Module 13: Long Term Care Resident
Minimum Number of Theory Hours: 2
Recommended Theory Hours: 13

Statement of Purpose:
The purpose of this unit is to introduce the student to the basic structure of the body and to review the effect of aging on body structure and function. Common physical and psychological conditions found in elderly patients are presented along with approaches to care. Community resources commonly available to assist elderly patients with their psychological, recreational, and social needs are presented.

Terminology:

Long Term Care Resident

1. Acute
2. Assisted living
3. Chronic
4. Debilitating
5. Dementia
6. Long-term care
7. Reality orientation
8. Reminiscing
9. Residents
10. Skilled nursing facility
11. Subacute care
12. Validation therapy

Medical and Anatomical Terms

13. Anatomic position
14. Anatomy
15. Anterior
16. Cells
17. Connective tissue
18. Contractures

Medical and Anatomical Terms (continued)

19. Disease
20. Distal
21. Epithelial tissue
22. Health
23. Inferior
24. Joints
25. Lateral
26. Membranes
27. Muscle tissue
28. Nerve tissue
29. Organ
30. Peritoneum
31. Physiology
32. Posterior
33. Prefix
34. Proximal
35. Suffix
36. Superior
37. System
38. Traction

Nervous System

39. Age-related Macular Degeneration (AMD)
40. Agitated
41. Alzheimer's disease
42. Aphasia
43. Autonomic dysreflexia
44. Bipolar disorder
45. Brain
46. Cataract
47. Catastrophic reaction
48. Cerebral palsy
49. Cerebral Vascular Accident (CVA)
50. Concussion
51. Confusion
52. Delirium
53. Delusion
54. Dementia
55. Developmentally disabled
56. Disruptive behavior
57. Elopement
58. Epilepsy
59. Generalized anxiety
60. Glaucoma
61. Hallucination
62. Hemianopsia
63. Hemiplegia
64. Multiple sclerosis
65. Nerve
66. Neuron
67. Otosclerosis
68. Panic disorder

Nervous System Continued

69. Paralysis
70. Paranoia
71. Paranoid schizophrenia
72. Paraplegia
73. Parkinson's disease
74. Peripheral nervous system
75. Post traumatic stress syndrome
76. Quadriplegia
77. Reality orientation
78. Seizure
79. Stroke
80. Sundowner syndrome
81. Transient Ischemic Attack(TIA)
82. Tremor
83. Vertigo

Immune System

84. Antibody
85. Antigen
86. Auto Immunodeficiency Syndrome (AIDS)
87. Carrier
88. Human Immunodeficiency Virus (HIV)
89. Immunity
90. Lymph node
91. T-cell
92. White blood cell

Cardiovascular System

93. Anemia
94. Angina
95. Anti-embolic stockings

Cardiovascular System Continued

96. Artery
97. Atherosclerosis
98. Blood
99. Capillary
100. Congestive Heart Failure (CHF)
101. Coronary artery disease
102. Dyspnea
103. Edema
104. Embolism
105. Heart
106. Hypertension
107. Hypoxia
108. Ischemia
109. Myocardial infarction
110. Orthopnea
111. Pacemaker
112. Peripheral vascular disease (PVD)
113. Phlebitis
114. Pulmonary edema
115. Sequential compression device (SCD)
116. Systole
117. Thrombus
118. Varicose vein
119. Vein
120. Vessel

Integumentary System

121. Abrasion
122. Allergies
123. Bony prominences
124. Cyanotic

Integumentary System Continued

125. Debride
126. Decubitus ulcer
127. Dermis
128. Epidermis
129. Excoriation
130. Friction
131. Gangrene
132. Hematoma
133. Lesion
134. Necrosis
135. Pallor
136. Pediculosis
137. Pressure ulcer
138. Pruritus
139. Psoriasis
140. Scabies
141. Shearing
142. Skin
143. Skin tears

Gastrointestinal System

144. Absorption
145. Bile
146. Bowel movement
147. Colon
148. Colostomy
149. Constipation
150. Defecation
151. Diarrhea
152. Digestion
153. Diverticulitis

154. Elimination

Gastrointestinal System Continued

155. Enema
156. Fecal impaction
157. Feces
158. Flatus
159. Gastrectomy
160. Gastric tube
161. Hernia
162. Ileostomy
163. Nasogastric tube (NG)
164. Obstruction
165. Occult blood
166. Ostomy
167. Percutaneous Endoscopic Gastrostomy (PEG)
168. Peristalsis
169. Stoma
170. Stool
171. Suppository
172. Ulcer
173. Urgency
174. Urostomy

Respiratory System

175. Alveoli
176. Asthma
177. Bronchi
178. Carbon dioxide
179. Chronic Heart Failure (CHF)
180. Chronic Obstructive Pulmonary Disease (COPD)
181. Dyspnea
182. Emphysema

Respiratory System Continued

183. Expiration
184. Inspiration
185. Larynx
186. Lungs
187. Mucous
188. Nasal cannula
189. Nebulizer
190. Orthopnea
191. Oxygen mask
192. Pharynx
193. Pneumonia
194. Sputum
195. Tracheostomy
196. Tuberculosis (TB)
197. Upper respiratory infection (URI)

Musculoskeletal System

198. Abduction
199. Adduction
200. Amputation
201. Arthritis
202. Atrophy
203. Bursitis
204. Contracture
205. Extension
206. Flexion
207. Fracture
208. Full weight-bearing (FWB)
209. Gout
210. Muscle
211. Muscular dystrophy

Musculoskeletal System Continued

212. Osteoarthritis
213. Osteoporosis
214. Phantom pain
215. Pronation
216. Prosthesis
217. Range of Motion (ROM)
218. Rheumatoid arthritis
219. Rotation
220. Skeleton
221. Supination
222. Total hip arthroplasty
223. Trapeze
224. Vertebrae

Urinary System

225. Catheter
226. Calculi
227. Chronic renal failure
228. Clean catch
229. Condom catheter
230. Cystitis
231. Dialysis
232. Diuresis
233. Dysuria
234. End-Stage Renal Disease (ESRD)
235. Hematuria
236. Indwelling catheter
237. Kidney
238. Micturition
239. Nephritis
240. Renal calculi

Urinary System Continued

241. Retention
242. Specimens
243. Ureter
244. Urethra
245. Urinalysis
246. Urinary bladder
247. Urinary drainage bag
248. Urinary incontinence
249. Urinary Tract Infection (UTI)
250. Void

Reproductive System

251. Benign prostatic hypertrophy
252. Chlamydia
253. Cystocele
254. Douche
255. Genitalia
256. Genital herpes
257. Human Papilloma Virus (HPV)
258. Gonorrhea
259. Hemorrhoid
260. Herpes simplex 2
261. Hormones
262. Hysterectomy
263. Mammogram
264. Mastectomy
265. Pelvis inflammatory disease (PID)
266. Penis
267. Prostate gland
268. Rectocele
269. Sexually transmitted disease (STD)

Reproductive System Continued

270. Syphilis
271. Testes
272. Trichomoniasis
273. Uterus
274. Vagina
275. Venereal
276. Vulvovaginitis

Endocrine System

277. Diabetes mellitus
278. Fasting Blood Sugar (FBS)
279. Glucose
280. Glycosuria
281. Goiter
282. Hormones
283. Hyperglycemia
284. Hypoglycemia
285. Insulin
286. Insulin-Dependent Diabetes Mellitus (IDDM)
287. Metabolism
288. Non-Insulin-Dependent Diabetes Mellitus (NIDDM)
289. Pituitary gland
290. Thyroxine

Performance Standards (Objectives):

Upon completion of two (2) hours of class plus homework assignments, the learner will be able to:

1. Define key terminology.
2. Describe common basic human needs and interventions for the elderly resident; environmental, psychological, social, recreational and spiritual.
3. Describe common community resources to meet the needs of the elderly.
4. Describe developmental and mental conditions found in the long-term care population, their unique needs, and interventions.
5. Describe the body's basic organization and composition.
6. List the body systems, including basic anatomy and physiology, common diseases of the elderly with signs and symptoms, Nurse Assistant duties and observations, aging changes and complications of immobility.
7. Describe changes in body systems associated with aging.

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section. B. Spell the listed terms accurately. C. Pronounce the terms correctly. D. Use the terms in their proper context.	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration. C. Encourage use of internet, medical dictionary, and textbooks. D. Create flashcards for learning purposes. E. Handout 13.1a- Long Term Care Resident Crossword. F. Handout 13.1b- Long Term Care Resident Crossword- KEY.	A. Have students select five words from the list of key terminology and write a sentence for each defining the term. B. Administer vocabulary pre-test and post-test. C. Uses appropriate terminology when charting and reporting to licensed personnel.
Objective 2 **Describe common basic human needs and interventions for the elderly resident; environmental, psychological, social, recreational and spiritual.** A. Environmental/physical 1. Safety a. More light for better vision. b. Freedom from hazards. c. Support (adaptive devices). d. Good personal hygiene. 2. Shelter a. Appropriate living situation.	A. Lecture B. Discussion C. Handout 13.2a- Elements of Friendship. D. Handout 13.2b- Empathy. E. Handout 13.2c- The Best Friends Philosophy of Communication.	A. Written test. B. Assists residents in meeting environmental, psychological, social, recreational and spiritual needs. C. Reports unusual signs to licensed nurse.

b. Environmental control (heating, air conditioning). 3. Nourishment a. Balanced nutrition. b. Adequate fluids. B. Psychological 1. Maintain self-esteem a. Respectful treatment. b. Recognition of individual differences. 2. Adjustment to role change and loss of independence a. Respect privacy. b. Give choices. c. Encourage activities. C. Social 1. Social interactions a. Encourage family involvement. b. Encourage social/community activities. 2. Adjustment to losses a. Death of spouse/friends. b. Encourage verbalization, such as reminiscing. c. Encourage new social contacts. 3. Financial a. Changes in income interfere with meeting basic needs of security, love, belonging and self-esteem. b. Refer to social service. D. Recreational 1. Diversion a. Encourage hobbies. b. Involve in facility/community events. c. Encourage family involvement. 2. Self-esteem a. Encourage involvement. b. Give compliments.		

c. Reinforce positive traits or abilities. E. Spiritual 1. Provide respect for individual choices. 2. Provide opportunities to participate in religious activities.		
Objective 3 **Describe common community resources to meet the needs of the elderly.** A. Area Agency on Aging-AAA, (Request Community Resource Manual). B. Adult Day Care Center. C. Support groups 1. American Diabetes Association. 2. Braille Institute or Blind Center. 3. Alzheimer's Society. 4. Parkinson's Support. 5. Multiple Sclerosis Support. 6. Muscular Dystrophy. 7. Hospice/Bereavement. D. County Health Center. E. Community Hospitals and their hospice. F. Internal Revenue Service (IRS) information. G. Long Term Care Ombudsman. H. Meals on Wheels. I. Medicare Office (see Social Security Office). J. Mental Health Department. K. National Alliance for the Mentally Ill (NAMI). L. American Disability Act. M. Adult Protective Services (APS). N. Red Cross/Blood Pressure Clinic. O. Senior Center. P. Senior Housing. Q. Social Security Office.	A. Lecture B. Discussion C. Ask group to share any information they have used on community resources.	A. Written tests B. Assists licensed nurse in providing information to residents regarding community resources.

R. Suicide prevention. S. Home health agencies. T. Voter registration. U. American Association of Retired Persons (AARP). V. Fraternal and social organizations. W. Regional centers. X. Churches/religious organizations.		
Objective 4 **Describe developmental and mental conditions found in the long term care population, their unique needs, and interventions.** A. Organic brain syndrome – dementia (Also included in "The Nervous System") 1. Dementia; any disorder of the brain that causes deficits in thinking, memory and judgment. 2. Causes a. Alzheimer's disease (most common); caused by plaques and tangles in the brain. Brain decreases in size as cells are lost. Progressive and incurable. b. Multi-infarction dementia (multiple Transient Ischemic Attack; TIAs). c. Parkinson's disease. d. Syphilis. e. AIDS. f. Nutrition problems. g. Medication problems. h. Depression. i. Metabolic disorders. B. Schizophrenia 1. Mental disorder characterized by paranoia, hallucinations, delusions, bizarre behavior and distortions of reality. 2. Nurse Assistant duties and responsibilities. a. Notify licensed nurse if behavior worsens or becomes	A. Lecture B. Discussion C. Handout 13.4- An Alzheimer's Disease Bill of Rights. D. Manual Skills 13.4- Reality Orientation to Promote or Maintain Awareness of Person Place and Time.	A. Written tests B. Reports unusual signs and symptoms to licensed nurse.

dangerous. b. Do not “feed in” to delusions, but do not try to convince them of reality. c. Be aware of suicide precautions. d. Keep resident involved in reality activities. e. Report and document observed responses to medication and psychotherapy. f. Monitor nutrition and fluid balance - these residents often refuse to eat or drink out of a fear of poisoning. g. Find ways of reducing resident’s fear and anxiety. C. Hypochondriasis 1. Resident imagines or magnifies each physical ailment. 2. Nurse Assistant duties and responsibilities a. Be supportive, some authorities feel this disorder stems from depression. b. Do not overlook real illness; report all complaints. c. Do not judge. D. Depression 1. Most common functional disorder in older people 2. Signs and Symptoms a. Feeling of sadness. b. Lack of interest in and withdrawal from environment. c. Feelings of worthlessness. d. Negative outlook on the future. 3. Nurse Assistant duties and responsibilities a. Notify licensed nurse if resident displays loss of appetite, weight loss, severe fatigue, crying, or sleeplessness. b. Notify licensed nurse if resident makes statements such as “I wish I could just die.” c. Remain non-judgmental. d. Listen with empathy. e. Encourage activities with others.		

f. Encourage aerobic activity, as well as outdoor activities (releases endorphins). E. Suicidal resident 1. The elderly are at risk of suicidal behavior, especially white males over the age of 65 who live alone, and the very old (75 years and above). 2. Nurse Assistant duties and responsibilities a. Report clues of suicide attempts to licensed nurse. b. Give constant care. c. Monitor activities. d. Work to preserve self-esteem. e. Help resident find support network; friends, clergy, family and support groups. f. Never ignore the person's statements or threats about suicide. F. Developmentally Disabled 1. Significant sub-average intellectual function and low adaptive ability. 2. Nurse Assistant duties and responsibilities a. Provide an environment as normal as possible (normalization). b. Emphasize individual strengths. c. Encourage independence, self-care. d. Treat with dignity at age appropriate level. e. Respect privacy. f. Provide safe, structured environment. G. Cerebral Palsy 1. Group of disorders characterized by motor dysfunctions. 2. Nurse assistant duties and responsibilities a. Provide safe, structured environment. b. Apply appropriate assistive devices. c. Emphasize individual strengths.		

d. Encourage independence. e. Treat with dignity. f. Respect privacy. H. Alcoholism/Drug Abuse 1. Abuse of alcohol or drugs when healthy coping mechanisms have failed. 2. 15% of elderly suffer from alcoholism. 3. Often triggered by a. Retirement. b. Loss of self-esteem. c. Loneliness. d. Chronic pain. e. Decline in health. f. Stress. 4. Nurse Assistant duties and responsibilities a. Report to the licensed nurse any sign that the resident is under the influence of alcohol or drugs. b. Be sure alcohol/drugs are not available (alcohol can be in products such as aftershave, perfume, cooking extracts, cleaning products). c. Watch for mental impairment; loss of coordination, poor judgment. d. Be careful when feeding, gag reflex may be impaired. e. Set boundaries, avoid being manipulated. f. Be aware of support groups such as Alcoholics Anonymous or the Mental Health Association. g. Notify licensed nurse if signs of withdrawal 1) Alcohol: tremors, shaking, agitation, seizures. 2) Drugs: runny nose, depression, headache, pacing, poor coping mechanisms, agitation. h. Follow resident's care plan. i. Be aware of dangerous behavior.		

I. The Agitated Resident 1. Uses inappropriate verbal, vocal, or motor activity due to causes other than disorientation or real need. 2. Nurse Assistant duties and responsibilities a. Report to the licensed nurse any signs of agitation including aimless wandering, pacing, cursing, screaming, spitting, biting, fighting, arguing, demanding, and talking to self. b. Maintain quiet, calm atmosphere. c. Encourage distracting activities. d. Check for constipation or other sources of discomfort/pain. e. Realize that resident may become more agitated due to feelings of loss of control. f. Avoid restraints. g. Allow resident to walk, or rock in chair to diffuse energy. h. Listen with empathy. i. Make sure you stay safe - maintain area to escape (don't let resident get between you and the door.) j. Call for help if resident gets violent. k. Do not attempt to control resident if they become violent. l. Redirect.		
Objective 5 **Describe the body's basic organization and composition.** A. Anatomy-Structure; Physiology-Function B. The Cell 1. The basic unit of body structure; building blocks of the body. 2. Function, size, and shape of cells may differ. 3. Cells need food, water, and oxygen to survive. C. Tissues 1. Groups of cells with similar functions. Four basic types of tissues in body.	A. Lecture B. Discussion	A. Written test

2. Epithelial tissue – protective. 3. Connective tissue – support and connect. 4. Muscle tissue – shorten and lengthen. 5. Nerve tissue – carry electrical impulses. D. Organs 1. Made up of different types of tissues. 2. Perform special functions. E. Systems 1. Groups of organs that work together to perform specific functions. 2. Ten major body systems a. Integumentary System. b. Respiratory System. c. Cardiovascular System. d. Musculoskeletal System. e. Endocrine System. f. Nervous System. g. Gastrointestinal System. h. Urinary System. i. Reproductive System. j. Immune System. F. Health; state of mental, physical and social well-being. G. Disease; any change from the healthy state.		
Objective 6 **List the body systems, including basic anatomy and physiology, common diseases of the elderly, signs and symptoms, and Nurse Assistant duties and observations.** A. Integumentary system (skin) 1. Anatomy a. Epidermis is the top surface layer. 1) It is primarily dry, dead cells that shed continuously. 2) Thin layer with no blood supply.	A. Lecture/Discussion B. Use visuals and videos to describe conditions. C. Ask student to share experiences regarding common diseases of the	A. Written test B. Reports unusual signs and symptoms to licensed nurse.

3) Functions as a barrier to water loss and prevention infection. b. Dermis is the second layer 1) Varies in thickness in different areas of the body. 2) Naturally very moist. 3) Gives skin its strength. 4) Contains the blood vessels, lymph vessels, nerve endings, oil glands, and hair follicles. 5) Function of dermis is to aid in body temperature control and is the origin of our sense of touch, pressure, and pain. c. Subcutaneous tissues are deeper tissues beneath the dermis. 1) Tissues are fat and connective tissue. 2) These tissues do not tolerate lack of oxygen and cell death results easily. 2. Functions a. Provides protective barrier against microorganisms and infection. b. Provides sensation through nerve endings. c. Shields body tissue from injury. d. Regulates body temperature. e. Eliminates waste products. f. Produces Vitamin D for body use. g. Prevents loss of too much water. h. It is the largest “organ” of the body. 3. Diseases and Disorders a. Skin Lesions/Wounds - change in skin structure caused by injury, trauma, aging, or disease. 1) Signs and Symptoms a) Rash. b) Raised spots filled with pus or fluid.	elderly.	

c) Irregular reddened areas that itch (Pruritus). d) Dry crusts; scabs. e) Break in skin integrity. 2) Nurse Assistant duties and observations a) Observation and reporting of any skin abnormalities. b) Observe drainage on dressing. c) Soap and water are contraindicated. d) Tepid water when bathing. e) Gloves. f) Do not remove crusts. g) Notify licensed nurse if: • Skin lesions drain. • Nature of drainage changes, increases. • Drainage has odor. • Drainage changes color. • Dressing needs changing. • Wound has signs of redness, red streaks, heat, pus, drainage. b. Pressure Sores (Decubiti) - break in skin integrity that develops over bony prominence as result of pressure. 1) Signs and Symptoms a) Stage One • Redness over bony prominence (dark skinned people may appear blue or black) that does not go away after 30 minutes. • Will reverse if precautions are taken. b) Stage Two • Reddened skin with abrasions, blisters or shallow crater. • Epidermis and/or dermis may both be		

involved. c) Stage Three • All layers of skin destroyed. • Deep crater forms. d) Stage Four • Ulcer extends through skin and subcutaneous tissue. • Bone, muscle, and underlying structures may be involved. 2) Nurse Assistant duties and observations a) Change position at least every two hours. b) When sitting, teach resident to shift every ten (10) minutes. c) Proper nutrition and hydration. d) Immediate removal of feces or urine. e) Inspect skin area whenever personal care is given, especially over bony prominences. f) Remove wrinkles and foreign objects from bed linens. g) Avoid hot water and friction. h) Lubricate skin with lotions. i) Separate body areas to avoid rubbing. j) Mechanical aids • Sheepskin. • Alternating-pressure mattress. • Pillows for bridging. • Gel and air cushions. • Heel protectors. k) Use turning sheet to move dependent residents in bed. l) Elevate HOB no more than 30 degrees.		

m) Check improperly fitted braces and restraints. n) Check tubing for rubbing. o) Know signs and symptoms of pressure sore, and report immediately to licensed nurse. p) PREVENT: much easier to prevent than treat. c. Pediculosis, Lice and Scabies: tiny parasites that are difficult or impossible to see. 1) Signs and Symptoms a) Intense itching • Pediculosis: in areas of hair growth. • Scabies: follows blood vessels, commonly seen in webs of fingers, inside wrists and elbows, underarms and waist and nipple areas. • Rash. 2) Nurse Assistant duties and observations a) Avoid direct contact; gloves. b) Report any signs or symptoms of disorder. c) Thorough washing of linen. d) Medicated shampoos/lotions may be used. d. Other related subjects (optional); Kaposi's Sarcoma, Monkey Pox, burns, impetigo. B. Respiratory System 1. Anatomy & Physiology a. Nose and mouth. b. Trachea. c. Bronchi. d. Lungs. e. Alveoli. 2. Functions a. Lifeline of the body.		

b. Bring oxygen into the body and eliminate carbon dioxide from the body. 3. Diseases and Disorders a. Upper respiratory infection (URI): infection in nose, sinuses, and throat. 1) Signs and Symptoms a) Fever b) Runny nose and eyes c) Cough d) Sore throat 2) Nurse Assistant duties and observations a) Encourage rest. b) Encourage fluids. c) Dispose of tissues promptly to avoid spread. d) Report to licensed nurse: • Fever • Dyspnea • Change in rate or rhythm of respiration • Change in mucus color from clear to green, yellow or blood-tinged • Pallor, cyanosis • Signs that infection is moving to chest or lungs b. Pneumonia: infection/inflammation of the lungs often seen in residents with compromised immune system. 1) Signs and symptoms a) Same as URI, only more severe. b) Chest pressure and discomfort. c) Extreme fatigue/weakness. d) Cough. 2) Nurse Assistant duties and observations		

a) As above for URI.
b) Monitor vital signs carefully, especially temperature & respiration.
c) Elevate head of bed/orthopneic position, as needed.

c. COPD (Chronic Obstructive Pulmonary Disease) - a condition that results in chronic obstruction of the respiratory system that is not reversible.
1) Signs and symptoms
a) Asthma: breathing disorder caused by reaction to allergen
- Wheezing.
- Tightened airways.
- Mucus blocks passageways.
- Labored breathing.
- Frequent coughing.

b) Chronic Bronchitis: prolonged inflammation in the bronchi due to infection or irritants
- Persistent cough.
- Sputum production (especially in the morning).
- Respiratory distress.

c) Emphysema: occurs when air flow is obstructed at the level of the alveoli
- Can bring O2 into lungs, but can't expel CO2.
- Triggered by pollutants, smoke and cold.
- Frequent lung infections.
- Extreme dyspnea.
- Loss of appetite/weight loss.
- Irritability.
- Air hunger.

2) Nurse Assistant duties and observations a) Teach pursed-lipped breathing (to increase expiration of CO2). b) Calm resident when anxious (to decrease O2 need). c) Raise head of bed/orthopneic position. d) Oxygen therapy (O2 precautions)-.Do not change Low O2 settings). e) Nutrient dense foods; frequent snacks, not meals. f) Encourage fluids. g) Pace activities. h) Avoid raising arms over head. d. Tuberculosis 1) Definition a) A highly contagious lung disease caused by a bacterium that is carried on mucous droplets suspended in the air. b) Two types of TB • Latent TB - Someone with latent TB shows no symptoms. • Active TB – Shows symptoms. Occurs when tuberculosis enters the body and the inactive tubercle breaks down; bacteria multiply and spread to other parts of the body. 2) Signs and symptoms a) Fatigue. b) Night sweats. c) Coughing up blood (hemoptysis). d) Prolonged coughing. e) Slight fever. f) Chills. g) Shortness of breath and/or dyspnea.		

h) Loss of appetite and weight. 3) Nurse Assistant duties and observations a) Annual PPD (Mantoux test). b) Chest x-ray every two years if positive skin test. c) Use of barriers if productive cough. d) Discard tissues, sputum promptly. 4. Other related subjects (optional): tracheostomy, esophageal speech and electronic speech, SARS, malignancies. C. Cardiovascular System 1. Anatomy and Physiology a. Heart; pumps blood which carries oxygen and nutrients to cells b. Blood 1) Transports oxygen, food and hormones to cells. 2) Removes carbon dioxide and other waste products from cells. 3) Controls pH level and body temperature. 4) Clots the blood and fights pathogens and poisons. c. Blood vessels 1) Arteries carry blood away from the heart. 2) Veins carry blood towards the heart. 3) Capillaries; smallest vessels that connect arteries and veins. 2. Functions a. Transportation system that delivers nutrition and oxygen to the cells and takes away waste products. b. Closed system is kept in motion by the force of the heart. 3. Common disease and disorders a. Coronary Artery Disease (CAD) occurs when the coronary arteries narrow, causing reduced blood supply to the heart depriving the heart muscle with oxygen and nutrients.		

1) Signs and Symptoms a) Chest pain. b) Pain in back, neck, jaw, arm, shoulder or back. c) Dyspnea. d) Cyanosis of lips, mucous membranes, and nail beds. e) Dizziness. 2) Nurse Assistant duties and observations a) Remain with resident. b) Notify licensed nurse immediately if above signs & symptoms are noted. c) Monitor vital signs. b. Myocardial Infarction (MI, heart attack) 1) Definition a) Clot in coronary artery causes a blockage of blood supply to the heart. b) Damaged area can no longer function and turns to scar tissue. 2) Signs and Symptoms a) Sudden, severe pain in chest usually described as crushing. b) Radiating pain to arm, jaw, neck or back. c) May present as indigestion or heartburn. d) Diaphoresis, cool, clammy skin. e) Dizziness. f) Pallor/cyanosis. g) Dyspnea (short of breath). h) Weak, irregular pulse. i) Low blood pressure. j) Loss of consciousness. k) Nausea/vomiting. l) Restless, anxious, feeling of impending doom.		

m) Denial. 3) Nurse Assistant duties and observations a) Notify licensed nurse immediately if above signs and symptoms are noted. b) Remain with resident; place resident in comfortable position; loosen clothing. c) Encourage resident to rest. d) Reassure resident that help is coming. e) Monitor vital signs. f) Do not give the resident liquids or food. g) Prepare to transfer to acute care facility. c. Congestive Heart Failure 1) Definition a) Occurs when the heart does not pump well enough to meet the body's needs. b) Normal cardiac output cannot meet the needs for activities of daily living. c) Can be left sided or right sided or both. 2) Signs and Symptoms a) Hemoptysis (spitting up blood). b) Cough. c) Dyspnea. d) Orthopnea (difficulty breathing while lying down). e) Fatigue. f) Decrease in ability to exercise and be active. g) Confusion. h) Increased pulse. i) Possible irregular heartbeat. j) Increased frequency of urination at night. k) Cyanosis. l) Edema in extremities. m) Moist respirations.		

n) High blood pressure. 3) Nurse Assistant duties and observations a) Low sodium diet. b) Raise head of bed. c) Fluid restriction (if ordered). d) Anti-embolic stockings. e) Assist with ADLs. f) Range of motion to improve muscle tone. g) Assist with O_2 therapy. h) Measure intake and output. i) Measure daily weight. j) Bedside commode as indicated. k) Check vital signs: monitor apical pulse for one full minute; report if it drops below 60. l) Pace activities. d. Peripheral Vascular Disease (PVD) 1) Definition a) Condition in which the blood supply to the legs, feet, arms, or hands is decreased due to poor circulation. b) Can be arterial or venous. 2) Signs and symptoms a) Painful cramping in the hips, thighs or calves when walking. b) Painful cramping in the legs that does not go away. c) Cyanotic hands or feet (blue or gray tinged). d) Arms and/or legs feel cool or cold to the touch. e) Edema in the hands and feet. f) Ulcers on the legs or feet (that are slow to heal or don't heal). g) Gangrene. 3) Nurse Assistant duties and observations a) Encourage resident to follow special diet/fluid		

restriction. b) Record accurately intake and output. c) Monitor for increased edema. d) Monitor vital signs report any changes (especially pulse and blood pressure). e) Report to nurse any complaints of pain or discomfort in the hands, legs or feet. f) Report any type of chest, back, jaw, or shoulder pain or discomfort. g) Apply anti-embolic stockings (if ordered). e. Anemia; a condition that results from a decrease in the quantity of quality of red blood cells. 1) Signs and symptoms a) Lethargy. b) Pale or jaundiced. c) Dyspnea. d) Digestive problems. e) Rapid pulse and increased respiratory rate. f) Cold. g) Dizzy. 2) Nurse Assistant duties and observations a) Provide nutritional meals; increase iron containing foods like red meat and green leafy vegetables. b) Notify licensed nurse if signs of bleeding or black stool. c) Monitor vital signs. d) Observe for and notify if above signs and symptoms appear or worsen. f. Hypertension, high blood pressure 1) Signs and symptoms a) Blood pressure elevated above 140 systolic and/or 90 diastolic. b) Nosebleed.		

c) Eye hemorrhage. d) Dizziness. e) Trembling. f) Red complexion. g) Headache. h) Blurred vision. 2) Nurse Assistant duties and observations a) Monitor blood pressure. b) Assist with stress management techniques. c) Low sodium diet. d) Assist with weight loss efforts. e) Encourage regular exercise. f) Notify licensed nurse if above symptoms are noted. g. Other related subjects (optional): pacemakers, angina, varicose veins, atherosclerosis, internal defibrillation, anemia, blood types. D. Musculoskeletal System 1. Anatomy & Physiology a. Bones – hard rigid structures made of connective tissue cells. b. Joints – point at which two or more bones meet; allow body movement. c. Muscle – allows movement of body parts, maintains posture, and produces body heat. 2. Functions a. Gives shape and form, maintains posture, permits movement, protects internal organs, stores calcium and phosphorus, produces heat and produces some blood cells b. Forms framework that supports the body and allows for movement.		

3. Common diseases and disorders a. Arthritis; inflammation of the joints 1) Rheumatoid; joint tissue lining is affected 2) Osteoarthritis; cartilage covering ends of bones deteriorates and ends of bones rub together, causing pain and deformity. 3) Gout; metabolic disease caused by deposits of crystals at joint due to increase in uric acid. 4) Signs and Symptoms a) Pain at joint. b) Deformity at joint. c) Swelling. d) Tenderness. e) Heat at inflamed site. f) Fatigue. 5) Nurse Assistant duties and observations a) Notify licensed nurse if resident requests medication for discomfort. b) Balance rest and exercise. c) ROM when no pain/inflammation, rest joint if pain/inflammation. d) Prevent contractures. b. Fractures; break in the continuity of the bone 1) Signs and symptoms (vary with type of fracture) a) Pain, swelling, bruising at fracture site. b) Exposed broken bone through skin (compound fracture). c) Immobility of area affected. d) Deformity. 2) Nurse Assistant duties and observations a) Keep area immobilized (cast, splint). b) Report pain.		

c) Reduce edema (elevate area affected). d) Maintain alignment. e) Cast care (no breaks, chips, check distal pulses, check color, movement, and sensation distal to cast. f) Report signs of infection. c. Osteoporosis; caused by lost bone mass and results in porous, spongy bones that are easily fractured. Most common in elderly females. 1) Signs and symptoms a) Fracture from very little or no trauma (often in hip or low back). b) Curvature of spine. c) Loss of height. d) Progressive weakness. 2) Nurse Assistant duties and observations a) Prevent further fractures. b) Report pain. c) Gentle ROM. d) Apply splints or braces as ordered. e) Encourage high calcium meals (milk, dairy products, and green leafy vegetables). f) Mechanical lift for transfers. g) Gentle handling and positioning. d. Fractured hip; fracture of the femur, most frequent cause is falling and osteoporosis. 1) Signs and symptoms a) Cannot get up after a fall. b) Affected side is shortened and externally rotated. c) Severe pain in hip or knee. d) Edema in hip, thigh and groin. 2) Nurse Assistant duties and observations		

a) Pre-surgery hip precautions • Avoid moving resident until instructed by licensed nurse. • Use sheet or back board to move. b) Post-surgery hip precautions • Do not flex hip more than 90 degrees. • Do not cross affected leg over midline of body. • Do not internally rotate hip on affected side. • Do not do passive ROM on affected side. • No weight bearing for several weeks after surgery. • Use fracture bedpan. • Maintain proper hip alignment; may use trochanter roll and abduction pillow. 4. Other related subjects (optional): fibromyalgia, traction, Continuous Passive Motion (CPM) machine, back injuries (ruptured disk), extremity amputation. E. Endocrine System 1. Anatomy and physiology a. Pituitary; master gland. b. Thyroid; controls metabolism. c. Pancreas; secretes insulin to promote glucose use by cells. d. Adrenals; secretes adrenalin (fight or flight hormone). 2. Function; network of glands that secrete hormones into the blood stream. 3. Common diseases and disorders a. Diabetes Mellitus; chronic disease that results from a deficiency of insulin or a resistance to the effects of insulin. Body is unable to properly process food, and		

convert food into energy. There are two types of diabetes: 1) Type 1; Insulin dependent diabetes mellitus (IDDM). 2) Type 2; Non-insulin dependent diabetes mellitus (NIDDM). 3) Signs and symptoms a) The 3 polys: polyuria (excessive urination), polydipsia (excessive thirst), and polyphagia (excessive hunger). b) Fatigue. c) Skin infections that are slow to heal. d) Itching. e) Burning on urination. f) Vision changes. g) Hyperglycemia; caused by inadequate insulin for metabolic needs. • Develops slowly (over 24 hour period). • Confusion, drowsiness, slow slippage into coma. • Headache. • Sweet fruity odor to breath. • Deep breathing. • Low blood pressure. • Nausea or vomiting. • Flushed, dry, hot skin. • Unconsciousness. • Sugar in urine. • High blood sugar on glucose monitoring. h) Hypoglycemia; occurs when blood glucose is below normal; most commonly from overdose of insulin (insulin shock or insulin reaction).		

• Occurs rapidly. • Hunger, weakness, dizziness, shakiness. • Moist and clammy. • Rapid, shallow respiration. • Nervous and excited. • Rapid pulse. • Unconscious. • No sugar in the urine. • Low blood sugar glucose monitoring. 4) Nurse Assistant duties and observations a) Know signs & symptoms of hyperglycemia and hypoglycemia. b) Notify licensed nurse immediately if diabetic symptoms appear. c) Offer meals and snacks at regular intervals, report uneaten portions. d) Be aware that illness, stress, and infection can make blood sugars increase. e) Observe extremities for infection, trauma or wounds (especially feet). f) Notify licensed nurse if resident vomits after meal. g) Offer easily assimilated source of carbohydrates if signs of hypoglycemia occur (after notifying licensed nurse). h) Make sure right diet is given. i) Urine testing for sugar and acetone (rarely done in LTC now). j) Special foot care • Wash daily, dry between toes. • Inspect feet for signs of irritation. • Toenails to be cut by licensed nurse or		

podiatrist only.
- Shoes and stockings to be worn at all time when out of bed (never go barefoot).
- Check for anything that impairs circulation.
- Remember: diet, exercise and medication are the most important components of diabetic treatment.

4. Related subjects (optional): hyper and hypothyroidism, Cushing's and Addison's disease, glucose monitoring.

F. Nervous System
1. Anatomy and Physiology (see handouts)
   a. Brain (part of CNS).
      1) Center of conscious thought and voluntary action.
      2) Motor coordination.
      3) Centers of control for respiration, heart function, and body temperature.
   b. Spinal Cord (part of CNS)
      1) Transmission of impulses to and from brain.
      2) Approximately 17 inches long.
      3) Protected by spinal column (vertebrae).
   c. Peripheral nerves
      1) Transmission of impulses to and from spinal cord.
      2) Connects the CNS with the various structures of the body.
   d. Sensory organs
      1) Eye
      2) Nose
      3) Tongue
      4) Skin
      5) Ears
2. Functions

a. Controls, directs, and coordinates functions of the body. b. There are two major divisions; the central nervous system (CNS) and the peripheral nervous system (PNS). 3. Common diseases and disorders a. Dementia; any disorder of the brain that causes deficits in thinking, memory and judgment. 1) Causes a) Alzheimer's disease (most common). b) Multi-infarction dementia (multiple TIAs). c) Parkinson's disease. d) Syphilis. e) AIDS. f) Nutrition problems. g) Medication problems. h) Depression. i) Metabolic disorders. 2) Alzheimer's disease (previously covered): caused by plaques and tangles in the brain's nervous system. Brain decreases in size as cells are lost. Progressive and incurable. 3) Signs and Symptoms a) Stage 1: Mild Dementia • Short-term memory loss. • Personality changes. • Disorientation to time. • Poor judgment. • Lack of safety awareness. • Careless in appearance. • Anxious, depressed. • Delusions of persecution. b) Stage 2: Moderate Dementia		

• Increased short-term memory loss. • Complete disorientation. • Wandering and pacing. • Sundowning. • Perseveration phenomena. • Motor skills deteriorate. • Speech, reading, writing deteriorates. • Incontinent of bowel and bladder. • Catastrophic episode. c) Stage 3: Severe Dementia • Totally dependent. • Verbally unresponsive. • May have seizures. 4) Nurse Assistant duties and observations for resident with dementia (all types). a) Protect resident from injury. b) Be compassionate, patient, and calm; maintain sense of humor. c) Encourage independence as long as possible. d) Provide mental and physical activities within resident's capabilities. e) Support resident's dignity and self-esteem. f) Provide structured quiet environment that is uncluttered. g) Use appropriate body language; resident's will "read" the staff's behavior and reflect the mood of the staff in their own behavior. h) Give one, short, simple direction at a time. i) Observe for signs and symptoms of physical ailments; resident may be unaware of illness. j) Assist residents to maintain a dignified, attractive		

appearance by helping with grooming and dressing. k) Monitor food and fluid intake. • Do not use plastic feeding utensils. • Provide nutritious finger foods when the resident is unable to use utensils. • Be aware of swallowing difficulties. • Prepare food (butter bread, cut into bites) and encourage resident to feed self as long as possible. • Check food temperatures. • Check resident's mouth after eating for "pocketing" (hoarding food in the cheeks.) • Weigh residents to detect patterns of weight gain or loss. l) Use touch appropriately; surprising resident can result in a catastrophic reaction. m) Avoid using logic, reasoning or lengthy explanations. n) When ability to speak is lost, resident may communicate through non-verbal means • Biting, scratching, and kicking to express displeasure. • Facial expressions and body language may express moods. • Observe for what triggers agitation or anger and work on prevention. o) Use distraction and diversion when resident is agitated, take hand and calmly walk to another activity. p) Realize that people with dementia are not		

responsible for what they say. • They cannot change. • They are not aware of what they are doing. • They have poor impulse control. • Allow them to “save face” by preserving their dignity. • No one really knows what is happening in the mind of people with dementia. q) Be aware of wandering and pacing concerns • Keep record to detect patterns of wandering and pacing. • Some triggers are as follows ○ Noise; keep quiet, avoid crowds. ○ Boredom; give activities. ○ Unmet physical needs; evaluate needs. ○ Stress; create calm environment. ○ Pain; evaluate for sources of discomfort. ○ Hunger; offer frequent snacks. ○ Thirst; encourage fluids. ○ Need to use restroom; take to restroom at least every two hours. ○ Looking for companionship, security, or loved one; therapeutic touch, talk, consistency. ○ Physical restraints; feel threatened. ○ Looking for a state of mind, not physical location. • If they are in an area they shouldn’t be, calmly take their hand and redirect them to a safe area. • Avoid large numbers of staff approaching		

resident. • Use positive directions “stay inside” instead of “don’t go outside”. • Use gentle persuasion. r) Compliment positive behavior and accomplishments. s) Encourage rocking chairs to diffuse nervous energy. t) Be aware that “sundowning” (increased agitation and confusion in late afternoon or evening) can occur and how to prevent it. • Avoid over-fatigue. • Encourage resident to remain awake as much as possible during the day. • Evening meal should be at least two hours before bedtime. • Eliminate caffeine. • Evening activities should be quiet and calm. • Soft music is calming. • Give massage/back rub. • Light bedtime snack. • Follow bedtime routine (check with family members). • Check lighting; shadows and reflections can be disturbing. u) Discourage “pillaging and hoarding” • Label all resident’s belongings to identify if they are taken by confused resident. • Check room daily for stale food. • Keep resident’s hands busy. • Provide a “rummaging” drawer or box for		

resident. v) Use reality orientation (R.O.) to regain connection to environment • Especially effective in 1st stages of Alzheimer's. • Use clock and calendar at bedside. • Call by name. • Answer questions honestly, but do not give information they are unable to handle; for example ○ The resident asks if their deceased husband is coming to visit. ○ Nurse Assistant could respond by saying "tell me about your husband" • Do not argue with resident's reality. • Use bulletin boards decorated for the season. • Keep curtains open during the day. • Make sure they have their glasses and hearing aids on. • Do not expect resident to remember you - identify yourself, as needed. w) Use reminiscing therapy • Encourage sharing memories of past events. • Use "prompting" questions to show interest in their history. • Use active listening skills. • Realize the need to reminisce increases as we age. • Reminiscing serves as a life review and may validate the worth of their life. • Acknowledge validity of feelings and emotions		

- be comfortable with resident's tears as well as laughter. • Reminiscing helps people adapt to aging by maintaining self-esteem and working through personal loss. x) Incorporate validation therapy into all your interactions with dementia resident (maintains disorientated person's dignity by acknowledging the person's memories and feeling). • Developed by Naomi Feil. • May be a way for resident's to work through issues from the past that were unresolved. • Maintain identity and dignity of resident by having pictures or reminders of who they once were in resident room. • Realize there is a reason for all behavior. What appears to be confusion could be the person acting on an experience long ago. • Disoriented people have a right to express emotions. • Living must be resolved in order to prepare for dying. • To live in reality is not the only way to live. • Disoriented people have worth; they can still experience joy, pleasure and the ability to appreciate kindness. • Within each confused person is a human being that was once a child and later an adult with hopes, joys, sadness, failures, and successes. They deserve to be respected, cared for, and loved in their final years.		

• This therapy has been effective on lessening the need for restraints. y) Incorporate music therapy. z) Incorporate animal therapy. b. Stroke (brain attack, cerebrovascular accident "CVA"): complete or partial loss of blood supply to cells of the brain. 1) Signs and Symptoms a) Loss of sensation. b) Paralysis/hemiplegia. c) Aphasia. d) Dysphagia. e) Emotional lability. f) Loss of consciousness/confusion. g) Cognitive impairments. 2) Nurse Assistant duties and observations a) Report changes in Level of Consciousness; headache or change in motor ability to licensed nurse. b) Sudden onset of symptoms indicates probable stroke. c) Prevent complications of immobility. d) Begin Restorative Care; assist with ADLs, encourage resident to do as much as possible. e) Be supportive emotionally. Patience is vital! f) Explore alternative methods of communication if unable to speak. g) Be aware of swallowing/choking difficulties when feeding. h) Incorporate reality orientation into care; clock, calendar, open curtains. c. TIA (Transient Ischemic Attack) "mini stroke": caused by		

lack of oxygen to the brain cells. Signs & symptoms are temporary and subside when circulation is improved. (See CVA/Stroke) for possible signs & symptoms. d. Parkinson's Disease 1) Signs and symptoms a) Tremors and "pill rolling." b) Muscle rigidity. c) Difficulty and slowness in carrying out voluntary motor activities. d) Shuffling manner of walking. e) Slurred speech. f) Loss of expressiveness in face. g) Drooling. h) Incontinence. i) Constipation. j) Urinary retention. k) Mood swings. l) Depression. 2) Nurse Assistant duties and observations a) Maintain calm environment; symptoms will worsen when resident is under stress. b) Assist in ADLs. c) Provide emotional support. d) Restorative care; exercises. e) Dementia care; as above. e. Seizure disorder; recurrent, transient attacks of disturbed brain function. 1) Signs and symptoms a) Generalized seizure (Grand mal) • May experience "aura" or certain taste before seizure occurs. • Jerking and twitching of the body occurs.		

• Entire body is involved. • May experience loss of consciousness. • Incontinence. • May be followed by period of fatigue, confusion, disorientation. b) Partial seizure (Petit mal) • Momentary loss of muscle tone. • May have periods of unconsciousness. • May chew, blink, or breathe rapidly. • Last 2-10 seconds. • "Absence seizures" in children can result in poor learning in school. • Only one extremity or part of an extremity may be involved. c) Status epilepticus • Seizure lasts for a long period. • Serious medical emergency; life threatening. • Death may result. 2) Nurse Assistant duties and observations a) During a seizure • Stay with person and call for assistance. • Assist to lay down. • Do not restrain movements or put anything in mouth. • Move away objects that may injure a person. • Maintain airway by loosening clothing, turn head so saliva/emesis drains to one side, lift shoulder and allow head to tilt back. • Watch and observe so you can report type of seizure activity. b) After a seizure		

• Allow to sleep. • Clean if incontinence has occurred. • Check vitals. f. Vision impairments; following are common disorders of the eye that cause visual limitation and/or blindness. 1) Cataracts; the normally clear lens of the eye becomes cloudy. a) Signs and symptoms • Cloudy lens over the eye. • Leading cause of vision loss in adults over the age of 55. b) Follow post-op protocol if surgery has been performed. 2) Glaucoma; increased pressure within the eye. a) Signs and symptoms • Eye pain. • Difficulty adjusting to darkness. • Unable to detect color. • May see “halos”. • Headache. • Fatigue. • Blurred vision. 3) Nurse Assistant duties and observations for visual impairments a) Announce yourself by name when entering the room. b) Encourage television or radio listening. c) Be extra careful in explaining what you are doing. d) Describe the food you are going to feed them; is it hot? Cold? Describe food placement like the hands of a clock.		

e) Do not disrupt environment; keep ADL supplies in same place and do not move furniture unless necessary. f) Encourage independence. g. Hearing Impairments 1) Otosclerosis; progressive form of deafness, unknown cause. 2) Signs and symptoms - progressive loss of hearing. 4. Related subjects (optional): West Nile Virus, Autonomic Dysreflexia, Mad Cow Disease. 5. Nervous system complications of inactivity a. Weakness, limited mobility. b. Insomnia from sleeping during the day. G. Gastrointestinal system 1. Anatomy and physiology a. Mouth, tongue, teeth. b. Esophagus. c. Stomach. d. Small intestine. e. Large intestine. f. Liver and gall bladder. g. Pancreas. 2. Functions a. Extends from mouth to anus. b. Responsible for breaking food into simpler substances that can then be used by the body cells for nutrition. 3. Common diseases and disorders a. Malignancies; cancerous growths in GI tract that can cause obstruction, and may result in surgery and/or an ostomy. 1) Signs and symptoms a) Vomiting.		

b) Extreme abdominal discomfort. c) Indigestion. d) Constipation. e) Blood in the stool. f) Flatus. g) No bowel movement at all. 2) Nurse Assistant duties and observations a) Monitor bowel movements. b) Report discomfort to licensed nurse. c) Care of ostomy; artificial opening in the abdominal wall for elimination of solid waste and flatus. • Standard precautions. • Remove appliance gently to prevent irritation to skin (follow facility policy.) • Empty bag and wash if reusable with soap and water. • Secure clamp at base. • Discard disposable bag in biohazard waste and replace with new bag. • Observe stoma for redness, irritation, and skin breakdown (report to licensed nurse if this is noted). • Wipe area around stoma gently after appliance is removed and wash with mild soap and water. • Apply creams as ordered. • Fit opening of appliance to stoma as needed. • When applying appliance, seal well to prevent leaking. • Observe color, character, amount and		

frequency of stools, and chart. • Be matter of fact, avoid looking repelled or disgusted (resident may be self-conscious). b. Common problems with elimination 1) Constipation a) Abdominal or rectal pain. b) Inability to pass stool. c) Loss of appetite. d) Feel urge to defecate, but unable to pass stool. e) Bloating. f) Abdominal distention/hardness. g) Liquid stool or mucus seeping from rectum. h) Hard, dry stool. i) Feces that moves too slowly through the body. j) Caused by decreased fluids, diet, inactivity, ignoring the urge to defecate. 2) Fecal impaction a) Stool is unable to pass from the rectum. b) Results from unrelieved constipation. 3) Diarrhea a) Liquid or unformed stool with increased frequency. b) Feces that moves rapidly through the intestines. c) Caused by infection, medications, irritating foods. 4) Bowel incontinence a) Inability to control the passage of feces and gas. b) Possible cause due to injury or diseases of the nervous system or sphincter damage. c) May result when residents do not receive the assistance they need in a timely manner. 5) Flatulence (gas) a) Excessive formation of gas in the stomach and		

intestines. b) Caused by foods, medications, or air swallowing. c. Nurse Assistant duties and observations 1) Monitor and record bowel movements. 2) Notify licensed nurse if above signs and symptoms develop. 3) Encouraged high fiber diet for constipation. 4) Encourage liquids whenever in contact with resident. 5) Encourage exercise to stimulate bowel activity. 6) Prompt attention to call light. 7) Monitor skin integrity. 8) Prompt attention to incontinence care. a) NOTE: Nurse Assistants never perform removal of an impaction (digital disimpaction). 4. Related subjects (optional): Diarrhea, bowel incontinence, gall bladder disease, cholecystitis, hernias, ulcerations, bowel training, enemas, rectal tube, hemorrhoids, gastroesophageal reflux disease (GERD). H. Urinary System 1. Anatomy and physiology a. Kidneys; filters the blood, forms urine. b. Ureter; tube carrying urine from the kidneys to the bladder. c. Bladder; storage for urine. d. Urethra; tube for passage of urine to outside during urination (voiding). 2. Functions a. Filters blood and produces urine in which excess fluids and toxins are excreted. b. The body excretes 1000 to 1500 ml of urine/day. c. Characteristics of normal urine 1) Clear.		

2) Amber (medium yellow color). 3) Mild odor. 4) Approximately 1000 - 1500 cc in a 24 hour period. 3. Common diseases and disorders a. Cystitis; inflammation of the urinary bladder, especially common in women. 1) Signs and symptoms a) Dysuria, burning. b) Frequent urination. c) Cloudy urine. d) Hematuria. e) Bladder spasm. f) Loss of appetite. g) Fever. h) Confused resident may exhibit agitation. 2) Nurse Assistant duties and observations a) Encourage fluids. b) Observe for normal urine. c) Sitz bath. d) Perineal care. e) Always wipe front to back (from anterior to posterior). f) Rest. b. Urinary incontinence; loss of control of urine 1) Signs and symptoms a) Unable to control urination. b) Stress incontinence; urinate when exerting (sneezing, standing up, coughing). 2) Nurse Assistant duties and observations a) Bladder training. b) Toilet resident regularly. c) Answer call light promptly.		

d) Be positive when changing soiled linen or garments, do not be critical. e) Perineal care. f) Avoid liquids after dinner (if incontinent at night, or to prevent nocturia). 4. Related subjects (optional): renal dialysis, suppression, retention, renal calculi, specimen collection, urinary drainage systems, pylonephritis, renal dialysis. I. Reproductive System 1. Anatomy and physiology a. Structures and organs (male): 1) Penis; tissue enlarges during sexual arousal to introduce sperm into vagina. 2) Testes; secretes male hormone, produces sperm. 3) Prostate gland; secretes fluid necessary for sperm activity. 4) Epidiymis; coiled tube on top of testis. 5) Vas deferens; stores sperm. b. Structures and organs (female) 1) Ovaries; produce female hormone and eggs. 2) Fallopian tubes; egg travels through to the uterus. 3) Uterus; internal pear-shaped organ in the pelvis; holds fetus during pregnancy. 4) Vagina; receives penis during sexual activity. 5) Vulva; the external female genitalia. 2. Functions a. Reproduction of human life b. Production of some hormones. 3. Common diseases and disorders a. Male reproductive system 1) Enlarged prostate gland; urethra passes through prostate, and the prostate enlarges. It “strangles”		

urethra, causing difficulty in starting stream and in emptying bladder completely. 2) Cancer of the prostate. 3) Cancer of the testes; self-check of the scrotal sac should be done monthly. b. Female reproductive system 1) Cystocele; weakening of muscles between bladder and vagina. a) Signs and symptoms • Urinary incontinence. • Frequent urinary tract infections. 2) Rectocele; weakening of muscles between wall of rectum and vagina. a) Signs and symptoms • Hemorrhoids (varicose veins of the rectum). • Constipation. b) Prolapsed uterus 3) Malignancies a) Breast. b) Ovarian. c) Uterine. d) Cervical. c. Nurse Assistant duties and observations 1) Supportive care. 2) Notify licensed nurse if distress occurs. 4. Sexually transmitted disease a. Human Immunodeficiency Virus (HIV)/AIDS: viral infection transmitted primarily through direct contact with the bodily secretions of an infected person. 1) Signs and symptoms a) Flu-like symptoms.		

b) Fever. c) Night sweats. d) Fatigue e) Swollen lymph nodes. f) Sore throat. g) GI upset. h) Headache. i) Kaposi's sarcoma. j) Pneumocystis carinii pneumonia. 2) Nurse Assistant duties and observations a) Be aware that virus is killed by 10:1 water to bleach solution; potency of solution good for three days. b) Prevent secondary infections (immunosuppressed). c) Report new symptoms and complaints of discomfort to licensed nurse. d) Provide comfort measures. 5. Related subjects (optional): vulvovaginitis, tumors of reproductive tract, sexually transmitted diseases (STDs), breast self-exam, testicular self-exam. J. Immune System 1. Special cells and substances function to produce immunity a. White blood cells. b. Antibodies. c. Antigens. d. "T" cells - type of cell that destroys invading cells. 2. When the body senses an antigen, the immune system is activated. 3. Functions to provide the body with immunity; protection against a disease or condition 4. Common diseases and disorders		

a. Acquired Immunodeficiency Syndrome (AIDS); caused by a virus called Human Immunodeficiency Virus (HIV) 1) Spread through certain body fluids a) Blood. b) Semen. c) Vaginal secretions. d) Breast milk. 2) Affects the body's ability to fight other viruses and bacteria. 3) Signs and Symptoms a) Loss of appetite. b) Weight loss. c) Fever. d) Night sweats. e) Diarrhea. f) Painful or difficulty swallowing. g) Tiredness, extreme or constant. h) Skin rashes. i) Swollen glands in the neck, underarms, and groin. j) Cough. k) Sores or white patches in the mouth or on the tongue. l) Purple blotches or bumps on the skin that look like bruises but do not disappear. m) Confusion. n) Forgetfulness. o) Dementia. 4) Nurse Assistant duties and observations a) Practice standard precautions. b) Follow bloodborne pathogen standard. c) Provide daily hygiene; avoid harsh soaps that		

irritate the skin. d) Provide oral hygiene before meals and at bedtime. Make sure the resident uses a toothbrush with soft bristles. e) Provide oral fluids as ordered by licensed nurse. f) Measure and record intake and output. g) Measure weight daily. h) Have resident perform deep breathing exercises as ordered. i) Practice measures to prevent pressure sores. j) Assist with range-of-motion exercises and ambulation as ordered. k) Encourage the resident to perform self-care as able. The person may need assistive devices (walkers, commode, eating devices, etc.) l) Encourage the resident to be as active as possible. m) Change linens, gowns, or pajamas as often as needed when fever is present. n) Be a good listener and provide emotional support. 5) Other Considerations a) AIDS is often missed during diagnosis because aging can mask the signs and symptoms of AIDS. b) Some persons infected with HIV don't develop AIDS for as long as 10-15 years and may not show signs/symptoms. However, they are carriers and can spread disease to others.		
Objective 7: **Describe changes in body systems associated with aging.** A. Integumentary System 1. Skin becomes thin, fragile, dry and wrinkled.	A. Lecture B. Discussion	A. Written test B. Reports signs and

2. Blood supply to fingers and toes decreases; sensitivity to hot and cold decreases. 3. Hair loses color. 4. Nails thicken. 5. Bruises easily due to fragile blood vessels. B. Respiratory System 1. Lung strength decreases. 2. Air sacs become less elastic and decrease in number. 3. Airways become stiff and less elastic. 4. Lung capacity decreases. 5. Cough reflex is less effective. 6. Cough becomes weaker. 7. Gas exchange in lungs is less effective. C. Cardiovascular System 1. Blood flow decreases leading to less efficient circulation. 2. Blood vessels narrow and lose elasticity. 3. Longer recovery to normal pulse after exercise. 4. Heart is a less effective pump. D. Musculoskeletal 1. Muscles weaken and lose tone. 2. Loss of elasticity in muscles. 3. Loss of muscle mass causes weight loss. 4. Less flexible. 5. Bones lose minerals, become porous and brittle (easily broken). 6. Height is gradually lost due to space between vertebrae shrinking; posture slumped. 7. Joints are less flexible and stiffer, slows normal body movement. 8. Degenerative changes in joints. 9. Decreased reflexes: prone to injury and falls. E. Endocrine System	C. Handout 13.7- Effects of Aging and Nursing Care Measures.	symptoms to licensed nurse.

1. Decrease in sex hormones (estrogen and progesterone) signals menopause; testosterone levels decrease. 2. Insulin production decreases. 3. Metabolism and body functions slow. 4. Body is less able to handle stress. 5. Body less able to handle sugar. 6. Metabolism and body functions slow. F. Nervous System 1. Slowing nerve transmission results in delayed reaction time, poor coordination and balance. 2. Less effective temperature regulation. 3. Decreased sensitivity to pressure and temperature changes. 4. Decreased blood flow to brain resulting in memory loss and confusion. 5. Deep sleep is shortened, naps are needed. G. Gastrointestinal System 1. Decreased saliva production causing dysphagia. 2. Taste buds not as sensitive. 3. Decreased gag reflex leading to chance of choking. 4. Slowed peristalsis leading to indigestion and constipation. 5. Increased flatulence. 6. Decreased digestive enzymes, avoid dry, fried and fatty foods. 7. Decreased ability to absorb nutrients. 8. Medication related to side effects. 9. Sensitivity to sensation of full bowel. 10. Urgency is exaggerated with the bowel. H. Urinary System 1. Kidneys decrease in size and are less efficient. 2. Bladder loses tone, leading to retention and infection (have resident bear down after voiding to completely empty bladder). 3. Decreased bladder capacity leads to frequency of urination. 4. Kidney function increases at rest, causing urination at night.		

5. Prostate enlargement in male causes frequency, dribbling, and urinary retention. 6. Elderly resident may exhibit behavior changes with usual UTI signs and symptoms. 7. Decreased sensitivity to sensation of a full bladder. 8. Urgency is exaggerated with the bladder. I. Reproductive System 1. Male reproductive system a. Scrotum less firm. b. Number and capability of sperm decreases. c. Sexual response delayed. d. Increase in size of prostate gland. e. Hormone production decreases. 2. Female reproductive system a. Menopause when menstruation ends. b. Decrease production of estrogen and progesterone results in loss of calcium, causing brittle bones and osteoporosis. c. Fewer hormones are produced. d. Ovulation and menstrual cycle cease. e. Vagina becomes thinner, drier. f. Breast tissue decreases and muscles supporting breast weaken.		

Sample Test: Module 13 - Long Term Care Resident

1. The following are common with otitis media **EXCEPT**
    A. Pain.
    B. Hearing loss.
    C. Tinnitus.
    D. Dizziness.

2. Arthritis is
    A. The surgical replacement of a joint.
    B. Joint inflammation.
    C. A disease in which bones become porous and brittle.
    D. The repair of a fracture.

3. Tissues die and become black, cold and shriveled. This is
    A. Cancer.
    B. Gangrene.
    C. Arthritis.
    D. Metastasis.

4. Which of the following body parts commonly enlarges in the elderly male causing urinary tract obstruction?
    A. Testes.
    B. Prostate gland.
    C. Ureter.
    D. Adrenal gland.

5. A malignant tumor
    A. Grows slowly and in a localized area.
    B. Can spread to other parts of the body.
    C. Invades nearby tissues.
    D. Is not cancer.

6. A resident has osteoarthritis. The person is overweight. Why is weight loss important for the person?
    A. It will improve the person's mental well-being.
    B. The person is too old to be overweight.
    C. Weight loss reduces stress on weight-bearing joints.
    D. It will be easier to lift and mover the person.

7. These statements are about arthritis. Which is incorrect?
    A. It is the most common joint disease.
    B. Pain is common.
    C. Decreased mobility is common.
    D. It is cured with arthroplasty.

8. A resident has a fractured right hip. What position is usually not allowed?
    A. Left side-lying position.
    B. Right side-lying position.
    C. Fowler's position.
    D. Semi-Fowler's position.

9. The two most common causes of stroke are
    A. Bleeding in the brain and blood clots.
    B. Hypertension and diabetes.
    C. Infection and accidental injury.
    D. Aging and poor nutrition.

10. Care of a person after a stroke often includes the following except
    A. Ostomy care.
    B. A bowel and/or bladder training program.
    C. ROM exercises to prevent contractures.
    D. Measures to prevent pressure ulcers.

11. Functions lost as a result of stroke depend on
    A. The cause of the stroke.
    B. The person's age.
    C. The area of brain damage.
    D. The person's attitude.

12. A resident has heart failure. The doctor is likely to order
    A. A splint or brace.
    B. Elastic stockings.
    C. Trochanter rolls.
    D. A cane or walker.

13. When the urinary bladder is removed, a new pathway is needed for urine to exit the body. The new pathway is called a
    A. Urinary diversion.
    B. Ureterostomy.
    C. Renal pathway.
    D. Renal tubule.

14. Heart failure means that the heart
    A. Has stopped beating.
    B. Is damaged.
    C. Cannot pump blood normally.
    D. Is old and weak.

15. In diabetes, the body lacks or is unable to use
    A. Estrogen.
    B. Testosterone.
    C. Insulin.
    D. Protein and carbohydrates.

16. Persons with diabetes need
    A. Good foot care.
    B. Frequent oral hygiene.
    C. Daily weight measurements.
    D. I & O measurements.

17. To prevent pressure ulcers, you must
    A. Keep the person's skin clean and dry.
    B. Massage pressure points.
    C. Use soap to clean the skin.
    D. Scrub and rub the skin during bathing.

18. You are applying an elastic bandage to a person's left leg. Which is incorrect?
    A. Position the part in good alignment.
    B. Face the person during the procedure.
    C. Start at the top (proximal) part of the extremity.
    D. Expose the toes if possible.

19. A female resident is obese. She is at risk for pressure ulcers in the following areas except.
    A. Between abdominal folds.
    B. Under her breasts.
    C. Between her legs and buttocks.
    D. Her forehead and chin.

20. A dressing is loose. What can happen?
    A. Microbes can enter the wound.
    B. Wound edges can separate.
    C. Dehiscence can occur.
    D. The wound can become larger.

21. The leading cause of blindness in persons 60 years of age or older is
    A. Glaucoma.
    B. Cataract.
    C. Eye infection.
    D. Age related Macular Degeneration (AMD).

22. A resident has a hearing aid. Which is incorrect?
    A. The hearing aid corrects the person's hearing problems.
    B. Hearing aids are costly.
    C. Batteries are removed at night.
    D. When not in use, the hearing aid is turned off.

23. A resident has glaucoma. What do you know about the person's sight?
    A. Print and colors appear faded.
    B. The person cannot see to the side.
    C. The person is blind in the affected eye.
    D. The person's vision is cloudy.

24. Which means low blood sugar?
    A. Hyperglycemia.
    B. Hypoglycemia.
    C. Hyperthyroidism.
    D. Hypothyroidism.

25. The person with Parkinson's disease needs protection from
    A. Falls.
    B. Burns.
    C. Poisoning.
    D. Cold, damp weather.

26. Risk factors for stroke include the following except
    A. Hypertension and a family history.
    B. Diabetes, osteoporosis, and obesity.
    C. Heart disease, inactivity, and excessive alcohol use.
    D. Smoking and high blood cholesterol.

27. The following are common with Parkinson's disease **EXCEPT**
    A. Tremors.
    B. Shuffling gait.
    C. Facial expression.
    D. Flare-ups or relapses.

28. With coronary artery disease, the coronary arteries are
    A. Hardened and narrow.
    B. Enlarged and less elastic.
    C. Infected.
    D. Opened or bypassed.

29. A hallucination is
    A. A false belief.
    B. An exaggerated belief.
    C. Seeing, hearing, smelling, or feeling something that is not real.
    D. A persistent thought or idea.

30. Delirium is
    A. A false belief.
    B. The loss of cognitive function caused by changes in the brain.
    C. A false disorder of the mind.
    D. A state of temporary but acute mental confusion.

31. Sundowning is
    A. When signs, symptoms, and behaviors of Alzheimer's disease increase during hours of darkness.
    B. The loss of cognitive and social function caused by changes in the brain.
    C. A false dementia.
    D. A state of temporary but acute mental confusion.

32. These statements are about permanent dementia. Which is incorrect?
    A. There is no cure.
    B. Loss of cognitive function worsens over time.
    C. Disease progression is the same for everyone affected.
    D. The person has signs and symptoms of dementia.

33. A resident has Alzheimer's disease. She is trying to rub her perineum through her clothes. Which statement is incorrect?
    A. The behavior is sexual.
    B. She may be wet or soiled from urine or feces.
    C. She may have a urinary or reproductive infection.
    D. She may have pain or discomfort in her urinary or reproductive system.

34. The Nurse Assistant is providing foot care to a resident with diabetes. What is he/she not allowed to do?
    A. Rub lotion on the resident's feet.
    B. Use an orange stick under the nails.
    C. Clip the nails.
    D. Check for fungus between the toes.

35. A resident has AD. The person has the following behaviors. Which has the greatest risk for danger?
    A. Wandering.
    B. Delusions.
    C. Catastrophic reactions.
    D. Screaming.

36. Which is not a risk factor for gastroesophageal reflux disease (GERD)?
    A. Being underweight.
    B. Alcohol use.
    C. Pregnancy.
    D. Smoking.

37. What is the greatest risk(s) from osteoporosis?
    A. Fractures.
    B. Burns.
    C. Infection.
    D. Pneumonia.

38. The resident has a cast on the right leg. Which action is **INCORRECT**?
    A. Allow the cast to get wet.
    B. Use your palms to lift and turn a casted extremity.
    C. Turn the person every two hours.
    D. Elevate the casted part on pillows.

39. The skin is injured. Which is a major threat?
    A. Incontinence.
    B. Infection.
    C. Gangrene.
    D. Evisceration.

40. An injury usually from unrelieved pressure is
    A. A wound.
    B. A thrombus.
    C. Phlebitis.
    D. A pressure ulcer.

41. Skin tears are caused by the following except
    A. Friction and shearing.
    B. Pulling or bumping a body part.
    C. Direct pressure on the skin.
    D. Incontinence and moisture on the skin.

42. The skin or mucous membrane is broken. This is
    A. An open wound.
    B. A clean wound.
    C. A closed wound.
    D. An intentional wound.

43. Elastic bandages and elastic stockings do the following except
    A. Promote comfort.
    B. Promote circulation.
    C. Prevent injury.
    D. Prevent infection.

44. A resident has cancer. You find him crying in his room. What should you do?
    A. Close the door after leaving the room. He needs to cry in private.
    B. Use touch and listening to communicate that you care.
    C. Tell the nurse at once.
    D. Tell his spiritual advisor what you observed.

45. The common causes of chronic renal failure are
    A. Tumors and infections.
    B. Hypertension and diabetes.
    C. Coronary artery disease and COPD.
    D. Severe allergic reactions and severe bleeding.

46. Hepatitis A is spread by
    A. Airborne droplets.
    B. Blood.
    C. The fecal-oral route.
    D. Direct contact.

47. What is the highest level of anxiety?
    A. Panic.
    B. Phobia.
    C. Obsession.
    D. Compulsion.

48. Which is not an early warning sign of dementia?
    A. Getting lost in familiar places.
    B. Personality changes.
    C. Poor or decreased judgment.
    D. Not recognizing self or family members.

49. A resident is confused. It is time for the person's shower. What should you do?
    A. Explain what you are going to do and why.
    B. Ask the person to undress.
    C. Ask if the person wants a tub bath or shower.
    D. Let the confusion pass before you assist with the person's shower.

Sample Test Answers: Module 13

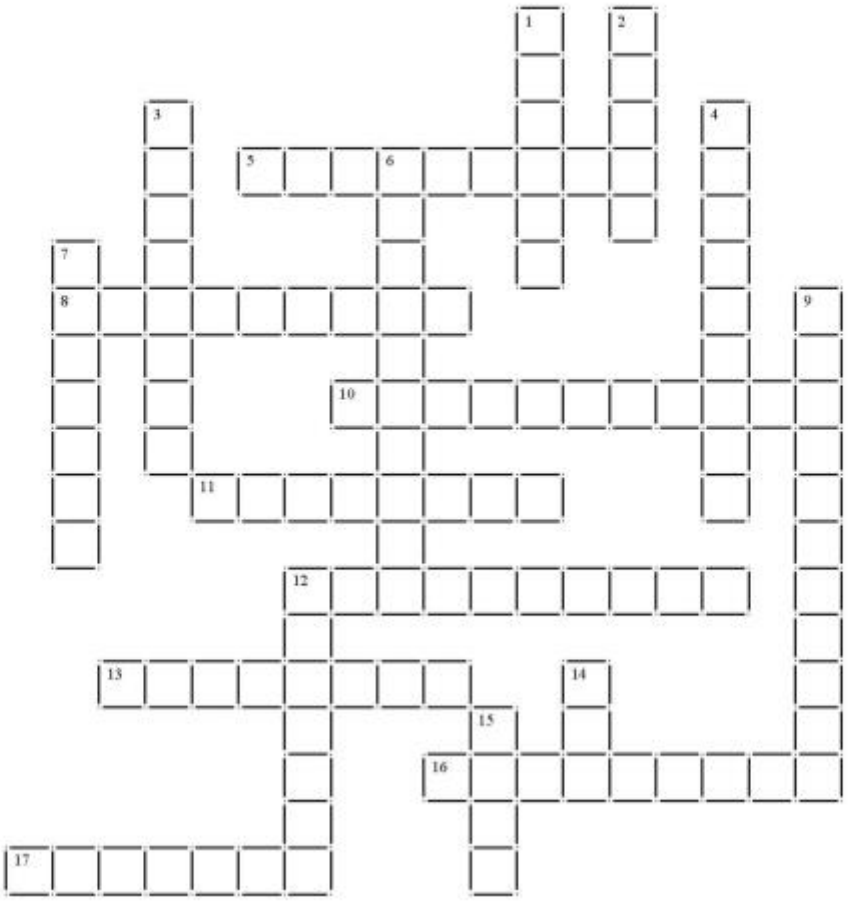
1. D
2. B
3. B
4. B
5. B
6. C
7. D
8. B
9. A
10. A
11. C
12. B
13. A
14. C
15. C
16. A
17. A
18. C
19. D
20. A
21. A
22. A
23. B
24. B
25. A
26. B
27. D
28. A
29. C
30. D
31. A
32. C
33. A
34. C
35. A
36. A
37. A
38. A
39. B
40. D
41. D
42. A
43. D
44. B
45. B
46. C
47. A
48. D
49. A

MANUAL SKILL: Reality Orientation to Promote or Maintain Awareness of Person, Time, Place

SKILL STEPS:

1. Be calm and gentle in approach, face person, and speak clearly and slowly.
2. Address the patient by name with each contact (know how he/she prefers to be addressed).
3. State your name and show your nametag.
4. Tell the person the date and time each morning. Repeat the information as often as necessary during the day and evening.
5. Be patient with repeated instructions.
6. Explain what you are going to do and why.
7. Give clear and simple answers to questions.
8. Ask clear and simple questions. Allow enough time for a response.
9. Keep calendars and clocks with large numbers in the resident's room and in view in other rooms.
10. Encourage the resident to wear glasses and a hearing aid if needed.
11. Keep glasses, dentures, and hearing aid in same place.
12. Use touch to communicate.
13. Encourage the resident to place familiar objects and pictures within view.
14. Provide newspapers and magazines, read to the individual if appropriate.
15. Discuss current events with the resident.
16. Allow the use of television and radio.
17. Maintain the day-night cycle. Open curtains, shades, and drapes during the day and close them at night.
18. Use a night light at night.
19. Encourage the person to wear regular clothes during the day, rather than gowns or pajamas.
20. Maintain a calm, relaxed atmosphere; avoid loud noise, rushing, or congested hallways and rooms.
21. Maintain a routine for resident for meals, bathing, and activities.
22. Keep furniture in same place.
23. Do not rearrange resident's belongings.
24. Encourage resident to participate in ADLs.
25. Be consistent with activities by all health care workers.
26. Remind the person of holidays, birthdays, and other special events.
27. Post activity boards and draw attention to it.
28. Post reality orientation boards and draw attention to it.
29. Call attention to color-coding of facility areas.

Long Term Care Resident Crossword



Across

5 Chemical breakdown of food for use by body

8 Loss of function of a part of the body.

10 The smallest blood vessels.

11 Itching.

12 Refers to signs of Alzheimer's Disease during the hours of darkness.

13 A decline in memory and other thought processes.

16 Disoriented to time, place, and person.

17 Wasting of muscle tissue.

Down

1 A condition causing severe pain in the chest.

2 Blood vessels that carry unoxygenated blood.

3 The front part.

4 The back portion.

6 Breathing out.

7 Loss of ability to speak.

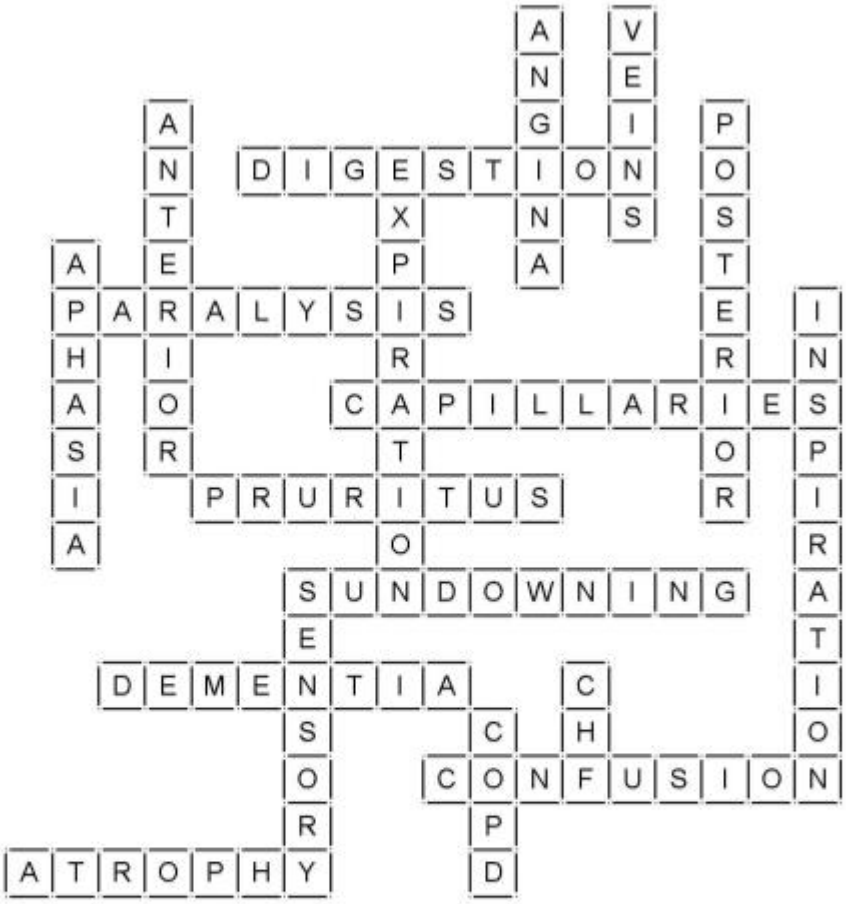
9 Breathing in.

12 Referring to organs responsible for sight, hearing, touch, taste, smell.

14 Short for "Congestive Heart Failure"

15 Short for "Chronic Obstructive Pulmonary Disease."

Long Term Care Resident Crossword



ELEMENTS OF FRIENDSHIP

Friends Know Each Other's History and Personality

In Alzheimer's care, a Best Friend

- Becomes the person's memory.
- Is sensitive to the person's traditions.
- Learns the person's personality, moods, and problem solving style.

Friends Do things Together

In Alzheimer's care, a Best Friend

- Involves the person in daily activities and chores.
- Initiates activities.
- Ties activities into the person's past skills and interests.
- Encourages the person to enjoy the simpler things in life.
- Remembers to celebrate special occasions.

Friends Build Self-Esteem

In Alzheimer's care, a Best Friend

- Gives compliments often.
- Carefully asks for advice or opinions.
- Always offers encouragement.
- Offers congratulations.

Friends Laugh Often

In Alzheimer's care, a Best Friend

- Tells jokes and funny stories.
- Takes advantage of spontaneous fun.
- Uses self-deprecating humor often.

Friends Communicate

In Alzheimer's care, a Best Friend

- Listens skillfully.
- Speaks skillfully.
- Asks questions skillfully.
- Speaks using body language.
- Gently encourages participation in conversations.

Friends Are Equals

In Alzheimer's care, a Best Friend

- Does not talk down to the person.
- Always works to protect the dignity of the person, to "save face."
- Does not assume a supervisory role.
- Recognizes that learning is a two-way street.

Friends Work at the Relationship

In Alzheimer's care, a Best Friend

- Is not overly sensitive.
- Does more than 50% of the work.
- Builds a trusting relationship.
- Shows affection often.

Empathy

Nurse Assistants who demonstrate empathy can deliver service and care more effectively. Empathizing improves communication because the empathetic listener focuses on the feelings of the speaker. Sympathy, sometimes confused with empathy, focuses on the listener's own feelings of being sorry or sad for the other person. Understanding the difference between sympathy and empathy can be difficult. The exercises below will help Nurse Assistants understand the nature of empathy and provide opportunities for them to practice skills that will increase their capacity to experience empathy, demonstrate understanding, reserve judgment, and communicate effectively. When Nurse Assistants have more empathy with residents, as well as with co-workers, the health care setting is more effective and humane.

Physical Limitations

What students will learn:

1. What it is like to experience the signs and symptoms of various physical conditions.
2. To develop empathy with patients and what they are experiencing.

What you will need:

1. Short (3-4 inches) straws that are not very large in diameter. Small cocktail straws work well.
2. Nonprescription eyeglasses with clear lenses that have been coated with petroleum jelly.
3. Gardening gloves
4. Blindfolds for half of the students.
5. Earphones or cotton balls.

What to do:

Instruct students to use the items on the list to create conditions that simulate physical limitations caused by disease, accident, or aging; for example:

1. Give each student a straw and have him/her breathe through the straw for 5 minutes (if they can last that long). This activity will simulate what it is like for a premature baby who struggles for air. It also simulates breathing with lung disorders such as asthma, emphysema, and bronchitis.

2. Have students put on the glasses coated with petroleum jelly to demonstrate what it is like to have a cataract or other vision disorder.
3. Students can wear the gloves and try to perform simple tasks like buttoning a shirt, picking up some coins, writing, opening the wrapper on chewing gum, etc. This activity will help them understand what it is like to have an impaired sense of touch.
4. Give a short lecture while students are wearing earphones or cotton balls in ears to simulate hearing loss. Give a "test" to let them see how much they missed.
5. Blindfold half the students and have the remaining half lead them around campus.
6. Have students maneuver around the classroom using a wheelchair, crutches, walker or cane. Make an obstacle course and time the students when they go through it in a wheelchair. If possible, have students take the wheelchair outside to use it on a sidewalk and other uneven surfaces. Ask the students using assistive devices to open doors by themselves. Have something on the floor for the students to pick up while seated in the wheelchair (be careful they don't fall).

Follow-up Discussion

1. How did it feel to experience a physical limitation?
2. What are the ways you might demonstrate empathy for future residents who have physical limitations?
3. What are some ways that you might help residents who have these limitations?

THE BEST FRIENDS PHILOSOPHY OF COMMUNICATION

- Create an environment that facilitates good communication.
- Do most of the work.
- Do not argue or confront.
- Do not take the person too literally.
- Employ good timing.
- Employ humor in communication.
- Maintain caregiving integrity.
- Make a good first impression.
- Remember the basics of good communication.
- Remember the importance of non-verbal communication.
- Respond to emotional needs.
- Screen out troubling messages or news.
- Speak using positive language.
- Treat the person as an adult.
- Understand the person's desire to communicate.
- Use repetition to facilitate better communication.

AN ALZHEIMER'S DISEASE BILL OF RIGHTS

Every person diagnosed with Alzheimer's disease or a related disorder deserves the following rights:

- To be informed of one's diagnosis.
- To have appropriate, ongoing medical care.
- To be productive in work and play for as long as possible.
- To be treated like an adult, not like a child.
- To have expressed feelings taken seriously.
- To be free from psychotropic medications, if possible.
- To live in a safe, structured, and predictable environment.
- To enjoy meaningful activities that fill each day.
- To be outdoors on a regular basis.
- To have physical contact, including hugging, caressing, and hand holding.
- To be with individuals who know one's life story, including cultural and religious traditions.
- To be cared for by individuals who are well trained in dementia care.

Effects of Aging and Nursing Care Measures Handout

Skin

Changes:

1. Wrinkles (loss of elasticity).
2. Dry and itchy (decrease in skin oils).
3. Chills easily (loss of fatty tissue).
4. Bruises easily (fragile blood vessels).
5. Discoloration, liver spots on back of hands (due to pigments in the hand being exposed to sun).
6. Easily irritated perineal area (decreased lubricant production glands).
7. Dry mouth (decrease in mucus production).
8. Brittle nails.
9. Hair color changes and balding (loss of pigmentation and wearing out-atrophy-of-hair follicles).

Nursing Care Measures:

1. Treat gently to avoid tissue damage, pat dry after bathing.
2. Adequate clothing/bed covering to prevent chilling. Keep environmental temperature constant.
3. Adequate nutrition and fluids.
4. Immobility can cause breakdown at a faster rate.
5. Avoid drying and irritating soaps, use soap sparingly.
6. Aged may not need as frequent bathing.
7. Apply lotion to bony prominences and itchy skin, especially after bathing.

Circulatory system (heart and blood vessels)

Changes:

1. Fatigues easier, loss of oxygen in tissues (heart wears out, heart valves become rigid, leading to decreased output of blood; blood vessels thicken).
2. Hardening of the arteries-arteriosclerosis (due to decreased elasticity of the blood vessels).
3. Fat deposits in heart and blood vessels-arteriosclerosis (due to decreased elasticity of the blood vessels).
4. Fainting-orthostatic hypotension (due to inability of heart and blood vessels to adjust rapidly to changes in position).
5. Increased and sustained blood pressure under stress or strain (heart and blood vessels cannot react fast to react to changes).

6. Faster pulse (due to hardening of arteries).
7. Feet and hands may be cold (due to hardening of arteries in feet and hands).

Nursing Care Measures:

1. Adequate nutrition and fluids.
2. Relief of undue stress and strain; periods of rest and relaxation.
3. Encourage active exercise and mobility to stimulate circulation.
4. Proper positioning if patient is in bed to prevent pressure on blood vessels.
5. Change position of patient frequently every 2 hours. Being in one position too long can cause pooling of blood, and slowing of circulation.
6. Ensure good bowel elimination to prevent strain on the heart from constipation.
7. Give patient time to get used to position changes. Protect from falls or fainting. Aged may need to move more slowly.

Respiratory system (lungs)

Changes:

1. Fatigue, less efficient breathing; must breathe harder and longer (decreased lung capacity, loss of elasticity in lung tissue).
2. Shallow breathing (chest muscle weakens).
3. Ineffective coughing (muscle weakens, less lung capacity).

Nursing Care Measures:

1. Accurate observation of patient's breathing rate and characteristics.
2. Proper positioning to allow for good chest expansion and breathing.
3. Deep breathing exercises.
4. Adequate rest and relaxation, although active exercise helps maintain good breathing and muscle tone.

Muscular system

Changes:

1. Weakness of muscles (muscles wear out-atrophy-because of disuse of muscle groups due to inactivity).
2. Fatigue of muscles, loss of energy reserve (decreased).
3. Shuffling, slow gait (muscle weakness in knees and hips).

Nursing Care Measures:

1. Maintain correct body alignment and positing.
2. Encourage active exercise and ambulation.
3. Adequate nutrition and fluids.
4. Provide for safety; prevent falls-remove scatter rugs from floor and keep paths for ambulation open and free of clutter.
5. Hand rails on walls and in toilets assist in transfer and ambulation.

Skeletal system (bones)

Changes:

1. Bones fracture easily (calcium is lost from bones, bones are porous).
2. Stiffness of joints and ligaments (hardening of tissues in joints).
3. Postural changes, stooped back (degeneration of back bones).

Nursing Care Measures:

1. Elderly are more prone to injury and fractures. Handle gently and take safety precautions to prevent falls.
2. Adequate nutrition-especially foods containing calcium (dairy products).
3. Active exercise helps relieve stiffness.

Digestive system (mouth, stomach, intestines)

Changes:

1. Poor appetite (loss of teeth, decrease in taste and smell).
2. Prone to constipation (loss of muscle tone in stomach and intestines).

Nursing Care Measures:

1. Encourage a balanced diet with adequate protein and bulk foods.
2. Fluids and exercise to help maintain normal bowel function.