

## Lesson #26

### **Title: Common Diseases and Disorders - Reproductive, Immune/Lymphatic Systems**

#### **Lesson Objectives:**

- I. The student will be able to describe common disease processes of the reproductive system which affect the elderly resident.
- II. The student will be able to describe common disease processes of the lymphatic system which affect the elderly resident.

#### **Key Terms:**

**Genitals** – the external male or female sexual organs.

**HIV/AIDS** – life-threatening condition that damages the immune system and interferes with the body's ability to fight disease.

**Immune System** – protects the body from disease.

**Lymphatic System** – removes excess fluids and waste products from the tissues of the body.

**Perineum** – the area between the anus and the scrotum (male) or vulva (female).

#### **Reproductive Systems:**

**Female- ovaries** – produce estrogen, progesterone and ova (eggs)

- **fallopian tubes** – carry eggs from ovaries to the uterus
- **uterus** – muscular sac where the eggs can develop
- **vagina** – muscular canal leading out of the body
- **vulva** – external genitalia of the female, including the labia and clitoris
- **breasts** – holds mammary glands which produce nutrients for infants

**Male- testes** – glands that produce testosterone and sperm

- **scrotum** – sac which contains the testes
- **prostate gland** – gland which produces the fluid for sperm
- **penis** – external organ through which males ejaculate and urinate

**Content:**

- I. Common Conditions of the Reproductive System
  - A. Breast, prostate and ovarian cancer
  - B. Vaginitis
  
- II. Normal Changes with Age
  - A. Hormone production decreases
  - B. Decreased estrogen in females causes menopause
  - C. Decreased testosterone in males slows sexual response
  - D. Prostate gland may become enlarged causing difficulty when urinating
  
- III. Role of the Nurse Aide
  - A. Observe and Report
    - 1. Abnormal bleeding
    - 2. Complaints of pain
  
- IV. Common Conditions of the Immune and Lymphatic Systems
  - A. HIV/AIDS
    - 1. Requires Standard Precautions unless coming in contact with blood or body fluids for which Contact Precautions would be necessary
  - B. Lymphoma (cancer of the immune system)
  - C. Result of cancer treatment/medications
  
- V. Normal Changes with Age
  - A. Increased risk of infection
  - B. Increased drying of tissue – causes irritation
  
- VI. Role of the Nurse Aide
  - A. Observe and Report
    - 1. Fever
    - 2. Diarrhea

3. Increased fatigue/weakness

**Visual Aides:**

- Reproductive System Body Chart
- Immune/Lymphatic System Body Chart

**RCPS:**

- None

**Review Questions**

1. Fever and/or fatigue must be reported to the nurse. True or False
2. Abnormal bleeding from the vaginal area and/or complaint of pain/cramping must be reported to the nurse. True or False

## Lesson #27

### **Title: Admission/Transfer/Discharge**

#### **Lesson Objectives:**

- I. The student will be able to describe the role of the direct caregiver to familiarize the newly admitted resident to new surroundings.
- II. The student will be able to explain the role of the direct caregiver in preparing a resident for transfer to an appointment or to the hospital.
- III. The student will be able to explain the role of the direct caregiver in assisting a resident to discharge to home or to another health care facility.

#### **Key Terms:**

**Admission** – resident arrival to reside at the facility.

**Discharge** – resident departure from the facility; no longer a resident of the facility.

**Personal Inventory Record** – record of personal items brought to the facility and belonging to the resident

**Transfer** – resident relocates to another location or to another area of the facility (e.g., Medicaid to Medicare unit).

**Room Change** – resident moves to another room in the same facility with same status (e.g., Medicaid to Medicaid; Medicare to Medicare).

#### **Content:**

- I. Admitting a New Resident to the Facility
  - A. Role of the Nurse Aide
    1. Prepare the room for the resident's arrival
    2. Introduce self to resident and family/responsible party and explain role
    3. Explain surroundings to resident, including use of call light to summon help, if needed
    4. Create a trusting relationship

5. Be available to family
6. Become a resource and support for the family
7. Refer family members requesting information about a resident to the nurse

## II. Assisting to Transfer a Resident to a Hospital (i.e., Care Transition)

### A. Role of the Nurse Aide

1. Respond to the directives given by the nurse to prepare the resident for transfer, particularly if the transfer is for an emergent condition
2. If resident is leaving for a non-emergent appointment, ensure that the resident has received appropriate care, assistance with grooming, toileting and is appropriately dressed for the weather conditions during transport
3. Assist emergency medical personnel, as requested, to ensure safe transfer of the resident

## III. Assisting a Resident to Discharge Home or to Another Facility

### A. Role of the Nurse Aide

1. Respond to the directives given by the nurse to prepare the resident for discharge
2. Assist to gather personal belongings, as requested, in preparation for transfer/discharge, using the personal inventory as reference to personal items on site

### **Visual Aides:**

- Personal Inventory Record

### **RCPS:**

- None

### **Review Questions**

1. Describe ways to welcome a new resident to his/her new environment.

2. The list used to describe the resident's belongings brought to the facility is called the \_\_\_\_\_.

## Lesson #28

### **Title: End of Life**

#### **Lesson Objectives:**

- I. The student will be able to explain the resident's right to formulate an advance directive which must be honored by staff.
- II. The student will be able to describe interventions to make the dying resident as comfortable as possible.
- III. The student will be able to demonstrate the steps to be taken to provide post mortem care to the deceased resident and prepare belongings for disposition.

#### **Key Terms:**

**Advance Directive** – the resident's spoken and/or written instruction about future medical care and treatment.

**Cheyne-Stokes** – a pattern of breathing with gradual increase in depth and sometimes in rate, followed by a decrease resulting in apnea (no breathing); the cycles ordinarily are 30 seconds to 2 minutes in duration, with 5–30 seconds of apnea (no breathing).

**Cyanotic** – bluish discoloration of the skin, mucous membranes, lips or nails due to lack of sufficient oxygen in the blood.

**DNR** – “Do not resuscitate”; no heroic measures are to be taken should the resident's respirations cease.

**Hospice** – support services provided to a resident with a terminal illness who is anticipated to have six months or less to live.

**Mottling** – the skin, especially on the hands and feet, appear blue and blotchy; caused by slow blood circulation. The underside of the body may become darker. There may be a bluish gray color around the mouth or paleness in the face.

#### **Content:**

- I. Advance Directives

- A. Purpose- by stating health care choices in an advance directive, the resident helps his/her family and physician understand their wishes about the resident's medical care
- B. Advance directives are normally one or more documents that list the resident's health care instructions. An advance directive may name a person of choice to make health care choices when the resident cannot make the choices for themselves. If desired, the resident may use an advance directive to prevent certain people from making health care decisions on their behalf
- C. An advance directive will not take away the resident's right to decide his/her current health care. As long as the resident is able to decide and express their own decisions, the resident's advance directive will not be used. This is true even under the most serious medical conditions. An advance directive will only be used when the resident is unable to communicate or when the physician decides that the resident no longer has the mental competence to make their own choices

## **II. Indiana recognizes the following types of advance directives:**

- Talking directly to your physician and family
- Organ and tissue donation
- Health Care Representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric Advance Directive
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

## **III. Role of Hospice**

- A. Participation- Resident is not expected to live more than six months
- B. Licensed nurse, clergy, social service and primary caregiver services may be provided
- C. Focus is on comfort measures and pain management
- D. Preserves dignity, respect and choice
- E. Plan of care is to be coordinated between facility staff and hospice staff
- F. Offers empathy and support for the resident and the family

#### IV. Care of the Dying Resident

- A. Place resident in most comfortable position for breathing and avoiding pain.  
Maintain body alignment.
- B. Bathe and groom resident as desired by the resident/family to promote self- esteem, yet do not be disruptive
- C. Keep resident's environment as normal as possible, as desired by the resident
- D. Provide skin care, including back rubs/comfort measures frequently
- E. Provide frequent oral care as needed. Keep dry/cracked lips lubricated for comfort
- F. Offer drinking water/fluids frequently
- G. Keep the resident's skin/linens clean
- H. Offer resident's favorite foods
- I. Communicate with the resident, even if he is not responsive, by identifying self and explaining everything you are doing
- J. Be guided by the resident's attitude
- K. Respect each resident's idea of death and spiritual beliefs
- L. Give the resident and the family privacy, but do not isolate them

#### V. Signs/Symptoms of Impending Death

- A. Circulation- slows as heart fails; extremities become cool; pulse becomes rapid and weak
- B. Respiration- irregular, rapid and shallow or slow and heavy; Cheyne Stokes
- C. Muscle tone- jaw may sag; body becomes limp; bodily functions slow and become involuntary
- D. Senses- sensory perception declines; the resident may stare yet not respond; hearing is believed to be the last sense to be lost

#### VI. Post Mortem Care

- A. Respect the family's religious restrictions regarding care of the body, if applicable

- B. Provide privacy and assist a roommate to leave the area until the body is prepared and removed
- C. Place the body in the supine position with one pillow under the head to prevent facial discoloration
- D. Put in dentures. Notify nurse to remove any tubes or dressings
- E. Wash the body, as necessary, and comb hair
- F. Put on a clean gown and cover perineal area with a pad

VII. Disposition of Personal Belongings

- A. Assist the family/responsible party to gather personal belongings and compare to the personal inventory record to ensure the personal belongings of the resident are accounted for and returned to the family/responsible party
- B. Send dentures, eyeglasses and prosthetic devices with the body to the mortuary

**Visual Aides:**

- None

**RCPS:**

- Post Mortem Care

**Review Questions**

1. Blue discoloration of the skin and mucous membranes is called \_\_\_\_\_.
2. Hospice services are intended to provide support to the resident who is anticipated to have six months or less to live. True or False

## **Lesson # 29**

### **Title: Daily Responsibilities**

#### **Lesson Objectives:**

- I. The student will be able to explain the importance of prioritization, organization and time management while providing daily care.
- II. The student will be able to describe the importance of the interdisciplinary team and the ongoing revision of the care plan based upon the resident's changing condition/needs.

#### **Key Terms:**

**Abbreviation** – a shortened form of a word.

**Assignment sheet** – a document which lists the residents assigned to a caregiver and the specifics regarding care to be provided.

**Care plan** – a plan developed for each resident by the interdisciplinary team to achieve certain goals.

**Care team** – people with different education and experience who help care for residents. It is often called the “interdisciplinary team” or “IDT”.

**Chronological order** – the sequence in which events occur.

#### **Content:**

- I. Day to Day Time Management/Resident Care
  - A. Beginning of Shift Report
  - B. Use of assignment sheets/communication of resident needs
  - C. Ancillary duties/assignments (e.g., cleaning, stocking supplies, etc.)
  - D. Documentation/Flow Records
    1. Resident's name on each page
    2. All entries in ink, neat and legible
    3. Entries are accurate and in chronological order as they occurred
    4. Never document before a procedure is completed
    5. Use facility-approved abbreviations
    6. No ditto marks

7. Time and date entries; sign with name and title, unless initials are acceptable per facility policy.
8. Never document for someone else
9. If correcting an error, draw a single line through the error, print word “error” above entry and initial and date the correction
10. Some facilities may use military time. In this case, for the hours between 1:00 p.m.to 11:59 p.m., add 12 to the regular time. For example to change 2:00 p.m. to military time, add 2 + 12. The time would be 1400 hours.
11. Some facilities use computers/electronic medical records. When using, make certain information seen on the screen remains private. Do not share confidential information with anyone except other caregivers on the team.
12. Be sure you are documenting on the correct resident

E. Reporting

1. Routine reporting
2. Immediate reporting of resident change in condition, unusual occurrence, accident, etc.

F. End of Shift Report

1. Report pertinent concerns regarding resident status
2. Communicate any duties unable to be completed on your shift
3. Report any resident condition that will need the attention of the oncoming shift (e.g., resident is on the bedpan, etc.)

II. Interdisciplinary Care Plan Meetings

A. Revisions of the plan of care/communication to direct caregivers

1. The Care Plan Team reviews the plan at least quarterly and with any significant change in condition.
2. The care plan is reviewed and revised to reflect the current condition(s) and needs of the resident.
3. The care plan must be accessible for review by all caregivers
4. When revisions are made to the care plan, the assignment sheet used by direct care staff should also be updated accordingly.

**Visual Aides:**

- Sample Nursing Assistant Assignment Sheet
- Sample Documentation Flow Records (BM Record, Food Consumption, ADL Record, Weight Record, etc.)

**RCPS:**

- None

**Review Questions**

1. Explain the procedure for correcting an error in documentation.
2. Describe information that should be communicated to the oncoming shift during report.

## Lesson # 30

### Title: Protecting Your Profession

#### Lesson Objectives:

- I. The student will be able to describe the common causes of stress/burnout in the healthcare industry.
- II. The student will be able to describe abuse/neglect/misappropriation of resident property and will be able to explain his/her responsibility to respond and report any allegations of abuse/neglect/misappropriation of resident property.
- III. The student will be able to explain the requirements for testing, certification, and renewal to maintain professional status.

#### Key Terms:

**Abuse** – the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse can be verbal (something said-oral, written or gestured), physical (something done to the resident-rough handling, hitting, slapping, pinching, etc.), emotional/mental (humiliation, harassment, threats of punishment or deprivation) or sexual (harassment, coercion or sexual assault). Any sexual relationship with a resident is considered to be abuse.

**Burnout** – a condition of feeling stressed and/or overworked to the point that the care provided to residents is negatively affected.

**Consensual** – agreed to by the people involved; done with the consent of the people involved.

**Involuntary Seclusion** – a separation of a resident from other residents or from their room or confinement against the resident's will, or the will of the legal representative

**Neglect** – failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness

**Misappropriation** – the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent

**Stress** – the state of being frightened, excited, confused, in danger, or irritated, which can result in an emotional and/or physical response.

**Stressor** – something that causes stress (divorce, marriage, new baby, new job, losing a job, etc.).

**Content:**

I. Reducing Stress/Burnout

A. Manage stress

1. Develop healthy habits of diet and exercise
2. Get sufficient rest/sleep
3. Drink alcohol in moderation
4. Do not smoke
5. Find time for relaxing activities such as taking walks, reading books, etc.

B. Signs that you are not managing stress

1. Exhibiting anger toward co-workers and/or residents
2. Arguing with a supervisor or co-workers about assignments
3. Complaining about responsibilities
4. Feeling tired, even when you are well rested
5. Difficulty focusing on residents and job duties

C. Develop a plan to manage stress

1. Identify the sources of stress in your life
2. Identify when you most often feel stress
3. Identify what effects of stress are evident in your life
4. Identify what can be changed to decrease the stress that you are feeling
5. Identify the things in your life that you will have to learn to cope with due to an inability to change them

II. Abuse/Neglect/Misappropriation

A. Responsibility to immediately protect the resident should a staff member witness abuse/neglect

1. You must stay with the resident and call for assistance
2. Ask a caregiver to leave the room if he/she is witnessed to be abusive to the resident

B. Know your facility's policy regarding reporting abuse

1. To whom should the Nurse Aide report? His/her immediate/direct supervisor
2. How should you report?
  - a) Verbally –to your immediate/direct supervisor
  - b) In writing –if requested by your immediate/direct supervisor
  - c) Form used –be familiar with the facility form to report concerns voiced by staff, family or residents
3. When should a Nurse Aide report?
  - a) Immediately!
4. The Nurse Aide Must Report When he/she...
  - a) Actually sees/witnesses an incident that you suspect is abuse or neglect
  - b) Observe signs that “suggest” abuse or neglect may have happened, including a change in the resident’s behavior/demeanor (e.g., a resident becomes quiet, withdrawn, or flinches as if fearful when touched), or suspicious injuries such as teeth marks, belt buckle or strap marks, old and new bruises, dislocation, burns of unusual shape and in unusual locations, scratches, etc. If the aide hears of an alleged incident from a resident or co-worker then it should be reported
5. The nurse aide doesn’t make a determination that abuse or neglect “has” or “has not” occurred and then decide whether to report. If the resident makes an allegation (even if it doesn’t seem that it can’t be true) it must be reported to the direct supervisor immediately. If the nurse aide hears of an alleged incident from a resident or co-worker, it must be reported to the direct supervisor immediately
6. NA Investigation
  - a) Conducted by ISDH when abuse has been reported
  - b) May result in revocation of certification

### III. Nurse Aide Testing/Certification

#### A. To Maintain Certification

1. The CNA must be offered at least 12 hours of in-service education per year
2. The CNA must work for a health care provider at least one eight hour shift every twenty-four months
3. The CNA must never have a verified complaint against them on the registry. If a complaint of abuse or misappropriation of resident's property or funds is found to be valid, the CNA will lose certification in all 50 states permanently
4. The CNA must be evaluated yearly for performance and offered in-service education on any weaknesses identified
5. The nurse aide must remain professional
  - a) Be responsible, calling the facility if unable to work the scheduled shift
  - b) Be on time for your scheduled shift
  - c) Arrive to work clean and neatly dressed and groomed
  - d) Maintain a positive attitude
  - e) Follow facility policies and procedures
  - f) Document and report carefully and correctly
  - g) Always ask questions, if uncertain
  - h) Report anything that keeps you from completing your duties/assignment
  - i) Offer suggestions for improving the living and working environment

### IV. Certification Renewal

- A. The CNA must renew certification with the ISDH CNA Registry on-line at the time of expiration
- B. Proof of continued good standing on the registry must be provided to the employer

V. Course Review

- A. Brief overview of each lesson
- B. Review of RCPS

**Visual Aides:**

- Introduce the student to the on-line means to renew certification

**RCPS:**

- None

**Review Questions**

1. Name common signs of stress and burnout in the healthcare industry
2. What is the minimum requirement of hours worked for a healthcare provider within a 24 month period to maintain CNA certification?