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REND LAKE COLLEGE MISSION

The mission statement is the essential purpose of the college from which all college activities originate:

Rend Lake College provides educational opportunities across cultural and economic boundaries to the diverse student population we serve. We are committed to our students' success in achieving their educational goals and to meeting our community-focused program objectives. With Rend Lake College, student journeys start here.

Value Statement:

In serving our students and community, we strive to be student- focused, authentic, and resourceful.

IMPORTANT

For information on your rights and responsibilities refer to the Rend Lake College Student Handbook. Located on the RLC website at https://rlc.edu/phocadownload/Student-Forms/Student%20Handbook%202022-2023-Rend%20Lake%20College%20-%20web.pdf

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GENERAL BEHAVIOR – PROFESSIONAL ETHICS

The student is responsible for his/her behavior as both an individual and as a member of the group. Rules of behavior which are endorsed as appropriate according to high social, ethical, and moral standards are expected to be followed. As a consequence, the student is held responsible for any acts which may violate these standards. The following rules have been established to provide guidelines for proper, professional conduct:

The student is expected to conduct himself/herself in a professional manner at all times while in the College, clinical site, or while participating in program functions.

The student is expected to be courteous to patients, staff, visitors, faculty, and other students. When speaking to or about a patient, the name of the patient should be used, unless circumstances dictate otherwise.

The student is expected to be congenial to all patients. Solicitation or acceptance of tips from patients or clinical site visitors is prohibited.

Visiting with a patient during clinical hours is not permitted. Friends who are hospital patients should be visited according to hospital regulations.

The student is to consider the affairs of patients, the specific program enrolled, the College, and the clinical site confidential. Such matters are not to be discussed with other students, staff, family, faculty, or friends.

Sleeping during clinical or didactic hours is unacceptable.

Students should act as responsible adults. Cheating may result in dismissal from the program.

Personal telephone calls are not to be made or received while at the clinical site, except in the case of an emergency.

All unusual incidents concerning patients, visitors, staff, etc. must be reported to the clinical instructor and supervisor. The proper incident form must be completed, and a copy given to the program director.

Cell phones may be used at clinical sites only at scheduled breaks. Cell phones should be kept in lockers or purses turned off while students are doing their scheduled rotations. If a clinical site reports misuse of a cell phone, this will result in disciplinary action.

The following are considered examples of severe, inexcusable behavior which may result in immediate dismissal from the program:

Deliberate damage to College, clinical site or other's property

Stealing

Physical assault of another individual

Indecent or lewd conduct

Carrying a weapon on college or clinical site premises

Falsification of any information to the clinical site or college

Smoking in hazardous area or in a non-smoking area

Consumption of intoxicants while on College or clinical site property or attempting to perform duties while under the influence of alcohol or other drugs.

Falsification or misuse of College or clinical site records

Working beyond the appropriate duties of a student

Drug dealing or attempted drug dealing

Excessive absenteeism/tardiness

Sharing confidential information/violating HIPPA

It is impossible to compile a complete summary of misconduct that requires disciplinary action. The Program Director is responsible for interpreting the rules of conduct, and any questions in this area should be addressed to the Program Director.

Failure of the student to abide by general rules and regulations will result in disciplinary action. If disciplinary action is taken, the student will be advised of this action in private consultation with program officials. The action will be documented in the student's record file and the student will be asked to sign the document to indicate their awareness of the action.

In the event a student is dismissed from the program, the student will receive a failing grade for all classes that they are enrolled in at the time of the dismissal.

STUDENT COMPLAINTS

Academic Complaints – Grade Appeal

A. The student is expected to initiate the appeal with the faculty member immediately responsible for the area in which the problem occurred within seven (7) calendar days of the occurrence giving rise to the complaint. The student should request a meeting with the instructor.

B. If the complaint is not resolved after the informal discussion, the student may appeal by submitting a Grade Appeal Form which can be found at www.rlc.edu within seven (7) calendar days of the informal discussion with the faculty member.

C. The Dean shall review the complaint and speak with the appropriate parties as needed.

D. The Dean shall respond in writing to the student within seven (7) calendar days after receiving the student's complaint.

E. If the results of the Dean's review are unsatisfactory to the student, the student may request a meeting with the Associate Vice President of Academic and Student Services and/or the Associate Vice President of CTE and Student Support within seven (7) calendar days of receiving the Dean's written response.

F. The Associate Vice President shall issue a response to the student within seven (7) calendar days of the meeting with the student.

G. The decision of the Associate Vice President shall be considered final.

Academic Complaint – Non Grade Related

A. The student is expected to initiate the complaint with the faculty member immediately responsible for the area in which the problem occurred within seven (7) calendar days of the occurrence giving rise to the complaint. The student should request a meeting with the instructor.

B. If the nature of the complaint is personal, involving the faculty member directly and his/her behavior or demeanor, the student may appeal informally to the faculty member's Dean or complete a Student Complaint Form found at www.rlc.edu thereby bypassing the informal discussion with the faculty member. The student should understand anonymity cannot and usually will not be protected.

C. The Dean shall review the complaint and speak with the appropriate parties as needed.

D. The Dean shall respond to the student within seven (7) calendar days after receiving the student's complaint.

E. If the results of the Dean's review are unsatisfactory to the student, the student may request a meeting with the Associate Vice President of Academic and Student Services and/or the Associate Vice President of CTE and Student Support within seven (7) calendar days of receiving the Dean's written 39 response.

F. The Associate Vice President shall issue a response to the student within seven (7) calendar days of the meeting with the student.

G. The decision of the Associate Vice President shall be considered final.

III. Student Non-Academic Complaints

The Associate Vice President of Academic and Student Services shall be responsible for responding to complaints from students for non-academic (non-classroom and non-grading) issues which would fall outside of the Student Code of Conduct which is described in a later section. These issues include, but are not limited to:

A. Refunds of tuition and fees
B. Admission, registration and records matters
C. Grade forgiveness
D. Financial aid matters
E. Advising and counseling matters
F. Student activities and organization matters
G. Academic and financial aid appeals
H. Title II complaints (complaints related to discrimination based upon disabilities)
I. Title IX complaints (complaints related to discrimination based upon protected class) Students who wish to dispute a non-academic matter related to their tenure as a student at RLC shall express these concerns as follows:

A. The student is expected to initiate a complaint with the staff member immediately responsible for the area in which the problem occurred within seven (7) calendar days of realizing the issue giving rise to the complaint. The student should request a meeting with the staff member. Both the student and the College have the right to end the informal process and begin the formal complaint process at any time. Both parties have the right to forgo the informal process and initiate a formal complaint.

B. If the complaint is not resolved after the informal discussion, the student may appeal by submitting an Appeal Form (which can be obtained in the office of the Associate Vice President of Academic and Student Services or online at www.rlc.edu) to the Associate Vice President of Academic and Student Services. This appeal should be made within seven (7) calendar days of the informal discussion with the staff member. The Associate Vice President of Academic and Student Services will schedule a meeting with the Appeals Committee. The Associate Vice President of Academic and Student Services shall issue a response to the student within seven (7) calendar days of the meeting.

C. If the results of the Appeals Committee are unsatisfactory to the student, the student may submit a written request to the Vice President of Instruction and Student Affairs within seven (7) calendar days of receiving the committee's decision.

D. The Associate Vice President of Academic and Student Services shall issue a written response to the student within seven (7) calendar days from the date the student complaint was received.

E. The Vice President of Instruction and Student Affairs shall issue a written response to the student within seven (7) calendar days of receipt of the student's written request.

F. The decision of the Vice President of Instruction and Student Affairs shall be considered final with regard to student non-academic complaints.

STUDENT RECORDS

In compliance with the Family Education Rights and Privacy Act the following records are maintained in the specific program directors' offices:

1. Application records
2. Health records and immunizations
3. Background check
4. Attendance records
5. Classroom and/or clinical evaluations
6. Clinical rotation schedule
7. Counseling records

TRANSPORTATION

Students must provide their own transportation to and from the College and the clinical affiliates.

ELECTRONIC COMMUNICATION DEVICES

In any learning setting, the use of electronic communication devices, such as pagers and telephones must be limited to emergency situations only. The devices must be set to silent mode at all times in the classroom. If it is necessary to respond to a call or page, the student should leave the classroom with minimal disruption, and may reenter the classroom at the next break. Students may not use a cellular telephone in the computer laboratory. If a cellular phone is used during any testing situation or during test review, it will be considered an act of academic dishonesty. Electronic communication devices may be used in the clinical setting for appropriate purposes only. These purposes will be determined by the clinical instructor. Tape recorders, PDAs, cameras and other recording devices are not to be used in the clinical setting for recording identifiable client data.

STUDENTS WITH A COMMUNICABLE/INFECTIOUS DISEASE

Detection and control of infectious disease is accomplished to assure a safe environment for students, employees, patients, faculty, staff, and visitors. Students are encouraged to promptly visit their physician for evaluation when suffering from potential infection (ex. fever, diarrhea, skin lesions).

The student is encouraged to discuss their infectious disease status with program faculty. Rend Lake College and the program faculty will protect the privacy of individuals who are self-disclosed. The faculty will refer the student for specific education necessary to avoid transfer of disease in the clinical areas. Clinical placement will be made with the welfare and safety of the student and potential patients in mind.

Rend Lake College does not discriminate against students with infectious diseases. Students with communicable diseases will not be excluded from the program in accordance with the American with Disabilities Act.

LATEX ALLERGY GUIDELINES

Latex allergy is a serious threat to health care workers as well as patients. Allergic reactions to latex may be mild, such as skin disturbances, to severe reactions resulting in death. Exposure to latex products may cause hypersensitivity response either locally or systemically. A systemic reaction may occur even with trivial exposure to latex and may result in cardiopulmonary arrest within minutes.

The guidelines recommended by Rend Lake College are to address potential incidences of acquired latex sensitivity by students in the clinical experiences of the program.

Procedure:
Students should become knowledgeable of latex allergy causes and potential signs and symptoms.
Students should seek medical care for EARLY diagnosis and treatment of hand dermatoses and symptoms suggestive of latex allergy.
Immediately report to the Supervisor any actual or suspected latex allergic responses.

BLOODBORNE PATHOGEN EXPOSURE

Students should immediately report to the clinical Instructor and to the Program Director as quickly as is reasonable any exposure or suspected exposure to blood borne pathogens.

Students are expected to follow the written protocol of the clinical site. The student will be responsible for physician, diagnostic, and treatment costs associated with bloodborne exposure incidents.

HEALTH EXAMINATION POLICY

A health examination by a physician/certified nurse practitioner/physician assistant is required prior to being admitted to the clinical site. The completed health exam form must be submitted to the program director by the first day of class. **The student may not participate in clinical experiences until this requirement is met. This policy requires completion of the RLC Student Health Evaluation and Immunization Record. Failure to meet the requirements of this policy could result in dismissal from the program.**

AHA BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS

All students enrolled in any of Rend Lake College's Allied Health Programs shall be required to obtain and maintain the **American Heart Association Basic Life Support (BLS) for Healthcare Providers** certification. For purposes of Rend Lake College student clinical rotations, ONLY **American Heart Association Basic Life Support (BLS) for Healthcare Providers** is acceptable per our hospital affiliates. The required certification must be taken through Rend Lake College each academic year, once you are accepted into a program. The certification also must be taken prior to the program's start date, unless special permission is given by the Division Dean.

ACCIDENT AT CLINICAL SITES

Patients and visitors are usually unfamiliar with hospital routines. Therefore, you must be constantly on guard to protect their safety. Many accidents are caused by unsafe acts or unsafe conditions. If you notice a potential accident hazard, report it to your clinical instructor or supervisor immediately. If you are in an accident or happen to see an accident occur, an incident report must be completed and submitted to the clinical instructor with a copy given to the Program Director. If you are injured, any treatment costs are your responsibility.

FIRE

Follow the clinical site's fire policy. In the event of a fire, remove all patients and others from the vicinity of the fire and smoke. Isolate the fire by closing all interior doors exposed to the area involved. Notify the switchboard operator and report the exact location of the fire or sound the building fire alarm at the closest fire pull station. DO NOT ENDANGER YOURSELF!

SMOKING

It is the policy of Rend Lake College to adhere to, and enforce, the Smoke-Free Illinois Act and the Smoke-Free Campus Act. Specifically, no person shall carry, smoke, burn, inhale, or exhale any kind of lighted pipe, cigar, cigarette, e-cigarette or any other lighted smoking equipment. This policy extends to all buildings, grounds, parking lots, and vehicles which are owned and operated by the college. Smoking is also not permitted on clinical site grounds. *Student Handbook* page 39

YOU AND THE PATIENT

The care for those who are ill or hospitalized is provided by people, like you, who exhibit a kind interest in all persons. It is only through the efforts and cooperation of each member of the health care team that the goal of expert, scientific, and compassionate care of patients can be maintained.

Your courtesy, tact, empathy, cheerfulness, kindness, and consideration of patients, anxious relatives, and your co-workers will help immeasurably. It is our sincere desire to assist you in finding enjoyment and satisfaction as a Rend Lake College student. We are interested in your education, happiness, health, and success.

UNIVERSAL PRECAUTIONS

Guidelines have been adopted in accordance with the current consensus of the medical and scientific community that many diseases cannot be transmitted by casual body contact in the clinical setting. However, because there is a risk of contracting an infectious disease, the student should adhere to the following guidelines:

1. Sharp items (needles, scalpel blades, etc.) should be considered infectious and be handled with extraordinary care to prevent accidental injuries.

2. Disposable syringes and needles, scalpel blades and other sharp items should be placed in puncture resistant containers located as practical as possible to the area in which they

are used. To prevent needle stick injuries, needles should NOT be recapped, purposely broken, removed from disposable syringes, or otherwise manipulated by hand.

3. When the possibility of exposure to blood or any other body fluids exists, appropriate attire should be worn. The anticipated exposure may require gloves alone, or may also require a gown, mask and/or goggles when performing procedures. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.

4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth-pieces, resuscitation bags, or other ventilation devices should be located and available for use in areas where the need for resuscitation is predictable.

CTE Success Center – Mary and George Slankard Learning Resource Center Room 142

TITLE III funds assisted Rend Lake College in establishing a CTE Success Center on campus. The Center will be a place in which students majoring in healthcare and technical education programs can seek out services. The CTE Success Center provides services such as tutoring, computers for online work, and group study areas to ensure students are successful in their vocational and educational goals, while keeping them up to date with industry's needs and demands.

Services provided in the Center include:

- One on One Tutoring Assistance
- Nurse Skills Lab
- Group Study Space
- Computer access for online coursework
- Math tutoring for technical education programs
- Quiet Study Area – LRC 114

PROFESSIONAL LICENSURE DISCLOSURE

Students who complete this program must obtain professional licensure in order to work in the State of Illinois.

RLC's curriculum and/or Illinois license may not transfer to another state and additional course work, assessments, or licensing may be required. Rend Lake College has provided processional license information that is available on RLC's website at www.rlc.edu.

Safe/Unsafe Clinical Practices

The Allied Health Programs identify safety as a basic human need. A safety need can be identified as physical, biological, and/or emotional in nature. Safe practices are a requirement of each program.

Unsafe clinical/practicum practice shall be deemed to be behavior demonstrated by the student which threatens or violates the physical, biological, or emotional safety of the patients, caregivers, students, staff or self. Unsafe or unprofessional clinical practice may result in implementation of the Progressive Discipline Policy outlined in the Student Handbook.

The following examples serve as guides to these unsafe behaviors but are not to be considered all-inclusive.

Physical Safety: Unsafe behaviors include but are not limited to:

- Inappropriate use of side rails, wheelchairs, other equipment
- Lack of proper protection of the patient which potentiates falls, lacerations, burns, new or further injury
- Failure to correctly identify patient(s) prior to initiating care
- Failure to perform pre-procedure safety checks of equipment, invasive devices or patient status

Biological Safety: Unsafe behaviors include but are not limited to:

- Failure to recognize violations in aseptic technique
- Improper medication administration techniques/choices
- Performing actions without appropriate supervision
- Failure to seek help when needed
- Attending clinical while ill
- Failure to properly identify patient(s) prior to treatments

Emotional Safety: Unsafe behaviors include but are not limited to:

- Threatening or making a patient, caregiver, or bystander fearful
- Providing inappropriate or incorrect information
- Performing actions without appropriate supervision
- Failure to seek help when needed, unstable emotional behaviors

Unprofessional Practice: Unprofessional behaviors include but are not limited to:

- Verbal or non-verbal language, actions, or voice inflections which compromise rapport and working relations with patients, family members, staff, or physicians, may potentially compromise contractual agreements and/or working relations with clinical affiliates, or constitute violations of legal/ethical standards
- Behavior which interferes with or disrupts teaching/learning experiences
- Using or being under the influence of any drug or alcohol that may alter judgment and interfere with safe performance in the clinical or classroom setting
- Breach of confidentiality in any form
- Falsifying data in a patient health record
- Misrepresenting care given, clinical errors, or any action related to the clinical experience
- Recording, taping, taking pictures in the clinical setting without expressed consent
- Leaving the clinical area without notifications to faculty and clinical staff or supervisor

CONFIDENTIALITY STATEMENT

In general, all information regarding patients, visitors, and staff of the clinical education centers is considered confidential. As such, this information is not to be discussed by the student to anyone.

Students should refer all such requests for information from the news media to the Department of Public Relations, with the exception of inquiries regarding a patient's condition, which should be referred to the clinical site's patient information service. Any request to take photographs on clinical premises must also be referred to the Department of Public Relations.

I understand and agree that prior to attending any clinical experience, I must read and become familiar with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") regarding the confidentiality of patient information and that I must complete the final exam in the HIPAA training book. I understand and agree that I will keep patient information confidential as required by HIPAA, the policies of Rend Lake College Allied Health Department, and the policies of any clinical agency at which I take a clinical practicum. I agree that in my clinical practicum experiences, I will only seek to access patient information which is essential to perform my role as a student.

Program Name: _____ Date: _____

Signature _____

Rend Lake College
Division of Allied Health
HEALTH AND PHYSICAL FORM

TO BE COMPLETED BY STUDENT:	
Name:	
Street Address:	**DOB:**
City/State/Zip	**Phone #:**
Allied Health Program: Circle your program	
Nursing Phlebotomy Radiology Medical Coding EMT Basic Paramedic Personal Care Aide Medical Support Specialist Medical Assistant Pharmacy Tech Biomedical Technology	

TO BE COMPLETED BY STUDENT'S HEALTH CARE PROVIDER:	
PHYSICAL EXAMINATION: Indicate ability to perform standards described below	**LIMITATIONS- Please explain any limitations if answer is "No" below.**
Mobility: Physical abilities sufficient to move from room to room and maneuver small spaces; move freely to observe and assess patients and perform emergency care such as CPR. Ability to touch floor to remove environmental hazards if necessary.	Yes or No
Motor Skills: Gross and fine motor abilities sufficient to provide safe and effective care	Yes or No
Hearing: Auditory abilities sufficient to monitor and assess patient needs and to provide a safe environment	Yes or No
Visual: Visual ability sufficient for observation and assessment necessary in the operation of equipment and care of patients	Yes or No
Tactile: Tactile ability sufficient for patient assessment and operation of equipment	Yes or No
Cognitive: Abilities to include analyzing, interpreting and carrying out provider orders, read and comprehend course materials, patient care documents and facility policies and procedures	Yes or No
PERSONAL HISTORY	
Describe any conditions (including allergies to substances normally found in a clinical setting) that could potentially impact the student's attendance and/or performance. If a student should present with any physical or cognitive limitation, each case will be reviewed on an individual basis. Reasonable accommodations will be made as determined by Disability Services.	
HEALTHCARE PROVIDER SIGNATURE AND/OR STAMP	
Following the performance of a physical exam and utilizing history and immunization information provided to me by the student, I verify the above information to be true.	
Signature and/or Stamp of Healthcare Provider (MD, DO, PA, ARNP)	**Date:**
Provider Printed Name:	**Phone:**

IMMUNIZATION INFORMATION	DATE	RESULTS
TUBERCULOSIS		
TST (tuberculosis skin test/PPD)-**2 step required** 1st step- Date Placed: / / Date Read: / / 2nd step- Date Placed: / / Date Read: / /		Positive Negative Positive Negative
CHEST X-RAY RESULTS/REPORT (if positive TST/PPD		Positive Negative
TB SCREEN/TB symptom sheet to be done annually if positive TST/PPD		
HEALTHCARE PROVIDER SIGN:		
MEASLES, MUMPS, RUBELLA	**DATE**	
Two MMR vaccines with dates or individual titers for each satisfy the requirement for Measles (Rubeola**), Rubella** (German Measles)		**RESULTS**
MMR VACCINES (given after 1st birthday		
Vaccine #1		
Vaccine #2 (not required if born before 1957)		
TITERS		
Rubeola Titer		Positive Negative
Rubella Titer		Positive Negative
HEALTHCARE PROVIDER SIGN:		
VARICELLA (CHICKENPOX)		
Two Varicella vaccines with dates, or a positive titer	**DATE**	**RESULTS**
Documentation of Disease	N/A	N/A
Varicella #1		
Varicella #2		
Titer		Positive Negative
HEALTHCARE PROVIDER SIGN:		
Tetanus/Diptheria or Tdap within 10 Years	**DATE**	
Tetanus/Diptheria		
Tdap		
HEALTHCARE PROVIDER SIGN:		
HEPATITIS B (strongly recommended for healthcare workers in patient care settings)	**DATE**	**RESULTS**
Vaccine #1		
Vaccine #2		
Vaccine #3		
Titer		Positive Negative
HEALTHCARE PROVIDER SIGN:		

HEPATITIS B Declination (to be signed by student if refusing this vaccine series)

I understand that, due to my exposure of blood or other potentially infectious materials, I may be at risk for acquiring the hepatitis B (HBV) infection. I have been informed of the recommendation that all healthcare workers be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I could be at risk of acquiring hepatitis B, a serious disease.

STUDENT'S PRINTED NAME:	**DATE**
STUDENT'S SIGNATURE:	
HEALTHCARE PROVIDER SIGNATURE:	

Student Name:

Rend Lake College Allied Health
Emergency Medical Information

Student Information

Student's Name: _____

Gender: _____ Date of Birth: _____

Address: _____ City/State: _____

Zip Code: _____ Phone Number: _____

Health Insurance Information

Insurance Carrier: _____

Policy Holder's Name: _____ Relationship: _____

Policy I.D. #: _____ Group #: _____

Emergency Contacts

Name: _____ Phone #: _____

Name: _____ Phone #: _____

List any allergies, medications, or health conditions that may be pertinent for emergency treatment.

1. _____

2. _____

3. _____

Student's Name: _____ Date: _____
(Print)

Student's Signature: _____ Date: _____

REND LAKE COLLEGE
ALLIED HEALTH PROGRAM
STUDENT INFORMATION RELEASE FORM

1. I have received a copy of my program specific Student Handbook and Policies. I have carefully read and understand the general information and policy statements and agree to abide by these as a student in the Allied Health Program. I have had the opportunity to have my questions answered regarding the policies in the Student Handbook.
2. I hereby give permission to release any necessary information to clinical agencies regarding my immunizations, reference requests, and CPR certification.
3. I understand that I must abide by the policies and procedures of all clinical facilities that I might attend as a student. I am aware that it is absolutely mandatory that I comply with the confidentiality/Health Insurance Portability and Accountability Act (HIPAA) statement and must demonstrate knowledge of it by passing the HIPAA examination.
4. I understand that I must provide proof of medical insurance or other financial means to cover myself as to expenses which may arise as the result of illness or injury occasioned during my clinical rotation. I acknowledge that since I am not an employee of the college or the facility that I am not protected by Workers Compensation and neither the college nor the facility assumes any liability for injuries or illness in the absence of a showing of actual negligence on the part of the college or facility or any of its agents.
5. **Criminal Background Checks and Drug Screen for Clinical Experience:** My signature below indicates that I have read the Substance Abuse policy of Rend Lake College and have been provided with a copy of the same. I understand that the results of the criminal background screening and drug testing results are to be used for the purposes of determining my eligibility for a clinical educational experience in my field. By this form I provide my irrevocable consent for the results of the drug screening and criminal background checks to be released to Rend Lake College who in turn may share said information with the clinical agency with whom I am being assigned for a clinical experience.
6. I understand that this program specific handbook has been designed to provide information about the program and is not a contract. The information in this handbook is subject to change.
7. I have read and understand the program specific handbook, College catalog and the RLC student handbook.
8. I grant Rend Lake College, The Allied Health Department, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize the Allied Health Department, its assignees and transferees to copyright, use and publish the same in print and/or electronically.
9. I agree that Rend Lake College and the Allied Health Department may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising and Web content.

I have read and understand the above:

_____/_____

Student's Signature Date

HIPAA AND SOCIAL MEDIA

Sharing information on any social media network is a HIPAA violation. There is not to be any information regarding patients, clinical sites, their radiographs or hospital records of any kind being shared over a social media site (Facebook, twitter and any others). For example, if you take a radiograph at your clinical site, remove the patient's information and place it on Facebook that is a HIPAA violation. Even if there is no patient information on that image that still violates the HIPAA policy. Descriptions regarding any information related to a patient's care that took place at a clinical site is a violation. If a student violates this HIPAA policy, it will result in immediate dismissal of the program.

Student Signature _____ Date_____

Acknowledgment Form

- I agree to abide by the policies of Rend Lake College and the Allied Health program in which I am enrolled.

- I am aware of the clinical practicum placement policies and procedures

- I am aware of the drug testing and criminal background check requirements by the Illinois Department of Public Health (IDPH) and the Joint Commission on Accreditation of Health Care Organization (JCAHO) and I agree to abide by them.

- I am aware that neither Rend Lake College nor the affiliated clinical site will assume the cost of treatment or care for injury or any medical condition occurring during my student laboratory classes (if required) and during my clinical practicum.

- I am aware of the confidentiality requirements (patient and medical records) and will abide by them.

- I have had an opportunity to ask questions about this material and have had those questions answered to my satisfaction.

- I agree that while enrolled in the Allied Health Program I will treat my studies, labs and clinical practicum as an employee would treat job responsibilities, recognizing that my instructor assumes the role of my supervisor. I will attempt to learn not only the technical skills, but will also strive to develop a professional manner and attitude.

- I understand that failure to abide by the policies will be grounds for disciplinary action and possible dismissal from the program.

- I understand that I may be required to drive at least one hour one way to my clinical site due to the limited space at our clinical sites in the immediate area. Every attempt will be made to cut down on the student's driving time but certain circumstances are out of the program's control. I am responsible for my own travel arrangements and will be held accountable for arriving to clinical on time.

Student's Name:_____ Date: _____
(Print)

Student's Signature: _____ Date: _____

Clinical Externship
Faculty/Staff/Student Confidentiality Agreement

The discussions, uses, and disclosures addressed by this agreement apply to any written, verbal, or electronic communications.
I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my assignment to the site. I understand that I am obligated to know and adhere to the privacy policies and procedures of the clinical site to which I am assigned. I acknowledge that medical records, accounting information, patient information, and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my clinical assignment to anyone other than the medical and nursing staff of the clinical site.
I understand that I may not remove any record from the clinical site without the written authorization of the site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, course presentation, class assignment, or research, I must attempt to exclude as much of the following information as possible:

- Names
- Geographical subdivisions smaller than a state
- Dates of birth, admission, discharge, and death
- Telephone numbers
- Fax numbers
- E-mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers
- Device identifiers
- Web locators
- Internet protocol addresses
- Biometric identifiers
- Full face photographs
- Any other unique identifying number, characteristic or code
- All ages over 89 years

Additionally, I acknowledge that any patient information, whether or not it excludes some or all of those identifiers, may only be used or disclosed for health care training and educational purposes and must otherwise remain confidential.
I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable law, or this confidentiality agreement, by me, or a student or faculty member to the college administrator.
Finally, I understand that, if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action.
By signing this agreement, I certify that I have read and understand its terms, and will comply with them.

Signature: _____ Date: _____

Printed Name: _____

INFLUENZA VACCINE WAIVER FORM

I understand that due to my occupational/educational exposure to the Influenza virus that I may encounter while doing class work and clinical rotations for the Allied Health Program, I may be at risk for acquiring the Influenza virus. I have been informed of the risks of infection and of the advantages of protection through the Influenza vaccination. I have been required by the Rend Lake College Allied Health program to become immunized and show written proof, or to sign a declination waiver form for Influenza vaccination due to religious beliefs or a known allergy to the vaccination. The cost of the Influenza vaccination is my responsibility.

If I choose not to obtain the Influenza vaccination due to my religious beliefs or a known allergy to the vaccination, I understand that I must abide by the clinical facilities requirements to wear protective apparel that they specify. **I also understand that a clinical site has the right to deny me access to my clinical experience there.** I understand that by not obtaining this vaccine, I continue to be at risk of acquiring the Influenza virus.

Student Signature: _____

Date: _____

ALCOHOL AND DRUG POLICY

Rend Lake College is committed to a drug and alcohol free educational environment. Therefore, the Board prohibits the use, illegal possession, sale, distribution or transfer of alcohol or illegal drugs on College premises or property owned or supervised by Rend Lake College. The Board also prohibits the use and possession of alcohol, illegal drugs and the abuse of legal drugs in any manner which impairs a student's ability to safely and effectively attend class or participate in school activities.

Recognizing that certain educational programs and/or activities expose students, participants, faculty, staff and observers to a greater risk of injury due to the nature of the activity, the Board authorizes the Administration and its designees the right to randomly test students/participants enrolled in such programs for the illegal use of any controlled substance or the use of legal substances impairing the ability of the student/participant to perform an activity or participate in any College sponsored event. In addition, the Board authorizes the Administration and its designees the right to remove any individual who appears to be under the influence of any controlled substance (drugs and/or alcohol) or who appears to be unduly under the influence of any legal drug impairing the immediate safety of the said individual or others participating in a College activity or while on College premises.

Certain fields of study require practical experiences which should be practiced without impaired judgement from drug or alcohol use. All students in health care and other required programs must pass a drug screening test before entering their practicum/clinical/externship as well as be subject to random testing throughout their program. Students may also be tested should there be reasonable suspicion that illegal use of any controlled substance (drugs and/or alcohol) or the abuse of legal drugs has occurred in such a manner in which an individual’s ability to participate safely in an activity has been compromised or has comprised others attending or participating in the activity or on the College premises. A reasonable suspicion referral for testing will be made on the basis of documented objective facts and circumstances that are consistent with short term effects of substance abuse.

Prior to enrollment in such educational programs deemed by the administration to require drug testing or participation in extracurricular activities, students must agree to participate in the drug screening program.

PROCEDURE

1. Allied Health Students and Other Required Screen Programs:

A. Each student is subject to drug screening at the time and place designated by Rend Lake College. For students with practicum/clinical/externship, the screening shall take place prior to beginning said practicum/clinical/externship.

B. The student shall immediately submit themselves for a drug screen upon being notified by a Rend Lake College representative at the place designated by said representative.

C. Immediately shall mean the student will not leave the sight of either the Rend Lake College representative or medical personnel conducting said screen until the screen is completed.

2. Reasonable Suspicion

A. Any student who has been advised that reasonable suspicion exists for a drug screen shall immediately submit themselves for a drug screen upon being notified by a Rend Lake College representative at the place designated by said representative.

B. Immediately shall mean the student will not leave the sight of either the Rend Lake College representative or medical personnel conducting said screen until the screen is completed.

C. Reasonable suspicion includes but is not limited to actions by student which places themselves or others on campus in any dangerous situation or in danger of injuring themselves or others.

3. Random Screenings

A. Rend Lake College shall use a computer program established for the random selection of students/athletes for a drug screen.

B. Upon selection, the student will be notified by a Rend Lake College representative and student/athlete shall immediately submit themselves for a drug screen upon being notified by a Rend Lake College representative at the place designated by said representative.

C. Immediately shall mean the student will not leave the sight of either the Rend Lake College representative or medical personnel conducting said screen until the screen is completed.

4. The drug screening shall be conducted by a qualified laboratory using regularly established procedures for collecting and testing samples by the healthcare field.

ACTIONS FOR RESULTS:

Negative Screen: No action taken.
Positive Screen: Student will be dismissed from the academic or athletic program.
Diluted Screen: Student will be allowed one retest at a time designated by a school official. If the second test comes back diluted or positive, the student will be dismissed from the academic or athletic program.
Adulterated Screen: Student will be dismissed from the college.
Substituted Screen: Student will be dismissed from the college.
Failure to Submit/Complete Drug Screen: Student will be dismissed from the academic or athletic program. (Example: leaving campus when contacted to present for drug testing).
Shy Bladder: If a student is unable to provide a specimen at the time of testing, the student will be given 1.5 hours and allowed up to 40 ounces of fluid to drink. After 1.5 hours if the student fails to submit a specimen, the student will be required to take a non-urine-based test. The extra cost of this test must be paid by the student and cannot be charged to the student's account.

If a screening tests positive for prescription drugs, a Medical Review Officer for the lab services will contact the student for more information. The Medical Review Officer may request that the student provide valid physician prescriptions and/or copies of medical records substantiating the prescribed medication and manner of dosage.

If the Medical Review Officer finds the prescribed drugs are being taken as prescribed, it will be considered a negative screen. If the Medical Review Officer finds the prescription is not valid or the drugs are being taken in a manner different from the prescription, or if the student fails to cooperate with the Medical Review Officer's request for proper medical documentation, it will be considered a positive screen and appropriate action will be taken.

Assistance for Addiction

Rend Lake College recognizes that addiction is a disease that takes assistance to overcome. Rend Lake College encourages any student facing drug or alcohol addiction to receive professional help. There are numerous treatment centers in the state of Illinois. For assistance in locating a treatment center, students will be directed to contact RLCares or the advisement department. Rend Lake College is not responsible for any costs related to treatment.

Re-Admission after Positive Drug Screening

Any student who is dismissed for a positive drug screening may reapply for admission after six months. However, the student must present proof of seeking treatment with a licensed substance abuse counselor within one week of removal from the program to be considered for readmission. Signed documentation by a substance abuse professional that the student has successfully completed an approved drug/alcohol rehabilitation program, as well as proof of drug screens performed as part of treatment, is required prior to readmission. For healthcare programs, a signed release by the substance abuse professional to attend a healthcare training program and clinical is also required. The student must also provide the results of a negative drug screen dated within 30 days of re-enrollment. The student must complete negative drug screenings provided randomly by Rend Lake College at least once every six months until graduation. A second violation of the drug policy will result in permanent dismissal from Rend Lake College. Readmission to programs and extracurricular activities will be at the discretion of college officials after review of all pertinent information.

BACKGROUND CHECK POLICY

All students enrolled in an Allied Health program are required to submit to a background check. A background check is required every year at the college's expense. Rend Lake College will designate the company/agency selected to do the criminal background screening. Rend Lake College will not accept criminal background screening from any other company/agency. Reasonable efforts will be made to ensure that results of criminal background checks are kept as confidential as possible with a limited number of persons authorized to review results.

If a student has a positive background check, and the facility refuses the student access to the clinical experience at the facility, Rend Lake College will make reasonable efforts to find an alternative site with equivalent clinical opportunities for the student to complete their clinical experience. Rend Lake College DOES NOT GUARANTEE that a student with a criminal conviction and/or criminal charges will be able to complete their clinical experience. A student who cannot be reasonably assigned to a clinical site will be dropped from the program.

INTRODUCTION

This information is provided to clarify what will be expected of the student in the Rend Lake College Certified Nursing Assistant (CNA) class. This Student Handbook will be implemented in conjunction with Rend Lake College Student Handbook, the Rend Lake College Catalog and the Illinois Department of Public Health (IDPH) CNA course requirements.

The CNA Student handbook will be followed by all CNA faculty members and students. Please read the student handbook carefully and maintain it for future reference. This material will also be reviewed in class by the CNA instructor the first day of class. If you do not understand any portion of the Handbook you must ask for clarification. We will ask you to sign a form indicating that you have read and understand the Handbook. The Handbook will be reviewed, revised, and updated annually and as needed.

MISSION STATEMENT

The mission of the Nursing Assistant Program of Rend Lake College is to prepare competent nursing assistants in the art and science of healthcare across the lifespan. This goal is accomplished through instruction and practice of basic nursing skills; demonstration and use of critical thinking throughout the steps of the nursing assistant process; and satisfactory evaluation of each student's performance in the clinical environment.

PROGRAM GOALS

1. Demonstrate professional communication skills including recording and reporting.
2. Demonstrate competency in the 21 manual skills mandated by the Illinois Department of Public Health.
3. Initiate basic life support (CPR) following American Heart Association guidelines.
4. Develop an understanding of the role of the nurse assistant as a part of the interdisciplinary health care team.
5. Identify Residents' Rights for Long Term Care Facilities.
6. Identify symptoms and physical changes of Alzheimer's disease and related disorders (including communication and handling of mood and behavioral disturbances with appropriate intervention to maintain staff safety).

PROGRAM PHILOSOPHY

The philosophy of the Rend Lake College Nursing Programs is in accordance with the college and department Mission Statements. Every student is viewed as a unique individual with inherent worth. Cultural diversity is embraced.

Nursing: Nursing is defined as both an art and a science. Compassion is a cornerstone of nursing care delivery. The nursing philosophy is based on Dr. Joyce Dungan's Model of Dynamic Integration. Dungan depicts each individual as having three integrated dimensions-

body, mind, and spirit. Changing life experiences require frequent modifications in the balance of these dimensions. Nurses assist individuals with these transactions.

Health: Health is considered to be the successful integration of life's challenges, which leads to optimum functioning at that particular moment.

Community: Nurses must be able to cope with an increasingly changeable, dynamic environment. The faculty strives to prepare nurses who can accept this challenge. The community affected by nurses expands to areas beyond the immediate geographical region. Students at Rend Lake College accept an obligation to contribute to their community.

Client: Client is viewed in the broad sense as encompassing individuals and groups. Clients use adaptation to cope with change and maintain health. Since nurses assist with this process, students will be introduced to processes for acquisition of these skills. As students move through the curriculum, the focus shifts to clients with more extensive needs.

Learning: The nursing program is based on adult learning theory. The goal is the preparation of competent, caring healthcare workers. The teaching-learning process operates within the cognitive, affective, and psychomotor domains. Nursing education involves the integration of knowledge and experience. Critical thinking is an integral part of nursing process application. It involves accepting responsibility and accountability for decisions while upholding ethical and legal standards. Learning is affected by such factors as motivation, prior experiences, and learning style. The program remains committed to practice oriented education.

GENERAL PROGRAM INFORMATION AND REQUIREMENTS

TRANSPORTATION

Students must assume personal responsibility and liability for transportation to classes, clinical facilities and assigned workshops. The College is not responsible for transporting students or for any liability incurred as the result of such transportation. When assigned to community health clinical, students must provide their own transportation and not ride with agency nurses to the home visit.

DRESS CODE

The student uniform includes: name pin, watch with a second hand, scissors, note pad, and a black pen. Students are required to wear a white uniform top, black uniform pants, and black shoes. Lab coats/jackets must be white. Dress codes and grooming regulations of the participating clinical facilities will be respected and followed. Shoes of the open-toe or clog style are not allowed.

The complete uniform should be worn in the clinical areas and community services projects.

While in uniform, students' hair must be clean and neatly styled in a manner not hazardous to patient care. Long hair must be up any time the student is in uniform.

Shorts must not be worn to any clinical or community service project.

Students must be conservative in the use of cosmetics. Clear or light pink nail polish is acceptable. Fingernails should be short. Students are not permitted to wear false/acrylic nails or nail wraps.

Students should guard against offensive body/breath odors by bathing frequently and using unscented deodorants, hair sprays, etc. Perfumes/colognes should be avoided since they may not only be offensive but may also trigger an allergic response in some patients.

Jewelry allowed in the clinical setting in limited to: one pair of small post earrings in the earlobes, a watch and a wedding/engagement ring. No other visible jewelry in body parts is permitted. Tattoos must be covered.

Food, drinks and gum are not permitted on nursing units. Breath mints only are allowed.

INSURANCE

All nursing students are required to carry liability insurance for clinical practice through the College. Nursing courses include liability insurance as part of the course fee. Coverage period consists of Rend Lake clinical practicum only. Clinical agencies do not provide treatment except at student expense.

CELL PHONE USE

Cell phones are not to be used in the classroom or clinical setting. In an emergency, students can be contacted by calling RLC Ina Campus Security, 618-525-1911 or RLC Marketplace Security, 618-237-1911. The caller needs to identify the student, the course, location, type of emergency and the name and number of who to contact. RLC Campus Security will locate the student and give them the message.

CNA TUITION WAIVERS

In-district students enrolled in the Certified Nursing Assistant course (CNA 1201) will receive a tuition waiver for the course. Students are responsible for books, fees, and supplies. Students can only receive the waiver twice. For any subsequent enrollment in this course, students will be responsible for tuition, fees, books, supplies. Students may appeal to the Dean of Allied Health or the Vice President of Student Services for extenuating circumstances.

HEALTH CARE WORKER BACKGROUND CHECK ACT

The Health Care Worker Background Check Act is a state law that went into effect on January 1, 1996. This law pertains to persons “in a position involving direct care to residents who are not licensed by the Department of Professional Regulation.”

“Direct care” is defined in the law as “the provision of nursing or personal care. Personal care means assistance with meals, dressing, movement, bathing or other personal needs.” This law applies to nursing assistants.

The law requires an Illinois State Police Criminal Background Check to be done on any individual hired after 1/1/96 to be a nursing assistant. The rules of the law require that a facility shall not knowingly hire any individual after January 1, 1996, in a position with duties involving direct care for residents if that person has been convicted of committing or attempting to commit one or more of the following offenses:

- murder, homicide, manslaughter or concealment of a homicidal death
- kidnapping or child abduction
- unlawful restraint, forcible detention
- battery, or inflection of great bodily harm, domestic battery
- assault
- sexual assault or sexual abuse
- abuse or gross neglect of a long term care facility resident
- criminal neglect of an elderly or disabled person
- theft
- retail theft
- financial exploitation of an elderly or disabled person
- robbery, armed robbery, aggravated robbery
- burglary, residential burglary
- home invasion
- armed violence
- criminal trespass to a residence
- arson
- unlawful use of weapons or aggravated discharge of a firearm
- manufacture and delivery of cannabis
- manufacture and delivery of controlled substance
- possession with intent to deliver (either drugs or cannabis)
- indecent solicitation of a child, sexual exploitation of a child
- tampering with food, drugs or cosmetics
- aggravated stalking
- endangering the life or health of a child
- vehicular hijacking, aggravated vehicular hijacking

Please note: you may have been convicted and not sent to jail. Often people are fined or given probation, but these are still convictions. If you are unsure whether an arrest ended up to be a conviction, contact the County in which you were arrested and speak to the people at the Circuit Clerk or State's Attorney office or your attorney.

A person **cannot** be added to the state nurse assistant registry if they have committed or attempted to commit any of the above listed crimes. A person cannot be hired, or retained if they are already hired, by a facility if they have committed or attempted to commit any of the above listed crimes.

There is a **waiver process** for a person if there is a criminal background. However, a facility does not have to hire or retain a person, even with the waiver. **Students requiring a waiver, must have waiver in hand and provide a copy to instructor before the student will be permitted to attend clinical. The student will be dropped from the program and will not be allowed to register for another CNA program with Rend Lake College until their waiver is granted.**

Some convictions that are **not** disqualifying (in other words, you can work if these are your only convictions).

- prostitution
- possession of cannabis or a controlled substance
- DUI
- Deceptive practices (writing "bad" checks on your own account)

The Health Care Worker Background Check Act is not a particularly complicated law, but it may be difficult to understand. **If you think it may pertain to you, please talk to your instructor. You will be provided additional information**. ***Please understand the rules are **NOT** Rend Lake College's rules. The Background Check Act is a **STATE LAW**.***

Illinois Health Care Worker Registry 1-217-785-5133

Background Check Code Requirements Section 395.171
Health Care Worker Background Check

a) A training program shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

b) A training program shall provide counseling to all individuals seeking admission to the training program concerning the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. The counseling shall include, at a minimum:

1) Notification that a fingerprint-based criminal history records check will be initiated;
2) A clear statement that a fingerprint-based criminal history records check is required for the individual to work as a direct access worker, a CNA or a Direct Support Person in Illinois; and
3) A listing of those offenses in Section 25 of the Health Care Worker Background Check Act for which a conviction would disqualify the individual from finding employment as a direct access worker, a CNA or a Direct Support Person unless the individual obtained a waiver pursuant to Section 40 of the Health Care Worker Background Check Act.

c) An individual shall not be allowed to enroll in a training program unless the individual has had:

1) A criminal background check that reveals no disqualifying convictions, unless a waiver has been granted; and
2) No administrative findings of abuse, neglect, or misappropriation of property.

http://www.idph.state.il.us/nar/disconvictions.htm#disqualify
(see below)

Disqualifying Convictions

In Accordance with the
Health Care Worker Background Check Act [225 ILCS 46]
And 77 Ill Adm. Code 955 Section 955.160

- **Disqualifying Offenses that May Be Considered for a Waiver by the Submission of a Waiver Application**
- **Disqualifying Offenses that May Be Considered for a Rehabilitation Waiver**
- **Offenses that Are Always Disqualifying Except Through the Appeal Process**

Disqualifying Offenses that May Be Considered for a Waiver by the Submission of a Waiver Application

Illinois Compiled Statutes Citation	Offense	Additional Offense Added To Act Effective
[720 ILCS 5/10-3]	Unlawful Restraint	N/A
[720 ILCS 5/10-3.1]	Aggravated Unlawful Restraint	N/A
[720 ILCS 5/10-4]	Forcible Detention	N/A
[720 ILCS 5/10-5]	Child Abduction	N/A
[720 ILCS 5/10-7]	Aiding and Abetting Child Abduction	N/A
[720 ILCS 5/12-1]	Assault	N/A
[720 ILCS 5/12-2]	Aggravated Assault	N/A
[720 ILCS 5/12-3]	Battery	N/A
[720 ILCS 5/12-3.1]	Battery of an Unborn Child	N/A
[720 ILCS 5/12-3.2]	Domestic Battery	N/A
[720 ILCS 5/12-4.5]	Tampering with Food, Drugs or Cosmetics	1/1/1998
[720 ILCS 5/12-7.4]	Aggravated Stalking	1/1/1998
[720 ILCS 5/12-11]	Home Invasion	1/1/1998
[720 ILCS 5/12-21.6]	Endangering the Life or Health of a Child	1/1/1998
[720 ILCS 5/12-32]	Ritual Mutilation	1/1/1998
[720 ILCS 5/12-33]	Ritual Abuse of a Child	1/1/1998
[720 ILCS 5/16-1]	Theft	N/A
[720 ILCS 5/16-2]	Theft of Lost or Mislaid Property	1/1/2004
[720 ILCS 5/16A-3]	Retail Theft	N/A
[720 ILCS 5/16G-15]	Identity Theft	1/1/2004
[720 ILCS 5/16G-20]	Aggravated Identity Theft	1/1/2004
[720 ILCS 5/17-3]	Forgery	1/1/1998
[720 ILCS 5/18-1]	Robbery	N/A
[720 ILCS 5/18-3]	Vehicular Hijacking	1/1/1998
[720 ILCS 5/19-1]	Burglary	1/1/1998
[720 ILCS 5/19-3]	Residential Burglary	N/A
[720 ILCS 5/19-4]	Criminal Trespass to Residence	N/A

[720 ILCS 5/20-1]	Arson	N/A
[720 ILCS 5/20-1.1]	Aggravated Arson	N/A
[720 ILCS 5/20-1.2]	Residential Arson	1/1/2004
[720 ILCS 5/24-1]	Unlawful Use of a Weapon	N/A
[720 ILCS 5/24-1.1]	Unlawful Use or Possession of Weapons by Felons or Persons in the Custody of the Department of Corrections Facilities	1/1/2004
[720 ILCS 5/24-1.2]	Aggravated Discharge of a Firearm	N/A
[720 ILCS 5/24-1.2-5]	Aggravated Discharge of a Machine Gun or a Firearm Equipped with a Device Designed or Used for Silencing the Report of a Firearm	N/A
[720 ILCS 5/24-1.5]	Reckless Discharge of a Firearm	1/1/1998
[720 ILCS 5/24-1.6]	Aggravated Unlawful Use of a Weapon	1/1/2004
[720 ILCS 5/24-3.2]	Unlawful Discharge of Firearm Projectiles	1/1/2004
[720 ILCS 5/24-3.3]	Unlawful Sale or Delivery of Firearms on the Premises of Any School	1/1/2004
[720 ILCS 5/33A-2]	Armed Violence	1/1/1998
[225 ILCS 65/10-5]	Practice of Nursing without a License	1/1/2004
[720 ILCS 150/4]	Endangering Life or Health of a Child	1/1/1998
[720 ILCS 150/5.1]	Permitting Sexual Abuse of a Child	1/1/2004
[720 ILCS 115/53]	Cruelty to Children	1/1/1998
[720 ILCS 250/4]	Receiving Stolen Credit Card or Debit Card	1/1/2004
[720 ILCS 250/5]	Receiving a Credit or Debit Card with Intent to Use, Sell, or Transfer	1/1/2004
[720 ILCS 250/6]	Selling a Credit Card or Debit Card, without the Consent of the Issuer	1/1/2004
[720 ILCS 250/8]	Using a Credit or Debit Card with the Intent to Defraud	1/1/2004
[720 ILCS 250/17.02]	Fraudulent Use of Electronic Transmission	1/1/2004
[720 ILCS 550/5]	Manufacture, Delivery, or Possession with Intent to Deliver, or Manufacture, Cannabis	N/A
[720 ILCS 550/5.1]	Cannabis Trafficking	N/A
[720 ILCS 550/5.2]	Delivery of Cannabis on School Grounds	1/1/1998
[720 ILCS 550/7]	Delivering Cannabis to a Person under 18	1/1/1998
[720 ILCS 550/9]	Calculated Criminal Cannabis Conspiracy	N/A
[720 ILCS 570/401]	Manufacture or Delivery, or Possession with Intent to Manufacture or Deliver, a Controlled Substance Other than Methamphetamine, a Counterfeit Substance, or a Controlled Substance Analog	N/A
[720 ILCS 570/401.1]	Controlled Substance Trafficking	N/A

[720 ILCS 570/404]	Distribution, Advertisement, or Possession with Intent to Manufacture or Distribute a Look-alike Substance	N/A
[720 ILCS 570/405]	Calculated Criminal Drug Conspiracy	N/A
[720 ILCS 570/405.1]	Criminal Drug Conspiracy	N/A
[720 ILCS 570/407]	Delivering a Controlled, Counterfeit or Look-alike Substance to a Person under 18	N/A
[720 ILCS 570/407.1]	Engaging or Employing Person under 18 to Deliver a Controlled, Counterfeit or Look-alike Substance	N/A
[720 ILCS 646]	Violations under the Methamphetamine Control and Community Protection Act	9/11/2005

Disqualifying Offenses that May Be Considered for a Rehabilitation Waiver

Illinois Compiled Statutes Citation	Offense	Additional Offense Added Effective
[720 ILCS 5/16-1]	Theft (as a misdemeanor)	N/A
[720 ILCS 5/16-2]	Theft of Lost or Mislaid Property	1/1/2004
[720 ILCS 5/16A-3]	Retail Theft (as a misdemeanor)	N/A
[720 ILCS 5/19-4]	Criminal Trespass to Residence	N/A
[720 ILCS 5/24-1.5]	Reckless Discharge of a Firearm	1/1/1998
[225 ILCS 65/10-5]	Practice of Nursing without a License	1/1/2004
[720 ILCS 115/53]	Cruelty to Children	1/1/1998
[720 ILCS 250/4]	Receiving Stolen Credit Card or Debit Card	1/1/2004
[720 ILCS 250/5]	Receiving a Credit or Debit Card with Intent to Use, Sell, or Transfer	1/1/2004
[720 ILCS 250/6]	Selling a Credit Card or Debit Card, without the Consent of the Issuer	1/1/2004
[720 ILCS 250/8]	Using a Credit or Debit Card with the Intent to Defraud	1/1/2004
[720 ILCS 250/17.02]	Fraudulent Use of Electronic Transmission	1/1/2004

Offenses that Are Always Disqualifying Except Through the Appeal Process

Illinois Compiled Statutes Citation	Offense	Additional Offense Added Effective
[720 ILCS 5/8-1.1]	Solicitation of Murder	1/1/1998
[720 ILCS 5/8-1.2]	Solicitation of Murder for Hire	1/1/1998
[720 ILCS 5/9-1]	First Degree Murder	N/A
[720 ILCS 5/9-1.2]	Intentional Homicide of an Unborn Child	N/A
[720 ILCS 5/9-2]	Second Degree Murder	N/A

[720 ILCS 5/9-2.1]	Voluntary Manslaughter of an Unborn Child	N/A
[720 ILCS 5/9-3]	Involuntary Manslaughter and Reckless Homicide	N/A
[720 ILCS 5/9-3.1]	Concealment of Homicidal Death	N/A
[720 ILCS 5/9-3.2]	Involuntary Manslaughter and Reckless Homicide of an Unborn Child	N/A
[720 ILCS 5/9-3.3]	Drug Induced Homicide	N/A
[720 ILCS 5/10-1]	Kidnapping	N/A
[720 ILCS 5/10-2]	Aggravated Kidnapping	N/A
[720 ILCS 5/11-6]	Indecent Solicitation of a Child	1/1/1998
[720 ILCS 5/11-9.1]	Sexual Exploitation of a Child	1/1/1998
[720 ILCS 5/11-9.5]	Sexual Misconduct with a Person with a Disability	7/24/2006
[720 ILCS 5/11-19.2]	Exploitation of a Child	1/1/1998
[720 ILCS 5/11-20.1]	Child Pornography	1/1/1998
[720 ILCS 5/12-3.3]	Aggravated Domestic Battery	1/1/2004
[720 ILCS 5/12-4]	Aggravated Battery	1/1/1998
[720 ILCS 5/12-4.1]	Heinous Battery	N/A
[720 ILCS 5/12-4.2]	Aggravated Battery with a Firearm	N/A
[720 ILCS 5/12-4.2-5]	Aggravated Battery with a Machine Gun or a Firearm Equipped with Any Device or Attachment Designed or Used for Silencing the Report of a Firearm	1/1/2004
[720 ILCS 5/12-4.3]	Aggravated Battery of a Child	N/A
[720 ILCS 5/12-4.4]	Aggravated Battery of an Unborn Child	N/A
[720 ILCS 5/12-4.6]	Aggravated Battery of a Senior Citizen	N/A
[720 ILCS 5/12-4.7]	Drug Induced Infliction of Great Bodily Harm	N/A
[720 ILCS 5/12-13]	Criminal Sexual Assault	N/A
[720 ILCS 5/12-14]	Aggravated Criminal Sexual Assault	N/A
[720 ILCS 5/12-14.1]	Predatory Criminal Sexual Assault of a Child	N/A
[720 ILCS 5/12-15]	Criminal Sexual Abuse	N/A
[720 ILCS 5/12-16]	Aggravated Criminal Sexual Abuse	N/A
[720 ILCS 5/12-19]	Abuse and Criminal Neglect of a LTC Facility Resident	N/A
[720 ILCS 5/12-21]	Criminal Abuse or Neglect of an Elderly Person or Person with a Disability	N/A
[720 ILCS 5/16-1.3]	Financial Exploitation of an Elderly Person or a Person with a Disability	N/A
[720 ILCS 5/18-2]	Armed Robbery	N/A
[720 ILCS 5/18-4]	Aggravated Vehicular Hijacking	1/1/1998

[720 ILCS 5/18-5]	Aggravated Robbery	1/1/1998

ATTENDANCE

The Illinois Department of Public Health, which approves this program, requires a specific number of hours to meet their requirements for the Nurse Aide Certification Program. See below:

Section 395.173 Successful Completion of the Basic Nursing Assistant Training Program

a) A student shall be considered to have successfully completed the BNATP when he or she has:
    1. Completed a minimum of 80 hours of theory and 40 hours of clinical instruction, including the required hours of content in accordance with Section 395.150; and
    2. Demonstrated competence in the Department-approved performance skills.
b) A student shall pass the Department-established written competency examination.

(Source: Amended at 37 Ill. Reg. 10546, effective June 27, 2013)

It is important that you attend each class and clinical day. According to the requirements listed above, you can miss a maximum of **24 theory** hours and **zero clinical** hours.

CLASS: Three (3) tardies, either late arrivals to class at the start of the day or after lunch break, or leaving early from theory class, equals one (1) day absent. A tardy is defined as 7 minutes late to theory class at the start of theory, after lunch, or coming back from a break. You will be counted absent if you are more than 30 minutes late to class. ***If you are absent on a class day***, it is your responsibility to make up missed work. It is the student's responsibility to make arrangements with the instructor to get all of the assignments missed. Missed tests are to be made up the next class day.
If a student has attendance issues, it is at the discretion of the Instructor and the Coordinator of Allied Health or Dean of Allied Health to proceed with administrative withdraw procedures.

CLINICAL: NO absences or tardies are allowed during clinical. In the event of extenuating circumstances, a make up clinical day will be provided.

Note: If you must drop the class for any reason, it is your responsibility to complete the necessary paperwork on campus with Student Records. The withdrawal form must be completed in person, NO phone drops will be allowed. If you do not officially withdraw from the class and just stop attending for any reason, you will receive a failing grade.

SLEEPING

Sleeping does not constitute active participation in either the classroom or clinical setting. If a student is caught sleeping in class, the instructor will issue a tardy. Students earning three (3) tardies due to this issue must withdraw from the course.

Sleeping at a clinical site is unacceptable and will not be tolerated. Students found sleeping at a clinical site must immediately withdraw from the course.

MEDICAL CONDITIONS

Declaration or disclosure of medical conditions is a voluntary act. The CNA program is willing to make reasonable accommodations for students with documented medical conditions when the

program is informed of the student's needs. If the student is unable to meet the minimum technical and/or physical standards that are required, they will be allowed to withdraw and return to a future class. Upon returning to the CNA program, students must present a note from their physician indicating they are able to meet the minimum technical and physical standards of the CNA program.

TB SCREENING

Prior to attending clinical, each student **must** have a two-step TB skin test with date and results verified.

TESTING AND GRADING

During the course you will have chapter tests, medical terminology tests and a comprehensive final exam. The grades of all tests will be averaged together for your final grade.

The clinical grade is pass/fail. Your clinical grade will be determined by your performance in the lab setting and in the long term care facility.

- 93 – 100 = A
- 85 – 92 = B
- 77 - 84 = C
- 76 and below = E

In order to pass the course and be eligible to apply to take the written competency exam, you must complete the course with an average of at least 77% in classroom and a passing grade in clinical.

NOTE: Active participation in class discussion, role-playing and demonstrations is part of your grade.

Weather related closings: WENS at www.rlc.edu website
In case of emergency on cell phones: ICE

Student Signature Page
Agreements

Directions: Please read, check each statement, print your name, sign your name and date at the bottom.

- I agree to maintain confidentiality regarding all aspects of clinical situations.
- I agree to abide by the patient's right to confidentiality.
- I hereby authorize Rend Lake College to release requested clinical requirements to agencies and Health Care Worker Registry, SIUC as required.
- I have read, understand, and agree to comply with the rules and regulations as stated in the Rend Lake College Basic Nurse Assistant Training Program Course Syllabus and Student Handbook, College Catalog and Clinical Facilities.

My signature acknowledges my receipt of this Handbook for CNA Students and the understanding that I am held accountable for knowing and abiding by the policies of the Rend Lake College Basic Nurse Assistant Training Program.

Student Name (print) _____

Student Signature _____

Date _____

Basic Nursing Assistant Training Performance Skill Evaluation

August 6, 2020

Illinois Department of Public Health

This instructional packet was developed collaboratively by the Illinois Department of Public Health and Illinois Nurse Assistant/Aide Training Competency Evaluation Program

Selected Manual Performance Skills

The selected 21 performance skills have been identified through the federal legislation that gives guidance to the Illinois Nurse Aide Competency Evaluation. A separate performance skill checklist is provided for each of the following skills:

- Performance Skill #1 Wash hands
- Performance Skill #2 Perform Oral Hygiene
- Performance Skill #3 Shave a Resident
- Performance Skill #4 Perform Nail Care
- Performance Skill #5 Perform Perineal Care
- Performance Skill #6 Give Partial Bath
- Performance Skill #7 Give a Shower or Tub Bath
- Performance Skill #8 Make Occupied Bed
- Performance Skill #9 Dress a Resident
- Performance Skill #10 Transfer Resident to Wheelchair Using a Transfer Belt
- Performance Skill #11 Transfer Using Mechanical Lift
- Performance Skill #12 Ambulate with Transfer Belt
- Performance Skill #13 Feed A Resident
- Performance Skill #14 Calculate Intake and Output
- Performance Skill #15 Place Resident in a Side-Lying Position
- Performance Skill #16 Perform Passive Range of Motion
- Performance Skill #17 Apply and Remove Personal Protective Equipment
- Performance Skill #18 Measure and Record Temperature, Pulse and Respiration
- Performance Skill #19 Measure and Record Blood Pressure
- Performance Skill #20 Measure and Record Weight
- Performance Skill #21 Measure and Record Height

STUDENTS MUST SHOW COMPENTENCE IN ALL 21 OF THESE PERFORMANCE SKILLS IN ORDER TO SUCCESSFULLY COMPLETE A BASIC NURSING ASSISTANT TRAINING PROGRAM.

Beginning and Completion Tasks

Performance skills 2-21 have “Beginning” and “Completion” tasks as defined below. Refer back to this page as necessary for the steps of those tasks.

BEGINNING TASKS

1. Wash Hands.
2. Assemble Equipment.
3. Knock and pause before entering.
4. Introduce self and verify resident identity as appropriate.
5. Ask visitors to leave.
6. Provide privacy for the resident.
7. Explain the procedure and answer questions.

Note: Let the resident assist as much as possible and honor preferences.

COMPLETION TASKS

1. Position the resident comfortably.
2. Remove or discard gloves/protective equipment.
3. Wash hands.
4. Return the bed to an appropriate position.
5. Place signal cords, phone and water within reach of the resident.
6. Conduct general safety check/resident and environment.
7. Open the curtains.
8. Care for the equipment as necessary.
9. Wash hands.
10. Let visitors reenter, as appropriate.
11. Report completion of task, as appropriate.
12. Document actions and observations.

Performance Skill #1: WASH HANDS

STANDARD: HANDS ARE WASHED WITHOUT RECONTAMINATION.

While equipment may vary, the principles noted on the competency exam must be followed at all times.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Stood so that clothes did not touch sink.	
2	Turned on water and adjusted temperature to warm; left water running.	
3	Wet wrists and hands; kept hands lower than level of elbow throughout procedure.	
4	Applied soap or cleaning agent to hands using available products.	
5	Washed hands and wrists using friction for 15-20 seconds.	
6	Rinsed hands and wrists well under running water with fingertips pointed down.	
7	Dried hands thoroughly with paper towel(s) from fingertips to wrists.	
8	Disposed of used paper towel(s).	
9	Used dry paper towel between hand and faucet to turn off water.	
10	Disposed of used paper towels.	

Performance Skill #2: PERFORM ORAL HYGIENE

STANDARD: MOUTH, TEETH AND/OR DENTURES WILL BE FREE OF DEBRIS.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Positioned resident appropriately.	
3	Cleaned oral cavity using appropriate oral hygiene products.	
4	Rinsed oral cavity.	
5	Repeated steps 3 and 4 until oral cavity was clean.	
6	Cleaned and rinsed teeth, dentures if applicable.	
7	Assisted resident to clean and dry mouth area.	
8	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill #3: SHAVE A RESIDENT

STANDARD: RESIDENT IS FREE OF FACIAL HAIR WITH NO ABRASIONS OR LACERATIONS.

The student is assigned the task of shaving a resident's (preferably male) face. The evaluator must obtain a list of residents who need to be shaved and for whom shaving is not contraindicated. Example: Residents taking anticoagulants should not be assigned.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks.	
2	Positioned resident.	
3	**Shaved resident:**	
	A. Non-Electric Shave:	
	a. Applied shaving cream or soap.	
	b. Shaved resident, holding skin taut and using single, short strokes primarily in the direction of the hair growth rinsing razor frequently.	
	c. Rinsed face with warm cloth.	
	d. Applied after shave product as appropriate.	
	e. Discarded razor into the appropriate container.	
	OR	

Performance Skill #3: SHAVE A RESIDENT (CONTINUED)

	B. Electric Shave:	
	a. Checked to be sure that the razor was clean.	
	b. Verified that the resident was prepared with a clean, dry face.	
	c. Turned on razor, observing precautions for using electrical equipment.	
	d. Shaved resident by holding skin taut and moving the razor over a small area of the face in the direction of the hair growth until the hair was removed.	
	e. Cleaned the razor after use.	
	f. Applied after shave product as appropriate.	
4	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill #4: PERFORM NAIL CARE

STANDARD: FINGERNAILS ARE CLEAN AND SMOOTH.

IMPORTANT: Do not assign residents with diabetes to students for nail care. Facility policies may vary in the area of nail care; at all times, facility policies must be observed. **NOTE: CNAs are not to trim the toenails of residents.**

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Washed, soaked and dried the resident's hands.	
3	Cleaned the nails with appropriate device.	
4	Clipped one nail at a time, so that edges are smooth according to resident preference.	
5	Filed nails, as needed, smoothing rough areas.	
6	Applied lotion as needed.	
7	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 5: PERFORM PERINEAL CARE

STANDARD: PERINEAL AREA IS CLEAN.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Filled basin with water at correct temperature to resident preference, if applicable.	
3	Covered the resident appropriately to avoid exposure and maintain dignity.	
4	Placed a waterproof pad under buttocks.	
5	Positioned resident appropriately.	
6	Wet washcloths and applied cleansing solution.	
7	Washed perineal area: A. Females: Separated the labia, cleaned front to back using downward strokes. Used a clean area of the cloth for each downward motion. Repeated using additional cloths, as needed. B. Males: Retracted foreskin in uncircumcised male. Grasped penis, cleaned tip of penis using a circular motion, washed down shaft of the penis and washed testicles. Replaced foreskin of uncircumcised male.	
8	Rinsed the perineal area, if applicable. Then pat dry.	
9	Turned the patient on their side facing away. Cleaned anal area by washing from front to back.	
10	Pat this area dry, if applicable.	
11	Removed waterproof pad and discarded.	
12	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 6: GIVE PARTIAL BATH

STANDARD: DESIGNATED BODY AREAS, INCLUDING THE PERINEAL AREA, ARE WASHED, RINSED AND DRIED.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Prepared resident for partial bath.	
3	Filled basin with water at correct temperature to resident preference.	
4	Washed, rinsed and dried face, hands, axilla, perineal area and other areas as appropriate.	
5	Removed linen used for bathing and placed in appropriate container.	
6	Prepared resident for dressing.	
7	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 7: GIVE A SHOWER OR TUB BATH

STANDARD: BODY IS CLEAN USING A SHOWER OR TUB BATH.

Directions: Place a “p” for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Prepared resident for shower or tub bath.	
3	Adjusted water temperature to resident preference throughout bath.	
4	Washed, rinsed and dried in appropriate head to toe sequence allowing for resident independence.	
5	Shampooed hair as appropriate.	
6	Prepared resident to leave shower or tub bath area.	
7	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 8: MAKE OCCUPIED BED

STANDARD: OCCUPIED BED MUST BE NEAT, WRINKLE FREE WITH PERSON AND BED PLACED IN THE APPROPRIATE POSITIONS.

The person must be in bed with the side rails up (if applicable) while the bed is being made. If side rails are not available, an alternative safety measure shall be used. When side rails are used as a safety measure during this procedure, care must be taken to prevent personal injury. Dirty linen is defined as linen that contain no visible body fluids. Gloves may be worn when handling dirty linen. Soiled linen is defined as linen that may be contaminated with body fluids. Gloves shall be worn when handling soiled linen.
At the completion of this task the bed must be left in the appropriate position with side rails up or down as indicated by the needs of the individual (if side rails are available).

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Removed top linen, keeping person covered. Raised bed to working height.	
3	Positioned individual on one side of bed with side rail up (if applicable) using appropriate safety measures on unprotected side, and using appropriate body mechanics.	
4	Tucked dirty linen under individual. Used gloves if linen is contaminated with blood or body fluids.	
5	Replaced bottom linen on first side. Tucked corners and sides neatly under mattress.	
6	Repositioned individual to other side using appropriate safety measures on unprotected side.	
7	Removed dirty linen by rolling together, held away from clothing, and placed dirty linen in appropriate container. Disposed of gloves, if used, and washed hands.	

Performance Skill # 8: MAKE OCCUPIED BED (CONTINUED)

8	Completed tucking clean linen under mattress with corners and sides tucked neatly under mattress on the second side.	
9	Repositioned the individual to a comfortable position.	
10	Placed top sheet over individual. Removed dirty covering. Tucked bottom corners and bottom edge of sheet under mattress, as indicated.	
11	Placed blanket/spread over person. Tucked bottom corners and bottom edge or blanket/spread under mattress, as indicated. Pulled top edge of sheet over top edge of blanket/spread.	
12	Removed and replaced pillowcase appropriately. Replaced pillow under individual's head. Toe pleat.	
13	Placed bed in appropriate position. (LTC side rails are down unless ordered or on Care Plan).	
14	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 9: DRESS A RESIDENT

STANDARD: RESIDENT IS DRESSED IN OWN CLOTHING, INCLUDING FOOTWEAR, WHICH IS NEAT AND CLEAN. RESIDENT IS COMFORTABLE DURING DRESSING PROCEDURE AND CHOOSES OWN CLOTHING WHEN ABLE.

Clothing should consist of undergarments, dress, or shirt or blouse and pants, socks and footwear.

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Asked resident preference and gathered resident’s own clean clothing.	
3	Dressed the resident in undergarments, top, pants (or dress) and footwear, as appropriate.	
4	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill #10: TRANSFER A RESIDENT TO WHEELCHAIR USING A TRANSFER BELT

STANDARD: APPLIED TRANSFER BELT; ASSISTED RESIDENT TO STAND, PIVOT AND SIT IN WHEELCHAIR WITH BODY ALIGNED.

This skill requires that a resident be transferred from the bed to a wheelchair with the use of a transfer belt which is also referred to as a gait belt.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Lowered bed to appropriate position.	
3	Positioned wheelchair at bedside.	
4	Locked brakes.	
5	Assisted resident to sitting position.	
6	Applied transfer belt firmly around the resident's waist (should be adjusted to allow evaluator to place one or two fingers between the belt and the resident).	
7	Adjusted transfer belt over clothing so that buckle is off center.	
8	Applied non-skid footwear to resident.	
9	Grasped transfer belt on both sides with underhand grasp.	
10	Assisted resident to stand; pivot and sit in wheelchair.	
11	Placed resident's feet on foot rests, if applicable.	
12	Aligned resident's body in wheelchair.	
13	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 11: TRANSFER USING A MECHANICAL LIFT

STANDARD: TRANSFERRED PERSON SAFELY UTILIZING A MECHANICAL LIFT.

Followed facility policy for use of lift according to manufacturer's instructions.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Identified appropriate lift for resident.	
3	Applied correct sling/belt.	
4	Attached sling/belt to mechanical lift.	
5	Verified resident's readiness for transfer.	
6	Operated the mechanical lift controls according to manufacturer's instructions.	
7	Maneuvered the lift safely.	
8	Lowered resident safely.	
9	Disconnected sling/belt from lift.	
10	Removed sling/belt if applicable.	
11	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 12: AMBULATE WITH TRANSFER BELT

STANDARD: AMBULATED PERSON SAFELY UTILIZING TRANSFER BELT.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Locked bed or chair wheels, if appropriate.	
3	Ensured the person was appropriately attired including non-skid footwear.	
4	Applied transfer belt firmly around person's waist (should be adjusted to allow evaluator to place two fingers between the belt and the person.)	
5	Assisted the person to standing position.	
6	Stood at the person's affected side (if applicable) while balance is gained.	
7	Ensured the person stood erect with head up and back straight, as tolerated. (verbal cues)	
8	Assisted the person to walk. Walked to the side and slightly behind the person. Held transfer belt using under hand grasp.	
9	Encouraged the person to ambulate normally with the heel striking the floor first. Discouraged shuffling or sliding, if noted. (verbal cues)	
10	Ambulated the required distance, if tolerated.	
11	Assisted the person to return to bed or chair.	
12	Removed transfer belt appropriately.	
13	Performed completion tasks (refer to page 38 in this manual).	

Performance Skills #13: FEED A RESIDENT

STANDARD: RESIDENT IS FED PRESCRIBED DIET IN A COURTEOUS AND SAFE MANNER.

The student should be assigned to feed someone without any special feeding techniques required.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Prepared the resident for the meal (i.e. allowed resident to use toilet and wash hands).	
3	Positioned resident in sitting position as appropriate.	
4	Matched food tray/diet items with resident's diet order.	
5	Matched food tray/dietary items with appropriate resident.	
6	Protected resident's clothing, as appropriate or as resident prefers.	
7	Noted temperature of food and liquids to avoid food that is too hot or too cold.	
8	Fed moderate-sized bites with appropriate utensil.	
9	Interacted with resident as appropriate (i.e., conversation, coaxing, cueing, being positioned at eye level with the resident).	
10	Alternated liquids with solids, asking resident preference.	
11	Ensured the resident has swallowed food before proceeding.	
12	Cleaned resident as appropriate when completed.	
13	Removed tray, cleaned area.	
14	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 14: CALCULATE INTAKE AND OUTPUT

STANDARD: TOTAL INTAKE AND OUTPUT QUANTITIES CALCULATED WITHOUT ERROR.

The student is to measure intake and output in cubic centimeters (cc) or milliliters (ml). The student may be told the fluid capacity of the containers (glasses, cups, bowls).

Directions: Place a “p” for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Wrote down the intake and output amounts in the units used to measure the intake and output quantities (i.e., cc=cubic centimeters, ml=milliliters, oz=ounces).	
3	Converted the measured unit into the units to be recorded on resident intake and output chart.	
4	Calculated all the measured quantities listed as resident intake to obtain a total amount of intake for the time period.	
5	Added all the measured quantities listed as resident output to obtain a total amount of output for the time period.	
6	Recorded the total intake and output to be compared to the recorded intake and output calculation of the evaluator.	
7	Performed completion tasks (refer to page 38 in this manual).	

-Worksheet

Performance Skill # 15: PLACE RESIDENT IN SIDE-LYING POSITION

STANDARD: BODY ALIGNED WITH DEPENDENT EXTREMITIES SUPPORTED AND BONY PROMINENCES PROTECTED.

Either of two positions is acceptable: side-lying position or a variation in which knees are flexed with appropriate padding between the knees and ankles.

Directions: Place a "p" for PASSED in the column to the right or each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Raised side rail on unprotected side of bed (if applicable).	
3	Positioned resident on side in the center of the bed in side-lying position.	
4	Placed appropriate padding.	
	a. Behind back.	
	b. Under head.	
	c. Between legs.	
	d. Supporting dependent arm.	
5	Ensured resident is in good body alignment.	
6	Raised side rails, if appropriate.	
7	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 16: PASSIVE RANGE OF MOTION

STANDARD: COMPLETED THREE DIFFERENT RANGE-OF-MOTION EXERCISES WITHOUT GOING PAST THE POINT OF RESISTANCE OR PAIN.

The body part to be exercised must be supported. The student is not to force a joint beyond its present range of motion or to the point of pain. The student is required to name the exercise being performed (e.g., abduction, flexion). The approved evaluator will verify the number of repetitions for the selected ROM exercise with the student.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Demonstrated three different range of motion movements.	
	a. Flexion and extension.	
	b. Abduction and adduction.	
	c. Pronation and supination.	
	d. Dorsal and plantar flexion.	
	e. Opposition.	
	f. Internal/External rotation.	
	g. Radial deviation and ulnar deviation.	
3	Supported the proximal and distal ends of the extremity or the joint itself.	
4	Observed the resident's reaction during the procedure.	
5	Demonstrated or verbalized the need to stop moving if pain or resistance was noted.	
6	Performed completion tasks (refer to page 38 in this manual).	

Appendix B Info too

Performance Skill # 17: APPLY AND REMOVE PERSONAL PROTECTIVE EQUIPMENT

STANDARD: APPLIED AND REMOVED PERSONAL PROTECTIVE EQUIPMENT WITHOUT CONTAMINATION.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Identified type of isolation required. (verbalize) Droplet Airborne Contact, Reverse/Protective/Neuropemiu	
3	Applied appropriate personal protective equipment outside the isolation room.	
	• Mask: Placed mask over nose and mouth, secured appropriately.	
	• Gown: Applied gown and secured it at neck and waist.	
	• Gloves: Applied gloves appropriately.	
4	Removed Personal Protective Equipment inside the isolation room.	
	• Gloves: Removed gloves appropriately. Washed hands.	
	• Gown: Removed gown appropriately. Washed hands.	
	• Mask: Removed mask appropriately. Washed hands.	
5	Discarded Personal Protective Equipment appropriately.	
6	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 18: MEASURE AND RECORD TEMPERATURE, PULSE, AND RESPIRATION

STANDARD: ORAL TEMPERATURE IS MEASURED TO WITHIN + OR – 0.2 DEGREES OF EVALUATOR'S READING UNLESS A DIGITAL THERMOMETER IS USED. RADIAL PULSE IS MEASURED TO WITHIN **+ OR – TWO BEATS OF EVALUATOR'S RECORDING OF RATE. RESPIRATON IS MEASURED TO WITHIN + OR – TWO RESPIRATIONS OF EVALUATOR'S RECORDING OF RATE.**

The evaluator must simultaneously count the rate for the length of time specified by the student and determine the correct rate.

Pulse and Respiration cannot be a combined procedure; they must be measured separately.

Directions: Place a "p" for PASSED in the column to the right of the step when it is performed according to the standard.

	MEASURE ORAL TEMPERATURE:	
1	Performed beginning tasks (refer to page 38 in this manual).	
2	Positioned resident, sitting or lying down.	
3	Activated the thermometer.	
4	Covered thermometer as appropriate.	
5	Placed the thermometer probe appropriately.	
6	Instructed the resident to close mouth around the thermometer.	
7	Stayed with the resident during the entire procedure.	
8	Removed the thermometer when appropriate.	
9	Read the thermometer.	
10	Recorded and reported the results within + or – 0.2 degrees of the evaluator's recorded temperature reading.	

Performance Skill # 18: MEASURE AND RECORD TEMPERATURE, PULSE, AND RESPIRATION (CONTINUED)

11	Performed completion tasks (refer to page 38 in this manual).	
	MEASURE RADIAL PULSE:	
1	Performed beginning tasks (refer to page 38 in this manual).	
2	Positioned resident, sitting or lying down.	
3	Located radial pulse at wrist.	
4	Placed fingers over radial artery. Student does this first, then evaluator locates pulse on opposite wrist.	
5	Determined whether to count for 30 seconds or 60 seconds.	
6	Counted pulsations for 30 seconds and multiplied the count by 2; or for one minute if irregular beat. **Student must tell** when to start and end count.	
7	Recorded the **pulse rate within + or – two beats** per minute of pulse rate recorded by evaluator.	
	MEASURE RESPIRATION:	
8	Positioned hand on wrist as if taking the pulse as appropriate.	
9	Determined whether to count for 30 seconds or 60 seconds.	
10	Counted respirations for 30 seconds and multiplied the count by 2; or for one minute if irregular. Student must tell when to start and end count.	
11	Recorded the respiratory rate within + or – two respirations per minute of respiratory rate recorded by evaluator.	
12	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 19: MEASURE AND RECORD BLOOD PRESSURE

STANDARD: MEASURE AND RECORD **BLOOD PRESSURE TO WITHIN + OR – 4MM OF THE** EVALUATOR'S READING USING DUAL STETHOSCOPE.

A teaching/training (dual head design) stethoscope must be used simultaneously by the student and the evaluator. On the exam itself, a safety issue is listed, "cuff deflated in a timely manner." This means that the cuff should not be left inflated over the resident's arm long enough to cause discomfort, discoloration or injury. In the event that a **student is hearing impaired, that student will be allowed to use an amplified stethoscope.**

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Cleaned earpieces of stethoscope.	
3	Positioned resident sitting or lying.	
4	Made sure the room was quiet; turned down loud TV or radio.	
5	Selected the appropriate size cuff and applied it directly over the skin, above the elbow.	
6	Positioned the stethoscope over the brachial artery.	
7	Inflated the cuff per the instructor's direction.	
8	Identified the systolic and diastolic measurements while deflating the cuff.	
9	Deflated the cuff in a timely manner.	
10	Re-measured, if necessary, to determine the accuracy (waited one minute if using the same arm or use the other arm, if appropriate).	
11	Recorded blood pressure measurement to be compared with the blood pressure recorded by the evaluator.	
12	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 20: MEASURE AND RECORD WEIGHT

STANDARD: MEASURE AND RECORD WEIGHT **TO WITHIN + OR – ½ POUND**.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Balanced scale at zero.	
3	Weighed individual.	
	A. Individual who is able to stand to be weighed:	
	a. Placed paper towel on scale platform.	
	b. Assisted individual to stand on scale platform without footwear.	
	c. Read weight measurement.	
	d. Recorded weight measurement to be compared to the weight measurement recorded by the evaluator.	
	e. Assisted individual off of scale with appropriate assistance as necessary.	
	OR	
	B. Individual who is weighed by wheelchair or bed scale:	
	a. Sanitized wheelchair/bed scale according to facility policy.	
	b. Assisted individual on wheelchair scale or bed scale as appropriate.	
	c. Read weight measurement.	
	d. Recorded weight measurement to be compared to the weight measurement recorded by the evaluator.	
	e. Assisted resident off wheelchair/bed scale as appropriate.	
4	Returned scale balanced to zero.	
5	Performed completion tasks (refer to page 38 in this manual).	

Performance Skill # 21: MEASURE AND RECORD HEIGHT

STANDARD: HEIGHT IS **MEASURED TO WITHIN ½ INCH IN EITHER** STANDING OR NONSTANDING INDIVIDUAL.

Directions: Place a "p" for PASSED in the column to the right of each step when it is performed according to the standard.

1	Performed beginning tasks (refer to page 38 in this manual).	
2	Measured height.	
	A. Individuals who are ABLE TO STAND:	
	a. Used appropriate measuring device.	
	b. Placed paper towel on platform as appropriate.	
	c. Instructed individual to stand erect without shoes.	
	d. Read height measurement.	
	e. Recorded height measurement and converted appropriately to be compared to the height measurement recorded by the evaluator.	
	OR	
	B. Individuals who are UNABLE TO STAND:	
	a. Position individual on side or back without shoes.	
	b. Used appropriate measuring device.	
	c. Read height measurement.	
	d. Recorded height measurement and converted appropriately to be compared with the height measurement recorded by the evaluator.	
	e. Repositioned individual, as necessary.	
3	Performed completion tasks (refer to page 38 in this manual).	

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Study Guide for Quiz
Medical Terminology and Abbreviations

ab-
abdomin
-algia
arteri
card
col
cyan
-cyte
dermat
-ectomy
-emesis
erythr
gastr
hemat
hepat
hypo
-itis
laryng
leuk
mast
-megaly
my
nephr
-pathy
-plasty
-plegia
pneum
pulmon
-ologist
-osis
ot
rhin
scler
ven
ADL
Fl

ac
ASAP
BRP
DON
cl liq
F
HOB
NPO
ROM
TPR
I&O
UA
VS
N&V
WNL
ad lib
SOB
w/c
prn
as tol
bid
tid
wt

Objective 1:

Textbook: Chapter 1: Introduction to Healthcare
Chapter 2: The Nursing Assistant
Chapter 3: Professionalism
Chapter 4: Legal and Ethical Issues-Resident Rights
Chapter 8: The Long-Term Care Resident
Chapter 13: Workplace Safety
Chapter 14: Resident Safety and Restraints
Appendix B: Medical Terminology and Abbreviations

Nursing Skills: Hand washing, beginning and ending steps,
Vocabulary Words: Medical terminology and abbreviations

1. Describe the different types of health care organizations (hospital, skilled care, long term care, home health, and hospice.)

2. Differentiate between acute, chronic, and terminal conditions

3. Explain the structure of healthcare organizations

4. Explain two important government regulations that affect the health care system (OBRA, OSHA)

5. Discuss how healthcare is paid for

6. Describe resident rights as set forth by the Omnibus Reconciliation Act of 1987

7. List common legal violations that are related to the provision of healthcare

8. Discuss legal aspects of healthcare delivery and display awareness one must have to avoid legal dilemmas

9. Describe signs of elder abuse and discuss the healthcare worker's obligation in reporting suspected abuse

10. Explain the difference between legal and ethical issues

11. Discuss the OBRA requirements for nursing assistant training

12. Describe the CNA registry

13. Discuss the responsibilities of the nursing assistant

14. List the members of the nursing team, and the roles of each team member

15. Identify other members of the health care team and their respective tasks

16. Define the terms professional and professionalism

17. Discuss characteristics that demonstrate professionalism and explain the importance
18. Define the term work ethic and describe how good work habits promote professionalism

19. Define the term body mechanics and demonstrate actions that make the body more effective when working

20. Demonstrate the use of good body mechanics when lifting

21. Describe ways to prevent back injury

22. List steps taken before and after every patient or resident care procedure and explain why these steps are taken

23. Describe importance of following policy/procedures

24. Describe chemical hazards, electrical hazards and ways to avoid them

25. Identify risk factors that put residents at higher safety risk

26. List elements necessary to start a fire

27. Describe the RACE fire response plan

28. Demonstrate how to use a fire extinguisher and understand acronym "PASS"

29. Identify risk factors that may put people at a higher risk for accidents and injuries

30. Describe basic safety methods designed to prevent accidents

31. Understand the importance of reporting and recording occurrences

32. List the different types of restraints, and methods used to reduce the need for restraints. Demonstrate the proper application of a vest, wrist and waist restraint

- Show 19 minute HIPAA Video and 16 minute Bloodborne Pathogens Video

Vocabulary Words
Objective 1

Holistic
Health Care Team
Interdisciplinary
Acute Illness
Chronic Illness
Terminal Illness
OBRA
OSHA

MSDS
Medicare
Medicaid
Minimum Data Set
Nurse Aide Registry
Nursing Care Plan
Policy
Procedure
Empathy
Job Description
Scope of Practice
Delegate
Body Mechanics
Alignment
Patient
Resident
Client
Ombudsman

Resident Rights
Criminal Law
Civil Law
False Imprisonment
Tort
Defamation of Character
Libel
Slander
Assault
Battery
Fraud
Malpractice
Negligence
Physical Abuse
Verbal Abuse
Confidentiality
Informed Consent
Incident
Restraint
Ethics
Attitude
Values
Larceny
Litigation
Abuse
Director of Nursing

Study Tip: Write out the definitions of these terms.

Resolving Grievances and Disputes

An ombudsman is assigned by law as the legal advocate for residents. The ombudsman visits and listens to residents. He or she decides what action to take if there is a problem. An ombudsman can help resolve conflicts and settle disputes. They provide an ongoing presence in nursing homes. They monitor care and conditions.

An ombudsman typically:

- Advocates for Residents' Rights and quality care
- Educates consumers and care providers
- Investigates and resolves complaints
- Appears in court and/or in legal hearings
- Works with investigators from the police, adult protective services, and health departments to resolve complaints
- Gives information to the public

Personnel Policies

Personnel policies describe both the benefits provided to employees and the expectations of the employer. Included are guidelines for acceptable employee behavior. Just as we all must follow the "rules of the road" to avoid chaos on the streets, employees must follow the "rules to work by" to have order within a facility. Review the sample standards of conduct that follow.

Standards of Conduct

The following behaviors are not acceptable in facilities. They may result in disciplinary and/or legal action.

1. Verbal and/or physical abuse to a resident, visitor, or supervisory personnel
2. Inefficiency, in ability, and/or gross or repeated negligence in performance of assigned duties
3. Stealing or willfully destroying or damaging any property of the facility, its residents, visitors, or other personnel
4. Disobedience or insubordination to supervisors
5. Disorderly, immoral, or indecent conduct
6. Reporting for work, or attempting to work, while under the influence of or addicted to alcohol, drugs, or narcotics
7. Borrowing money or other possessions from residents and/or accepting gratuities or tips from patients and/or their families
8. Unauthorized possession of firearms or other weapons on facility property
9. Absence without notifying the supervisor or administrator
10. Smoking in an unauthorized area
11. Selling tickets, pools, raffles, or soliciting of any kind on facility premises
12. Using the facility business phone for personal calls
13. Altering, falsifying, or making a willful misstatement of facts on any resident record or chart, job or work report
14. Failure to provide care to residents in such a way as to guarantee them their right to be treated with respect and dignity
15. Failure to protect confidentiality of resident records, information, and so on, or disclosing anything of a personal nature concerning a resident at any time either inside or outside the facility
16. Punching another person's time card or requesting that another person punch your time card
17. Refusal to work where assigned

Resident's Rights
For People in Long Term Care Facilities

Your rights to safety and good care:

- Your facility must provide services to keep your physical and mental health, and sense of satisfaction with yourself, at their highest practical levels.
- Your facility must be clean and stay at a healthy temperature.
- You must not be abused by anyone-physically, verbally, mentally or sexually.
- Your facility must not be physically restraining you unless there is no other way to keep you safe and you agree to the restraint.
- You may be given medicine intended to change your mood or how you think only with your permission and only as part of an overall plan designed to change or remove the problems for which the medicines are given.

Your rights to participate in your own care:

- Your facility must develop a written care plan which states all the services your facility will provide to you and everything you are expected to do. Your facility must make reasonable arrangements to meet your needs and choices.
- You may go to the care plan conference where your care is decided.
- You may choose to have family, friends or a representative participate in the care plan conference.
- You have the right to choose your own doctor. You will have to pay the doctor yourself unless Medicare, your insurance plan or Medicaid will pay the doctor bill.
- Your facility must tell you the name and specialty of each doctor responsible for your care, and how to contact that doctor.
- You have the right to be in charge of taking your own medicine if your care planning team and your doctor say that you are able to do so.
- You have the right to refuse any medical treatment. If you refuse a treatment, your facility must tell you what may happen because of your refusal and tell you of other possible treatments.
- You have the right to complete information about your medical condition and treatment in a language that you can understand.
- You have the right to make a Living Will or a Durable Power of Attorney for Health Care, so the facility will know your wishes if you can no longer speak for yourself.
- You may refuse to participate in any experimental treatment on you or allow anyone to use information about you for research without your permission.
- Your facility must allow you to see your medical records within 24 hours of your request. You may purchase a copy or part or all of your record at a reasonable copy fee with two working days notice.
- Your facility may not require you to work.
- You have the right to move out of your facility after you give the administrator, nurse, or doctor written notice that you plan to move.

Your right to privacy:

- Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care.
- Facility staff must knock before entering your room.
- Your facility may not give information about you or your care to unauthorized persons without your permission, unless you are being transferred to a hospital or to another health care facility.
- You have the right to have private visits at a reasonable hour. The only exception is if you doctor has ordered limited visits for medical reasons.
- You may ask any visitor to leave your personal living area at any time.
- You have the right to make and receive phone calls in private.
- Your facility must deliver your mail to you promptly, and promptly send mail out for you. Your facility may not open your mail.
- If you are married, you and your husband or wife has the right to share a room unless no room is available or your doctor has said you cannot share a room for medical reasons.

Your rights regarding your money:

- You have the right to manage your own money. Your facility may not require you to let them manage your money or be your Social Security representative payee.
- If you ask your facility to manage your personal money for you, it must do so.
- You may see your financial record at any time.
- If your facility manages your money,
  - It may spend your money only with your permission.
  - It must give you an itemized written statement at least once every three months of all money put into and taken out of your account.
  - It must put your money in a bank account that earns interest.
- If you die, within 30 days of your death your facility must give your family, or whoever is in charge of distributing your property, a final accounting of all money left in any account which the facility manages for you.
- You have the right to expect your facility to have a safe place where you can keep small valuables which you can get to daily.
- Your facility must try to keep your property from being lost or stolen. If your property is missing, the facility must try to find it.

Your personal property rights:

- You have the right to keep and wear your own appropriate clothing.
- You may keep and use your own property, including some furniture if there is enough space, unless this interferes with the health and safety of other residents.

Your rights in paying for your care and getting Medicare and Medicaid:

- If you are paying for some of all of your care at your facility, you must be given a contract that states what services are provided by the facility and how much they cost. The contract must say what expenses are not part of the regular rate.
- Your facility must not require anyone else to sign an agreement saying that they will pay your bill if you cannot pay it yourself. The only one who can be required to pay your bill

for you is a court appointed guardian or someone else who is handling your money for you.

- Your facility must give you information about how to apply for Medicaid and Medicare and rules about "spousal impoverishment." Spousal impoverishment rules allow you to give money and property to your husband or wife and still be eligible for Medicaid.
- You have the right to apply for Medicaid or Medicare to help pay for your care. Your facility must not make you promise not to apply for Medicare or Medicaid.
- If you get Medicaid, the facility may not make you pay for anything that Medicaid pays for. The facility must give you a written list of what items and services Medicaid pays for, and for items and services for which you could be charged.

Your rights to stay in your facility:

- You have the right to keep living in your facility, unless your facility forces you to move because you are dangerous to yourself or others, for medical reasons, you have not paid or are late paying your bill, or your facility closes.
- You must be given written notice (Notice of Involuntary Transfer or Discharge Pursuant to the Nursing Home Care Act), if your facility wants you to move from the facility. Ask for it or, by moving and not receiving it, you may be agreeing to a voluntary transfer to another facility. If requested, the notice must:
  - tell you why you must leave
  - Tell you how to appeal to the IDPH
  - Provide a stamped, addressed envelope for you to mail your appeal
  - Be received 30 days prior to the day they want you to move from a Medicare or Medicaid certified facility or
  - Be received 21 days prior to the day they want you to move from a State licensed facility.
- You have the right to appeal to the IDPH and if you choose to appeal:
  - A DPH hearing officer will travel to your facility to hear why you believe you should stay in the facility and why the facility believes you should move; and
  - Usually your facility cannot make you leave until the appeal is decided by the DPH.
- Before your facility can transfer or discharge you, it must prepare and orient you to be sure that you discharge is safe and is being made to an appropriate setting.
- You cannot be forced to leave your facility because you are applying for Medicaid or you are on Medicaid and a Medicaid bed is available. It is important to ask the facility how many Medicaid beds it has.
- You have the right to ask the Long Term Care Ombudsman for help in appealing your facility's forcing you to move.
- If you get Medicaid and are hospitalized for ten or fewer days, your facility must let you return when you leave the hospital even if the facility has given you a written involuntary discharge notice.
- If you are hospitalized for more than ten days, your facility must let you return if it has a bed available and you still need that kind of care.
- If your facility is full, you must be allowed to have the first available semi-private room, if you still need that kind of care.
- You have the right to be told in advance if your room or roommate is being changed.
- Your facility must let you see reports of all inspections by the IDPH from the last five

years and the most recent survey of your facility along with any plan that your facility gave to the surveyors saying how your facility plans to correct the problem.

- You do not lose your rights as a citizen of Illinois and the United States because you live in a long term care facility.
- If a court of law has appointed a legal guardian for you, your guardian may exercise your rights for you.
- If you have named an agent under a Durable Power of Attorney for Health Care, your agent may exercise your rights for you.
- You have freedom of religion. At your request, the facility must make arrangements for you to attend religious services of your choice as long as you agree to pay any cost. The facility may not force you to follow any religious beliefs or practices and cannot require you to attend any religious services.
- You have the right to vote for the candidate of your choice.
- You have the right to participate in social and community activities that do not interfere with the rights of other residents.
- You have the right to participate with other residents in the Resident Council. Your facility must respond to concerns raised by the council.
- You have the right to meet with the Long Term Care Ombudsman, community organizations, social service groups, legal advocates, and Representatives of these groups may come to your facility to give you services, tell you about your rights, or help you assert your rights.
- You have the right to present grievances…
  - To your facility and to get a prompt response. Your facility may not threaten or punish you in any way for asserting your rights or presenting grievances.
  - To outside organizations and advocates including the following agencies:
  - Long Term Care Ombudsman
  - Equip for Equality
  - IDPH

Legal Issues for CNA's

Legal Standards
These are guidelines to lawful behavior. When laws are not obeyed you can be prosecuted and found liable for injury and damages. Legal guilt can result in fines and imprisonment, as well as loss of certification/license to work as a CNA.

Laws are passed by local, state, and federal government. All citizens are expected to obey these laws…when you disobey a law you are liable for fines and/or imprisonment. CNA's can avoid this by:

- Knowing and staying within their state's scope of practice rules.
- Do only those task and skills you have been taught; if you're asked to do tasks you have not been trained to do ask for guidance.
- Carry out your tasks and procedures carefully and only as you were taught.
- Keep up to date with your skills and education and in-service requirements.
- In questionable situations, seek the advice of your supervisor.
- Make sure you fully understand your assignment and what is expected of you.
- Know your facility policies and procedures and follow them.
- Do no harm to your patients.
- Respect the personal property of your patients.

Legal Definitions and Examples
As a CNA the legal issues you might encounter and witness would be negligence, theft, defamation, false imprisonment, assault, battery and abuse. You need to understand what these are.

Negligence:
The failure to provide a degree of care that others would consider reasonable under the circumstances; when injury results to your patient. Negligence is often caused by rushing around to get your work done and by not thinking first.

- You give a patient a bath….and don't check the water temp first. The patient is burned.

Theft
One would think this is pretty simple but often it isn't. Taking anything that doesn't belong to you is considered theft. It doesn't matter how cheap or expensive the item is. When you see another person take something that isn't theirs, and you fail to report this, you are guilty of aiding and abetting the crime. Keep your standards high. We need all the honest people we can get in this work-don't be scared or indifferent to report theft you witness. I've seen aides take wash clothes, briefs, deodorants, and soaps from their facility. I've also seen aides steal jewelry and clothing from patients. It's never acceptable to do this.

Defamation
This means making statements about another person, either verbally or in writing when the character of the person is injured. Examples would be you telling a co-worker wrongful and inaccurate information about patients. I've seen this happen. Unless you know something to be actual face, keep your mouth shut.

False Imprisonment
This is an area many nursing staff have trouble understanding. It's not just about restraints. It's about a mindset. It is defined as restraining a person's movements or actions without the proper authorization. Patients have rights and we must respect these rights. In the hospital setting, a patient can leave the hospital without a doctor's permission. They can also leave a nursing home/assisted living home. Under very few circumstances can we interfere with this right. If you do, its call false imprisonment.

Physical Restraints
Using them requires a doctor's order. Threatening to use them is considered false imprisonment.

Physical restraints are defined as any manual or physical device, material, or equipment attached to or near to the patient's body, that:

- A patient cannot easily remove
- Restricts movement of any and all body parts
- Restricts the patient from accessing their own body or parts of their body
  Examples of physical restraints:
- Wrist, arm, leg and ankle restraints
- Vests
- Jackets
- Hand Mitts
- Geri chairs, recliners
- Seatbelts, safety belts
- Bed rails and the pads sometimes used on them
- In some populations the use of certain clothing would be considered a restraint: For example, donning a one piece undershirt on a child to prevent him for having access to his body. Or, a long sleeved shirt to prevent access to an IV site.

Also many practices are considered a restraint. When a patient doesn't have the physical strength to remove a device it is a restraint.

- When a patient doesn't have the strength to sit up from a low rise sofa, for example, this practice is considered a restraint.
- Tucking in blankets and sheets so tightly the resident cannot more is considered a restraint. Using Velcro and tape to secure sheets is also a restraint.
- A lap tray being used with a wheelchair is a restraint if the patient cannot remove it.
- Using recliners and Geri chairs, tilted back, is a restraint.
- Moving chairs and beds so close to a wall that it prevents a patient from rising is a restraint.
- Placing a patient up into a table so close they cannot move their chair is a restraint.

Any actions or device (designed for the sole purpose or something put together by you) that prevents the free movement of body parts is a physical restraint). Some patients require splints to maintain alignment and posture. These are restraints as well, but are often referred to as enablers because they assist the patient with ADL's. The patient may not be able to remove the splints, but it's not an overt restraint. An MD order is always in place for these items.

Many medications are considered restraints. This is called chemical restraining and it is a very different thing than physical restraints. Nurses and doctors must understand the ramifications of using meds to induce sleep, states of relaxation, pain control that could be considered restraining activity.

Assault and Battery

There is some confusion about the meanings of these terms. Assault means purposely attempting to touch the body of another person without their permission, and threatening to do so. Battery is when you actually do this. These terms are not all about hitting and hurting patients like so many of us have been taught. Every task we perform is done so with the patient's informed consent. This means the patient needs to know what it is we want to do, why, the benefits of the task-and they have to agree to it. Informed consent can be withdrawn at any time and we must honor this. More and more patients are taking their healthcare into their own hands these days, and many will question the value of treatments. In spite of our best efforts to explain the need for treatments, the patient always retains the right to refuse. If you continue with the treatments you are guilty of battery. Threatening to get the nurse of others to assist you with treatments is battery as well. You must report to the nurse any and all refusals of care by your patients, but do so quietly and not within hearing distance of the patient. Let the nurse handle the situation from this point forward.

To avoid being charged with battery:

- Tell the patient what you plan to do
- Make sure the patient understands what you're saying
- Asking the patient if they have any questions or concerns
- Allowing the patient some time to think about this
- If the patient refuses, don't push the issue. Quietly report the refusal to the nurse and document facts only.
- Never carry out the refused treatment

In our work we will come across a lot of coercion-which is forcing a patient to do something against their will. Unfortunately, it's a problem within nursing in general. We always think we know what is best. This happens more with patients who are confused, mentally incapacitated or those with dementia. Almost always, these patients are not their own legal guardian, their family is. This makes it difficult for us to do our job at times because the patient is still refusing the care but we have to do it anyway-because the family has consented on behalf of the patients. It's always best to try to get the patient to cooperate with us vs. a full struggle. It really helps to wait and come back later when a confused patient refuses care. They tell us to always assume the patient would want our care if they were not confused so we have to think of things differently.

Abuse

Abuse: Doing harm to a patient. Abusing a patient is ethically wrong as well as legally wrong. Ethical standards require us to do no harm and legal standards enforce this through laws. There are severe penalties if you're found guilty.

Abuse is defined as the act (or failure to act) that is non-accidental and causes or could cause harm or death to a patient. It's not just about hitting here. It's also about mental abuse, verbal abuse and other more subtle forms. Abuse comes in many shapes:

- Physical
- Verbal
- Emotional
- Sexual
- Involuntary seclusion

Physical Abuse:

- Handling the patient roughly
- Hitting, slapping, punching, kicking, pinching a patient
- Performing the wrong treatment on the patient

Verbal Abuse:

- Swearing when you're dealing with the patient
- Raising your voice, yelling
- Calling the patient unpleasant names
- Teasing the patient
- Embarrassing the patient at anytime
- Using gestures
- Making threats
- Use of inappropriate words/terms to describe a patient's race or nationality

Sexual Abuse:

Using physical means and verbal threats to force patients to perform sexual acts. In most states sexual abuse is any behavior that is seductive, sexually demeaning, harassing. As with Sexual Harassment policies, this harassment need only be considered as such by the patient without regard to your intentions. Be careful. Think before your interactions with patient (and everyone else for that matter). Be considerate of your patient's values and morals.

Emotional/Psychological Abuse:

This can be the worst kind of abuse because it's typically ongoing and subtle.

- Causing a patient to be afraid of you (through threats, actions, attitude, and body language)
- Threatening the patient
- Threatening to withhold treatment
- Threatening to tell others about the patient's condition
- Making fun of the patient
- Belittling the patient (this includes all those cute little nicknames we tend to have)
- Calling the attention of others to the patient's behavior

Involuntary Seclusion

I see this happen a lot in nursing homes. A resident is being noisy and disruptive so we remove them to another area. This is another one of those hard spots to be in-trying to balance the needs

of the larger group of residents without violating the rights of one. A good care plan, communication with everyone, documentation and other interventions should really be in place to prevent the resident from having outbursts in the first place. The nurse should always be the one who directs you to remove a resident. Don't ever make this decision on your own.

Other forms of involuntary seclusion:

- Closing the door to the patient's room when they want it kept open
- Placing a patient in a wheelchair away from others
- Leaving a patient without a means to communicate-removing the call bell for example

Abuse by Others

There are times when we will witness another CNA or nurse does harm to a patient, as described above in all the various forms. Often the CNA/nurse will not realize they are doing these things. It doesn't matter whether she knows better or not. The abuse must be reported. As soon as it occurs, not at the end of the shift, the next day or next week. All healthcare workers are required by law to report actual or suspected abuse. When you don't report, you're just as guilty.

Sometimes it is a member of the patient's family who abuses them. This is difficult to see happen, to suspect is happening. Again, if you suspect this you are required to report it to the nurse. I've seen nursing home residents go out on a day trip with a family member and return to the facility with bruises and cuts; or with complaints of hunger and thirst. These things caused me to suspect some sort of abuse or neglect and I reported the findings to the nurses. I made sure they came down and looked at the bruises and cuts firsthand as well.

Neglect

Neglect is failing to provide the services, care and treatments necessary to avoid physical harm, mental anguish or mental illness. Neglect can be intentional or unintentional. Neglect is against the law no matter what. CNA's are not expected to decide if neglect has occurred- that is the nurse's job. However, you must report signs of neglect. Some examples of neglect we might see on the job:

- Routine hygiene and care not being provided. Patients not being repositioned, bathed, toileted, ROM exercises not being performed according to the care plan.
- Patients not being given enough time to eat
- Patients not being offered water and snacks

Invasion of Privacy

This is an area where every CNA should put themselves in the patient's shoes. Would you like it if someone went around talking about your medical condition to anyone? How would you feel if you were in a hospital room and the nurse came in, started to do a treatment without closing the privacy curtain? You wouldn't like these things at all. Most people don't. Every patient has a right to expect their medical information will be kept confidential and that only those who need to know will have access to this information.

Aiding and Abetting

To assist someone in committing or to encourage someone to commit a crime, ie- not reporting abuse. Generally, an aider or abett is criminally liable to the same extent as the person committing the crime.

When a Resident is Restrained

The resident must be checked at least every 15 minutes. At regular intervals the following must be done:

- Release the restraint or discontinue use
- Offer assistance with toileting. Check for episodes of incontinence and provide care.
- Offer fluids
- Check for skin irritation. Report signs to the nurse immediately.
- Check for swelling
- Reposition the resident
- Ambulate resident if able

Problems from Restraint Use

- Reduced blood circulation
- Stress on the heart
- Incontinence
- Constipation
- Weakened muscle and bones
- Loss of bone mass
- Muscle atrophy
- Pressure sores
- Risk for suffocation
- Pneumonia
- Less activity leading to poor appetite
- Sleep disorders
- Loss of dignity
- Loss of independence
- Increased agitation or depression
- Poor self-esteem
- Possible death
- Reality vs Perceptions

    - CNA Ob

Restraint Alternatives

Answer call lights immediately

Improve lighting

Use postural devices

Add more exercise into the care plan

Let confused residents wander in designated safe areas

Give frequent help with toileting

Encourage independence with all tasks

Encourage participation in social activities

Involve residents with hobbies

Create activities for those who wander at night

Offer reading materials, and read to the resident if needed

Offer backrubs

Increase visits and social interaction

Increase the number of family caregivers

Get the family involved

Offer snacks and drinks

Redirect interest

Decrease the noise level

Use soothing music

Report complaints of pain immediately

CNA responsible for these alternatives

Objective 2

Textbook: Chapter 5, 6, 7, 10, 11, 12, 17, 18,19
Nursing Skills: cleaning the patient unit, hand washing, infection control measures, occupied bed making
Vocabulary Words, Medical Terminology and Abbreviations; see below

1. Define communication

2. Describe two major forms of communication, giving examples of each

3. Discuss techniques that promote effective communication

4. Describe blocks to effective communication and discuss methods to avoid them

5. Identify causes of conflict and ways to resolve conflict

6. Discuss methods of reporting and recording information in a health care setting

7. Explain function of the medical record as a communication tool among team members

8. Explain why the nursing assistant is a vital link in the communication chain

9. Understand the role of effective communication in the provision of quality health care.

10. Understand that development changes are common throughout the lifespan of an individual

11. Draw Maslow's hierarchy of basic human needs and explain each level

12. Describe ways that a nursing assistant helps residents to meet their needs

13. Understand the difference between sex and sexuality and discuss how a person's sexuality can be affected by illness

14. Explain the concept of diversity and why it is important for health care workers to recognize their resident's diversity

15. Explain the role change an individual goes through the last decades of life, as well as the well role versus the sick role and how living in a nursing facility can affect those roles

16. List different types of microbes that can cause disease and discuss the conditions that are essential for their survival and growth

17. Define the term normal flora and pathogen

18. Explain the defense mechanisms the body uses to keep us from getting sick

19. Define the term infection and describe the chain of events required for infection to occur

20. Discuss factors that make a person a more susceptible host

21. Define nosocomial illness and measures that can be used to prevent/control the spread of infection

22. List methods of infection control

23. Demonstrate correct use of PPE in infection control

24. List the standard precautions and know when to use and how blood borne pathogens are transmitted

25. Describe measures a healthcare worker can take to protect from exposures to blood/body fluids

26. Describe the three types of transmission based precautions and explain when they are used as well as measures that can be taken to prevent the spread of pathogens

27. Demonstrate proper hand washing, gloving, masking, gowning, and double bagging technique

28. Describe two major blood borne diseases (HIV & Hepatitis B) and one airborne disease (TB) that put health care workers at risk and steps to protect oneself.

29. Discuss OBRA regulations relating to the physical environment in long term care facilities

30. Understand your role in keeping resident's environment in long term care facilities

31. Discuss importance of resident's personal items

32. Explain why admission to a health care facility may be emotionally difficult for resident/family and describe the CNA role in making this a more pleasant experience.

33. Describe ways a properly made bed can increase patient comfort and well-being.

34. List different types of linens and their uses

35. Demonstrate proper way to handle linens

36. Explain infection control measure that are used during bed making

37. Demonstrate techniques of proper bed making -Closed, Surgical, Open, Occupied

Vocabulary Words
Objective 2

Communication
Feedback
Non-Verbal
Conflict
Physiologic
Self-Esteem
Self-Actualization
Sexuality
Masturbation
Culture
Heredity
Race
Religion
Patient Unit
Gatch
Wheel Locks
Body Fluids
Nosocomial
Medical Asepsis
Contaminate
PPE
Standard Precautions
Blood Borne Pathogen
Microorganism
Opportunistic Microbe
Vector
Barrier
Transmission Based Precautions
Pathogen
Microscopic
Antibodies
Antibiotics
Fitted Sheet
Flat Sheet
Draw Sheet
Bath Blanket
Mitered
Fanfold
Infection Control
Disinfectant
Sterile
Sterilization
Subjective Data
Objective Data
Growth
Development
Occupied Bed
Closed Bed
Strict Precautions for both Contact and Air
Communicable Disease
Aseptic
Fomite
Nosocomial Infection

Study Tip – Write out the definitions of these terms.

Medical Records Documentation for CNA's and HHA's

Introduction

Learning to document the right way on a patient's medical record-that is, when to document, what to document, and how to document-is absolutely vital if you want to have a successful career as a certified nursing assistant. Hospitals and other health care facilities can be extremely busy and hectic places. There is a lot going on and the pace of the environment can be very fast. There is simply no way that good care could be delivered without a single, centralized place where the essential facts about each patient have been recorded. So for the patient to receive the best care possible, all of the information on that record must be properly documented.

Point: The patient's medical record is the only place where all of the important information about that person can be found. It is also the place where health professionals communicate to each other about the patients and what has been done for them.

Point: The basic purpose of documentation is to produce a clear, concise, and accurate record that allows everyone involved in the care of a patient to know what has happened, what is planned, and what needs to be done.

When the student has finished this module, he/she will be able to:

1. Identify the first and most important rule of medical documentation
2. Identify three reasons why everything concerning a patient's care must be documented.
3. Identify three aspects of proper documentation.
4. Identify the four "do's" of proper documentation
5. Identify the three "don'ts" of proper documentation.
6. Identify a CNA note that is an example of poor documentation.
7. Identify a CNA note that is an example of good documentation.
8. Identify three things that a CNA may document about his/her patients.
9. Identify the proper way to document a note that is entered late.
10. Identify what is important to document when performing a therapeutic activity.

The Basics of Documentation

"If it wasn't documented, it wasn't done."

That phrase is one you might have heard before, and it is certainly not new. But it is the first, and probably the most important rule of medical documentation. It is also one of the most crucial pieces of information you need to remember if you want to have a successful career as a CNA. All of the information about the patient-what is done for him or her, what the plan of care is, how the patient responded to this care, what needs to be done on his/her behalf, etc.- must be documented. There are three basic reasons why:

- Dangerous duplication: If someone doesn't document that a medication has been given, or someone doesn't document that a treatment of a therapy has been performed, it is possible that the medication could be given twice or the treatment or therapy could be repeated-and that could be dangerous.

Learning Break: You are assisting a patient for a walk of a specific distance down the hall as part of this post-operative rehabilitation after knee surgery. Midway through the walk, he becomes very weak and tired and despite your best efforts, falls to the floor, hitting his knee. The suture line breaks open. You find out later that another CNA, trying to be helpful, had gotten the patient up and walking just one hour ago but had not documented the fact.

Learning Break: Notice that the patient didn't mention to the CNA that someone had already gotten him out of bed just an hour ago. Remember: You cannot depend on the patient to tell you about duplication of efforts. Most of the time, the patients assume that the staff are doing their jobs correctly.

- Dangerous omissions: It can be just as serious to document something that hasn't been done. It may seem at times efficient to document something and then perform the task, but this is never correct. It is also very, very important that all of your observations are documented. The care that a patient receives will often depend on what you have seen.

Learning Break: You are assigned to irrigate a patient's PEG tube. (Note: a PEG tube is a short, soft rubber tube that is inserted through the wall of the abdomen into the stomach. It is used to deliver food and medications to patients that cannot swallow.) PEG tubes must be irrigated periodically with water or saline so that they do not become clogged. The CNA working the shift before you decided to document that he had irrigated the patient's PEG tube the tube before he actually performed the task, but then he forgot to do the irrigation. Eight hours passed without the tube being irrigated, it became clogged and it subsequently had to be removed and replaced. The patient missed receiving her feedings and some of her scheduled medications.

- Liability: You might be a very good and conscientious caregiver, but if for some reason there is legal action involving a patient's care, the courts are more inclined to believe a written record than what you remember. If there is no documentation that something was done or there is no documentation that something has happened, the courts would be very likely to conclude that there is no proof and that you had not done what you say you had done.

How to Document Correctly

- Timeliness: In a perfect world, you would be able to document everything right away or shortly afterwards. But your job as a CNA can get very, very busy and it is not unusual for CNAs to document what they have done and observed many hours after the events. Each institution you work for may have different rules, but if you find that you are documenting something hours after the fact, make a notation that clearly indicates you are making a late entry. Example: Late Entry, 18:00, 11/15/2009. Assisted patient in range of motions exercises of the hips and knees, both sides, 10 flexions and extensions,

at 15:00, 11/15/2009. However, the longer you wait between doing and documenting the greater the risk that you will forget to document or you will forget something that is important to document.

- Accuracy: It seems really obvious to point out that accuracy is a very important part of good documentation. But it would surprise you to see how easy it is to make mistakes in accuracy when documenting. It pays to always review your notes before you enter them in order to make sure they are correct and complete. Make sure that everything is spelled correctly, especially words that may sound alike but are actually very different.

Learning Break: Always review your notes when you have finished writing. Imagine a CNA who wrote a long, comprehensive, and very well done entry in a patient's chart. Everything in the note was done perfectly-except that the note was written on the wrong chart. Does that sound unlikely? It happens more often than you would imagine. Always review your notes when you have finished writing.

Learning Break: Accuracy is especially important when you are documenting what a patient says. It can be difficult to remember word for word the details of what someone told you, but if it is important, you should make a good faith effort to do so.

- Be objective: It is very important to avoid documenting your opinions about what happened, what you observed and what you did. Anything that you write down should be factual. Ideally, anyone who was in your position would be able to see and note exactly what you saw and what you wrote down. Document what can be seen, measured, etc. Not only will being objective help the patients you are caring for, it can protect you, as well. Imagine if someone documented that they thought that a patient was intoxicated. Do not be humorous, judgmental, or profane.

Learning Break: The CNA who was caring for a patient prior to you documented surgical dressing of incision site changed. Patient was whining and crying during the procedure. There are several reasons why this is bad documentation. First, the word whining is demeaning; also, stating that someone is whining is an opinion not a fact. If there was some indication that the patient was experiencing pain or discomfort during a procedure, write down what you noticed that made you come to this conclusion. Try and have the patient tell you why he/she is having pain and how much pain is being experienced. Second, there is nothing in the note about the condition of the incision site or the presence or absence of any drainage. Third, there is no documentation of where the surgical dressing is; the patient could have more than one. The right way to document this would be: 13:00, 12/25/2009. Patient noted to be sweating, crying, and gripping bedclothes tightly during change of surgical dressing on right knee. When asked, patient stated that he was experiencing pain when surgical dressing was changed. Patient stated when asked that the pain was a level of 7 on a scale of 1-10. There was redness and swelling that extended approximately 3 centimeters out from the incision on all sides. No drainage was observed. New dressing applied. John Doe, RN notified of patient's discomfort. Jane Doe, CNA.

- Use approved abbreviations: Abbreviations are very useful. They save time and allow for clear and accurate communication. Any institution that you work in will have-or should have- a list of approved abbreviations, and those are the only one you should use.
- Never document for someone else: It may seem like a nice thing to do, especially if one of your co-workers is very busy. But you should only document what you saw or what you did.
- Never change what you have written: Electronics records are becoming the standard everywhere, but if you are still writing your notes on paper, never attempt to change a note after it has been written. If you have made a mistake, do not use erasers, do not use correction fluids and do not cross out a note and write over it. Your institution should have a policy in place that can tell you how to correct a written mistake; ask your nurse manager or supervisor. Many times, it is considered acceptable to cross out the incorrect note with a single line, write "error" immediately after the note, and then enter the date, the time, and your initials.

Learning Break: If a note on a medical record has been altered, this can raise fears about the truthfulness of the documentation and the honestly of whoever has made the change. If there is legal action, it would be almost impossible to defend yourself against suspicions that you have not been honest with your documentation and that you have something to hide.

- Write down important conversations with nurses and physicians: You may have observed something crucial about a patient you are caring for. Perhaps the patient told you that a certain medication was giving him uncomfortable side effects, or perhaps you noted that his temperature was elevated. Naturally, you would relay this information to a nurse or physician. But is it enough that you simply told someone? No, it isn't. You should certainly mention certain issues to the RN or the MD. However, remember the first rule of documentation: if it wasn't documented, it wasn't done and this is especially important when it involves what you have said to someone else. Unfortunately, although it would be very unusual, it is not unknown for someone to deny that they were informed of a change in a patient's condition when at a later date the patient's condition worsens. Or, that person may simply forget what was said.

That is a lot of information. However, after a little practice, good documentation becomes easy and is not terribly time-consuming. You can break down and simplify the process by remembering the four basics "dos" and three basic "don'ts" of documentation.

Do be objective
Do be complete
Do be accurate
Do be timely

Don't be subjective
Don't change an entry after it has been written
Don't document for someone else

What Will You Be Documenting?

As a CNA, you will be spending a lot of time with the patients, perhaps more time than anyone else, so your documentation is very important. It has already been stressed that a good CNA will document everything that is important. But what exactly does that mean? This is a list of the – and it's not everything-of what you may be entering in a patient's chart:

- Level of consciousness
- Temperature, blood pressure, heart rate, and respiratory rate
- Fluid intake
- Urinary output
- Bowel elimination patterns
- Food intake
- Color and condition of the patient's skin
- Important things that the patient says or does
- Important conversations you have had with other members of the health care team
- Height and weight
- Therapeutic activities that you have performed. These could include range of motion exercise, assisting the patient to ambulate, application of cold compresses or hot packs, urinary catheter care, bandage changes, turning and positioning patients who are confined to bed, and many other activities.
- The patient's response to those therapeutic activities

Good Documentation/Bad Documentation: Examples

Bad documentation: "Got patient OOB this am. Patient seemed very unhappy; I don't know why. Walked short distance and patient was complaining. "Returned to bed."

First, OOB (meaning out of bed) is probably not an approved abbreviation. Stating that the patient was unhappy without providing some evidence of this conclusion is incorrect, and the CNA also made himself/herself look careless by admitting that there was no attempt to find out why the patient was uncooperative. The distance and the amount of time the patient walked are not recorded, the patient's complaints are not documented, there is no documentation of when all of this happened, and the note is not signed. Finally, no one was notified about the patient's fears or his hip pain.

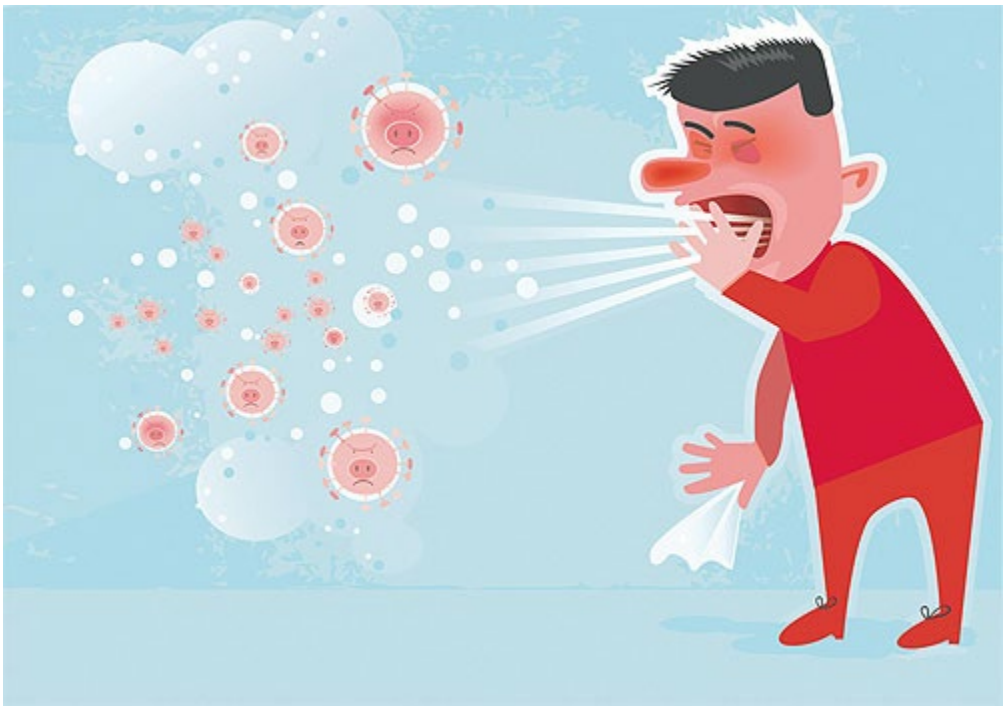
Good documentation: "11:00, 12/25/2009. Assisted patient out of bed. Patient complained that he did not want to ambulate as he was tired and he was afraid to get out of bed so soon after his surgery. I advised patient that T.I.D. ambulation was ordered by his physician. Helped patient walk from entrance of room to end of hall and back, total time 10 minutes. During this time, patient complained against of feeling tired and of pain in his right hip. Returned patient to bed at 11:10. Advised Jane Doe, RN, of patient's fear of ambulation and of his complaints of pain in right hip. Jane Doe, CNA.

Individual Resident Care Plan (Initiate within 24 hours of admission) Date: _____

Initials:_____

DNR/DNI Full Code	Discharge Plan/Comments:		
***Fall Risk Yes No (If yes, implement safety measures) Bed alarm Chair Alarm Sensor Grab Bar (L / R) Floor Mat Other: ***Skin Risk (Braden on admit) High Risk-Initiate CP – tissue tolerance Special Mattress Heel Protectors / Elevate heels Barrier cream W/C cushion Repositioning Q_____ hrs Incision_____ Wound location: _____ Prior to admit: Yes No ***Behavior/Mood/Safety History of abusive behaviors Behaviors increase res. To res. Altercation Mood Issues: _____ _____ _____ _____ Behaviors: _____ _____ _____ Interventions: _____ _____ _____ Environmental Risks: _____ _____ _____ Elopement Risk: _____ _____ Wanderguard: _____ _____ ***Pain Control (Observe for pain) Has pain or discomfort or potential. Location: _____ _____ Use pain scale as applicable Pain management plan Interventions: _____ _____ ***Isolation Precautions: _ _____	**Bathing:** Tub Schedule Shower Schedule Bed bath Independent Assist with bathing 1 2 **Dressing** Obtains own clothing Assist with dressing 1 2 Ind. Set-up Cues Partial Total Other **Grooming** Independent Set-up/Cues Partial Assist Total Assist Special Instructions **Oral Hygiene** Ind Set-up Assist total **Dental Status:** Own teeth Dentures Upper Lower Partial Upper Lower **Bowel:** Continent Incontinent Assist 1 2 Last BM: _____ Bowel program **Bladder:** Continent Incontinent Assist 1 2 Self Foley Straight Cath Leg bag Ostomy	**Toileting Plan:** Toilet Urinal Bedpan Commode Check and Change Prompt Habit Training Product: **Schedule:** **Ambulation:** Independent with ambulation Assist with ambulation 1 2 Aids for mobility **Transfer** Independent transfer Assist transfer 1 2 Special transfer aids or mechanical lift **Mobility:** Assist repositioning 1 2 Assist with bed mobility 1 2 Wheelchair mobility 1 2 Side rails Type **Splints:** Type **Vision:** Adequate Impaired Glasses Reading glasses only Contacts **Cognitive:** Comatose Alert and Oriented Forgetfulness Confusion **Communication:** Adeaure hearing Hearing Aid L R Deaf Other	**Activity Pursuits:** Awake during day, sleeps all night Naps in a.m. Naps in p.m. Independent in activities Assist to activities In-Room ***Dehydration Risk: Yes No Comments: **Fluid Restriction _ _____cc** **Nutritional Status:** Oral problems: Chewing Mouth Pain Swallowing problems Choking/aspiration **Diet Order:** Allergies Special Likes Dislikes Special Needs Thickened Liquids Type **Meal Assistance:** Independent Set-up Partial assist with feeding Total assist with feeding Adaptive equipment – i.e. built-up spoons, plate guard, nosey cup, etc. **Dining Room:** Breakfast Noon Evening Room Tray: Snacks Nourishments **Enteral Tube Feeding:** _____ IV Fluids: Type: NACL Lock PICC Central Line Dialysis Shunt **Oxygen:** _____ _____ lters/min per _____

Transparency 6-2: Airborne Precautions



Airborne Precautions prevent the spread of pathogens that travel through the air after being expelled.

Tuberculosis (TB) is an example of an airborne disease.

For Airborne Precautions:

- **Follow all Standard Precautions**
- **Keep windows in patients rooms closed; keep doors closed to airborne infection isolated rooms (AIR)**
- **Wear a special mask during resident care. Remove masks properly**
- **Residents will wear masks if transported outside the room**
- **Other examples are measles or chicken pox**

Transparency 6-3: Droplet Precautions

Droplet Precautions are used for diseases that are spread by droplets in the air.
Droplets normally do not travel further than three feet.
Talking, singing, sneezing, laughing, or coughing can spread droplets.
Mumps is an example of a droplet disease.

- **For Droplet Precautions:**
- **Follow all Standard Precautions**
- **Apply a mask before entering the room**
- **Observe Respiratory/Cough Etiquette**
- **When necessary for the patient to leave room, he/she wears a mask.**
- **Visits from uninfected people may be restricted**
- **Pull the privacy curtain between beds**
- **Other examples are Flu, Whooping Cough, Rubella, Meningitis, Scarlet Fever, Epiglottitis, Strep Throat**

Transparency 6-4: Contact Precautions

Contact Precautions are used when a person may spread an infection by direct contact with another person or object.
Conjunctivitis (pink eye) and Clostridium difficile (C.diff) are examples of a contact disease.

For Contact Precautions:

- **Follow all Standard Precautions**
- **Wear proper PPE**
- **Wash hands while still in the room**
- **Do not share residents' equipment with other residents**
- **Other examples of this are MRSA, VRE, Lice, Scabies**
- ***Hint* Fomites Vector**

Working in an Isolation Unit

Residents in an isolation unit may feel abandoned or lonely. They may feel like they have been "locked up." It should be emphasized that it is the disease that is being isolated, not the person. Interact with residents in isolation units as frequently as possible. Listen to their feelings and concerns. Encourage visitors. Make sure that the television and telephone are working and that the resident can reach the call signal.

Guidelines for Serving a Meal in an Isolation Unit

- As with all residents, be sure that the diet card matches the resident's name and that the food on the tray matches the diet card.
- Be sure to wear the proper PPE as indicated by the type of transmission-based precautions being followed.
- At the door of the isolation room, food will be transferred from the original meal tray to an isolation tray that is kept in the resident's room.
- Assist the resident with feeding as necessary, allowing him to do as much as he can himself.
- Remember to record the resident's food and beverage intake.
- After the meal, reusable items are returned to the food service department. Disposable items are discarded in the waste container in the resident's room.
- The tray that the resident eats from is cleaned and stored in the resident's room.
- Double bag to return to cart or kitchen.

Guidelines for Measuring Vital Signs in an Isolation Unit

- If possible, each resident in isolation should have his or her own equipment to use for measuring vital signs. If equipment must be shared, it must be properly cleaned and disinfected before being used again.
- Be sure to wear the proper PPE as indicated by the type of transmission-based precautions being followed.
- Your wristwatch should be removed and placed on a clean paper towel where you can see it while measuring vital signs, if no clock is in the room.

Guidelines for Transferring Patient to and from Isolation Unit

- Airborne Precautions: Should the resident have to leave the room for any reason, he must wear a disposable surgical mask or other type of mask.
- Droplet Precautions: Should the resident have to leave the room for any reason she must wear a disposable surgical mask.
- Contact Precautions: Limit transporting resident, if possible. If you must transport, take precautions not to spread the microorganisms to others or contaminate any other outside objects.

Guidelines for Transferring Non-disposable Equipment Outside of Isolation Unit

- Equipment should not be shared among residents if possible. For any equipment that must be used by more than one resident, the equipment must be completely cleaned and disinfected before being used again.

- Be sure to wear the proper PPE as indicated by the type of transmission-based precautions being followed.
- Equipment must be placed in biohazard bags for transportation outside of isolation unit. Follow facility policy for disinfecting and sterilizing equipment.

Guidelines for Specimen Collection from Resident in Isolation Unit

- Specimen will be transported from the resident's room in a biohazard bag. The bag and the specimen container should both be labeled before you enter the resident's room.
- The biohazard bag remains outside of the resident's room while you collect the specimen.
- Do not touch the outside of the container while you are placing the specimen inside it.
- Use a paper towel to pick up the specimen container. Take it outside the resident's room and place it in the biohazard bag.

Guidelines for Caring for Linens in Isolation Unit

- Soiled linens should be removed from the bed by rolling the dirty side inside.
- Hold linens away from your uniform.
- Linens from isolation units need to be placed in bags with BIOHAZARD labels.
- Transport linens according to facility policy. Many facilities use melt away bags, which can be placed directly into the laundry with the soiled linens inside them and dissolve during washing.
- Change gloves if necessary and make the resident's bed using clean linens.

When transporting linens, specimens, other items from isolation, you should use a "double bag" procedure as explained in your textbook.

Objective 2
CLEANING THE PT'S UNIT

This is done on a pt's discharge from the facility. It is also done on a weekly basis as the long term care facility.

Procedure

1. Wash your hands.

2. Gather your equipment
    1) Bucket
    2) Gloves
    3) Paper towels
    4) Cleaning cloths

3. Prepare the unit for cleaning:
    1) Strip soiled linen from bed; dispose of it appropriately.
    2) Remove equipment from bedside cabinet; clean and disinfect/sterilize the equipment as indicated.
    3) Place the pillow on the chair.

4. Wash the unit:
    1) Wash the top of the overbed table; place a paper-towel on the table, set your bucket here.
    2) Wash the mattress; damp dust if linen covering; damp dust pillow and place on mattress. Allow to air dry.
    3) Wash bed frame including head board, foot board, springs, and side rails.
    4) Wash bedside cabinet inside and outside.
    5) Wash rest of the overbed table.
    6) Wash chair.
    7) Damp dust the overbed light, call system, window ledge, if applicable.

5. Stock bedside cabinet per facility policy.

6. Make bed-usually a closed bed.

7. Arrange the unit appropriately.

8. Return or dispose of your cleaning equipment.

9. Wash your hands.

Wash from cleanest to dirty

Appendix B Page 865

1. Complete each of the following statements using the term superior or inferior.
   A) The nose is _____to the neck.
   B) The mouth is _____to the nose.
   C) The chest is _____to the abdomen.
   D) The teeth are _____to the heart.
   E) The abdomen is _____to the head.

2. Complete each of the following statement using the term anterior or posterior.
   A) The trachea is _____to the esophagus
   B) The heel is _____to the toes.
   C) The heart is _____to the backbone (vertebral column).
   D) The breastbone (sternum) is _____to the shoulder blade (scapula).
   E) The esophagus is _____to the larynx.

3. Complete each of the following statements using the term medial or lateral.
   A) The eyes are _____to the nose.
   B) The eyes are _____to the ears.
   C) The index finger is _____to the thumb.
   D) The smallest toe is _____to the big toe.
   E) The pinky or little finger is _____to the index finger.

4. Complete each of the following statements using the term proximal or distal.
   A) The wrist is _____to the fingers.
   B) The wrist is _____to the forearm.
   C) The forearm is _____to the upper arm.
   D) The foot is _____to the calf.
   E) The thigh is _____to the calf.

Physical Changes During the Aging Process

Integumentary System

- Skin becomes less elastic
- Skin loses its strength
- Brown spots ("age spots" or "liver spots") on the wrists and hands
- Fewer nerve endings
- Fewer blood vessels
- Fatty tissue layer is lost
- Skin thins and sags
- Skin is fragile and easily injured
- Folds, lines, and wrinkles appear
- Decreased secretion of oil and sweat glands
- Dry skin
- Itching
- Increased sensitivity to heat and cold
- Decreased sensitivity to pain
- Nails become thick and tough
- Whitening or graying hair
- Facial hair in some women
- Loss or thinning of hair
- Drier hair

Musculoskeletal System

- Muscle atrophy
- Strength decrease
- Bone mass decrease
- Bone strength decrease
- Bones become brittle; can break easily
- Vertebrae shortens
- Joints become stiff and painful
- Hip and knee joints become flexes
- Gradual loss of height
- Decreased mobility

Nervous System

- Fewer nerve cells
- Slower nerve conduction
- Reflexes slow
- Reduced blood flow to the brain
- Progressive loss of brain cells
- Shorter memory
- Forgetfulness
- Slower ability to respond
- Eyelids thin and wrinkle
- Less tear secretion
- Pupils less responsive to light
- Decreased vision at night or in dark rooms
- Problems seeing green and blue colors

Cardiovascular System

- Heart pumps with less force
- Arteries narrow and are less elastic
- Less blood flows through narrowed arteries
- Weakened heart works harder to pump blood through narrowed vessels

Respiratory System

- Respiratory muscles weaken
- Lung tissue becomes less elastic
- Difficulty breathing
- Decreased strength for coughing

Digestive System

- Decreased saliva production
- Difficulty in swallowing
- Decreased appetite
- Decreased secretion of digestive juices
- Difficulty digesting fried and fatty foods
- Indigestion loss of teeth
- Decreased peristalsis, causing flatulence and constipation

Urinary System

- Kidney function decreases
- Reduced blood supply to kidneys
- Kidneys atrophy
- Urine becomes concentrated
- Bladder muscles weaken
- Urinary frequency
- Urinary urgency may occur
- Urinary incontinence may occur
- Night-time urination may occur

Reproductive System

- See Chapter 34

• Confusion • Dizziness • Sleep patterns change • Reduced sensitivity to touch • Reduced sensitivity to pain • Smell and taste decrease	

Objective 3
Integumentary System

Textbook: Chapter 22, 23, and 29
Nursing Skills: bathing, pericare, shaving, nail care, hair care, oral care, dentures, dressing/undressing, vision/hearing accessories, draping
Vocabulary Words, Medical Terminology, and Abbreviations

1. Describe the basic structure and function of the Integumentary System

2. Describe the effects of aging on the system

3. Describe how culture can affect hygiene practice

4. Describe diseases that affect the Integumentary System

5. Explain how pressure ulcers are formed and what may increase a resident's risk of developing one

6. Define terms used to describe skin lesions

7. Understand the importance of good hygiene in relation to physical and emotional well being

8. Describe the practices that are part of oral hygiene for natural teeth, dentures, unconscious residents and situations that may require more frequent oral care
9. Describe safe care of dentures

10. Explain why perineal care is an important aspect of personal hygiene; discuss sensitivity issues related to this and be able to demonstrate appropriate technique for male and female residents

11. Explain how bathing and skin care benefit a person's health; list methods of bathing and describe observations that should be made while assisting with bath and skin care

12. Explain benefits of a back massage and demonstrate proper technique

13. Understand importance of proper hand and foot care

14. Demonstrate methods of helping a person to dress or undress

15. Describe different methods to assist with hair care, as well as proper technique for shampooing a bedridden resident

16. Demonstrate how to safely shave a man's face; recognize responsibility relating to standard precautions

Vocabulary Words
Objective 3

Integumentary
Decubitus Ulcer
Pressure Points
Lesion
Rash
Pustule
Excoriation
Blister
Bruise
Wound
Burn
Erythema
Cyanosis
Jaundice
Pallor
Eschar
Perineum
Peri-Care
Prosthesis
Alopecia
Complete Bed Bath
Partial Bed Bath
Bath Basin
Emesis Basin
Edentulous
Circumcised
Uncircumcised
Ophthalmologist
Optometrist
Audiologist
Dermatologist

Study Tip: Write out the definitions of these words.

Guidelines for Giving a Whirlpool Bath

- Check with the nurse before giving a whirlpool to a patient with an infection, surgical incision, or pressure ulcer.
- If the patient is combative or disoriented, check with the nurse before giving the patient a whirlpool. The noise from the whirlpool may worsen agitation in some patients.
- Disinfect the whirlpool tub immediately before and after each use.
- The water temperature in the whirlpool tub is usually set at 97°F to 100°F because the temperature in the tub remains constant. (Use common sense; if tub is steaming, the water is probably too hot. Use a thermometer to check the water temperature.) The constant movement of warm water stimulates a patient's circulation.
- Never leave a patient alone in the whirlpool tub, even for a minute.
- Always fasten the safety belt when moving a patient into or out of a whirlpool tub with a hydraulic life seat. The safety belt should remain fastened throughout the procedure.
- The patient may be frightened when using the hydraulic lift. Explain the procedure and reassure the patient.
- Drape the patient's genital area with a bath towel for modesty during the whirlpool bath.
- Use low-suds or no-suds products that are designed specifically for whirlpool use.
- Never pour liquid soap or shampoo into the whirlpool tub. A tiny bit of liquid soap will result in an abundance of suds. If the patient accidentally creates a suds problem, rub a bar of soap against the walls of the tub to reduce the bubbles.
- The whirlpool activity provides a cleansing action. However, if you will be assisting the patient with bathing, apply the principles of standard precautions.
- Wrap the patient with a bath blanket for warmth and modesty immediately after removing him or her from the whirlpool tub.
- The jets in some whirlpool tubs have the potential to harbor dangerous pathogens. Follow facility policies for carefully cleaning the tub with the proper disinfectant solution. Make sure that you follow directions correctly and run the disinfectant through the tub for the correct length of time.
- When the bath is completed, raise the lift seat out of the soapy water and rinse with the hose using comfortably warm water.

Objective 4
Musculoskeletal System

Textbook: Chapter 30, 15, 21, and 39
Nursing Skills: body alignment, repositioning, gait belts, transfers, ambulation, range of motion, use of assistive devices, mechanical lifts

1. Describe the basic structure and function of the musculoskeletal system as well as the effects of aging on these systems

2. Describe diseases/disorders that affect the musculoskeletal system

3. Define terms used to describe joint movement

4. Define normal range of motion and describe methods used to maintain joint function; demonstrate passive range of motion

5. Explain complications of immobility

6. Describe the concept of proper body alignment

7. Identify the different body positions and explain the purpose of regular, frequent repositioning

8. Discuss safety measures related to lifting and transferring people

9. Demonstrate techniques of gait belt use, safe lifting/transfers, and use of mechanical lifts and assisting with ambulation

10. Discuss nursing measures related to care of patient with fractures

11. Discuss rehabilitation and restorative measures that are commonly used in the health care setting

12. Explain the goal of rehabilitation and how the concept of humanistic care applies to rehabilitation

13. Understand the nursing assistants responsibilities related to providing restorative care

14. Discuss use of heat and cold applications relating to effect and safety

Vocabulary Words
Objective 4
Musculoskeletal System

Atrophy
Contracture
Osteoporosis
Radius
Rheumatoid Arthritis
Scoliosis
ROM
Fracture
Amputation
Dorsiflexion
Flex
Restorative Care
Shearing
Friction
Lift Sheet
Transfer
Gait Belt
Weight-Bearing
Logrolling
Sim's
Cartilage
Joints
Ligaments
Tendons
Traction
Dangling
Prosthetic Devices
Semi-supine
Semi-Prone
Arthritis
Osteoarthritis
Pronation
Suppination
PROM
AROM
Phantom Pain
Extend
Rehabilitation
Abduction
Adduction
Rotation
Inversion
Eversion
Plantar Flexion
Semi-Fowlers
Fowlers
High Fowlers
Prone
Supine
Reduction
Fixation
Gangrene
Supportive (orthotic) Devices
Assistive Devices

Study Tip: Write out the definitions to these terms.

Moving, Lifting, and Transporting Patients

Gait Belts

Gait belts are used for the safe transfer of a resident from one place to another.

They are to be worn by everyone as part of their uniform, nurse's aides and orderlies alike. They are to be worn around the waist and not slung over the shoulder or carried in your pocket. They are to be used for all residents who can bear weight on one of two legs. There will be instances when it will be impossible to use them as in the case of someone who is unable to use his legs. But for the majority of the residents needing to be transferred it is much safer to use the gait belt and much kinder to the resident as it eliminates strain on the shoulder joints.

Procedure:

1. Put gait belt around resident's waist being sure that there is cloth between the belt and the skin of the resident.
2. Buckle the belt by first bringing the belt end through the teeth of the buckle, then through the other side.
3. Make it snug around waist leaving room for your two hands, being careful not to pinch the skin.
4. Position the wheelchair next to the bed or commode closest to the resident's strongest side and lock the brakes of the wheelchair.
5. If the resident is unable to help, place his arms on your shoulders or fold them on his lap causing him to lean toward you when you begin to transfer. If he can help place his hand on the far arm of the wheelchair.
6. Place your hands at both sides of resident, palms up and grasp the gait belt.
7. Place your feet in front of the resident's feet, pointing each foot to the side to prevent his feet from slipping forward.
8. Brace your knees against his knees.
9. Rock backwards and at the same time lift and pivot resident transferring him to the wheelchair or commode.
10. Remove the gait belt and place it again around your waist.

Other Things to Remember

1. The gait belt can also be used to help a resident walk by placing the belt around the waist of the resident and steadying him with one or two persons. Place one hand on the gait belt. If there are two persons to steady the resident each can put one hand on each side of the belt. If one person, he can be steadied by placing one of your hands on the gait belt behind him. Then if he begins to fall you can ease him to the floor.

2. A person can also be helped up with use of gait belt.

Range of Motion

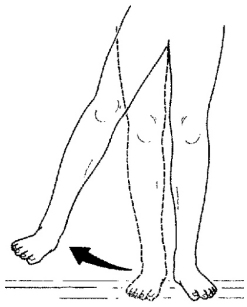
The movement of a joint to the extent possible without causing pain is the range of motion (ROM) of that joint. ROM exercises involve moving the joints through their complete range of motion without forcing the joint beyond its present range or to the point of pain.

Types

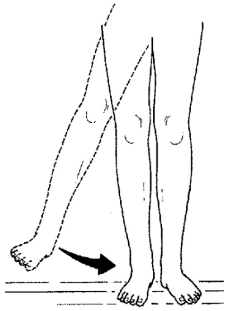
- Active ROM exercises-are done by the person.
- Passive ROM exercises-health care worker moves the joints through their range of motion.
- Active-assistive ROM exercises-the person does the exercises with some help from the health care worker.

Movements of Joints

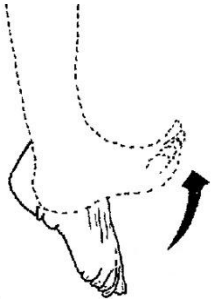
- Abduction-moving a body part away from the midline of the body
- Adduction-moving a body part toward the midline of the body
- Extension-straightening a body part
- Flexion-bending a body part
- Hyperextension-excessive straightening of a body part
- Dorsiflexion-bending the toes and foot up at the ankle
- Rotation-turning the joint
- Internal rotation-turning the joint inward
- External rotation-turning the joint outward
- Plantar flexion-bending the foot down at the ankle
- Pronation-turning the joint downward
- Supination-turning the joint upward



Dorsiflexion

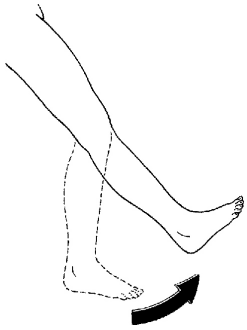


Shoulder flexion & extension

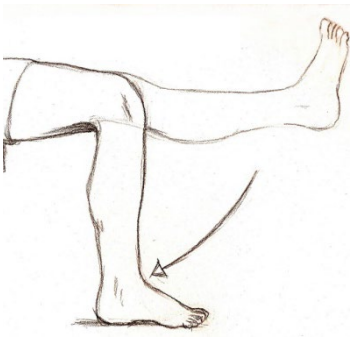


Abduction

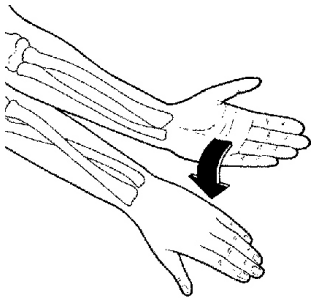
Adduction



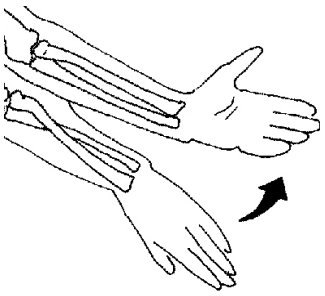
Extension
Knee



Flexion
Knee



Pronation



Supination

Warm and Cold Applications

Some states allow nursing assistants to prepare and apply warm and cold applications. Never perform a procedure you are not trained or allowed to do. Only perform procedures that are assigned to you.

Heat relieves pain and muscular tension, decreases swelling, elevates temperature in the tissues, and increases blood flow, bringing more oxygen and nutrients to tissues. Cold stops bleeding, prevents swelling, reduces pain, and helps bring down high fevers. Warm and cold applications may be dry or moist. Moisture strengthens the effect of heat and cold. Observe the area for redness, pain, blisters, or numbness.

Types of dry applications are:

- Aquamatic K-pad ® (warm or cold)
- Electric heating pad (warm)
- Disposable warm pack (warm)
- Ice bag (cold)
- Disposable cold pack (cold)

Types of moist applications are:

- Compresses (warm or cold)
- Soaks (warm or cold)
- Tub baths (warm)
- Sitz baths (warm)
- Ice packs (cold)

A sitz bath is a warm soak of the perineal area. Sitz baths clean perineal wounds and reduce inflammation and pain. Circulation is increased. Voiding may be stimulated by a sitz bath. Residents with perineal swelling (such as hemorrhoids) may be ordered to take sitz baths. Because the sitz bath causes increased blood flow to the pelvic area, blood flow to other parts of the body decreases. Residents may feel weak, faint, or dizzy after a sitz bath. There is a disposable commercial-type sitz basin that sits on the commode.

There is also a sitz chair that is used in facilities. The temperature of the water depends upon the reason the sitz bath is ordered (100-104°F for cleansing purposes and 105-110°F for pain or to stimulate circulation). The resident must be checked every five minutes and not left in the water for longer than 20 minutes.

	Temperature	**Timing**	**Special Consideration**
Warm Compresses	105°-115°F	Remove after 20 min	Cover with plastic wrap
Warm Soaks	105°-110°F	Check temp every 5 minutes	Observe for redness. Soak 15-20 minutes.
Aquamatic K-Pad	Pre-set	Remove after 20 min	Tubing should not hang below bed. Check water level and refill when necessary.

Sitz bath	100°-104°F or 105°-110°F	20 minutes only	Fill 2/3 full. Provide privacy.
Ice packs		Check after 10 min. Remove after 20 min.	Fill bag 2/3 full of ice. Cover bag; watch for blisters and white or pale skin
Warm Soaks	105°-110°F	Check temp every 5 min.	Observe for redness. Soak 15-220 minutes.
Aquamatic K-Pad	Pre-set	Remove after 20 min.	Tubing should not hang below bed. Check water level and refill when necessary.
Sitz bath	100°-104°F or 105°-110°F	20 minutes only	Fill 2/3 full. Provide privacy.
Ice packs		Check after 10 min. Remove after 20 min.	Fill bad 2/3 full or ice. Cover bag; watch for blisters and white or pale skin

Applying Warm Compresses

Equipment: washcloth or compress, plastic wrap, towel, basin, bath thermometer

1. Wash your hands.
2. Identify yourself by name. Identify the resident by name.
3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for resident's privacy with curtain, screen or door.
5. If the bed is adjustable, adjust to a safe working level, usually waist high. If the bed is movable, lock bed wheels.
6. Fill basin one-half to two-thirds with hot water. Test water temperature with thermometer or your wrist. Ensure it is safe. Water temperature should be 105° to 110° F. Have resident check water temperature. Adjust if necessary.
7. Soak the washcloth in the water. Wring it out. Immediately apply it to the area needing a warm compress. Note the time. Quickly cover the washcloth with plastic wrap and the towel to keep it warm.
8. Check the area every five minutes. Remove the compress if the area is red or numb or if the resident has pain or discomfort.
9. Commercial warm compresses are also available. If you are using these, follow the package directions and the nurse's instructions.
10. Place soiled clothing and linens in appropriate containers.
11. Empty, rinse, and wipe basin. Return to proper storage. Discard plastic wrap.

12. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.

13. Return bed to appropriate position. Remove privacy measures.

14. Before leaving, place call light within resident's reach.

15. Wash your hands.

16. Report any changes in resident to the nurse.

17. Document procedure using facility guidelines.

Administering Warm Soaks

Equipment: towel, basin, bath thermometer, bath blanket

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face- contact whenever possible.

4. Provide for resident's privacy with curtain, screen, or door.

5. If the bed is adjustable, adjust to a safe working level, usually waist high. If the bed is movable, lock bed wheels.

6. Fill basin half full of hot water. Test water temperature with thermometer or your wrist. Ensure it is safe. Water temperature should be 105° to 110°F. Have resident check water temperature. Adjust if necessary.

7. Immerse the body part in the basin. Pad the edge of the basin with a towel if needed. Use a bath blanket to cover the resident if needed for extra warmth.

8. Check water temperature every five minutes. Add hot water needed to maintain the temperature. Never add water hotter than 110°F. To prevent burns, tell the resident not to add hot water. Observe the area for redness. Discontinue the soak if the resident has pain or discomfort.

9. Soak for 15-20 minutes, or as ordered.

10. Remove basin. Use the towel to dry resident.

11. Place soiled clothing and linens in appropriate containers.

12. Empty, rinse, and wipe basin. Return to proper storage. Discard plastic wrap.

13. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.

14. Return bed to appropriate position. Remove privacy measures.

15. Before leaving, place call light within resident's reach.

16. Wash your hands.

17. Report any changes in resident to the nurse.

18. Document procedure using facility guidelines.

Applying an Aquamatic K-Pad

Equipment: K-Pad ® and control unit, covering for pad, distilled water

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

4. Provide for resident's privacy with curtain, screen or door.

5. If the bed is adjustable, adjust to a safe working level, usually waist high. If the bed is movable, lock bed wheels.

6. Place the control unit on the bedside table. Make sure cords are not frayed or damaged. Check that tubing between pad and unit is intact.

7. Remove cover of control unit to check level of water. If it is low, fill it with distilled water to the fill line.

8. Put the cover of the control unit back in place.

9. Plug unit in. Turn pad on. Temperature should have been pre-set. If it was not, check with the nurse for proper temperature.

10. Place the pad in the cover. Do not pin the pad to the cover.
11. Uncover area to be treated. Place the covered pad. Note the time. Make sure the tubing is not hanging below the bed. It should be coiled on the bed.

12. Return and check area every five minutes. Remove the pad if the area is red or numb or if the resident reports pain or discomfort.

13. Check water level. Refill with distilled water to the fill line when necessary.

14. Remove pad after 20 minutes.

15. Clean and store supplies.

16. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.

17. Return bed to appropriate position. Remove privacy measures.

18. Before leaving, place call light within resident's reach.

19. Wash your hands.

20. Report any changes in resident to the nurse.

21. Document procedure using facility guidelines.

Applying Ice Packs

Equipment: ice pack or sealable plastic bag and crushed ice, towel to cover pack or bag

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

4. Provide for resident's privacy with curtain, screen or door.

5. If the bed is adjustable, adjust to a safe working level, usually waist high. If the bed is movable, lock bed wheels.

6. Fill plastic bad or ice pack ½ to 2/3 full with crushed ice. Seal bag. Remove excess air. Cover bag or ice pack with towel.

7. Apply bag to the area as ordered. Note the time. Use another towel to cover bag if it is too cold.

8. Check the area after ten minutes for blisters or pale, white, gray skin. Stop treatment if resident reports numbness or pain.

9. Remove ice after 20 minutes or as ordered.

10. Store ice pack.

11. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.

12. Return bed to appropriate position. Remove privacy measures.

13. Before leaving, place call light within resident's reach.

14. Wash your hands.

15. Report any changes in resident to the nurse.

16. Document procedure using facility guidelines.

Assisting with Rehabilitation

Be patient. Example: Even though you can dress the resident faster, encourage him/her to do it for himself/herself.

Have a positive attitude. Example: Create an atmosphere that motivates the resident to dress himself/herself.

Focus on small accomplishments and small tasks. Example: Break the task of dressing himself/herself into small steps, such as putting on a shirt today, learning to button it tomorrow.

Recognize that setbacks occur. Example: When he/she can't button the shirt on the expected day, downplay the setback.

Be sensitive to the resident's needs. Example: Encourage him/her to keep trying a task by showing a real sense of understanding and acceptance of both successes and disappointments.

Encourage independence. Example: Use assistive devices to allow him/her to do as much as possible for him/her.

Applying an arm sling

Equipment: arm sling, padding for neck

1. Wash your hands.
2. Identify yourself by name. Identify the resident by name.
3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
4. Provide for resident's privacy with curtain, screen or door.
5. Help the resident hold the arm at a 90° angle. Support the arm throughout the procedure.
6. Guide the sling over the resident's hand. The elbow should be covered and the fingers should be exposed.
7. Carefully wind the strap around the resident's neck.
8. Fasten the strap with the buckle on the sling. The fingers should be elevated.
9. Place padding between the strap and the resident's neck to prevent discomfort.
10. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.
11. Return bed to appropriate position. Remove privacy measures.
12. Before leaving, place call light within resident's reach.
13. Wash your hands.
14. Report any changes in resident to the nurse.

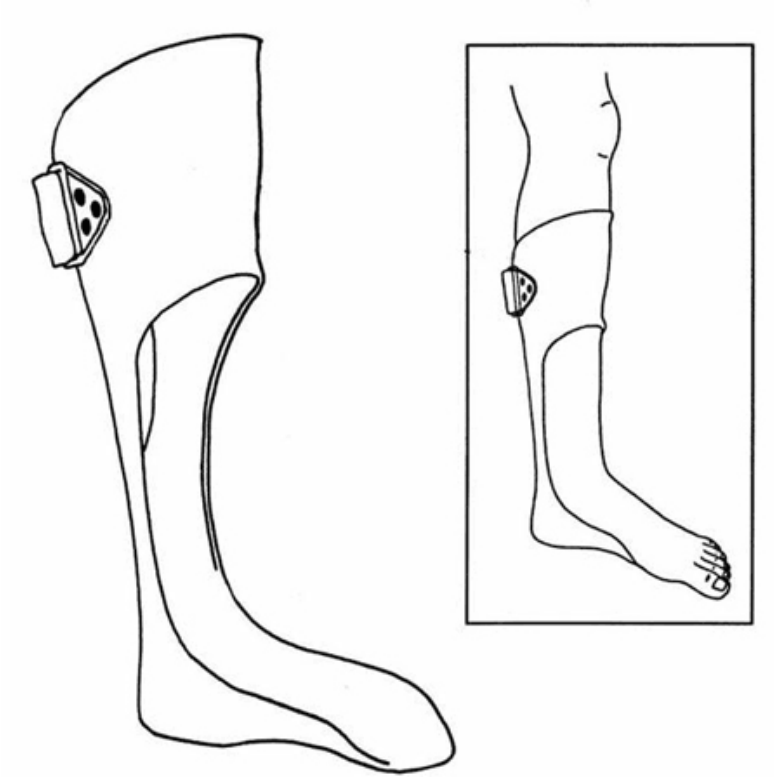
Document procedure using facility guidelines.

Splints

Splints may be prescribed by a doctor to keep a resident's joints in the correct position. Follow the manufacturer's directions for applying the splint. The care plan will indicate a schedule for applying and removing the splint. Follow the care plan carefully. Splints and the skin area around them should be cleaned at least once daily and as needed. Watch for irritation of the skin or any sign of infection around the splint.

Goals of Rehabilitation

- Help resident regain abilities or recover from illness.
- Develop and promote a resident's independence.
- Allow resident to feel in control of his or her life.
- Help resident accept or adapt to limitations of a disability.



Braces

Braces support weak body parts. They also prevent or correct deformities or prevent joint movement. Metal, plastic, or leather is used for braces. A brace is applied over the ankle, knee, or back (Fig. 26-37). An ankle-foot orthosis (**AFO**) is placed in the shoe (Fig. 26-38). Then the foot is inserted. The **AFO** is secured in place with a Velcro strap. This type of brace is common after a stroke.

Skin and bony points under braces are kept clean and dry. This prevents skin breakdown. Report redness or signs of skin breakdown at once. Also report complaints of pain or discomfort. The nurse assesses the skin under braces every shirt. The care plan tells you when to apply and remove a brace.

Transferring a Resident Onto and Off of a Toilet

Equipment: disposable gloves, toilet tissue, wheelchair, transfer belt, non-skid shoes

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

4. Provide for resident's privacy with curtain, screen or door.

5. Position wheelchair at a right angle to the toilet to face the hand bar/wall rail.

6. Remove wheelchair footrests. Lock wheels. Put on gloves.

7. Apply a transfer belt around the resident's waist. Grasp the belt. Put one of your hands toward the resident's back and one toward the resident's front.

8. Ask resident to push against the armrests of the wheelchair and stand, reaching for and grasping the hand bar.

9. Ask the resident to pivot her foot and back up so that she can feel the front of the toilet with the back of her legs.

10. Help resident to pull down underwear and pants. You may need to keep one hand on the transfer belt while helping to remove clothing.

11. Help resident to slowly sit down onto the toilet. Allow privacy unless resident cannot be left alone.

12. When the resident is finished, apply gloves. Assist with perineal care as necessary. Ask her to stand and reach for the hand bar.

13. Use toilet tissue or damp cloth to clean the resident. Make sure he or she is clean and dry before pulling up clothing. Pull up clothing and assist resident to sit down in wheelchair. Remove and dispose gloves.

14. Help resident to the sink to wash hands.

15. Wash hands.

16. Help resident to leave the bathroom. Make sure resident is comfortable. Remove privacy measures.

17. Before leaving, place call light within resident's reach.

18. Report any changes in resident to the nurse.

19. Document procedure using facility guidelines.

Assisting with Protection Needs

Date	Time	
9/9	0900	Assisted to sit on the side of the bed with assistance of one. Active leg exercises performed. Tolerated procedure without complaints of pain or discomfort. No c/o dizziness. BP 130/78 (L) arm sitting, P=74 regular rate and rhythm, R=20 unlabored. Color good. Assisted to lie down after 5 minutes. Positioned on (L) side. Bed in low position, signal light within reach. Adam Aims, CNA----------

Safety Alert: Dangling
Problems with sitting and balance often occur after illness, injury, surgery, and bed rest. Some persons who are disabled also have problems sitting and with balance. Provide support when the person is sitting on the side of the bed. This protects the person from falling and other injuries.

Focus on Older Persons Sitting on the Side of the Bed (Dangling)
Many older persons have circulatory changes. They may become dizzy or faint when getting up too fast. They may need to sit on the side of the bed for a few minutes before a transfer or walking.

Objective 5
Cardiovascular/Respiratory System

Textbook: Chapter 16, 20, 31, 32, 43
Nursing Skills: temperature, pulse, respiration, blood pressure, height, weight, TED hose, pain assessment, and documentation
Vocabulary Words

1. List and describe the structures and function of the cardiovascular and respiratory systems.
2. Describe how the aging process affects the cardiovascular and respiratory systems.
3. Describe some of the diseases/disorders of the cardiovascular and respiratory systems.
4. Describe symptoms of a heart attack and actions that a CNA should take to assist a person with these symptoms.
5. Describe how oxygen therapy is used to assist with respiration; describe guidelines nursing assistant should follow when caring for residents receiving oxygen therapy.
6. Discuss other methods used to help a person who is having trouble with respiration.
7. Explain how exercise and healthy lifestyle can diminish the effects of aging on the cardiovascular system.
8. Describe rehabilitation that may be necessary for a person who has a cardiovascular/respiratory disorder.
9. Define vital signs and discuss how they reflect changes in medical condition.
10. Understand the importance of accurately measuring and recording vital signs and reporting changes to the nurse.
11. Describe factors affecting a person's body temperature; discuss various terms used to describe abnormal body temperature.
12. Discuss common sites used for measuring body temperature; demonstrate technique.
13. Define pulse and describe factors that may affect it; list common sites used for taking a pulse.
14. Demonstrate the proper way to measure and record a radial and apical pulse.
15. Describe factors that may affect respirations and terms used to describe respirations.
16. Demonstrate proper way to measure and record respirations.
17. Define the term blood pressure and describe factors that may affect blood pressure as well as various terms used to describe abnormal blood pressure.
18. Describe how a sphygmomanometer and stethoscope work and demonstrate how to use these tools to take blood pressure.
19. Discuss factors that can lead to a change in a person's weight.
20. Demonstrate the proper way to measure a person's height and weight using an upright scale.
21. Demonstrate the proper way to measure a person's height while in bed.

- CPR Class- Quiz over 16 CPR (read)

Vocabulary Words
Objective 5

Mucous Membrane
Mucus
Respiration
Diaphragm
Lung
Trachea
Bronchus
Bronchioles
Alveolus
Pharynx
Larynx
Epiglottis
Plasma
RBC
WBC
Platelets
O2
CO2
Arteries
Arterioles
Capillaries
Atherosclerosis
Coronary Artery Disease
Vital Signs
Hypertension
Intra-Operative
Tachycardia
Bradycardia
Ventilation
Pleurisy
Incentive Spirometry
Aneurysm

Veins
Venules
Lymph Vessels
Lymph Nodes
Hemoglobin
Erythrocytes
Leukocytes
Thrombocytes
Circulation
Constrict
Anesthesia
Ventricle
Atrium
Septum
Pacemaker
Diastolic
Systolic
Blood Pressure
Pulse
Apical
TCDB
Thrombus
Plaque
Stethoscope
Hypotension
Pre-Operative
Hypoxia
TED Hose
Inhalation
Pneumothorax
Varicose Veins
SA Node

Brachial Pulse
Carotid Pulse
Pedal Pulse
Dilate
Cheyne-Stokes
Arrhythmia
Anemia
Myocardial Infarction
Angina Pectoris
Congestive Heart Failure
Peripheral Vascular Disease
Asthma
COPD
Emphysema
Pneumonia
Sputum
Bronchitis
Influenza
Cyanosis
Eupnea
Mechanical Ventilation
Embolus
Temperature
Sphygmomanometer
Orthostatic Hypotension
Post-Operative
Tachypnea
Bradypnea
Exhalation
Hemothorax
Heart Valve
Femoral Artery

Radial Pulse
Myocardium

Study Tip: Write out the definitions to these terms.

The Respiratory System

Respiration, the body taking in oxygen and removing carbon dioxide, involves breathing in (inspiration) and breathing out (expiration). The lungs accomplish this.

The respiratory system has two functions:

1. It brings oxygen into the body.

2. It eliminates carbon dioxide produced as the body uses oxygen.

As the lungs inhale, the air is pulled in through the nose and into the pharynx, a tubular passageway for both food and air. From the pharynx, air passes into the larynx, or voice box. The larynx is located at the beginning of the trachea, or windpipe. The trachea divides into two branches at its lower portion, the right bronchus and the left bronchus, or bronchi. Each bronchus leads into each lung and then subdivides into bronchioles. These smaller airways subdivide further. They end in alveoli, tiny, one cell sacs that appear in grapelike clusters. Blood is supplied to the alveoli by capillaries. Oxygen and carbon dioxide are exchanged between the alveoli and capillaries.

Oxygen-saturated blood then circulates through the capillaries and venules (small veins) of the lung, into the pulmonary vein and left side of the heart. The carbon dioxide is exhaled through the alveoli into the bronchioles and bronchi of the lungs, the trachea, through the larynx, the pharynx, and out the nose and mouth.

Each lung is covered by the pleura, a membrane with two layers. One is attached to the chest wall. One is attached to the surface of the lung. The space between the layers is filled with a thin fluid that lubricates the layers, preventing them from rubbing together during breathing.

Guidelines for Pulse Oximeter

- Report to the nurse immediately if alarm sounds.
- Tell the nurse if pulse oximeter falls off or resident requests you remove it.
- Check the skin around device often. Report any of the following:
  - Swelling
  - Bluish, or cyanotic skin
  - Shiny, tight skin
  - Skin that is cold to the touch
  - Sores, redness, or irritation
  - Numbness or tingling
  - Pain or discomfort
- Check vital signs as ordered and report changes to the nurse.

Care Guidelines for Congestive Heart Failure

- Medications can help control CHF.
- Medications mean more trips to bathroom. Answer call lights promptly.
- Low-sodium diet or fluid restriction may be prescribed.
- Limited activity or bed rest may be prescribed.
- I&O may need to be measured.
- Residents may need to be weighed daily.
- Elastic leg stockings help reduce swelling.
- ROM exercises improve muscle tone.
- Extra pillows may help breathing.
- Help with personal care and ADLs as needed.
- High-potassium foods can help with dizziness.
- Fluid Restrictions

Handout 20-1 Oxygen Therapy Using a Humidification Device

Oxygen administration can dry out the mucous membranes of the nose and mouth. Because of this, humidifying devices are often added to oxygen therapy devices. The humidifying container is filled with sterile or distilled water. The oxygen moves through the water and collection moisture before t is transferred to the resident.

Humidification devices are commonly pre-filled devices; nurses or respiratory therapists will replace the humidification device when its water level is low with a new, pre-filled container. Some facilities may use humidification devices that have to be re-filled by the nurse of the respiratory therapist when the water level becomes low. The nursing assistant's responsibility is to observe the humidification device and report promptly when the water level becomes low. In addition, if the device is not bubbling, or the bubbling decreases, report this promptly to the nurse.

Guidelines for Oxygen Therapy using a Humidifying Device

- Check the humidification device often to make sure it is bubbling. Carefully observe the water level in the humidification device.

Notify the nurse if the following occurs:

- The water in the humidification device stops bubbling; there is a decrease in bubbling; the water level in the humidification device becomes low. AKA= "Bubbler"

Care for the COPD Resident

Symptoms
Chronic cough or wheeze
Difficulty breathing
Shortness of breath
Pale or bluish or reddish-purple skin
Confusion
Weakness
Difficulty completing meals
Fear and anxiety

Care Guidelines
Observe and report symptoms getting worse
Help residents sit upright or lean forward
Offer fluids and small meals frequently
Encourage proper nutrition
Keep oxygen supply available
Be calm and supportive
Use good infection control
Encourage independence
Remind resident to avoid exposure to infections
Encourage pursed-lip breathing
Encourage rest and saving energy

Observe and Report
Temperature over 101°F
Changes in breathing pattern
Changes in color or consistency of lung secretions
Changes in mental state
Refusal to take medications
Weight loss
Increasing dependence

Collecting a Sputum Specimen

Equipment: Specimen container with cover, label, tissues, plastic bag, gloves, mask

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

4. Provide for resident's privacy with curtain, screen or door.

5. Put on mask and gloves. If the resident has known or suspected TB or another infectious disease, wear a mask when collecting a sputum specimen.

6. Ask the resident to cough deeply, so that sputum comes up from the lungs. To prevent the spread of infectious material, give the resident tissues to cover his or her mouth. Ask the resident to spit the sputum into the container.

7. When you have obtained a good sample, cover the container tightly. Wipe any sputum off the outside of the container with tissues. Discard the tissues. Put the container in the plastic bag, and seal the bad.

8. Remove and dispose of gloves and mask.

9. Complete the label for the container. Write the resident's name, room number, the date, and time.

10. Before leaving, place call light within resident's reach.

11. Wash your hands.

12. Report any changes in resident to the nurse.

13. Document procedure using facility guidelines.

Handout 20-2 Deep Breathing and Coughing Techniques

Deep breathing and coughing exercises are often necessary for residents who are recovering from surgery. These exercises can help prevent complications of bed rest, such as pneumonia. Ask the nurse if the resident is allowed to perform the exercises. Deep breathing and coughing exercises may not be safe to perform following certain types of surgeries. Never perform these exercises without first making sure the resident has an order for the exercises. Carefully follow the doctor's order when performing these exercises.

When the exercises are performed following surgery, it may be necessary to ask the nurse to give the resident pain medication prior to starting the exercises. The caregiver may need to wear PPE such as a face shield or a mask to help protect her during the coughing exercises. A pillow is generally used by the resident to help support the abdomen, especially if recovering from abdominal surgery.

Equipment: gloves, face shield or mask, goggles, pillow, tissues, emesis basin

1. Identify yourself by name. Identify the resident. Greet the resident by name.
2. Wash your hands. Apply gloves and face shield or goggles and mask.
3. Explain procedure to resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible. Encourage resident to assist, if possible.
4. Provide for the resident's privacy with a curtain, screen or door.
5. Position resident in the Fowler's position with a pillow over the abdomen, if needed. You may also be instructed to position the person in a dangling position.
6. Ask the resident to wrap her arms around the pillow and hold the pillow tightly against the abdomen.
7. Tell the resident to take a deep breath and hold the breath for a few seconds.
8. Ask the resident to exhale for as long as possible through lips that are pursed.
9. Tell the resident to then repeat the deep breathing exercise a few more times. Ideally, the resident should perform the deep breathing exercise five times in a row.
10. Make sure the tissues are nearby. Ask the resident to hold the pillow tightly, breathe in once deeply, and then cough as forcefully as possible. Collect any secretions with the tissues and dispose of tissues temporarily in the emesis basin.
11. Repeat the sequence above the designated number of times or the number of times the resident is able to perform the exercises.
12. Make resident comfortable.
13. Return bed to low position, if raised. Ensure resident's safety. Remove privacy measures.
14. Dispose of tissues properly.
15. Clean and store emesis basin.
16. Remove and dispose of gloves.
17. Leave call light within resident's reach.
18. Wash your hands.
19. Be courteous and respectful at all times.
20. Report any changes in the resident to the nurse. Document procedure using facility guidelines.

The Circulatory System

The circulatory system is made up of the heart, blood vessels, and blood. The heart pumps blood through the blood vessels to the cells. The blood carries food, oxygen, and other substances cells need to function properly.

The circulatory system performs these major functions:

- Supplying food, oxygen, and hormones to cells
- Producing and supplying infection-fighting blood cells
- Removing waste products from cells
- Controlling body temperature

A healthy circulatory system is essential for life. Cells, tissues, and organs need good circulation to function well. If circulation is reduced, cells do not receive enough oxygen and nutrients. Waste products of cell metabolism are not removed. Organs become diseased.

Blood contains blood cells and plasma. Plasma is the liquid portion of the blood. It carries many substances, including blood cells, nutrients, and waste products. Analyzing these parts of blood samples can help identify illness and infections:

1. Red blood cells carry oxygen from the lungs to all parts of the body. Red blood cells are produced by bone marrow, a substance found inside hollow bones. Iron, found in bone marrow and red blood cells, is essential to blood. It gives it its red color. Red blood cells function for a short time, and then die. They are filtered out of the blood by the liver and spleen. Iron in diets allows bodies to produce new red blood cells.
2. While blood cells defend the body against foreign substances, such as bacteria and viruses. When the body becomes aware of these invaders, white blood cells rush to the site of infections. They multiply rapidly. The bone marrow, spleen and thymus gland produce white blood cells.
3. Platelets are also carried by the blood. They cause the blood to clot, preventing excess bleeding. Platelets are also produced by the bone marrow.

The heart is the pump of the circulatory system. The heart is a muscle. It is located in the middle lower chest, on the left side. The heart muscle is made up of three layers; the pericardium, the myocardium and the endocardium.

The interior of the heart is divided into four chambers. The two upper chambers, called atria or the left atrium and right atrium, receive blood. The two lower chambers, or ventricles, pump blood. The right atrium receives blood from the veins. This blood, containing carbon dioxide, then flows into the right ventricle. It is pumped to the blood vessels in the lungs. Carbon dioxide is exchanged for oxygen. The heart's left atrium receives the oxygen-saturated blood. It then flows into the left ventricle. There it is pumped through the arteries to all parts of the body. Two valves, one located between the right atrium and right ventricle and the other between the left atrium and left ventricle, allow the blood to flow in only one direction

The heart functions in two phases:

1. The resting phase or diastole, when the chambers fill with blood.
2. The contracting phase or systole, when the ventricles pump blood through the blood vessels. When a blood pressure is taken, the numbers measure these two phases.

Three types of blood vessels are found in the body: arteries, capillaries, and veins.

Arteries carry oxygen-rich blood away from the heart. The blood is pumped from the left ventricle, through the aorta, the largest artery. Blood is then pumped through other arteries that branch off from it. The coronary arteries carry blood to the heart itself.

Capillaries are tiny blood vessels that receive blood from the arteries. Nutrients, oxygen, and other substances in the blood pass from the capillaries to the cells. Waste products, including carbon dioxide, pass from the cells into the capillaries.

Veins carry the blood containing waste products from the capillaries back to the heart. Near the heart, the veins come together to form the two largest veins, the inferior vena cava and the superior vena cava. These empty into the right atrium. The inferior vena cava carries blood from the legs and trunk. The superior vena cava carries blood from the arms, head and neck.

Taking and Recording Apical-Radial Pulse

Equipment: stethoscope, watch with second hand, alcohol wipes, pen and paper

1. Wash your hands.

2. Identify yourself by name. Identify the resident by name.

3. Explain procedure to the resident. Speak clearly, slowly, and directly. Maintain face-to-face contact whenever possible.

4. Provide for resident's privacy with curtain, screen or door.

5. If the bed is adjustable, adjust to a safe working level, usually waist high. If the bed is movable, lock bed wheels.

6. Fit the earpieces of the stethoscope snugly in your ears. Place the flat metal diaphragm on the left side of your chest, just below the nipple. Listen for the heartbeat.

7. Use the second hand of your watch. Count beats for one full minute. Each "lubdub" that you hear is counted as one beat.

8. Have a co-worker check the radial pulse for one minute. Write down the results of both apical and radial pulse for comparison.

9. Determine the pulse deficit, if any, by subtracting the smaller number from the larger one. Example: if the apical pulse is 100 beats per minute and the radial pulse is 92 beats per minute, subtract 92 from 100. The pulse deficit is 8.

10. Clean earpieces and bell of stethoscope with alcohol wipes.

11. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs

12. Return bed to appropriate position. Remove privacy measures.

13. Before leaving, place call light within resident's reach.

14. Wash your hands.

15. Report any changes in resident to the nurse.

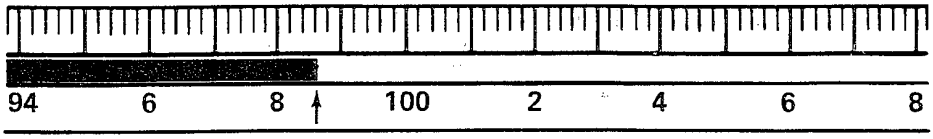
16. Document procedure using facility guidelines.

Thermometer Worksheet

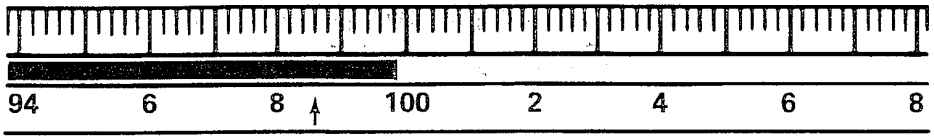
[redacted] _____

ANSWERS

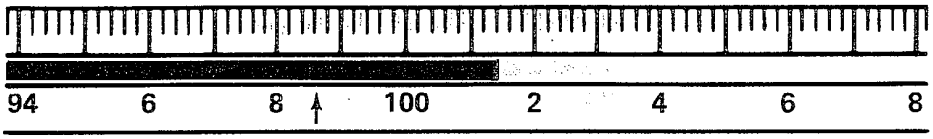
B. _____



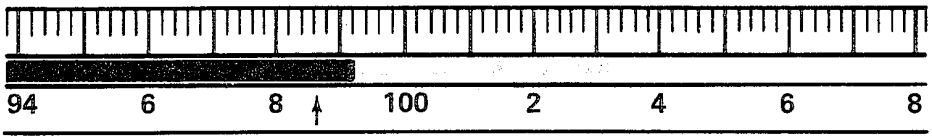
C. _____



D. _____



E. _____



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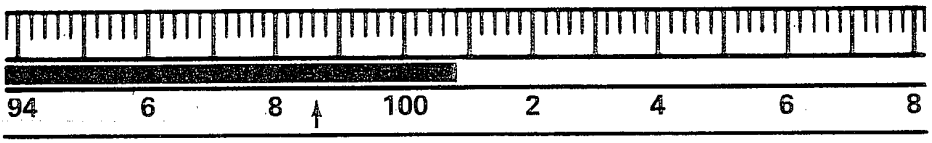
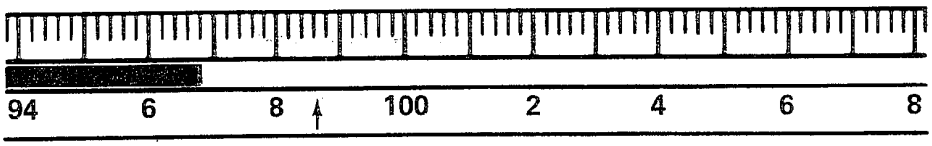


G. _____



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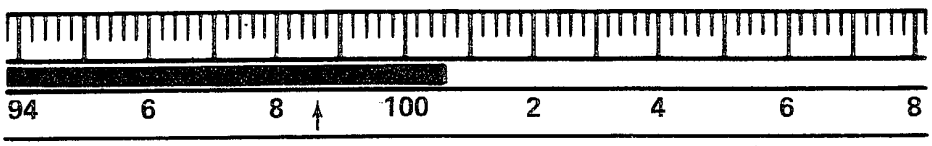
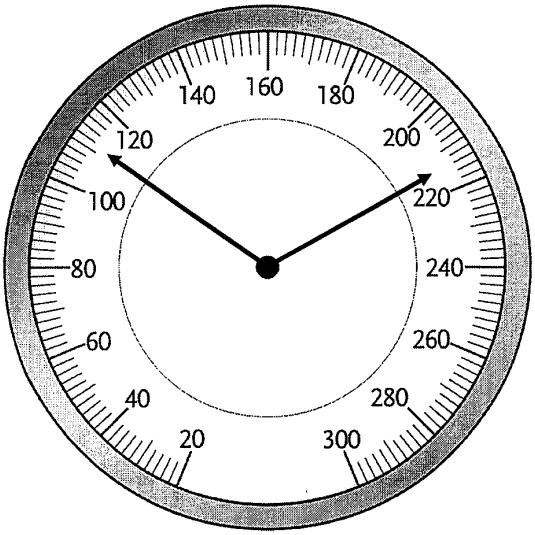


Handout 13-2 Blood Pressure Worksheet

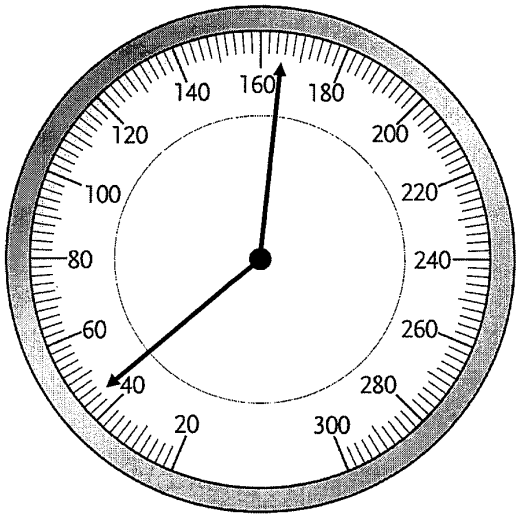
Record the blood pressure shown on the appropriate line and answer the question below.



1. _____

Is this reading within normal range?

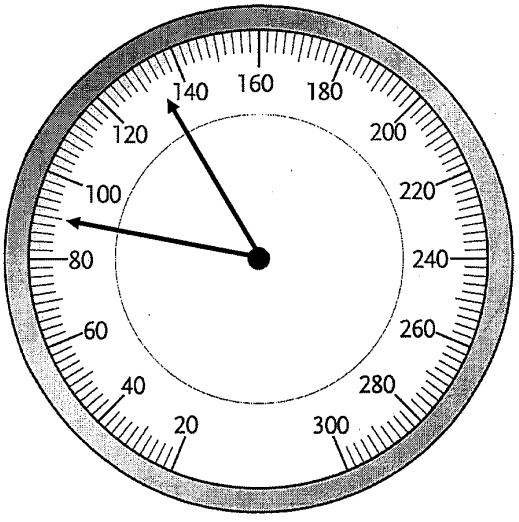
_____



3. _____

Is this reading within normal range?

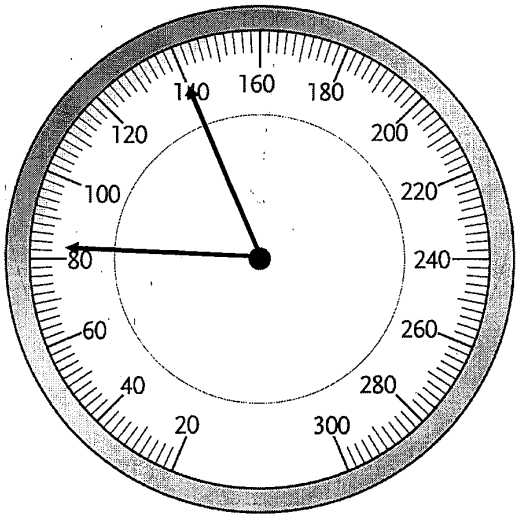
_____



2. _____

Is this reading within normal range?

_____



4. _____

Is this reading within normal range?

_____

Objective 6
Nutrition-GI/GU

Textbook: Chapter 24, 25, 36, 37
Nursing Skills: feeding, elimination assistance, bedpan, urinal, specimen collection, enema, ostomy care, I&O, catheter care
Vocabulary words, medical terminology, and abbreviations

1. Define term nutrition and explain why our bodies need adequate nutrition.
2. List general types of nutrients and describe how the body uses them.
3. Explain factors that influence food preferences.
4. Describe common special diets.
5. Discuss importance of making meals attractive and dining experience pleasant.
6. Explain steps to prepare a person for meal time; describe ways to help a person during meal time.
7. Demonstrate proper technique for feeding a person unable to feed himself.
8. Describe how to document amount of food eater.
9. Discuss other ways of providing nutrition for people unable to take food by mouth.
10. Explain fluid needs of the body and factors that affect the fluid balance.
11. Demonstrate methods used to measure and record fluid intake and output.
12. List body structure and function for the digestive and urinary system.
13. Discuss effects of aging on digestive and urinary system.
14. Discuss common digestive and urinary disorders and their symptoms.
15. Demonstrate how to provide routine stoma care.
16. Discuss special care needs of people who have urinary system disorders.
17. Describe how the body eliminates waste.
18. Discuss attitudes that people may have regarding the processes or urinary and bowel elimination.
19. Discuss actions the nursing assistant can take to promote normal urinary and bowel elimination; explain why normal elimination is essential to health.
20. List normal characteristics of urine and stool; describe observations which should be reported and/or documented.
21. Describe the use of urinary catheters and demonstrate how to provide routine catheter care.
22. Describe methods to assist people who are incontinent.
23. Understand underlying principles of bladder training.
24. Define problems with bowel elimination that are frequently seen.
25. List types of enemas or other methods to assist with bowel elimination.
26. Demonstrate proper technique for assisting with urinary and bowel elimination, obtaining urine and stool specimens, providing catheter care and administering enemas.

Vocabulary Words
Objective 6

Nutrition
Nutrients
Carbohydrates
Protein
Glucose
Fats
Vitamins
Appetite
Anorexia
Dietitian
Intake
Output
Fluids
Dehydration
Edema
Graduate Cylinder
Urination
Micturation
Defecation
Voiding
Urgency
Frequency
Nocturia
Hematuria
Ostomy
Stoma
Digestion
Calorie
Intravenous Therapy
TPN/Hyperalimentation
Fresh Fractional Urine/Double Voided Specimen

Diarrhea
Constipation
Fecal Impaction
Nasogastric
Ileostomy
Colostomy
Ureterostomy
Urostomy
Gastrostomy
Jejunostomy
Urinary Catheter
Foley Catheter
Condom Catheter
Incontinence
Urine Retention
Bladder Training
Oliguria
Polyuria
Anuria
Dysuria
Flatus
Laxative
Suppository
Stool
Gastritis
Emesis
Absorption
Amino Acid
Enteral Nutrition

Gastrointestinal
Salivary Glands
Pharynx
Esophagus
Stomach
Small Intestine
Large Intestine
Rectum
Anus
Liver
Gallbladder
Pancreas
Ulcer
Hernia
Gallstones
Hemorrhoids
Kidney
Ureter
Urinary Bladder
Urethra
Kidney Stones
Dialysis
Urinalysis
Clean Catch Urine Specimen
Occult
Ingestion
Metabolism
Mineral
PEG Tube

Diets: Regular
Clear Liquid
Full Liquid
Soft
Diabetic
Sodium-Restricted
Low-Cholesterol

Study Tip: Write out the definitions for these terms.

The Digestive System

The gastrointestinal (GI) system, also called the digestive system, has two functions:

1. Digestion is the process of breaking down food so that it can be absorbed into the cells.
2. Elimination is the process of expelling solid wastes that are not absorbed into the cells.

The GI system is made up of the alimentary canal and the other digestive organs.

The alimentary canal is a long passageway extending from the mouth to the anus, the opening of the rectum. Food passes from the mouth through the pharynx, esophagus, stomach, small intestine, large intestine, and out of the body as solid waste. The teeth, tongue, salivary glands, liver, gall bladder, and pancreas are the accessory organs to digestion. They help prepare the food so it can be absorbed.

Food is first placed in the mouth. The teeth chew it by cutting it, then chopping and grinding it into smaller pieces that can be swallowed. Saliva moistens the food and begins chemical digestion. The tongue helps with chewing and swallowing by pushing the food around between the teeth and then into the pharynx.

The pharynx is a muscular structure located at the back of the mouth. It extends into the throat. It contracts with swallowing and pushes food into the esophagus. The muscles of the esophagus then move food into the stomach through involuntary contractions called peristalsis.

The stomach is a muscular pouch located in the upper left part of the abdominal cavity. It provides physical digestion by stirring and churning the food to break it down into smaller particles. The glands in the stomach lining aid in digestion. They secrete gastric juices that chemically break down food. This process turns food into a semi-liquid substance called chyme. Peristalsis continues in the stomach, pushing the chyme into the small intestine.

The small intestine is about twenty feet long. Here enzymes secreted by the liver and the pancreas finish digesting the chyme. Bile, a green liquid produced by the liver, is stored in the gallbladder and released into the small intestine. Bile helps break down dietary fat. The liver converts fats and sugars into glucose, a sugar that can be carried to cells by the blood. The liver also stores glucose. The pancreas produces insulin, an enzyme that regulates the body's conversion of sugar into glucose.

The chyme is moved by peristalsis through the small intestine. There villi, tiny projections lining the small intestine, absorb the digested food into the capillaries.

Peristalsis moves the chyme that has not been digested through the large intestine. In the large intestine most of the water in the chyme is absorbed. What remains is feces, a semisolid material of water, solid waste material, bacteria, and mucus. Feces pass by peristalsis through the rectum, the lower end of the colon. It moves out of the body through the anus, the rectal opening.

Factors Affecting Bowel Elimination

Normal changes of aging

- Peristalsis slows
- There is less muscle tone
- Possible tooth loss and less saliva affect digestion

Psychological factors

- Stress, anger, and fear increase peristalsis
- Depression decreases peristalsis
- A lack of privacy can greatly affect elimination

Food and fluids

- Fiber improves elimination
- Animal fats and low-fiber foods can cause constipation
- Some foods cause gas, which can help with elimination
- Proper fluid intake helps elimination

Physical activity

- Regular activity helps elimination
- Immobility weakens muscles and may slow elimination

Personal habits

- Time of day varies but it usually occurs after meals
- Supine position causes most trouble for bowel elimination
- Best position for elimination is squatting and leaning forward

Medications

- Laxatives help elimination
- Pain relievers can slow elimination
- Antibiotics may cause diarrhea

Giving a Cleansing Enema

Equipment: 2 pairs of gloves, bath blanket, IV pole, enema solution, tubing and clamp, bed protector, bedpan with cover, lubricating jelly, bath thermometer, tape measure, toilet paper, 2 washcloths

1. Wash hands.
2. Identify yourself to resident by name. Address resident by name.
3. Explain procedure to resident, speaking clearly, slowly and directly, and maintaining face-to-face contact whenever possible.
4. Provide for resident's privacy during procedure with curtain, screen, or door.
5. Adjust bed to a safe working level, usually waist high. Lock bed wheels.
6. Raise side rail on far side of bed. Lower side rail nearest you.
7. Assist resident into left-sided Sims' position. Cover with a bath blanket.
8. Place the IV pole beside the bed. Raise the side rail.
9. Clamp the enema tube. Prepare the enema solution. Fill bad with 500-100 cc of warm water-105°F.
10. Unclamp the tube. Allow a small amount of solution to run through the tubing. Re-clamp the tube.
11. Hang bags on IV pole. Make sure bottom of enema bag is not more than 12 inches above the resident's anus.
12. Apply gloves.
13. Lower the side rail. Uncover resident enough to expose anus only.
14. Place bed protector under resident. Place bedpan close to resident's body.
15. Lubricate tip of tubing with lubricating jelly.
16. Ask resident to breathe deeply to relieve cramps during procedure.
17. Place one hand on the upper buttock and lift to expose the anus. Using other hand, gently insert the tip of the tubing two to four inches into the rectum. Stop immediately if you feel resistance or if the resident complains of pain. If this happens notify the nurse immediately.
18. Unclamp the tubing and allow the solution to flow slowly into the rectum. Ask resident to take slow deep breaths. If resident complains of cramping, clamp the tubing and stop for a couple of minutes. Encourage the resident to take as much of the solution as possible.
19. Clamp the tubing when the solution is almost gone. Remove the tip from the rectum. Place the tip into the enema bag, without contaminating yourself, resident or bed linens.
20. Request that the resident hold the solution inside as long as possible.
21. Assist resident in using bedpan, commode or to the bathroom.
22. Place call light and toilet paper within resident's reach. If using the bathroom, ask resident not to flush the toilet when finished.
23. Leave the resident if possible. Ask him to signal when he's finished.
24. Discard disposable equipment and clean area.
25. Remove gloves. Wash your hands.
26. When resident is done, put on clean gloves. Assist with perineal care.
27. Cover and remove bedpan. Remove the bed protector.
28. Empty bedpan. Check contents for consistency, color, and amount. If resident used toilet, check the contents of toilet.

29. Rinse bedpan, pouring rinse water into toilet. Return to proper storage. Dispose of soiled washcloths.
30. Remove gloves and wash your hands.
31. Assist resident with washing hands.
32. Remove bath blanket and assist resident to comfortable position.
33. Report any changes in resident to the nurse.
34. Document procedure according to facility guidelines.

Collecting a 24 hour Urine Specimen

Equipment: 24 hour specimen container, label, bedpan or urinal, "hat" for toilet, plastic bag, gloves, washcloth, towel, supplies for perineal care, sign to alert other team members that a 24 hour urine specimen is being collected.

1. Wash hands.
2. Identify yourself to resident by name. Address resident by name.
3. Explain procedure to resident, speaking clearly, slowly and directly, and maintaining face-to-face contact whenever possible.
4. Provide for resident's privacy during procedure with curtain, screen, or door.
5. Place a sign on the resident's bed to let all care team members know that a 24 hour specimen is being collected. Sign may read "Save all urine for 24 hour specimen."
6. When starting the collection, have the resident completely empty the bladder. Discard the urine. Note the exact time of this voiding. The collection will run until the same time the next day.
7. Label the container. Write resident's name, address, and dates and times the collection period began and ended.
8. Put on gloves each time the resident voids.
9. Pour urine from bedpan, urinal, or toilet attachment into the container. Container may be stored on ice when not used. The ice will keep the specimen cool. Follow facility policy.
10. After each voiding, help as necessary with perineal care. Help the resident wash his or her hands.
11. Clean equipment after each voiding.
12. Remove gloves.
13. Wash your hands.
14. After the last void of the 24 hour period, add the urine to the specimen container. Remove the sign.
15. Place container in plastic bag. Remove and dispose of gloves.
16. Wash your hands
17. Make resident comfortable. Make sure sheets are free from wrinkles and the bed free from crumbs.
18. Return bed to appropriate position. Remove privacy measures.
19. Before leaving, place call light within resident's reach
20. Report any changes in resident to the nurse.
21. Document procedure using facility guidelines.

Conversion Table

A milliliter (mL or ml) is a unit of measure equal to one cubic centimeter (cc).

1 oz. = 30 mL or 30 cc
2 oz. = 60 mL
3 oz. = 90 mL
4 oz. = 120 mL
5 oz. = 150 mL
6 oz. = 180 mL
7 oz. = 210 mL
8 oz. = 240 mL
¼ cup = 2 oz. = 60 mL
½ cup = 4 oz. = 120 mL
1 cup = 8 oz. = 240 mL
5cc = 1 teaspoon
15cc = 1 tablespoon

Study Tip: Memorize this chart.

Intake and Output Sheet

Name: _____

1 oz. = 30 cc or 30 mL
Total number of ounces x 30= total number of cc or ml

1. Your resident/client drinks two 8 oz. glasses or water.
   The resident/client's intake = _____ ml or _____ oz.

2. Your resident/client drinks 4 oz. of milk and eats 4 oz. of ice cream for lunch.
   What is the total intake in ml? _____ ml

3. The resident/client is limited to 720 ml liquids in 8 hours. How many glasses of water may he/she have? (Remember: 1 glass = 240 ml)
   Total number of glasses is _____

4. For the evening meal, the resident/client is served a 6 oz. bowl of soup, a 4 oz. cup of coffee, and 8 oz. glass of cranberry juice and a 3 oz. serving of sherbet.
   Total ml of intake is _____

5. Urine output measures 20 oz. How many cc does that total? _____ml

6. The resident/client drinks 4 oz. of orange juice, 6 oz. of coffee and 2 oz. of milk.
   What is the total intake of ml? _____ml

7. When converting measurements to the metric system, you will need to know that 1 oz. is equal to _____ml

8. The oral intake for lunch is 6 oz. of juice, 4 oz. of ice cream, and 7 oz. of coffee.
   What is the total number of ml for lunch? _____ml

9. Your resident/client has 4 oz. of juice for breakfast, 8 oz. of milk, and 6 oz. of tea; he drinks half (1/2) the tea, and all the milk.
   What is the total number of ml for breakfast? _____ml

10. Mrs. Brown receives a mid-morning snack. She receives supplemental liquid nourishment. The Ensure container is 8 oz. She drinks 4 oz.
    What is the total number of ml for her morning snack? _____ml

11. Mr. Jones drinks 8 oz. of ginger ale, 4 oz. of Jell-O, and 4 oz. of tea for his evening meal.
    What is the total number of ml? _____ml

12. You can calculate the resident/client's total intake and output at the end of your eight-hour shift. The resident/client's urinary output measures 10 oz. and oral intake measures 10 oz. Is the resident/client in fluid balance? _____

Name: _____

OBJ 6
I & O Worksheet

Total the following I & O's:

_____ 1. 1 oz, 50 cc, 5 tsp
_____ 2. 3 cc, 10 cc, 560 cc
_____ 3. 6 oz cup of coffee, 8 oz water, 240 ml juice
_____ 4. 90 cc soup, 4 ml jello, 1 oz broth
_____ 5. 2 tsp broth, 3 tbsp juice, 5 cc water
_____ 6. 500 cc urine, 6 oz emesis, 240 cc urine
_____ 7. 600 ml urine, 480 cc urine, 660 cc urine
_____ 8. 900 cc soda, 6 oz coffee, 5 oz coffee
_____ 9. 1 carton of milk, 1 can of Dr. Pepper, 6 oz juice
_____ 10. 5 oz emesis, 60 ml emesis, 240 cc urine
_____ 11. 1 can soda, ½ carton of milk, 90 cc soup
_____ 12. 1 tbsp milk, 6 oz coffee, 120 cc milk
_____ 13. 30 cc, 560 ml, 640 cc
_____ 14. 9 cc soda, 22 cc soup, 60 cc milk
_____ 15. 75 ml popsicle, 90 cc jello, 6 oz soup
_____ 16. 500 cc emesis, 12 oz urine, 5 cc emesis
_____ 17. 4 oz cranberry juice, 4 oz water, 8 oz milk
_____ 18. 120 ml prune juice, 2 pancakes, 5 oz coffee
_____ 19. 2 cups of coffee (6 oz each), 1 carton of milk, 360 cc
_____ 20. 8 oz, 2 tsp, 30 cc, 2 oz
_____ 21. 120 cc juice, 240 ml milk, 360 cc pop
_____ 22. 70 cc, 7 oz, 7 cc, 7 tsp
_____ 23. 30 cc, 50 cc, 10 oz
_____ 24. 2 tsp, 3 tsp, 10 tsp
_____ 25. 90 ml urine, 360 cc urine, 1200 cc urine
_____ 26. 1 oz, 1 cc, 1 tsp, 1 tbsp

Objectives 7-1
Neurology & Special Senses

Textbook: Chapter 33, 34, 41

1. List and describe the structures and functions of the two main divisions of the nervous system.
2. Describe how against affects the nervous system.
3. Describe the function of the nervous system.
4. Discuss the various diseases/disorders of the nervous system and the s/s of each.
5. Describe how you would care for an individual having a seizure.
6. Describe how you would care for a resident after a stroke.
7. Describe how you would care for a resident with a spinal cord injury.
8. What is the goal of rehabilitation of neurologic disorders?
9. Define the term mental illness and some of the common mental illnesses that might be encountered in the health care setting.
10. Describe the responsibilities of the CNA when caring for mentally ill residents.
11. Discuss how aging affects the special senses.
12. List and describe common disorders of the eye and ear.
13. Describe technique for communicating with hearing impaired person.
14. Describe special considerations that are taken when caring for a blind person.
15. Describe how to care for eye glasses and hearing aids.
16. Discuss methods that people use to cope with stress effectively.
17. What are the common defense mechanisms people use when under stress?
18. Describe ways a CNA can help with pain.

Vocabulary Words
Objective 7-1

Coping Mechanism
Defense Mechanism
Depression
Suicide
Anxiety
Delusions
Hallucinations
Rationalization
Projection
Conjunctivitis
Panic Attack
Schizophrenia
Bipolar Disorder
Parkinson's disease
Stroke
Seizure
Epilepsy
Tonic-Clonic
Petite Mal Seizure
Grand Mal Seizure
Transient Ischemic Attack
Multiple Sclerosis
Amyotrophic Lateral Sclerosis
Acute Pain
Myopia
Astigmatism
Conversion
Displacement
Repression
Psychologist
Obsessive-Compulsive Disorder
Bulimia Nervosa
Stress
Receptive Aphasia
Expressive Aphasia
Hemiplegia
Quadriplegia
Paraplegia
Glaucoma
Cataracts
Presbyopia
Diabetic Retinopathy
Vertigo
Tinnitus
Autonomic Dysreflexia
Cerebrovascular Accident
EEG
Cerumen
Otitis Media
Dementia
Emotional Liability
Presbycusis
Neuron
CNS
PNS
Chronic Pain
Hyperopia
Compensation
Denial
Regression
Psychiatrist
Phobia
Anorexia Nervosa

Study Tip: Write out the definitions for these terms.

Care Guidelines for Stroke

- Assist with exercises as ordered, keeping safety in mind.
- Use terms “weaker” or “involved”, not “bad.”
- Assist with speech therapy as needed.
- Use verbal and nonverbal communication to express positive attitude.
- Residents may experience confusion, memory loss, and emotions. Be patient and understanding.
- Encourage independence and self-esteem.
- Always check on resident’s body alignment.
- Pay special attention to skin care.
- If residents have lost sense of touch of sensation, be aware of potentially harmful situations such as proximity to heat and sharp objects.
- Adapt procedures when caring for residents with one-sided paralysis or weakness.
- For transfers:
  - Always use gait belt.
  - Stand on and support weaker side.
  - Lead with stronger side.
- For assisting with dressing:
  - Dress weaker side first. Undress stronger side first.
  - Use assistive equipment to help resident dress himself.
- For assisting with eating:
  - Place food in resident’s field of vision.
  - Use assistive devices.
  - Watch for signs of choking.
  - Serve soft foods if swallowing is difficult.
  - Always place food in unaffected side of mouth.
  - Make sure food is swallowed.

  - Be fast, LKW

Treatment and Care for Stroke Resident

- PT, OT offer therapy for paralysis, weakness, or loss of movements.
- NAs adapt procedures for paralysis or weakness.
- NAs assist transfers on weaker or involved side. Lead with stronger side.
- NAs check for harmful situations for residents who have loss of sensation.
- NAs assist with speech therapy.
- NAs need patience and keep routine of care.
- NAs encourage independence and self-esteem.
- NAs make tasks less difficult.
- NAs notice and praise efforts and successes.

Guidelines for assisting one-sided weakness with dressing:

- Dress weaker side first.
- Undress stronger side first.
- Use adaptive equipment for dressing.
- Encourage self-care.

Communications techniques:

- Keep questions and directions simple.
- Ask “yes” and “no” questions.
- Use agreed-upon signals.
- Give resident time to respond.
- Use pencil and paper.
- Use pictures, gestures, or pointing.
- Keep call light within resident’s reach.

Managing Pain

- Report pain promptly to the nurse.
- Position the body in good alignment.
- Help in changes of position.
- Give backrubs.
- Offer warm bath or shower.
- Help the resident to use the bathroom, bedpan, or urinal.
- Encourage slow, deep breaths.
- Provide calm environment.
- Use soft music.
- Be patient, caring, gentle, and sympathetic.
- Note resident’s emotional response to pain.

Objective 7-2
Alzheimer's

Textbook: Chapter 9

1. Explain difference between dementia and delirium.

2. Describe two major types and causes of dementia.

3. List and describe stages of Alzheimer's disease.

4. Describe behaviors that are common in people with dementia.

5. Describe strategies for managing difficult behaviors in people with dementia.

6. Describe special considerations that the nursing assistant must keep in mind while helping a person with dementia with ADLs.

7. Describe special care measures that are taken to help maintain quality of life for a person with dementia.

8. Describe the effects of caring for a person with dementia on the caregiver and strategies for coping.

- Videos for:
    - L.A.T.E
    - Lewy Body
    - CTE (Concussions, TBI)
    - Alzheimer's (Sporadic and Familial)
    - FTD
    - Down syndrome
    - HIV/AIDS
    - Vascular- multi infract

Vocabulary Words
Objective 7-2

Dementia
Delirium
Confusion
Alzheimer's disease
Vascular (Multi-Infarct) Dementia
Wandering
Pacing
Repetition
Perseveration
Rummaging
Delusions
Hallucinations
Agitation
Catastrophic Reaction
Sun downing
Validation Therapy
Reminiscence Therapy

Study Tip: Write out the definitions for these terms.

Difficult Behaviors and Management

Agitation- Avoid triggers, keep routine, remain calm, distract, and soothe.

Pacing and Wandering- Let pace in safe place, eliminate cause, give snacks, encourage exercise, maintain toileting schedule, and suggest another activity.

Hallucinations or Delusions- Ignore if harmless, reassure, do not argue, and be calm. Do not make fun of resident or pretend to see/hear hallucination. Redirect to other activities or thoughts.

Sun Downing- Eliminate triggers, avoid stress, play soft music, set bedtime routine, plan calming activity, distract, eliminate caffeine, and encourage daily exercise. Give snacks or encourage rest. Give back massage.

Catastrophic Reaction- Remove triggers, focus on soothing activity.

Depression- Report signs and symptoms to the nurse. Encourage independence and self-care, and encourage activity. Listen if resident wants to talk. Encourage social interaction.

Perseveration or Repetitive Phrasing- Respond with patience, do not stop behavior, and answer questions each time.

Violent Behavior- Block blows, never hit back, step out of reach, call for help, and eliminate triggers.

Disruptiveness- Praise improved behavior, inform resident of changes in routine, encourage independence, and focus on positive activities.

Inappropriate Social Behavior- Do not take it personally, stay calm, and reassure resident. Try to find triggers and direct resident to private area.

Inappropriate Sexual Behavior- Do not overreact, distract, and direct resident to a private area. Provide more appropriate physical stimulation.

Pillaging and Hoarding- Label personal belongings and door to resident's room. Prepare the family but do not say the resident has been "stealing." Provide a rummage drawer.

Improvisation
Validation therapy
caregiver support groups
Common Problems -noise, hunger, toilet, pain meds

Alzheimer's Disease

Alzheimer's disease (AD) is the most common cause of dementia in the elderly. The disease usually occurs after age 65. It can strike younger people. Almost 50% of people over age 85 may have AD. The National Center for Health Statistics estimates that over half of the people in nursing homes have AD or a related disorder. A person can live with AD for three to twenty years; the average is eight years. While each person with AD will show different symptoms at different times, the general progression of the disease occurs in three stages. The symptoms of each stage are:

Stage 1:

- Recent (short term) memory loss
- Disorientation to time
- Lack of interest in doing things, including work, dressing, recreation
- Inability to concentrate
- Mood swings
- Irritability
- Petulance: peevish, ill-humored, rude behavior
- Tendency to blame others
- Carelessness in personal habits
- Poor judgment

Stage 2:

- Increased memory loss, may forget family members and friends
- Slurred speech
- Difficulty finding right word, finishing thoughts, or following directions
- Tendency to make statements that are illogical
- Inability to read, write, or do math
- Inability to care for self or perform ADLs without assistance
- Incontinence
- Dulled senses (for example, cannot distinguish between hot and cold)
- Restlessness, wandering, and/or agitation (increase of these in the evening is called "sun downing")
- Sleep problems
- Lack of impulse control (for example: swears excessively or is sexually aggressive or rude)
- Obsessive repetition of movements, behavior, or words
- Temper tantrums
- Hallucinations or delusions

Stage 3:

- Total disorientation to time, place and person
- Apathy
- Total dependence on others for care
- Total incontinence
- Inability to speak or communicate, except for grunting, groaning, or screaming

- Total immobility/confined to bed
- Inability to recognize family or self
- Increased sleep disturbances
- Difficulty swallowing, which produces risk of choking
- Seizures
- Coma
- Death = pneumonia & hemorrhage (hemorrhage- due to plaques immune response)

Encourage residents with AD to do ADLs. Help them keep their minds and bodies as active as possible. Working, socializing, reading, problem solving and exercising should all be encouraged. Meaningful activities help promote independence, memory, self-esteem, and quality of life.

Alzheimer's Disease and Problems with Eating

A person with Alzheimer's disease may have a change in eating habits in the second and third stages. Food may not interest the resident at all or may be of increased interest to the resident. A resident may only want to eat a few types of food. Whatever the case may be, a resident with AD is at risk for malnutrition. Nutritious food intake should be encouraged. Here are some suggestions for improving eating habits:

- Offer meals at regular, consistent times each day.
- Food should look and smell good
- Make sure there is good lighting.
- Keep noise and distraction to a minimum during meals.
- You may need to remind the person that it is mealtime.
- Keep the task of eating simple.
- Finger foods are easier to eat and allow residents with AD to choose the food they want to eat. Finger good is food that is easy to pick up with the fingers. Examples include sandwiches cut into quarters, chicken nuggets or small pieces of cooked boneless chicken, fish sticks, cheese cubes, halved hard-boiled eggs, and fresh fruit and soft vegetables cut into bite-sized pieces.
- Do not serve steaming or extremely hot foods or liquids.
- Use dishes without a pattern. White usually works best. Use a simple place setting with a single eating utensil. Remove other items from the dining table.
- Put only one item of food on the plate at a time. The food tray may be overwhelming.
- You may have to help him or her taste a sample of the meal first.
- Place a spoon to the lips. This will encourage the person to open his or her mouth.
- Ask the person to open his or her mouth.
- Guide the person through the meal, providing simple instruction.
- Offer regular drinks of water, juice, and other fluids to avoid dehydration.
- Use adaptive equipment, such as special spoons and bowls, as necessary.
- Make sure mealtimes are simple and relaxed. Allow plenty of time for eating.
- Seating residents with AD with others at small tables encourages socializing.
- Always observe for eating or swallowing problems. Report these problems to the charge nurse as soon as possible.

Hint Slow Approach (cueing), muscle memory for ADL's, Visual Ques, Verbal Ques, Hand under Hand, Positive Feedback

Signs of Approaching Death- Objective 7 & 8

- Cyanotic, pale, or darkening skin or mucous membranes
- Cold skin
- Skin that looks bruised (mottling)
- Heavy perspiration
- Fever
- Extreme weakness and exhaustion
- Loss of muscle tone
- Fallen jaw, causing the mouth to stay open
- Decreased sense of touch
- Loss of feeling, beginning in the legs and feet
- Loss of vision
- Pupils dilate and eyes may stare
- Inability to speak
- Extreme drowsiness
- Disorientation or confusion
- Hallucinations
- Low blood pressure
- Increased pulse
- Cheyne-Stokes breathing
- Gurgling and rattling sound when breathing
- Difficulty swallowing
- Decreased appetite and sense of thirst
- Dry mouth
- Nausea, vomiting, and diarrhea
- Incontinence of urine and stool
- Decreased urinary output
- Loss of hearing

Alzheimer's helpline 1-800-272-3900

Ways to Treat Dying People and their Families with Dignity

- Respect their wishes in all ways possible
- Listen for ideas on how to provide simple gestures that may be appreciated
- Do not make promises that cannot and should not be kept
- Listen if they want to talk
- Do not babble or be especially cheerful or sad
- Keep them comfortable
  - Pain free, if possible
  - Clean and dry
- Do not isolate or avoid them
- Assure privacy when they want it
- Respect the privacy of the family and other visitors

The Dying Person's Bill of Rights

I have the right to:

- Be treated as a living human being until I die.
- Maintain a sense of hopefulness, however changing its focus may be.
- Be cared for by those who can maintain a sense of hopefulness, however changing this might be.
- Express my feelings and emotions about my approaching death in my own way
- Participate in decisions concerning my care
- Expect continuing medical and nursing attentions even though "cure" goals must be changed to "comfort" goals
- Not die alone
- Be free from pain
- Have my questions answered honestly
- Not be deceived
- Have help from and for my family in accepting my death
- Die in peace and dignity
- Retain my individuality and not be judged for my decisions
- Discuss and enlarge my religious and/or spiritual experiences, whatever these may mean to others
- Expect that the sanctity of the human body will be respected after death
- Be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.

Objective 8 Endocrine System- Diabetes Caring for Patients with HIV/AIDS	 Chapter 34 Chapter 42
Caring for People with Cancer Caring for People Who Are Terminally Ill Caring for People Who Are Dying	Chapter 41 Chapter 25 Chapter 26
Caring for People with Developmental Disabilities Introduction to Home Health Care Infection Control and Safety in Home Health Job Seeking Skills	Chapter 39 Chapter 46 Chapter 47 Chapter 3 (p 34-44)
FINAL EXAM 100 points	-Nurseaidetesting.com (Practice Test) certification test -Instructor Evals -Rosters -Review IDPH task list

Hot & Dry= Sugar High
Cold & Clammy= Need Candy
Insulin Resistance
Pre-Diabetes

Sample Cover Letters

Your Name
Your Address
Your City, State, Zip Code

Date
Employer Name
Company
Address
City, State, Zip Code

Dear Mr. /Mrs. Last Name,

I am writing this cover letter in reference to the advertisement that came out in the XYZ newspaper for the full time position of a Certified Nursing Assistant. I am even ready to relocate for this position.

As you can see in the enclosed resume, I have a very strong academic background in nursing combined with over five years work experience in health and medical care. My recent internship at ABC location allowed me to further develop and strengthen my communication skills. I believe that I could make a significant and valuable contribution in your firm.

I would appreciate the opportunity to discuss how my education and experience will be helpful to you. I will be contacting you tomorrow morning on the phone to talk about the possibility of arranging an interview.

Thank you for your time and consideration.

Sincerely,

Signature

Typed Name

Your Name
Your Address
Your City, State, Zip Code
Your Phone Number
Your Email

Date

Employer Name
Company
Address
City, State, Zip Code

Dear Mr. / Mrs. Last Name,

I am interested in Nursing Assistant position available with your hospital. I have visited your web site recently and there I got the news that you are hiring people in your hospital. I am having genuine interest in this field. I have also enclosed my resume with this letter. It describes about my educational background and experience.

I am a certified nursing assistant with 5 years of experience. I am efficient in providing nursing and nursing related services to the residents. I can easily provide useful services such as bathing, grooming, and feeding patients. I have excellent clinical, customer service and communication skills.

I eagerly want to join your hospital. Please let me know if I can provide you with any other information or references, I look forward to hearing from you.

Thanks for your consideration.

Sincerely,

Signature

Typed Name

Resume Writing Tips and Sample Resumes

A resume is the first interface between you and a prospective employer. When applying for the job as a certified nursing assistant, include all the skills, qualifications and work experiences related to the job description that may give you an advantage over other job applicants.

Contact Information

1. Your name should be at the top of the resume, followed by contact details such as address, phone number and email address. Your name and address ideally should be on the left hand corner of the page, with phone number and email on the right side. Another option is to center all this information at the top of the page.

Education Qualifications

2. Your education qualifications should be the first thing mentioned on your resume. Start with your highest degree, and present your degrees in descending order. This helps the employer to quickly assess your qualifications against the desired profile of a nursing assistant. Mention your license and registration details in this section or create a separate section for the information. Always mention the dates of registration and license.

Experience

3. Highlight your employment history as a nursing assistant along with details relevant to the position. You must include specific job details, such as administering medication, addressing the feeding and bathing needs of the patient, recording details such as temp, blood pressure, dressings and bandaging, and so on. These should be presented as abilities rather than responsibilities, focusing on your accomplishments. You can also include whether you were part of an ambulance or emergency service. Mention only those jobs related to the nursing assistant job description.

Training

4. This part of your resume should include any certification programs, diplomas, or training programs you have attended. If you have attended several programs or courses, include only those which are relevant to the nursing assistant job profile.

5. List relevant references from past CNA jobs.

   If you have any experience in health care, list references from those jobs on your CNA application and resume. Listing references of people who can testify for your professionalism as a CNA can help you get the job.

Format

6. Your resume should be easy to read while highlighting your strengths. Refrain from using bold colors and large font sizes. The font size should be 10 or 12 point, with sub-headings being 16 point and your name in 20 point. Fonts such as Times New Roman, Arial and Book Antiqua are easy to read. The skills relevant to the job can be highlighted in bold text. It is best to avoid using italics, shadowing, format painting, or anything jarring to the reader. Also, make sure that adequate spacing is provided, so the information does not look cluttered. Finally, always proofread your resume before submitting it to a potential employer.

Read more: Example of a CNA resume at eHow.com
http://www.ehow.com/about_6801338_example-cna-resume.html#ixzz1FZORj8T9

Nurse Aide Resume

- Full name
- Present and permanent address
- Telephone numbers
- Email address

Professional or career objective

Your objective is the one that clearly underlines your aims and aspirations in the profession. For example a Nursing Graduate will have to write as objective which is concise and precisely speaks about his role that he wants to play in the Organization.

Sample Objective for Nurse Aide

A challenging position where I can utilize my skills and enhance the quality of life of others

Career Achievements

If you have any major career achievements or any appreciation then this is the section where they should be listed. For example, a nurse aide can add his/her career achievements like this:

- Successfully completed CNA training
- Prepare patients, equipment and supplies for specific procedures and provide manual assistance as required
- Collect, deliver and conduct routine tests on patient specimens
- Escort and transport patients to various hospital locations
- Clean assigned area, stock and replenish supplies and equipment as required
- Participate as a member of the ED Triage Team to manage a sudden influx of patients into the ED. Insuring that ED maintains constant readiness for HAZMAT decontamination
- Provide assistance during HAZMAT decontamination procedures
- Perform other related duties as assigned

Experience

Previous work experience plays an important role while applying for a job and hence it should be well presented in the resume. Most of the questions during your resume will be related to the previous job that you had and hence you should be well prepared for it. You should begin with putting the name of the organization that you worked for, the duration of your work and the post or the designation at which you were working. After this, you can effectively place points in a bulleted format that talk about the responsibilities and the achievements that you may have achieved during your stay at the previous organization. The work experience of an experienced nurse aide applying for a job would look like:

Nurse Aide

New Heaven Hospital, Delhi, 2007-Present

- Change, feed and bathe residents
- Attending to other personal and grooming needs such as combing hair, trimming nails, brushing teeth, passing bed-pans and helping residents to the bathroom (transferring to and from commodes)
- Assist residents in moving within New Heaven House
- Use mechanical lifts during transfers
- Use bathing tubs (carousel/serenade), trolleys
- Serve meals to residents and feed those unable to feed themselves, prepare trays for self-feeders
- Take temperature, pulse, blood pressure, and respiration
- Perform range of motion on residents as ordered
- Turn and position bed patients according to turning schedules
- Remove or releases restraints as scheduled.

Nurse Aide

St. John Hospital, Delhi, 2005-2006

- Keep module cards on specific residents while on duty.
- Assist and encourage residents in obtaining correct goals as stated in Care Plans and module cards
- Clean up spills on the floor in order to prevent accidents; participate in safety drills
- Keep tract of splints and adaptable equipment
- Note any unusual changes in resident's condition and report to nurse
- Verbally communicate nurse care problems/concerns to oncoming shift on assigned unit
- Keep linen and utility area clean and in order, empty and clean urinals and bedpans, empty dirty linen hampers

Nurse Aide

Siddhi Hospitals, Delhi, 2000-2004

- Perform incontinence checks on residents every two hours
- Record data on BM sheet, weight sheet and Nurse Aide flow sheet
- Perform duties such as Labstix as assigned by the nurse
- Attend all mandatory in-services (maintaining 12 hour Federal requirement) and in-services offered on a regular basis
- Attend and participate in unit meetings
- Report all unusual circumstances that may involve the safety and well-being of the residents and co-workers, directly to the nurse on the unit, Clinical Coordinator, Nurse Supervisor, ADON, or DON. Marginal Functions

Mischa Seefried
221 Broughton Road, Hartfield, MO 65624
Tel: (098) 765-4321

Certified Nursing Assistant

CNA currently working with long-term care patients in nursing home. Previous experience as Home Health Aide visiting patients in their homes. Efficient and cheerful worker who relates to patients with compassion and understanding. Discreet and trustworthy, dedicated to helping those in need.

- Daily living assistance
- Toileting, incontinence management
- Bed-making/ linen changing
- Ambulation/ patient exercise
- Post-mortem duties

Recording vital signs
Flow chart records
Patient observation/reporting
Infection control
Emergency evacuation procedures

PROFESSIONAL EXPERIENCE

Morris Assisted Living, Brewster, MO (2007-present)
Certified Nursing Assistant

- Assist bathing, personal hygiene, dressing of patients
- Help with toilet and bathroom needs
- Handle emesis bags, urinals, and bedpans
- Assist/change patients with incontinence
- Take urine/stool/spectrum specimens as directed
- Serve meals and assist those who cannot feed themselves
- Participate in admissions, transfer and discharge procedures
- Help move/lift patients with limited mobility to chair, bed, assist/encourage ambulation
- Make beds, change bed linen to schedule or as needed, tidy rooms
- Monitor and record vital signs, height, weight, blood pressure, temperature, pulse, respiration
- Observe and report relevant physical, psychological, social developments and interactions with fellow patients and staff.
- Help manage, move, re-order supplies
- Follow procedures for disease/ infection control
- Follow emergency procedures and policies
- Foster cheerful, positive outlook and provide compassionate response to patients' emotional needs
- Act as float after six weeks
- Participate in Initial Staffing, Regularly Scheduled Staffing and Special Staffing for residents

Education and Certification

The academic details need to be mentioned in a tabulated format with respect to the degrees or the courses that the candidate would have undertaken in the past. The latest degree or course comes first followed by the last completed course and hence forth going backwards. For example, a nurse aide who has completed post- graduation or graduation course is applying for a job or to a company or an organization then his/her details would be like:

- Certification In Nursing Aide

Govt. College of Nursing, Jaipur

Honors

If you have won any competitions national or international then they could also be highlighted here. For example, a nurse aide could lay stress on any exams that he may have given or any seminars or conferences attended. If you are a part of any honorary society or any nonprofit organization then that could also be added here.

The honors and the activities section of a nurse aide would look like:

- Certified Nurses Aide Certification
- Certification in Behavior Modification
- Basic Skills for Autism Certification
- Diabetes Mastery Certification
- Weight Management Certification

References

The references are generally required so that your present employer can gauge you through the eyes of the people who you were associated with or have worked for. So your teachers or college professors' details could be placed here or your past employer who you would have worked under can also be used as a reference. Ensure that the people whose names you enter know you well and do inform them that you are placing their names as reference because many companies call to confirm. For example the reference section of a nurse aide could also look like:

Mr. Abc Def
Sr. Manager
Soman Systems
abc@idken.com

St. Joseph Home Care Services, Southwell, MO (2005-2007)
Home Health Aide

- Visiting elderly, disabled, convalescent, or mentally disabled patients in their homes
- Cooking, including managing special diet needs
- General housekeeping, cleaning tasks, laundry, bed making/changing
- Light shopping duties on request
- Help with bathing, showering, getting dressed and other personal hygiene
- Moving/ lifting patients with limited mobility to/from bed, bath, chair, wheelchair
- Measuring and recording vital signs
- Supervise prescribed exercise routines
- Administer medications prescribed by physician
- Assist with post-surgical skin care, dressings
- Help manage artificial limbs
- Note and report progress, sudden developments to case manager
- Assist with hospital appointments, visits to doctor
- Be a reliable and efficient aide and warm-hearted companion, reading, conversing, providing mental stimulation

Education and Certification

Nursing Assistant Program (2004)
Brooks Community College, MO
CNA Certification

References:

Jesse Kendall

123 Elm Street Merrimack, NH 03121
295-232-2424, jkendall@hotmail.com

Focus: Passionate about providing exceptional patient care as a Certified Nursing Assistant

Profile: Graduating health-care professional seeking a position in a new-graduate program as a registered nurse. Solid grounding in nursing theories and practices in acute care medical-surgical, pediatrics, outpatient surgery, and ICU. Excellent clinical assessment and decision making skills. Compassionate and efficient professional able to remain clam through emergent/critical situations.

History: Professional excellence in providing comprehensive assistance

Certified Nursing Assistant (CNA) | ABC Hospital, Merrimack, NH, 2000-2001
Tested and charted vital signs and blood sugar levels. Provided assistance in numerous departments. Including Orthopedic Unit, ICU, and the Birthing Center. Supervised confused patients, providing daily care, feedings and sheet changes.

- Quickly identified pain issues when patients were transferred to the x-ray table. Recommended implementation of an inflatable mattress to improve patient comfort.

Certified Nursing Assistant (CNA) | BCD Medical Center, Merrimack, NH, 2001-2003
Applied comprehensive nursing abilities in the medical/surgical and critical care units. Monitored patients' progress and reported changes to nurses

- Received training in 12-lead EKG, commencing and discontinuing Foley catheters, IVs and proper trach and vent suctioning.

Education: **Bachelor of Science in Nursing/ GPA: 4.0**

Graduating in December 2000 with Highest Honors
CDE College- Merrimack, NH

Licensure: **American Heart Association Certifications**

Basic Life Support (BLS) for Healthcare Providers. 2000
Advanced Cardiovascular Life Support (ACLS). 2001
Cardiopulmonary resuscitation (CPR). 2001
Emergency Cardiovascular Care (ECC). 2001

References available upon request.

Questions to Ask Employers

It's important to realize, as noted in the other post, that the interview process goes two ways: You are also interviewing the employer. Here are some sample questions you can ask an employer. You may even want to memorize a set of questions so you are fairly well prepared.

- What are this hospital/nursing facility's strengths and weaknesses compared to its competition?
- How important does upper management consider the function of a CNA?
- What is the hospital's plan for the next five years, and how does this department fit in?
- Could you explain your organizational structure?
- How will my leadership responsibilities and performance be measured? By whom?
- What are the day to day responsibilities of this job?
- What kind of employee does your facility feel are ideal for the position?
- What kind of educational or advancement opportunities does the hospital/facility offer?
- Are there training seminars, workshops, and so on?
- Who will review my performance and how often?
- How much assistance in setting career goals is provided?
- How much opportunity for decision making will I have in the beginning and will this increase as time goes on?
- What is the facility's policy on transfer of employees to other cities?
- What recourse do I have as an employee if I experience on the job harassment or unfairness?
- What is the turnover rate for CNA's at the facility?
- Why do you think I should accept a job offer from your facility?
- How much flexibility is there for changing my schedule?
- How much notice do you need if I need to reschedule work hours or if I need to temporarily be out of town?

- The difference between a job and THE JOB. Very important, job satisfaction

Final Exam Review- Study Guide

Medical Terminology
Vocabulary Words
Resident Rights
Maslow's Hierarchy of Needs
Isolation Precautions/ Rules of Isolation
Body Mechanics/ Lifting Guidelines
Reasons for Ambulation
Concepts of Bed-Making and Removing Soiled Linens
Vital Sign Measurements
Technique for Complete Bed Bath
Calculating Intake and Output
4 Techniques of Medical Asepsis
Concepts of Hand-washing
Type of Illnesses- Acute, Chronic, Terminal
The Nursing Team
Nursing Assistant Role and Responsibilities
Scope of Practice
Positive Qualities that Make a Good Nursing Assistant
Aspects of Effective Communication
Function of the GI system
Restraints and Safety
Logrolling
Patient Positions While in Bed
Unconscious Patient Care
Skin Care and Prevention of Decubitus Ulcers
Elimination Terminology
Assisting Blind Resident
Concepts of NPO
Complications of Immobility
Range of Motion Terminology
Weighing a Patient
Heat/Cold Application
Sputum Collection Techniques
Oxygen Therapy Guidelines
Protective/Reverse Isolation
TED hose

Elderly Calorie Intake
Abuse in Elderly
Cast Care
Characteristics of AD
Diabetes Care
Military Time
Communication Techniques
Fire Safety
OBRA
Ted Hose
Documentation
MDS
CPR/Choking
Geri Chair
Diets/meals
Cath care
Sitz Bath
Hearing aids
24 hour urine
Shampoo
Nail Care
Rehabilitation