk of pressure sores and skin infections 4. decreased circulation slows response of the blood to an infection 5. decreased circulation slows wound healing			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
9. Compare different methods used to achieve medical asepsis.	6. wear a gown if your body may come in contact with blood or body fluids 7. wear a mask, goggles and/or face shield if your face may come in contact with blood or body fluids 8. place all contaminated supplies in special containers 9. dispose of all sharp objects in biohazard containers 10. never recap a needle 11. clean all surfaces potentially contaminated with infectious waste C. Medical asepsis 1. physically removing or killing pathogens 2. uses a. soap b. water c. antiseptics d. disinfectants e. heat 3. sanitation a. basic cleanliness b. hand washing c. washing the body, clothes, linen, dishes 4 antisepsis a. kills pathogens or stops them from growing b. rubbing alcohol c. iodine 5. disinfect a. kills pathogen b. cleaning solutions 6. sterilization a. uses pressurized steam to kill			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Demonstrate proper hand washing technique.	pathogens D. Hand hygiene 1. most important factor in preventing transmission of pathogens 2. alcohol-based solutions are not a substitute for proper hand washing a. hand hygiene must include washing with soap and water versus hand sanitizer 3. keep fingernails short and clean 4. do not wear artificial nails or tips 5. rings and bracelets collect pathogens and should not be worn 6. use lotion to keep skin soft and intact 7. when to wash hands a. arrival at work b. entering resident's room c. leaving resident's room d. before and after feeding resident e. before putting on gloves and after removing gloves f. after contact with blood or body fluids g. before and after handling food h. before and after drinking and eating i. after smoking j. after handling your hair k. after using the bathroom l. after coughing, sneezing or blowing your nose m. before leaving the facility n. when you get home 8. hand washing technique a. use technique in most current			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	Virginia Nurse Aide Candidate Handbook E. Personal protective equipment (PPE) 1. barrier between a person and disease 2. gloves, mask, gown, goggles, face shield 3. don and remove PPE a. use technique in most current Virginia Nurse Aide Candidate Handbook			
11. Demonstrate proper donning and removing technique for personal protective equipment. 12. Identify various types of isolation precautions.	F. Isolation precautions 1. for residents who may be infected or colonized with certain infectious agents (CDC) 2. measures taken to contain pathogens 3. follow CDC guidelines or facility policy 4. protocols to prevent exposure of other residents/staff to pathogens 5. Two levels of isolation precautions a. 1st level - Standard Precautions i. For all resident care ii. For protection from blood and body fluids which may contain infectious agents b. 2nd level – Transmission-based 6. Three types a. contact – transmitted by touching such as skin, wound infections, feces, respiratory secretions b. droplet – transmitted by droplets from mouth or nose such as influenza, strep throat, pneumonia			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Describe the disposition of infectious waste material in a health care facility.	c. airborne – transmitted through air, like tuberculosis, chicken pox 7. infectious agents commonly seen: a. MRSA (Methicillin Resistant Staphlococcus Aureus) b. VRE (Vancomycin Resistant Enterococcus) i. multi-drug resistant bacteria ii. indicative of chronic illness c. C. Diff (Clostridium difficile) – a bacterium which causes inflammation of the colon resulting in diarrhea and serious illness G. Personal hygiene 1. keep yourself clean 2. wear clean uniform each day 3. keep yourself well-hydrated and well-nourished 4. give yourself adequate rest/sleep 5. if you are ill do not come to work 6. keep hair pulled back and secured 7. follow facility policy for nails and jewelry H. Disposition of contaminated waste 1. infectious waste a. contaminated with blood or body fluids 2. biohazard bags used to dispose of infectious waste a. red bags 3. biohazard bags are not disposed with ordinary trash a. must be incinerated 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Demonstrate an understanding of the OSHA Bloodborne Pathogen Standard.	I. Prevention of Common Accidents A. Occupational Safety and Health Administration (OSHA) 1. federal agency 2. responsible for safety and health of workers in USA 3. establishes workplace rules for safety 4. conducts workplace inspections 5. mandates workplace training for safety issues 6. Bloodborne Pathogen Standard a. requires regular in-service training b. identifies steps to take when exposed to bloodborne pathogens c. requires employers to provide PPE for staff, residents, visitors d. requires each resident room to have biohazard containers to dispose of contaminated equipment/supplies e. requires employers to provide free hepatitis B vaccine for employees f. examples of bloodborne diseases: AIDS, hepatitis			

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Identify the importance of reporting falls to the appropriate supervisor. 5. Discuss measures to prevent various common accidents in health care facilities.	risk resident behavior 3. report a fall to appropriate licensed nurse immediately – follow health care facility policy for care of resident who has fallen D. Prevention of scalds and burns 1. scalds a. burns caused by hot liquid such as water, coffee or tea b. liquid temperature 140° or greater 2. burns a. cigarette burns b. liquid burns c. chemical burns d. electrical burns 3. measures to prevent scalds or burns a. water temperature should be 110° b. do not have resident use toe to check water temperature c. staff should check temperature of water before giving resident bath or shower d. use low setting on hair dryers e. do not use microwave oven to prepare a warm soak or application f. encourage resident to allow hot drinks to cool before drinking g. if resident has tremors, encourage use of closed cup when drinking hot liquids h. pour hot liquids away from residents i. require to follow facility smoking policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Identify the information contained on a Safety Data Sheet (SDS).	j. frequently check electrical cords for fraying and report any that are frayed; use safety outlet plugs k. avoid keeping cleaning chemicals in areas where have access 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 4. Safety Data Sheets (SDS) a. an OSHA requirement in all health care facilities for any dangerous chemical on site b. all staff should have access and know where these are kept c. information included on SDS i. chemical ingredient ii. danger of the product 5. PPE to be worn when using chemicals 6. correct way to use and clean up the chemical 7. emergency action to take if the chemical is spilled, splashed or ingested 8. safe handling procedures for the chemical E. Prevention of poisoning 1. risk factors a. personal care items – nail polish remover, soaps, perfume, hair products b. cleaning supplies c. some plants/flowers			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	2. Poison Control phone number required to be prominently displayed 3. measures to prevent poisoning a. keep cleaning chemicals in locked cabinet b. check drawers for hoarded food that may have spoiled c. keep medications away from the bedside 4. report a poisoning to appropriate licensed nurse immediately a. follow health care facility policy for care of a who has been poisoned F. Prevention of choking 1. object blocks the trachea (windpipe) 2. risk factors a. difficulty swallowing b. disoriented 3. measures to prevent choking a. resident in upright position for eating/feeding b. do not rush resident while eating c. cut food into small pieces d. use thickening for liquids if resident has difficulty with thin liquids e. make sure dentures fit correctly 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 a. follow health care facility guidelines for obstructed airway			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
8. Discuss the use of restraints, including the reasons to avoid their use.	G. Prevention of suffocation 1. risk factors a. improperly fitting dentures b. poor feeding technique c. unattended baths d. use of restraints 2. measures to prevent suffocation a. report to appropriate licensed nurse any dentures that do not fit properly b. always have resident in upright position when eating c. never leave resident unattended in a bath tub, whirlpool or shower d. avoid use of physical or chemical restraints H. Avoiding the need for restraints 1. restraints a. restrict voluntary movement or behavior b. may be physical or chemical 2. physical restraints/protective devices a. examples – vest, wrist/ankle restraints, waist/belt restraint, mitt b. bed side rails c. any chair that prevents resident from rising (geriatric table chair; recliner) 3. chemical restraints - medication that controls resident's behavior 4. problems with restraints/protective devices a. bruising			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
9. Explain the importance of and frequency of monitoring the resident while restraints/protective devices are in use. 10. Identify alternatives to restraints/protective devices.	b. decreased mobility i. pressure sores ii. pneumonia iii. incontinence iv. constipation c. social isolation d. stress and anxiety e. increased agitation f. loss of independence g. loss of dignity h. loss of self-esteem i. risk of suffocation 5. use of restraints/protective devices a. requires health care provider order b. illegal to use for convenience of the staff c. resident must be continually monitored, at least every 15 minutes d. restraint must be released every 2 hours e. know how to use 6. restraint alternatives (restraint-free care) - evaluate situation for cause of behavior or problem by anticipating resident's needs: a. is resident wet? b. is resident soiled? c. is resident tired? d. is resident thirsty? e. is resident hungry? f. is resident bored? 7. observe for emotional status 8. observe for pain			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	9. is resident confused/disoriented? a. encourage resident independence i. provide meaningful activities ii. encourage to participate in activities to the best of resident's ability iii. redirect the resident's interests b. reduce boredom - encourage resident's engagement i. involve in activities/life enrichment appropriate for resident ii. take resident for walk iii. encourage participation in social activities that are meaningful to the resident iv. provide reading materials v. read to resident if desired 10. provide a safe area for resident to ambulate a. well-lighted b. free of clutter c. make sure resident wears non-skid footwear d. provide activity for resident who wanders at night 11. reduce tension and anxiety a. toilet every 2 hours b. escort resident to social activities c. provide backrub d. offer snack or drink e. reduce noise level around			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	resident f. play soothing music 12. involve family in resident's care a. encourage visits b. encourage participation in care of resident 13. other alternatives to restraints a. bed/chair alarms b. specially shaped cushions 14. report any changes in resident's behavior or mental status to appropriate licensed nurse 15. answer call bells immediately			
11. Demonstrate the use of good body mechanics.	II. Workplace Safety A. Body mechanics 1. definitions a. alignment – keeping muscles and joints in proper position to prevent unnecessary stress on them b. balance – keeping center of gravity close to base of support c. coordinated body movement – using your body weight to help move the object 2. lifting a. feet hip distance apart b. back straight c. knees bent d. object close to you e. tighten abdominal muscles f. lift with leg muscles g. keep object close to your body h. keep your back straight			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
12. Demonstrate the correct way to assist a falling resident. 13. Discuss the importance of and methods for reporting incidents/accidents to the appropriate supervisor.	3. resident care a. if resident is in bed, raise bed to waist height. Remember to lower bed when you are finished b. push, slide or pull rather than lifting, if possible c. avoid twisting when lifting by pivoting your feet d. do not try to lift with one hand e. ask for help from co-workers f. tell resident what you are planning to do so they can help you, if possible 4. assisting the falling resident a. do not try to prevent the fall b. stand behind the resident with arms around his torso c. slide resident down your body and leg, as a sliding board d. ease resident to the floor e. protect the head f. stay with resident and call for help g. report the incident to the appropriate licensed nurse as soon as possible B. Incident/Accident reports 1. incident – accident, problem or unexpected event that occurs while providing resident care a. may involve staff, resident and/or visitor 2. report should be written as soon as possible after the event a. document exactly what happened			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	b. give time and condition of person involved c. only use facts, not opinions 3. information is confidential 4. report is given to the charge nurse 5. always file an incident report if you are injured on the job a. provides protection for you b. identifies that injury occurred at work C. Fire safety 1. fire requires a. object that will burn b. fuel – oxygen c. heat to make the flame			
14. Identify potential causes of a fire in a health care facility.	2. potential causes of fire a. smoking b. frayed/damaged electrical cord/wires c. electrical equipment in need of repair d. space heaters e. overloaded electrical plugs/outlets f. oxygen use g. careless cooking h. oily cleaning rags 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 a. stay with resident who is smoking b. make sure cigarettes and ash are in ashtray c. only empty an ashtray if cigarette and ash are not hot d. report frayed/damaged			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
16. Demonstrate the proper use of a fire extinguisher. 17. Discuss the sequence of events to be taken if fire is discovered in a health care facility.	cords/outlets immediately e. keep fire doors closed and accessible f. keep halls clear and accessible 4. RACE a. if fire occurs b. R – remove resident from danger c. A – activate alarm d. C – contain fire by closing doors and windows e. E – extinguish fire if possible or evacuate the area 5. use of a fire extinguisher - PASS a. P – pull the pin b. A – aim at the base of the fire c. S – squeeze the handle d. S – sweep back and forth at the base of the fire 6. know facility policy/procedure for a fire a. call for help immediately b. know location of fire evacuation plan c. remain calm and do not panic d. remove all persons in the immediate area of the fire (RACE) e. if a door is close, always check it for heat before opening it f. stay low in room when trying to escape fire to avoid the smoke g. use wet towels to block doorways to prevent smoke from entering a room h. use covering over face to reduce smoke inhalation			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	i. if clothing is on fire…Stop…Drop…Roll 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 1. definition a. sudden unexpected event b. hurricane c. ice/snow storm d. flood e. tornado f. earthquake 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 3. know your responsibilities during a disaster a. listen carefully to directions b. follow instructions c. know location of all exits and stairways d. know where fire alarms and extinguishers are located e. resident safety comes first f. keep calm 4. know facility evacuation plan			
20. Discuss the role of the nurse aide and oxygen use in a health care facility.	E. Safety precautions for oxygen use 1. oxygen use a. resident with difficulty breathing b. prescribed by health care provider 2. role of the nurse aide a. observation only b. only licensed person (RN or LPN) can adjust the flow rate 3. special safety precautions			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	a. post "No Smoking" and "Oxygen in Use" signs in room and on the door to the room b. smoking is not permitted in the resident's room or around oxygen equipment c. remove fire hazards from the room such as electrical equipment: razors, hair dryers, radios d. remove flammable liquids from resident's room: nail polish remover, alcohol e. do not permit candles, lighters or matches around oxygen equipment 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 g. check resident's nose and behind their ears for irritation caused by oxygen tubing and report irritation to appropriate licensed nurse h. learn how to turn off oxygen equipment in case of a fire 4. report any changes in the resident's condition to the appropriate licensed nurse 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Identify the basic steps a nurse aide should take in any emergency situation. 2. Identify symptoms a resident may display when experiencing an emergency.	I. Life-threatening Emergency Measures A. Emergency 1. definition a. condition requiring immediate medical or surgical treatment to prevent the resident from having a permanent disability or from dying 2. basic steps for nurse aide in an emergency a. collect information from resident or situation b. call or send for help c. use gloves and a breathing barrier d. remain calm e. know your limitations f. assist medical personnel after help arrives 3. emergency situations a. change in level of consciousness b. irregular breathing or not breathing c. has no pulse d. severely bleeding e. unusual color or feel to the skin f. choking g. poisoning h. severe pain i. shock j. allergic reaction			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
3. Demonstrate the appropriate response to a conscious or unconscious resident in an emergency situation.	B. Responding to change in level of consciousness 1. definitions a. conscious – mentally alert and aware of surroundings, sensations and thoughts b. confused – disoriented to time, place, and/or person c. unconscious – resident is unable to respond to touch or speech 2. responding to conscious resident a. has a pulse and is breathing b. observe skin color, warmth, moisture c. call for help d. question resident regarding pain, illnesses, current medical issues e. take vital signs (VS) f. remain calm g. reassure resident h. stay with resident until help arrives i. document what occurred, the time, and VS 3. responding to an unconscious resident a. this is an emergency b. know resident's DNR status c. know facility policy/procedure for activating the EMS or 911 d. activate emergency medical system by calling for help or have someone call immediately e. initiate CPR (if facility policy permits) or first aid until EMS or medical personnel arrive			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Demonstrate CPR, including the use of an AED, on an adult manikin (not required by regulation). 5. Discuss appropriate nurse aide actions for a resident who is bleeding. 6. Discuss appropriate nurse aide actions for a resident who is having a nose bleed.	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) a. follow the most current national guidelines for performing CPR II. Basic Emergency Measures A. Bleeding 1. call nurse immediately 2. put on gloves 3. have resident lie down 4. apply pressure to source of bleeding with a clean cloth 5. elevate source of bleeding above level of the heart, if possible 6. place another cloth on top of original cloth if the 1st one becomes saturated 7. when help arrives, remove gloves, wash hands and document what occurred B. Nose bleed (Epistaxis) 1. may be caused by dry air, medical condition, medications 2. notify nurse immediately 3. put on gloves 4. have resident tilt head slightly forward and squeeze bridge of the nose with your fingers 5. apply pressure until bleeding stops 6. apply ice pack or cool cloth to back of the neck, forehead or upper lip to help slow the bleeding 7. stay with resident until bleeding stops			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
7. Demonstrate appropriate nurse aide actions for a resident who has fainted. 8. Discuss appropriate nurse aide actions for a resident who has vomited.	8. remove gloves and document what occurred C. Fainting (syncope) 1. caused by decreased blood flow to the brain 2. notify nurse immediately 3. assist resident to floor 4. if resident is in chair, have him/her place head between his/her knees 5. elevate feet about 12 inches above level of the heart 6. take VS 7. loosen any tight clothing 8. do not leave resident unattended 9. if resident vomits, turn on side in recovery position 10. after symptoms disappear have resident remain lying down for 5 minutes 11. slowly assist resident to seated position 12. document what occurred, the time and VS D. Vomiting (emesis) 1. notify nurse immediately 2. put on gloves 3. use emesis basin, wash basin or trash can 4. wipe resident's mouth and nose 5. be calm and reassuring to the resident 6. when resident is finished offer water or mouthwash to rinse the mouth 7. encourage resident to brush teeth or provide oral care to dependent resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	8. provide resident with clean clothes and/or clean linen as necessary 9. flush vomit down the toilet after showing it to the nurse and wash the basin 10. place soiled linen in proper containers 11. remove gloves and wash hands 12. document time, amount, color, odor and consistency of vomitus			
9. Discuss appropriate nurse aide actions for a resident who has been burned.	E. Burns (1st, 2nd, & 3rd degree) 1. notify nurse immediately – assist only as directed by licensed health professional (i.e.-nurse, N.P., physician, P.A.) 2. put on gloves to protect resident and self 3. lightly cover with dry, sterile gauze, if directed 4. never apply butter, oil, or ointment, water or any other solution to a burn 5. have resident lie down and wait for EMS to arrive 6. stay with resident until help arrives 7. remove gloves, wash hands and document what occurred per facility policy			
10. Explain the signs/symptoms of a heart attack.	F. Heart attack - myocardial infarction (MI) 1. Signs - (may differ in males and females) a. c/o "heaviness" or pain in the chest b. female may feel tight discomfort described as a full feeling across entire chest c. c/o pain radiating down left arm			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	(either male or female) d. c/o sharp upper body pain (female) e. difficulty breathing or SOB f. sweating – may be mistaken for hot flash in females g. skin looks pale or bluish h. complaint of nausea or indigestion i. stomach cramps (female) j. jaw pain (female)			
11. Discuss appropriate nurse aide actions for a resident who has signs/symptom of a heart attack.	G. Heart attack - actions 1. have resident lie down 2. notify nurse immediately 3. this is medical emergency 4. elevate resident's head to help him/her breathe better 5. initiate CPR if necessary 6. stay with resident until help arrives 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 1. clear the immediate area of objects that may cause harm 2. assist resident to the floor 3. notify nurse immediately 4. protect the head, but allow remainder of body to move 5. note time seizure began 6. do not try to put anything in resident's mouth 7. after seizure, turn resident on side in recovery position 8. document time seizure began, what occurred per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Explain the signs/symptoms of a stroke. 14. Discuss appropriate nurse aide actions for a resident who is having a stroke. 15. Discuss definition of and causes of shock.	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 1. change in level of consciousness 2. complaint of severe headache 3. drooping on one side of the face 4. weakness on one side of the body 5. sudden on-set of slurred speech J. Stroke - actions 1. notify nurse immediately 2. this is medical emergency 3. have resident lie down 4. note time of on-set of symptoms 5. stay with resident until EMS arrives 6. document time of on-set of symptoms and what occurred 7. Observe and Report - FAST a. FACE: Does one side of the face droop? b. ARMS: Does one arm drift downward when both arms are raised? c. SPEECH: Is speech slurred or strange? 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 K. Shock 1. definition a. lack of adequate blood supply to body organs b. medical emergency			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	2. causes a. bleeding b. heart attack c. severe infection d. low blood pressure e. exposure to environmental changes			
16. Identify the signs/symptoms of shock.	3. signs/symptoms a. pale or bluish skin b. staring c. increased pulse and respirations d. decreased blood pressure e. extreme thirst			
17. Discuss appropriate nurse aide actions for a resident who is in shock.	4. care of resident experiencing shock a. notify nurse immediately b. have resident lie down c. control any bleeding that you can see d. check VS e. if no respirations or pulse begin CPR f. cover resident with blanket to maintain temperature g. elevate feet about 12 inches h. do not give resident anything to eat or drink i. remain with resident until EMS arrives j. document what occurred			
	L. Diabetic reactions 1. mnemonic - hot and dry, sugar high; cold and clammy, need some candy			
18. Explain the signs/symptoms of hypoglycemia.	2. low blood sugar (hypoglycemia) a. signs/symptoms i. nervous ii. dizzy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iii. hungry iv. headache v. rapid pulse vi. disoriented vii. cool, clammy skin viii. unconscious			
19. Discuss appropriate nurse aide actions for a resident/resident who is hypoglycemic.	b. care of resident with low blood sugar i. notify the nurse immediately ii. if conscious, give glass of orange juice or something to eat that has sugar or complex carbohydrates iii. know facility policy for low blood sugar iv. stay with resident until feels better v. document what symptoms you saw, when they occurred and what you did			
20. Explain the signs/symptoms of hyperglycemia.	3. high blood sugar (hyperglycemia) a. signs/symptoms i. increased thirst ii. increased urination iii. increased hunger iv. flushed, dry skin v. drowsy vi. nausea, vomiting vii. unconscious			
21. Discuss appropriate nurse aide actions for a resident who is hyperglycemic.	b. care of resident with high blood sugar i. notify nurse immediately ii. follow nurse's instructions 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Identify the four (4) basic rights of all clients/residents. 2. Explain client/resident rights identified in the Omnibus Budget Reconciliation Act (OBRA) and the Health Insurance Portability and Accountability Act (HIPAA).	I. Basic Rights of All Clients/Residents A. Right to be treated fairly and with respect B. Right to live in dignity C. Right to be free from fear D. Right to pursue a meaningful life II. Rights of Clients/Residents of Long-term Care Facilities A. Part of Omnibus Budget Reconciliation Act (OBRA) B. Client/resident has right to: 1. make decisions regarding care 2. privacy 3. be free from physical or psychological abuse, including improper use of restraints 4. receive visitors and to share room with a spouse if both partners are clients/residents in the same facility 5. use personal possessions 6. control own finances 7. confidentiality of his/her personal and clinical records 8. information about eligibility for Medicare or Medicaid funds			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	9. information about facility's compliance with regulations, planned changes in living arrangement and available services 10. voice grievances without discrimination or reprisal 11. examine results of recent survey 12. exercise his/her rights as a citizen or resident of the U.S. 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 14. organize and participate in groups organized by other clients/residents or families of residents including social, religious and community activities 15. choose to work at the facility either as a volunteer or a paid employee, but cannot be obligated to work C. HIPAA (Health Insurance Portability and Accountability Act) i. Federal law since 1996 (Privacy Rule 2000 & Security Rule 2003, Enforcement) b. identifies protected health information that must remain confidential c. only those who must have information for care or to process records can have access to this information d. nurse aide must never share protected health information with anyone not directly involved in care of client/resident (including			
3. Identify nurse aide actions that maintain client/resident privacy and confidentiality.				

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	g. do not share client/resident information on any form of social media, including photos, videos, texts and emails 2. right to make personal choices to accommodate individual needs a. client/resident has right to make choices about their care i. may choose own physician ii. participate in planning their therapies, treatments and medications 3. right to refuse care, medication a. encourage client/resident to make choices during personal care i. when to bathe/shower ii. what to wear iii. how to style hair b. encourage client/resident to make choices at mealtime i. filling out menu ii. order in which food is eaten iii. what fluids offered c. encourage client/resident to choose activities and schedules d. honor client/resident choices regarding when to get up and when to go to bed e. permit client/resident enough time to make choices f. make offering client/resident choices a habit of providing care g. offer input to Interdisciplinary Care Team regarding client/resident choices			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
5. Identify nurse aide actions that assist the client/resident with their right to receive assistance resolving grievances and disputes. 6. Describe the role of the ombudsman in a long-term care facility. 7. Identify nurse aide actions that provide the client/resident with assistance necessary to participate in client/resident and family groups and other activities.	h. freedom of sexual expression/gender identity 4. assistance resolving grievances and disputes a. listen to client/resident b. obtain all the facts c. report facts to charge nurse d. follow up with the client/resident e. avoid involvement in family matters f. do not take sides g. do not give confidential information to family members h. report disagreements to charge nurse i. remember the nurse aide is the client/resident advocate j. involve the ombudsman of the facility i. legal problem solver on behalf of client/resident ii. listens to client/resident and decides what action to take iii. telephone number is listed in the facility k. client/resident may not be punished or fear retaliation for voicing concerns or complaints 5. provide assistance necessary to participate in client/resident and family groups and other activities a. provide client/resident with calendar of daily activities b. allow time to make choices c. be flexible with client/resident schedule to permit participation in activities			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	d. encourage client/resident to participate in activities e. encourage family to visit f. procure appropriate assistive devices to be able to attend activities i. wheelchair ii. walker iii. cane g. assist client/resident to dress appropriately to attend activities i. glasses ii. hearing aid iii. attractive, clean, appropriate clothing iv. hair care and grooming h. assist client/resident to toilet before attending activities i. provide means to attend activities in facility i. escort or take client/resident to activities in facility ii. return client/resident to room after activities in facility 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 a. mark all clothing with name and room number b. encourage family to take valuable items and money home			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
9. Identify nurse aide actions that promote client's/resident's right to be free from mistreatment, including abuse, neglect and exploitation.	c. if client/resident wants to keep valuables, encourage use of lock box or facility safe d. honor privacy of client/resident regarding their possessions e. assist client/resident to keep personal possessions neat and clean f. permit client/resident right to decide where personal items are kept, if possible g. be careful when working around client/resident personal items h. complaint of stolen, lost or damaged property must immediately be reported and investigated i. avoid placing client/resident personal possessions in areas where nursing care is performed 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) a. vulnerable adults (clients/residents) have the right (APS philosophy) to: i. to be treated with dignity ii. refuse assistance if they are capable of making decisions			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iii. make their own choices regarding how and where they live iv. privacy b. vulnerable adults are persons 18 years of age or older who are incapacitated, or persons 60 years of age or older c. mandatory reporting of suspicion of willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm or mental anguish – Elder Justice Act d. mandatory reporters include, but are not limited to: 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 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. i. if there is harm/injury, reporting must be immediate			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Define the types of adult abuse recognized in Virginia. 11. Recognize the indicators of sexual abuse of older or incapacitated adult.	ii. if there is harm/injury local law enforcement must be notified 8. define abuse a. abuse – the intentional infliction of physical pain or injury i. also includes mental anguish and extends to unreasonable confinement – physical or chemical restraints, isolation, 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 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 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,			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
12. Recognize the indicators of physical abuse of older or incapacitated adult. 13. Recognize the indicators of unreasonable confinement of older or incapacitated adult (client/resident).	intimidation, or advantage d. indicators of physical abuse i. multiple and/or severe bruises, burns, and welts ii. unexplained injuries iii. a mix of old and new bruises (may indicate abuse over time) iv. signs of broken bones and fractures (may complain of pain or weakness) e. indicators of unreasonable confinement i. restraints used on chairs or bed ii. an adult who is placed or locked in a room iii. social isolation iv. pressure sores from prolong stays in a restrained position f. indicators of mental of psychological abuse i. verbal assaults, threats, or intimidation by a caregiver ii. the client/resident demonstrates fear of the caregiver iii. the caregiver doesn't allow anyone to visit with the adult alone iv. adult is withdrawn/doesn't communicate in the presence of the caregiver			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
14. Discuss the definition of neglect of vulnerable or incapacitated adults (clients/residents). 15. Recognize the indicators of neglect of older or incapacitated adult (client/resident). 16. Discuss the definition of exploitation of incapacitated adults (clients/residents). 17. Recognize the indicators of exploitation of older or incapacitated adult (client/resident).	9. define neglect 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 b. indicators of neglect i. untreated medical or mental health problems ii. medication not taken or administered as prescribed iii. dehydration and malnourishment, including not providing adults with necessary special dietary needs 10. define exploitation 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 b. indicators of exploitation i. misappropriation of client's/resident's possessions; taking money or personal items that belong to the client/resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	ii. deceiving client/resident into signing documents that benefit nurse aide (titles of possessions, bank signature cards, credit card applications) iii. personal belongings, especially those of value are missing after a visit with family or friends 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 was signed), the nurse aide should report it.			
18. Discuss the definition of negligence of vulnerable or incapacitated adults (clients/residents).	11. define negligence a. causing harm or injury to another person without the intent to cause harm 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 a. yelling at client/resident b. directing obscenities toward client/resident c. threatening client/resident with physical injury d. false imprisonment e. withdrawal of food or fluids			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	f. withdrawal of physical assistance g. hitting h. shaking i. biting j. forced isolation k. teasing in a cruel manner l. inappropriate sexual comments or acts 13. actions of the nurse aide that constitute neglect a. inadequate personal care b. inadequate nutrition c. inadequate hydration d. failure to turn and reposition a bed ridden client/resident e. living areas not kept neat and clean 14. actions of the nurse aide that constitute exploitation a. taking client/resident possessions b. forcing client/resident to perform activities in exchange for care c. asking for or borrowing money from a client/resident d. forging client/resident's signature for personal gain e. unauthorized receipt of gifts or gratuities f. accepting money beyond normal compensation			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
20. Identify signs and symptoms that indicate client/resident abuse, neglect or exploitation. 21. Describe the nurse aide's role as a mandated reporter.	15. signs and symptoms that client/resident has been abused, neglected or exploited a. unexplained bruising b. unexplained broken bones c. bruising/broken bones that occur repeatedly d. burns shaped like the end of a cigarette e. bite or scratch marks f. unexplained weight loss g. signs of dehydration such as extremely dry and cracked skin or mucous membranes h. missing hair i. broken or missing teeth j. blood in underwear k. bruising in the genital area l. unclean body and/or clothes m. strong smell of urine n. poor grooming and hygiene o. depression or withdrawal p. mood swings q. fear or anxiety when a particular caregiver is present r. fear of being left alone 16. nurse aide is a mandated reporter a. definition i. required by law to report suspected or observed abuse or neglect or exploitation ii. immediately report suspected or observed adult abuse or neglect to appropriate supervisor and/or Adult Protective Services			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
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 c. immunity from criminal or civil liability for making a report in good faith d. protection from employer retaliation from reporting. Employers cannot prevent an employee from reporting directly to APS e. know your facility policy/procedure for reporting suspected or observed abuse, neglect, and/or exploitation f. if the perpetrator is registered, certified or licensed by the Virginia Board of Nursing an investigation will be initiated 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/residents) h. 18VAC90-25-100(2)(h) 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)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
23. Explain how the nurse aide can help the client/resident meet their basic needs described by Maslow.	i. 18VAC90-25-81identifies actions nurse aide may take to remove a finding of neglect from certification based on a single occurrence III. Holistic Needs of Residents in Long-term Care Facilities A. Maslow's Hierarchy of Needs 1. physical needs a. oxygen b. water c. food d. elimination e. rest f. nurse aide helps client/resident meet these needs by encouraging eating, drinking and adequate rest and assisting with toileting, if necessary 2. safety and security a. shelter b. clothing c. protection from harm d. stability e. nurse aide helps client/resident meet these needs by listening, being compassionate and caring 3. need for love a. feeling loved b. feeling accepted c. feeling of belonging d. nurse aide helps client/resident meet these needs by welcoming client/resident to facility, encourage interaction with other client/residents			

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
25. Define culture, and what represents culture. 26. Describe cultural sensitivity awareness, ethnic cultures, and national cultures.	C. Provide culturally sensitive care 1. culture definition – the arts, beliefs, customs, and institutions of a certain group of people at a particular time a. culture represents the ideas, learned beliefs, values, behaviors, and attitudes groups possess i. gender ii. faith iii. sexual orientation iv. socioeconomic status v. race vi. ethnicity 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 3. ethnic cultures in the United States a. numerous ethnic cultures b. some ethnic groups may live in the same area c. value and respect each unique person d. learn to embrace cultural differences 4. national cultures - various cultures from different parts of the world a. ethnicity is usually by country of origin			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
27. Recognize cultural differences as they relate to clients/residents and their family members. 28. Identify strategies to provide culturally sensitive care.	5. cultural differences that impact nursing care a. religious differences – respect client's/resident's beliefs b. ethnicity – you will encounter people from different backgrounds c. language barrier – provide available interpreter services per facility policy d. cultural and religious diets – clients/residents may not eat foods that are unfamiliar; family may bring traditional meals; know cultural diet restrictions e. spatial distance – some cultures are uncomfortable when you are in their personal space f. interaction of genders – approach client/resident according to his/her preferred gender identification g. generational interaction – each generation has its own set of values, beliefs, and life experiences; take time to learn from others h. fear of the unknown or what is different i. death and dying j. post mortem care f. strategies to provide culturally sensitive care a. always respect client/resident b. honor resident/family requests to follow cultural guidelines c. provide resident/family privacy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
29. Identify developmental tasks for each age group described by Erikson.	d. ask resident/family if they have specific ways of celebrating holidays e. ask if resident/resident has special dietary guidelines to follow f. respect differences in cultural values g. self-awareness of your own culture 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 i. do not engage in gossip about clients/residents because of gender preferences or any differences D. Stages of human growth and development 1. Eric Erikson's Development Tasks a. birth to 1 year i. receives care and develops trust ii. sense of security b. toddler (1-3 years) i. learns self-control (bowel and bladder control) and develops autonomy (self-identity) c. preschool (3-6 years) i. explores the world ii. develops initiative, ambition d. school age (6–9 years) i. gains skills, learns to get along with others ii. develops industry (work)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
30. List psychosocial changes occurring in late adulthood. 31. Discuss how the changes of late adulthood affect the psychosocial and physical care of the client/resident in long-term care.	e. late childhood (9-12 years) i. gains confidence ii. develops moral behavior f. teenage or adolescence (13-18) i. changes in the body ii. develops identity (individuality and sexuality) g. young adult (18-40) i. starts family ii. develops close relationships and intimacy h. middle adulthood (40-65) i. pursues career ii. physical changes iii. develops generatively (productivity) i. late adulthood (65 and older) i. reviews own life ii. resolves remaining life conflicts iii. accepts own mortality without despair or fear iv. represents major change of focus from previous life tasks E. Psychosocial changes in late adulthood 1. self-esteem threatened by physical changes a. graying hair or loss of hair b. wrinkles c. slow movement d. weight e. loss of sex drive and/or decreased libido 2. autonomy threatened by a. change in income b. decreased ability to care for self			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	3. relationships and intimacy are threatened by a. death of spouse b. death of family and friends 4. coping with aging depends on a. health status b. life experiences c. finances d. education			

UNIT VII – BASIC SKILLS

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
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 A. Beginning steps 1. before entering resident's room, knock on the door a. resident's room is his home 2. identify yourself a. resident has right to know who is going to be caring for them 3. identify resident a. shows respect b. use resident's name, not "honey," "sugar," "Bubba" c. assures you have the correct resident 4. wash your hands a. Standard Precautions b. prevent spread of infections 5. explain what you are going to do a. speak clearly, slowly and directly to the resident b. resident has right to know what to expect c. encourages resident independence and cooperation 6. provide for privacy a. resident has right to privacy b. promotes resident dignity c. pull privacy curtain or close the door 7. use good body mechanics a. raise bed to waist height b. lock wheels on the bed			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. if using a wheelchair, lock the wheels d. only use side rails if specifically ordered B. Ending steps 1. ensure resident is comfortable a. sheets are wrinkle-free and crumb-free b. helps to prevent pressure sores c. replace pillows and blankets d. resident's body should be in good alignment 2. put bed in low position a. promotes resident safety 3. if side rails were used as part of the procedure, return them to the position ordered for the resident 4. remove privacy measures a. open privacy curtain b. open door c. bath blanket 5. place call bell within reach of resident a. permits resident to communicate with staff as needed 6. announce to resident when you are leaving the room 7. wash your hands before leaving resident room a. prevents spread of micro-organisms b. Standard Precautions 8. report any changes to licensed nurse of physical or mental changes observed while providing care			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
2. Identify changes in mental status that the nurse aide might observe. 3. Identify changes in physical appearance that the nurse aide might observe. 4. Identify changes in appetite that the nurse aide might.	II. Recognizing Changes in Body Functioning and the Importance of Reporting these Changes to the Appropriate Licensed Nurse A. Changes in mental status 1. confusion 2. combativeness 3. agitation 4. restlessness 5. extreme or unusual verbalization 6. expression of fear 7. complaints of hallucinations 8. being very quiet or withdrawn 9. report changes to appropriate licensed nurse B. Change in physical appearance 1. swelling/edema (i.e. hands, or feet, face, abdomen, or any body part) 2. pallor, pale skin, yellow skin 3. blue lips, hands or feet 4. an expression of pain 5. change in a mole or wart 6. any change in bowel or bladder contents 7. any change in breast such as dimple or lump 8. any change in genitalia such as discharge 9. unusual grimace or drooling of saliva 10. report changes to appropriate licensed nurse C. Change in appetite 1. increase in appetite 2. decrease in appetite 3. report changes to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
5. Identify signs of infection that the nurse aide might observe. 6. Discuss changes to the skin and hair that occurs in geriatric residents. 7. Identify signs and symptoms that should be reported to the appropriate supervisor or the appropriate licensed nurse during daily care.	D. Signs of infection 1. elevated temperature 2. chills and/or sweating 3. skin hot or cold, flushed or bluish 4. area of skin that is inflamed (warm, red, swollen) 5. delirium/confusion/change in mental status E. Age-related changes to skin and hair 1. wrinkles (due to less elasticity) 2. hair – grey/white, balding 3. age spots 4. fragile, thinner skin 5. dry, itchy skin – due to less oil production 6. nails – harder, thicker, brittle, fungus, discoloration 7. what to report to the appropriate licensed nurse a. skin that is abnormally pale, bluish, yellowish, or flushed b. rash, abrasion, bruising c. mole that has changed in appearance d. redness over a pressure point that does not go away within 5 minutes e. area over a pressure point that has become pale or white f. drainage from a wound g. wound that does not heal h. blisters i. swelling j. c/o pain, tingling, numbness, burning k. weight changes			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
8. Describe changes to the musculoskeletal system that may occur in geriatric residents and what to report to the licensed nurse. 9. Identify changes to the respiratory system that may occur in geriatric residents and what to report to the licensed nurse.	F. Age-related changes to the musculoskeletal system 1. osteoporosis 2. loss of muscle mass 3. arthritis 4. what to report to the appropriate licensed nurse a. resident has fallen b. area of body that is swollen, red, bruised or painful to touch c. complaints of pain when moving a joint d. range of motion for a joint that has decreased movement e. resident limps or has pain when walking or repositioning G. Age-related changes to the respiratory system and what to report to appropriate licensed nurse 1. short of breath - lung strength and capacity decrease, voice weakens 2. more susceptible to respiratory infections (cold, pneumonia, influenza) 3. what to report to the appropriate licensed nurse a. persistent cough, nasal congestion b. changes in respiration c. cough produces sputum that is yellowish, greenish or pinkish d. sudden onset of difficulty breathing e. resident experiences wheezing or gurgling respirations f. skin has blue or gray tinge			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Discuss changes to the cardiovascular system that may occur in geriatric residents and what to report to the licensed nurse. 11. Describe changes to the nervous 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 1. heart beats less effectively 2. heart rate slows or speeds up 3. fluid may accumulate in hands and feet 4. orthostatic hypotension 5. chest pain due to lack of oxygen to the heart muscle 6. high blood pressure or low blood pressure 7. what to report a. complaints of chest pain or pressure b. difficulty breathing c. rapid, slow or erratic pulse d. blood pressure that is unusually low or high e. face, lips or fingers are bluish f. shortness of breath on exertion g. complaints of chest or leg pain on exertion h. unusual pain, swelling or redness in legs i. bluish or cool/cold areas on the legs or feet I. Age-related changes to the nervous system and what to report to appropriate licensed nurse 1. slowed reaction time 2. poor balance 3. difficulty remembering recent events 4. loss of sensation in hands and feet 5. reduced grip strength 6. what to report a. changes in level of consciousness			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
12. Discuss changes to the eyes and ears that may occur in geriatric residents and what to report to the licensed nurse.	b. suddenly becomes confused or disoriented c. speech becomes slurred d. eyelid or corner of the mouth begins to droop e. sudden onset of severe headache f. sudden onset of numbness, tingling, loss of sensation in arm, leg or face J. Age-related changes to the eyes and ears and what to report to appropriate licensed nurse 1. eyes adjust more slowly to change in light 2. becomes more difficult to read small print 3. lens becomes cloudy and cataracts form decreasing ability to see 4. less tears are produced causing eye to become dry and irritated 5. what to report about the eyes a. drainage from eyes b. complaints of dryness c. redness in or around the eyes d. glasses that are broken or do not fit 6. outer ear continues to grow 7. hearing decreases 8. what to report about the ears a. drainage from the ears b. changes in ability to hear c. hearing aid not functioning properly (batteries, wax filters or other maintenance)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Describe changes to the digestive system that may occur in geriatric residents and what to report to the licensed nurse. 14. Identify changes to the urinary 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 1. poor teeth cause less efficient chewing 2. decrease in saliva and stomach acids causes poor breakdown of food 3. decrease motility in intestinal tract causes constipation 4. what to report a. teeth that are loose or painful b. dentures that do not fit or are broken c. choking while eating d. complaints of constipation or abdominal pain e. changes in bowel patterns f. blood in stool L. Age-related changes to the urinary system and what to report to appropriate licensed nurse 1. kidneys less efficient at filtering waste from the blood 2. loss of muscle tone increases risk of urinary incontinence (particularly in women) 3. enlarged prostate in men causes a. difficulty starting urine stream b. dribbling between voids c. increased risk of urinary tract infections 4. what to report a. complaint of pain or burning upon urination b. frequent complaints of urgency and then unable to void or voids small amount			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. urine with a strong or unusual odor d. episodes of dribbling before getting to the toilet 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 1. adult onset diabetes mellitus 2. what to report a. increased thirst b. increased urination c. increased appetite d. drowsiness and confusion e. cold, clammy skin f. shaky with increased perspiration g. complaint of headache h. sweet smelling breath i. seizure j. loss of consciousness			
16. Describe changes to the reproductive system that may occur in geriatric residents and what to report to the licensed nurse.	N. Age-related changes to the reproductive system and what to report to appropriate licensed nurse 1. menopause 2. breast cancer 3. prostate cancer 4. what to report a. unusual vaginal discharge b. changes in breast tissue i. dimpling, lump, thickening of skin ii. discharge from breast or nipple c. discharge from penis d. pain or burning with urination for male resident e. change in skin of the scrotum f. lump in scrotum			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
17. Discuss six (6) conditions that effect the resident's environment.	III. Caring for the Resident's Environment A. Conditions that affect resident's environment 1. cleanliness a. reflection of quality of care b. this is resident's home c. impedes spread of micro-organisms d. everyone's responsibility, not just housekeeping 2. odor control a. follow facility policy for handling of waste and soiled linens b. close laundry and waste receptacle lids c. empty urinals, bedside commodes and bedpans promptly d. flush toilets promptly e. use air fresheners as appropriate, per facility policy f. assist resident to maintain personal care and good oral hygiene g. be aware of your personal hygiene, particularly if you are a smoker 3. ventilation a. may create drafts b. position resident away from draft c. provide sweaters, blankets and/or lap covers if needed to keep resident warm 4. room temperature a. 71° to 81° is OBRA regulation for temperature in long-term care facility			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	5. lighting a. general lighting i. light from the window ii. ceiling lights iii. ask resident for preference iv. encourage light from windows during the day and closed curtains at night b. task lighting i. overbed light ii. light focused on a chair for reading c. night light 6. noise control a. provide quiet times for nap or at night time for restful sleep b. answer call bells and telephones promptly			
18. Identify the six (6) OBRA requirements for a resident room in a long-term care facility. 19. Describe the furnishings located in a typical resident room in a long-term care facility.	B. Features of a long-term care room 1. OBRA requirements for room in long-term care facility a. one window b. call system c. odor free d. pest free e. bed wheels lock f. personal supplies are labeled and stored appropriately 2. bed a. when resident is unattended always keep bed in low position with the wheels locked b. adjustable height, positioning of head and feet c. basic bed positions i. Fowler's ii. semi-fowler's			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iii. Trendelenburg iv. reverse Trendelenburg d. practice how to use bed i. raise and lower bed ii. lock the wheels iii. raise and lower head iv. raise and lower feet e. siderails (see facility policy) 3. overbed table a. fits over bed or chair b. height can be adjusted c. holds personal care items and/or meal tray d. considered a "clean" area e. do not put used urinal or bedpan on overbed table 4. bedside table a. stores personal care items, basins, bedpans b. surface area should be kept neat and tidy 5. personal furniture a. residents encouraged to bring own furniture to make the room more like home (chairs, chest of drawers, tables, wardrobes) a. keep personal furniture well-cared for, dusted and clean 6. call bell/intercom system a. communication link between resident and staff b. call bell should always be kept within easy reach of resident c. educate resident on use of call bell			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
20. Demonstrate the nurse aide's responsibilities for care of the resident's environment.	7. privacy curtain/room dividers a. divide one room into multiple resident areas b. use to provide privacy when giving resident personal care C. Nurse aide's responsibilities for care of the resident's environment 1. always knock before entering resident's room 2. assist resident to keep room neat and clean 3. clean up spills immediately 4. assist resident to keep personal items in good condition 5. label all items upon admission 6. keep clutter to a minimum 7. always straighten up the resident's area after meals and procedures 8. assist resident to keep room at comfortable temperature 9. do not place urinals on tables used for eating 10. flush toilets and empty beside commodes and urinals as soon as they have been used 11. use lighting to provide good illumination so resident can see to get around the room 12. keep noise in hallways to minimum especially at rest times to promote resident's ability to sleep/rest 13. always have call bell within easy reach of the resident 14. use care when dealing with resident's clothing and personal items so damage, loss or misplacement does not occur			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
21. Describe what the nurse aide should report to the supervisor or licensed nurse regarding the resident's room. 22. Discuss the difference between an unoccupied, closed and open bed and an occupied bed.	15. re-stock resident's supplies every day and prn 16. refill water pitcher every shift unless the resident has a fluid restriction D. What nurse aide should report to the licensed nurse 1. piece of equipment or furniture that is not working properly 2. resident injured by piece of equipment or furniture in the room 3. staff injured by a piece of equipment or furniture in the room 4. suspicion that resident is storing unwrapped food in his room 5. signs of pests or insects 6. resident or family member complains that personal items are missing 7. belongings from other residents found in room 8. personal item belonging to resident is accidentally broken 9. room and/or bathroom is not properly cleaned 10. waste receptacles are not consistently emptied 11. there is an odor in the room that will not go away E. Making the bed 1. unoccupied bed a. no one is in the bed 2. closed bed a. when resident is out of bed all day b. completely made with bedspread, blankets and pillows in place 3. open bed a. linen is folded down to the foot of the bed			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
23. Describe the different types of linen the nurse aide uses to make a bed in a long-term care facility.	b. makes it easier for resident to get into bed by himself 4. occupied bed a. made while the resident is in the bed 5. linen required to make a bed a. mattress pad i. makes mattress more comfortable ii. protects mattress from liquid spills b. top and bottom sheets i. bottom sheet is often fitted ii. top sheet is flat c. draw sheet i. small, flat sheet placed over the middle of the bed ii. goes from resident's shoulders to below buttocks iii. used to help lift or turn resident iv. sides are tucked under the mattress d. bed protector i. absorbent fabric-backed waterproof material ii. used with residents who are incontinent e. blankets i. may be personal or provided by facility f. bedspread i. adds decorative look to room ii. may be personal or provided by facility g. pillow and pillowcases i. for comfort and for positioning resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
24. Identify various devices used on the bed in a long-term care facility. 25. Demonstrate correct handling of linen.	ii. pillows always covered with pillowcase h. bath blanket i. keep resident warm during bed bath or linen change 6. other bed equipment a. pressure-relieving mattresses i. egg-crate mattress ii. alternating air mattress b. bed board i. wood board placed under the mattress to make bed more firm c. bed cradle i. metal frame that prevents top linen from placing pressure on the feet and causing foot drop d. foot board i. piece of wood placed at foot end of mattress to keep the feet in proper anatomical alignment e. fall mats 7. how to handle linen a. wash hands b. collect linen in order they will be used on the bed c. do not take linen from one resident room to another d. when carrying linen, take care not to touch linen to your uniform e. wear gloves to remove soiled linen f. when removing linen from the bed turn it from the ends of the bed toward the center of the bed g. NEVER place used linen on the floor			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
26. Demonstrate how to make a closed bed.	h. do not have used linen come in contact with your uniform i. place used linen in receptacle per facility policy j. wash hands 8. make a closed bed a. wash hands b. obtain linen and place on chair or table in resident's room c. flatten bed and raise to waist level d. loosen used linen and place in hamper or linen bag e. remake the bed starting with the bottom sheet with the seams down 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 g. place draw sheet if appropriate 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 i. place blanket on bed, flush with 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 j. place clean pillowcase on pillow, and pillow at head of bed k. cover pillow and blanket with bedspread and tuck under the pillow l. return bed to low position			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	m. place call bell where resident can reach it n. dispose of used linen o. wash hands			
27. Demonstrate how to make an open bed.	9. make an open bed a. follow steps a-j for closed bed above 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 c. place clean pillowcase on pillow, and pillow at head of bed d. return bed to low position e. place call bell where resident can reach it f. dispose of used linen g. wash hands			
28. Demonstrate how to make an occupied bed.	10. make an occupied bed a. identify yourself by name b. wash hands c. explain procedure to resident d. provide for resident privacy e. place clean linen on clean surface within reach f. adjust bed to waist height g. put on gloves h. loosen top linen from end of bed on side you will work on first i. unfold bath blanket over top sheet to cover resident and remove top sheet keeping resident covered at all times j. raise side rail on far side of bed to protect resident from falling out of bed while you are making it			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	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 l. loosen bottom soiled linen, mattress pad, and protector on the working side m. roll bottom soiled linen toward resident, soiled side inside and tuck it snugly against resident's back n. place mattress pad on bed, attaching elastic corners on working side o. place and tuck in clean bottom linen; finish with bottom sheet free of wrinkles p. smooth bottom sheet out toward resident; roll extra material toward resident; tuck it under resident's body 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 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 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 t. pull clean linen through as quickly as possible starting with mattress pad; pull and tuck in clean bottom			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	linen just like the other side; finish with bottom sheet free of wrinkles u. assist resident to turn onto back; keep resident covered and comfortable with pillow under head; raise side rail 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 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 x. remove pillow and change pillowcase placing soiled one in hamper or bag y. remove and discard gloves 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. aa. take laundry hamper/bag to proper area bb. wash hands cc. report any resident changes to nurse dd. document procedure using facility guidelines			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
29. Discuss the importance of measuring and recording routine vital signs on geriatric residents. 30. Demonstrate the knowledge of types and use of thermometers to accurately measure and record resident's temperature.	IV. Vital Signs (VS) A. Purpose of VS 1. measurement of body functions that are automatically regulated 2. change may indicate body is out of balance 3. indicate if the body is healthy or not healthy B. When are VS measured? 1. upon admission to long-term care facility (baseline VS) 2. weekly, monthly according to facility policy 3. before and after certain medications as ordered by the health care provider 4. after diagnostic procedure or surgery 5. after a fall 6. during an emergency C. Temperature 1. types of thermometers and/or methods of taking temperature a. oral – by mouth b. tympanic - in the ear c. NCIT (no contact infrared thermometer) - forehead d. rectal - by rectum (usually distinguished by red to deter use in mouth) e. axillary - under the armpit (axilla) f. most facilities use digital thermometers 2. measures the warmth of the body a. adult oral temperature 97.6° - 99.6°			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
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.	6. signs of elevated temperature due to infection a. headache b. fatigue c. muscle aches d. chills e. skin warm and flushed 7. measure, record, and report temperature a. follow facility policy for taking temperature b. follow facility policy for recording c. report changes to licensed nurse 8. factors that can affect temperature a. raise the temperature i. eating/drinking something hot ii. smoking iii. wait 10-15 minutes to take temp. iv. physical activity v. heavy clothing or blankets b. lower the temperature i. eating/drinking something cold (wait 10-15 minutes to take temp.) ii. incorrect placement of thermometer iii. not waiting long enough for thermometer to read temperature 9. special considerations for taking temperatures a. do not force a rectal thermometer b. do not force tympanic thermometer			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
39. Identify equipment needed to take a blood pressure. 40. Demonstrate how to measure and record blood pressure. 41. Report any changes or abnormal blood pressure to the appropriate licensed nurse.	g. orthostatic hypotension i. when resident changes position from lying to sitting, or sitting to standing the BP drops ii. when BP drops, resident becomes dizzy, lightheaded and may faint 2. equipment needed to take BP a. stethoscope b. blood pressure cuff (sphygmomanometer) i. size of cuff should match size of resident's arm ii. electronic iii. aneroid c. alcohol wipes 3. measure and record blood pressure a. follow the procedure for "Measures and Records Blood Pressure" per facility policy b. report any changes or abnormal blood pressure to appropriate licensed nurse 4. considerations for where to take BP a. do not take BP in arm with an IV (intravenous line) present b. do not take BP in arm with a shunt used for dialysis c. do not take BP in arm on same side as mastectomy surgery for breast cancer d. do not take BP in arm paralyzed due to stroke (CVA) e. do not take BP in extremity with an amputation			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
42. Identify specific factors that may affect the BP reading. 43. Identify specific factors that may affect the accuracy of BP reading.	f. do not take BP in an arm with a cast g. if both arms have a dialysis shunt or resident has had double mastectomy take BP in thigh using the popliteal pulse 5. factors affecting BP a. age - increases BP b. exercise - decrease or increase c. stress - increases d. race - ethnicity may affect BP (i.e. -African-Americans more likely to have high BP than Caucasians) e. heredity - familial tendency to high BP f. obesity - increases BP g. alcohol - high intake may increase BP h. tobacco - may increase BP i. time of day - BP lower in morning and higher in the evening j. illness - diabetics and residents with kidney disease may have high BP k. medications 6. factors affecting accuracy of BP reading a. wrong size cuff b. not inflating cuff sufficiently c. releasing cuff pressure too quickly d. taking BP multiple times in rapid succession in same arm e. cuff placement f. using cuff over clothing			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
44. Define the physiology of respirations, how respirations are measured and terminology related to respirations. 45. Demonstrate how to count and record respirations. 46. Report any changes or abnormal respirations to the appropriate licensed nurse. 47. Discuss pain management, the pain scale, and questions the nurse aide may asked to understand the resident's pain level.	g. resident talking h. most recent physical activity G. Respirations 1. definitions a. inspiration – taking air and oxygen into the lungs (inhale), chest rises b. expiration - letting air and carbon dioxide out of the lungs (exhale), chest falls c. respiration - 1 complete inhalation and exhalation d. measured in breaths/minute e. normal adult respiratory rate 12-20 breaths/min f. apnea - absence of breathing g. dyspnea - difficulty breathing 2. measure and record respirations a. follow the procedure for "Counts and Records Respirations" in the most current edition of Virginia Nurse Aide Candidate Handbook b. report any changes or abnormal respiratory rate to appropriate licensed nurse H. Pain management 1. definitions a. fifth vital sign b. different for every person (some residents have higher pain tolerance than others) c. pain scale i. know facility's pain scale ii. some pain scales are 0-10 and some are 1-10 iii. objective value to sensation of pain			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
48. Describe observations that the nurse aide can make to understand the resident's pain level. 49. Describe comfort measures the nurse aide can perform in response to the resident's pain.	2. questions to ask to understand resident's pain a. where is the pain? b. when did pain start? c. does the pain go away with rest? d. how long does pain last? e. describe the pain…sharp, shooting, dull, ache, burning, electric-like, constant, comes and goes 3. observations nurse aide may make that indicate resident is experiencing pain a. increased P, R, BP b. sweating c. nausea d. vomiting e. tightening of the jaw f. frowning g. groaning on movement h. grinding teeth i. increased restlessness j. agitation k. changes in behavior l. crying m. difficulty moving n. guarding/protecting an area 4. report any complaints or observations of pain to appropriate licensed nurse 5. actions nurse aide can take to alleviate pain a. offer back rub b. assist to change position c. offer warm bath or shower d. encourage slow, deep breaths e. be patient, caring and gentle			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
50. Demonstrate how to measure and record height of a resident. 51. Demonstrate how to measure and record weight of ambulatory resident. 52. Report any changes in weight to the appropriate licensed nurse.	V. Height and Weight A. Height (per facility policy) 1. usually performed on admission 2. assist to step onto the scale and measure height by extending height rod 3. if unable to stand, may use tape measure while resident is lying on bed 4. record accurately in feet and inches B. Weight 1. performed on admission and at regular intervals afterwards (per facility policy) 2. ambulatory resident uses standing scale 3. portable wheelchair scale, lift & tub scales, and/or bed scale may be available 4. measured in pounds or kilograms, per facility policy 5. uses a. data on nutritional status of resident b. calculate correct medication dosage 6. measure and record weight a. follow the procedure for "Measures and Records Weight of Ambulatory Resident" in the most current edition of Virginia Nurse Aide Candidate Handbook b. report any changes in weight to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
53. Measure and record fluid intake. 54. Identify the major anatomical structures of the urinary system. 55. Describe the fluids that can be recorded as fluid output.	VI. Measure and Record Fluid Intake and Output A. Measure and record fluid intake 1. fluid taken into the body a. fluid that resident drinks b. liquids that are eaten: soup, jello, pudding, ice cream, popsicles 2. measurement a. milliliter (ml) b. ounce (oz) c. 1 oz = 30 ml 3. measure and record fluid intake a. convert all fluid measurements into milliliters b. add together all fluid taken into the body c. at end of shift record all fluid intake per facility policy d. fluid taken into the body should be approximately equal to the amount of fluid that the body eliminated B. Urinary system 1. kidneys - filter waste products and water out of blood to make urine 2. urethra - carry urine from kidneys to bladder 3. bladder - collects and holds urine 4. ureters - carries urine from bladder to the outside of body 5. urine - water and waste products that kidneys filtered out of the blood C. Fluid output 1. fluid that is eliminated by the body a. urine b. vomit (emesis)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. blood d. wound drainage e. diarrhea 2. measured in ml or cc 3. at end of shift record all fluid output per facility policy 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 1. equipment a. graduate b. commode hat c. urinal d. catheter drainage bag 2. measuring output a. 1ml = 1cc (cc = cubic centimeter) b. 30 ml = 1 oz c. always measure fluid output in graduate, not in urinal, commode hat or catheter drainage bag d. urinary output should not be less than 30ml per hour e. always wear gloves to measure output			
57. Demonstrate accurate measurement and recording of urinary output. 58. Report any changes in urinary output to the appropriate licensed nurse.	3. measure and record urinary output a. follow the procedure for "Measures and Records Urinary Output" in the most current edition of Virginia Nurse Aide Candidate Handbook b. report unusually low or high urinary output to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
59. Identify factors that may affect the resident's urinary output. 60. Demonstrate accurate measurement and recording of food intake. 61. Report any changes in food intake to the appropriate licensed nurse.	4. factors affecting urinary output a. decreased intake of fluids b. fever (increased temperature) c. increased salt in diet d. excessive perspiration e. medical condition f. medications E. Measure and record food intake 1. know facility policy a. percentage methods – percentage of each food item i. calculated by dietician ii. record percentage (%) of each item on meal tray eaten iii. add together all the percentages and record total percent of meal eaten iv. some facilities use percentage of entire meal rather than percentage of each item on meal tray b. be accurate and consistent c. at end of shift record all food intake per facility policy 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Identify the components of personal care. 2. Explain routine personal care for both morning and bedtime.	I. Guidelines for Assisting with Personal Care A. Definitions 1. hygiene a. methods of keeping the body clean 2. grooming a. hair, nail and foot care b. shaving facial hair 3. diaphoretic a. perspired, sweaty B. Components of personal care 1. bathing 2. oral hygiene 3. shaving 4. back rub 5. dressing and undressing 6. hair care 7. nail care 8. elimination 9. bed-making C. Routine personal care (with attention to resident preference) 1. early AM care a. after waking and before breakfast b. going to the bathroom c. washing hands, face d. mouth care 2. morning (AM) care – preparing for the day a. take resident to bathroom or assist with elimination b. assist to wash hands			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
5. Describe the guidelines for assisting the resident with person-centered personal care.	3. resident lives in an environment of trust and respect 4. resident is in a close relationship with staff that are attuned to his/her changes and can respond appropriately 5. resident continues to live in a way that is meaningful to him/her E. Guidelines for assisting with personal care in a person-centered home-like environment 1. promote resident dignity a. address by name b. treat as an adult c. explain what you will be doing d. provide privacy during personal care 2. promote resident independence a. encourage resident to perform tasks b. provide time for resident to perform tasks 3. respect resident preferences a. permit resident to make choices regarding clothing, hair style, make-up b. allow resident to choose when to take bath or perform mouth care 4. follow resident's routine a. routine may be comforting b. allows resident choice in care 5. follow care plan instructions a. consistency among staff helps to prevent behavior problems b. assures that resident receives all the care and assistance they require			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Explain what the nurse aide is able to observe while assisting the resident with personal care. 7. Identify different pain scales (per facility policy). 8. Identify the purpose of bathing.	F. Observation during personal care 1. skin a. areas that are red, white, bluish b. areas of broken skin c. bruises d. edema e. condition of fingernails and toenails f. blisters g. odors 2. mobility a. difficulty walking b. difficulty raising arms to dress c. difficulty repositioning 3. flexibility a. difficulty bending a joint 4. complaint of pain (verbal or nonverbal) a. location of pain b. cause of pain c. description of pain d. duration of pain e. what causes pain to cease 5. change in level of consciousness a. drowsy b. confused c. disoriented to person, place, time d. not able to arouse II. Bathing A. Purpose 1. clean the skin 2. eliminate body odor 3. relax and refresh resident 4. exercise muscles 5. stimulate blood flow to skin 6. improve resident self-esteem 7. nurse aide can observe skin			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
9. Identify the supplies required for bathing. 10. Describe the safety guidelines the nurse aide should follow when assisting the resident to bathe.	B. Supplies 1. soap (resident may have personal preference for type of soap used) 2. wash clothes 3. bath towels 4. clean clothes 5. non-skid footwear 6. gloves 7. lotion/cream/oil 8. deodorant 9. shampoo C. Types of baths 1. shower 2. tub bath a. uses a whirlpool or bath tub 3. partial a. face, underarms, hands, perineal area, feet b. can be performed in bathroom or while resident is in bed 4. bed bath a. resident unable to leave bed b. entire body washed while resident in bed D. Safety guidelines during bathing 1. follow nursing care plan for special instructions 2. if nurse aide cannot handle resident alone, ask for help 3. gather all supplies before entering the bathing area and put them where they are easily accessible 4. resident should wear non-skid shoes to and from the bathing area 5. keep resident covered on way from room to bathing room			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
11. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor/licensed nurse. 12. Explain the importance of following the correct sequence of bathing.	6. have bathing room warm before bringing resident to room 7. follow facility policy for cleaning bathing area before and after resident use 8. make sure floor in bathing area is dry before resident walks on it 9. use non-slip mats in tub 10. hand rails and grab bars should be sturdy and secured to the walls 11. do not leave resident unattended in bathing area 12. check water temperature before resident tests water (should not be greater than 105°F.); test on inside of wrist or elbow 13. have resident check water temperature (not too hot; not too cold) 14. wear gloves to bathe resident 15. do not have electrical items (razors, hair dryers) near water source 16. remember to report any observations of changes in resident's condition or behavior to appropriate supervisor E. Order of bathing 1. clean to dirty to prevent transferring micro-organisms from one part of the body to another 2. eyes first – nose to temple (no soap) 3. face (no soap) 4. ears 5. neck 6. arms, underarms (axilla), hands – from torso outward 7. chest			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Demonstrate how to give a shower.	8. abdomen 9. legs, feet – from torso downward 10. back 11. perineum 12. buttocks F. Giving a shower 1. Supplies a. soap (resident may have personal preference for type of soap used b. washcloths c. towels d. clean clothes e. non-skid footwear f. gloves g. lotion/cream/oil h. deodorant i. shampoo 2. make sure shower room is clean, including shower chair 3. explain procedure to resident 4. with resident's input gather clean clothing, personal toiletries 5. have resident wear non-skid footwear 6. transport resident to shower room, making sure resident is fully covered and warm 7. lock wheels of shower chair when resident has been transported to shower 8. test temperature of water before running water on resident 9. put on gloves 10. assist resident to undress, removing non-skid footwear last 11. encourage resident to wash face, arms, chest, abdomen, and hands			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
14. Accurately document performance of a shower on facility ADL Form.	12. wash resident's back, legs, feet and perineum 13. rinse, being careful to remove all soap residue 14. cover resident's back with towel after washing and rinsing to keep resident warm 15. unlock shower chair wheels, roll resident to dressing area and dry with bath towels, including under breasts and between the toes 16. place bath blanket around shoulders to keep resident warm 17. apply deodorant and lotion per resident's request and as needed 18. remove gloves and wash hands 19. assist resident to put on clean clothes, including non-skid footwear 20. return resident to room 21. assist with remainder of grooming: hair care, shaving, nail care 22. help resident to comfortable position 23. place call bell within reach 24. wash hands 25. be courteous and respectful to resident at all times 26. report any observations of changes in resident's condition or behavior to appropriate supervisor 27. document on ADL (Activities of Daily Living) form or designated documentation tool per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
15. Demonstrate how to give a tub bath.	G. Giving a tub bath 1. equipment is the same as shower 2. make sure tub room is clean, including the bathtub 3. explain procedure to resident 4. with resident's input gather clean clothing, personal toiletries 5. have resident wear non-skid footwear 6. ambulate or transport resident to tub room, making sure resident is fully covered and warm 7. lock wheels of tub chair or tub lift when resident has been safely transferred to chair or lift 8. test temperature of water and fill tub half-full with warm water 9. put on gloves 10. assist resident to undress, removing non-skid footwear last 11. encourage resident to wash face, arms, chest, abdomen, and hands 12. wash resident's back, legs, feet and perineum 13. rinse, being careful to remove all soap residue 14. cover resident's back with towel after washing and rinsing to keep resident warm 15. remove resident from tub and dry with bath towels, including under breasts and between the toes 16. place bath blanket around shoulders to keep resident warm 17. apply deodorant and lotion per resident's request and as needed 18. remove gloves and wash hands			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
16. Accurately document performance of a tub bath on facility ADL Form. 17. Demonstrate how to give a partial bed bath.	19. assist resident to put on clean clothes, including non-skid footwear 20. return resident to room 21. assist with remainder of grooming: hair care, shaving, nail care 22. help resident to comfortable position 23. place call bell within reach 24. wash hands 25. be courteous and respectful to resident at all times 26. report any observations of changes in resident's condition or behavior to appropriate supervisor 27. document on ADL (Activities of Daily Living) Form or designated documentation tool per facility policy H. Giving a partial bath 1. used on days resident does not receive complete bath or shower 2. explain procedure to resident 3. with resident's input gather clean clothing, personal toiletries 4. have resident wear non-skid footwear 5. transport resident to bathroom, making sure resident is fully covered and warm 6. lock wheels of chair when resident has been transported to bathroom 7. if giving a partial bed bath, raise level of bed to waist-height of the nurse aide (lock bed wheels)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	8. test temperature of water at sink or before filling bath basin about half-full 9. Have resident test water temperature (not too hot; not too cold) 10. put on gloves 11. assist resident to undress, removing non-skid footwear last 12. encourage resident to wash face, underarms, and hands 13. assist resident to wash perineum remembering to wash front to back, rinse front to back and dry front to back 14. help resident to rinse being careful to remove all soap residue 15. apply deodorant and lotion per resident's request and as needed 16. remove any wet bed linens 17. remove gloves and wash hands 18. assist resident to put on clean clothes, including non-skid footwear 19. remake bed, if needed 20. assist with remainder of grooming: hair care, shaving, nail care 21. help resident to comfortable position chair or bed) 22. place call bell within reach 23. if partial bed bath was given, return bed to low position 24. wash hands 25. be courteous and respectful to resident at all times			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
18. Accurately document performance of a partial bed bath on facility ADL Form. 19. Demonstrate how to give a complete bed bath.	26. report any observations of changes in resident's condition or behavior to appropriate supervisor 27. document on ADL (Activities of Daily Living) Form, or designated documentation tool per facility policy I. Giving a complete bed bath 1. supplies are the same as above with addition of bath basin 2. explain procedure to resident 3. provide resident privacy be pulling privacy curtain or closing resident's door 4. with resident's input gather clean clothing, personal toiletries 5. test temperature of water at sink before filling bath basin about half-full and taking to bedside 6. have resident verify water temperature is OK 7. raise level of bed to waist-height of the nurse aide and lock wheels of bed 8. cover resident with bath blanket to maintain warmth and remove night clothing 9. put on gloves 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 11. wash remainder of face 12. dry face with towel			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	13. keeping resident covered with bath blanket, expose one (1) arm placing a clean, dry towel under the exposed arm 14. with soap on the washcloth, wash arm, hand and underarm 15. rinse arm, hand, underarm and pat dry with towel and place under bath blanket 16. repeat process for 2nd arm 17. expose resident's chest and abdomen and with soap on washcloth wash chest (including under the breasts) and abdomen 18. rinse and dry chest and abdomen and cover with bath blanket 19. expose one leg and foot and place clean, dry towel under leg 20. with soap on the washcloth, wash leg and foot (including between the toes) and rinse 21. dry leg and foot with towel that is underneath leg 22. cover leg and foot with bath blanket 23. repeat process for 2nd leg and foot 24. wash front of perineum, front to back a. use clean area of washcloth for each stroke b. using clean washcloth, rinse soap from perineum, front to back using clean area of washcloth for each stroke 25. dry perineum, front to back with towel 26. return bed to low position			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
24. Describe observations that the nurse aide may make while providing oral hygiene to a resident as. 25. Identify the guidelines for good oral hygiene.	C. Observations to make while assisting with oral care 1. lips a. dry b. cracked c. bleeding d. chapped e. cold sores (fever blisters) 2. tongue, gums, and cheeks a. red, white or swollen areas b. sores or white spots c. bleeding 3. teeth a. loose b. cracked c. chipped d. broken e. discolored f. missing 4. dentures (partial, upper, lower) a. chipped b. cracked c. fit poorly 5. breath a. bad breath that does not go away with brushing b. fruity aroma to breath 6. difficulty swallowing a. gagging b. choking 7. resident complains of pain in mouth D. Guidelines for good oral hygiene 1. brush teeth after each meal and at bedtime 2. floss once a day 3. rinse dentures after each meal			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
26. Demonstrate how to provide mouth care. 27. Accurately document performance of mouth care on facility ADL form. 28. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	4. remove dentures at bedtime and soak overnight in soaking solution E. Supplies to provide oral care 1. toothbrush 2. toothpaste 3. emesis basin 4. gloves 5. towel 6. glass of water 7. denture cup for resident with dentures 8. floss 9. mouthwash F. Provide mouth care 1. consider the toothbrush as a "clean" instrument throughout procedure 2. encourage resident to be as independent as he can 3. independent resident may only need assistance gathering supplies or transport to the bathroom 4. follow the procedure for "Provides Mouth Care" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility policy 6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
29. Demonstrate how to provide mouth care for an edentulous resident. 30. Accurately document performance of mouth care on facility ADL form. 31. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 32. Demonstrate how to floss a resident's teeth.	G. Provide mouth care for edentulous resident 1. even though teeth are absent, mouth care is important 2. use foam-tipped applicators moistened with mouthwash or half-strength mouthwash/hydrogen peroxide to clean gums 3. use applicators to clean tongue 4. rinse mouth with mouthwash 5. document procedure on Activities of Daily Living form, or designated documentation tool per facility policy 6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse H. Flossing teeth 1. purpose a. cleans food and bacteria from between teeth where toothbrush cannot reach 2. equipment a. dental floss b. gloves c. towel d. water for resident to drink e. emesis basin 3. procedure a. identify yourself to resident b. explain what you will be doing c. provide privacy d. wash hands e. gather supplies f. place resident in upright sitting position with towel over chest			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	i. if resident in bed, raise bed to waist-height and lower side rail closest to you g. put on gloves h. wrap ends of floss securely around each of your index fingers i. beginning with back teeth, using a sawing motion, move floss up and down between teeth j. gently slip floss into space between gum and tooth k. repeat on each side of the tooth l. after every 2 teeth, unwind floss and use a new area of floss m. offer resident water to drink and provide emesis basin to spit the water into n. clean resident's mouth with towel o. return bed to low position, replace side rail as appropriate p. place call bell within reach of resident q. clean and return supplies to appropriate storage area r. remove and dispose of gloves and used floss s. wash hands t. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy u. report any observations of changes in resident's condition or behavior to appropriate licensed nurse			
33. Accurately document performance of flossing teeth on facility ADL form. 34. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
35. Demonstrate how to provide denture care. 36. Accurately document performance of denture care on facility ADL form. 37. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 38. Demonstrate how to provide mouth care for an unconscious resident.	I. Provide denture care 1. always wear gloves when handling dentures 2. dentures are very expensive, handle with care 3. always store in water a. prevents cracking 4. follow the procedure for "Cleans Upper or Lower Denture" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. document procedure on Activities of Daily Living form or designated documentation tool, per facility policy 6. report any observations of changes in resident's condition or behavior to appropriate licensed nurse J. Provide oral care for unconscious resident 1. require frequent mouth care a. prevent mucous membranes from drying b. keep teeth and gums moist c. keeps lips moist to prevent cracking 2. supplies a. toothbrush or foam-tipped applicator b. toothpaste or cleaning solution c. gloves d. towel e. emesis basin f. lip lubricant 3. procedure a. identify yourself to resident and explain what you will do, even			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
39. Accurately document performance of mouth care for the unconscious resident on facility ADL form.	though resident is unconscious b. provide resident privacy c. wash hands d. gather supplies e. raise bed to waist-height and lock wheels of bed f. lower side rail closest to you g. turn resident on side, facing you h. put on gloves i. place towel under resident cheek and chin j. place emesis basin next to cheek and chin to catch fluid from mouth k. using moistened toothbrush or foam-tipped applicator gently clean teeth, gums, tongue l. rinse and remoisten brush or applicator as needed m. when finished use towel to dry resident's face n. remove towel and basin o. apply lip lubricant p. reposition resident q. replace side rail to appropriate position r. return bed to low position s. place call bell within resident's reach t. clean and store equipment u. dispose of linen v. remove gloves and wash hands w. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
40. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 41. Identify the components of personal grooming. 42. Explain how to shampoo a resident's hair.	x. report any observations of changes in resident's condition or behavior to appropriate licensed nurse IV. Grooming A. Maintaining neat, clean, and well-groomed appearance 1. hair care 2. shaving 3. make-up 4. fingernail care 5. foot care B. Hair care 1. shampooing resident's hair a. always ask resident if he/she wants hair shampooed b. many facilities have beauty shop for resident to use weekly or bi-weekly c. easiest to perform during shower i. provide resident cloth to cover/protect eyes ii. with hand-held shower head, wet hair with warm water iii. apply resident's preferred shampoo and lather, gently massaging scalp iv. thoroughly rinse shampoo from hair v. towel dry hair and wrap hair in towel to transport resident back to room vi. document procedure on Activities of Daily Living form, per facility policy vii. report any observations of			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
43. Demonstrate how to provide hair care.	changes in resident's condition or behavior to appropriate licensed nurse d. shampoo in bed (some facilities have shampoo basin for use in bed) e. dry, powder shampoo may be used for bed-ridden resident 2. daily hair care a. improves self-esteem b. resident chooses how to style his/her hair c. brushing hair massages scalp d. prevents tangles 3. equipment a. resident's own comb and/or brush b. mirror c. towel d. hair care items requested by resident 4. procedure to provide hair care a. identify yourself to resident and explain what you will be doing b. gather supplies c. wash hands d. provide for resident privacy e. place towel over shoulders to collect hair that comes out while combing/brushing f. gently comb/brush hair starting at the ends and working toward the scalp g. remove tangles first h. then brush hair from scalp to ends of hair i. style as resident prefers			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
44. Accurately document performance of hair care on facility ADL form. 45. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 46. Explain guidelines for nurse aide when shaving a resident.	j. clean hair from comb and/or brush and return equipment to appropriate storage k. dispose of towel per facility policy l. position resident comfortably m. place call bell within resident's reach n. wash hands o. document procedure on Activities of Daily Living form, or designated documentation tool, per facility policy p. report any observations of changes in resident's condition or behavior to appropriate licensed nurse C. Shaving 1. guidelines for shaving men facial hair a. respect resident preference b. follow the facility policy for shaving c. some residents do not wish to shave daily d. always wear gloves when shaving e. before shaving with safety or disposable razor, soften facial hair with warm, moist cloth f. always shave in same direction as the hair grows g. follow resident preference for shaving and after-shave products h. discard disposable razors in the biohazard container			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
47. Describe the different types of razors including how the nurse aide would use each type. 48. Demonstrate how to shave a resident.	i. never cut or trim resident's facial hair without their permission 2. supplies a. electric razor i. safest ii. does not require shaving cream or soap iii. prevents nicks and cuts iv. should be used if resident receiving anti-coagulant medications v. do not use near water source or when oxygen is in use b. disposable razor i. requires shaving cream or soap ii. may make nicks or cuts because they are very sharp c. safety razor i. requires shaving cream or soap ii. blades need to be changed when become dull iii. dispose of old blades in biohazard container iv. may make nicks or cuts because they are very sharp d. towels e. washcloth f. mirror g. shaving cream or soap h. gloves 3. procedure for shaving male resident a. identify yourself and explain what you will be doing b. gather supplies			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. fill basin half-full of warm water for use with resident in bed d. provide for resident privacy e. if resident is in bathroom, position him in front of mirror 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 g. put on gloves h. for safety or disposable razor i. drape towel over resident's chest ii. moisten beard with warm, moist cloth iii. apply shaving cream or lathered soap to cheeks, chin and front of neck iv. holding skin taut shave in direction hair grows (downward on face, upward on neck) v. rinse razor frequently to get rid of excess cream/soap/whiskers vi. offer mirror to resident for approval vii. wash, rinse and dry face and neck viii. apply after-shave per resident preference ix. remove and dispose of towel x. remove gloves and wash hands i. for electric razor i. do not use near the sink ii. place towel on resident's chest iii. put on gloves			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
49. Accurately document shaving on facility ADL form. 50. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 51. Discuss procedure for shaving a female resident.	iv. apply pre-shave lotion per resident preference 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) vi. offer mirror to resident for approval vii. apply after-shave per resident preference viii. remove and dispose of towel ix. remove gloves and wash hands x. remove any loose hairs from resident xi. position resident comfortably j. if in bed, return bed to low position k. place call bell within resident's reach l. clean razor of hair and/or soap m. return equipment to appropriate storage n. document procedure on Activities of Daily Living form, per facility policy o. report any observations of changes in resident's condition or behavior to appropriate licensed nurse 4. procedure for shaving a female resident a. always obtain resident consent b. some women want to shave unwanted facial c. hair, underarm hair and/or leg			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
. 56. Demonstrate how to provide fingernail care.	4. supplies a. orangewood stick b. emery board (nail file) c. lotion d. basin with warm water e. soap f. gloves g. towel 5. provide fingernail care a. identify yourself by name b. wash your hands c. explain procedure to resident d. provide for privacy with curtain, screen or door e. if resident is in bed, adjust bed to safe level, usually waist high and lock the wheels f. fill basin halfway with warm water, no warmer than 105° and place basin at comfortable level for resident (have resident check water temperature) g. put on gloves h. soak resident's hands and nails in water at least 5 minutes i. remove one hand from water, wash with soapy wash cloth; rinse; pat dry with towel, including between fingers j. place hand on towel k. gently clean under each fingernail with the orangewood stick, wiping orangewood stick on towel after cleaning under each nail l. repeat steps i-k for the second hand			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	m. wash and rinse both hands again and dry thoroughly between fingers n. shape fingernails with emery board or nail file o. finish with nail smooth and free of rough edges p. apply lotion from fingertips to wrists q. empty, rinse and dry basin before placing in designated dirty supply area or returning to storage per facility policy r. place soiled clothing and linens in proper containers s. remove and discard gloves before washing your hands t. make resident comfortable u. return bed to low position and remove privacy measures v. place call bell within reach of resident w. wash hands x. document procedure on Activities of Daily Living form, per facility policy y. report any observations of changes in resident's condition or behavior to appropriate licensed nurse			
57. Accurately document performance of fingernail care on facility ADL form. 58. Discuss the importance of foot care.	F. Foot care 1. purpose a. prevent foot odor b. prevent infection c. prevent pressure ulcer d. prevent complications of diabetes mellitus			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
59. Identify guidelines for foot care. 60. Discuss observations that the nurse aide may make while providing foot care.	e. provides nurse aide opportunity to observe feet and toes f. long toenails make wearing shoes uncomfortable 2. guidelines of foot care a. nurse aide may not cut toenails, corns or calluses b. always dry feet thoroughly, including between the toes c. put on clean socks every day 3. observations the nurse aide may make during foot care a. dry skin b. breaks or tears in the skin (including between toes) c. ingrown nails d. red areas on the feet, heels, or toes e. drainage or bleeding f. change in color of skin or nails g. heels that are soft or whitish or discolored h. corns, blisters, calluses, warts i. complaints of pain, burning or tenderness in feet, heels, or toes j. rash k. unusual odor 4. supplies a. basin b. towels c. soap d. lotion e. gloves f. washcloth g. clean socks			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
61. Demonstrate how to provide foot care. 62. Accurately document performance of foot care on facility ADL form. 63. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 64. Describe the importance of daily dressing. 65. Discuss guidelines the nurse aide should follow when helping a resident to dress	5. provide foot care a. follow the procedure for "Provides Foot Care on One Foot" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in resident's condition or behavior to appropriate licensed nurse V. Dressing A. Purpose 1. everyone should dress in clean clothes every day 2. promotes self-esteem 3. cleanliness helps to prevent odors B. Guidelines for dressing resident (explain procedure and provide privacy) 1. encourage resident to be as independent as possible within their capabilities 2. provide resident opportunity to make choices regarding what clothing to wear 3. allow resident time to make decisions and choices 4. clothing should be appropriate to time of year, temperature of surroundings 5. all of resident's clothing should be labeled with name and room number			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
66. Identify assistive devices that are useful for residents when they are dressing themselves. 67. Explain observations the nurse aide may make when assisting the resident to dress.	6. handle resident's clothing with care 7. report to supervisor any clothing that needs to be repaired in any way 8. provide resident privacy when dressing or undressing 9. report to supervisor or family clothing and shoes that are too big or too small 10. begin dressing on the weak side 11. begin undressing on the strong side 12. dresses that open in the front are easier to put on than ones that open in the back 13. slacks, skirts and pants with elastic waistbands are preferable 14. shoes should have non-skid soles 15. to promote resident independence, assistive clothing devices may be required a. zipper-pull b. extended shoe horn c. button hole helper d. long handled graspers e. Velcro openings C. Observations nurse aide may make when assisting resident to dress 1. change in flexibility of joints 2. weakness of one side of body 3. loss of weight if clothing becomes loose 4. gaining weight if clothing becomes tight			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
68. Identify safety measures and precautions the nurse aide should be aware of when assisting the resident to dress. 69. Demonstrate how to dress resident with affected (weak) right arm. 70. Accurately document dressing on facility ADL form. 71. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	D. Safety measures and precautions when assisting resident to dress and undress 1. clothing should fit properly a. not too long b. not too tight c. not too loose 2. shoes should have non-skid soles 3. encourage resident to sit when putting on socks/stockings and shoes 4. provide sweaters and long-sleeved tops if resident complains of feeling cool or cold E. Dress resident 1. if resident is independent, provide assistance as requested 2. if resident needs assistance follow the procedure for "Dresses Resident with Affected (weak) Right Arm" in the most current edition of Virginia Nurse Aide Candidate Handbook a. document procedure on Activities of Daily Living form, per facility policy b. report any observations of changes in resident's condition or behavior to appropriate licensed nurse 3. Care of resident's personal clothing a. labeled with name and room number b. place in hamper for laundry when soiled or when removed at end of the day c. store clean clothes per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
72. Explain the anatomy and physiology of the urinary system.	d. report to supervisor and/or family clothing that needs to be mended e. report to supervisor and/or family clothing/shoes that no longer fit VI. Toileting A. Anatomy and physiology of urinary system 1. kidneys a. most people have 2 kidneys, one on each side of the small of the back b. cleanse and filter the blood c. regulate the balance of water, sodium, potassium d. remove toxins and waste products from blood e. assist to regulate blood pressure 2. urine - fluid created by kidneys from the water and waste products filtered from the blood 3. ureters - thin tube that carries urine from each kidney to the bladder 4. bladder - collects urine 5. internal urethral sphincter - muscle that holds the neck of the bladder closed, keeping the urine in the bladder 6. urethra - tube that carries urine from bladder to the outside of the body a. about 3- 4 inches long in females b. about 7 – 8 inches long in males 7. external urethral sphincter - muscle that contracts to prevent urine from exiting the urethra			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
73. Define the terms used in the urinary system. 74. Describe age-related changes seen in the urinary system.	8. urethral meatus - opening to the outside of the body at the end of the urethra B. Process of passing urine from the body 1. voiding 2. micturating 3. urinating C. Urinary incontinence 1. unable to control the internal sphincter 2. involuntary passing of urine D. Definitions 1. hematuria - blood in the urine 2. anuria – no urine 3. dysuria – painful urination 4. nocturia – urinating at night 5. polyuria – excessive urination E. Age-related changes to the urinary system 1. kidneys do not filter the blood as efficiently a. increase in blood pressure b. urethral sphincter muscle tone decreases i. increases risk of urinary incontinence 2. bladder is not able to hold as much urine before the sensation that it needs to empty a. more frequent urination 3. bladder does not empty completely i. increased risk of urinary tract infection			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
75. Identify normal characteristics of urine. 76. Identify abnormal characteristics of urine that the nurse aide should report to the appropriate supervisor.	F. Urine 1. color a. pale yellow – normal b. dark yellow to amber – dehydrated c. can be affected by food, medications and/or illnesses 2. clarity a. should be clear b. cloudy – sign of infection 3. odor a. smells of ammonia b. foods can affect smell – asparagus 4. amount a. adults produce 1200-1500 ml/24 hours b. minimum is 30ml/hour 5. should not contain a. blood b. pus c. mucus d. bacteria e. glucose f. sediment 6. report the following to the appropriate licensed nurse a. cloudy urine b. dark or rust-colored urine c. strong, offensive smelling urine d. fruity-smelling urine e. blood, pus, mucus in urine f. bacteria or glucose in urine g. sediment h. complaints of pain or burning on urination i. frequent urinary incontinence			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
77. Explain the guidelines the nurse aide should follow to promote normal urination patterns. 78. Discuss common disorders of the urinary system, including their signs and symptoms.	j. resident wakes up frequently during the night to urinate G. Guidelines to promote normal urination 1. provide privacy 2. take to the bathroom as needed 3. assist male residents to stand to void, if possible 4. if resident must use bedpan, raise head of bed to sitting position 5. encourage adequate fluid intake 6. provide fresh water in easy reach of resident 7. frequently offer residents fluids to drink 8. encourage activity and exercise 9. teach Kegel exercises to female residents 10. answer call bells promptly 11. take resident to bathroom every 2 hours to avoid incontinence H. Common disorders of the urinary system 1. urinary tract infection (UTI) a. usually a bacterial infection b. causes i. wiping incorrectly and contaminating urethra with bowel movement ii. not emptying the bladder completely iii. indwelling urinary catheter c. symptoms i.urgency ii. complaints of pain or burning with urination iii. urinating frequently in small			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	amounts iv. blood in urine v. lower abdominal pain vi. flank pain vii. change in mental status or behavior viii. nausea d. measures to avoid UTI i. wipe perineum front to back ii. drink plenty of fluids iii. Vitamin C helps to prevent UTI a) orange juice b) cranberry juice iv. take shower rather than tub bath e. report to nurse i. complaints of pain or burning on urination ii. foul-smelling urine iii. dark-colored urine iv. blood in urine v. resident voids frequently in small amounts vi. urine that looks cloudy vii. sediment in urine 2. urinary retention a. possible causes i. in men – commonly caused by enlarged prostate - benign prostatic hypertrophy (BPH) ii. in women – may be caused by cystocele (sagging of the bladder) and rectocele (sagging of the lower part of the colon)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	b. symptoms i. unable to empty bladder completely ii. frequent urge to void iii. difficulty starting urine stream iv. weak flow of urine stream v. dribbling after finished voiding vi. distended lower abdomen c. report any of the above 6 symptoms to the appropriate licensed nurse 3. urinary incontinence a. involuntary loss of urine from the bladder b. decreased muscle tone at internal or external sphincter allows urine to "leak" c. symptoms i. urine leaks when resident coughs, sneezes, laughs ii. resident cannot "make it to the bathroom in time" 4. chronic renal failure a. kidneys do not function correctly b. unable to filter waste products and toxins from blood c. unable to regulate water balance and blood pressure d. life-threatening e. most frequent causes i. high blood pressure ii. diabetes mellitus f. symptoms i. unexplained weight gain ii. itching iii. fatigue			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	resident has had hip surgery; thin end is placed under resident's/resident's buttocks c. may be very uncomfortable and may damage the resident's/resident's skin 3. bedside commode a. chair frame with a toilet seat and collection bucket b. kept at bedside for residents unable to walk into bathroom 4. catheter a. tube inserted through the urinary meatus into the bladder b. drains urine from the bladder c. 3 types i. straight – temporary – removed as soon as bladder is emptied ii. indwelling – remains in bladder to continuously drain urine into a collection bag iii. condom – fits over the penis and drains urine into a drainage bag a) Texas catheter is another name 5. urinary drainage bags J. Care for resident with urinary incontinence 1. can be emotionally traumatic for resident and family 2. treat with respect and dignity			
80. Discuss how to provide care to the resident/resident with urinary incontinence.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
81. Demonstrate how to provide perineal care. 82. Accurately document performance of perineal care on facility ADL form. 83. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	3. follow the procedure for "Provides Perineal Care (Peri-Care) for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook 4. adaptations of peri-care for male resident a. if resident is not circumcised retract foreskin of penis b. hold penis by the shaft c. wash in circular motion from tip of penis down toward the body d. use clean area of washcloth for each stroke e. wash scrotum, then the groin f. rinse and dry g. turn resident on side h. wash, rinse, dry rectal area i. document procedure on Activities of Daily Living form, per facility policy j. report any observations of changes in resident's condition or behavior to appropriate licensed nurse 5. management of urinary incontinence a. answer call bell promptly b. encourage fluids c. encourage resident to walk or exercise d. toilet resident q2h e. resident wears incontinent pad or brief f. check pad or brief q2h for dryness and change if wet g. keep perineum clean and dry to			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	prevent odor and skin breakdown h. change wet clothing immediately i. treat resident with respect and dignity j. anticipate need to toilet k. resident may need a catheter K. Care of resident with a catheter 1. Guidelines for the indwelling catheter a. always wear gloves when emptying catheter drainage bag b. do not touch tip of the clamp to any object when draining the bag c. do not touch the drainage spout to the graduate d. drainage bag should always be lower than the level of the hips or bladder to prevent urine flowing back into the bladder e. never hang the drainage bag from the side rail of the bed f. hang drainage bag from bed frame g. do not have the drainage bag on the floor h. catheter tubing should not touch the floor i. check catheter tubing frequently to assure it is not kinked k. catheter tubing should drape over the thigh, not be under the leg l. use catheter strap to position catheter over the thigh m. do not place tubing over the side rail			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
84. Demonstrate how to provide catheter care. 85. Accurately document performance of catheter care on facility ADL form. 86. Demonstrate how to empty a urinary drainage bag.	n. always clean perineum front to back to prevent infection o. keep perineum clean and dry to prevent infection p. do not disconnect drainage tubing from the catheter q. notify appropriate licensed nurse immediately if drainage tubing becomes disconnected 2. Care of the resident with an indwelling catheter a. follow the procedure for "Provides Catheter Care for Female" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observation of changes in resident's condition or behavior to appropriate licensed nurse 3. measuring urinary output a. always wear gloves b. always measure with a graduate i. do not use lines on urinal or drainage bag to measure urine output c. place graduate on counter top and bend knees to have urine level at your eye level to measure d. measure in milliliters (ml) i. 1ml=1cc (cc= centimeter) ii. 30 ml = 1 ounce (oz)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
87. Accurately document urinary output. 88. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 89. Discuss how to collect routine urine specimen.	4. how to empty a drainage bag a. identify yourself and explain what you will be doing b. wash hands and put on gloves c. provide for privacy d. obtain graduate e. place paper towel on floor under graduate f. open clamp on drainage bag and allow urine to empty into graduate g. empty entire content of drainage bag h. close clamp and return to housing on drainage bag i. measure urine in bathroom by placing graduate on counter top and reading at eye level j. empty urine into toilet and flush k. rinse and dry graduate and store per facility policy l. remove gloves and wash hands m. document output per facility policy n. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse L. Urinary specimens 1. routine urine specimen a. not a sterile specimen b. can be obtained from bedpan, urinal or speci-hat (collector that fits over the porcelain bowl of the toilet and under the seat) c. equipment needed i. specimen container and lid			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
90. Accurately document specimen collection.	ii. completed label and lab slip iii. gloves iv. means to collect urine v. supplies for perineal care d. procedure i. identify yourself and explain what you need the resident to do ii. provide for privacy iii. wash hands and put on gloves iv. assist resident to toilet with speci-hat, bedside commode (BSC), or provide urinal or bedpan v. instruct resident to urinate but put toilet paper in trash for disposal vi. remove gloves and wash hands vii. assist resident to return to comfortable position in room viii. put on clean gloves ix. in bathroom, pour urine into specimen cup until cup is half full, keeping outside of cup clean x. place lid on cup and label immediately xi. rinse and dry any equipment used to collect urine xii. remove gloves and wash hands xiii. place call bell within easy reach of resident xiv. document specimen			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
91. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 92. Discuss how to collect clean-catch urine specimen.	collection per facility policy xv. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse 2. clean-catch urine specimen (mid-stream specimen) a. used to determine the presence of bacteria in the urine b. resident urinates a small amount to clear the urethra, stops, if possible, then collects sample c. procedure for collecting clean-catch specimen i. identify yourself and explain what you need the resident to do ii. provide for privacy iii. wash hands and put on gloves iv. assist resident to bathroom v. open specimen kit keeping inside of specimen cup from touching anything vi. instruct resident to clean perineum prior to obtaining specimen a) female – separate labia and clean front to back in 3 separate strokes with a clean towelette or wipe each time - down the left side - down the right side - down the middle b) male – clean head of penis with circular strokes using clean towelette for each			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
93. Accurately document specimen collection. 94. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	stroke - if uncircumcised, pull back foreskin and clean as above c) return foreskin to un-retracted position after urinating vii. ask resident to urinate a small amount and then stop, if possible viii. place container and ask resident to continue urinating, collecting until cup is about half full ix. instruct resident to finish urinating and wipe with toilet paper as usual x. place lid on specimen cup and clean outside of cup with paper towel xi. apply label and place cup in plastic bag provided xii. remove gloves and wash hands xiii. assist resident to comfortable position in room xiv. place call bell within easy reach of resident xv. document specimen collection per facility policy xvi. report any observations of changes in resident's urine and/or condition or behavior to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
95. Explain the anatomy and physiology of the gastrointestinal system.	M. Anatomy and physiology of the gastrointestinal system (GI) – digestive system 1. begins at the mouth and ends at the rectum 2. tongue moves food around the mouth 3. salivary glands – secrete saliva which begins the breakdown of food 4. teeth – break up food 5. esophagus – carries food to stomach 6. stomach – contains acid to break down food into chyme (semifluid mass of partly digested food) 7. chyme enters small intestines where it is propelled via peristalsis (wavelike motion that moves contents through small and large intestines) a. continues to be digested by bile from liver enzymes b. about 90% of absorption of nutrients from food occurs in small intestines 8. large intestines – help regulate water balance a. chyme takes 3-10 hours to become feces b. feces water, sold waste material, bacteria and mucus c. defecation – eliminating feces from the body 9. functions of the GI system a. ingestion – taking food/fluid into the body b. digestion – breakdown of food			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	into nutrients to be absorbed 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 1. decreased taste (sweet is last taste to remain) 2. loss of teeth affects ability to chew 3. decreased saliva and digestive fluids slow digestion of food 4. medical conditions may cause difficulty swallowing 5. decreased absorption of vitamins and minerals 6. decreased rate of digestion leads to constipation 7. age related changes and behaviors a. inactivity b. drinking less fluids c. some chronic or acute illnesses d. medications			
97. Identify normal characteristics of stool.	O. Bowel elimination 1. called stool, feces, bowel movement (BM) 2. frequency a. varies by individual b. regularity prevents complications 3. color a. brown b. foods can cause color to change c. iron medication changes color to black d. illness 4. consistency a. soft, moist, formed b. foods can cause change to consistency			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
98. Discuss the importance of identifying abnormal characteristics of stool that the nurse aide should report to the appropriate supervisor. 99. Explain the guidelines the nurse aide should follow to promote normal bowel elimination patterns.	5. illness 6. not normally found in feces a. blood b. mucus c. pus d. worms 7. report the following to the appropriate licensed nurse a. abnormally colored feces (white, black, bloody) b. hard, dry feces c. liquid stool (diarrhea) d. inability to have bowel movement (constipation) e. pain with bowel movement f. stool that contains blood, mucus, pus g. stool incontinence P. Guidelines to promote normal bowel elimination 1. encourage adequate fluid intake 2. warm fluids stimulate peristalsis 3. diet with adequate fiber/roughage 4. promote regular exercise 5. provide good oral care to keep mouth and teeth healthy 6. provide privacy when using the bathroom 7. allow plenty of time for resident to use bathroom 8. follow resident's pattern for bowel elimination 9. laxatives may be ordered to stimulate bowel activity			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
105. Discuss how to collect routine stool specimen. 106. Accurately document specimen collection.	c. saline - 500-1000ml water with salt added d. pre-packaged (Fleets) – 120ml saline or oil T. Stool specimens 1. stool specimen 2. purpose a. identify parasites, microorganisms, or blood 3. procedure a. identify yourself and explain what you are going to do b. wash hands c. put on gloves d. place speci-hat in toilet or bedside commode e. have resident defecate in speci-hat f. assist with perineal care g. using 2 tongue blades place stool in specimen cup and close lid h. attach label immediately i. dispose of tongue blades per facility policy j. remove gloves and wash hands k. position resident comfortably in room l. place call bell within reach of resident m. dispose of tongue blades per facility policy n. document procedure on Activities of Daily Living form, per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
107. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 108. Explain why a resident might have a colostomy. 109. Describe care issues for a resident with a colostomy including what observations the nurse aide should make. 110. 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 U. Ostomies 1. ostomy - opening from an area inside the body to the outside of the body 2. colostomy – intestine is brought to outside of abdomen a. stoma - opening in abdomen b. colostomy bag – appliance that covers the stoma and into which the stool drains c. no stool will be eliminated via the rectum 3. some causes a. cancer of colon, rectum b. trauma – gunshot c. diverticulitis d. Crohn's disease 4. care for resident with ostomy i. treat resident with respect ii. be sensitive and supportive iii. provide privacy for resident or nurse to change bag 5. observations nurse aide should report to the appropriate licensed nurse a. color and consistency of stool b. unusual odor c. blood, pus, mucus in stool in bag d. leaking around the seal of the bag e. flatus accumulating in the ostomy bag f. complaints of pain in abdomen			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	g. distended abdomen			
111. Discuss the importance of nutrition, hydration, and elimination as it relates to the client/resident.	VII. Eating and Hydration A. Basic nutrition 1. purpose of GI (gastrointestinal) system a. ingestion – take in food b. digestion – breakdown food into nutrients the body can absorb and use c. elimination – eliminate parts of food not absorbed			
112. Describe the six (6) main nutrients in a healthy diet.	2. types of nutrients a. water i. most important nutrient ii. essential for life iii. ingested as liquid but also as part of foods iv. 50-60% of body weight v. transports waste products out of body vi. keeps us cool – perspiration vii. keeps mucous membranes moist viii. helps joints to move smoothly b. carbohydrates i. source of glucose – food for the cells of the body ii. if not used for energy (food) for the body they are stored as fat iii. 1 gram carbohydrate = 4 calories iv. grains, cereals, fruit, some vegetables c. protein i. contain the "building blocks"			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	for the cells ii. found in fish, meat, nuts, bean, legumes, eggs and dairy products iii. helps body to build new tissue and to rebuild tissue that is damaged iv. 1 gram = 4 calories d. vitamins i. fat soluble – only dissolve in presence of fat – vitamins D, E, A, K ii. water soluble – dissolve in water – B vitamins, vitamin C iii. essential for the body to function correctly e. minerals i. help provide structure to the body ii. calcium – builds bones and teeth iii. iron – required to transport oxygen throughout the body f. fat (lipids) i. found in meat and oils, milk, cheese, nuts ii. make food taste good iii. take long time to breakdown giving the sensation of being "full" longer iv. most be present in the body to use Vitamin D, E, A, K v. 1 gram = 9 calories			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
113. Explain how to use My Plate as a guide for a healthy diet. 114. Identify various special diets that residents may receive.	3. USDA My Plate a. general guide for types and quantities of foods to eat each day b. fruits and vegetables i. half of plate ii. vegetables - fresh, frozen, dried, canned, juice, dark green vegetables, red and orange vegetables, dry beans and peas, starchy vegetables iii. fruits – fresh, frozen, dried, canned, juice c. grains i. one quarter of plate ii. half should be whole grain d. protein i. one quarter of plate ii. meat, poultry, seafood, eggs iii. beans, peas, soy products, nuts, seeds e. dairy i. 3 cups each day ii. milk, yogurt, cheese, anything made with milk 4. Special diets a. regular diet - well-balanced diet without restrictions b. soft diet i. restricts foods hard to chew or swallow ii. restricts raw fruits and vegetables iii. restricts high fiber and spicy foods c. mechanical soft diet i. foods are chopped or blended			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	to make them easier to chew ii. does not restrict spices, fat or fiber d. pureed diet i. consistency of baby food ii. for resident with difficulty chewing and/or swallowing e. clear liquid diet i. only includes liquids you can see through ii. jello, apple juice, bouillon, water, coffee or tea without cream iii. does not provide enough nutrients to maintain health for prolonged period of time f. full liquid diet i. clear liquids and any food that can be poured at room or body temperature ii. puddings, cream soups, yogurt, breakfast drinks g. bland diet i. restricts spicy and acidic foods h. fiber-specific diet i. may be high or low fiber depending on medical needs of resident i. low sodium diet (low NA diet) i. restrict amount of salt resident may use ii. ordered for resident with high blood pressure iii. may be “no added salt: diet (NAS) j. diabetic diet			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
115. Describe the three (3) consistencies of thickening that may be ordered for residents with swallowing difficulties.	i. ordered for residents with diabetes mellitus ii. may restrict caloric intake iii. restricts amount of sugar and carbohydrates k. fluid restricted diet i. ordered for resident with heart or kidney disease ii. identifies specific quantity of fluid resident may have in 24-hour period l. gluten-free diet i. may be resident choice or due to intolerance to gluten ii. gluten is a general term for proteins found in wheat iii. residents/residents with celiac disease cannot tolerate gluten m. NPO i. nothing by mouth n. liquid modifications i. may be required for residents with difficulty swallowing "thin" fluid like water ii. Thick-It – works like corn starch to thicken the liquid iii. nectar thick (consistency of thick fruit juice) iv. honey thick (consistency of honey) v. pudding thick (consistency of pudding) vi. know facility policy and procedures for who can thicken fluids			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
116. Identify age-related changes that affect eating and nutrition.	B. Age-related changes to eating and nutrition 1. physical changes a. dysphagia – difficulty swallowing b. loss of teeth – difficulty chewing c. decrease saliva – difficulty swallowing d. decrease sensations of taste and smell – food is less appealing e. decreased ability to see – makes it difficult to feed oneself and food appears less appealing 2. decreased activity level a. less appetite b. increases risk of constipation 3. special diets a. foods not prepared with spices have less flavor b. pureed diets not very appealing to the eye 4. psychosocial a. decreased income makes it difficult to buy foods that resident purchased earlier in life b. lack of social interaction may decrease appetite c. depression may decrease appetite 5. physical ailments a. medical conditions can make eating/cooking difficult b. Parkinson's Disease, stroke, certain cancers, Alzheimer's Disease (AD)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
117. Identify cultural considerations that affect eating and nutrition.	6. medications a. can alter the taste of food b. can leave bad taste in the mouth c. can decrease appetite d. may cause nausea, diarrhea, constipation C. Cultural considerations for eating and nutrition 1. religious considerations a. Jewish religion i. may not eat pork ii. may require Kosher diet iii. food specially prepared to religious specifications b. Muslim (Islam) i. will not eat pork ii. may require halal diet (foods allowed under Islamic dietary guidelines) iii. food specially prepared to religious specifications c. Hindu (may not eat beef) d. Buddhist (many are vegetarian) e. Mormon i. may not drink caffeine – coffee, tea, cola ii. may not drink alcohol 2. social considerations a. vegan i. will may not eat any animal products ii. restricts eggs, dairy products, meat b. vegetarian (restrict meat, fish and poultry) c. fasting (voluntarily gives up eating for a period of time)			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	3. ethnic considerations 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 1. eats less than 70% of meals 2. complains of mouth pain 3. dentures do not fit 4. teeth are loose 5. difficulty chewing or swallowing 6. frequent coughing/choking while eating 7. needs help eating or drinking 8. weight loss – clothes become loose-fitting 9. weight gain – clothes become tight 10. complaints of constipation 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 1. check diet card on resident's tray to make sure it is the correct tray for the correct resident 2. season food following resident's choices 3. assist resident to fill out menu 4. if resident does not like food on tray try to replace with food of his choice 5. encourage resident to eat by making mealtime a pleasant experience 6. assist resident to rinse mouth if resident receives medication immediately before mealtime			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	7. assist resident with adaptive devices to help him maintain his independence and feed himself 8. accurately record food and fluid intake for each meal 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 1. encourage resident to toilet before going to the dining room 2. assist to wash hands and face, brush teeth 3. encourage resident to wear glasses, hearing aides 4. provide pleasant area for eating a. encourage resident to eat in dining room with other residents to promote social interaction 5. if eating in his room, clear a clean area for resident's tray a. remove urinal/bedpan from view b. position in an upright position c. if positioned in a wheelchair, lock the wheels			
121. Demonstrate how to serve resident trays.	G. Serving the tray 1. wash hands 2. offer/provide clothing protector or napkin 3. check diet card of tray a. correct resident b. correct diet 4. assist resident to prepare food a. season food per resident choice b. if resident requests, cut food into bite-sized pieces			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. open cartons, containers at resident's request 5. provide resident with appropriate assistive devices to promote resident independence a. plate guard b. silverware with built-up handles c. sippy cup 6. decrease distractions by lowering TV/radio volume 7. allow resident sufficient time to eat, do not rush 8. talk with resident respectfully 9. for a visually impaired resident identify the location of foods on the plate using the numbers on a clock-face H. Guidelines for feeding resident 1. assist resident to wash hands 2. place a clothing protector over the resident's chest 3. sit at the same level as resident, facing the resident 4. identify foods for the resident 5. ask resident in what order he/she would like to have his/her food 6. do not mix foods unless requested by resident 7. offer liquids between bites of food 8. do not touch food to test for hotness, place hand above food 9. do not force resident to eat 10. provide resident ample time to chew and swallow food before offering another bite 11. do not rush resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
122. Demonstrate how to feed a resident who cannot feed self. 123. Accurately document food and fluid intake. 124. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 125. Describe actions to help prevent aspiration.	I. Feed a resident who cannot feed himself 1. follow the procedure for "Feeds Resident who Cannot Feed Self" in the most current edition of Virginia Nurse Aide Candidate Handbook 2. document procedure on Activities of Daily Living form, per facility policy 3. report any observations of changes in resident's condition or behavior to appropriate licensed nurse J. Calculate food intake 1. know facility procedure for calculating food intake 2. some facilities use a percentage eaten of the entire plate of food 3. some facilities calculate percentage based on type of food eaten, for example: a. all of protein eaten = 30% b. all of carbohydrates eaten = 50% c. all of vegetable eaten = 20% 4. document and report food intake and fluid intake per facility policy K. Guidelines to help prevent aspiration 1. aspiration – taking food/liquid into the lungs 2. resident should be in up-right position (90°) to eat 3. feed resident slowly 4. reduce distractions 5. use thickener in liquids per nursing care plan 6. cut food into small bites			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
127. Describe signs and symptoms of dehydration. 128. Accurately describe actions of the nurse aide to prevent resident dehydration.	N. Signs of dehydration the nurse aide should report to the appropriate licensed nurse 1. drinking less that 6-8oz glasses (1400ml) of fluid/day 2. complaints of thirst 3. dry, cracked lips 4. dry mucous membranes 5. sunken eyes 6. decrease urine output 7. urine is dark and strong smelling 8. complaints of constipation 9. loss of weight 10. weak, dizzy, light-headed 11. low blood pressure 12. complaints of headache 13. irritable 14. confusion 15. weak, rapid heartbeat O. Actions the nurse aide can take to prevent dehydration 1. provide resident with fresh water every shift and place pitcher where resident can easily reach it 2. frequently ask resident if they would like something to drink 3. offer fluids that resident likes to drink 4. provide fluids at temperature resident prefers 5. provide resident with assistive devices if needed 6. keep accurate I/O records 7. follow nursing care plan and specific fluid			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	8. report to appropriate licensed nurse any signs of dehydration P. Signs of too much fluid (fluid overload) that the nurse aide should report to the appropriate licensed nurse 1. edema a. body retains fluid b. hands and feet swell c. rings and shoes become tight 2. weight gain 3. moist cough 4. shortness of breath on exertion 5. increased heart rate 6. skin on legs and feet becomes tight and shiny			
129. Identify signs and symptoms of fluid overload to report to the appropriate supervisor.				
130. Explain the anatomy and physiology of the skin.	VIII. Care of the Skin (Integumentary System) A. Anatomy and physiology of the skin 1. layers of the skin a. epidermis i. outer layer ii. made up of dead cells iii. has no blood vessels iv. contains melanin – pigment that gives color to the skin b. dermis i. inner layer ii. contains oil glands, sweat glands, hair follicles, blood vessels iii. protects internal organs from injury iv. produces Vitamin D when exposed to the sun 2. subcutaneous tissue a. layer of fat under the dermis b. blood vessels and nerve of the			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
131. Describe age-related changes seen in the skin.	skin originate here c. nerves provide sense of touch 3. glands in the dermis a. oil glands (sebaceous glands) i. secrete oily substance to prevent skin from drying and from harmful bacteria b. sweat glands i. produce sweat a) excrete waste products b) help to cool the body 4. hair - helps to keep body warm 5. nails - protects the ends of fingers and toes B. Age-related changes of the skin that may occur in geriatric residents/residents 1. decrease in fat in subcutaneous layer a. wrinkles b. sagging skin c. resident feels cooler 2. decrease in amount of melatonin a. gray hair b. age spots 3. decreased production of oil and sweat a. skin becomes drier b. becomes thinner c. becomes fragile d. more prone to infections and tearing 4. nails thicken and may become yellow C. Factors promoting healthy skin 1. good nutrition 2. adequate hydration			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
132. Discuss common disorders of the skin, including signs and symptoms.	3. adequate sleep 4. adequate exercise D. Common disorders of the skin 1. burns a. first degree i. involves epidermis ii. redness and pain b. second degree i. involves dermis ii. red, painful, swelling, blistering c. third degree i. dermis and underlying tissue ii. scarring iii. muscle and bone may be involved d. pain, swelling, peeling e. causes i. hot liquid ii. electrical equipment iii. hair dryer iv. heating pad v. chemicals f. never put oil, lotion or butter on a burn g. cool and cover loosely h. notify appropriate licensed nurse immediately 2. shingles a. related to chicken pox reactivation b. viral infection that follow path of a nerve c. blistery rash that appears as a single line on one side of the body d. very painful			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	e. contagious for someone who has never had chicken pox f. keep rash covered g. wash hands frequently 3. wounds a. two types i. open wound a) abrasion b) puncture wound c) gunshot wound d) laceration ii. closed would a) bruise b) hematoma b. symptoms i. pain ii. damage to the skin iii. discoloration of the skin iv. bleeding v. fever, chills vi. difficulty breathing c. report any wounds to the appropriate licensed nurse immediately E. Pressure Sores (decubitus ulcers) 1. pressure points a. bony prominences b. heels c. shoulder blades d. elbows e. sacrum f. areas with very little fat between bone and skin 2. pressure sores a. breakdown of skin over a bony prominence b. harder to cure than to prevent			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. caused by i. immobility – lying, or sitting on same area for a prolonged period of time a) weight of body prevents blood flow to tissue and body tissue begins to die after 2 – 3 hours ii. lying on wrinkled linen iii. lying on an object in the bed iv. sitting on bedpan for prolonged time v. wearing splint or brace that does not fit properly			
133. Identify risk factors for developing pressure sores.	3. risk factors for developing pressure sores a. aging – skin becomes more fragile b. poor nutrition and hydration c. skin that has prolonged contact with water or moisture – causes epidermis to breakdown d. cardiovascular and respiratory problems – decreases amount of oxygen reaching cells e. skin exposed to friction and shearing - during turning and positioning 4. signs of developing pressure sores a. skin becomes whitish or reddened b. skin is dry, cracked and/or torn c. blisters, bruises			
134. Describe the staging of pressure sores.	5. staging of pressure sores – *performed by a licensed nurse, not a nurse aide a. Stage 1			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	i. skin intact, but red, blue or grey non-blanchable ii. relieving pressure for 15-30 minutes does not return skin to normal coloration iii. can be reversed if treated early b. stage 2 i. involves both epidermis and dermis ii. looks like clear fluid filled blister or shallow crater iii. epidermis cracks or peels away iv. open area is portal of microorganism to enter v. no dead tissue yet c. stage 3 i. both epidermis and dermis are gone ii. looks like a deep crater iii. drainage is present iv. necrotic (dead) tissue may be visible but doesn't obscure depth of tissue loss v. takes weeks or months to completely heal d. stage 4 i. crater of damaged tissue extends down to the muscle or bone ii. often becomes seriously infected iii. takes months to heal iv. may require skin graft 6. deep tissue injury (DTI) a. purple or discolored area with intact skin			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
135. Describe actions the nurse aide can take to prevent pressure sores.	b. firm, mushy, boggy, or warmer or cooler than adjacent tissue c. unstageable i. unable to see wound bed ii. eschar or slough in wound iii. can be yellow, tan, brown, black iv. can be firm, soft, or draining 7. actions to prevent pressure sores a. prevention is easier than treating and healing b. perform skin care and skin checks on regular basis i. during routine personal care ii. throughout the day as needed iii. use moisturizer on unbroken skin iv. keep skin clean and dry v. where skin comes in contact with skin a) under pendulous breasts b) between scrotum and legs c) between abdominal folds vi. clean and dry immediately after urinary or bowel incontinence a) replace soiled linen protectors and clothing with clean, dry linen and clothing b) assist resident to wipe well, drying perineum c) toilet q2hrs. to avoid incontinence d) keep linen clean, dry and free of wrinkles (if			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	resident eats in bed remove any crumbs from linen) c. turn and reposition immobile residents at least q2h d. encourage mobile residents to change position frequently e. during transfer and repositioning resident i. avoid dragging resident across the linen by using draw sheet to turn and reposition resident ii. use mechanical lift to transfer from bed to chair iii. use transfer board to transfer bedridden resident from bed to stretcher iv. avoid bumping resident against side rails or wheelchair leg rests f. use positioning devices to keep pressure off areas at risk i. foot boards ii. bed cradles iii. heel/elbow protectors iv. sheepskin pads to protect the back g. perform range of motion exercises on regular basis h. massage healthy skin to increase circulation (do not massage skin that is white, red, purplish) i. encourage healthy diet and adequate hydration			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
136. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 137. Demonstrate how to perform a back massage.	8. observations to report to the appropriate licensed nurse a. change in skin coloration over a bony prominence or in a skin fold (whitish, red, grey, purplish) b. dry, cracked, flaking skin, particularly on heels or elbows c. torn skin d. blisters, bruises, cuts e. resident itches or scratches skin frequently f. broken skin anywhere on the body, including between the toes g. any change in an existing pressure sore i. drainage ii. odor iii. peeling skin iv. change in color of skin v. change in size of crater F. Back massage (back rub) 1. relaxes tired, tense muscles 2. improves circulation 3. check nursing care plan for instructions on when to perform 4. procedure for performing back rub a. identify yourself and explain what you are going to do b. wash hands c. put on gloves if there is an area of broken skin d. provide for privacy e. adjust bed to waist-height and lock bed wheels f. lower side rail closest to you g. position resident on his side or back, if tolerated			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
138. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor. 139. Identify the structure and function of the skeletal system.	h. pour lotion on hands and rub hands together i. using full palm of your hand, start at base of spine and with firm, even stroke gently massage upward toward the shoulders j. at shoulders, circle hands outward and stroke along outside of back, down toward base of spine k. repeat circular motion for 3-5 minutes l. using circular motion, gently massage bony prominences m. if bony prominences are red, massage around them, not over them n. if there is extra lotion, remove it o. redress and reposition resident p. raise side rail, if appropriate q. return bed to low position r. place call bell in easy reach of resident s. store lotion per facility policy and resident request t. wash hands u. report to appropriate licensed nurse any changes in resident or skin that you observed IX. Transfer, Positioning and Turning A. Anatomy and physiology of musculoskeletal system 1. skeleton a. long bones (arms and legs) b. short bones (wrists and ankles) c. flat bones			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
143. Identify complications of immobility.	ii. range of motion exercises iii. anti-inflammatory medications iv. weight loss v. heat vi. total joint replacement surgery e. considerations for the nurse aide providing care i. encourage activity per nursing care plan ii. range of motion exercises as ordered iii. assist with ADLs iv. encourage use of assistive devices to promote resident independence f. report the following to the appropriate licensed nurse i. unusual stiffness of joints ii. swelling of joints iii. resident complaint of pain in joints iv. decreased ability to perform range of motion exercises v. decreased ability of resident to perform daily activities D. Complications of immobility 1. physical discomfort 2. pressure sores 3. contractures 4. bones become brittle due to loss of calcium 5. pneumonia 6. blood clots, especially in the legs			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
144. Demonstrate the various positions for the resident in bed.	E. Proper body alignment 1. positioned so spine is straight and not twisted 2. promotes comfort and good health 3. supine a. flat on back b. support head and shoulders with a pillow c. support arms and hands with pillow or rolled washcloth d. place pillow under calves so heels are elevated off bed to prevent pressure sores e. use footboard to keep ankles flexed to promote anatomical position of feet and ankles 4. lateral a. lying on side b. pillow to support the head and neck c. pillow to the back to maintain side-lying position d. flex top knee and place pillow under the knee and lower leg for support e. pillow under bottom foot to keep toes from touch the bed 5. prone a. lying on the abdomen b. many residents do not like this position c. head turned to the side and placed on small pillow d. place pillow under abdomen to allow room for breasts and to allow chest to expand during inhalation			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	e. do not leave resident prone for a long period of time 6. Fowler's a. resident on back with head of bed (HOB) elevated 45 - 60° b. semi-Fowler's – HOB elevated 30 - 45° c. high Fowler's – HOB elevated 60 - 90° d. raise knee gatch or place pillow under knees to help prevent resident from sliding down the mattress 7. Sims' a. extreme side-lying position, almost prone b. head turned to side and supported with pillow c. lower arm positioned behind the back d. upper knee is flexed and supported with pillow e. pillow under each foot to prevent toes from touching bed 8. Trendelenburg a. head is lower than the rest of the body b. used to increase blood flow to the brain if resident is in shock 9. reverse Trendelenburg a. mattress placed at an angle with the head higher than the foot of the mattress b. used for residents with digestive disorders			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
145. Demonstrate how to raise a resident's head and shoulders. 146. Demonstrate how to move a resident up in bed.	10. logrolling a. turning resident onto side while keeping spine straight b. use a draw sheet and a helper F. Repositioning resident 1. raising resident's head and shoulders a. use good body mechanics b. raise bed to waist-height and lower side rail c. place closest hand and arm under resident back to the far shoulder d. place other hand and arm under resident's closest shoulder e. gently raise head and shoulders on the count of three f. re-fluff, turn, and replace pillow g. make resident comfortable, provide with call bell h. lower bed and replace side rail, as appropriate i. document procedure and report any resident changes to appropriate licensed nurse 2. assisting resident to move up in bed a. practice good body mechanics b. raise bed to waist-height and lower side rail and head of bed c. place 1 arm under resident's shoulders d. place other arm under resident's knees and turn your feet toward the HOB e. have resident bend knees			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
147. Demonstrate how to move a resident up in bed using a draw sheet. 148. Accurately document moving resident up in bed on facility ADL form. 149. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	f. on count of 3, have resident push with feet while you lift body up in bed g. make resident comfortable, raise HOB, return h. document procedure and report any resident changes to appropriate licensed nurse 3. assisting resident to move up in bed with a draw sheet a. practice good body mechanics b. raise bed to waist-height and lower side rail and head of bed c. have one nurse aide on each side of bed turned slightly toward HOB d. with 1 hand at the shoulder and 1 hand at the hips, roll draw sheet toward resident e. grasp roll of draw sheet with palms up f. on count of 3 both nurse aides lift the draw sheet and resident toward the HOB g. unroll draw sheet and tuck edges under mattress h. make resident comfortable, raise HOB, return bed to low position i. place call bell in resident's reach j. wash hands k. document procedure and report any resident changes to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
150. Demonstrate how to position resident on side. 151. Accurately document positioning resident on side on facility ADL form. 152. Demonstrate how to transfer resident from bed to wheelchair using a transfer belt. 153. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	4. position resident on side a. follow the procedure for "Position Resident on Side" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in resident's condition or behavior to appropriate licensed nurse G. Transferring Resident 1. assisting resident to move from one location to another 2. weight-bearing a. resident's ability to stand on one or both legs 3. gait belt or transfer belt a. device nurse aide uses to assist unsteady or weak resident to transfer or ambulate 4. transfer resident from bed to wheelchair using transfer belt 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 b. document procedure on Activities of Daily Living form, per facility policy			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
154. Demonstrate how to transfer resident from bed to wheelchair using a mechanical lift.	c. report any observations of changes in resident's condition or behavior to appropriate licensed nurse 5. mechanical lifts a. equipment used to lift and move residents b. Fair Labor Standards Act, Hazardous Occupation Order Number 7 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 c. should only be used by nurse aides 18 years of age and older d. nurse aide should receive training to use the specific lift in the facility e. at least 2 nurse aides should be present when a mechanical lift is used to move a resident f. practice good body mechanics g. raise bed to waist-height and lower side rail and head of bed h. position wheelchair next to bed with footrests removed and wheels locked i. lower side rail on side nearest nurse aide j. assist resident to turn on side and place lift pad under resident k. assist resident to turn to opposite side and position lift pad under resident without wrinkles			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
155. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	l. roll mechanical lift to bedside with base at its widest point, the wheels locked and the overhead bar directly over the resident m. with resident on his back attach the straps to each side of the lift pad and the overhead bar n. fold resident arms over chest to protect arms and elbows o. raise resident about 2 inches off bed p. with assistance of 2nd nurse aide, guide resident to the wheelchair 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 r. replace footrests and support resident's feet on wheelchair footrests s. remove straps from overhead bar and lift pad t. make sure resident is comfortable and is wearing non-skid footwear u. cover resident's lap and legs with blanket or robe v. place call bell in resident's reach w. wash hands x. document procedure and report any resident changes to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
156. Demonstrate how to ambulate resident using transfer/gait belt. 157. Identify complaints and concerns the nurse aide should report to the appropriate supervisor related to ambulation. 158. Accurately document ambulating resident on facility ADL form. 159. Discuss the importance of reporting abnormal observations or changes to the appropriate supervisor.	H. Ambulating a resident 1. walking a resident 2. assistive devices a. transfer or gait belt b. walker c. cane d. crutches 3. report to the appropriate licensed nurse a. complaints of dizziness b. shortness of breath c. chest pain d. rapid heart beat e. sudden complaints of head pain f. unusual pain on weight bearing g. changes in resident's strength or ability to walk h. change in resident attitude toward walking i. assistive equipment that is broken or not working correctly 4. assist resident to ambulate using transfer belt a. follow the procedure for "Assists to Ambulate Using Transfer Belt" in the most current edition of Virginia Nurse Aide Candidate Handbook b. document procedure on Activities of Daily Living form, per facility policy c. report any observations of changes in resident's condition 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Identify basic physical needs of the client/resident. 2. Identify basic psychosocial needs of the client/resident.	I. Basic Psychosocial Needs A. Physical needs 1. food and water 2. protection 3. activity 4. rest and sleep 5. safety 6. comfort B. Psychosocial needs 1. recognition as a unique individual a. love and affection b. supportive environment c. acceptance by others d. independence e. social interaction f. security g. success and self-esteem h. spiritual expression i. sexual expression C. Problems meeting these needs 1. physical loss of body functions and/or body parts 2. social losses a. spouse b. relatives c. friends 3. economic losses a. retirement b. health costs 4. loss of personal control over decision-making a. loss of driver's license b. loss of personal dwelling when			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Identify defense mechanisms.	II. Mental health A. Client/resident is able to make adjustments to maintain state of emotional balance 1. stress a. anxiety, burden, pressure, worry b. causes i. loss of independence ii. loss of significant other/s iii. loss of economic resources iv. loss of body part/function v. many other causes 2. defense mechanisms a. compensation i. substituting for the loss b. conversion i. may have physical symptoms that cannot be explained medically ii. may use physical problem to avoid participating in an activity iii. "changes" the real reason into something else c. denial i. refuses to believe d. displacement i. shifting an emotion from one person to another less threatening person e. projection i. blaming someone else for own actions or feelings f. rationalization i. creating acceptable reasons for behavior or action g. regression			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	i. demonstrate behaviors from an earlier time in life h. repression i. refusing to remember frightening or unpleasant memory III. Mental Illness A. Anxiety 1. feeling of uneasiness, dread, worry can be helpful response unless it persists and effects ability to cope with everyday life signs and symptoms a. rapid pulse b. dry mouth c. sweating d. nausea e. difficulty sleeping f. loss of appetite g. restless h. irritable B. Obsessive-Compulsive Disorder (OCD) 1. obsession a. recurring unwanted thoughts 2. compulsion a. rituals that client/resident cannot control b. hand-washing frequently c. repeatedly checking door to make certain it is locked, for example 3. prohibiting the ritual increases the level of anxiety C. Phobias 1. excessive, abnormal fear			
5. Describe the signs and symptoms of anxiety.				
6. Identify the behaviors associated with obsessive-compulsive disorder.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	a. fear of heights b. fear of water c. fear of flying d. fear of dogs e. fear of closed in spaces 2. can be very debilitating			
7. Identify the signs and symptoms of depression.	D. Depression 1. overwhelming sadness prohibits client/resident from functioning 2. signs and symptoms a. lack of interest b. frequent crying c. fatigue d. weight loss e. sleep disturbances f. irritability g. frequent physical complaints h. feelings of worthlessness i. feelings of hopelessness			
8. Describe the behavior associated with bipolar disorder.	E. Bipolar Disorder 1. severe mood swings a. manic phase i. everything is wonderful ii. hyperactive b. depression phase i. excessive sadness ii. not enough energy to participate in ADLs 2. caused by chemical imbalance in brain			
9. Describe the signs and symptoms associated with schizophrenia.	F. Schizophrenia 1. loss of contact with reality 2. signs and symptoms a. delusions i. false ideas of who or what is around client/resident ii. delusions of grandeur			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iii. delusions of persecution iv. paranoia b. hallucinations i. false sensations that are real to client/resident ii. hearing voices iii. seeing things that are not really there iv. may involve any of the 5 senses c. disorganized speech i. flight of ideas d. catatonic behavior - may stop in mid-sentence and stare			
10. Demonstrate ways the nurse aide can modify his behavior in response to the behavior of the client/resident.	IV. Guidelines to Modify the Nurse Aide's Behavior in Response to the Behavior of Clients/Residents A. Know the client/resident 1. greet client/resident when entering the room 2. encourage self-care as appropriate 3. encourage independence with ADLs and activities 4. allow client/resident to make choices 5. offer to come back at a later time 6. remember the aide is not the cause of the client's/resident's behavior 7. do not take client's/resident's actions and behavior personally 8. stop when client/resident resists what you are doing B. Be aware of your actions 1. monitor your body language 2. stay calm			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	3. do not yell at or argue with client/resident 4. use silence appropriately 5. treat client/resident like an adult, not a child 6. use appropriate eye contact 7. be respectful of resident 8. provide privacy, if appropriate for resident 9. review reality with resident 10. answer questions about time, place, people honestly			
11. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	C. Report unusual behavior to appropriate licensed nurse 1. change in ability to perform ADLs 2. change in mood 3. behavior that is extreme, dangerous or frightening to other clients/residents 4. hallucinations or delusions 5. comments about suicide 6. client/resident not taking medications or hiding medications 7. any activity that causes a change in client's/resident's behavior			
12. Demonstrate principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated.	V. Behavior Management Techniques A. Principles of behavior management 1. ABCs a. antecedent – what precedes the behavior b. behavior – an action, activity, or process which can be observed and measured c. consequence – how people in the environment react to the behavior			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	b. words of praise 3. physical rewards a. touch b. hug c. pat on the arm 4. rewards must be given in a way that would normally occur in the environment 5. rewards should suit the preferences of the client/resident receiving the reward			
13. Demonstrate strategies to reinforce appropriate behavior.	D. Strategies to reinforce appropriate behavior 1. remain calm 2. maintain client's/resident's routine 3. maintain client's/resident's toileting schedule 4. encourage independence 5. provide privacy 6. encourage socialization 7. respond positively to appropriate behavior			
14. Demonstrate strategies to reduce inappropriate behavior.	E. Strategies to reduce client's/resident's inappropriate behavior 1. ignore behavior if it is safe to do so 2. remove behavior triggers 3. focus on the familiar 4. avoid caffeine 5. allow to pace in a safe place 6. do not argue with client/resident 7. try distraction – redirect behavior 8. do not take behavior personally 9. continue to reinforce appropriate behavior			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
15. Identify age-appropriate strategies to reinforce client/resident dignity. 16. Identify guidelines for nurse aide to reinforce client/resident dignity.	VI. Supporting Age-appropriate Behavior A. Age-appropriate strategies 1. participate in planning own care 2. encourage to make independent choices 3. maintain privacy 4. maintain confidentiality 5. encourage client/resident to have own possessions 6. encourage participation in social activities 7. encourage participation in recreational activities 8. respect client's/resident's decisions and choices B. Guidelines for nurse aide to reinforce client/resident dignity 1. address resident in a dignified manner 2. take time to listen to what client/resident has to say 3. converse with client/resident as with an adult 4. do not ignore or humor client/resident 5. respect client's/resident's privacy 6. explain what you are going to do 7. treat client/resident as you would want to be treated 8. encourage client/resident to make choices 9. client/resident has right to refuse treatment, medications, activities VI. Responding Appropriately to Client's/Resident's Behavior A. Aggressive behavior			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
17. Identify warning signs that frequently precede aggressive behavior. 18. Demonstrate strategies to respond to aggressive behavior. 19. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	1. common causes a. pain b. lack of sleep c. fear d. medication side effects e. too hot or too cold f. hunger g. unable to communicate h. forgetting i. infection and/or illness j. being approached by unknown residents and/or staff 2. warning signs preceding aggressive behavior a. fear b. restlessness c. pacing d. clenching fists e. clenching jaw f. yelling g. trying to leave facility h. throwing things 3. strategies to respond to aggressive behavior a. stay calm b. avoid touching client/resident c. try to identify the trigger for the behavior d. take threats seriously e. get help f. do not argue with client/resident g. protect yourself and others from harm h. report observations to appropriate licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
20. Identify warning signs that frequently precede angry behavior. 21. Demonstrate strategies to respond to angry behavior.	B. Angry behavior 1. common causes a. disease b. fear c. pain d grief e. loneliness f. loss of independence g. changes in daily routine 2. warning signs preceding angry behavior a. yelling b. throwing things c. threatening d. sarcasm e. pacing f. narrowed eyes g. clenched, raised fists h. withdrawal i. silent, sulking 3. strategies to respond to angry behavior a. be pleasant and supportive b. try to find cause of anger c. listen to client/resident d. observe body language e. think before speaking f. do not argue with client/resident g. speak in a normal tone of voice h. treat client/resident with respect i. respond promptly to requests j. report behavior to licensed nurse 4. strategies if anger escalates a. stay a safe distance away from client/resident b. provide for safety of other clients/residents			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
22. Identify signs of combative behavior. 23. Demonstrate strategies to respond to combative behavior.	c. leave client/resident alone if it is safe to do so d. summon help C. Combative behavior 1. common causes a. disease affecting the brain b. escalating anger or frustration c. medication side effects 2. combative behavior a. hitting b. shoving c. kicking d. throwing things e. insulting others 3. strategies to respond to combative behavior a. immediately call for help b. keep yourself and others at a safe distance from the client/resident c. stay calm d. be reassuring, speak calmly e. try to find the trigger for the behavior f. do not respond to insults g. do not hit back h. follow the direction of the licensed nurse i. when behavior is under control sit with client/resident to provide comfort, if instructed by licensed nurse j. report behavior to licensed nurse D. Inappropriate language 1. examples a. cursing b. name calling c. yelling			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
24. Demonstrate strategies to respond to inappropriate language. 25. Identify common causes of confusion and/or disorientation.	d. sexually suggestive language 2. strategies to respond to inappropriate language a. remain calm b. do not take the language personally c. do not argue with the client/resident d. politely tell client/resident that language is inappropriate e. do not respond emotionally to the language f. if appropriate, permit client/resident to have private time g. tell client/resident you will return when he has had opportunity to calm down h. report behavior to licensed nurse E. Confused/disoriented behavior 1. inability to think clearly a. disoriented to time, place and/or person b. unable to focus on a task c. temporary or permanent 2. common causes a. low blood sugar b. stroke c. head trauma/injury d. dehydration e. nutritional problems f. fever g. sudden drop in body temperature h. lack of oxygen i. medication side effects j. infection k. illness			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
26. Demonstrate strategies to respond to confused and/or disoriented behavior.	l. loss of sleep m. seizure n. constipation o. difficulty hearing 3. strategies to respond to confusion/disorientation a. do not leave client/resident alone b. stay calm c. provide quiet environment c. speak slowly, softly, simply d. introduce yourself every time you encounter client/resident e. reality orientation f. repeat directions as needed g. break ADL tasks into simple steps h. do not rush client/resident to complete tasks i. keep client's/resident's routine j. observe client's/resident's body language as well as listen to what client/resident is saying k. tell client/resident when you are leaving room l. encourage use of glasses and hearing aides m. allow client/resident to make choices n. encourage independence as appropriate o. report observations to the appropriate licensed nurse F. Inappropriate sexual behavior 1. examples a. sexual advances or comments b. inappropriate touching of staff c. inappropriate touching of			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
27. Demonstrate strategies to respond to inappropriate sexual behavior.	themselves d. removing clothing in public e. masturbation in public 2. common causes a. illness b. dementia c. confusion d. medication side effects 3. strategies to respond to inappropriate sexual behavior a. do not over-react b. be matter-of-fact c. distract the client/resident d. do not judge behavior e. if client/resident wants to talk, listen f. client/resident has right to express sexuality, provide privacy g. report inappropriate behavior to licensed nurse			
28. Identify the role of family/concerned others as a source of emotional support for the client/resident.	VII. Family/Concerned Others as Source of Emotional Support A. Role of family/concerned others on the health care team 1. provide love, support, self-esteem for client/resident 2. lessen loneliness of client/resident 3. participate in care planning, if desired by client/resident 4. participate in care decisions on behalf of client/resident 5. provide vital information to assist staff in planning appropriate behavior management plan as needed			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
29. Demonstrate strategies to meet the emotional needs of the client/resident and the family/concerned others. 30. Demonstrate strategies to encourage family/concerned others to provide emotional support to the client/resident.	B. Strategies to meet emotional needs of client/resident and family/concerned others 1. be kind and respectful 2. ask appropriate questions 3. answer questions from client/resident and family/concerned others promptly and appropriately 4. listen 5. provide competent care to gain confidence of family/concerned others and client/resident 6. create permanent assignments so client/resident and family/concerned others can develop relationship with caregiver 7. allow client/resident to contact family/concerned others as desired C. Strategies to encourage family/concerned others to provide emotional support to client/resident 1. invite family to care conferences as appropriate 2. send newsletters informing of up-coming events and special occasions 3. make space for family/concerned others to celebrate private events (birthday, anniversary, etc.) 4. be friendly and respectful to visiting family/concerned others 5. keep facility welcoming, clean and odor-free			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
31. Demonstrate appropriate clinical care of the aged. 32. Describe the effects developmental disabilities may have on the client/resident.	VIII. Providing Appropriate Clinical Care to the Aged and Disabled A. Clinical care for the aged 1. respect client/resident rights at all times 2. provide for privacy 3. maintain confidentiality 4. know each client/resident as an individual 5. provide care within the nurse aide scope of practice, as assigned 6. promote client/resident independence 7. keep client/resident free from pain and discomfort 8. follow nursing care plan 9. observe and report physical and/or behavioral changes to appropriate licensed nurse B. Developmental disabilities 1. definition a. present from birth b. restricts physical and/or mental ability c. client/resident has difficulty with language, mobility and/or learning 2. examples a. cerebral palsy – caused by oxygen deficit at birth b. autism c. mental retardation 3. functions limited by developmental disabilities a. affect b. self-care c. learning			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	d. mobility e. self-direction f. expressing language g. expressing understanding			
33. Identify various physical disabilities the nurse aide may find in a long-term care facility.	C. Physical disabilities 1. examples a. visual impairment b. hearing impairment c. amputee d. cerebral vascular accident (CVA/stroke) 2. functions limited by physical disability a. depends on part of the body affected			
34. Demonstrate appropriate clinical care of the disabled.	D. Guidelines for clinical care for the disabled 1. treat as adults regardless of behavior 2. praise and encourage 3. be patient 4. maintain privacy 5. maintain confidentiality 6. keep free from pain and discomfort 7. encourage client/resident independence 8. encourage client/resident to make personal choices 9. help teach ADLs as appropriate 10. repeat words and directions as needed 11. allow time to process what you have said 12. encourage participation in restorative care 13. follow nursing care plan 14. observe and report any physical			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. guidelines for caring for client/resident recovering from a CVA i. encourage independence by using assistive devices as appropriate ii. promote self-esteem iii. allow client/resident time to respond by providing ample time for tasks iv. assist with range of motion to maintain muscle tone and joint mobility v. be aware of changes in or loss of sensation when providing or assisting with personal care vi. assist with nutrition and fluid intake as appropriate to maintain weight and avoid constipation vii. do not refer to a "bad" body part viii. place food in the strong or unaffected side of the mouth when feeding client/resident ix. keep communication simple and use a communication board if appropriate x. if client/resident forgets about paralyzed body part, gently remind him when transferring or repositioning client/resident xi. reposition client/resident q2hrs to prevent pressure sores and contractures			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	xii. be aware client/resident emotions can suddenly change xiii. encourage client/resident progress xiv. encourage client/resident to socialize and participate in activities d. notify appropriate licensed nurse of the following i. change in level of consciousness ii. change in ability to use a body part iii. change in degree of sensation iv. signs of dehydration v. weight loss vi. signs of depression 2. Parkinson's Disease a. resident progressively deteriorates b. signs and symptoms i. uncontrollable tremors ii. mask-like facial expression iii. drooling iv. pill-rolling v. rigid muscles vi. shuffling gait vii. stooped posture c. guidelines for caring for client/resident with Parkinson's Disease i. assist with ambulation to prevent falls ii. when ambulating, encourage resident to stand as straight as possible and to pick up his			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
5. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	feet iii. allow client/resident ample time to complete simple tasks iv. assist with ADLs as appropriate v. provide assistive devices to help with eating vi. encourage socialization and participation in activities to prevent depression d. notify the appropriate licensed nurse of the following i. severe trembling ii. severe muscle rigidity iii. mood swings iv. sudden incontinence v. dehydration vi. signs of depression 3. seizures a. caused by a short-circuit in brain's electrical pathways i. head trauma ii. tumor in the brain iii. high fever iv. alcohol and/or drug abuse v. deficiency of oxygen to the brain at birth b. signs and symptoms i. change in level of consciousness ii. tonic-clonic muscle movements iii. staring c. guidelines for care of the client/resident having a seizure			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse .	i. lower client/resident to floor and protect the head from injury ii. watch breathing, turn client/resident on his/her side to help keep airway open if needed iii. allow the rest of the body to move iv. do not attempt to put anything in resident's mouth v. when seizure is finished position resident on side in the recovery position vi. when resident recovers assist into clean, dry clothes if appropriate vii. be supportive of resident to promote self-esteem viii. notify licensed nurse immediately a) report time seizure began b) how long it lasted c) describe seizure 4. multiple sclerosis (MS) a. progressive disorder that affects the nervous system's ability to communicate with muscles and control movement b. occurs in young adults most often c. signs and symptoms i. numbness and tingling ii. muscle weakness iii. extreme fatigue iv. tremors v. decreased sensation in			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
7. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	extremities vi. blurred or double vision vii. poor balance viii. difficulty walking because the feet drag ix. bowel and/or bladder incontinence x. paralysis in late stages of disease d. guidelines for caring for the resident with MS i. assist with ambulation to prevent falls ii. allow resident ample time to complete tasks and ADLs iii. offer frequent rest periods during tasks and ADLs iv. turn, reposition, and provide skin care q2h to prevent pressure sores v. assist with range of motion to maintain muscle tone and joint mobility vi. encourage socialization and participation in activities to prevent depression e. notify the appropriate licensed nurse of the following i. skin that is red, pale or looks like the beginning of a pressure sore ii. joints that do not move as easily as they did iii. complaints of burning on urination, frequency of urination, urine that is concentrated or foul-smelling			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iv. change in level of consciousness v. signs of depression 5. head and spinal cord injuries a. causes i. concussion – banging injury to the brain ii. accidents b. sign and symptoms i. headache ii. unequal pupils iii. drowsy iv. seizure v. change in level of consciousness c. guidelines for care of the client/resident with a head or spinal cord injury i. turn, reposition and give skin care q2h to maintain skin and prevent pressure sores and contractures ii. perform range of motion exercises on a regular basis iii. encourage as much independence with ADLs as appropriate iv. encourage hydration v. provide assistive devices as necessary to promote independence and self-esteem vi. follow bowel and bladder schedule vii. encourage client/resident to socialize and participate in activities to prevent depression			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
8. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 9. Explain the anatomy and physiology of the eye. 10. Describe age-related changes seen in the eye.	d. report to the appropriate licensed nurse the following i. skin that looks as though a pressure sore is forming ii. joints that do not move as easily as they did iii. complaints of burning on urination, frequency of urination, urine that is concentrated or foul smelling iv. change in level of consciousness v. signs of depression D. The eye 1. organ of sight a. sclera – white of the eye b. cornea – clear part of sclera that allows light to enter into the eyeball c. lens – clear structure that refracts (bends) the light to focus on the retina d. retina – inner-most part of the eyeball i. contains receptors (rods and cones) that convert light into nerve impulses that travel to the brain where the impulses are processed 2. effects of aging on the eye a. decreased number of receptors in the retina b. lens becomes cloudy and opaque c. lens becomes less flexible, unable to properly focus the light on the retina			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
11. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	d. decrease in tear production 3. common disorders of the eye a. conjunctivitis (pink eye) i. infection and inflammation of the eyelid ii. signs and symptoms a) eye is red, itchy b) eye tears a lot c) white or yellow discharge from the eye iii. guidelines for caring for the client/resident with pink eye a) wash hands before and after caring for the client/resident b) keep your hands away from your face and eyes c) encourage client/resident to avoid touching or rubbing his eyes and to use a tissue if he must iv. report the following to the appropriate licensed nurse a) discharge from eyes b) complaint of burning or itching in the eyes b. cataracts i. lens becomes cloudy preventing light from entering into the eye and decreasing vision ii. treated by surgery to remove the lens and replace it with an artificial lens iii. guidelines for caring for the client/resident with a cataract			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	a) provide extra light in room or when performing tasks such as reading b) do not sit facing a bright window, turn and sit with back toward window c) encourage independence d) assist with ADLs as appropriate c. glaucoma i. increased pressure inside the eye a) can lead to blindness if not treated ii. signs and symptoms a) decreased vision b) nausea/vomiting c) seeing "halo" around lights d) blurred vision d. age-related macular degeneration (AMD) i. receptors in center of retina are destroyed a) resident can only see the periphery of the field of sight			
12. Demonstrate an understanding of the visually impaired client/resident. 13. Respond appropriately to the behavior of the visually impaired client/resident.	4. guidelines for caring for the client/resident with vision impairment a. encourage use of their glasses b. check glasses daily to assure they are clean i. wash glasses with warm water and dry with soft towel; never dry with a paper towel c. knock before entering client's/resident's room			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
14. Explain the anatomy and physiology of the ear.	d. identify yourself whenever enter client's/resident's room e. announce to client/resident when you are leaving client's/resident's room f. leave furniture where client/resident knows where it is g. use numbers of a clock to tell client/resident where an item or food is located on the plate h. when assisting client/resident to ambulate, walk slightly ahead of client/resident and allow client/resident to hold your arm or elbow i. report to appropriate licensed nurse glasses that need to be repaired E. The ear 1. anatomy and physiology of the ear a. outer ear i. tympanic membrane – ear drum ii. cerumen – ear wax b. middle ear i. equalizes air pressure ii. 3 small bones – malleus, incus and stapes c. inner ear i. cochlea – contains receptors for hearing ii. vestibule iii. semicircular canals – help keep our balance 2. function of the ear a. hearing b. balance			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
15. Describe age-related changes seen in the ear. 16. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	3. effects of aging on the ear a. tympanic membrane becomes stiff b. 3 small bones don't vibrate as easily c. sensory receptors in cochlea decrease d. decreased hearing 4. common disorders of the ear a. otitis media i. infection of the middle ear ii. signs and symptoms a) ear pain b) fever c) discharge from the ear d) difficulty hearing iii. report to appropriate licensed nurse the following a) discharge from the ear b) complaints of ear pain c) complaints of difficulty hearing d) fever b. Meniere's Disease i. disease of the inner ear ii. signs and symptoms a) dizzy b) tinnitus – ringing in the ears c) temporary hearing loss d) nausea/vomiting iii. guidelines for care of client/resident with Meniere's Disease a) lie down b) keep eyes from moving c) allow resident ample time			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	to complete ADLs c. deafness i. conductive hearing loss – sound waves prevented from reaching receptors in cochlea ii. sensorineural hearing loss – receptors unable to transmit nerve impulses or to receive stimuli 5. hearing aids a. battery operated device to amplify sound b. very expensive, handle with care c. guidelines for caring for hearing aids i. treat with care ii. turn off when not in use iii. store in labeled container in a cool, dry place iv. check batteries frequently to ensure they are in working order v. do not get batteries wet vi. remove hearing aid before bathing, showering or shampooing hair vii. report to licensed nurse dead batteries, hearing aid that need repair 6. guidelines for caring for the client/resident with hearing impairment a. reduce or eliminate background noise b. encourage client/resident to wear hearing aid and verify that hearing aid is turned on			
17. Demonstrate an understanding of the hearing impaired client/resident. 18. Respond appropriately to the behavior of the hearing impaired resident.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. check that batteries for hearing aid are functional d. face client/resident when speaking e. use note pad to write important directions f. consider learning sign language II. Cognitive Impairment – Memory Care A. Introduction 1. inability to think, to remember or to reason 2. causes a. delirium – temporary confusion b. depression c. dementia 3. dementia in long-term care a. brain atrophies, nerve fibers become tangled and covered with a sticky protein b. progressive c. not reversible d. there is no cure e. many causes i. brain injury ii. AIDS iii. prolonged substance abuse iv. CVA v. Parkinson's Disease vi. Alzheimer's Disease (AD) 4. types of dementia a. over 100 different types b. vascular dementia – may occur after a stroke due to interruption of blood supply i. symptoms of impaired judgment and problems			
19. Define the terms used with cognitive impairment.				
20. Define the various types of dementia.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
21. Discuss the three stages of Alzheimer's Disease.	planning, concentrating and thinking c. dementia with Lewy bodies – less common i. symptoms of memory loss, thinking problems, visual hallucinations, muscle rigidity d. Alzheimer's Disease - most common type B. Alzheimer's Disease (AD) 1. three (3) stages a. stage 1- early/mild i. short-term memory loss ii. disorientated to time iii. loses interest in work and hobbies iv. unable to concentrate v. decreased attention span vi. mood swings vii. rude behavior viii. tends to blame others ix. poor judgment x. poor personal hygiene and safety awareness b. stage 2 - middle/moderate i. increased disorientation ii. increased memory loss – may forget family and friends iii. slurred speech iv. difficulty finding the right words v. difficulty following directions vi. loses ability to read, write or do math vii. unable to perform own ADLs without assistance viii. unable to recognize common			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	items like a comb or eating utensils ix. becomes incontinent x. restless, wanders, paces, sundown syndrome xi. difficulty sleeping xii. poor impulse control – inappropriate language, sexually aggressive xiii. hallucinations (experiences sensations that are not real) and/or delusions (false ideas about who one is or what is going on around them) c. stage 3 – late/severe i. total disorientation to time, place and person ii. total dependence on others for care iii. completely incontinent iv. verbally unresponsive v. confined to bed, unable to walk vi. unable to recognize family or self vii. difficulty swallowing and eating viii. seizures ix. coma x. death C. Behaviors associated with dementia 1. wandering or pacing a. causes i. over-stimulating environment ii. feeling scared or lost iii. looking for someone or something			
22. Demonstrate an understanding of the behavior of the cognitively impaired client/resident.				

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
26. Demonstrate appropriate responses to a client/resident experiencing catastrophic reactions. 27. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 28. Define pillaging, rummaging, and hoarding. 29. Demonstrate appropriate responses to a client/resident experiencing pillaging, rummaging and/or hoarding.	iii. over-stimulation in environment iv. pain or discomfort v. hunger or need to toilet c. appropriate responses to catastrophic reactions i. remove triggers ii. use calming techniques iii. do not leave the client/resident alone iv. block blows v. never hit back vi. stay out of reach vii. protect yourself and others viii. call for help ix. notify licensed nurse immediately 5. pillaging, rummaging and/or hoarding a. pillaging – taking items that belong to someone else b. rummaging – going through drawers, closets, personal items that belong to oneself or to others c. hoarding – collecting more items than one needs and never throwing anything away d. appropriate responses to pillaging, rummaging and/or hoarding i. do not judge clients/residents – these behaviors are out of their control ii. label all of client/resident belongings			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
30. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 31. Demonstrate appropriate responses to a client/resident experiencing sundowning. 32. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	iii. check hiding places periodically iv. notify family so they are aware of behavior v. set aside special drawer for rummaging or hoarding vi. notify licensed nurse immediately 6. sundown syndrome a. client/resident becomes restless and agitated in late afternoon, evening or night b. causes i. hunger ii. fatigue iii. change in routine iv. new situation c. appropriate responses to sundowning i. provide adequate lighting before it gets dark ii. avoid stressful situations in afternoon or evening iii. discourage daytime naps iv. follow a bedtime routine v. plan calming activity just before bedtime vi. eliminate caffeine from diet vii. give soothing back rub viii. redirect behavior to a calm activity ix. maintain daily exercise routine x. notify licensed nurse of behavior			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
33. Demonstrate appropriate responses to a client/resident experiencing perseveration. 34. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 35. Demonstrate appropriate responses to a client/resident experiencing inappropriate social behavior. 36. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	7. perseveration a. repeat words, phrases or questions over and over again b. may repeat same activity over and over again c. appropriate responses to perseveration i. remember that client/resident is unaware of behavior ii. respond each time to a question iii. remain calm iv. do not attempt to silence or stop client/resident v. redirect client/resident to another activity vi. notify licensed nurse of behavior 8. inappropriate social behavior a. cursing, yelling b. banging on furniture, slamming doors, etc. c. causes i. pain ii. constipation iii. frustration iv. desire for attention d. appropriate responses to inappropriate social behavior i. remain calm ii. speak slowly, simply, softly iii. try to determine cause of the behavior iv. report behavior to licensed nurse			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
37. Demonstrate appropriate responses to a client/resident displaying inappropriate sexual behavior. 38. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 39. Demonstrate strategies for communicating with the cognitively impaired client/resident.	9. inappropriate sexual behavior a. removing clothing, inappropriate touching of self or others b. causes i. client/resident is hot ii. need to toilet iii. attempting to remove soiled clothing iv. pleasant sensation c. appropriate responses to inappropriate sexual behavior i. stay calm and professional ii. try to find reason for behavior iii. direct client/resident to private area iv. distract client/resident v. report behavior to licensed nurse D. Strategies for communicating with the cognitively impaired client/resident 1. always introduce yourself to Client/resident 2. be careful with touching client/resident, as this may frighten or upset client/resident 3. maintain eye contact when speaking with client/resident 4. allow client/resident ample time to respond 5. speak slowly, simply, softly 6. reduce environmental noise 7. give directions one at a time, not a list of directions 8. repeat directions and answers as often as needed 9. if client/resident does not seem to			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	understand what you are saying, try using different words 10. watch for body-language clues that indicate what client/resident needs or is trying to say 11. always describe what you are doing 12. break tasks into simple steps 13. use pictures or a communication board 14. post reminders such as calendars, signs, activity boards, pictures 15. frequently offer praise 16. if language is offensive, ignore it or gently try to redirect client/resident to another activity 17. do not talk to or about client/resident as though he is a child 18. use validation therapy a. acknowledge the client's/resident's reality b. do not argue with client/resident 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 1. bathing a. schedule bathing when client/resident is least agitated b. adhere to the schedule c. gather all supplies before beginning procedure d. use sponge bath if client/resident becomes upset with tub bath or			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	shower e. have bathroom warm and well-lit f. make sure water is warm g. provide for privacy and safety h. encourage independence by giving client/resident washcloth i. explain everything you are doing j. be calm and reassuring throughout procedure 2. grooming and dressing a. assist with grooming to maintain self-esteem and dignity b. use clothing that opens in the front, has elastic waistbands, Velcro instead of buttons c. choices may agitate client/resident; therefore, do not give client/resident too many choices when selecting clothes; may be best to offer only one outfit to wear 3. toileting a. establish toileting schedule and adhere to it b. toilet q2h or more often if necessary c. toilet before meals and before bedtime d. place sign on bathroom door so client/resident will recognize it e. keep bathroom lit f. assist client/resident to clean self after toileting g. change client's/resident's clothing if they become soiled			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	h. keep skin clean and dry i. document bowel movements j. reassure family and friends if they are upset by client's/resident's incontinence k. encourage fluid intake to avoid dehydration 4. eating a. establish a meal schedule and adhere to it b. encourage independence at mealtime with the use of assistive devices c. dining area should be well-lit, pleasant, with a minimum of background noise (turn off TV) d. seat client/resident with others to promote socialization e. food should look pleasant and appealing f. food and drink should not be too hot or too cold g. keep table setting simple i. no patterns on the tablecloth or plates ii. do not put unnecessary plates, glasses or silverware on the table h. finger foods are acceptable i. offer plenty of fluids j. give simple directions k. use cueing to give client/resident idea of how to feed self l. allow ample time for client/resident to feed self m. give resident smaller meals at more frequent intervals if			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
41. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 42. Demonstrate methods to reduce the effects of cognitive impairment.	wandering interferes with meals n. report to appropriate licensed nurse i. choking or difficulty swallowing ii. changes in intake and/or output 5. general health issues a. assist to wash hands at frequent intervals b. be alert to risk for falls and reduce risks for client/resident c. be diligent with skin care d. observe for non-verbal cues regarding pain or discomfort and report to appropriate licensed nurse e. promote self-esteem by encouraging independence in activities where possible f. provide daily/weekly calendar g. encourage participation in activities and socialization h. reward behavior with smiles, hugs and praise 6. therapies used with cognitively impaired clients/residents a. reality orientation i. calendars ii. clocks iii. signs iv. lists b. validation therapy i. acknowledge client's/resident's reality ii. do not argue iii. redirect activity to more			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
43. Identify strategies the nurse aide can use to keep a positive, empathetic attitude when caring for clients/residents with cognitive impairment. 44. Define the anatomy of the endocrine system.	appropriate behavior c. reminiscence therapy i. reminds resident of past experiences and people d. re-motivation therapy i. promote self-esteem, socialization ii. groups to focus on specific topic F. Care for the caregiver 1. do not take behavior personally 2. consider what client/resident is feeling 3. work with client/resident as they are today 4. work as a team making sure everyone follows the person-centered care plan 5. work with and support family members 6. take care of yourself III. Diabetes Mellitus A. The endocrine system 1. regulates many body functions 2. made up of glands that secrete hormones directly into the bloodstream 3. glands a. pituitary gland – 7 hormones including growth-stimulating hormone b. thyroid –controls metabolism c. parathryoids – regulates body's use of calcium d. thymus – regulates immune system			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
45. Describe age-related changes seen in the endocrine system. 46. Discuss common disorders of the endocrine system, including their signs and symptoms. 47. Describe the difference between Type 1 and Type 2 diabetes mellitus.	e. adrenals – regulate BP and fight vs. flight f. pancreas – produces insulin to regulate blood sugar g. ovaries – female sex hormones h. testes – male sex hormones 4. age-related changes in the endocrine system a. levels of hormones decrease i. menopause in women b. levels of insulin decrease c. body handles stress less efficiently 5. common disorders of the endocrine system a. diabetes mellitus b. hypothyroidism B. Diabetes mellitus (DM) 1. insulin a. the key that opens the door to allow glucose to enter the cell b. cells use glucose for energy/food c. without glucose, cells will die d. without insulin, glucose stays in the blood and cannot get into the cells 2. type 1 – insulin dependent diabetes mellitus (IDDM) a. pancreas produces little or no insulin b. must have outside source of insulin (injection) 3. type 2 – non-insulin dependent diabetes mellitus (NIDDM) a. pancreas produces insulin but the body has become resistant to			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
48. Identify signs and symptoms of diabetes mellitus. 49. Discuss hypoglycemia, including the signs and symptoms and the care of the client/resident experiencing hypoglycemia.	its own insulin b. may take oral hypoglycemic tablet c. may be treated with diet and exercise d. may require injection of insulin 4. signs and symptoms of DM a. increased thirst b. increased urination c. increased hunger d. fatigue e. elevated blood sugar f. blurred vision g. slow-healing cuts or sores h. numbness/tingling in hands/feet i. increased number of infections 5. complications of DM a. hypoglycemia i. signs a) change in level of consciousness b) skin cool and clammy c) complaint of headache d) shaky e) nauseated ii. causes a) skipped a meal b) too much exercise c) received too much insulin iii. notify licensed nurse immediately iv. if conscious, give orange juice or peanut butter crackers or follow facility policy b. hyperglycemia i. signs a) skin warm and flushed			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
50. Discuss hyperglycemia, including the signs and symptoms and the care of the client/resident experiencing hyperglycemia. 51. Describe long-term complications of diabetes mellitus. 52. Discuss guidelines for the nurse aide caring for the client/resident with diabetes mellitus.	b) breath has fruity smell c) blood sugar is elevated ii. causes a) over-eating b) not enough exercise c) did not receive enough insulin iii. notify licensed nurse immediately c. damage to blood vessels i. damage to blood vessels in the retina leads to blindness ii. damage to blood vessels in the kidneys leads to kidney failure and dialysis iii. damage to blood vessels in the feet and legs leads to amputation d. damage to nerves i. numbness and tingling in hands and feet ii. loss of sensation in fingers and toes 6. guidelines for the care of the client/resident with DM a. maintain meal schedule b. encourage client/resident to follow diet and not eat concentrated sweets c. monitor blood sugar per facility policy d. inspect client's/resident's feet and toes every day for blisters, reddened areas e. client/resident should always wear well-fitting shoes when ambulating			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
53. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	f. if client/resident has loss of sensation in hands, assist with activities such as eating, writing or holding objects g. if client/resident has loss of sensation in feet, assist with ambulation h. never cut client's/resident's toenails; only a podiatrist can do this i. always dry between client's/resident's toes after washing feet 7. what to report to the appropriate licensed nurse a. a missed meal b. complaints of increased thirst c. complaints of increased urination, particularly at night d. complaints of blurred vision e. change in level of consciousness f. skin that is cool and clammy g. skin that is warm and flushed h. observing client/resident eating concentrated sweets between meals i. cuts, bruises, sores that do not seem to be healing j. blisters, sores, redness, cracks on/between toes or on feet k. increased incidence of infections C. Hypothyroidism 1. description a. lack of thyroid hormone b. causes body metabolism to slow down			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	5. discharge planners 6. nurses 7. nurse aides 8. resident 9. resident's family D. Goals of rehabilitation team 1. assist resident to maintain and/or regain ability to perform ADLs 2. promote resident independence 3. assist resident adaptation to disability 4. prevent complications of disability E. Restorative care 1. actions of health care workers 2. goals a. assist resident to maintain health, strength, function b. increase independence 3. includes a. treatment b. education c. prevention of complications II. Guidelines of Rehabilitation and Restorative Care A. Understand diagnosis and disability 1. be aware of resident's limitations 2. know resident's abilities and strengths 3. follow person-centered care plan B. Display patience with resident and significant others 1. small improvements may be significant 2. respond appropriately and offer praise			
3. Describe restorative care.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Discuss the role of the nurse aide in rehabilitation and restorative care. 5. Describe ways to teach, with supervision, a resident to participate in self-care. 6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	C. Display positive attitude 1. staff sets the tone for the day 2. show support, encouragement, and patience D. Listen to resident's thoughts and feelings - emotional needs are important E. Provide for resident privacy 1. avoids distractions 2. allows resident to practice new skills without an audience 3. promote resident independence within the resident's level of functioning - accomplishing a task by himself improves resident self-esteem F. Promote personal choice - supports self-esteem G. Encourage physical activity 1. helps prevent complications of disability 2. encourages social interaction H. Be aware resident may have setbacks I. Report the following to appropriate licensed nurse 1. lack of motivation 2. signs of withdrawal or depression 3. change in ability, both increased or decreased 4. change in resident strength, both increased and decreased 5. change in ability to perform range of motion 6. changes in pain level, or signs that resident is in pain			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
7. Describe reasons why resident may not want to participate in self-care. 8. Identify assistive devices the nurse aide may use for transferring residents, including bed to chair and bed to stretcher.	III. Methods to Teach Resident to Participate in Self-Care Program A. Nurse aide project positive attitude 1. be enthusiastic 2. nurse aide's attitude will encourage resident B. Establish reasonable goals with resident's participation 1. what does resident want to achieve? 2. how will resident work toward goal? 3. how will resident know when goal has been achieved? 4. begin at resident's current level of function 5. use cueing, mirroring, behavior reinforcement C. Reasons resident may refuse 1. fear of hurting themselves 2. fear of failure 3. feeling of hopelessness 4. not understanding why self-care is helpful 5. not understanding why self-care is necessary IV. Assistive Devices A. Definition 1. devices to make specific tasks easier 2. promote independence B. Transferring resident 1. transfer belt (gait belt) for ambulation and transfer bed to wheelchair 2. slide board to transfer resident			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	from bed to stretcher 3. mechanical lift (manual or electronic) to transfer resident from bed to chair 4. U.S. Department of Labor Fair Labor Standards Act (FLSA) Hazardous Occupation Order No. 7 a. prohibits minors under 18 from operating or assisting in the operation of most power-driven hoists, including those designed to lift and move residents 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 1. transfer belt (gait belt) 2. cane a. C-cane: handle in shape of a "C" b. quad cane: has 4 rubber-tipped feet 3. walker- provides more support than cane 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 1. check assistive device for any defect or damage prior to use 2. resident should always wear non-skid shoes that fit correctly when ambulating 3. clothing should fit properly, not be too long or too loose-fitting			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	4. promptly clean spills and clutter from floors where resident will be walking 5. encourage resident to stand as straight as possible when walking 6. do not rush resident 7. do not use walker to hang items 8. resident should use cane in strong hand 9. when assisting resident to walk, stay near resident on the weak side 10. have chair available for resident to use if he experiences pain or discomfort while ambulating 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 1. plate guard 2. utensils with built-up handles 3. utensils with curved handles 4. utensils that have a Velcro strap to hold utensil in resident's hand 5. sippy cup 6. cup holders			
12. Identify assistive devices the nurse aide may use to assist the resident to dress.	F. Assistive devices for dressing/grooming 1. zipper pulls 2. Velcro fasteners instead of buttons 3. long handled shoe horn 4. long-handled graspers 5. button hole hooks 6. elastic shoelaces 7. denture brush 8. long handled bathing sponge			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Define terms associated with range of motion. 14. Describe benefits of exercise.	V. Range of Motion Exercises A. Definitions 1. abduction - move away from the body's midline 2. adduction - move toward the body's midline 3. extension - straighten the body part 4. flexion - bend the body part 5. dorsiflexion - bend body part backward 6. pronation - turn body part downward 7. rotation - turn the joint 8. supination - turn body part upward 9. contraction a. joint remains in permanently bent position b. caused by lack of movement c. prevented by i. proper positioning ii. range of motion (ROM) exercises to joint B. Benefits of exercise 1. increase muscle strength 2. maintain joint mobility 3. prevent contractures 4. improve coordination to help prevent falls 5. improve self-image to prevent depression 6. maintain/reduce weight 7. improve circulation to prevent leg ulcers C. Range of motion exercises 1. active range of motion exercise (AROM) - resident exercises own joints without assistance			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	2. passive range of motion exercise (PROM) – staff exercises resident's joints without assistance from the resident 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 range of motion (PROM) to upper extremity.	E. Perform passive range of motion (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 F. Signs to stop or withhold range of motion exercises 1. pain in the joint 2. red, swollen joint G. Ways to maintain range of motion 1. therapeutic positioning to maintain good body alignment 2. use of positioning devices 3. range of motion exercises on a 4. regular schedule			
17. Discuss the guidelines for range of motion exercises.	H. Guidelines for range of motion exercises 1. follow person-centered care plan 2. use proper body mechanics when performing range of motion exercises to protect your body			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	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) 4. support the extremity above and below the joint during range of motion 5. do not exercise joint that is bandaged or has dressing, cast, IV tubing 6. never exercise a joint that is red, bruised, has open sore, draining fluid 7. provide for privacy when doing range of motion exercises 8. do not exercise joint to point of discomfort -hyperextension can cause damage to joint 9. maintain resident in good body alignment 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 1. joint that is red, swollen, painful, draining 2. complaints of pain during range of motion exercise 3. lack of motivation 4. signs of withdrawal or depression 5. change in ability, both increased or decreased 6. change in resident strength, both increased and decreased 7. change in ability to perform range			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
19. Identify positioning devices the nurse aide may use when turning and position residents in bed and in the chair.	of motion VI. Turning and Positioning in Bed and Chair A. Positioning devices 1. backrests a. pillow b. special wedge-shaped foam pillows c. provide support, comfort d. maintain proper body alignment 2. bed cradles/foot cradles a. keep sheets/blankets from pushing down on the resident's toes and feet 3. footboards a. padded boards or device placed against resident's feet to keep ankles and foot in proper alignment b. prevent foot drop 4. heel/elbow protectors a. padded protectors wrapped around foot and ankle (heel) or elbow and arm (elbow) b. prevents rubbing, irritation and pressure on the heel or elbow c. heel protector maintains proper body alignment for ankle d. heel protector prevents foot drop 5. abduction wedges - keep hips in proper position after hip surgery 6. trochanter roll a. rolled blanket or towel placed on outside of leg b. prevent hip and leg from turning outward			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	7. handroll a. rolled washcloths placed in palm of hand b. keep hand and/or fingers in proper alignment c. prevents contractures of finger, hand or wrist B. Turning resident in bed 1. protects against problems of immobility a. blood clots in the legs b. pneumonia c. contractures d. depression e. urinary tract infection 2. prevents pressure sores - turn and reposition q2h around the clock 3. comfort 4. position resident on side - follow the procedure for "Positions on Side" in the most current edition of Virginia Nurse Aide Candidate Handbook 5. use positioning devices for proper body alignment and comfort C. Position resident in chair 1. feet on floor 2. hips touching back of chair 3. use positioning devices to maintain body alignment and comfort 4. place call bell within resident's reach			
20. Demonstrate positioning resident on his side. 21. Demonstrate positioning resident in a chair.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
22. Describe caring for and using prosthetic devices. 23. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	VII. Prosthetic and Orthotic Devices A. Prosthetic devices 1. definition - artificial replacement for legs, feet, arms or other body parts 2. examples a. artificial arm or leg b. artificial eye 3. caring for and using prosthetic devices a. handle with extreme care – they are very expensive b. follow instructions when applying and removing prosthesis c. assist resident as needed to apply or remove prosthesis d. follow person-centered care plan and manufacturer's instructions e. make sure skin is always clean and dry under prosthesis f. use special stockings under an artificial leg or arm g. if resident experiences phantom pain, be supportive h. do not react negatively to sight of anatomical stump or prosthesis 4. report the following to the appropriate licensed nurse a. redness, swelling of stump or extremity b. drainage, bleeding or sores of any kind on the stump or extremity			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
24. Describe caring for and using orthotic devices.	c. phantom pain, phantom sensation, stump pain d. decreased ability to move extremity e. cyanosis of any part of the extremity f. any difficulty applying or using prosthesis g. need repair or need to be changed B. Orthotic devices 1. definition a. device applied over a body part for support and protection b. keep joint in correct alignment c. improve function of body part d. prevent contractures of body part e. splints and braces 2. examples a. splints b. shoe inserts c. knee/leg braces d. surgical shoes e. elastic stockings 3. caring for and using orthotic devices a. do not immerse in water b. do not use hot water to clean c. clean with warm, damp cloth d. check braces and splints for wear and tear e. after removal wash elastic stocking in warm, soapy water every day f. gradually increase wearing time of device			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
30. Describe the process for bowel training. 31. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	16. be positive with success and understanding of accidents C. Guidelines for bowel training 1. identify pattern of elimination 2. establish schedule for use of bathroom 3. explain training schedule to resident 4. follow schedule consistently 5. provide diet that stimulates the bowels a. high in fiber b. fresh fruits and vegetables c. adequate hydration 6. provide exercise as tolerated 7. provide privacy when in the bathroom 8. provide encouragement 9. answer call bell promptly 10. do not rush resident 11. assist with change of clothing if accident occurs 12. be positive with success and understanding of accidents 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Explain the anatomy and physiology of the respiratory system.	I. Respiratory System A. Anatomy 1. airway a. mouth b. nasal cavities c. throat – pharynx d. voice box – larynx e. epiglottis – flap that closes off opening to trachea when resident swallows f. trachea – windpipe g. bronchi – 2 branches of the trachea i. one to right lung, one to left lung h. lungs i. where respiration occurs ii. exchanges carbon dioxide from the body for oxygen from the environment i. bronchioles j. alveoli – where gas exchange actually occurs k. inhalation – breathe air and oxygen into the lungs l. exhale – breathe out carbon dioxide B. Ventilation 1. diaphragm a. muscle separating chest from abdomen			

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iv. symptoms a) short of breath b) coughing c) difficulty breathing f. signs and symptoms of COPD i. coughing/wheezing ii. difficulty breathing (dyspnea) iii. short of breath especially during exercise iv. cyanosis v. complaints of chest tightness or pain vi. confusion vii. weakness viii. loss of appetite and weight ix. fear and anxiety g. guidelines for COPD i. use pillows to assist resident to sit up and lean slightly forward to facilitate breathing ii. plan periods of rest during ADLs to prevent resident from getting overly tired iii. practice good hand washing to protect resident from infections iv. encourage a healthy diet v. provide plenty of fluids to help keep resident well-hydrated vi. be supportive and calm if resident is anxious and fearful vii. provide trash can close to resident to help with appropriate disposal of used tissues			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
4. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	viii. if resident is receiving oxygen, follow instructions on use of oxygen h. report the following to the appropriate licensed nurse i. signs and symptoms of colds or the flu a) fever b) chills c) complaints of feeling achy ii. confusion iii. change in breathing patterns iv. shortness of breath on exertion v. change in color or consistency of sputum vi. complaints of chest pain or tightness vii. insomnia due to anxiety or fear 2. asthma a. chronic b. causes i. allergens ii. infection iii. cold air iv. environmental irritants or pollution v. obesity c. signs and symptoms i. wheezing ii. coughing iii. complaints of tightness in the chest iv. difficulty breathing			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
5. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse. 6. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	d. report the following to the appropriate licensed nurse i. changes in respirations and/or pulse ii. wheezing iii. shortness of breath iv. cyanosis v. complaints of chest pain or chest tightness 3. pneumonia a. acute inflammation of lungs b. cause i. infection – viral, bacterial or fungal ii. chemical irritant c. signs and symptoms i. high fever ii. chest pain during inhalation iii. coughing iv. difficulty breathing v. shortness of breath vi. chills vii. increased pulse viii. thick, colored sputum d. report the following to the appropriate licensed nurse i. changes in vital signs ii. complaints of difficulty breathing iii. complaints of chest pain or discomfort iv. unusual sputum production v. sputum that has a distinct color F. Oxygen therapy 1. administration of oxygen to improve oxygen levels in the body			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
7. Describe the use of various types of oxygen therapy equipment. 8. Discuss the guidelines for caring for the resident receiving oxygen therapy.	a. normal blood oxygen level is 95-100% b. residents with certain disease processes have different optimal blood oxygen levels 2. methods of delivery a. compressed air – green oxygen tank or in wall unit b. air condenser – connects to electrical outlet and pulls oxygen out of room air c. appliance i. nasal cannula – 2 nasal prongs and tubing that goes around the ears and cinches under the chin; tubing is attached to oxygen source ii. mask – mask fits over nose and mouth and attaches to tubing attached to oxygen source 3. oxygen is a medication a. requires physician's order b. ordered in liters/minute c. nurse aide may only observe and report administration of oxygen 4. guidelines for oxygen delivery a. ensure oxygen tubing is not on the floor b. no smoking can take place in same room as oxygen administration c. post "No Smoking" signs outside of room and in resident's room			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
9. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	d. any spark can cause a fire in presence of oxygen, including static electricity from wool, and from dry air in winter e. perform frequent skin care to areas in contact with oxygen equipment (under the nose, behind the ears) f. observe these areas for redness and drainage g. use water-based lubricant to keep nostrils and lips moist and to prevent skin cracking h. monitor oxygen delivery device frequently to assure resident is receiving correct amount of oxygen i. encourage activity as tolerated by resident j. provide emotional support to resident k. know where fire alarms and extinguishers are located l. report the following to the appropriate licensed nurse i. sores or crusty areas on or under resident's nose or ears ii. dry, red areas on skin in contact with oxygen tubing iii. shortness of breath iv. changes in respirations and/or pulse v. changes in respiratory patterns vi. changes in character or color of sputum vii. cyanosis			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Explain the anatomy and physiology of the circulatory system.	viii. complaints of chest pain or tightness II. Cardiovascular System A. Anatomy 1. blood a. red blood cells i. carry oxygen to the individual cells and carbon dioxide to the lungs b. white blood cells i. part of immune system ii. attack invading micro-organisms (infection) c. platelets - assist the blood to clot d. plasma- fluid portion of blood 2. heart a. pump that circulates blood throughout the body b. has 4 chambers i. right atrium – blood from the body enters heart through right atrium and flows into the right ventricle ii. right ventricle – blood goes from right ventricle to the lungs where carbon dioxide leaves the blood and is replaced with oxygen iii. left atrium – blood returns to the heart from the lungs and enters the left atrium iv. left ventricle – blood flows from the left atrium into left ventricle which pumps oxygen-rich blood to the			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	body 3. arteries a. arteries carry oxygen-rich blood to the cells b. exception is pulmonary arteries which carry deoxygenated blood from right ventricle to lungs 4. veins - carry deoxygenated blood from the cells back to the heart (right atrium) 5. capillaries a. connect arteries to veins at the cellular level b. where actual exchange of oxygen from the arteries to the cells and pick-up of carbon dioxide to return to the heart B. Functions of the circulatory system 1. blood a. carries oxygen, nutrients and chemicals to cells b. removes carbon dioxide and waste products from cells c. controls acidity of body d. controls body temperature e. fights infection and foreign bodies within the body 2. heart a. pumps blood to every cell in the body C. Effects of aging on the circulatory system 1. heart muscle weakens and pumps less effectively 2. blood vessels become clogged with cholesterol and clots and become			
11. Describe age-related changes seen in the circulatory system.				

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
12. Discuss common disorders of the circulatory system, including their signs and symptoms.	less efficient at circulating blood 3. blood vessels become less elastic 4. blood flow decreases D. Common disorders of the circulatory system 1. hypertension – high blood pressure a. follow current guidelines b. causes i. arteries become less elastic (hardening of the arteries) ii. arteries become more narrow iii. kidney disease iv. stress and/or pain v. side effect of medication c. signs and symptoms i. headache ii. blurred vision iii. dizziness d. if untreated i. may cause kidney damage ii. may cause rupture of blood vessel in the brain (cerebrovascular accident – CVA– stroke) e. treatment i. medication ii. diet with controlled sodium (salt) and/or fat intake 2. coronary artery disease (CAD) 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 b. heart muscle deprived of oxygen causes chest pain – angina			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
13. Discuss the guidelines for caring for the resident experiencing angina.	i. may occur with activity or at rest ii. described a) pressure/tightness in chest b) pain radiating down left arm c) pain in back, neck, jaw, shoulder iii. symptoms a) sweaty b) trouble breathing c) complexion pales d) cyanosis of lips, nail beds e) complaints of dizziness iv. guidelines for resident experiencing angina a) have resident lie down and rest b) notify licensed nurse immediately c) reduce stressors d) encourage rest periods during ADLs e) avoid large meals close to bedtime f) avoid exposure to weather extremes g) report to licensed nurse complaints of chest pain, shortness of breath that occurs with activity or at rest c. when muscle cells begin to die – myocardial infarction (MI or heart attack) i. area of the heart is permanently damaged			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
14. Discuss the guidelines for caring for the resident experiencing possible cardiac event.	ii. signs and symptoms are same as angina iii. guidelines for resident experiencing a possible cardiac event a) a medical emergency b) notify licensed nurse immediately c) have resident lie down d) remain calm and stay with resident e) remove constrictive clothing f) if resident becomes unresponsive, begin CPR g) report to licensed nurse complaints of chest pain, shortness of breath that occurs with activity or at rest 3. peripheral vascular disease (PVD) a. decreased blood supply to extremities (arms, hands, legs, feet) b. causes i. narrowed blood vessels ii. blood vessels less elastic iii. blockages in blood vessels iv. decreased amount of blood being pumped by heart v. inflammation of veins in legs c. signs and symptoms i. pain in legs when walking or during activity ii. pain in legs that remains after activity is stopped iii. cyanosis in hands and/or feet			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
15. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	iv. cyanotic nail beds v. extremities that are cool to touch vi. swelling of the hands and/or feet vii. sores on arms, hands, legs, feet that do not heal in expected time-frame d. report the following to the appropriate licensed nurse i. complaints of pain or discomfort in extremities with activity or at rest ii. change in skin color of extremities iii. change in temperature of extremities iv. change in pulse or blood pressure v. edema in feet and/or hands vi. increase in weight vii. urine output that is significantly less than intake viii. complaints of headache ix. complaints of blurred vision x. complaints of chest pain xi. change in level of consciousness 4. congestive heart failure (CHF) 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 b. signs and symptoms i. fatigue ii. swelling (edema) in hands and feet			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	iii. difficulty breathing iv. shortness of breath not relieved by rest v. persistent cough vi. decreased activity tolerance vii. increased pulse viii. irregular pulse ix. chest pain x. dizziness xi. change in level of consciousness xii. weight gain xiii. increased urination 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 i. include rest periods during ADLs ii. daily weights iii. record intake and output daily iv. follow care plan for diet and fluid intake v. use elastic stockings as ordered vi. position resident so breathing is comfortable			
17. Discuss the importance of reporting abnormal observations or changes to the appropriate licensed nurse.	d. report the following to the appropriate licensed nurse i. change in level of consciousness ii. change in activity tolerance iii. change in vital signs iv. shortness of breath with activity or at rest v. coughing and/or wheezing vi. weight gain vii. increase in urination			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
18. Discuss HIV/AIDS, including signs and symptoms and guidelines for care. 19. Discuss the guidelines for caring for the resident with HIV/AIDS.	viii. unusual swelling in hands, feet, legs III. Resident with AIDS (Acquired Immune Deficiency Syndrome) A. Description 1. human immunodeficiency virus (HIV) attacks immune system 2. damages or destroys cells of immune system 3. weakens and disables immune system B. Causes - exposure to HIV infected blood and/or body fluids C. Possible signs and symptoms 1. flu-like symptoms 2. swollen glands 3. headache 4. fever 5. weight loss 6. night sweats 7. difficulty breathing 8. cold sores 9. frequent infections of skin, respiratory system and mouth 10. change in mental status D. Guidelines for care of resident with HIV/AIDS 1. practice Standard Precautions and encourage resident and significant others to practice Standard Precautions 2. disinfect surfaces in resident's room and bathroom on a regular basis 3. discourage visitors who have infections or colds from visiting			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	4. observe resident's skin on regular basis 5. keep skin clean and dry 6. turn and reposition q2h 7. provide rest periods during ADLs 8. provide mouth care at frequent intervals 9. monitor vital signs 10. measure and record weight, intake and output 11. follow person-centered care plan 12. encourage independence as much as possible 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 1. change in appetite 2. weight loss 3. mouth sores 4. difficulty swallowing 5. changes in the skin 6. changes in vital signs 7. bleeding from any opening on the body 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 A. Definitions 1. tumor - abnormal growth of tissue 2. benign - slowly growing tumor that is easily treated; not malignant 3. malignant a. abnormal cells that do not function properly b. divide rapidly			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
22. Identify the American Cancer Society signs of cancer.	c. invade nearby tissue 4. cancer - abnormal cells growing in an uncontrolled manner 5. metastasis - cancer cells spread from their original location to a new location 6. biopsy - removal of a sample of tissue to test for cancer cells B. Risk factors for cancer 1. inheritance a. race b. gender c. family history 2. environmental factors a. history of smoking b. alcohol use c. exposure to chemical and food additives 3. lifestyle factors a. diet/obesity b. lack of exercise c. exposure to sun C. American Cancer Society signs of cancer 1. fever 2. fatigue 3. unexplained weight loss 4. pain 5. skin changes 6. new mole or change in existing mole/wart 7. change in bowel/bladder function 8. sore that does not heal/unusual bleeding/discharge 9. thickening in breast, scrotum 10. indigestion, difficulty swallowing 11. nagging cough or hoarseness			

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

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

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
28. Discuss care measures for the resident when death is imminent.	drink 6. difficulty swallowing 7. decreased muscle tone 8. decreased vision 9. change in level of consciousness 10. hallucinations 11. hearing is the last sense to decline E. Guidelines for meeting the physical needs of the dying resident 1. care of the skin a. turn and reposition q2hrs. b. keep skin clean and dry c. change soiled clothing and linen immediately 2. care of mucous membranes a. oral care q2h if needed b. moisten lips and mucous membranes as needed c. using warm, wet washcloth gently clean eyes of any accumulated crust d. apply water-based lubricant to nostrils if resident is receiving oxygen therapy 3. positioning a. use positioning devices to assure proper body alignment b. turn and reposition q2h c. notify licensed nurse of pain d. elevate head of bed if resident having difficulty breathing 4. comfort measures a. back rub b. soft music c. keep room well ventilated d. use soft lighting, adequate to see but not glaring			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	e. remove soiled linens and bedpans immediately f. encourage and assist family/significant others to visit g. do not leave resident alone h. remember that dying resident 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 1. do not isolate or avoid the dying resident 2. provide opportunity for dying resident to talk 3. be non-judgmental about resident and anything he tells you 4. allow resident to express his views on death and dying 5. respect resident's wishes for visits from spiritual leaders 6. provide privacy for resident and family/friends 7. maintain confidentially regarding anything resident and/or family shares 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 1. communicate what is happening to the resident 2. provide space for family members to be by themselves 3. provide time for family members to be with the resident 4. permit family members to care for			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
31. Demonstrate proper procedure for postmortem care.	dying resident, if they so desire 5. allow family members to verbalize feelings in a non-judgmental environment 6. permit family to follow religious rituals of their choice 7. do not be afraid to show your own emotions H. Postmortem care 1. provide for privacy 2. explain procedure to family and request they leave the room 3. gently close the eyes 4. bathe body and comb hair 5. place in clean gown or pajamas 6. place in proper body alignment 7. elevate head slightly 8. make resident's room neat and tidy for the family 9. turn lights down for family 10. provide privacy and time for family to grieve 11. prepare body for funeral home to transport 12. follow facility policy for handling and removal of personal items 13. have a witness for any personal items that is given to a family member 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Describe preparation of resident room prior to admission. 2. Identify areas of orientation that must be provided to the resident during admission.	I. Admission to the Long-Term Care Facility A. Prepare the room 1. admission pack a. wash basin b. bedpan/urinal c. toiletry items d. water pitcher/cup 2. assemble vital sign equipment a. stethoscope b. BP cuff c. thermometer 3. open curtains/blinds 4. adjust room temperature 5. bed in low position with wheels locked B. Orientation to facility 1. introduce yourself, including your title 2. identify how you will work with resident providing care 3. introduce roommate, if there is one 4. be friendly, polite 5. include family and significant others 6. review resident rights 7. review facility rules a. meal times b. smoking policy c. visitation policy d. how to complete menu 8. tour facility a. dining area			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Discuss the importance of reporting abnormal observations or findings to the appropriate licensed nurse. 7. Discuss important factors in preparing resident for transfer from his room and/or facility. 8. Demonstrate preparing resident for transfer. 9. Discuss care of the resident room after transfer has occurred.	12. document vital signs, height, weight 13. report any abnormal findings to appropriate licensed nurse II. Transfer of resident A. Prepare resident 1. inform resident of transfer as soon as you know 2. assist resident to prepare for moving belongings 3. accompany resident to new unit 4. provide report to new unit personal a. vital signs b. condition of skin c. mobility d. ability to communicate 5. introduce resident to new unit staff 6. assist resident to unpack belongings on new unit 7. make resident comfortable 8. have call bell in easy reach 9. wash hands 10. document procedure 11. report any changes in the resident to the appropriate licensed nurse B. Care of room after transfer in accordance with facility policy 1. strip bed 2. place all linen, used and unused in laundry hamper 3. inform housekeeping service that room is empty and ready for terminal cleaning			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
10. Identify responsibilities of nurse aide during the discharge of the resident. 11. Demonstrate discharge of the resident, including care of personal belongings and assisting to transport to the pick-up area.	III. Discharge A. Responsibilities of nurse aide 1. explain what you will be doing to resident 2. provide for privacy 3. compare admission resident inventory sheet to items being packed for discharge 4. carefully assist resident/family to pack belongings 5. assist resident to dress in personal clothing 6. assist resident to say "Good-byes" to staff 7. using wheelchair, take resident to area where family vehicle is waiting 8. lock wheels on wheelchair 9. assist resident into vehicle, engage seatbelt and close door 10. return to unit with wheelchair 11. wash hands 12. document procedure B. Care of room after discharge 1. strip bed 2. place all linen, used and unused in laundry hamper 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	INSTRUCTION TIME (classroom, skills lab, clinical)
1. Discuss professional behaviors of the nurse aide.	I. Professional Behaviors of a Nurse Aide A. Positive attitude B. Maintain confidentiality and privacy 1. resident information 2. staff information C. Be polite and cheerful D. Listen to residents E. Perform assigned duties 1. in timely manner 2. to the best of your ability F. Do not give or accept money or gifts from residents G. Follow facility policies and procedures H. Take directions and constructive criticism I. Practice good personal hygiene J. Dress neatly and appropriately K. Be punctual to work L. Be respectful 1. to residents 2. to staff 3. to visitors M. Be dependable 1. report to work on assigned shifts 2. call in following facility policy if you will be late or are sick 3. complete assignments without having to be prompted 4. if you volunteer to perform a task,			

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

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	1. be honest at all times 2. protect resident's/resident's privacy 3. keep staff information confidential 4. report abuse or suspected abuse of residents 5. follow the care plan and your assignments 6. report mistakes you make immediately 7. do not perform tasks outside your scope of practice 8. report all resident observations and incidents to the licensed nurse 9. document accurately and promptly according to your facility policy 10. follow rules about safety and infection prevention 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 A. Report conflicts to appropriate licensed nurse 1. conflicts between residents 2. conflicts between resident and staff 3. conflicts among staff B. Respect resident's rights 1. right to complain without fear for their safety or care 2. right to have assistance in resolving grievances and disputes 3. right to contact the Ombudsman C. Resolve conflict in professional manner 1. remain calm			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	2. do not be aggressive or argumentative 3. do not use inappropriate language 4. do not take resident's behavior personally 5. do not act inappropriately			
4. List two (2) regulatory agencies that are involved with nurse aides.	IV. Regulatory Agencies for Nurse Aides A. Nurse Aide Training and Competency Evaluation Program (NATCEP) 1. makes rules for training and testing 2. Federal Government Omnibus Budget Reconciliation Act (OBRA) 1987 3. individual state programs assure federal rules are followed in facilities receiving Medicare/Medicaid funds 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) 1. Health regulatory board of the Department of Health Professions 2. protects the welfare of the public 3. enforces the Virginia Nurse Practice Act 4. establishes and enforces Regulations for Nurse Aide Education Programs (18VAC90-26-10 et seq.) a. approves nurse aide education programs b. establishes curriculum requirements for nurse aide education programs			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
6. Describe abuse, including the signs of abuse that the nurse aide might observe.	5. establishes and enforces Regulations Governing Certified Nurse Aides in Virginia (18VAC90-25-10 et seq.) a. establishes certification process for nurse aides b. establishes nurse aide competency standards c. maintains the Nurse Aide Registry d. denies, revokes, suspends or reinstates certification for nurse aides e. otherwise discipline nurse aide certificate holders in Virginia V. Inappropriate Behavior for the Nurse Aide A. Abuse 1. causing physical, mental or emotional pain to resident 2. failure to provide food, water, care and/or medications 3. involuntary confinement or seclusion 4. withholding Social Security checks and/or other sources of income 5. intentional or unintentional misappropriation of resident's money 6. intentional or unintentional posting pictures of residents on any type of social media or texting pictures of residents 7. types of abuse a. verbal b. financial			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	c. assault – threatening to harm resident d. battery – touching resident without their permission e. domestic abuse – within the family f. sexual abuse 8. signs of abuse a. bruising, swelling, pain or other injuries b. fear and anxiety c. sudden changes in resident's personality or behavior			
7. Give examples of inappropriate nurse aide behavior, including neglect and misappropriation of resident property.	B. Neglect 1. harming resident physically, mentally, emotionally by failing to provide care C. Misappropriation of resident's property 1. deliberate misappropriation, exploitation, or wrongful use of resident's belongings or money without the resident's consent 2. may be temporary or permanent			
8. Describe strategies the nurse aide can use to avoid inappropriate behavior.	D. How to avoid inappropriate behavior 1. remain calm 2. do not take resident's behavior personally 3. always remember there is no excuse for abusing a resident 4. if nurse aide is feeling overwhelmed with assigned duties or a certain resident a. discuss it with supervisor b. get help from co-workers c. make arrangements to take a break and compose self			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	5. if nurse aide sees a co-worker who appears overwhelmed a. offer support and assistance b. encourage co-worker to report situation c. report situation to supervisor			
9. Discuss the role of the mandated reporter as described in the Code of Virginia, including who is a mandated reporter, what must be reported, to whom it must be reported, and the penalty for not reporting.	VI. Mandated Reporter Authority (§63.2-1606 of Virginia Code) A. Who is a mandated reporter? 1. any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine 2. any mental health services provider as defined in §54.1-2400.1 3. any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5 4. any guardian or conservator of an adult 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 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 7. any law-enforcement officer B. What to report 1. required to report suspected abuse, neglect, or exploitation of adults			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	60 years or older or incapacitated adults 18 years or older 2. name, age, address or location of the person suspected of being abused and as much about the suspected situation as possible 3. to be reported immediately C. Where to report 1. report suspected finding to supervisor 2. local departments of social services in the city or county where the adult resides or the Virginia Department of Social Services APS hotline at 1 (888) 832-3858 D. Rights of mandated reporters 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. 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 3. a person who reports has a right to hear from the investigating local department of social services confirming that the report was investigated E. Failure to report suspected abuse 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			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	subsequent failures 2. failure to report may also subject a mandated reporter to administrative action by the appropriate licensing authority 3. not obligated to report if mandated reporter has actual knowledge the same matter has been already reported to APS hotline			
10. List reasons why the Virginia Board of Nursing would begin disciplinary proceedings for a Certified Nurse Aide.	VII. Disciplinary Proceedings Against a Certified Nurse Aide A. Regulation 18VAC90-25-100 1. disciplinary provisions for nurse aides 2. examples of allegations investigated by VBON a. unprofessional conduct i. abuse ii. neglect iii. abandoning resident iv. falsifying documentation v. obtaining money or property of a resident by fraud, misrepresentation or duress vi. entering into an unprofessional relationship with a resident vii. violating privacy of resident information viii. taking supplies or equipment or drugs for personal or other unauthorized use b. performing acts outside the scope of practice for a nurse aide in Virginia c. providing false information during a Virginia Board of			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	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 1. permanent bar to employment in health care 2. revocation of certification 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) A. Requirements of approved nurse aide education program B. Notify Board of Nursing of name change C. Notify Board of Nursing of address change D. Renew certification every year 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 A. Board of Nursing may be notified of certified nurse aide's unprofessional/unethical conduct B. Notify the Board of Nursing of disciplinary actions taken against a certified nurse aide			
14. Describe the process of applying for the NNAAP examination.	X. Obtaining Certification A. Academic requirements 1. successfully complete nurse aide education program approved by Board of Nursing			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
	2. enrolled in Registered Nurse or Practical Nursing education program and have completed at least one (1) clinical course with a minimum of 40 clinical hours providing direct resident care 3. completion of Registered Nurse or Practical Nursing education program 4. previously certified nurse aide in Virginia who allowed certificate to expire B. Required accompanying documentation 1. roster submitted to Pearson Vue by nurse aide program 2. letter (on official educational program letterhead) from the program director documenting attendance in nursing education program C. Complete on-line registration 1. Please refer to the most current Virginia Nurse Aide Candidate Handbook by Pearson Vue for instructions on how to complete on-line registration 2. PearsonVUE can be contacted at (866) 340-355 3. completed registration valid for twelve (12) months from the date of approval or the original receipt date 4. failure to accurately answer questions on registration is considered falsification of the registration and grounds for denial			

OBJECTIVES	CONTENT OUTLINE	TEACHING TOOLS/RESOURCES	STUDENT EVALUATION	INSTRUCTION TIME (classroom, skills lab, clinical)
15. Describe what the nurse aide graduate is required to bring to the testing site the day of the NNAAP exam.	of certification or disciplinary action by the Board of Nursing, even after successful completion of the NNAAP exam D. Day of the NNAAP exam 1. arrive 30 minutes prior to testing time 2. provide proper identification a. one (1) current picture identification b. one additional current identification c. both identifications must have a signature d. name on both identifications must be identical to name on NNAAP application 3. also bring a. three (3) no. 2 pencils b. eraser c. watch with a second hand (analog watch); smart watches (e.g. Apple or Google watches) are not allowed to be used during the written or skills portion of the examination 4. testing apparel a. wear flat, slip-on, non-skid footwear b. loose-fitting top with sleeveless top underneath (scrubs are comfortable for testing)			

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
$\overline{c}$	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

Frequently Used Abbreviations

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

Frequently Used Abbreviations

$\overline{s}$	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