Competency Evaluation Review

Preparing for the Competency Evaluation

After completing your state's training program, you need to pass the competency evaluation. The purpose of the competency evaluation is to make sure you can do your job safely. This section will help you prepare for the test.

Competency Evaluation

The competency evaluation has a written test and a skills test. The number of questions varies with each state. Each question has 4 answer choices. Although some questions may appear to have more than one possible answer, there is only 1 best answer. You will have about 1 minute to read and answer each question. Some questions take less time to read and answer. Other questions take longer. You should have enough time to take the test without feeling rushed.

The content of the written test varies depending on your state. Content may include:

- Activities of Daily Living—hygiene, dressing and grooming, nutrition and hydration, elimination, rest/sleep/comfort
- Basic Nursing Skills—infection control, safety/emergency, therapeutic/technical procedures (e.g., vital signs, bedmaking), data collection and reporting
- Restorative Skills—prevention, self-care/independence
- Emotional and Mental Health Needs
- Spiritual and Cultural Needs
- The Person's Rights
- Legal and Ethical Behavior
- Being a Member of the Health Care Team
- Communication

The written test is given as a paper and pencil test in most states. Some test sites may use computers. You do not need computer experience to take the test on the computer. If you have difficulty reading English, you may request to take an oral test. Talk with your instructor or employer about details for computer testing or oral testing.

The skills test involves performing 5 nursing skills that you learned in your training program. These skills are chosen randomly. You do not select the skills. You are allowed about 30 minutes to do the skills. See p. 503 for more information about the skills test.

Taking the Competency Evaluation

To register for the test, you need to complete an application. Your instructor or employer tells you when and where the tests are given. There is a fee for the evaluation. If you work in a nursing center, the employer may pay this fee. If you pay the fee, you may need to purchase a money order or certified check. Make sure your name is on the money order or certified check. Cash and personal checks may not be accepted.

Plan to arrive at the test site about 15 to 30 minutes before the evaluation begins. Most centers do not admit you if you are late. Know the exact location of the test site and room. Actually drive or take transportation to the test site a few days or a week before the test. Making a "dry run" lets you know how much time you need to travel, park, and get to the test site. It will also help decrease your anxiety level on the test day.

To be admitted to the test, you need two pieces of identification (ID). The first form of ID is a government-issued document such as a driver's license or passport. It must have a current photo and your signature. The name on the ID must be the same as the name on your application form. If your name has changed and you have not been able to have the name changed on your identification documents, ask your instructor or employer what to do. The second form of ID must include your name and signature. Examples include a library card, hunting license, or credit card.

Take several sharpened Number 2 pencils to the test. For the skills test you will need a watch with a second hand. You may need a person to play the role of the patient or resident. Ask your instructor or employer how this is done in your state.

Taking the written test and skills test may take several hours. You may want to bring snacks or lunch and a beverage to the testing site. Eating and drinking are not allowed during the test. However, you may be told where you can eat while waiting for the test.

You cannot bring textbooks, study notes, or other materials into the testing room. The only exception may be a language translation dictionary that you show to the proctor (a person who monitors the test) before the test begins. Cellphones, pagers, calculators, or other electronic devices are not permitted during testing. Children and pets are not allowed in the testing areas.

Studying for the Competency Evaluation

You began to prepare for the written test and skills test during your training program. You learned the basic nursing content and skills needed to provide safe, quality care. The following suggestions can help you study for the competency evaluation.

- Begin to study at least 2 to 3 weeks before the test. Plan to study for 1 to 2 hours each day.
- Decide on a specific time to study. Choose a study time that is best for you. This may be early in the morning before others are awake. It may be in the evening after others go to sleep. Try to choose a time when you are mentally alert.
- Choose a specific area to study in. This area should be quiet, well lit, and comfortable. You should have enough room to write and to spread out your books, notes, and other study aids. The area does not need to be noise-free. The testing site is not absolutely quiet. You want to concentrate and not be distracted by the noise around you.

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- Collect everything you need before settling down to study. This includes your textbook, notes, paper, highlighters, and pens or pencils.
- Take short breaks when you need them. Take a break when your mind begins to wander or if you feel sleepy.
- Develop a study plan. Write your plan down so you can refer to it. Study 1 content area before going on to the next. For example, study personal hygiene before going on to vital signs. Do not jump from 1 subject to another.
- Use a variety of ways to study.
  - Use index cards to help you review abbreviations and terminology. Put the abbreviation or term on the front of the card and place the meaning on the back. Take the cards with you and review them whenever you have a break or are waiting.
  - Record key points. You can listen to the recording while cooking or while riding in the car.

Study groups are another way to prepare for a test. Group members can quiz each other.

- To remember what you are learning, try these ideas.
  - Relax when you study. When relaxed, you learn information quickly and recall it with greater ease.
  - Repeat what you are learning. Say it out loud. This helps you remember the idea.
  - Make the information you are learning meaningful. Think about how the information will help you be a good nursing assistant.
  - Write down what you are learning. Writing helps you remember information. Prepare study sheets.
  - Be positive about what you are learning. You remember what you find interesting.
- Suggestions for studying if you have children:
  - When you first come home from work or school, spend time with your children. Then plan study time.
  - Select educational programs on TV that your children can watch as you study.
  - When you take your study breaks, spend time with your children.
  - Ask other adults to take care of the children while you study.
- Take the two 75-question practice tests in this section. Each question has the correct answer and the reason why an answer is correct or incorrect. If you practice taking tests, you are more likely to pass them. Take the practice tests under conditions similar to the real test. Work within time limits.
- If your state has a practice test and a candidate handbook, study the content. Some states have practice tests on-line.

Managing Anxiety

Almost everyone dreads taking tests. It is common and normal to experience anxiety before taking a test. If used wisely, anxiety can actually help you do well. When you are anxious, that means you are concerned. You may be concerned about how prepared you are to take the test. Or you may be concerned about how you will feel about yourself if you do not pass the test. Being concerned usually results in some action. To overcome anxiety before the test:

- Study and prepare for the test. That helps increase your confidence as you recall or clarify what you have learned. Anxiety decreases as confidence increases. When you think you know the information, keep studying. This reinforces your learning.
- Develop a positive mental attitude. You can pass this test. You took tests in your training program and passed them. Praise yourself. Talk to yourself in a positive way. If a negative thought enters your mind, stop it at once. Challenge the mental thought and tell yourself you will pass the test.
- Visualize success. Think about how wonderful you will feel when you are notified that you have passed the test.
- Perform breathing exercises. Breathe slowly and deeply.
- Perform regular exercise. Exercise helps you stay physically fit. It also helps keep you calm.
- Good nourishment helps you think clearly. Eat a nourishing meal before the test. Do not skip breakfast. Vitamin C helps fight short-term stress. Protein and calcium help overcome the effects of long-term stress. Complex carbohydrates (pasta, nuts, yogurt) can help settle your nerves. Eat familiar foods the day before and the day of the test. Do not eat foods that could cause stomach or intestinal upset.
- Maintain a normal routine the day before the test.
- Get a good night's sleep before the test. Go to bed early enough so you do not oversleep or are too tired to get up. Set your alarm clock properly. You may want to set two alarm clocks.
- Do not "cram" the evening before or the day of the test. Last-minute cramming increases your anxiety. Do something relaxing with family and friends.
- Avoid drinking large amounts of coffee, colas, water, or other beverages. You do not want to be uncomfortable with a full bladder when you take the test.
- Wear comfortable clothes. Dress in layers so that you are prepared for a cold or warm room.
- If you are a woman, remember that worry and anxiety can affect your menstrual cycle. Wear a panty liner, sanitary napkin, or tampon if you think your period may start. This eliminates worry about soiling your clothing during the test.
- Allow plenty of time for travel, traffic, and parking.
- Arrive early enough to use the restroom before the test begins.
- Do not talk about the test with others. Their panic or anxiety may affect your self-confidence.

Taking the Test

Follow these guidelines for taking the test.

- Listen carefully and follow the instructions given by the proctor (person administering the test).
- When you receive the test, make certain you have all the test pages.
- Read and follow all directions carefully.
- You are not allowed to ask questions about the content of the test questions.

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- Do deep-breathing and muscle-relaxation exercises as needed.
- Cheating of any kind is not allowed. If the proctor sees you giving or receiving any type of assistance, your test booklet is taken and you must leave the testing site.
- If using a computer answer sheet, completely fill in the bubble.
- If you make a mistake, erase the wrong answer completely. Do not make any stray marks on the paper. Not erasing completely or leaving stray marks could cause the computer to misread your answer.
- Do not worry or get anxious if people finish the test before you do. Persons who finish a test early do not necessarily have a better score than those who finish later.
- You cannot take any evaluation materials or notes out of the testing room.

Answering Multiple-Choice Questions

Pace yourself during the test. First, answer all the questions that you know. Then go back and answer skipped questions. Sometimes you will remember the answer later. Or another test question may give you a clue to the one you skipped. Spending too much time on a question can cost you valuable time later. To help you answer the questions or statements:

- Always read the questions or statements carefully. Do not scan or glance at questions. Scanning or glancing can cause you to miss important key words. Read each word of the question.
- Before reading the answers, decide what the answer is in your own words. Then read all 4 answers to the question. Select the 1 best answer.
- Do not read into a question. Take the question as it is asked. Do not add your own thoughts and ideas to the question. Do not assume or suppose "what if." Just respond to the information provided.
- Trust your common sense. If unsure of an answer, select your first choice. Do not change your answer unless you are absolutely sure of the correct answer. Your first reaction is usually correct.
- Look for key words in every question. Sometimes key words are in italics, highlighted, or underlined. Common key words are *always, never, first, except, best, not, correct, incorrect, true,* and *false*.
- Know which words can make a statement correct (e.g., *may, can, usually, most, at least, sometimes*). The word "except" can make a question a false statement.
- Be careful of answers with these key words or phrases: *always, never, every, only, all, none, at all times,* or *at no time*. These words and phrases do not allow for exceptions. In nursing, exceptions are generally present. However, sometimes answers containing these words are correct. For example, which of the following is correct and which are incorrect?
  a. Always use a turning sheet.
  b. Never shake linens.
  c. Soap is used for all baths.
  d. The call light must always be attached to the bed.
  The correct answer is b. Incorrect answers are a, c, and d.
- Omit answers that are obviously wrong. Then choose the best of the remaining answers.
- Go back to the questions you skipped. Answer all questions by eliminating or narrowing your choices. Always mark an answer even if you are not sure.
- Review the test a second time for completeness and accuracy before turning it in.
- Make sure you have answered each question. Also check that you have given only 1 answer for each question.
- Remember, the test is not designed to trick or confuse you. The written competency evaluation tests what you know, not what you do not know. You know more than you are asked.

On-Line Testing

The test may be given by computer at the test site. Ask your instructor what computer skills you will need. You usually do not need keyboard or typing skills. You will use a computer mouse to select answers. Also, you will usually receive instruction before the test begins. This will let you practice using the computer before starting the test.

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Textbook Chapters Review

Note: This review covers selected chapters only based on Competency Evaluation requirements.

CHAPTER 1 INTRODUCTION TO HEALTH CARE AGENCIES

Health Care Agency Purposes
- Health promotion
- Disease prevention
- Detection and treatment of disease
- Rehabilitation and restorative care

Hospitals
- Hospitals provide emergency care, surgery, nursing care, x-ray procedures and treatments, and laboratory testing.
- Hospitals also provide respiratory, physical, occupational, speech, and other therapies.
- Persons cared for in hospitals are called *patients*. Hospital patients have acute, chronic, or terminal illnesses.

Rehabilitation and Sub-Acute Care Agencies
- Provide medical and nursing care for people who do not need hospital care but are too sick to go home.

Long-Term Care Centers
- Provide care for people who do not need hospital care but cannot care for themselves at home.
- Provide medical and nursing, dietary, recreational, rehabilitative, and social services. Housekeeping and laundry services are also provided.
- Residents are older or disabled.
- Skilled nursing facilities provide more complex care.
- Some residents are recovering from illness, injury, or surgery.
- Some residents return home when well enough. Some residents need nursing care until death.

Assisted Living Facilities
- Provide housing, personal care, support services, health care, and social activities in a home-like setting for persons needing help with daily activities.

Other Health Agencies
- Other health agencies include mental health centers, home care, hospice, and health care systems.

The Health Team
- Involves many health care workers whose skills and knowledge focus on total care.
- Works together to provide coordinated care to meet each person's needs.
- Follows the direction of the registered nurse (RN) leading the team.

The Nursing Team
- Provides quality care to people.
- Care is coordinated by an RN.

Nursing Assistants
- Report to the nurse supervising their work.
- Perform delegated tasks under the supervision of a licensed nurse.
- Have passed a nursing assistant training and competency evaluation program.

Meeting Standards

Survey Process
- Surveys are done to see if agencies meet standards for licensure, certification, and accreditation.
- A license is issued by the state. A center must have a license to operate and provide care.
- Certification is required to receive Medicare and Medicaid funds.
- Accreditation is voluntary. It signals quality and excellence.

Your Role
- Provide quality care.
- Protect the person's rights.
- Provide for the person's and your own safety.
- Help keep the center clean and safe.
- Conduct yourself in a professional manner.
- Have good work ethics.
- Follow agency policies and procedures.
- Answer questions honestly and completely.

CHAPTER 1 REVIEW QUESTIONS

Circle the BEST answer.

1. Nursing assistants do all of the following *except*
   a. Provide quality care
   b. Follow agency policies and procedures
   c. Conduct themselves in an unprofessional manner
   d. Help keep the agency clean and safe
2. Nursing assistants report to
   a. Other nursing assistants
   b. Licensed nurses
   c. The administrator
   d. The medical director
3. All the following are true about the health team *except*
   a. Involves many health care workers
   b. Follows the direction of the physician
   c. Works together to provide coordinated care
   d. Follows the direction of the RN

Answers to these questions are on p. 516.

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CHAPTER 2 THE PERSON'S RIGHTS

- Centers must protect and promote residents' rights. Residents must be free to exercise their rights without interference. If residents are not able to exercise their rights, legal representatives do so for them.

The Omnibus Budget Reconciliation Act of 1987 (OBRA)

- OBRA is a federal law.
- OBRA requires that nursing centers provide care in a manner and in a setting that maintains or improves each person's quality of life, health, and safety.
- OBRA requires nursing assistant training and competency evaluation.
- Resident rights are a major part of OBRA.

Information

- The right to information includes:
  - Access to all records about the person, including medical records, incident reports, contracts, and financial records
  - Information about the person's health condition
  - Information about the person's doctor, including name, specialty, and contact information
- Report any request for information to the nurse.

Refusing Treatment

- The person has the right to refuse treatment.
- A person who does not give consent or refuses treatment cannot be treated against his or her wishes.
- The center must find out what the person is refusing and why.
- Advance directives are part of the right to refuse treatment.
- Report any treatment refusal to the nurse.

Privacy and Confidentiality

- Residents have the right to:
  - Personal privacy. The person's body is not exposed unnecessarily. Only staff directly involved in care and treatments are present. The person must give consent for others to be present. A person has the right to use the bathroom in private. Privacy is maintained for all personal care measures.
  - Visit with others in private—in areas where others cannot see or hear them. This includes phone calls.
  - Send and receive mail without others interfering. No one can open mail the person sends or receives without his or her consent. Unopened mail is given to the person within 24 hours of delivery to the center.
- Information about the person's care, treatment, and condition is kept confidential. So are medical and financial records. Consent is needed to release information to other agencies or persons.

Personal Choice

- Residents have the right to make their own choices. They can:
  - Choose their own doctors.
  - Take part in planning and deciding their care and treatment.
  - Choose activities, schedules, and care based on their preferences.
  - Choose when to get up and go to bed, what to wear, how to spend their time, and what to eat.
  - Choose friends and visitors inside and outside the center.

Grievances

- Residents have the right to voice concerns, questions, and complaints about treatment or care.
- The center must try to correct the matter promptly.
- No one can punish the person in any way for voicing the grievance.

Work

- The person is not required to work or perform services for the center.
- The person has the right to work or perform services if he or she wants to.
- Residents volunteer or are paid for their services.

Taking Part in Resident Groups

- The person has the right to:
  - Form and take part in resident and family groups.
  - Take part in social, cultural, religious, and community events. The resident has the right to help in getting to and from events of their choice.

Personal Items

- The resident has the right to:
  - Keep and use personal items, such as clothing and some furnishings.
  - Have his or her property treated with care and respect. Items are labeled with the person's name.
- Protect yourself and the center from being accused of stealing a person's property. Do not go through a person's closet, drawers, purse, or other space without the person's knowledge and consent. If you have to inspect closets and drawers, follow center policy for reporting and recording the inspection.

Freedom From Abuse, Mistreatment, and Neglect

- Residents have the right to be free from:
  - Verbal, sexual, physical, or mental abuse
  - Involuntary seclusion—separating a person from others against his or her will, confining a person to a certain area, or keeping the person away from his or her room without consent
- No one can abuse, neglect, or mistreat a resident. This includes center staff, volunteers, staff from other agencies or groups, other residents, family members, friends, visitors, and legal representatives.
- Nursing centers must investigate suspected or reported cases of abuse.

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Freedom From Restraint

- Residents have the right to not have body movements restricted by restraints or drugs.
- Restraints are used only if required to treat the person's medical symptoms or if necessary to protect the person or others from harm. If a restraint is required, a doctor's order is needed.

Quality of Life

- Residents must be cared for in a manner that promotes dignity and self-esteem. Physical, psychological, and mental well-being must be promoted. Review Box 2-3, OBRA-Required Actions to Promote Dignity and Privacy, in the Textbook.
- Centers must provide activity programs that promote physical, intellectual, social, spiritual, and emotional well-being.
- Residents have the right to a safe, clean, comfortable, and home-like setting. The center must provide a setting and services that meet the person's needs and preferences. The setting and staff must promote the person's independence, dignity, and well-being.

Ombudsman Program

- The Older Americans Act requires a long-term care ombudsman program in every state.
- Ombudsmen are employed by a state agency. They are not nursing center employees. Some are volunteers.
- Ombudsmen protect the health, safety, welfare, and rights of residents. They also may investigate and resolve complaints, provide support to resident and family groups, and help the center manage difficult problems.
- OBRA requires that nursing centers post the names, addresses, and phone numbers of local and state ombudsmen where the residents can easily see it.
- Because a family member or resident may share a concern with you, you must know the state and center policies and procedures for contacting an ombudsman.

CHAPTER 2 REVIEW QUESTIONS

Circle the BEST answer.

1. Residents have all the following rights *except*
   a. Refusing a treatment
   b. Making a telephone call in private
   c. Choosing activities to attend
   d. Being punished for voicing a grievance
2. OBRA does not require nursing assistant training and competency evaluation.
   a. True
   b. False
3. The person has a right to take part in planning and deciding their care and treatment.
   a. True
   b. False
4. The person is required to work for the center.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 3 THE NURSING ASSISTANT

Federal and State Laws

Nurse Practice Acts

- Each state has a nurse practice act. It regulates nursing practice in that state.

Nursing Assistants

- A state's nurse practice act is used to decide what nursing assistants can do. Some nurse practice acts also regulate nursing assistant roles, functions, education, and certification requirements. Some states have separate laws for nursing assistants.
- Nursing assistants must be able to function with skill and safety. They can have their certification, license, or registration denied, revoked, or suspended.

The Omnibus Budget Reconciliation Act of 1987 (OBRA)

- The purpose of OBRA, a federal law, is to improve the quality of life of nursing center residents.
- OBRA sets minimum training and competency evaluation requirements for nursing assistants. Each state must have a nursing assistant training and competency evaluation program (NATCEP). A nursing assistant must successfully complete a NATCEP to work in a nursing center, hospital, long-term care unit, or home care agency receiving Medicare funds.
- OBRA requires at least 75 hours of instruction. Some states have more hours. At least 16 hours of supervised training in a laboratory or clinical setting are required.
  - The competency evaluation has a written test and a skills test.
  - The written test has multiple-choice questions.
  - The number of questions varies from state to state.
  - The skills test involves performing certain skills learned in your training program.
- OBRA requires a nursing assistant registry in each state. It is an official record that lists persons who have successfully completed the NATCEP.
- Re-training and a new competency evaluation program are required for nursing assistants who have not worked for 24 months. To work in another state, nursing assistants must meet that state's NATCEP.
- Each state's NATCEP must meet OBRA requirements.

Roles and Responsibilities

- Nurse practice acts, OBRA, state laws, and legal and advisory opinions direct what nursing assistants can do.
- The range of functions for nursing assistants varies among states and agencies. Before performing a nursing task make sure that:
  - The state allows nursing assistants to do that task.
  - It is in the job description.
  - You have the necessary education and training.
  - A nurse is available to answer questions and to supervise the task.
- Rules for nursing assistants to follow are in Box 3-2 in the Textbook.
  - You are an assistant to the nurse.
  - A nurse assigns and supervises your work.
  - You report observations about the person's physical and mental status to the nurse. Report changes in the person's condition or behavior at once.

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- The nurse decides what should be done for a person. You do not make these decisions.
- Review directions and the care plan with the nurse before going to the person.
- Perform only those nursing tasks that you are trained to do.
- Ask a nurse to supervise you if you are not comfortable performing a nursing task.
- Perform only the nursing tasks that your state and job description allow.

- State laws and rules limit nursing assistant functions. State laws differ. Know what you can do in the state in which you are working.
- Role limits for nursing assistants are in Box 3-3 in the Textbook.
  - Never give drugs.
  - Never insert tubes or objects into body openings. Do not remove tubes from the body.
  - Never take oral or telephone orders from doctors.
  - Never perform procedures that require sterile technique.
  - Never tell the person or family the person's diagnosis or treatment plans.
  - Never diagnose or prescribe treatments or drugs for anyone.
  - Never supervise others, including other nursing assistants.
  - Never ignore an order or request to do something. This includes nursing tasks that you can do, those you cannot do, and those that are beyond your legal limits.

Nursing Assistant Standards

- OBRA defines the basic range of functions for nursing assistants.
- All NATCEPs include those functions. Some states allow other functions.
- Review Box 3-4, Nursing Assistant Standards, in the Textbook.

Job Description and Job Titles

- Always obtain a written job description when you apply for a job. Do not take a job that requires you to:
  - Act beyond the legal limits of your role.
  - Function beyond your training limits.
  - Perform acts that are against your morals or religion.
- For job purposes, agencies often use other titles for nursing assistants who have completed a NATCEP and are on a state registry. Your job title depends on the setting and your roles and functions in the agency.

CHAPTER 3 REVIEW QUESTIONS

Circle the BEST answer.

1. Nursing assistants perform nursing tasks delegated to them by a registered nurse (RN) or licensed practical nurse/licensed vocational nurse (LPN/LVN).
   a. True
   b. False
2. A resident asks you about his or her medical condition. You
   a. Tell the nurse about the resident's request
   b. Tell the resident what is in his or her medical record
   c. Ignore the question
   d. Tell another nursing assistant about the resident's request
3. You answer the telephone. The doctor starts to give you an order. You
   a. Take the order from the doctor
   b. Politely give your name and title, ask the doctor to wait for the nurse, and promptly find the nurse
   c. Politely ask the doctor to call back later
   d. Ask the doctor if the nurse may call him or her back
4. When should you refuse a task?
   a. The task is not in your job description.
   b. The task is within the legal limits of your role.
   c. The directions for the task are clear.
   d. A nurse is available for questions and supervision.

Answers to these questions are on p. 516.

CHAPTER 4 DELEGATION

Who Can Delegate

- Registered nurses (RNs) can delegate tasks to nursing assistants. In some states, licensed practical nurses/licensed vocational nurses (LPNs/LVNs) can delegate tasks to nursing assistants.
- The delegating nurse is legally responsible for his or her actions and the actions of others who performed the delegated tasks.
- Nursing assistants cannot delegate. You cannot delegate any task to other nursing assistants or to any other worker.

The Delegation Process

- Delegation decisions must protect the person's health and safety.
- If you perform a task that places the person at risk, you may face serious legal problems.
- Step 1—Assessment and Planning. The nurse assesses the person's needs and then decides if it is safe to delegate the task.
- Step 2—Communication. The nurse must give clear and complete directions about the task and you must understand the directions to give safe care. After the task, you report and record the care that was given.
- Step 3—Surveillance and Supervision. The nurse observes the care you give and makes sure you complete the task correctly. The nurse must follow up on problems or concerns if you did not perform the task according to expectations or there is a change in the person's condition.
- Step 4—Evaluation and Feedback. The nurse decides if the delegation was successful by observing if the task was done correctly and the outcome and the person's response were as expected. The nurse should provide feedback to the nursing assistant about what was done correctly and what errors should be corrected.

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The Five Rights of Delegation

- *The right task.* Can the task be delegated and is the nurse allowed to delegate the task? Is the task in your job description?
- *The right circumstances.* What are the person's physical, mental, emotional, and spiritual needs at the time?
- *The right person.* Do you have the training and experience to perform the task safely?
- *The right directions and communication.* The nurse gives clear directions and instructions. The nurse allows questions and helps you set priorities.
- *The right supervision.* The nurse guides, directs, and evaluates the care you give. The nurse demonstrates tasks as needed and is available for questions. The nurse assesses how the task affected the person and how well you performed the task and tells you what you did well and how to improve your work.

Your Role in Delegation

- When you agree to perform a delegated task on a person, you must protect the person from harm. You are responsible for your own actions. You must complete the task safely. You must ask for help if you have questions or are unsure. Report to the nurse what you did and the observations you made.
- You should refuse to perform a task when:
  - The task is beyond the legal limits of your role.
  - The task is not in your job description.
  - You were not trained to perform the task.
  - The task could harm the person.
  - The person's condition has changed.
  - You do not know how to use the supplies or equipment.
  - Directions are not ethical or legal.
  - Directions are against agency policies.
  - Directions are unclear or incomplete.
  - A nurse is not available for supervision.
- Never ignore an order or refuse a task because you do not like it or do not want to do it. Tell the nurse about your concerns.

CHAPTER 4 REVIEW QUESTIONS

Circle the BEST answer.

1. A nurse delegates a task that you did not learn in your training. The task is in your job description. What is your appropriate response to the nurse?
   a. "I cannot do that task."
   b. "I did not learn that task in my training. Can you show me how to do it?"
   c. "I will ask the other nursing assistant to watch me do the task."
   d. "I will ask the other nursing assistant to do the task for me."
2. You are busy with a new resident. It is time for another resident's bath. You may delegate the bath to another nursing assistant.
   a. True
   b. False
3. You may perform a task that is not in your job description as long as a nurse has delegated the task.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 5 ETHICS AND LAWS

Ethical Aspects

- Ethics is the knowledge of what is right conduct and wrong conduct. It also deals with choices or judgments about what should or should not be done. An ethical person does not cause a person harm.
- Ethical behavior involves not being prejudiced or biased. To be prejudiced or biased means to make judgments and have views before knowing the facts. You should not judge a person by your values and standards. Also, do not avoid persons whose standards and values differ from your own.
- Ethical problems involve making choices. You must decide what is the right thing to do.

Codes of Ethics

- Professional groups have codes of ethics. A **code of ethics** has rules, or standards of conduct, for group members to follow.
- Rules of conduct for nursing assistants can be found in Box 5-1 in the Textbook.

Boundaries

- **Professional boundaries** separate helpful behaviors from behaviors that are not helpful.
- A **boundary crossing** is a brief act of over-involvement with the person in order to meet the person's needs, such as giving a crying patient a hug.
- A **boundary violation** is an act or behavior that meets your needs, not the person's. The act or behavior is unethical. Boundary violations include abuse, keeping secrets with a person, or giving a lot of personal information about yourself to another.
- **Professional sexual misconduct** is an act, behavior, or comment that is sexual in nature. It is sexual misconduct even if the person consents or makes the first move.
- To maintain professional boundaries, review Box 5-2, Rules for Maintaining Professional Boundaries. Be alert to **boundary signs** (acts, behaviors, or thoughts that warn of a boundary crossing or violation).

Legal Aspects

- Ethics is about what you *should or should not do.* Laws tell you what you *can and cannot do.*
- **Negligence** is an unintentional wrong. The negligent person did not act in a reasonable and careful manner. As a result, the person or person's property was harmed. The person causing harm did not mean to cause harm.
- **Malpractice** is negligence by a professional person.

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- You are legally responsible (liable) for your own actions. The nurse is liable as your supervisor.
- **Defamation** is injuring a person's name and reputation by making false statements to a third person. **Libel** is making false statements in print, writing (including e-mails and texts), or through pictures or drawings. **Slander** is making false statements orally. Never make false statements about a patient, resident, family member, co-worker, or any other person.
- **False imprisonment** is the unlawful restraint or restriction of a person's freedom of movement. It involves threatening to restrain a person, restraining a person, and preventing a person from leaving the agency.
- **Invasion of privacy** is violating a person's right not to have his or her name, photo, or private affairs exposed or made public without giving consent. Review Box 5-4, Protecting the Right to Privacy, in the Textbook.
- The Health Insurance Portability and Accountability Act (HIPAA) of 1996 protects the privacy and security of a person's health information. **Protected health information** refers to identifying information and information about the person's health care that is maintained or sent in any form (paper, electronic, oral). Direct any questions about the person or the person's care to the nurse.
- **Fraud** is saying or doing something to trick, fool, or deceive a person. The act is fraud if it does or could cause harm to a person or the person's property.
- **Assault** is intentionally attempting or threatening to touch a person's body without the person's consent. The person fears bodily harm.
- **Battery** is touching a person's body without his or her consent. Protect yourself from being accused of assault and battery. Explain to the person what you are going to do and get the person's consent.

Wrongful Use of Electronic Communication

- Electronic communications include e-mail, text messages, faxes, websites, video sites, and social media sites. Video and social media sites include Facebook, Twitter, LinkedIn, YouTube, Instagram, Pinterest, Tumblr, blogs and comments to blog postings, chat rooms, bulletin boards, and so on.
- Wrongful use of electronic communications can result in job loss and loss of your certification (license, registration) for:
  - Defamation
  - Invasion of privacy
  - HIPAA violations
  - Violating the right to confidentiality
  - Patient or resident abuse
  - Unprofessional or unethical conduct

Informed Consent

- A person has the right to decide what will be done to his or her body and who can touch his or her body. Consent is informed when the person clearly understands all aspects of treatment.
- Persons who cannot give consent are persons who are under the legal age or are mentally incompetent. Unconscious, sedated, or confused persons cannot give consent. Informed consent is given by a responsible party—wife, husband, daughter, son, or legal representative.
- You are never responsible for obtaining written consent.

Reporting Abuse

- **Abuse** is
  - The willful infliction of injury, unreasonable confinement, intimidation, or punishment that results in physical harm, pain, or mental anguish. Intimidation means to make afraid with threats of force or violence.
  - Depriving the person (or the person's caregiver) of the goods or services needed to attain or maintain well-being.
- Abuse also includes involuntary seclusion.
- **Vulnerable adults** are persons 18 years old or older who have disabilities or conditions that make them at risk to be wounded, attacked, or damaged. They have problems caring for or protecting themselves due to:
  - A mental, emotional, physical, or developmental disability
  - Brain damage
  - Changes from aging
- All residents are vulnerable. Older persons and children are at risk for abuse.
- **Elder abuse** is any knowing, intentional, or negligent act by a caregiver or another person to an older adult. It may include physical abuse, neglect, verbal abuse, involuntary seclusion, financial exploitation or misappropriation, emotional or mental abuse, sexual abuse, or abandonment. Review Box 5-7, Signs of Elder Abuse, in the Textbook.
- Federal and state laws require the reporting of elder abuse.
- If you suspect a person is being abused, report your observations to the nurse.

CHAPTER 5 REVIEW QUESTIONS

Circle the BEST answer.

1. A resident offers you a gift certificate for being kind to her. You should
   a. Say "thank you" and accept the gift
   b. Accept the gift and give it to charity
   c. Thank the resident for thinking of you and then explain it is against policy for you to accept the gift
   d. Accept the gift and give it to your daughter
2. To protect a person's privacy, you should do the following *except*
   a. Keep all information about the person confidential
   b. Discuss the person's treatment or diagnosis with the nurse supervising your work
   c. Open the person's mail
   d. Allow the person to visit with others in private

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3. What should you do if you suspect an older person is being abused?
   a. Report the situation to the health department.
   b. Notify the nurse and discuss the observations with him or her.
   c. Notify the doctor about the suspected abuse.
   d. Ask the family why they are abusing the person.
4. A resident needs help going to the bathroom. You do not answer her call light promptly. She gets up without help, falls, and breaks a leg. This is an example of
   a. Negligence
   b. Defamation
   c. False imprisonment
   d. Slander
5. Examples of defamation include all the following *except*
   a. Implying or suggesting that a person uses drugs
   b. Saying that a person is insane or mentally ill
   c. Implying that a person steals money from staff
   d. Burning a resident with water that is too hot
6. Which statement about ethics is *false?*
   a. An ethical person does not judge others by his or her values and standards.
   b. An ethical person avoids persons whose standards and values differ from his or her own.
   c. An ethical person is not prejudiced or biased.
   d. An ethical person does not cause harm to another person.
7. Examples of false imprisonment include all of the following *except*
   a. Threatening to restrain a resident
   b. Restraining a resident without a doctor's order
   c. Treating the resident with respect
   d. Preventing a resident from leaving the agency
8. To protect yourself from being accused of assault and battery, you should explain to the resident what you plan to do before touching him or her and get consent.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 6 STUDENT AND WORK ETHICS

- **Professionalism** involves following laws, being ethical, having good work ethics, and having the skills to do your work.
- **Work ethics** deals with behavior in the workplace. Work ethics also applies to students in nursing assistant training and competency evaluation programs (NATCEPs).
- To be a successful student, practice good work ethics in the classroom and clinical setting and in your relationships with instructors and fellow students.

Health, Hygiene, and Appearance

- To give safe and effective care, you must be physically and mentally healthy. You need a balanced diet, sleep and rest, good body mechanics, and exercise on a regular basis. Smoking, drugs, and alcohol can affect performance and safety.
- Personal hygiene needs careful attention. Bathe daily, use deodorant or antiperspirant, and brush your teeth often. Shampoo often. Keep fingernails clean, short, and neatly shaped.
- Review Box 6-2, Practices for a Professional Appearance, in the Textbook.

Teamwork

- Practice good work ethics—work when scheduled, be cheerful and friendly, perform delegated tasks, be kind to others, and be available to help others.
- Be ready to work when your shift starts. Arrive on your nursing unit a few minutes early. Stay the entire shift. When it is time to leave, report off duty to the nurse.
- A good attitude is needed. Review Box 6-1, Qualities and Traits for Good Work Ethics, in the Textbook.
- Gossiping is unprofessional and hurtful. To avoid being a part of gossip:
  - Remove yourself from a group or setting where people are gossiping.
  - Do not make or repeat any comment that can hurt another person or the agency.
  - Do not make or repeat any comment that you do not know is true.
  - Do not talk about residents, family members, patients, visitors, co-workers, or the agency at home or in social settings.
- **Confidentiality** means trusting others with personal and private information. The person's information is shared only among staff involved in his or her care. Agency, family, and co-worker information also is confidential.
- Your speech and language must be professional.
  - Do not swear or use foul, vulgar, or abusive language.
  - Do not use slang.
  - Speak softly, gently, and clearly.
  - Do not shout or yell.
  - Do not fight or argue with a person, family member, visitor, or co-worker.
- A courtesy is a polite, considerate, or helpful comment or act.
  - Address others by Miss, Mrs., Ms., Mr., or Doctor. Use a first name only if the person asks you to do so.
  - Say "please" and "thank you." Say "I'm sorry" when you make a mistake or hurt someone.
  - Let residents, families, and visitors enter elevators first.
  - Be thoughtful—compliment others, give praise.
  - Wish the person and family well when they leave the center.
  - Hold doors open for others.
  - Help others willingly when asked.
  - Do not take credit for another person's deeds. Give the person credit for the action.
- Keep personal matters out of the workplace.
  - Make personal phone calls during meals and breaks.
  - Do not let family and friends visit you on the unit.
  - Do not use the agency's computers and other equipment for personal use.

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- Do not take agency supplies for personal use.
  - Do not discuss personal problems at work.
  - Control your emotions.
  - Do not borrow money from or lend money to co-workers.
  - Do not sell things or engage in fund-raising at work.
  - Do not have wireless phones or personal pagers on while at work.
  - Do not text message.
- Leave for and return from breaks and meals on time. Tell the nurse when you leave and return to the unit.
- Protect yourself and others from harm.
  - Understand the roles, functions, and responsibilities in your job description.
  - Follow agency rules, policies, and procedures in the employee handbook or policy and procedure manual.
  - Know what is right and wrong conduct and what you can and cannot do.
  - Follow the nurse's directions and instructions and question unclear directions and things you do not understand. Ask for any training you might need.
  - Help others willingly when asked.
  - Report accurately. This includes measurements, observations, the care given, the person's complaints, and any errors.
  - Accept responsibility for your actions. Admit when you are wrong or make mistakes. Do not blame others. Do not make excuses for your actions. Learn what you did wrong and why. Always try to learn from your mistakes.
  - Handle the person's property carefully and prevent damage.
  - Always follow safety measures.
- Planning your work involves setting priorities. Decide:
  - Which person has the greatest or most life-threatening needs.
  - What task the nurse or person needs done first.
  - What tasks need to be done at a certain time.
  - What tasks need to be done when your shift starts.
  - What tasks need to be done at the end of your shift.
  - How much time it takes to complete a task.
  - How much help you need to complete a task.
  - Who can help you and when.
- Priorities change as the person's needs change.

Managing Stress

- These guidelines can help you reduce or cope with stress.
  - Exercise regularly.
  - Get enough sleep or rest.
  - Eat healthy.
  - Plan personal and quiet time for yourself.
  - Use common sense about what you can do.
  - Do 1 thing at a time.
  - Do not judge yourself harshly.
  - Give yourself praise.
  - Have a sense of humor.
  - Talk to the nurse if your work or a person is causing too much stress.
- Conflict in the workplace can cause stress and care can suffer. Resolving conflict involves defining and collecting information about the problem, identifying possible solutions, carrying out the best solution, and evaluating the results.
- Communication and good work ethics help prevent and resolve conflicts.
- **Burnout** is a job stress resulting in physical or mental exhaustion and doubts about your abilities or the value of your work. Managing stress can prevent burnout.

Harassment

- **Harassment** means to trouble, torment, offend, or worry a person by one's behavior or comments.
- Harassment can be sexual or it can involve age, race, ethnic background, religion, or disability.
- You must respect others. Do not offend others by your gestures, remarks, or use of touch. Do not offend others with jokes, photos, or other pictures.

CHAPTER 6 REVIEW QUESTIONS

Circle the BEST answer.

1. You believe you have good work ethics. This means you do the following *except*
   a. Work when scheduled
   b. Act cheerful and friendly
   c. Refuse to help others
   d. Perform tasks assigned by the nurse
2. A nursing assistant is gossiping about a co-worker. You should
   a. Stay with the group and listen to what is being said
   b. Repeat the comment to your family
   c. Remove yourself from the group where gossip is occurring
   d. Repeat the comment to another co-worker
3. You want to maintain confidentiality about others. You do the following *except*
   a. Share information about a resident with a nurse who is on another unit
   b. Avoid talking about a resident in the elevator, hallway, or dining area
   c. Avoid talking about co-workers and residents when others are present
   d. Avoid eavesdropping
4. When you are at work, you should do which of the following?
   a. Swear and use foul language.
   b. Use slang.
   c. Argue with a visitor.
   d. Speak clearly and softly.
5. To give safe and effective care, you do all of the following *except*
   a. Eat a balanced diet
   b. Get enough sleep and rest
   c. Exercise on a regular basis
   d. Drink too much alcohol
6. While at work, you should do all of the following *except*
   a. Be courteous to others
   b. Make personal phone calls
   c. Admit when you are wrong or make mistakes
   d. Respect others

Answers to these questions are on p. 516.

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CHAPTER 7 COMMUNICATING WITH THE HEALTH TEAM

Communication

- For good communication:
  - Use words that mean the same thing to you and the receiver of the message.
  - Use familiar words.
  - Be brief and concise.
  - Give information in a logical and orderly manner.
  - Give facts and be specific.

The Medical Record

- The **medical record, chart, or clinical record** is the permanent, legal account of the person's condition and response to treatment and care. Medical records can be written or stored electronically. The electronic health record (EHR) or electronic medical record (EMR) is the electronic version of the person's medical record. It is a permanent legal document.
- The medical record is a way for the health team to share information about the person. Agencies have policies about medical records and who can see them. Some agencies allow nursing assistants to read and/or record observations in medical records. Follow your agency's policies.
- Medical records can include the person's admission record, health history, graphic and flow sheets for recording measurements and observations, and progress reports.
- The Kardex or care summary is a summary of the person's medical record. The summary can be in a type of card file or computers organize the record in an electronic summary.

Reporting and Recording

- The health team communicates by reporting and recording.

Reporting

- You report care and observations to the nurse. Report to the nurse:
  - Whenever there is a change from normal or a change in the person's condition. Report these changes at once.
  - When the nurse asks you to do so.
  - When you leave the unit for meals, breaks, or other reasons.
  - Before the end-of-shift report.
- Follow the rules of reporting.
  - Be prompt, thorough, and accurate.
  - Give the person's name and room and bed numbers.
  - Give the time your observations were made or the care was given.
  - Report only what you observed or did yourself.
  - Report care measures that you expect the person to need.
  - Report expected changes in the person's condition.
  - Give reports as often as the person's condition requires or when the nurse asks you to.
  - Report any changes from normal or changes in the person's condition at once.
  - Use your written notes to give a specific, concise, and clear report.

Recording

- When recording or documenting, communicate clearly and thoroughly what you observed, what you did, and the person's response.
- The general rules for recording are:
  - Always use ink. Use the color required by the center.
  - Include the date and time for every recording.
  - Make sure writing is readable and neat.
  - Use only agency-approved abbreviations.
  - Use correct spelling, grammar, and punctuation.
  - Do not use ditto marks.
  - Never erase or use correction fluid. Follow agency procedure for correcting errors.
  - Sign all entries with your name and title as required by agency policy.
  - Do not skip lines.
  - Make sure each form has the person's name and other identifying information.
  - Record only what you observed and did yourself.
  - Never chart a procedure, treatment, or care measure until after it is completed.
  - Be accurate, concise, and factual. Do not record judgments or interpretations.
  - Record in a logical and sequential manner.
  - Be descriptive. Avoid terms with more than one meaning.
  - Use the person's exact words whenever possible. Use quotation marks to show that the statement is a direct quote.
  - Chart any changes from normal or changes in the person's condition. Also chart that you informed the nurse (include the nurse's name), what you told the nurse, and the time you made the report.
  - Do not omit information.
  - Record safety measures. Example: Reminding a person not to get out of bed.
- Review the 24-hour clock, Figure 7-6, and Box 7-1 in the Textbook.
- Review Box 7-3 for recording rules on paper and on computer.

Computers and Other Electronic Devices

- Computers contain vast amounts of information about a person. Therefore the right to privacy must be protected. If allowed access, you must follow the agency's policies.
- Review Box 7-4, Computers and Other Electronic Devices, in the Textbook.

Phone Communications

- Guidelines for answering phones:
  - Answer the call after the first ring if possible.
  - Do not answer the phone in a rushed or hasty manner.

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- Give a courteous greeting. Identify the nursing unit and your name and title.
- When taking a message, write down the caller's name, phone number, date and time, and message.
- Repeat the message and phone number back to the caller.
- Ask the caller to "Please hold" if necessary.
- Do not lay the phone down or cover the receiver with your hand when not speaking to the caller. The caller may hear confidential information.
- Return to a caller on hold within 30 seconds.
- Do not give confidential information to any caller.
- Transfer a call if appropriate. Tell the caller you are going to transfer the call. Give the name and phone number in case the call gets disconnected or the line is busy.
- End the conversation politely.
- Give the message to the appropriate person.

Medical Terminology and Abbreviations

- Medical terminology and abbreviations are used in health care. Someone may use a word or phrase that you do not understand. If so, ask the nurse to explain its meaning.
- Review Box 7-6, Medical Terminology, and Box 7-7, Common Health Care Terms and Phrases, in the Textbook.
- Use only the abbreviations accepted by the center. If you are not sure that an abbreviation is acceptable, write the term out in full. See the inside back cover of the Textbook for common abbreviations.

CHAPTER 7 REVIEW QUESTIONS

Circle the BEST answer.

1. For good communication, you should do the following *except*
   a. Use words with more than 1 meaning
   b. Use words familiar to the person or family
   c. Give facts in a brief and concise manner
   d. Give information in a logical and orderly manner
2. When you record in a person's chart, you do the following *except*
   a. Record what you observed and did
   b. Record the person's response to the treatment or procedure
   c. Use abbreviations that are not on the accepted list for the center
   d. Record the time the observation was made or the treatment performed
3. When reporting care and observations to the nurse, you do the following *except*
   a. Give the person's name and room and bed numbers
   b. Report only what you observed or did yourself
   c. Report any changes from normal or changes in the person's condition at once
   d. Report any changes from normal or changes in the person's condition at the end of the shift

Answers to these questions are on p. 516.

CHAPTER 8 ASSISTING WITH THE NURSING PROCESS

- The **nursing process** is the method nurses use to plan and deliver nursing care. It has 5 steps: assessment, nursing diagnosis, planning, implementation, and evaluation.
- **Assessment** involves collecting information about the person. A health history is taken. A registered nurse (RN) assesses the person's body systems and mental systems. Although the nursing assistant does not assess, you play a key role in assessment. You make many observations as you give care and talk to the person.
- **Observation** is using the senses of sight, hearing, touch, and smell to collect information.
- Basic observations are outlined in Box 8-2 in the Textbook. Observations you need to report to the nurse at once are (see Box 8-1 in the Textbook):
  - A change in the person's ability to respond
  - A change in the person's mobility
  - Complaints of sudden, severe pain
  - A sore or reddened area on the person's skin
  - Complaints of a sudden change in vision
  - Complaints of pain or difficulty breathing
  - Abnormal respirations
  - Complaints of or signs of difficulty swallowing
  - Vomiting
  - Bleeding
  - Vital signs outside their normal ranges
- **Objective data (signs)** are seen, heard, felt, or smelled by an observer. For example, you can feel a pulse.
- **Subjective data (symptoms)** are things a person tells you about that you cannot observe through your senses. For example, you cannot see the person's nausea.
- The nurse uses assessment data to form a **nursing diagnosis,** or a health problem that can be treated by nursing measures.
- The nurse will then conduct **planning** to set priorities and goals for the person's care.
- **Nursing interventions** or **implementations** are the actions taken by the nursing team to help the person reach a goal.
- The nursing diagnoses, goals, and actions for each goal are recorded in the **nursing care plan**. The care plan is a communication tool. Each agency has a care plan tool.
- The RN may conduct a care conference with the health care team to share information and ideas about the person's care.
- The nurse will **evaluate** the planning and implementation based on the person's progress toward the stated goal.
- The nurse may delegate tasks to the nursing assistant via the assignment sheet during any step of the nursing process.

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CHAPTER 8 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement about observations is *false?*
   a. You make observations as you care for and talk with people.
   b. Observation uses the senses of smell, sight, touch, and hearing.
   c. A reddened area on the person's skin is reported to the nurse at once.
   d. You report observations to the doctor.
2. Objective data include all the following *except*
   a. The person has pain in his abdomen
   b. The person's pulse is 76
   c. The person's urine is dark amber
   d. The person's breath has an odor

Answers to these questions are on p. 516.

CHAPTER 9 UNDERSTANDING THE PERSON

Caring for the Person

- The whole person needs to be considered when you provide care—physical, social, psychological, and spiritual parts. These parts are woven together and cannot be separated.
- Follow these rules to address persons with dignity and respect.
  - Call persons by their titles—Mrs. Dennison, Mr. Smith, Miss Turner, or Dr. Gonzalez.
  - Do not call persons by their first names unless they ask you to.
  - Do not call persons by any other name unless they ask you to.
  - Do not call persons Grandma, Papa, Sweetheart, Honey, or other names.

Basic Needs

- **A need** is something necessary or desired for maintaining life and mental well-being.
- According to Maslow, basic needs must be met for a person to survive and function. Needs are arranged in order of importance, lower level to higher level.
  - *Physiological or physical needs*—are required for life. They are oxygen, food, water, elimination, rest, and shelter.
  - *Safety and security needs*—relate to feeling safe from harm, danger, and fear.
  - *Love and belonging needs*—relate to love, closeness, affection, and meaningful relationships with others. Family, friends, and the health team can meet love and belonging needs.
  - *Self-esteem needs*—relate to thinking well of oneself and to seeing oneself as useful and having value. People often lack self-esteem when ill, injured, older, or disabled.
  - *The need for self-actualization*—involves learning, understanding, and creating to the limit of a person's capacity. Rarely, if ever, is it totally met.

Culture and Religion

- **Culture** is the characteristics of a group of people. People come from many cultures, races, and nationalities. Family practices, food choices, hygiene habits, clothing styles, and language are part of their culture. The person's culture also influences health beliefs and practices.
- **Religion** relates to spiritual beliefs, needs, and practices. A person's religion influences health and illness practices. Many may want to pray and observe religious practices. Assist residents to attend religious services as needed. If a person wants to see a spiritual leader or adviser, tell the nurse. Provide privacy during the visit.
- A person may not follow all the beliefs and practices of his or her culture or religion. Some people do not practice a religion.
- Respect and accept the person's culture and religion. Learn about practices and beliefs different from your own. Do not judge a person by your standards.

Communicating With the Person

- For effective communication between you and the person, you must:
  - Follow the rules of communication in Chapter 7 in the Textbook.
  - Understand and respect the patient or resident as a person.
  - View the person as a physical, psychological, social, and spiritual human being.
  - Appreciate the person's problems and frustrations.
  - Respect the person's rights.
  - Respect the person's religion and culture.
  - Give the person time to understand the information that you give.
  - Repeat information as often as needed.
  - Ask questions to see if the person understood you.
  - Be patient. People with memory problems may ask the same question many times.
  - Include the person in conversations when others are present.

Verbal Communication

- When talking with a person, follow these rules.
  - Face the person. Look directly at the person.
  - Position yourself at the person's eye level.
  - Control the loudness and tone of your voice.
  - Speak clearly, slowly, and distinctly.
  - Do not use slang or vulgar words.
  - Repeat information as needed.
  - Ask 1 question at a time and wait for an answer.
  - Do not shout, whisper, or mumble.
  - Be kind, courteous, and friendly.
- Use written words if the person cannot speak or hear but can read. Keep written messages brief and concise. Use a black felt pen on white paper and print in large letters.
- Some persons cannot speak or read. Ask questions that have "yes" or "no" answers. A picture board may be helpful.

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Nonverbal Communication

- Messages are sent with gestures, facial expressions, posture, body movements, touch, and smell. Nonverbal messages more accurately reflect a person's feelings than words do. A person may say one thing but act another way. Watch the person's eyes, hand movements, gestures, posture, and other actions.
- Touch conveys comfort, caring, love, affection, interest, trust, concern, and reassurance. Touch should be gentle. Touch means different things to different people. Some people do not like to be touched. To use touch, follow the care plan. Maintain professional boundaries.
- People send messages through their **body language**—facial expressions, gestures, posture, hand and body movements, gait, eye contact, and appearance. Your body language should show interest, enthusiasm, caring, and respect for the person. Often you need to control your body language. Control reactions to odors from body fluids, secretions, or excretions.

Communication Methods

- *Listening* means to focus on verbal and nonverbal communication. You use sight, hearing, touch, and smell. To be a good listener:
  - Face the person.
  - Have good eye contact with the person.
  - Lean toward the person. Do not sit back with your arms crossed.
  - Respond to the person. Nod your head and ask questions.
  - Avoid communication barriers.
- *Paraphrasing* is re-stating the person's message in your own words.
- *Direct questions* focus on certain information. You ask the person something you need to know.
- *Open-ended questions* lead or invite the person to share thoughts, feelings, or ideas. The person chooses what to talk about.
- *Clarifying* lets you make sure that you understand the message. You can ask the person to repeat the message, say you do not understand, or re-state the message.
- *Focusing* deals with a certain topic. It is useful when a person wanders in thought.
- *Silence* is a very powerful way to communicate. Silence gives time to think, organize thoughts, choose words, make decisions, and gain control. Silence on your part shows caring and respect for the person's situation and feelings.

Communication Barriers

- *Language*. You and the person must use and understand the same language.
- *Cultural differences*. A person from another country may attach different meanings to verbal and nonverbal communication than what you intended.
- *Changing the subject*. Avoid changing the subject whenever possible.
- *Giving your opinions*. Opinions involve judging values, behaviors, or feelings. Let others express feelings and concerns without adding your opinion. Do not make judgments or jump to conclusions.
- *Talking a lot when others are silent*. Talking too much is usually because of nervousness and discomfort with silence.
- *Failure to listen*. Do not pretend to listen. It shows lack of caring and interest. You may miss complaints of pain, discomfort, or other symptoms that you must report to the nurse.
- *Pat answers*. "Don't worry." "Everything will be okay." These make the person feel that you do not care about his or her concerns, feelings, and fears.
- *Illness and disability*. Speech, hearing, vision, cognitive function, and body movements may be affected. Verbal and nonverbal communication is affected.
- *Age*. Values and communication styles vary among age-groups.

Persons With Special Needs

- Common courtesies and manners apply to any person with a disability. Review Box 9-1, Disability Etiquette, in the Textbook.
- The person who is comatose is unconscious and cannot respond to others. Often the person can hear and feel touch and pain. Assume that the person hears and understands you. Use touch and give care gently. Practice these measures.
  - Knock before entering the person's room.
  - Tell the person your name, the time, and the place every time you enter the room.
  - Give care on the same schedule every day.
  - Explain what you are going to do.
  - Tell the person when you are finishing care.
  - Use touch to communicate care, concern, and comfort.
  - Tell the person what time you will be back to check on him or her.
  - Tell the person when you are leaving the room.

Family and Friends

- If you need to give care when visitors are there, protect the person's right to privacy. Politely ask the visitors to leave the room when you give care. A partner or family member may help you if the patient or resident consents.
- Treat family and visitors with courtesy and respect.
- Do not discuss the person's condition with family and friends. Refer questions to the nurse. A visitor may upset or tire a person. Report your observations to the nurse.

Behavior Issues

- Many people do not adjust well to illness, injury, and disability. They have some of the following behaviors.
  - *Anger*. Anger may be communicated verbally and nonverbally. Verbal outbursts, shouting, and rapid speech are common. Some people are silent. Others are uncooperative and may refuse to answer questions. Nonverbal signs include rapid movements, pacing, clenched fists, and a red face. Glaring and getting close to you when speaking are other signs. Violent behaviors can occur.

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- *Demanding behavior*. Nothing seems to please the person. The person is critical of others.
- *Self-centered behavior*. The person cares only about his or her own needs. The needs of others are ignored. The person becomes impatient if needs are not met.
- *Aggressive behavior*. The person may swear, bite, hit, pinch, scratch, or kick. Protect the person, others, and yourself from harm.
- *Withdrawal*. The person has little or no contact with family, friends, and staff. Some people are generally not social and prefer to be alone.
- *Inappropriate sexual behavior*. Some people make inappropriate sexual remarks or touch others in the wrong way. These behaviors may be on purpose. Or they are caused by disease, confusion, dementia, or drug side effects.

- You cannot avoid persons with unpleasant behaviors or lose control. Review Box 9-2, Dealing With Behavior Issues, in the Textbook.

CHAPTER 9 REVIEW QUESTIONS

Circle the BEST answer.

1. While caring for a person, you need to
   a. Consider only the person's physical and social needs
   b. Consider the person's physical, social, psychological, and spiritual needs
   c. Consider only the person's cultural needs
   d. Ignore the person's spiritual needs
2. When referring to residents, you should
   a. Refer to them by their room number
   b. Call them "Honey"
   c. Call them by their first name
   d. Call them by their name and title
3. Based on Maslow's theory of basic needs, which person's needs must be met first?
   a. The person who wants to talk about her granddaughter's wedding
   b. The person who is uncomfortable in the dining room
   c. The person who wants mail opened
   d. The person who asks for more water
4. Which statement about culture is *false?*
   a. A person's culture influences health beliefs and practices.
   b. You must respect a person's culture.
   c. You should ignore the person's culture while you give his or her care.
   d. You should learn about another person's culture that is different from yours.
5. Which statement about religion and spiritual beliefs is *false?*
   a. A person's religion influences health and illness practices.
   b. You should assist a person to attend services in the nursing center.
   c. Many people find comfort and strength from religion during illness.
   d. A person must follow all beliefs of his or her religion.
6. A person is angry and is shouting at you. You should do the following *except*
   a. Stay calm and professional
   b. Yell so the person will listen to you
   c. Listen to what the person is saying
   d. Report the person's behavior to the nurse
7. A person tries to scratch and kick you. You should
   a. Protect yourself from harm
   b. Argue with the person
   c. Become angry with the person
   d. Refuse to care for the person
8. When speaking with another person, you do the following *except*
   a. Position yourself at the person's eye level
   b. Speak slowly, clearly, and distinctly
   c. Shout, mumble, and whisper
   d. Ask 1 question at a time
9. Which statement about listening is *false?*
   a. You use sight, hearing, touch, and smell when you listen.
   b. You observe nonverbal cues.
   c. You have good eye contact with the person.
   d. You sit back with your arms crossed.
10. Which statement about silence is *false?*
    a. Silence is a powerful way to communicate.
    b. Silence gives people time to think.
    c. You should talk a lot when the other person is silent.
    d. Silence helps when the person is upset and needs to gain control.
11. A person speaks a foreign language. You should do the following *except*
    a. Keep messages short and simple
    b. Use gestures and pictures
    c. Shout or speak loudly
    d. Repeat the message in other words
12. When caring for a person who is comatose, you do the following *except*
    a. Tell the person your name when you enter the room
    b. Explain what you are doing
    c. Use touch to communicate care and comfort
    d. Make jokes about how sick the person is
13. A person is in a wheelchair. You should do all of the following *except*
    a. Lean on a person's wheelchair
    b. Sit or squat to talk to a person in a wheelchair or chair
    c. Think about obstacles before giving directions to a person in a wheelchair
    d. Extend the same courtesies to the person as you would to anyone else
14. A person's daughter is visiting and you need to provide care to the person. You
    a. Expose the person's body in front of the visitor
    b. Politely ask the visitor to leave the room
    c. Decide to not provide the care at all
    d. Discuss the person's condition with the visitor

Answers to these questions are on p. 516.

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CHAPTER 11 GROWTH AND DEVELOPMENT

- **Growth** is the physical changes that are measured and that occur in a steady and orderly manner.
- **Development** relates to changes in mental, emotional, and social function.
- Growth and development occur in a sequence, order, and pattern. Review the stages of growth and development detailed in the Textbook.
- Middle adulthood (40 to 65 years old). At this stage, developmental tasks are adjusting to physical changes, having grown children, developing leisure-time activities, and adjusting to aging parents.
- Late adulthood (65 years and older). At this stage, developmental tasks are adjusting to decreased strength and loss of health, adjusting to retirement and reduced income, coping with a partner's death, developing new friends and relationships, and preparing for one's own death.

CHAPTER 11 REVIEW QUESTIONS

Circle the BEST answer.

1. Growth and development occur in a sequence, order, and pattern.
   a. True
   b. False
2. Growth relates to changes in mental, emotional, and social function.
   a. True
   b. False
3. Which is a developmental task of late adulthood?
   a. Accepting changes in appearance
   b. Adjusting to decreased strength
   c. Developing a satisfactory sex life
   d. Performing self-care

Answers to these questions are on p. 516.

CHAPTER 12 CARE OF THE OLDER PERSON

- Aging is normal. It is not a disease. Normal changes occur in body structure and function. Psychological and social changes also occur.

Psychological and Social Changes

- Physical reminders of growing old affect self-esteem and may threaten self-image, feelings of self-worth, and independence.
- People cope with aging in their own way. How they cope depends on their health status, life experiences, finances, education, and social support systems.
- *Retirement.* Many people enjoy retirement. Others are in poor health and have medical bills that can make retirement hard.
- *Reduced income.* Retirement usually means reduced income. The retired person still has expenses. Reduced income may force life-style changes. One example is the person avoids health care or needed drugs.
- *Social relationships.* Social relationships change throughout life. Family time helps prevent loneliness. So do hobbies, religious and community events, and new friends.
- *Children as caregivers.* Some older persons feel more secure when children care for them. Others feel unwanted and useless. Some lose dignity and self-respect. Tensions may occur among the child, parent, and other household members.
- *Death and grieving.* Death of an adult child or a partner can cause immense grief. Emotional needs will be great. The person may be left with few family and friends to provide support.

Physical Changes

- Body processes slow down. Energy level and body efficiency decline.
- *The integumentary system.* The skin loses its elasticity, strength, and fatty tissue layer. Wrinkles appear. Dry skin occurs and may cause itching. The skin is fragile and easily injured. The person is more sensitive to cold. Nails become thick and tough. Feet may have poor circulation. White or gray hair is common. Hair thins. Facial hair may occur in women. Hair is drier. The risk of skin cancer increases.
- *The musculo-skeletal system.* Muscle and bone strength are lost. Bones become brittle and break easily. Vertebrae shorten. Joints become stiff and painful. Mobility decreases. There is a gradual loss of height.
- *The nervous system.* Confusion, dizziness, and fatigue may occur. Responses are slower. The risk for falls increases. Forgetfulness increases. Memory is shorter. Events from long ago are remembered better than recent ones. Older persons have a harder time falling asleep. Sleep periods are shorter. Older persons wake often during the night and have less deep sleep. Less sleep is needed. They may rest or nap during the day. They may go to bed early and get up early.
- *The senses.* Hearing and vision losses occur. Taste and smell dull. Appetite decreases. Touch and sensitivity to pain, pressure, hot, and cold are reduced.
- *The circulatory system.* The heart muscle weakens. Arteries narrow and are less elastic. Poor circulation occurs in many body parts.
- *The respiratory system.* Respiratory muscles weaken. Lung tissue becomes less elastic. Difficult, labored, or painful breathing may occur with activity. The person may lack strength to cough and clear the airway of secretions. Respiratory infections and diseases may develop.
- *The digestive system.* Less saliva is produced. The person may have difficulty swallowing (dysphagia). Indigestion may occur. Loss of teeth and ill-fitting dentures cause chewing problems and digestion problems. Flatulence and constipation can occur. Fewer calories are needed as energy and activity levels decline. More fluids are needed.
- *The urinary system.* Urine is more concentrated. Bladder muscles weaken. Bladder size decreases. Urinary frequency or urgency may occur. Urinary tract infections are risks. Many older persons have to urinate at night. Urinary incontinence may occur. In men, the prostate gland enlarges. This may cause difficulty urinating or frequent urination.

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- *The reproductive system.* In men, testosterone decreases. An erection takes longer. Orgasm is less forceful. Women experience menopause. Female hormones of estrogen and progesterone decrease. The uterus, vagina, and genitalia shrink (atrophy). Vaginal walls thin. There is vaginal dryness. Arousal takes longer. Orgasm is less intense.

Housing Options

- A person's home is more than a place to live. It holds memories, is a link to neighbors and communities, and brings pride and self-esteem. Aging can lead to changes in a person's home setting.
- Most older people live in their own homes. Others need help from family or community agencies. Review Box 12-3, In-Home and Community-Based Services, in the Textbook.

Nursing Centers

- The person needing nursing center care may suffer some or all of these losses.
  - Loss of identity as a productive member of a family and community
  - Loss of possessions—home, household items, car, and so on
  - Loss of independence
  - Loss of real-world experiences—shopping, traveling, cooking, driving, hobbies
  - Loss of health and mobility
- The person may feel useless, powerless, and hopeless. The health team helps the person cope with loss and improve quality of life. Treat the person with dignity and respect. Also practice good communication skills. Follow the care plan.

CHAPTER 12 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Physical changes occur with aging.
   b. Energy level and body efficiency decline with age.
   c. Some people age faster than others.
   d. Normal aging means loss of health.
2. As a person ages, the integumentary system changes. Which statement is *false?*
   a. Dry skin and itching occur.
   b. Nails become thick and tough.
   c. The person is less sensitive to cold.
   d. Skin is injured more easily.
3. Which statement is *false* about the musculo-skeletal system and aging?
   a. Strength decreases.
   b. Vertebrae shorten.
   c. Mobility increases.
   d. Bone mass decreases.
4. Which statement about the nervous system and aging is *false?*
   a. Reflexes slow.
   b. Memory may be shorter.
   c. Sleep patterns change.
   d. Forgetfulness decreases.
5. Which statement about the digestive system and aging is *false?*
   a. Appetite decreases.
   b. Less saliva is produced.
   c. Flatulence and constipation may decrease.
   d. Teeth may be lost.
6. Which statement about the urinary system and aging is *false?*
   a. Urine becomes more concentrated.
   b. Urinary frequency may occur.
   c. Urinary urgency may occur.
   d. Bladder muscles become stronger.

Answers to these questions are on p. 516.

CHAPTER 13 SAFETY

Accident Risk Factors

- *Age.* Older persons are at risk for falls and other injuries.
- *Awareness of surroundings.* People need to know their surroundings to protect themselves from injury.
- *Agitated and aggressive behaviors.* Pain, confusion, fear, and decreased awareness of surroundings can cause these behaviors.
- *Vision loss.* Persons can fall or trip over items. Some have problems reading labels on containers.
- *Hearing loss.* Persons have problems hearing explanations and instructions. They may not hear warning signals or fire alarms. They do not know to move to safety.
- *Impaired smell and touch.* Illness and aging affect smell and touch. The person may not detect smoke or gas or may be unaware of injury. Burns are a risk.
- *Impaired mobility.* Some diseases and injuries affect mobility. A person may know there is danger but cannot move to safety. Some persons are paralyzed. Some persons cannot walk or propel wheelchairs.
- *Drugs.* Drugs have side effects. Reduced awareness, confusion, and disorientation can occur. Report behavior changes and the person's complaints.

Identifying the Person

- You must give the right care to the right person. To identify the person:
  - Compare identifying information on the assignment sheet or treatment card with that on the identification (ID) bracelet.
  - Call the person by name when checking the ID bracelet. Just calling the person by name is not enough to identify him or her. Confused, disoriented, drowsy, hard-of-hearing, or distracted persons may answer to any name.
- Use at least 2 identifiers. Agencies have different requirements. Some may require the person to state and spell his or her name and give a birth date. Others require using the person's ID number. Always follow agency policy.

Preventing Burns

- Smoking, spilled hot liquids, very hot water, and electrical devices are common causes of burns. See Box 13-1 in the Textbook for safety measures to prevent burns.

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Preventing Poisoning

- Drugs and household products are common poisons. Poisoning in adults may be from carelessness, confusion, or poor vision when reading labels. To prevent poisoning:
  - Make sure patients and residents cannot reach hazardous materials.
  - Follow agency policy for storing personal care items.
- See Box 13-2 in the Textbook for safety measures to prevent poisoning.

Preventing Suffocation

- **Suffocation** is when breathing stops from the lack of oxygen. Death occurs if the person does not start breathing.
- To prevent suffocation, review Box 13-5, Preventing Suffocation, in the Textbook.

Choking

- Choking or foreign-body airway obstruction (FBAO) occurs when a foreign body obstructs the airway. Air cannot pass through the air passages into the lungs. The body does not get enough oxygen. This can lead to cardiac arrest.
- Choking often occurs during eating. A large, poorly chewed piece of meat is the most common cause. Other common causes include laughing and talking while eating.
- With *mild airway obstruction*, some air moves in and out of the lungs. The person is conscious. Usually the person can speak. Often, forceful coughing can remove the object.
- With *severe airway obstruction*, the conscious person clutches at the throat—the "universal sign of choking." The person has difficulty breathing. Some persons cannot breathe, speak, or cough. The person appears pale and cyanotic (bluish color). Air does not move in and out of the lungs. If the obstruction is not removed, the person will die. Severe airway obstruction is an emergency.
- Use abdominal thrusts to relieve severe choking. Chest thrusts are used for very obese persons and pregnant women.
- Call for help when a person has an obstructed airway. Report and record what happened, what you did, and the person's response.

Preventing Equipment Accidents

- All equipment is unsafe if broken, not used correctly, or not working properly. Inspect all equipment before use. Review Box 13-7, Preventing Equipment Accidents, in the Textbook.

Hazardous Chemicals

- A hazardous substance is any chemical in the workplace that can cause harm. Hazardous substances include oxygen, mercury, disinfectants, and cleaning agents.
- Hazardous substance containers must have a warning label. If a label is removed or damaged, do not use the substance. Take the container to the nurse. Do not leave the container unattended.
- Check the material safety data sheet (MSDS) before using a hazardous substance, cleaning up a leak or spill, or disposing of the substance. Tell the nurse about a leak or spill right away. Do not leave a leak or spill unattended. Review Box 13-8 in the Textbook.

Disasters

- A **disaster** is a sudden catastrophic event. The agency has procedures for disasters that could occur in your area. Follow them to keep patients, residents, visitors, staff, and yourself safe.
- Natural disasters include tornadoes, hurricanes, blizzards, earthquakes, volcanic eruptions, floods, and some fires.
- Human-made disasters include auto, bus, train, and airplane accidents. They also include fires, bombings, nuclear power plant accidents, gas or chemical leaks, explosions, and wars.
- Follow agency protocol for a bomb threat or if you find an item that looks or sounds strange.

Fire Safety

- Faulty electrical equipment and wiring, over-loaded electrical circuits, and smoking are major causes of fires.
- Safety measures are needed where oxygen is used and stored.
- Review Box 13-9, Fire Prevention Measures, in the Textbook.
- Know your center's policies and procedures for fire emergencies. Know where to find fire alarms, fire extinguishers, and emergency exits. Remember the word *RACE*.
  - **R—*rescue*.** Rescue persons in immediate danger. Move them to a safe place.
  - **A—*alarm*.** Sound the nearest fire alarm. Notify the telephone operator.
  - **C—*confine*.** Close doors and windows. Turn off oxygen or electrical items.
  - **E—*extinguish*.** Use a fire extinguisher on a small fire.
- Remember the word *PASS* for using a fire extinguisher.
  - **P—*pull*** the safety pin.
  - **A—*aim*** low. Aim at the base of the fire.
  - **S—*squeeze*** the lever. This starts the stream of water.
  - **S—*sweep*** back and forth. Sweep side to side at the base of the fire.
- Do not use elevators during a fire.

Elopement

- Elopement is when a resident leaves the agency without staff knowledge. The Centers for Medicare & Medicaid Services (CMS) requires that an agency's disaster plan address elopement.
- The agency must:
  - Identify persons at risk for elopement.
  - Monitor and supervise persons at risk.
  - Address elopement in the person's care plan.
  - Have a plan to find a missing patient or resident.

Workplace Violence

- **Workplace violence** is violent acts (including assault or threat of assault) directed toward persons at work or while on duty. Review Box 13-10, Workplace Violence—Safety Measures, in the Textbook.

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CHAPTER 13 REVIEW QUESTIONS

Circle the BEST answer.

1. You see a water spill in the hallway. What will you do?
   a. Ask housekeeping to wipe up the spill right away.
   b. Wipe up the spill right away.
   c. Report the spill to the nurse.
   d. Ask the resident to walk around the spill.
2. An electrical outlet in a person's room does not work. What will you do?
   a. Tell the administrator about the problem.
   b. Tell another nursing assistant about the problem.
   c. Try to repair the electrical outlet.
   d. Follow the center's policy for reporting the problem.
3. Accident risk factors include all of the following *except*
   a. Walking without difficulty
   b. Hearing problems
   c. Dulled sense of smell
   d. Poor vision
4. To prevent a person from being burned, you should do the following *except*
   a. Supervise the smoking of persons who are confused
   b. Turn cold water on first; turn hot water off first
   c. Do not let the person sleep with a heating pad
   d. Allow smoking in bed
5. To prevent suffocation, you should do the following *except*
   a. Make sure dentures fit properly
   b. Check the care plan for swallowing problems before serving food or liquids
   c. Leave a person alone in a bathtub or shower
   d. Position the person in bed properly
6. Which statement about mild airway obstruction is *false?*
   a. Some air moves in and out of the lungs.
   b. The person is conscious.
   c. Usually the person cannot speak.
   d. Forceful coughing will often remove the object.
7. The "universal sign of choking" is
   a. Clutching at the chest
   b. Clutching at the throat
   c. Not being able to talk
   d. Not being able to breathe
8. Which of the following is *not* a safety measure with oxygen?
   a. NO SMOKING signs are placed on the resident's door and near the bed.
   b. Lit candles and other open flames are permitted in the room.
   c. Electrical items are turned off before being unplugged.
   d. The person wears a cotton gown or pajamas.
9. You have discovered a fire in the nursing center. You should do the following *except*
   a. Rescue persons in immediate danger
   b. Sound the nearest fire alarm
   c. Open doors and windows and keep oxygen on
   d. Use a fire extinguisher on a small fire that has not spread to a larger area
10. When using a fire extinguisher, you do the following *except*
    a. Pull the safety pin on the fire extinguisher
    b. Aim at the top of the flames
    c. Squeeze the lever to start the stream
    d. Sweep the stream back and forth

Answers to these questions are on p. 516.

CHAPTER 14 FALL PREVENTION

- Falls are a leading cause of injuries and deaths among older persons. A history of falls increases the risk of falling again.
- Most falls occur in resident rooms and bathrooms.
- Causes for falls are poor lighting, cluttered floors, throw rugs, needing to use the bathroom, out-of-place furniture, wet and slippery floors, bathtubs, and showers. Review Box 14-1, Fall Risk Factors, in the Textbook.
- Agencies have fall prevention programs. Review Box 14-2, Safety Measures to Prevent Falls, in the Textbook. The person's care plan also lists measures specific for the person.
- Bed and chair alarms alert staff when the person is moving from the bed or chair.

Bed Rails

- A **bed rail** *(side rail)* is a device that serves as a guard or barrier along the side of the bed.
- The nurse and care plan tell you when to raise bed rails. They are needed by persons who are unconscious or sedated with drugs. Some confused and disoriented people need them. If a person needs bed rails, keep them up at all times except when giving bedside nursing care.
- Bed rails present hazards. The person can fall when trying to get out of bed. Or the person can get caught, trapped, entangled, or strangled.
- Bed rails are considered restraints if the person cannot get out of bed or lower them without help.
- Accrediting agency standards and state and federal laws affect bed rail use. They are allowed when the person's condition requires them. The need for bed rails is carefully noted in the person's medical record and the care plan. If a person uses bed rails, check the person often. Record when you checked the person and your observations.
- To prevent falls:
  - Never leave the person alone when the bed is raised.
  - Always lower the bed to its lowest position when you are done giving care.
  - If a person does not use bed rails and you need to raise the bed, ask a co-worker to stand on the far side of the bed to protect the person from falling.
  - If you raise the bed to give care, always raise the far bed rail if you are working alone.
  - Be sure the person who uses raised bed rails has access to items on the bedside stand and over-bed table. The call light, water pitcher and cup, tissues, phone, and TV and light controls should be within the person's reach.

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Hand Rails and Grab Bars
- Hand rails give support to persons who are weak or unsteady when walking.
- Grab bars provide support for sitting down or getting up from a toilet. They also are used for getting in and out of the shower or tub.

Wheel Locks
- Bed wheels are locked at all times except when moving the bed.
- Wheelchair and stretcher wheels are locked when transferring a person.

Transfer/Gait Belts
- Use a **transfer belt (gait belt)** to support a person who is unsteady or disabled. Always follow the manufacturer's instructions. Apply the belt over clothing and under the breasts. The belt buckle is never positioned over the person's spine. Tighten the belt so it is snug. You should be able to slide your open, flat hand under the belt. Tuck the excess strap under the belt. Remove the belt after the procedure.
- Check with the nurse and care plan before using a transfer/gait belt if the person has:
    - A colostomy, ileostomy, gastrostomy, or urostomy
    - A gastric tube
    - Chronic obstructive pulmonary disease
    - An abdominal wound, incision, or drainage tube
    - A chest wound, incision, or drainage tube
    - Monitoring equipment
    - A hernia
    - Other conditions or care equipment involving the chest or abdomen

The Falling Person
- If a person starts to fall, do not try to prevent the fall. You could injure yourself and the person. Ease the person to the floor and protect the person's head.
- Do not let the person get up before the nurse checks for injuries. An incident report is completed after all falls.

CHAPTER 14 REVIEW QUESTIONS

Circle the BEST answer.

1. Most falls occur in
    a. Resident rooms and bathrooms
    b. Dining rooms
    c. Hallways
    d. Activity rooms
2. Which statement about falls is *false?*
    a. Poor lighting, cluttered floors, and throw rugs may cause falls.
    b. Improper shoes and needing to use the bathroom may cause falls.
    c. Most falls occur between 4:00 PM and 8:00 PM.
    d. Falls are less likely to occur during shift changes.
3. You note the following after a person got dressed. Which is unsafe?
    a. Non-skid footwear is worn.
    b. Pant cuffs are dragging on the floor.
    c. Clothing fits properly.
    d. The belt is fastened.
4. Which statement about bed rails is *false?*
    a. The nurse and care plan tell you when to raise bed rails.
    b. Bed rails are considered restraints.
    c. You may leave a person alone when the bed is raised and the bed rails are down.
    d. Bed rails can present hazards because people try to climb over them.
5. Which statement about transfer/gait belts is *false?*
    a. To use the belt safely, follow the manufacturer's instructions.
    b. Always apply the belt over clothing.
    c. Tighten the belt so it is very snug and breathing is impaired.
    d. Place the belt buckle off-center so it is not over the spine.
6. A person becomes faint in the hallway and begins to fall. You should do the following *except*
    a. Ease the person to the floor
    b. Protect the person's head
    c. Let the person get up before the nurse checks him or her
    d. Help the nurse complete the incident report

Answers to these questions are on p. 516.

CHAPTER 15 RESTRAINT ALTERNATIVES AND SAFE RESTRAINT USE
- The Centers for Medicare & Medicaid Services (CMS) has rules for using restraints. These rules protect the person's rights and safety.
- Restraints may be used only to treat a medical symptom or for the immediate physical safety of the person or others. Restraints may be used only when less restrictive measures fail to protect the person or others. They must be discontinued at the earliest possible time.
- The CMS uses these to define restraints.
    - A **physical restraint** is any manual method or physical or mechanical device, material, or equipment attached to or near the person's body that he or she cannot remove easily and that restricts freedom of movement or normal access to one's body.
    - A **chemical restraint** is a drug that is used for discipline or convenience and not required to treat medical symptoms. The drug or dosage is not a standard treatment for the person's condition.
    - **Freedom of movement** is any change in place or position of the body or any part of the body that the person is able to control.
    - **Remove easily** is the manual method, device, material, or equipment used to restrain the person that can be removed intentionally by the person in the same manner it was applied by staff.
    - **Convenience** is any action taken to control or manage a person's behavior that requires less effort by the staff; the action is not in the person's best interest.
    - **Discipline** is any action taken by the agency to punish or penalize a patient or resident.
- Federal, state, and accrediting agencies have guidelines about restraint use. They do not forbid restraint use. They require considering or trying all other appropriate alternatives first.

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- Every agency has policies and procedures about restraints. They include identifying persons at risk for harm, harmful behaviors, restraint alternatives, and proper restraint use. Staff training is required.

Restraint Alternatives

- Knowing and treating the cause for harmful behaviors can prevent restraint use. There are many alternatives to restraints, such as answering the call light promptly. For other alternatives see Box 15-1, Restraint Alternatives.

Safe Restraint Use

- Restraints are used only when necessary to treat a person's medical symptoms—physical, emotional, or behavioral problems. Sometimes restraints are needed to protect the person or others.

Physical and Chemical Restraints

- *Physical restraints* are applied to the chest, waist, elbows, wrists, hands, or ankles. They confine the person to a bed or chair. Or they prevent movement of a body part. Some furniture or barriers prevent free movement.
- Drugs or drug dosages are *chemical restraints* if they:
  - Control behavior or restrict movement.
  - Are not standard treatment for the person's condition.

Risks From Restraints

- Restraints can cause many complications. Injuries occur as the person tries to get free of the restraint. Injuries also occur from using the wrong restraint, applying it wrong, or keeping it on too long. Cuts, bruises, and fractures are common. The most serious risk is death from strangulation. Review Box 15-2, Risks From Restraint Use, in the Textbook.

Legal Aspects

- *Restraints must protect the person.* A restraint is used only when it is the best safety measure for the person.
- *A doctor's order is required.* The doctor gives the reason for the restraint, what body part to restrain, what to use, and how long to use it.
- *The least restrictive method is used.* It allows the greatest amount of movement or body access possible.
- *Restraints are used only after other measures fail to protect the person.* Box 15-1 in the Textbook lists alternatives to restraint use.
- *Unnecessary restraint is false imprisonment.* If you apply an unneeded restraint, you could face false imprisonment charges.
- *Informed consent is required.* The person must understand the reason for the restraint. If the person cannot give consent, his or her legal representative must give consent before a restraint can be used. The doctor or nurse provides the necessary information and obtains the consent.

Safety Guidelines

- Review Box 15-3, Safety Measures for Using Restraints, in the Textbook.
- *Observe for increased confusion and agitation.* Restraints can increase confusion and agitation. Restrained persons need repeated explanations and re-assurance. Spending time with them has a calming effect.
- *Protect the person's quality of life.* Restraints are used for as short a time as possible. You must meet the person's physical, emotional, and social needs.
- *Follow the manufacturer's instructions.* The restraint must be snug and firm but not tight. You could be negligent if you do not apply or secure a restraint properly.
- *Apply restraints with enough help to protect the person and staff from injury.*
- *Observe the person at least every 15 minutes or more often as noted in the care plan.* Injuries and deaths can result from improper restraint use and poor observation.
- *Remove or release the restraint, re-position the person, and meet basic needs at least every 2 hours or as often as noted in the care plan.* The restraint is removed for at least 10 minutes. Provide for food, fluid, comfort, safety, hygiene, and elimination needs and give skin care. Perform range-of-motion exercises or help the person walk.

Reporting and Recording

- Report and record the following:
  - Type of restraint applied
  - Body part or parts restrained
  - Reason for the application
  - Safety measures taken
  - Time you applied the restraint
  - Time you removed or released the restraint
  - Care given when restraint was removed
  - Person's vital signs
  - Skin color and condition
  - Condition of the limbs
  - Pulse felt in the restrained part
  - Changes in the person's behavior
- Report these complaints to the nurse at once: complaints of discomfort; a tight restraint; difficulty breathing; or pain, numbness, or tingling in the restrained part.

CHAPTER 15 REVIEW QUESTIONS

Circle the BEST answer.

1. A geriatric chair or a bed rail may be considered a restraint if free movement is restricted.
   a. True
   b. False
2. Restraints can be used for staff convenience.
   a. True
   b. False
3. Restraints can increase a person's confusion and agitation.
   a. True
   b. False
4. The person with a restraint should be observed at least every
   a. 15 minutes
   b. 30 minutes
   c. Hour
   d. 2 hours

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5. Restraints need to be removed at least every
   a. Hour
   b. 2 hours
   c. 3 hours
   d. 4 hours
6. You should record all the following *except*
   a. The type of restraint used
   b. The consent for the restraint
   c. The time you removed the restraint
   d. The care you gave when the restraint was removed

Answers to these questions are on p. 516.

CHAPTER 16 PREVENTING INFECTION

- An **infection** is a disease state resulting from the invasion and growth of microbes in the body. Infection is a major safety hazard.
- The health team follows certain practices and procedures to prevent the spread of infection **(infection control).**

Microorganisms

- A **microorganism (microbe)** is a small *(micro)* living plant or animal *(organism).*
- Some microbes are harmful and can cause infections **(pathogens).** Others do not usually cause infection **(non-pathogens).**

Multidrug-Resistant Organisms

- *Multidrug-resistant organisms (MDROs)* can resist the effects of antibiotics. Such organisms are able to change their structures to survive in the presence of antibiotics. The infections they cause are harder to treat.
- MDROs are caused by prescribing antibiotics when they are not needed (over-prescribing). Not taking antibiotics for the prescribed length of time is also a cause.
- Two common types of MDROs are resistant to many antibiotics.
  - *Methicillin-resistant Staphylococcus aureus (MRSA)*
  - *Vancomycin-resistant Enterococcus (VRE)*

Infection

- **A local infection** is in a body part.
- **A systemic infection** involves the whole body.
- Older persons may not show the normal signs and symptoms of infection. The person may have only a slight fever or no fever at all. Redness and swelling may be very slight. The person may not complain of pain. Confusion and delirium may occur.
- Infections can become life-threatening before the older person has obvious signs and symptoms. Be alert to minor changes in the person's behavior or condition.
- Report any concerns to the nurse at once. Review Box 16-1, Signs and Symptoms of Infection, in the Textbook.

Healthcare-Associated Infection

- **A healthcare-associated infection (HAI)** is an infection that develops in a person cared for in any setting where health care is given. Review Box 16-2 in the Textbook. The infection is related to receiving health care. Hospitals, nursing centers, clinics, and home care settings are examples. HAIs also are called *nosocomial infections.*
- The health team must prevent the spread of HAIs by:
  - Medical asepsis. This includes hand hygiene.
  - Surgical asepsis.
  - Standard Precautions and Transmission-Based Precautions.
  - The Bloodborne Pathogen Standard.

Medical Asepsis

- **Asepsis** is being free of disease-producing microbes.
- **Medical asepsis (clean technique)** refers to the practices used to:
  - Remove or destroy pathogens.
  - Prevent pathogens from spreading from 1 person or place to another person or place.

Common Aseptic Practices

- To prevent the spread of microbes, wash your hands:
  - After urinating or having a bowel movement.
  - After changing tampons or sanitary pads.
  - After contact with your own or another person's blood, body fluids, secretions, or excretions. This includes saliva, vomitus, urine, feces, vaginal discharge, mucus, semen, wound drainage, pus, and respiratory secretions.
  - After coughing, sneezing, or blowing your nose.
  - Before and after handling, preparing, or eating food.
  - After smoking.
- Also do the following:
  - Provide all persons with their own linens and personal care items.
  - Cover your nose and mouth when coughing, sneezing, or blowing your nose.
  - Bathe, wash hair, and brush your teeth regularly.
  - Wash fruits and raw vegetables before eating or serving them.
  - Wash cooking and eating utensils with soap and water after use.

Hand Hygiene

- *Hand hygiene is the easiest and most important way to prevent the spread of infection.* Practice hand hygiene before and after giving care. Review Box 16-3, Rules of Hand Hygiene, in the Textbook.

Supplies and Equipment

- Most health care equipment is disposable. Bedpans, urinals, wash basins, water pitchers, and drinking cups are multi-use items. Do not "borrow" them for another person.
- Non-disposable items are cleaned and then disinfected. Then they are sterilized.

Other Aseptic Measures

- Review Box 16-4, Aseptic Measures, in the Textbook.

Isolation Precautions

- Isolation precautions prevent the spread of **communicable diseases (contagious diseases).** They are diseases caused by pathogens that spread easily.
- The Centers for Disease Control and Prevention's (CDC's) isolation precautions guideline has 2 tiers of precautions.

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- Standard Precautions
- Transmission-Based Precautions

Standard Precautions

- Standard Precautions reduce the risk of spreading pathogens and known and unknown infections. Standard Precautions are used for all persons whenever care is given. They prevent the spread of infection from:
  - Blood.
  - All body fluids, secretions, and excretions even if blood is not visible. Sweat is not known to spread infections.
  - Non-intact skin (skin with open breaks).
  - Mucous membranes.
- Review Box 16-5, Standard Precautions, in the Textbook.

Transmission-Based Precautions

- Some infections require Transmission-Based Precautions. Review Box 16-6, Transmission-Based Precautions, in the Textbook.
- Agency policies may differ from those in the Textbook. The rules in Box 16-7, Rules for Isolation Precautions, in the Textbook are a guide for giving safe care.

Personal Protective Equipment (PPE)

- The PPE needed —gloves, a gown, a mask, and goggles or a face shield—depends on the task, the procedures, care measures, and the type of Transmission-Based Precautions used. The nurse will tell you what equipment is needed.
- Gowns must completely cover you from your neck to your knees. The gown front and sleeves are considered contaminated. A wet gown is contaminated. Gowns are used once. When removing a gown, roll it away from you. Keep it inside out.
- Masks are disposable. A wet or moist mask is contaminated. When removing a mask, touch only the ties or elastic bands. The front of the mask is contaminated.
- The front of goggles or a face shield is contaminated. Use the device's ties, headband, or ear-pieces to remove the device.

Gloves

- Wear gloves whenever contact with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin is likely. Wearing gloves is the most common protective measure used with Standard Precautions and Transmission-Based Precautions. Remember the following when using gloves.
  - The outside of gloves is contaminated.
  - Gloves are easier to put on when your hands are dry.
  - Do not tear gloves when putting them on.
  - You need a new pair for every person.
  - Remove and discard torn, cut, or punctured gloves at once. Practice hand hygiene. Then put on a new pair.
  - Apply a new pair for every person.
  - Wear gloves once. Discard them after use.
  - Put on clean gloves just before touching mucous membranes or non-intact skin.
  - Put on new gloves whenever gloves become contaminated with blood, body fluids, secretions, or excretions. A task may require more than 1 pair of gloves.
  - Change gloves whenever moving from a contaminated body site to a clean body site.
  - Change gloves if interacting with the person involves touching portable computer keyboards or other mobile equipment that is transported from room to room.
  - Put on gloves last when worn with other PPE.
  - Make sure gloves cover your wrists. If you wear a gown, gloves cover the cuffs.
  - Remove gloves so the inside part is on the outside. The inside is clean.
  - Practice hand hygiene after removing gloves.
- Latex allergies are common and can cause skin rashes. Asthma and shock are more serious problems. Report skin rashes and breathing problems at once. If you or a resident has a latex allergy, wear latex-free gloves.

Donning and Removing PPE

- According to the CDC, PPE is donned in the following order.
  - Gown
  - Mask or respirator
  - Eyewear (goggles or face shield)
  - Gloves
- Removing PPE (removed at the doorway before leaving the person's room):
  - *Method 1*
    1. Gloves
    2. Eyewear (goggles or face shield)
    3. Gown
    4. Mask or respirator (respirator is removed after leaving the person's room and closing the door)
  - *Method 2*
    1. Gown and gloves
    2. Eyewear (goggles or face shield)
    3. Mask or respirator (respirator is removed after leaving the person's room and closing the door)
- Review Figure 16-18 Donning and Removing PPE, in the Textbook.
- Practice hand hygiene after removing PPE. Practice hand hygiene between steps if your hands become contaminated. Then practice hand hygiene again after removing all PPE.
- NOTE: Some state competency tests require hand hygiene after removing each PPE item. And some states use a different order for donning and removing PPE. Follow the procedures used in your state and agency.
- Some infections such as Ebola are very severe and deadly. Such infections require additional PPE.

Bagging Items

- Contaminated items, linens, and trash are bagged to remove them from the person's room. Leak-proof plastic bags are used. They have the BIOHAZARD symbol. Double-bagging is not needed unless the outside of the bag is wet, soiled, or may be contaminated.

Bloodborne Pathogen Standard

- The health team is at risk for exposure to human immunodeficiency virus (HIV) and the hepatitis B virus (HBV). HIV and HBV are bloodborne pathogens found in the blood.

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- The Bloodborne Pathogen Standard is intended to protect you from exposure.
- Staff at risk for exposure to HIV and HBV receive free training.
- *Hepatitis B vaccination*. You can receive the hepatitis B vaccination within 10 working days of being hired. The agency pays for it. If you refuse the vaccination, you must sign a statement. You can have the vaccination at a later date.

Work Practice Controls

- *Work practice controls* reduce employee exposure in the workplace. All tasks involving blood or other potentially infectious materials (OPIM) are done in ways to limit splatters, splashes, and sprays. The Occupational Safety and Health Administration (OSHA) requires these work practice controls.
  - Do not eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses in areas of occupational exposure.
  - Do not store food or drinks where blood or OPIM are kept.
  - Practice hand hygiene after removing gloves.
  - Wash hands as soon as possible after skin contact with blood or OPIM.
  - Never re-cap, bend, or remove needles by hand.
  - Never shear or break needles.
  - Discard needles and sharp instruments (razors) in containers that are closable, puncture-resistant, and leak-proof. Containers are color-coded in red and have the BIOHAZARD symbol.

Personal Protective Equipment (PPE)

- This includes gloves, goggles, face shields, masks, laboratory coats, gowns, shoe covers, and surgical caps. OSHA requires these measures for PPE.
  - Remove PPE before leaving the work area.
  - Remove PPE when a garment becomes contaminated.
  - Place used PPE in marked areas or containers when being stored, washed, decontaminated, or discarded.
  - Wear gloves when you expect contact with blood or OPIM.
  - Wear gloves when handling or touching contaminated items or surfaces.
  - Replace worn, punctured, or contaminated gloves.
  - Never wash or decontaminate disposable gloves for re-use.
  - Discard utility gloves that show signs of cracking, peeling, tearing, or puncturing. Utility gloves are decontaminated for re-use if the process will not ruin them.

Equipment

- Contaminated equipment is cleaned and decontaminated. Decontaminate work surfaces with a proper disinfectant:
  - Upon completing tasks
  - At once when there is obvious contamination
  - After any spill of blood or OPIM
  - At the end of the work shift when surfaces become contaminated since the last cleaning

Laundry

- OSHA requires these measures for contaminated laundry.
  - Handle it as little as possible.
  - Wear gloves or other needed PPE.
  - Bag contaminated laundry where it is used.
  - Mark laundry bags or containers with the BIOHAZARD symbol for laundry sent off-site.
  - Place wet, contaminated laundry in leak-proof containers before transport. The containers are color-coded in red or have the BIOHAZARD symbol.

Exposure Incidents

- An **exposure incident** is any eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM (other potentially infectious materials).
- Report exposure incidents at once. Medical evaluation, follow-up, and required tests are free. Your blood is tested for HIV and HBV. Confidentiality is important.

CHAPTER 16 REVIEW QUESTIONS

Circle the BEST answer.

1. A healthcare-associated infection (nosocomial infection) is
   a. An infection free of disease-producing microbes
   b. An infection that develops in a person cared for in any setting where health care is given
   c. An infection acquired by health care workers
   d. An infection acquired only by older persons
2. Which statement about hand hygiene is *false?*
   a. Hand hygiene is the easiest way to prevent the spread of infection.
   b. Hand hygiene is the most important way to prevent the spread of infection.
   c. Hand hygiene is practiced before and after giving care to a person.
   d. If hands are visibly soiled, hand hygiene can be done with an alcohol-based hand rub.
3. When washing your hands, you should do the following *except*
   a. Stand away from the sink so your clothes do not touch the sink
   b. Keep your hands lower than your elbows
   c. Wash your hands for at least 15 seconds
   d. Dry your arms from the forearms to the fingertips
4. Which statement about wearing gloves is *false?*
   a. The insides of gloves are contaminated.
   b. You need a new pair of gloves for each person you care for.
   c. Change gloves when moving from a contaminated body site to a clean body site.
   d. Gloves need to cover your wrists.
5. Which statement is *false?*
   a. Gowns must cover you from your neck to your waist.
   b. A moist mask is contaminated.
   c. The outside of goggles is contaminated.
   d. You should wash your hands after removing a gown, mask, or goggles.

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6. Which statement about PPE is *false?*
   a. Remove PPE when a garment becomes contaminated.
   b. Wear gloves when handling or touching contaminated items or surfaces.
   c. Wash or decontaminate disposable gloves for re-use.
   d. Remove PPE before leaving the work area.

Answers to these questions are on p. 516.

CHAPTER 17 BODY MECHANICS

Principles of Body Mechanics

- Your strongest and largest muscles are in the shoulders, upper arms, hips, and thighs. Use these muscles to lift and move persons and heavy objects.
- For good body mechanics:
  - Bend your knees and squat to lift a heavy object. Do not bend from your waist.
  - Hold items close to your body and base of support.
- Review Box 17-1, Rules for Body Mechanics, in the Textbook.

Work-Related Injuries

- **Work-related musculo-skeletal disorders (MSDs)** are injuries and disorders of the muscles, tendons, ligaments, joints, and cartilage.
- The Occupational Safety and Health Administration (OSHA) identifies MSD risk factors as:
  - Force: the amount of physical effort needed to perform a task.
  - Repeating action: doing the same motions or series of motions continually or frequently.
  - Awkward postures: assuming positions that place stress on the body.
  - Heavy lifting: manually lifting people who cannot lift themselves.
- According to the U.S. Department of Labor, nursing assistants are at the greatest risk of MSDs.
- Always report a work-related injury as soon as possible. Early attention can help prevent the problem from becoming worse. Review Box 17-2, Preventing Work-Related Injuries, in the Textbook.

Positioning the Person

- The person must be properly positioned at all times. Regular position changes and good alignment promote comfort and well-being. Breathing is easier. Circulation is promoted. Pressure ulcers and contractures are prevented.
- Whether in bed or in a chair, the person is re-positioned at least every 2 hours. To safely position a person:
  - Use good body mechanics.
  - Ask a co-worker to help you if needed.
  - Explain the procedure to the person.
  - Be gentle when moving the person.
  - Provide for privacy.
  - Use pillows as directed by the nurse for support and alignment.
  - Provide for comfort after positioning.
  - Place the call light within reach after positioning.
  - Complete a safety check before leaving the room.
- **Fowler's position** is a semi-sitting position. In **semi-Fowler's** position, the head of the bed is raised 30 degrees but some agencies define semi-Fowler's position as raising the head of the bed 30 degrees and the knee portion 15 degrees. In **high-Fowler's** position, the head of the bed is raised between 60 and 90 degrees.
- The **supine position (dorsal recumbent position)** is the back-lying position.
- A person in the **prone position** lies on the abdomen with the head turned to 1 side.
- A person in the **lateral position (side-lying position)** lies on 1 side or the other.
- The **Sims' position (semi-prone side position)** is a left side-lying position. The upper (right) leg is sharply flexed so it is not on the lower (left) leg. The lower (left) arm is behind the person.
- Persons who sit in chairs must hold their upper bodies and heads erect. For good alignment:
  - The person's back and buttocks are against the back of the chair.
  - Feet are flat on the floor or wheelchair footplates. Never leave feet unsupported.
  - Backs of the knees and calves are slightly away from the edge of the seat.

CHAPTER 17 REVIEW QUESTIONS

Circle the BEST answer.

1. To lift and move residents and heavy objects you should
   a. Use the muscles in your lower arms
   b. Use the muscles in your legs
   c. Use the muscles in your shoulders, upper arms, hips, and thighs
   d. Use the muscles in your abdomen
2. For good body mechanics, you should do all of the following *except*
   a. Bend your knees and squat to lift a heavy object
   b. Bend from your waist to lift a heavy object
   c. Hold items close to your body and base of support
   d. Bend your legs; do not bend your back
3. Which statement is *false?*
   a. A person must be properly positioned at all times.
   b. Regular position changes and good alignment promote comfort and well-being.
   c. Regular position changes and good alignment promote pressure ulcers and contractures.
   d. When a person is in good alignment, breathing is easier and circulation is promoted.
4. In high-Fowler's position
   a. The head of the bed is raised to 30 degrees
   b. The head of the bed is raised between 30 and 45 degrees
   c. The head of the bed is raised between 45 and 60 degrees
   d. The head of the bed is raised between 60 and 90 degrees

Answers to these questions are on p. 516.

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CHAPTER 18 SAFELY MOVING THE PERSON

Preventing Work-Related Injuries

- Good body mechanics alone will not prevent injury. The Occupational Safety and Health Administration (OSHA) recommends
  - Minimizing manual lifting in all cases.
  - Eliminating manual lifting whenever possible.
  - Getting help from other staff.
- Careful planning is needed to move the person safely. You must know the person's functional status, the number of staff needed, what procedure to use, and the equipment needed.

Protecting the Skin

- Protect the person's skin from friction and shearing. Both cause infection and pressure ulcers. To reduce friction and shearing:
  - Roll the person.
  - Use friction-reducing devices such as a lift sheet (turning sheet), turning pads, and slide sheets.

Moving Persons in Bed

- Know how much help and what equipment or friction-reducing devices are needed.
- Review Box 18-2, Guidelines for Moving Persons in Bed, in the Textbook.

Raising the Person's Head and Shoulders

- You can raise the person's head and shoulders easily and safely by locking arms with the person (do not pull on the person's arm or shoulder).
- Have help with older persons and with those who are heavy or hard to move.

Moving the Person Up in Bed

- You can sometimes move light-weight adults up in bed alone if they can assist using a trapeze.
- Two or more staff members are needed to move heavy, weak, and very old persons up in bed. Always protect the person and yourself from injury.

Moving the Person Up in Bed With an Assist Device

- Assist devices are used to reduce shearing and friction. Such assist devices include a drawsheet (lift sheet), flat sheet folded in half, turning pad, slide sheet, and large incontinence product.
- Assist devices are used to move most patients and residents and at least 2 staff members are needed to position and use the assist device.
- Moving the person to the side of the bed can be done alone if the person is small enough. You move the person in segments by placing your hands and arms underneath the person. Move the upper body first (while supporting the person's neck), then the lower body, and finally the legs and feet.

Turning Persons

- Turning persons onto their sides helps prevent complications from bedrest. Certain procedures and care measures also require the side-lying position. After the person is turned, position him or her in good alignment. Use pillows as directed to support the person in the side-lying position.
- **Logrolling** is turning the person as a unit, in alignment, with 1 motion. The spine is kept straight.

Sitting on the Side of the Bed (Dangling)

- Many persons become dizzy or faint when getting out of bed too fast. They may need to sit on the side of the bed for 1 to 5 minutes before walking or transferring. Some persons increase activity in stages—bedrest, to sitting on the side of the bed, to sitting in a chair, to walking.
- While dangling, the person coughs and deep breathes. He or she moves the legs back and forth in circles to stimulate circulation. Provide for warmth during dangling.
- If dizziness or faintness occurs, lay the person down.

Re-Positioning in a Chair or Wheelchair

- Some persons slide down into the chair. For good alignment and safety, the person's back and buttocks must be against the back of the chair.
- Follow the nurse's directions and the care plan for the best way to re-position a person in a chair or wheelchair. Do not pull the person from behind the chair or wheelchair.
- If the chair reclines, have a co-worker assist, recline the chair, put an assist device under the person, and use the assist device to move the person up.
- If the person is in a wheelchair and has strength to assist, lock the wheels of the wheelchair and move the foot rests to the sides. Position a transfer belt around the person, stand in front of the person, and grasp the transfer belt with both hands. Ask the person to push with his or her feet and arms on the count of 3 and move the person back into the wheelchair while the person pushes with his or her feet and arms.

CHAPTER 18 REVIEW QUESTIONS

Circle the BEST answer.

1. Friction and shearing are reduced by doing all the following *except*
   a. Rolling the person
   b. Using a lift sheet or turning pad
   c. Using a pillow
   d. Using a slide board or slide sheet
2. After a person is turned, you must position him or her in good alignment.
   a. True
   b. False
3. Which statement about dangling is *false?*
   a. Many older persons become dizzy or faint when they first dangle.
   b. The person should cough and deep breathe while dangling.

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c. The person moves his or her legs before dangling.
d. You should cover the person's shoulders with a robe or blanket while dangling.

Answers to these questions are on p. 516.

CHAPTER 19 SAFELY TRANSFERRING THE PERSON

- A transfer is how a person safely moves to and from surfaces—bed, chair, wheelchair, toilet, or standing position.
- The amount of help needed and the method used vary with the person's ability.

Wheelchair and Stretcher Safety

- Wheelchairs are used for persons who cannot walk or who have severe problems walking. Stretchers are used to transfer persons who are seriously ill, cannot sit up, or must stay in a lying position from 1 area to another.
- Review Box 19-2, Wheelchair and Stretcher Safety, in the Textbook.

Stand and Pivot Transfers

- Some persons are able to stand and pivot (move one's body from a set standing position). Use this transfer if the person's legs are strong enough to bear weight and the person is cooperative and can follow directions and assist in the transfer.
- Transfer belts (gait belts) are used to support persons during transfers and to re-position persons in chairs and wheelchairs.
- Arrange the room so there is enough space for a safe transfer. Correct placement of the chair, wheelchair, or other device also is needed for a safe transfer.
- Have the person wear non-skid footwear for transfers.
- Lock the wheels of the bed, wheelchair, stretcher, or other assist device.
- The person must not put his or her arms around your neck when assisting the person to stand.
- After the transfer, position the person in good alignment.
- For bed to chair or wheelchair transfers, the strong side moves first. Help the person out of bed on his or her strong side. When transferring the person from the chair or wheelchair back to bed, the same rules apply. Help the person from the wheelchair to the bed on his or her strong side. If the person is weak on 1 side, position the chair or wheelchair so that the person's strong side is nearest the bed. The strong side moves first.
- Transferring the person to and from the toilet is often hard because bathrooms are small. If the wheelchair can fit in the bathroom, place it at a 90-degree angle to the toilet and use a sliding board or the stand and pivot transfer from the wheelchair to the toilet.

Lateral Transfers

- A lateral transfer moves a person between 2 horizontal surfaces, such as from a bed to a stretcher. The person slides from 1 surface to the other.
- Use friction-reducing devices to protect the skin from friction and shearing during lateral transfers.
- When moving a person from a bed to a stretcher, use a friction-reducing device and at least 2 or 3 staff members to assist. If the person weighs more than 200 pounds, a mechanical lift with supine sling, mechanical lateral device, or inflatable device is used.
- Persons who cannot help themselves are transferred with mechanical lifts. So are persons who are too heavy for the staff to transfer.
- Before using a mechanical lift, you must be trained in its use. The sling, straps, hooks, and chains must be in good repair. The person's weight must not exceed the lift's capacity. At least 2 staff members are needed. Always follow the manufacturer's instructions for using the lift.
- Falling from the lift is a common fear. To promote the person's mental comfort, always explain the procedure before you begin. Also show the person how the lift works.

CHAPTER 19 REVIEW QUESTIONS

Circle the BEST answer.

1. You are transferring a person from the bed to a wheelchair. Which statement is *false?*
   a. The person should wear non-skid footwear.
   b. The person may put his or her arms around your neck.
   c. You should use a gait/transfer belt.
   d. You should lock the wheelchair wheels.
2. A person has a weak left side and a strong right side. In transferring the person from the bed to the wheelchair, his or her strong (right) side moves first.
   a. True
   b. False
3. Before using a mechanical lift, you do all of the following *except*
   a. Check the sling, straps, and chains to ensure good repair
   b. Check the person's weight to be sure it does not exceed the lift's capacity
   c. Follow the manufacturer's instructions for using the lift
   d. Operate the lift without a co-worker

Answers to these questions are on p. 516.

CHAPTER 20 THE PERSON'S UNIT

- A person's unit is the personal space, furniture, and equipment provided for the person by the agency. The Omnibus Budget Reconciliation Act of 1987 (OBRA) requires that resident units be as personal and home-like as possible.
- Keep the person's room clean, neat, safe, and comfortable. Follow the rules in Box 20-1, Maintaining the Person's Unit, and Box 20-2, OBRA and CMS Requirements for Resident Rooms, in the Textbook.

Comfort

- Age, illness, and activity are factors that affect comfort.
- Temperature, ventilation, noise, odors, and lighting are factors that are controlled to meet the person's needs.

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Temperature and Ventilation

- Older persons and those who are ill may need higher temperatures for comfort. Ventilation systems provide fresh air and move air within the room.
- To protect older and ill persons from drafts, make sure the person wears enough clothing, offer lap robes to cover the legs, provide blankets, cover the person with a bath blanket when providing care, and move the person from drafty areas.

Odors

- To reduce odors in nursing centers:
  - Empty, clean, and disinfect bedpans, urinals, commodes, and kidney basins promptly.
  - Check to make sure toilets are flushed.
  - Check incontinent people often.
  - Clean persons who are wet or soiled from urine, feces, vomitus, or wound drainage.
  - Change wet or soiled linens and clothing promptly.
  - Keep laundry containers closed.
  - Follow agency policy for wet or soiled linens and clothing.
  - Dispose of incontinence and ostomy products promptly.
  - Provide good hygiene to prevent body and breath odors.
  - Use room deodorizers as needed and as allowed by agency policy.
- If you smoke, practice hand-washing after handling smoking materials and before giving care. Give careful attention to your uniforms, hair, and breath because of smoke odors.

Noise

- To decrease noise:
  - Control your voice.
  - Handle equipment carefully.
  - Keep equipment in good working order.
  - Answer phones, call lights, and intercoms promptly.

Lighting

- Adjust lighting to meet the person's needs. Glares, shadows, and dull lighting can cause falls, headaches, and eyestrain. A bright room is cheerful. Dim light is better for relaxing and rest. Persons with poor vision need bright light. Always keep light controls within the person's reach.

Room Furniture and Equipment

- Rooms are furnished and equipped to meet basic needs.

The Bed

- Beds are raised horizontally to give care. This reduces bending and reaching.
- Bed wheels are locked at all times except when moving the bed.
- Use bed rails as the nurse and care plan direct.
- Basic bed positions:
  - *Flat*—the usual sleeping position.
  - *Fowler's position*—a semi-sitting position. The head of the bed is raised between 45 and 60 degrees.
  - *High-Fowler's position*—a semi-sitting position. The head of the bed is raised 60 to 90 degrees.
  - *Semi-Fowler's position*—the head of the bed is raised 30 degrees. Some agencies define semi-Fowler's position as when the head of the bed is raised 30 degrees and the knee portion is raised 15 degrees. Know the definition used by your agency.
  - *Trendelenburg's position*—the head of the bed is lowered and the foot of the bed is raised. A doctor orders the position.
  - *Reverse Trendelenburg's position*—the head of the bed is raised and the foot of the bed is lowered. A doctor orders the position.

Bed Safety

- *Entrapment* means the person can get caught, trapped, or entangled in spaces created by bed rails, the mattress, the bed frame, or the head-board and foot-board. Serious injuries and deaths have occurred from entrapment. If a person is at risk for entrapment, report your concerns to the nurse at once. If a person is caught, trapped, or entangled, try to release the person. Call for the nurse at once.

The Over-Bed Table

- Only clean and sterile items are placed on the table. Never place bedpans, urinals, or soiled linens on the over-bed table or on top of the bedside stand.
- Clean the table and bedside stand after using them for a work surface and before serving meal trays.

Privacy Curtains

- Always pull the curtain completely around the bed before giving care. Privacy curtains do not block sound or conversations.

The Call System

- The call light must always be kept within the person's reach—in the room, bathroom, and shower or tub room. You must:
  - Place the call light on the person's strong side.
  - Remind the person to signal when help is needed.
  - Answer call lights promptly.
  - Answer bathroom and shower or tub room call lights at once.
- Persons with limited hand mobility may need special communication measures.
- Be careful when using the intercom. Remember confidentiality. Persons nearby can hear what you and the person say.

The Bathroom

- Grab bars are by the toilet so persons can use them to get on and off the toilet.
- Some toilet seats are raised to make transfers easier and for persons with joint problems.
- A call light or button is within reach of the toilet if the person needs assistance.

Closet and Drawer Space

- The person must have free access to the closet and its contents. You must have the person's permission to open or search closets or drawers.
- Agency staff can inspect a person's closet or drawers if hoarding is suspected. The person is informed of the inspection and is present when it takes place. Have a co-worker present when you inspect a person's closet.

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CHAPTER 20 REVIEW QUESTIONS

Circle the BEST answer.

1. Serious injuries and death have occurred from entrapment.
   a. True
   b. False
2. You should never place bedpans, urinals, or soiled linens on the over-bed table.
   a. True
   b. False
3. You should clean the bedside stand if you use it for a work surface.
   a. True
   b. False
4. The following protect a person from drafts *except*
   a. Wearing enough clothing
   b. Lap robes
   c. Using a sheet when giving care
   d. Providing blankets
5. To reduce odors, you do the following *except*
   a. Empty bedpans and commodes promptly
   b. Keep laundry containers open
   c. Check to make sure toilets are flushed
   d. Clean persons who are wet or soiled from urine or feces
6. Which statement about the call light is *false?*
   a. The call light must always be within the person's reach.
   b. Place the call light on the person's strong side.
   c. You have to answer the call lights only for residents assigned to you.
   d. Answer call lights promptly.
7. You suspect a person is hoarding food in her closet. Before you inspect the closet, what do you do?
   a. Tell another nursing assistant what you suspect.
   b. Inspect the closet without telling the resident.
   c. Tell the family.
   d. Ask the resident if you can inspect the closet.

Answers to these questions are on p. 516.

CHAPTER 21 BEDMAKING

- Clean, dry, and wrinkle-free linens promote comfort. Skin breakdown and pressure ulcers are prevented.
- To keep beds neat and clean:
  - Change linens whenever they become wet, soiled, or damp.
  - Straighten linens whenever loose or wrinkled and at bedtime.
  - Check for and remove food and crumbs after meals and snacks.
  - Check linens for dentures, eyeglasses, hearing aids, sharp objects, and other items.
  - Follow Standard Precautions and the Bloodborne Pathogen Standard.

Types of Beds

- Beds are made in these ways.
  - A closed bed is not in use or the bed is ready for a new resident. Top linens are not folded back.
  - An open bed is in use. Top linens are fan-folded back so the person can get into bed. A closed bed becomes an open bed by fan-folding back the top linens.
  - An occupied bed is made with the person in it.
  - A surgical bed is made to transfer a person from a stretcher. This bed is also made for persons who arrive by ambulance.

Linens

- When handling linens and making beds:
  - Practice medical asepsis.
  - Always hold linens away from your body and uniform. Your uniform is considered dirty.
  - Never shake linens.
  - Place clean linens on a clean surface.
  - Never put clean or used linens on the floor.
- Collect enough linens. Do not bring unneeded linens to the person's room. Once in the room, extra linens are considered contaminated. They cannot be used for another person.
- Roll each piece of used linens away from you. The side that touched the person is inside the roll and away from you.

Making Beds

- When making beds, safety and medical asepsis are important. Use good body mechanics. Follow the rules for safe resident handling, moving, and transfers. Practice hand hygiene before handling clean linens and after handling used linens. To save time and energy, make beds with a co-worker.
- Review Box 21-1, Rules for Bedmaking, in the Textbook.
- Closed beds are made for nursing center residents who are up and away from the bed for all or most of the day. Change linens as needed. For beds awaiting new residents or patients, the entire bed requires clean linens after the bed system has been cleaned and disinfected.
- The closed bed becomes an open bed by fan-folding back the top linens so the person can get into bed with ease.
- An occupied bed is made while the person stays in bed. Keep the person in good alignment. Follow restrictions or limits in the person's movement or position. Explain each procedure step to the person before it is done. This is important even if the person cannot respond to you.

CHAPTER 21 REVIEW QUESTIONS

Circle the BEST answer.

1. Once in the person's room, extra linens are considered contaminated. They can be used for another person.
   a. True
   b. False
2. Roll each piece of used linens away from you. The side that touched the person is inside the roll.
   a. True
   b. False
3. Wear gloves when removing linens from the person's bed.
   a. True
   b. False

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4. To keep beds neat and clean, do the following *except*
   a. Straighten linens whenever loose or wrinkled
   b. Check for and remove food and crumbs after meals
   c. Check linens for dentures, eyeglasses, and hearing aids
   d. Change linens monthly
5. Which statement is *false?*
   a. Practice medical asepsis when handling linens.
   b. Always hold linens away from your body and uniform.
   c. Shake linens to remove crumbs.
   d. Put used linens in the used laundry bin.

Answers to these questions are on p. 516.

CHAPTER 22 PERSONAL HYGIENE

- Besides cleansing, good hygiene prevents body and breath odors. It is relaxing and increases circulation.
- Culture and personal choice affect hygiene.

Daily Care

- Most people have hygiene routines and habits. Hygiene measures are often done before and after meals and at bedtime. You assist with hygiene whenever it is needed. Protect the person's right to privacy and to personal choice.

Oral Hygiene

- Oral hygiene keeps the mouth and teeth clean. It prevents mouth odors and infections, increases comfort, and makes food taste better. Mouth care also reduces the risk for cavities and periodontal disease.
- Assist with oral hygiene after sleep, after meals, and at bedtime. Follow the care plan.
- Follow Standard Precautions and the Bloodborne Pathogen Standard.
- Report and record:
  - Dry, cracked, swollen, or blistered lips
  - Mouth or breath odor
  - Redness, swelling, irritation, sores, or white patches in the mouth or on the tongue
  - Bleeding, swelling, or redness of the gums
  - Loose teeth
  - Rough, sharp, or chipped areas on dentures

Brushing and Flossing Teeth

- Flossing removes plaque and tartar from the teeth as well as food from between the teeth. Flossing is usually done after brushing. If done once a day, bedtime is the best time to floss.
- Some persons need help gathering and setting up equipment for oral hygiene. You may have to perform oral care for persons who are weak, cannot move their arms, or are too confused to brush their teeth.

Mouth Care for the Unconscious Person

- Unconscious persons have dry mouths and crusting on the tongue and mucous membranes. Oral hygiene keeps the mouth clean and moist. It also helps prevent infection.
- Use sponge swabs to apply the cleaning agent. To prevent cracking of the lips, apply a lubricant to the lips. Check the care plan.
- To prevent aspiration on the unconscious person:
  - Position the person on 1 side with the head turned well to the side.
  - Use only a small amount of fluid to clean the mouth.
  - Do not insert dentures. Dentures are not worn when the person is unconscious.
- When giving oral hygiene, keep the person's mouth open with a padded tongue blade.
- Mouth care is given at least every 2 hours. Follow the nurse's direction and the care plan.

Denture Care

- Mouth care is given and dentures are cleaned as often as natural teeth. Dentures are usually removed at bedtime. Some persons remove dentures at meal time. Remind people not to wrap dentures in tissues or napkins at meal time, as they could be discarded accidentally.
- Dentures are slippery when wet. Hold them firmly. During cleaning, hold them over a basin of water lined with a towel. Use a cleaning agent and follow the manufacturer's instructions.
- Hot water causes dentures to lose their shape. If dentures are not worn after cleaning, store them in a container with cool water or a denture soaking solution.
- Label the denture cup with the person's name, room number, and bed number. Report lost or damaged dentures to the nurse at once. Losing or damaging dentures is negligent conduct.
- Many people do not like being seen without their dentures. Privacy is important. If you clean dentures, return them to the person as quickly as possible.
- Persons with partial dentures have some natural teeth. They need to brush and floss the natural teeth.

Bathing

- Bathing cleans the skin. The mucous membranes of the genital and anal areas are cleaned as well. A bath is refreshing and relaxing. Circulation is stimulated and body parts exercised. You have time to talk to the person and make observations.
- Review Box 22-2, Rules for Bathing, in the Textbook.
- Soap dries the skin. Therefore older persons usually need a complete bath or shower twice a week. Partial baths are taken the other days. Some bathe daily but not with soap. Thorough rinsing is needed when using soap. Lotions and oils keep the skin soft.
- Water temperature for complete bed baths and partial bed baths is between 110°F and 115°F. Older persons have fragile skin and need lower water temperatures. Measure water temperature according to agency policy.
- Report and record:
  - The color of the skin, lips, nail beds, and sclera (whites of the eyes)
  - If the skin appears pale, grayish, yellow (jaundice), or bluish (cyanotic)
  - The location and description of rashes
  - Skin texture—smooth, rough, scaly, flaky, dry, moist

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- ○ Diaphoresis—profuse (excessive) sweating
- ○ Bruises or open areas
- ○ Pale or reddened areas, particularly over bony parts
- ○ Drainage or bleeding from wounds or body openings
- ○ Swelling of the feet and legs
- ○ Corns or calluses on the feet
- ○ Skin temperature
- ○ Complaints of pain or discomfort
- Use caution when applying powders. Do not use powders near persons with respiratory disorders. Do not sprinkle or shake powder onto the person. To safely apply powder:
  - ○ Turn away from the person.
  - ○ Sprinkle a small amount onto your hands or a cloth.
  - ○ Apply the powder in a thin layer.
  - ○ Make sure powder does not get on the floor. Powder is slippery and can cause falls.

The Complete Bed Bath

- The complete bed bath involves washing the person's entire body in bed. Wash around the person's eyes with water. Do not use soap. Gently wipe from the inner to the outer aspect of the eye. Use a clean part of the washcloth for each stroke. Ask the person if you should use soap to wash the face. Let the person wash the genital area if he or she is able.
- Give a back massage after the bath. Apply deodorant or antiperspirant, lotion, and powder as requested. Comb and brush the hair. Empty and clean the wash basin.

The Partial Bath

- The partial bath involves bathing the face, hands, axillae (underarms), back, buttocks, and perineal area. You assist the person as needed. Most need help washing the back.

Tub Baths and Showers

- Falls, burns, and chilling from water are risks. Review Box 22-2, Rules for Bathing, and 22-3, Tub Bath and Shower Safety, in the Textbook.
- A tub bath can cause a person to feel faint, weak, or tired. The person may need a transfer bench, a tub with a side entry door, a wheelchair or stretcher lift, or a mechanical lift to get in and out of the tub.
- Some people can use a regular shower. Have the person use the grab bars for support during the shower. Use a bath mat if the shower does not have non-skid surfaces. Never let weak or unsteady persons stand in the shower. They may need to use shower chairs, shower stalls or cabinets, or shower trolleys. Some shower rooms have 2 or more stations. Protect the person's privacy. Properly screen and cover the person.
- Water temperature for tub baths and showers is usually 105°F. Report and record dizziness and light-headedness.
- Clean and disinfect the tub or shower before and after use.

Perineal Care

- Perineal care involves cleaning the genital and anal areas. It is done daily during the bath and whenever the area is soiled with urine or feces. The person does perineal care if able.
- *Perineal* and *perineum* are not common terms. Most people understand *privates, private parts, crotch, genitals,* or *the area between the legs*. Use terms the person understands.
- Standard Precautions, medical asepsis, and the Bloodborne Pathogen Standard are followed.
- Work from the cleanest area to the dirtiest---commonly called cleaning from "front to back." On a woman, clean from the urethra (cleanest) to the anal (dirtiest) area. On a male, start at the meatus of the urethra and work outward.
- Use warm water. Use washcloths, towelettes, cotton balls, or swabs according to agency policy. Rinse thoroughly. Pat dry. Water temperature is usually 105°F to 109°F.
- Report and record:
  - ○ Bleeding, redness, swelling, irritation, discharge
  - ○ Complaints of pain, burning, or other discomfort
  - ○ Signs of urinary or fecal incontinence
  - ○ Signs of skin breakdown
  - ○ Odors

CHAPTER 22 REVIEW QUESTIONS

Circle the BEST answer.

1. Oral hygiene does the following *except*
   a. Keep the mouth and teeth clean
   b. Prevent mouth odors and infections
   c. Decrease comfort
   d. Make food taste better
2. When giving oral hygiene, you should report and record the following *except*
   a. Dry, cracked, swollen, or blistered lips
   b. Redness, sores, or white patches in the mouth
   c. Bleeding, swelling, or redness of the gums
   d. The number of fillings a person has
3. A person is unconscious. When you do mouth care, you do the following *except*
   a. Use only a small amount of fluid to clean the mouth
   b. Use your fingers to keep the mouth open
   c. Explain what you are doing
   d. Give mouth care at least every 2 hours
4. Which statement about dentures is *false?*
   a. Dentures are slippery when wet.
   b. During cleaning, hold dentures over a basin of water lined with a towel.
   c. Store dentures in cool water.
   d. Remind people to wrap their dentures in tissues or napkins.
5. Bathing does the following *except*
   a. Cleanses the skin
   b. Stimulates circulation
   c. Makes a person tense
   d. Permits you to observe the person's skin
6. The water temperature for a complete bed bath is
   a. 102°F to 108°F
   b. 110°F to 115°F
   c. 115°F to 120°F
   d. 120°F to 125°F

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7. Which statement is *false?*
   a. Use powder near persons with respiratory disorders.
   b. Before applying powder, check with the nurse and the care plan.
   c. Before applying powder, sprinkle a small amount of powder onto your hands.
   d. Apply powder in a thin layer.
8. When washing a person's eyes, you should do the following *except*
   a. Use only water
   b. Gently wipe from the inner to the outer aspect of the eye
   c. Gently wipe from the outer to the inner aspect of the eye
   d. Use a clean part of the washcloth for each stroke
9. When giving female perineal care, you should work from the urethra to the anal area.
   a. True
   b. False
10. When giving male perineal care, start at the meatus and work outward.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 23 GROOMING

- Hair care, shaving, nail and foot care, and clean garments prevent infection and promote comfort. They also affect love, belonging, and self-esteem needs.

Hair Care

- You assist patients and residents with brushing and combing hair and with shampooing as needed and according to the care plan. The nursing process reflects the person's culture, personal choice, skin and scalp condition, health history, and self-care ability.

Brushing and Combing Hair

- Encourage residents to brush and comb their own hair but assist as needed.
- Daily brushing and combing prevent tangled and matted hair.
- When brushing and combing hair, start at the scalp and brush or comb to the hair ends.
- Never cut hair for any reason.
- Special measures are needed for curly, coarse, and dry hair. Check the care plan.
- When giving hair care, place a towel across the person's back and shoulders to protect garments from falling hair. If the person is in bed, give hair care before changing the linens and pillowcase.

Shampooing

- Shampooing frequency depends on the person's needs and preferences.
- Keep shampoo away from and out of eyes. Have the person hold a washcloth over the eyes.
- Wear gloves if the person has scalp sores.
- Follow Standard Precautions and the Bloodborne Pathogen Standard.
- Water temperature is usually 105°F.
- Hair is dried and styled as soon as possible after the shampooing.
- During shampooing, report and record:
  - Scalp sores
  - Flaking
  - Itching
  - Presence of nits or lice
  - Patches of hair loss
  - Hair falling out in patches
  - Very dry or very oily hair
  - Matted or tangled hair
  - How the person tolerated the procedure

Shaving

- Many men shave for comfort and well-being. Many women shave their underarms and legs.
- Electric shaver or safety razors are used. Some persons have their own shavers. Do not use safety razors on persons with healing problems or persons taking anticoagulant drugs. Older persons with wrinkled skin are at risk for nicks and cuts. Safety razors are not used to shave them or persons with dementia.
- Wash and comb mustaches and beards daily and as needed. Ask the person how to groom his mustache or beard. Never trim a mustache or beard without the person's consent.
- Many women shave their legs and underarms. This practice varies among cultures. Legs and underarms are shaved after bathing when the skin is soft.
- Review Box 23-1, Rules for Shaving, in the Textbook.

Nail and Foot Care

- Nail and foot care prevent infection, injury, and odors.
- Nails are easier to trim and clean right after soaking or bathing.
- Use nail clippers to cut fingernails. Never use scissors. Use extreme caution to prevent damage to nearby tissues.
- Some agencies do not let nursing assistants cut or trim toenails. Follow agency policy.
- Follow Standard Precautions and the Bloodborne Pathogen Standard.
- Report and record:
  - Dry, reddened, irritated, or callused areas
  - Breaks in the skin
  - Corns on top of and between the toes
  - Blisters
  - Very thick nails
  - Loose nails
- You do not cut or trim toenails if a person has diabetes or poor circulation to the legs and feet or takes drugs that affect blood clotting. Also, do not cut or trim toenails if the person has very thick nails or ingrown toenails. The nurse or podiatrist cuts toenails and provides foot care for these persons.
- When doing foot care, check between the toes for cracks and sores. If left untreated, a serious infection could occur.

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- The feet of persons with decreased sensation or circulatory problems may easily burn because they do not feel hot temperatures.
- After soaking, apply lotion to the feet. Because the lotion can cause slippery feet, help the person put on non-skid footwear before you transfer the person or let the person walk.

Changing Garments

- Garments are changed after the bath and whenever wet or soiled.
- When changing clothing:
  - Provide for privacy.
  - Encourage the person to do as much as possible.
  - Let the person choose what to wear. Make sure the right under-garments are chosen.
  - Make sure garments and footwear are the correct size.
  - Remove clothing from the strong or "good" (unaffected) side first.
  - Put clothing on the weak (affected) side first.
  - Support the arm or leg when removing or putting on a garment.
  - Move or handle the body gently. Do not force a joint beyond its range of motion or to the point of pain.
- When changing gowns, remove the gown from the strong arm first while supporting the weak arm. Put a clean gown on the weak arm first and then the strong arm.
- To change the gown of a person with an intravenous (IV) bag, gather the sleeve of the arm with the IV bag and slide it over the IV site and tubing. Remove the IV bag, draw it through the sleeve, and re-hang the IV bag. Gather the sleeve of the clean gown, remove the IV bag, slide the sleeve over the IV bag, then re-hang the bag. Slide the sleeve over the tubing, hand, arm, and IV site. Do not pull on the tubing.
- Have the nurse check the flow rate after changing the gown of a person with an IV. If the person is on an IV pump, do not change the gown.

CHAPTER 23 REVIEW QUESTIONS

Circle the BEST answer.

1. Hair care, shaving, and nail and foot care prevent infection and promote comfort.
   a. True
   b. False
2. If a person's hair is matted, you may cut the hair.
   a. True
   b. False
3. When giving hair care, place a towel across the person's back and shoulders to protect garments from falling hair.
   a. True
   b. False
4. You should wear gloves when shampooing a person who has scalp sores.
   a. True
   b. False
5. A person takes an anticoagulant. Therefore he shaves with a blade razor.
   a. True
   b. False
6. You should wear gloves when shaving a person with a safety razor.
   a. True
   b. False
7. Never trim a mustache or beard without the person's consent.
   a. True
   b. False
8. Mustaches and beards need daily care.
   a. True
   b. False
9. A person has diabetes. You can cut his or her toenails.
   a. True
   b. False
10. Fingernails are cut with
    a. Scissors
    b. Nail clippers
    c. An emery board
    d. A nail file
11. Which statement is *false?*
    a. Provide privacy when a person is changing clothes.
    b. Most residents wear street clothes during the day.
    c. Let the person choose what to wear.
    d. You may tear a person's clothing.

Answers to these questions are on p. 516.

CHAPTER 24 URINARY ELIMINATION

Normal Urination

- The healthy adult produces about 1500 milliliters (mL) of urine a day.
- The frequency of urination is affected by amount of fluid intake, habits, availability of toilet facilities, activity, work, and illness. People usually void at bedtime, after sleep, and before meals. Some people void every 2 to 3 hours. The need to void at night disturbs sleep. Some persons need help getting to the bathroom and others use bedpans, urinals, or commodes. Review Box 24-1, Rules for Normal Urination, in the Textbook.

Observations

- Observe urine for color, clarity, odor, amount, particles, and blood. Normal urine is pale yellow, straw-colored, or amber. It is clear with no particles. A faint odor is normal.
- Some foods and drugs affect urine color. Ask the nurse to observe urine that looks or smells abnormal.
- Report the following urinary problems.
  - **Dysuria**—painful or difficult urination
  - **Hematuria**—blood in the urine
  - **Nocturia**—frequent urination at night
  - **Oliguria**—scant amount of urine; less than 500mL in 24 hours
  - **Polyuria**—abnormally large amounts of urine
  - **Urinary frequency**—voiding at frequent intervals

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- **Urinary incontinence**—involuntary loss or leakage of urine
- **Urinary urgency**—the need to void at once

- Follow Standard Precautions and the Bloodborne Pathogen Standard when handling bedpans, urinals, commodes, and their contents.
- Thoroughly clean and disinfect bedpans, urinals, and commodes after use.
- Men stand or sit at the side of the bed to use the urinal. Some men need support when standing.
- You may have to place and hold the urinal for some men. This may embarrass both the person and you. Act in a professional manner at all times.
- Remind men to hang urinals on bed rails and to signal after using them.
- Commodes are chairs or wheelchairs with an opening for a container. Persons unable to walk to the bathroom often use commodes.

Urinary Incontinence

- **Urinary incontinence** is the involuntary loss or leakage of urine.
- If urinary incontinence is a new problem, tell the nurse at once.
- Incontinence is embarrassing. Garments are wet and odors develop. Skin irritation, infection, and pressure ulcers are risks. The person's pride, dignity, and self-esteem are affected. Social isolation, loss of independence, and depression are common.
- Good skin care and dry garments and linens are essential. Promoting normal urinary elimination prevents incontinence in some people. Other people may need bladder training.
- Review Box 24-3, Nursing Measures for Urinary Incontinence, in the Textbook.
- Caring for persons with incontinence is stressful. Remember, the person does not choose to be incontinent. If you find yourself becoming short-tempered and impatient, talk to the nurse at once. Kindness, empathy, understanding, and patience are needed.

Applying Incontinence Products

- Incontinence products are used to keep the person dry. Most are disposable and only used once.
- Incontinence products include a complete incontinence brief, a pad and under-garment, pull-on underwear, or a belted under-garment. Follow the manufacturer's instructions for applying incontinence products.
- Observations to report and record:
  - Complaints of pain, burning, irritation, or the need to void
  - Signs and symptoms of skin breakdown, including redness, irritation, blisters, and complaints of pain, burning, itching, or tingling
  - The amount of urine and urine color
  - Blood in the urine
  - Leakage or a poor product fit
- Review Box 24-4, Applying Incontinence Products, in the Textbook.

Bladder Training

- Bladder training helps some persons with urinary incontinence. Control of urination is the goal. Bladder control promotes comfort and quality of life. It also increases self-esteem.
- You assist with bladder training as directed by the nurse and the care plan. The care plan may include one of the following: bladder rehabilitation, prompted voiding, habit training/scheduled voiding, or catheter clamping.

CHAPTER 24 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Normal urine is yellow, straw-colored, or amber.
   b. Urine with a strong odor is normal.
   c. A person normally voids 1500 mL a day.
   d. Observe urine for color, clarity, odor, amount, and particles.
2. Which observation does *not* need to be reported to the nurse promptly?
   a. Complaints of urgency
   b. Burning on urination
   c. Painful or difficult urination
   d. Clear amber urine
3. Which statement is *false?*
   a. Incontinence is embarrassing.
   b. Caring for persons with incontinence may be stressful.
   c. Incontinence is a personal choice.
   d. Be kind and patient to persons who are incontinent.
4. A person with a catheter complains of pain. You should notify the nurse at once.
   a. True
   b. False
5. The goal of bladder training is to
   a. Allow the person to use the toilet
   b. Keep the catheter
   c. Gain control of urination
   d. Decrease self-esteem

Answers to these questions are on p. 516.

CHAPTER 25 URINARY CATHETERS

- A catheter is a tube used to drain or inject fluid through a body opening. A urinary catheter is inserted through the urethra into the bladder and is used to drain urine.
- The types of catheters are a **straight catheter,** which is used to drain the urine and then removed, and an **indwelling catheter (retention or Foley catheter),** which is left in the bladder and drains urine constantly into a drainage bag.

Catheter Care

- The risk of a urinary tract infection (UTI) is high. Review Box 25-1, Indwelling Catheter Care, in the Textbook.
- The catheter must not pull at the insertion site. Hold the catheter securely during catheter care. Then properly secure the catheter. Also make sure the tubing is not under the person. Besides obstructing urine flow, lying

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on the tubing is uncomfortable. It can also cause skin breakdown.

- Follow Standard Precautions and the Bloodborne Pathogen Standard.
- Report and record:
  - Complaints of pain, burning, irritation, or the need to void (report at once)
  - Crusting, abnormal drainage, or secretions
  - The color, clarity, and odor of urine
  - Particles in the urine
  - Blood in the urine
  - Cloudy urine
  - Urine leaking at the insertion site
  - Drainage system leaks

Urine Drainage Systems

- A closed urinary drainage system is used for indwelling catheters. Infections can occur if microbes enter the drainage system. The two types of drainage bags are standard drainage bags and leg bags.
- The standard drainage bag hangs from the bed frame, chair, or wheelchair. It must not touch the floor. The bag is always kept lower than the person's bladder. Do not hang the drainage bag on a bed rail.
- If the drainage system is disconnected accidentally, tell the nurse at once. Do not touch the ends of the catheter or tubing. Do the following:
  - Practice hand hygiene. Put on gloves.
  - Wipe the end of the drainage tube with an antiseptic wipe.
  - Wipe the end of the catheter with another antiseptic wipe.
  - Do not put the ends down. Do not touch the ends after you clean them.
  - Connect the drainage tubing to the catheter.
  - Discard the wipes into a biohazard bag.
  - Remove the gloves. Practice hand hygiene.
- Check with the nurse and care plan about when to empty and measure the urine in the drainage bag. Follow Standard Precautions and the Bloodborne Pathogen Standard.
- A leg bag is a drainage system that attaches to the thigh or calf. Empty and measure a leg bag when it is half full.
- Report and record:
  - The amount of urine measured
  - The color, clarity, and odor of urine
  - Particles in the urine
  - Blood in the urine
  - Cloudy urine
  - Complaints of pain, burning, irritation, or the need to urinate
  - Drainage system leaks

Removing Indwelling Catheters

- Before removing an indwelling catheter, be sure that your state allows you to perform this procedure, the procedure is in your job description, you know how to use the supplies and equipment, and you review the procedure with the nurse.
- The balloon of an indwelling catheter is inflated with water injected with a syringe. A syringe is also used to remove the water. Before removing the indwelling catheter, learn the size of the balloon before deflating it. If the balloon is 5 mL in size, you must withdraw 5 mL of water with the syringe. Do not remove the catheter if water remains in the balloon. Call the nurse.
- Report and record the following observations.
  - The amount of urine in the drainage bag
  - The color, clarity, and odor of urine
  - Particles in the urine
  - Blood in the urine
  - How the person tolerated the procedure
  - Complaints of pain, burning, irritation, or the need to void

Condom Catheters

- Condom catheters are often used for incontinent men. They are also called external catheters, Texas catheters, and urinary sheaths.
- These catheters are changed daily after perineal care.
- To apply a condom catheter, follow the manufacturer's instructions. Thoroughly wash and dry the penis before applying the catheter.
- Some condom catheters are self-adhering. Other catheters are secured in place with elastic tape in a spiral manner. Never use adhesive tape to secure catheters. It does not expand. Blood flow to the penis is cut off, injuring the penis.
- When removing or applying a condom catheter, report and record the following observations.
  - Reddened or open areas on the penis
  - Swelling of the penis
  - Color, clarity, and odor of urine
  - Particles in the urine
  - Blood in the urine
  - Cloudy urine
- Do not apply a condom catheter if the penis is red, is irritated, or shows signs of skin breakdown. Report your observations to the nurse at once.

CHAPTER 25 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. The urine drainage system should hang from the bed frame or chair.
   b. The urine drainage system should hang on a bed rail.
   c. The urine drainage system must be off the floor.
   d. The urine drainage system must be kept lower than the person's bladder.
2. If the drainage system becomes accidentally disconnected, you need to
   a. Call the nurse
   b. Put on gloves and use antiseptic wipes to clean the ends of the tubing
   c. Pub on gloves and clamp the tubing
   d. Put the ends of the tubing on paper towels

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3. Before removing an indwelling catheter, what do you do first?
   a. Tug on the catheter to see if it will come out.
   b. Wipe the meatus with an antiseptic wipe.
   c. Drain the balloon with a syringe.
   d. Check the balloon size.
4. Which statement is *false?*
   a. Condom catheters are changed daily.
   b. Follow the manufacturer's instructions when applying a condom catheter.
   c. Use adhesive tape to secure a condom catheter in place.
   d. Report and record open or reddened areas on the penis at once.

Answers to these questions are on p. 516.

CHAPTER 26 BOWEL ELIMINATION

Normal Bowel Elimination

- Stools are normally brown, soft, formed, moist, and shaped like the rectum. They have a normal odor caused by bacterial action in the intestines. Certain foods and drugs cause odors.
- Carefully observe stools before disposing of them. Observe and report the color, amount, consistency, odor, and shape of stools. Also observe and report the presence of blood or mucus, the time the person had the bowel movement (BM), the frequency of BMs, and any complaints of pain or discomfort.

Factors Affecting Bowel Elimination

- *Privacy*. Bowel elimination is a private act.
- *Habits*. Many people have a BM after breakfast. Some read. Defecation is easier when a person is relaxed.
- *Diet—high-fiber foods*. Fiber helps prevent constipation.
- *Diet—other foods*. Some foods cause constipation. Other foods cause frequent stools or diarrhea.
- *Fluids*. Drinking 6 to 8 glasses of water daily promotes normal bowel elimination. Warm fluids—coffee, tea, hot cider, warm water—increase peristalsis.
- *Activity*. Exercise and activity maintain muscle tone and stimulate peristalsis.
- *Drugs*. Drugs can prevent constipation or control diarrhea. Some have diarrhea or constipation as side effects.
- *Disability*. Some people cannot control BMs. A bowel training program is needed.
- *Aging*. Older persons are at risk for constipation. Some older persons lose bowel control and have fecal incontinence.
- To provide comfort and safety during bowel elimination, review Box 26-1, Safety and Comfort During Bowel Elimination, in the Textbook. Follow Standard Precautions and the Bloodborne Pathogen Standard.

Common Problems

- Common problems include constipation, fecal impaction, diarrhea, fecal incontinence, and flatulence.
- **Constipation** is the passage of a hard, dry stool.
- Common causes of constipation are a low-fiber diet and ignoring the urge to defecate. Other causes include decreased fluid intake, inactivity, drugs, aging, and certain diseases.
- Dietary changes, fluids, and activity prevent or relieve constipation. So do stool softeners, laxatives, suppositories, and enemas.
- A **fecal impaction** is the prolonged retention and buildup of feces in the rectum.
- Fecal impaction results if constipation is not relieved. The person cannot defecate. Liquid feces pass around the hardened fecal mass in the rectum. The liquid feces seep from the anus.
- Abdominal discomfort, abdominal distention, nausea, cramping, and rectal pain are common. Older persons have poor appetite or confusion. Some persons have a fever. Report these signs and symptoms to the nurse.
- Checking for and removing a fecal impaction can be dangerous, because the vagus nerve can be stimulated, resulting in a slowing of the heart rate. Check with your state and agency policies to determine if you may perform this procedure.
- **Diarrhea** is the frequent passage of liquid stools.
- The need to have a BM is urgent. Some people cannot get to a bathroom in time. Abdominal cramping, nausea, and vomiting may occur.
- Assist with elimination needs promptly, dispose of stools promptly, and give good skin care. Liquid stools irritate the skin. So does frequent wiping with toilet paper. Skin breakdown and pressure ulcers are risks.
- Follow Standard Precautions and the Bloodborne Pathogen Standard when in contact with stools.
- Report signs of diarrhea at once. Ask the nurse to observe the stool.
- **Fecal incontinence** is the inability to control the passage of feces and gas through the anus.
- Fecal incontinence affects the person emotionally. Frustration, embarrassment, anger, and humiliation are common. The person may need:
  - Bowel training
  - Help with elimination after meals and every 2 to 3 hours
  - Incontinence products to keep garments and linens clean
  - Good skin care
- **Flatulence** is the excessive formation of gas or air in the stomach and intestines.
- Causes include swallowing air while eating and drinking and bacterial action in the intestines. Other causes may be gas-forming foods, constipation, bowel and abdominal surgeries, and drugs that decrease peristalsis.
- If flatus is not expelled, the intestines distend (swell or enlarge from the pressure of gases). Abdominal cramping or pain, shortness of breath, and a swollen abdomen occur. "Bloating" is a common complaint. Exercise, walking, moving in bed, and the left side-lying position often produce flatus. Enemas and drugs may be ordered.

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Bowel Training

- Bowel training has 2 goals.
  - To gain control of BMs.
  - To develop a regular pattern of elimination. Fecal impactions, constipation, and fecal incontinence are prevented.
- Factors that promote elimination are part of the care plan and bowel training program.

Suppositories

- A suppository is a cone-shaped, solid drug that is inserted into a body opening. A rectal suppository is inserted into the rectum. Suppositories melt at body temperature.
- A BM occurs about 30 minutes after inserting a suppository.
- Check with your state and agency policies to determine if you can insert a suppository.

Enemas

- An **enema** is the introduction of fluid into the rectum and lower colon.
- Doctors order enemas to:
  - Remove feces.
  - Relieve constipation, fecal impaction, or flatulence.
  - Clean the bowel of feces before certain surgeries and diagnostic procedures.
- Review Box 26-2, Giving Enemas, in the Textbook.
- The preferred position for an enema is the Sims' or left side-lying position.
- A cleansing enema is used to clean the bowel of feces and flatus and to relieve constipation and fecal impaction. Cleansing enemas take effect in 10 to 20 minutes.
- A small-volume enema irritates the bowel and distends the rectum, causing a BM. The person should retain the enema solution until he or she needs to have a BM, which usually takes 5 to 10 minutes.
- An oil-retention enema relieves constipation and fecal impaction by softening the feces and lubricating the rectum so the feces can pass. The oil is retained for 30 minutes to 1 to 3 hours.

The Person With an Ostomy

- Sometimes part of the intestines is removed surgically. An ostomy is sometimes necessary. An **ostomy** is a surgically created opening for the elimination of body wastes. The opening is called a **stoma.** The person wears an ostomy pouch over the stoma to collect stools and flatus.
- Stools irritate the skin. Skin care prevents skin breakdown around the stoma. The skin is washed and dried. Then a skin barrier is applied around the stoma. It prevents stools from having contact with the skin. The skin barrier is part of the ostomy pouch or a separate device.
- The pouch has an adhesive backing that is applied to the skin. Sometimes pouches are secured to ostomy belts.
- The pouch is changed every 3 to 7 days and when it leaks. Frequent pouch changes can damage the skin.
- Many pouches have a drain at the bottom that closes with a clip, clamp, or wire closure. The drain is opened to empty the pouch. The drain is wiped with toilet tissue before it is closed.
- Observations to report and record include signs of skin breakdown, color, amount, consistency, and odor of stools, and complaints of pain or discomfort.

CHAPTER 26 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Lack of privacy can prevent defecation.
   b. Low-fiber foods promote defecation.
   c. Drinking 6 to 8 glasses of water daily promotes normal bowel elimination.
   d. Exercise stimulates peristalsis.
2. Which of the following does *not* prevent constipation?
   a. A high-fiber diet
   b. Increased fluid intake
   c. Exercise
   d. Ignoring the urge to defecate
3. A person has fecal incontinence. You should do the following *except*
   a. Be patient
   b. Help with elimination after meals
   c. Provide good skin care
   d. Scold the person for being incontinent
4. The preferred position for an enema is the
   a. Sims' position or the left side-lying position
   b. Prone position
   c. Supine position
   d. Trendelenburg's position

Answers to these questions are on p. 516.

CHAPTER 27 NUTRITION AND FLUIDS

- Food and water are necessary for life. A poor diet and poor eating habits:
  - Increase the risk for disease and infection.
  - Cause chronic illnesses to become worse.
  - Cause healing problems.
  - Increase the risk of accidents and injuries.

Basic Nutrition

- **Nutrition** is the process involved in the ingestion, digestion, absorption, and use of foods and fluids by the body. Good nutrition is needed for growth, healing, and body functions.
- A *nutrient* is a substance that is ingested, digested, absorbed, and used by the body.
- A *calorie* is the fuel or energy value of food.

Dietary Guidelines for Americans

- The Dietary Guidelines help people attain and maintain a healthy weight, reduce the risk of chronic disease, and promote overall health. The Dietary Guidelines focus on consuming fewer calories, making informed food choices, and being physically active.

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MyPlate

- The MyPlate symbol, issued by the United States Department of Agriculture (USDA), helps you make wise food choices by balancing calories, increasing certain foods like fruits and vegetables, and reducing certain foods with excess salt and sugar.

Nutrients

- A well-balanced diet ensures an adequate intake of essential nutrients.
- *Protein*—is needed for tissue growth and repair. Sources include meat, fish, poultry, eggs, milk and milk products, cereals, beans, peas, and nuts.
- *Carbohydrates*—provide energy and fiber for bowel elimination. They are found in fruits, vegetables, breads, cereals, and sugar.
- *Fats*—provide energy, add flavor to food, and help the body use certain vitamins. Sources include meats, lard, butter, shortening, oils, milk, cheese, egg yolks, and nuts.
- *Vitamins*—are needed for certain body functions. The body stores vitamins A, D, E, and K. The vitamin C and the B complex vitamins are not stored and must be ingested daily.
- *Minerals*—are needed for bone and tooth formation, nerve and muscle function, fluid balance, and other body processes.
- *Water*—is needed for all body processes.
- Review Tables 27-2, Common Vitamins, and 27-3, Common Minerals, in the Textbook.

OBRA Dietary Requirements

- The Omnibus Budget Reconciliation Act of 1987 (OBRA) has requirements for food served in nursing centers.
  - Each person's nutritional and dietary needs are met.
  - The person's diet is well-balanced. It is nourishing and tastes good. Food is well-seasoned.
  - Food is appetizing. It has an appealing aroma and is attractive.
  - Hot food is served hot. Cold food is served cold.
  - Food is served promptly.
  - Food is prepared to meet each person's needs. Some people need food cut, ground, or chopped. Others have special diets ordered by the doctor.
  - Other foods are offered if the person refused the food served. Substituted food must have a similar nutritional value to the first foods served.
  - Each person receives at least 3 meals a day. A bedtime snack is offered.
  - The center provides needed adaptive equipment and utensils.

Factors Affecting Eating and Nutrition

- *Culture.* Culture influences dietary practices, food choices, and food preparation.
- *Religion.* Selecting, preparing, and eating food often involve religious practices. A person may follow all, some, or none of the dietary practices of his or her faith.
- *Finances.* People with limited incomes often buy the cheaper carbohydrate foods. Their diets often lack protein and certain vitamins and minerals.
- *Appetite.* Illness, drugs, anxiety, pain, and depression can cause loss of appetite. Unpleasant sights, thoughts, and smells are other causes.
- *Personal choice.* Food likes and dislikes are influenced by foods served in the home. Usually food likes expand with age and social experiences.
- *Body reactions.* People usually avoid foods that cause allergic reactions. They also avoid foods that cause nausea, vomiting, diarrhea, indigestion, gas, or headaches.
- *Illness.* Appetite usually decreases during illness and recovery from injuries. However, nutritional needs are increased.
- *Drugs.* Drugs can cause loss of appetite, confusion, nausea, constipation, impaired taste, or changes in gastro-intestinal (GI) function. They can cause inflammation of the mouth, throat, esophagus, and stomach.
- *Chewing problems.* Mouth, teeth, and gum problems can affect chewing. Examples include oral pain, dry or sore mouth, gum disease, and dentures that fit poorly. Broken, decayed, or missing teeth also affect chewing, especially the meat group.
- *Swallowing problems.* Many health problems can affect swallowing. They include stroke, pain, confusion, dry mouth, and diseases of the mouth, throat, and esophagus.
- *Disability.* Disease or injury can affect the hands, wrists, and arms. Adaptive equipment lets the person eat independently.
- *Impaired cognitive function.* Impaired cognitive function may affect the person's ability to use eating utensils. And it may affect eating, chewing, and swallowing.

Special Diets

The Sodium-Controlled Diet

- A sodium-controlled diet decreases the amount of sodium in the body. The diet involves:
  - Omitting high-sodium foods. Review Box 27-3, High-Sodium Foods, in the Textbook.
  - Not adding salt when eating.
  - Limiting the amount of salt used in cooking.
  - Diet planning.

Diabetes Meal Planning

- Diabetes meal planning is for people with diabetes. It involves the person's food preferences and calories needed. It also involves eating meals and snacks at regular times.
- Serve the person's meals and snacks on time to maintain a certain blood sugar level.
- Always check the tray to see what was eaten. Tell the nurse what the person did and did not eat. If not all the food was eaten, a between-meal nourishment is needed. The nurse tells you what to give. Tell the nurse about changes in the person's eating habits.

The Dysphagia Diet

- **Dysphagia** means difficulty swallowing. Food thickness is changed to meet the person's needs. Review Box 27-4, Dysphagia, in the Textbook.

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- You may need to feed a person with dysphagia. To promote the person's comfort:
  - Know the signs and symptoms of dysphagia. Review Box 27-4 in the Textbook.
  - Feed the person according to the care plan.
  - Follow aspiration precautions (see Box 27-5, Aspiration Precautions, in the Textbook) and the care plan.
  - Report changes in how the person eats.
  - Report choking, coughing, or difficulty breathing during or after meals. Also report abnormal breathing or respiratory sounds. Report these observations at once.

Food Intake

- Food intake is measured in different ways. Follow agency policy for the method use.
- *Percentage of food eaten.* Some agencies measure the percent of the whole meal tray. Other agencies measure the percent of each food item eaten.
- *Calorie counts.* Note what the person ate and how much. A nurse or dietitian converts the portion amounts into calories.

Fluid Balance

- Fluid balance is needed for health. The amount of fluid taken in **(intake)** and the amount of fluid lost **(output)** must be roughly equal. If fluid intake exceeds fluid output, body tissues swell with water **(edema).**
- **Dehydration** is a decrease in the amount of water in body tissues. Fluid output exceeds intake. Review Box 27-6, Common Causes of Dehydration, in the Textbook.

Normal Fluid Requirements

- An adult needs 1500 milliliters (mL) of water daily to survive. About 2000 to 2500 mL of fluid per day is needed for normal fluid balance. Water requirements increase with hot weather, exercise, fever, illness, and excess fluid loss.
- Older persons may have a decreased sense of thirst. Their bodies need water but they may not feel thirsty. Offer fluids according to the care plan.

Special Fluid Orders

- The doctor may order the amount of fluid a person can have in 24 hours. Intake and output (I&O) measurements may be ordered by the doctor or nurse.
- *Encourage fluids.* The person drinks an increased amount of fluid.
- *Restrict fluids.* Fluids are limited to a certain amount.
- *Nothing by mouth (NPO).* The person cannot eat or drink.
- *Thickened liquids.* All liquids are thickened, including water.

Intake and Output

- All fluids taken by mouth are measured and recorded—water, milk, and so forth. So are foods that melt at room temperature—ice cream, sherbet, custard, pudding, gelatin, and Popsicles.
- Output includes urine, vomitus, diarrhea, and wound drainage.

Measuring Intake and Output (I&O)

- To measure I&O, you need to know:
  - 1 cubic centimeter (cc) equals 1 mL.
  - 1 teaspoon equals 5 mL.
  - 1 ounce (oz) equals 30 mL.
  - A pint is about 500 mL.
  - A quart is about 1000 mL.
  - The serving sizes of bowls, dishes, cups, pitchers, glasses, and other containers.
- An I&O record is kept at the bedside. Record I&O measurements in the correct column. Amounts are totaled at the end of the shift. The totals are recorded in the person's chart. They are also shared during the end-of-shift report.
- The urinal, commode, bedpan, or specimen pan is used for voiding. Remind the person not to void in the toilet. Also remind the person not to put toilet tissue into the receptacle.

Meeting Food and Fluid Needs

- Preparing residents for meals promotes their comfort.
  - Assist with elimination needs.
  - Provide oral hygiene. Make sure dentures are in place.
  - Make sure eyeglasses and hearing aids are in place.
  - Make sure incontinent persons are clean and dry.
  - Position the person in a comfortable position.
  - Assist the person with hand-washing.
- Food is served in containers that keep foods at the correct temperature. Hot food is kept hot. Cold food is kept cold.
- Prompt serving keeps food at the correct temperature.

Feeding the Person

- Serve food and fluid in the order the person prefers. Offer fluids during the meal.
- Use teaspoons to feed the person.
- Persons who need to be fed are often angry, humiliated, and embarrassed. Some are depressed or refuse to eat. Let them do as much as possible. If strong enough, let them hold milk or juice glasses. Never let them hold hot drinks.
- Tell the visually impaired person what is on the tray. Describe what you are offering. For persons who feed themselves, use the numbers on the clock for the location of foods.
- Many people pray before eating. Allow time and privacy for prayer.
- Meals provide social contact with others. Engage the person in pleasant conversations. Also sit facing the person. Allow time for chewing and swallowing. The person will eat better if not rushed. Wipe the person's hands, face, and mouth as needed during the meal.
- Report and record:
  - The amount and kind of food eaten
  - Complaints of nausea or dysphagia
  - Signs and symptoms of dysphagia
  - Signs and symptoms of aspiration
- Many special diets involve between-meal snacks. These snacks are served upon arrival on the nursing unit. Follow the same considerations and procedures for serving meal trays and feeding persons.

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Providing Drinking Water

- Patients and residents need fresh drinking water each shift. Follow the agency's procedure for providing fresh water.
- Water mugs and pitchers can spread microbes. To prevent the spread of microbes:
  - Label the water mug with the person's name and room and bed number.
  - Do not touch the rim or inside of the mug or lid.
  - Do not let the ice scoop touch the mug, lid, or straw.
  - Place the ice scoop in the holder or on a towel, not in the ice container or dispenser.
  - Make sure the person's water mug is clean and free of cracks and chips. Provide a new mug as needed.

CHAPTER 27 REVIEW QUESTIONS

Circle the BEST answer.

1. A person is on a sodium-controlled diet. Which statement is *true?*
   a. High-sodium foods are allowed.
   b. Salt is added at the table.
   c. Pretzels and potato chips are a good snack.
   d. The amount of salt used in cooking is limited.
2. A person is a diabetic. You should do the following *except*
   a. Serve his meals and snacks late
   b. Always check his tray to see what he ate
   c. Tell the nurse what he ate and did not eat
   d. Provide a between-meal snack as the nurse directs
3. A person has dysphagia. You should do the following *except*
   a. Report choking and coughing during a meal at once
   b. Report difficulty in breathing during a meal at the end of the shift
   c. Report changes in how the person eats
   d. Follow aspiration precautions
4. Older persons have a decreased sense of thirst.
   a. True
   b. False
5. When feeding a person, you do the following *except*
   a. Use a teaspoon to feed the person
   b. Offer fluids during the meal
   c. Let the person do as much as possible
   d. Stand so you can feed 2 people at once
6. A person is visually impaired. You do the following *except*
   a. Tell the person what is on the tray
   b. Use the numbers on a clock to tell the person the location of food
   c. If feeding the person, describe what you are offering
   d. Let the person guess what is served
7. A person is on intake and output. He just ate ice cream. This is recorded as intake.
   a. True
   b. False
8. A person drank a pint of milk at lunch. You know she drank
   a. 250 mL of milk
   b. 350 mL of milk
   c. 500 mL of milk
   d. 750 mL of milk
9. The soup bowl holds 6 ounces. A person ate all of the soup. You record his intake as
   a. 50 mL
   b. 120 mL
   c. 180 mL
   d. 200 mL

Answers to these questions are on p. 516.

CHAPTER 29 MEASURING VITAL SIGNS

Vital Signs

- The vital signs of body function are temperature, pulse, respirations, blood pressure, and, in some agencies, pain.
- Accuracy is essential when you measure, record, and report vital signs. If unsure of your measurements, promptly ask the nurse to take them again.
- Report the following at once.
  - Any vital sign that is changed from a prior measurement
  - Vital signs above or below the normal range

Body Temperature

- Thermometers are used to measure temperature. It is measured using the Fahrenheit (F) and centigrade or Celsius (C) scales.
- Temperature sites are the mouth, rectum, axilla (underarm), tympanic membrane (ear), and temporal artery (forehead).
- Review Box 29-2, Temperature Sites, in the Textbook.
- Normal range for body temperatures depends on the site.
  - Oral: 97.6°F to 99.6°F
  - Rectal: 98.6°F to 100.6°F
  - Axillary: 96.6°F to 98.6°F
  - Tympanic membrane: 98.6°F
  - Temporal artery: 99.6°F
- Older persons have lower body temperatures than younger persons.

Thermometers

- Electronic thermometers show the temperature on the front of the device when the temperature is registered.
- Electronic thermometers include:
  - Standard electronic thermometers with a blue probe for oral and axillary temperatures and red probes for rectal temperatures. A disposable cover protects the probe.
  - Tympanic membrane thermometer, which measures body temperature at the tympanic membrane in the ear.
  - Temporal artery thermometer, which measures body temperature at the temporal artery in the forehead.
  - Digital thermometers, which measure body temperature at the oral, axillary, or rectal sites.
  - Pacifier thermometers, which look like a baby pacifier. The baby sucks on the device to record temperature.
- Other thermometers include disposable thermometers, temperature-sensitive tape, and glass thermometers.

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Taking Temperatures

- *The oral site.* Place the thermometer under the person's tongue and to the side.
- *The rectal site.* Lubricate the bulb end of the rectal thermometer. Insert the probe ½ inch into the rectum. Privacy is important.
- *The axillary site.* The axilla must be dry. Place the probe in the center of the axilla and place the person's arm over the chest to hold the probe in place.
- Tympanic membrane thermometers are inserted gently into the ear. Pull the adult ear up and back to straighten the ear canal.
- Glass thermometers are rarely used in hospitals and nursing centers but may be used in the home. Review Box 29-3, Glass Thermometers.

Pulse

- The adult pulse rate is between 60 and 100 beats per minute. Report these abnormal rates to the nurse at once.
  - *Tachycardia*—the heart rate is more than 100 beats per minute.
  - *Bradycardia*—the heart rate is less than 60 beats per minute.
- The rhythm of the pulse should be regular. Report and record an irregular pulse rhythm.
- Report and record if the pulse force is strong, full, bounding, weak, thready, or feeble.

Taking Pulses

- The radial pulse is used for routine vital signs. Place the first 2 or 3 fingers against the radial pulse. Do not use your thumb to take a pulse. Count the pulse for 30 seconds and multiply by 2 if the agency policy permits. If the pulse is irregular, count it for 1 minute. Report and record if the pulse is regular or irregular, strong or weak.
- The apical pulse is on the left side of the chest slightly below the nipple. A stethoscope is used to measure the apical or the apical-radial pulse. Count the apical pulse for 1 minute.

Respirations

- The healthy adult has 12 to 20 respirations per minute. Respirations are normally quiet, effortless, and regular. Both sides of the chest rise and fall equally.
- Count respirations when the person is at rest. Count respirations right after taking a pulse.
- Count respirations for 30 seconds and multiply the number by 2 if the agency policy permits. If an abnormal pattern is noted, count the respirations for 1 minute.
- Report and record:
  - The respiratory rate
  - Equality and depth of respirations
  - If the respirations were regular or irregular
  - If the person has pain or difficulty breathing
  - Any respiratory noises
  - An abnormal respiratory pattern

Blood Pressure

Normal and Abnormal Blood Pressures

- Blood pressure has normal ranges.
  - *Systolic pressure* (upper number)—90 mm Hg and higher but lower than 120 mm Hg
  - *Diastolic pressure* (lower number)—60 mm Hg and higher but lower than 80 mm Hg
- **Hypertension**—blood pressure measurements that remain above a systolic pressure of 140 mm Hg or a diastolic pressure of 90 mm Hg. Report any systolic measurement above 120 mm Hg. Also report a diastolic pressure above 80 mm Hg.
- **Hypotension**—when the systolic blood pressure is below 90 mm Hg and the diastolic pressure is below 60 mm Hg. Report a systolic pressure below 90 mm Hg. Also report a diastolic pressure below 60 mm Hg.
- Review Box 29-6, Guidelines for Measuring Blood Pressure, in the Textbook.

CHAPTER 29 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement about taking a rectal temperature is *false?*
   a. The bulb end of the thermometer needs to be lubricated.
   b. The thermometer is inserted 1 inch into the rectum.
   c. Privacy is important.
   d. The normal range is 98.6°F to 100.6°F.
2. Which pulse rate should you report at once?
   a. A pulse rate of 52 beats per minute
   b. A pulse rate of 60 beats per minute
   c. A pulse rate of 76 beats per minute
   d. A pulse rate of 100 beats per minute
3. Which statement is *false?*
   a. An irregular pulse is counted for 1 minute.
   b. You may use your thumb to take a radial pulse rate.
   c. The radial pulse is usually used to count a pulse rate.
   d. Tachycardia is a fast pulse rate.
4. Which blood pressure should you report?
   a. 120/80 mm Hg
   b. 88/62 mm Hg
   c. 110/70 mm Hg
   d. 92/68 mm Hg

Answers to these questions are on p. 516.

CHAPTER 30 EXERCISE AND ACTIVITY

Bedrest

- The doctor may order bedrest to treat a health problem.
- Bedrest is ordered to:
  - Reduce physical activity.
  - Reduce pain.
  - Encourage rest.
  - Regain strength.
  - Promote healing.

Complications From Bedrest

- Pressure ulcers, constipation, and fecal impactions can result. Urinary tract infections and renal calculi (kidney stones) can occur. So can blood clots and pneumonia.

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- The musculo-skeletal system is affected by lack of exercise and activity. These complications must be prevented to maintain normal movement.
  - A **contracture** is the lack of joint mobility caused by abnormal shortening of a muscle. Common sites are the fingers, wrists, elbows, toes, ankles, knees, and hips. The person is permanently deformed and disabled.
  - **Atrophy** is the decrease in size or the wasting away of tissue. Tissues shrink in size.
- **Orthostatic hypotension (postural hypotension)** is abnormally low blood pressure when the person stands up suddenly. The person is dizzy and weak and has spots before the eyes. Fainting can occur. To prevent orthostatic hypotension, have the person change slowly from a lying or sitting position to a standing position.

Positioning

- Supportive devices are often used to support and maintain the person in a certain position.
  - *Bed-boards*—are placed under the mattress to prevent the mattress from sagging.
  - *Foot-boards*—are placed at the foot of mattresses to prevent plantar flexion that can lead to footdrop.
  - *Trochanter rolls*—prevent the hips and legs from turning outward (external rotation).
  - *Hip abduction wedges*—keep the hips abducted (apart).
  - *Hand rolls or hand grips*—prevent contractures of the thumb, fingers, and wrist.
  - *Splints*—keep the elbows, wrists, thumbs, fingers, ankles, and knees in normal position.
  - *Bed cradles*—keep the weight of top linens off the feet and toes.

Range-of-Motion Exercises

- **Range-of-motion (ROM)** exercises involve moving the joints through their complete range of motion without causing pain. They are usually done at least 2 times a day.
  - *Active ROM*—exercises are done by the person.
  - *Passive ROM*—you move the joints through their range of motion.
  - *Active-assistive ROM*—the person does the exercises with some help.
- Review Box 30-2, Range-of-Motion Exercises, in the Textbook.
- ROM exercises can cause injury if not done properly. Practice these rules.
  - Exercise only the joints the nurse tells you to exercise.
  - Expose only the body part being exercised.
  - Use good body mechanics.
  - Support the part being exercised.
  - Move the joint slowly, smoothly, and gently.
  - Do not force a joint beyond its present range of motion.
  - Do not force a joint to the point of pain.
  - Ask the person if he or she has pain or discomfort.
  - Perform ROM exercises to the neck only if allowed by your agency and if the nurse instructs you to do so.

Ambulation

- **Ambulation** is the act of walking.
- Follow the care plan when helping a person walk. Use a gait (transfer) belt if the person is weak or unsteady. The person uses hand rails along the wall. Always check the person for orthostatic hypotension.
- When you help the person walk, walk to the side and slightly behind the person on the person's weak side. Encourage the person to use the hand rail on his or her strong side.

Walking Aids

- A cane is held on the strong side of the body. The cane tip is about 6 to 10 inches to the side of the foot. It is about 6 to 10 inches in front of the foot on the strong side. The grip is level with the hip. To walk:
  - Step A: The cane is moved forward 6 to 10 inches.
  - Step B: The weak leg (opposite the cane) is moved forward even with the cane.
  - Step C: The strong leg is moved forward and ahead of the cane and the weak leg.
- A walker gives more support than a cane. Wheeled walkers are common. They have wheels on the front legs and rubber tips on the back legs. The person pushes the walker about 6 to 8 inches in front of his or her feet.
- Braces support weak body parts, prevent or correct deformities, or prevent joint movement. A brace is applied over the ankle, knee, or back. Skin and bony points under braces are kept clean and dry. Report redness or signs of skin breakdown at once. Also report complaints of pain or discomfort. The care plan tells you when to apply and remove a brace.

CHAPTER 30 REVIEW QUESTIONS

Circle the BEST answer.

1. To prevent orthostatic hypotension, you should
   a. Move a person from the lying position to the sitting position quickly
   b. Move a person from the sitting position to the standing position quickly
   c. Move a person from the lying or sitting position to a standing position slowly
   d. Keep the person in bed
2. Exercise helps prevent contractures and muscle atrophy.
   a. True
   b. False
3. When performing ROM exercises, you should force a joint to the point of pain.
   a. True
   b. False
4. A person's left leg is weaker than his right. The person holds the cane on his right side.
   a. True
   b. False

Answers to these questions are on p. 516.

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CHAPTER 31 COMFORT, REST, AND SLEEP

- Comfort is a state of well-being. Many factors affect comfort.
- Pain or discomfort means to ache, hurt, or be sore. Pain is subjective. You cannot see, hear, touch, or smell pain or discomfort. You must rely on what the person says.
- Pain is often considered the fifth vital sign. Report the person's complaints of pain and your observations to the nurse.

Factors Affecting Pain

- *Past experience.* The severity of pain, its cause, how long it lasted, and if relief occurred all affect the person's current response to pain.
- *Anxiety.* Pain and anxiety are related. Pain can cause anxiety. Anxiety increases how much pain the person feels. Reducing anxiety helps lessen pain.
- *Rest and sleep.* Pain seems worse when a person is tired or restless. Pain often seems worse at night.
- *Attention.* The more a person thinks about pain, the worse it seems.
- *Personal and family duties.* Often pain is ignored when there are children to care for. Some deny pain if a serious illness is feared.
- *The value or meaning of pain.* To some people, pain is a sign of weakness. For some persons, pain means avoiding work, daily routines, and people. Some people like doting and pampering by others. The person values pain and wants such attention.
- *Support from others.* Dealing with pain is often easier when family and friends offer comfort and support. Facing pain alone is hard for persons.
- *Culture.* Culture affects pain responses. Non–English-speaking persons may have problems describing pain.
- *Illness.* Some diseases cause decreased pain sensations.
- *Age.* Older persons may have chronic pain that masks new pain. They may deny or ignore new pain, thinking it is related to a known problem. Or they may deny or ignore pain because they are afraid of what it may mean. For persons who cannot tell you about pain, changes in usual behavior may signal pain. Loss of appetite also signals pain. Report any changes in a person's usual behavior to the nurse.

Signs and Symptoms

- You cannot see, hear, touch, or smell the person's pain. Rely on what the person tells you. Promptly report any information you collect about pain. Use the person's exact words when reporting and recording pain.
- The nurse needs the following information.
  - *Location.* Where is the pain?
  - *Onset and duration.* When did the pain start? How long has it lasted?
  - *Intensity.* Ask the person to rate the pain. Use a pain scale.
  - *Description.* Ask the person to describe the pain.
  - *Factors causing pain.* Ask what the person was doing before the pain started and when it started.
  - *Factors affecting pain.* Ask what makes the pain better and what makes it worse.
  - *Vital signs.* Increases often occur with acute pain. They may be normal with chronic pain.
  - *Other signs and symptoms.* Dizziness, nausea, vomiting, weakness, numbness, and tingling.
- Review Box 31-2, Signs and Symptoms of Pain, and Box 31-3, Comfort and Pain-Relief Measures, in the Textbook.

The Back Massage

- The back massage can promote comfort and relieve pain. It relaxes muscles and stimulates circulation.
- A good time to give a massage is after baths and showers and with evening care. Massages last 3 to 5 minutes.
- Observe the skin for breaks, bruises, reddened areas, and other signs of skin breakdown.
- Lotion reduces friction during the massage. It is warmed before applying.
- Use firm strokes. Keep your hands in contact with the person's skin.
- After the massage, apply some lotion to the elbows, knees, and heels.
- Back massages are dangerous for persons with certain heart diseases, back injuries, back and other surgeries, skin diseases, and some lung disorders. Check with the nurse and the care plan before giving back massages to persons with these conditions.
- Do not massage reddened bony areas. Reddened areas signal skin breakdown and pressure ulcers. Massage can lead to more tissue damage.
- Wear gloves if the person's skin is not intact. Always follow Standard Precautions and the Bloodborne Pathogen Standard.
- Report and record skin breakdown, redness, bruising, and breaks in the skin.

Rest

- *Rest* means to be calm, at ease, and relaxed with no anxiety or stress. Rest may involve inactivity. Or the person does things that are calming and relaxing.
- Promote rest by meeting physical, safety, and security needs.
  - Thirst, hunger, pain or discomfort, and elimination needs can affect rest. A comfortable position and good alignment are important. A quiet setting promotes rest.
  - The person must feel safe from falling or other injuries. The person is secure with the call light within reach. Understanding the reasons for care and knowing how care is given also help the person feel safe.
- Many persons have rituals or routines before resting. Follow them whenever possible.
- Love and belonging are important for rest. Visits or calls from family and friends may relax the person. Reading cards and letters may also help.
- Meet self-esteem needs.
- Some persons are refreshed after a 15- or 20-minute rest. Others need more time.

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- Ill or injured persons need to rest more often. Do not push the person beyond his or her limits.

Sleep

- Sleep is a basic need. Tissue healing and repair occur during sleep. Sleep lowers stress, tension, and anxiety. It refreshes and renews the person. The person regains energy and mental alertness. The person thinks and functions better after sleep.

Factors Affecting Sleep

- *Age.* The amount of sleep needed decreases with age.
- *Illness.* Illness increases the need for sleep.
- *Nutrition.* Sleep needs increase with weight gain. Foods with caffeine prevent sleep.
- *Exercise.* People feel good after exercise. Eventually they tire, which helps people sleep well. Avoid exercise at least 2 hours before bedtime.
- *Environment.* People adjust to their usual sleep settings.
- *Drugs and other substances.* Sleeping pills promote sleep. Drugs for anxiety, depression, and pain may cause the person to sleep but may interfere with the quality of sleep.
- *Life-style changes.* Changes in daily routines may affect sleep.
- *Emotional problems.* Fear, worry, depression, and anxiety affect sleep.

Sleep Disorders

- **Insomnia** is a chronic condition in which the person cannot sleep or stay asleep all night.
- **Sleep deprivation** means that the amount and quality of sleep are decreased. Sleep is interrupted.
- **Sleepwalking** is when the person leaves the bed and walks about. If a person is sleepwalking, protect the person from injury. Guide sleepwalkers back to bed. They startle easily. Awaken them gently.

Promoting Sleep

- To promote sleep, allow a flexible bedtime, provide a comfortable room temperature, and have the person void before going to bed. Review Box 31-6, Promoting Sleep, in the Textbook for other measures.

CHAPTER 31 REVIEW QUESTIONS

Circle the BEST answer.

1. A person complains of pain. You will do the following *except*
   a. Ask where the pain is
   b. Ask when the pain started
   c. Ask what the intensity of the pain is on a scale of 1 to 10
   d. Ask why the person is complaining about pain
2. Older persons or persons who cannot communicate may not complain of pain. Which of the following might be a signal of pain?
   a. Illness
   b. Mental alertness
   c. Loss of appetite
   d. Forgetfulness
3. Which statement is *false?*
   a. A back massage relaxes and stimulates circulation.
   b. Massages are given after the bath and with evening care.
   c. You can observe the person's skin before beginning the massage.
   d. You should use cold lotion for the massage.
4. You can promote rest for a person by doing the following *except*
   a. Asking the person if he or she would like coffee or tea
   b. Placing the call light within reach
   c. Providing a quiet setting
   d. Following the person's routines and rituals before rest
5. To promote sleep for a person, you should do the following *except*
   a. Follow the person's wishes
   b. Follow the care plan
   c. Follow the person's rituals and routines before bedtime
   d. Tell the person when to go to bed

Answers to these questions are on p. 516.

CHAPTER 32 ADMISSIONS, TRANSFERS, AND DISCHARGES

- Admission is the official entry of a person into a health care setting. It can cause anxiety and fear in patients, residents, and families.
- Transfer is moving the person to another health care setting or moving the person to a new room within the agency.
- Discharge is the official departure of a person from a health care setting.
- During the admission process:
  - Identifying information is obtained from the person or family.
  - A nurse or social worker explains the resident's rights to the person and family.
  - The person is given an identification (ID) number and bracelet.
  - The person signs admitting papers and a general consent form.
- You prepare the person's room before the person arrives.

Admitting the Person

- Admission is your first chance to make a good impression. You must:
  - Greet the person by name and title. Use the admission form to find out the person's name.
  - Introduce yourself by name and title to the person, family, and friends.
  - Make roommate introductions.
  - Act in a professional manner.
  - Treat the person with dignity and respect.
- During the admission procedure the nurse may ask you to:
  - Collect some information for the admission form.
  - Measure the person's weight and height.
  - Measure the person's vital signs.
  - Obtain a urine specimen (if needed).

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- Complete a clothing and personal belongings list.
- Orient the person to the room, nursing unit, and agency.

Weight and Height

- When weighing a person, follow the manufacturer's instructions and center procedures for using the scales. Follow these guidelines when measuring weight and height.
  - The person wears only a gown or pajamas. No footwear is worn.
  - The person voids before being weighed and a dry incontinence product is worn if needed.
  - Weigh the person at the same time of day. Before breakfast is the best time.
  - Use the same scale for daily, weekly, and monthly weights.
  - Balance the scale at zero before weighing the person.

Moving the Person to a New Room

- Sometimes a person is moved to a new room because of a change in condition or care needs, the person requests a room change, or roommates do not get along. Support and reassure the person moving to a new room with new staff.
- The person is transported by wheelchair, stretcher, or the bed.

Transfers and Discharges

- When transferred or discharged, the person leaves the agency. He or she goes home or to another health care setting.
- Transfers and discharges are usually planned in advance by the health team.
- For discharges, the health team teaches the person and family about diet, exercise, and drugs. They also teach them about procedures and treatments and arrange for home care, equipment, and therapies as needed.
- The nurse tells you when to start the transfer or discharge procedure. The doctor must give the order before the person can leave. Usually a wheelchair is used. If leaving by ambulance, a stretcher is used.
- If a person wants to leave the agency without the doctor's permission, tell the nurse at once. The nurse or social worker handles the matter.

CHAPTER 32 REVIEW QUESTIONS

Circle the BEST answer.

1. When admitted, you explain the resident's rights to the person and family.
   a. True
   b. False
2. When a person is admitted, you do the following *except*
   a. Greet the person by name and title
   b. Treat the person with dignity and respect
   c. Introduce the person to his or her roommate
   d. Rush the admission procedure
3. Which statement is *false?*
   a. Have the person void before being weighed.
   b. Weigh the person at the same time of day.
   c. Balance the scale at zero before weighing the person.
   d. Have the person wear shoes when being weighed.
4. A person wants to leave the nursing center without the doctor's permission. You should tell the nurse at once.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 35 THE PERSON HAVING SURGERY

- Surgery may be in-patient, requiring a hospital stay, or same-day surgery, also called out-patient, 1-day, or ambulatory surgery. The person is prepared for what happens before, during, and after surgery.

Pre-Operative Care

- The person may have special tests such as chest x-ray or electrocardiogram (ECG). Nutrition and fluids may be restricted 6 to 8 hours before surgery.
- Personal care before surgery includes:
  - A complete bath, shower, or tub bath and shampoo. A special soap or shampoo may be ordered to reduce the number of microbes and the risk of infection.
  - Make-up, nail polish, and fake nails are removed.
  - Hair accessories, wigs, and hairpieces are removed and a surgical cap keeps the hair out of the face and the operative site.
  - Dentures, eyeglasses, contact lenses, hearing aids, and other prostheses are removed.
- Skin prep before surgery may include cleansing with an anti-microbial soap, clipping the hair at and around the site, or removing the hair at and around the site.
- After skin prep, report and record the following: the area prepped; any cuts, nicks, or scratches from skin shaving; bleeding; and sites of non-intact skin.

Post-Operative Care

- The person's room must be ready. Make a surgical bed, place supplies in the room, and move furniture out of the way for a stretcher.
- Your role in post-operative care depends on the person's condition. Often vital signs and pulse oximetry are taken. The nurse tells you how often to check the person. Review Box 35-2, Post-Op Complications and Observations, in the Textbook.
- The person is positioned for comfort and to prevent complications. The person is re-positioned every 1 to 2 hours to prevent respiratory and circulatory complications. Turning may be painful. Provide support and use smooth, gentle motions.
- Coughing and deep-breathing exercises help prevent respiratory complications.
- Circulation must be stimulated for blood flow in the legs. If blood flow is sluggish, blood clots may form.
- Report the following at once.
  - Swollen area of a leg.

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- Pain or tenderness in a leg. This may occur only when standing or walking.
- Warmth in the part of the leg that is swollen or painful.
- Red or discolored skin.

Elastic Stockings

- Elastic stockings exert pressure on the veins. The pressure promotes venous blood return to the heart. The stockings help prevent blood clots in the leg veins.
- Elastic stockings also are called AE stockings (anti-embolism or anti-embolic). They also are called TED hose. TED means thrombo-embolic disease.
- The nurse measures the person for the correct size of elastic stockings. Most stockings have an opening near the toes that is used to check circulation, skin color, and skin temperature.
- The person usually has 2 pairs of stockings. One pair is washed; the other pair is worn.
- Stockings should not have twists, creases, or wrinkles after you apply them. Twists can affect circulation. Creases and wrinkles can cause skin breakdown.
- Loose stockings do not promote venous blood return to the heart. Stockings that are too tight can affect circulation. Tell the nurse if the stockings are too loose or too tight.

CHAPTER 35 REVIEW QUESTIONS

Circle the BEST answer.

1. A person with a swollen calf with red, discolored skin is at risk for a blood clot.
   a. True
   b. False
2. Which statement about elastic stockings is *true?*
   a. Elastic stockings should be loose to promote venous blood return to the heart.
   b. Stockings should not have twists, creases, or wrinkles after you apply them.
   c. The doctor measures the person for the correct size of elastic stockings.
   d. The person should have only 1 pair of stockings.

Answers to these questions are on p. 516.

CHAPTER 36 WOUND CARE

- A **wound** is a break in the skin or mucous membrane.
- The wound is a portal of entry for microbes. Infection is a major threat. Wound care involves preventing infection and further injury to the wound and nearby tissues.

Skin Tears

- A **skin tear** is a break or rip in the skin.
- Skin tears are caused by friction, shearing, pulling, or pressure on the skin. Bumping a hand, arm, or leg on any hard surface can cause a skin tear. Beds, bed rails, chairs, wheelchair footplates, and tables are dangers. So is holding the person's arm or leg too tight, removing tape or adhesives, bathing, dressing, and other tasks. Buttons, zippers, jewelry, or long or jagged finger or toenails can also cause skin tears.
- Skin tears are painful. They are portals of entry for microbes. Wound complications can develop. Tell the nurse at once if you cause or find a skin tear.
- Review Box 36-2, Preventing Skin Tears, in the Textbook.

Circulatory Ulcers

- *Circulatory ulcers (vascular ulcers)* are open sores on the lower legs or feet. They are caused by decreased blood flow through the arteries or veins.
- Review Box 36-3, Preventing Circulatory Ulcers, in the Textbook.
- *Venous ulcers (stasis ulcers)* are open sores on the lower legs or feet. They are caused by poor blood flow through the veins. The heels and inner aspect of the ankles are common sites for venous ulcers.
- *Arterial ulcers* are open wounds on the lower legs or feet caused by poor arterial blood flow. They are found between the toes, on top of the toes, and on the outer side of the ankle.
- A *diabetic foot ulcer* is an open wound on the foot caused by complications from diabetes. When nerves are affected, the person can lose sensation in a foot or leg. The person may not feel pain, heat, or cold. Therefore the person may not feel a cut, blister, burn, or other trauma to the foot. Infection and a large sore can develop. When blood flow to the foot decreases, tissues and cells do not get needed oxygen and nutrients. A sore does not heal properly. Tissue death (gangrene) can occur. Review Box 36-4, Diabetes Foot Care, in the Textbook.

Prevention and Treatment

- Check the person's feet and legs every day. Report any sign of a problem to the nurse at once. Follow the care plan to prevent and treat circulatory ulcers.
- Some agencies let you apply simple, dry, non-sterile dressings to simple wounds. Follow the rules in Box 36-6, Applying Dressings, in the Textbook.

CHAPTER 36 REVIEW QUESTIONS

Circle the BEST answer.

1. The following can cause a skin tear *except*
   a. Friction and shearing
   b. Holding a person's arm or leg too tight
   c. Rings, watches, bracelets
   d. Trimmed, short nails
2. A person is diabetic. Which statement is *false?*
   a. The person may not feel pain in her feet.
   b. The person may not feel heat or cold in her feet.
   c. You need to check her feet weekly for foot problems.
   d. The person is at risk for diabetic foot ulcers.
3. Which statement about elastic stockings is *false?*
   a. Elastic stockings are also called anti-embolic stockings.
   b. Elastic stockings should be wrinkle-free after being applied.
   c. A person usually has 2 pairs of elastic stockings.
   d. Elastic stockings are applied after a person gets out of bed.

Answers to these questions are on p. 516.

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CHAPTER 37 PRESSURE ULCERS

- A **pressure ulcer** is defined by the National Pressure Ulcer Advisory Panel as a localized injury to the skin and/or underlying tissue. The Centers for Medicare & Medicaid Services (CMS) define pressure ulcers as any lesion caused by unrelieved pressure that results in damage to underlying tissues.
- Pressure ulcers usually occur over a bony prominence—the back of the head, shoulder blades, elbows, hips, spine, sacrum, knees, ankles, heels, and toes.
- *Decubitus ulcer, bed sore,* and *pressure sore* are other terms for pressure ulcer.
- Pressure, shearing, and friction are common causes of skin breakdown and pressure ulcers. Risk factors include breaks in the skin, poor circulation to an area, moisture, dry skin, and irritation by urine and feces.

Persons at Risk

- Persons at risk for pressure ulcers are those who:
  - Are confined to a bed or chair.
  - Need some or total help in moving.
  - Are agitated or have involuntary muscle movements.
  - Have loss of bowel or bladder control.
  - Are exposed to moisture.
  - Have poor nutrition or poor fluid balance.
  - Have limited awareness.
  - Have problems sensing pain or pressure.
  - Have circulatory problems.
  - Are obese or very thin.
  - Have a medical device.
  - Have a healed pressure ulcer.

Pressure Ulcer Stages

- In persons with light skin, a reddened bony area is the first sign of a pressure ulcer. In persons with dark skin, a bony area may appear red, blue, or purple. The area may feel warm or cool. The person may complain of pain, burning, tingling, or itching in the area.
- Box 37-2 in the Textbook describes pressure ulcer stages.
- Figure 37-5 in the Textbook shows the stages of pressure ulcers.

Prevention and Treatment

- Preventing pressure ulcers is much easier than trying to heal them. Review Box 37-3, Preventing Pressure Ulcers, in the Textbook.
- The person at risk for pressure ulcers may be placed on a foam, air, alternating air, gel, or water mattress.
- Protective devices are often used to prevent and treat pressure ulcers and skin breakdown. Protective devices include:
  - Bed cradle
  - Heel and elbow protectors
  - Heel and foot elevators
  - Gel or fluid-filled pads and cushions
  - Special beds
  - Other equipment—pillows, trochanter rolls, and foot-boards

CHAPTER 37 REVIEW QUESTIONS

Circle the BEST answer.

1. You may expect to find a pressure ulcer at all of the following sites *except*
   a. Back of the head
   b. Ears
   c. Top of the thigh
   d. Toes
2. Which of the following is not a protective device used to prevent and treat pressure ulcers?
   a. Heel elevator
   b. Bed cradle
   c. Draw sheet
   d. Elbow protector
3. In obese people, pressure ulcers can occur between abdominal folds.
   a. True
   b. False
4. Pressure ulcers never occur over a bony prominence.
   a. True
   b. False

Answers to these questions are on p. 516.

CHAPTER 38 HEAT AND COLD APPLICATIONS

Heat Applications

- Heat relieves pain, relaxes muscles, promotes healing, reduces tissue swelling, and decreases joint stiffness.

Complications

- High temperatures can cause burns. Report pain, excessive redness, and blisters at once. Also observe for pale skin.
- Metal implants pose risks. Pacemakers and joint replacements are made of metal. Do not apply heat to an implant area.
- Heat is not applied to a pregnant woman's abdomen. The heat can affect fetal growth.

Moist and Dry Heat Applications

- In moist heat applications, water is in contact with the skin. Moist heat applications include hot compresses, hot soaks, sitz baths, and hot packs.
- Dry heat applications do not use water, allowing the application to stay at the desired temperature longer. Some hot packs and warming therapy pads are dry heat applications, as well as aquathermia pads.

Cold Applications

- Cold applications reduce pain, prevent swelling, and decrease circulation and bleeding.
- Complications include pain, burns, blisters, and poor circulation. Burns and blisters occur from intense cold. They also occur when dry cold is in direct contact with the skin.

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Applying Heat and Cold

- Protect the person from injury during heat and cold applications. Review Box 38-1, Applying Heat and Cold, in the Textbook.

CHAPTER 38 REVIEW QUESTIONS

Circle the BEST answer.

1. Complications from a heat application include the following *except*
   a. Excessive redness
   b. Blisters
   c. Pale skin
   d. Cyanotic (bluish) nail beds
2. When applying heat or cold, you should do the following *except*
   a. Ask the nurse what the temperature of the application should be
   b. Cover dry heat or cold applications before applying them
   c. Observe the skin every 2 hours
   d. Know how long to leave the application in place

Answers to these questions are on p. 516.

CHAPTER 39 OXYGEN NEEDS

Altered Respiratory Function

- Hypoxia means that cells do not have enough oxygen.
- Restlessness, dizziness, and disorientation are signs of hypoxia.
- Report signs and symptoms of hypoxia to the nurse at once. Hypoxia is life-threatening.
- Review Box 39-1, Altered Respiratory Function, in the Textbook.

Abnormal Respirations

- Adults normally have 12 to 20 respirations per minute. They are quiet, effortless, and regular. Both sides of the chest rise and fall equally. Report these observations at once.
  - **Tachypnea**—rapid breathing. Respirations are 20 or more per minute.
  - **Bradypnea—**slow breathing. Respirations are fewer than 12 per minute.
  - **Apnea**—lack or absence of breathing.
  - **Hypoventilation**—respirations are slow, shallow, and sometimes irregular.
  - **Hyperventilation**—respirations are rapid and deeper than normal.
  - **Dyspnea**—difficult, labored, painful breathing.
  - **Cheyne-Stokes respirations**—respirations gradually increase in rate and depth. Then they become shallow and slow. Breathing may stop for 10 to 20 seconds.
  - **Orthopnea**—breathing deeply and comfortably only when sitting.
  - **Biot's respirations**—rapid and deep respirations followed by 10 to 30 seconds of apnea.
  - **Kussmaul respirations**—very deep and rapid respirations.

Pulse Oximetry

- Pulse oximetry measures the oxygen concentration in arterial blood.
- A sensor attaches to a finger, toe, earlobe, nose, or forehead.
- Avoid swollen sites and sites with skin breaks. Do not use a finger site if blood flow to the fingers is poor, the person has fake nails, or the person has movements from shivering, seizures, or tremors.

Promoting Oxygenation

- Breathing is usually easier in semi-Fowler's and Fowler's positions. Persons with difficulty breathing often prefer the **orthopneic position** (sitting up and leaning over a table to breathe).
- Deep breathing moves air into most parts of the lungs. Coughing removes mucus. Deep breathing and coughing are usually done every 1 to 2 hours while the person is awake. They help prevent pneumonia and atelectasis (the collapse of a portion of the lung).

Oxygen Devices

- A nasal cannula allows eating and drinking. Tight prongs can irritate the nose. Pressure on the ears and cheekbones is possible.
- A simple face mask covers the nose and mouth. Talking and eating are hard to do with a mask. Listen carefully. Moisture can build up under the mask. Keep the face clean and dry. Masks are removed for eating. Usually oxygen is given by cannula during meals.

Oxygen Flow Rates

- When giving care and checking the person, always check the flow rate. Tell the nurse at once if it is too high or too low. A nurse or respiratory therapist will adjust the flow rate.

Oxygen Safety

- You do not give oxygen. You assist the nurse in providing safe care.
- Always check the oxygen level when you are with or near persons using oxygen systems that contain a limited amount of oxygen. Oxygen tanks and liquid oxygen systems are examples. Report a low oxygen level to the nurse at once.
- Follow the rules for fire and the use of oxygen in Chapter 13 in the Textbook.
- Never remove the oxygen device. However, turn off the oxygen flow if there is a fire.
- Make sure the oxygen device is secure but not tight.
- Check for signs of irritation from the oxygen device—behind the ears, under the nose, around the face, and on the cheekbones.
- Keep the face clean and dry when a mask is used.
- Never shut off the oxygen flow.
- Do not adjust the flow rate unless allowed by your state and agency.
- Tell the nurse at once if the flow rate is too high or too low.

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- Tell the nurse at once if the humidifier is not bubbling.
- Secure tubing to the person's garment. Follow agency policy.
- Make sure there are no kinks in the tubing.
- Make sure the person does not lie on any part of the tubing.
- Report signs of hypoxia, respiratory distress, or abnormal breathing to the nurse at once.
- Give oral hygiene as directed. Follow the care plan.
- Make sure the oxygen device is clean and free of mucus.
- Make sure the oxygen tank is secure in its holder.

CHAPTER 39 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Restlessness, dizziness, and disorientation are signs of hypoxia.
   b. Hypoxia is life-threatening.
   c. Report signs and symptoms of hypoxia at the end of the shift.
   d. Anything that affects respiratory function can cause hypoxia.
2. Adults normally have
   a. 8 to 10 respirations per minute
   b. 12 to 20 respirations per minute
   c. 10 to 12 respirations per minute
   d. 20 to 24 respirations per minute
3. Dyspnea is
   a. Difficult, labored, or painful breathing
   b. Slow breathing with fewer than 12 respirations per minute
   c. Rapid breathing with 24 or more respirations per minute
   d. Lack or absence of breathing
4. Which statement about positioning is *false?*
   a. Breathing is usually easier in semi-Fowler's or Fowler's position.
   b. Persons with difficulty breathing often prefer the orthopneic position.
   c. Position changes are needed at least every 4 hours.
   d. Follow the person's care plan for positioning preferences.
5. A person has a nasal cannula. Which statement is *false?*
   a. You will leave the nasal cannula on while the person is eating.
   b. You will watch the nose area for irritation.
   c. You will watch the ears and cheekbones for skin breakdown.
   d. You will take the nasal cannula off while the person is eating.

Answers to these questions are on p. 516.

CHAPTER 41 REHABILITATION AND RESTORATIVE NURSING CARE

- A **disability** is any lost, absent, or impaired physical or mental function.
- **Rehabilitation** is the process of restoring the person to his or her highest possible level of physical, psychological, social, and economic function. The focus is on improving abilities. This promotes function at the highest level of independence.

Rehabilitation and the Whole Person

- Rehabilitation takes longer in older persons. Changes from aging affect healing, mobility, vision, hearing, and other functions. Chronic health problems can slow recovery.

Physical Aspects

- Rehabilitation starts when the person first seeks health care. Complications, such as contractures and pressure ulcers, are prevented.
- *Elimination.* Bowel or bladder training may be needed. Fecal impaction, constipation, and fecal incontinence are prevented.
- *Self-care.* Self-care for activities of daily living (ADL) is a major goal. Self-help devices are often needed.
- *Mobility.* The person may need crutches, a walker, a cane, a brace, or a wheelchair.
- *Nutrition.* The person may need a dysphagia diet or enteral nutrition.
- *Communication.* Speech therapy and communication devices may be helpful.

Psychological and Social Aspects

- A disability can affect function and appearance. Self-esteem and relationships may suffer. The person may feel unwhole, useless, unattractive, unclean, or undesirable. The person may deny the disability. The person may expect therapy to correct the problem. He or she may be depressed, angry, and hostile.
- Successful rehabilitation depends on the person's attitude. The person must accept his or her limits and be motivated. The focus is on abilities and strengths. Despair and frustration are common. Progress may be slow. Old fears and emotions may recur.
- Remind persons of their progress. They need help accepting disabilities and limits. Give support, re-assurance, and encouragement. Spiritual support helps some people. Psychological and social needs are part of the care plan.

The Rehabilitation Team

- Rehabilitation is a team effort. The person is the key member. The health team and family help the person set goals and plan care. All help the person regain function and independence.

Your Role

- Every part of your job focuses on promoting the person's independence. Preventing decline in function also is a goal. Review Box 41-2, Assisting With Rehabilitation and Restorative Care, in the Textbook.

Quality of Life

- To promote quality of life:
  - *Protect the right to privacy.* The person re-learns old or practices new skills in private. Others do not need to see mistakes, falls, spills, clumsiness, anger, or tears.
  - *Encourage personal choice.* This gives the person control.

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- *Protect the right to be free from abuse and mistreatment.* Sometimes improvement is not seen for weeks. Repeated explanations and demonstrations may have little or no results. You and other staff and family may become upset and short-tempered. However, no one can shout, scream, or yell at the person. Nor can they call the person names or hit or strike the person. Unkind remarks are not allowed. Report signs of abuse or mistreatment.
- *Learn to deal with your anger and frustration.* The person does not choose loss of function. If the process upsets you, discuss your feelings with the nurse.
- *Encourage activities.* Provide support and re-assurance to the person with the disability. Remind the person that others with disabilities can give support and understanding.
- *Provide a safe setting.* The setting must meet the person's needs. The over-bed table, bedside stand, and call light are moved to the person's strong side.
- *Show patience, understanding, and sensitivity.* The person may be upset and discouraged. Give support, encouragement, and praise when needed. Stress the person's abilities and strengths. Do not give pity or sympathy.

CHAPTER 41 REVIEW QUESTIONS

Circle the BEST answer.

1. Successful rehabilitation depends on the person's attitude.
   a. True
   b. False
2. A person with a disability may be depressed, angry, and hostile.
   a. True
   b. False
3. A person needs rehabilitation. You should do the following *except*
   a. Let the person re-learn old skills in private
   b. Let the person practice new skills in private
   c. Encourage the person to make choices
   d. Shout at the person
4. You saw a family member hit and scream at a person. You need to report your observations to the nurse.
   a. True
   b. False
5. A person has a weak left arm. You will
   a. Place the call light on his left side
   b. Place the call light on his right side
   c. Give him sympathy
   d. Give him pity

Answers to these questions are on p. 517.

CHAPTER 42 HEARING, SPEECH, AND VISION PROBLEMS

Hearing Loss

- Hearing loss is not being able to hear the normal range of sounds associated with normal hearing. Deafness is the most severe form of hearing loss.
- Obvious signs and symptoms of hearing loss include:
  - Speaking too loudly
  - Leaning forward to hear
  - Turning and cupping the better ear toward the speaker
  - Answering questions or responding inappropriately
  - Asking for words to be repeated
  - Asking others to speak louder or to speak more slowly and clearly
  - Having trouble hearing over the phone
  - Finding it hard to follow conversations when 2 or more people are talking
  - Turning up the TV, radio, or music volume so loud that others complain
- Persons with hearing loss may wear hearing aids or lip-read (speech-read). They watch facial expressions, gestures, and body language. Some people learn American Sign Language (ASL). Others may have hearing assistance dogs.
- Review Box 42-3, Measures to Promote Hearing, in the Textbook.
- Hearing aids are battery-operated. If they do not seem to work properly:
  - Check if the hearing aid is on. It has an on and off switch.
  - Check the battery position.
  - Insert a new battery if needed.
  - Clean the hearing aid. Follow the nurse's direction and the manufacturer's instructions.
- Hearing aids are turned off when not in use. The battery is removed.
- Handle and care for hearing aids properly. If lost or damaged, report it to the nurse at once.

Speech Disorders

Aphasia

- **Aphasia** is the total or partial loss of the ability to use or understand language.
- *Expressive aphasia* relates to difficulty expressing or sending out thoughts. Thinking is clear. The person knows what to say but has difficulty or cannot speak the words.
- *Receptive aphasia* relates to difficulty understanding language. The person has trouble understanding what is said or read. People and common objects are not recognized.

Eye Disorders

- *Cataract.* Cataract is a clouding of the lens in the eye. Signs and symptoms include cloudy, blurry, or dimmed vision. Persons may also be sensitive to light and glares or see halos around lights. Poor vision at night and double vision in 1 eye are other symptoms. Surgery is the only treatment.
- *Age-related macular degeneration (AMD).* AMD blurs central vision needed for reading, sewing, driving, and seeing faces and fine detail. Risk factors include smoking and family history. Whites are at greater risk than any other group. Treatment may stop or slow the disease progress.

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- *Diabetic retinopathy*. Diabetic retinopathy causes blood vessels in the retina to become damaged. Usually both eyes are affected. It is the leading cause of blindness. Control of diabetes, blood pressure, and cholesterol can control diabetic retinopathy.
- *Glaucoma*. Glaucoma results when fluid builds up in the eye and causes pressure on the optic nerve. The optic nerve is damaged. Vision loss with eventual blindness occurs. Drugs and surgery can control glaucoma and prevent further damage to the optic nerve. Prior damage cannot be reversed.

Impaired Vision and Blindness
- Birth defects, injuries, accidents, and eye diseases are among the many causes of impaired vision and blindness. They also are complications of some diseases.
- Review Box 42-6, Caring for Blind and Visually Impaired Persons, in the Textbook.

Corrective Lenses
- Clean eyeglasses daily and as needed.
- Protect eyeglasses from loss or damage. When not worn, put them in their case.
- Contact lenses are cleaned, removed, and stored according to the manufacturer's instructions.

CHAPTER 42 REVIEW QUESTIONS

Circle the BEST answer.

1. A person is hard-of-hearing. You do the following *except*
   a. Face the person when speaking
   b. Speak clearly, distinctly, and slowly
   c. Use facial expressions and gestures to give clues
   d. Use long sentences
2. A person has taken his hearing aid out for the evening. You do the following *except*
   a. Make sure the hearing aid is turned off
   b. Keep the battery in the hearing aid
   c. Place the hearing aid in a safe place
   d. Handle the hearing aid carefully
3. A person is blind. You do the following *except*
   a. Identify yourself when you enter her room
   b. Describe people, places, and things thoroughly
   c. Re-arrange her furniture without telling her
   d. Encourage her to do as much for herself as possible
4. Fluid buildup in the eye that causes pressure on the optic nerve is
   a. Cataract
   b. Cerumen
   c. Glaucoma
   d. Tinnitus

Answers to these questions are on p. 517.

CHAPTER 43 CANCER, IMMUNE SYSTEM, AND SKIN DISORDERS

Cancer
- Cancer is the second leading cause of death in the United States.
- Review Box 43-1, Cancer: Signs and Symptoms, in the Textbook.
- Surgery, radiation therapy, and chemotherapy are the most common treatments.
- Persons with cancer have many needs. They include:
  - Pain relief or control
  - Rest and exercise
  - Fluids and nutrition
  - Preventing skin breakdown
  - Preventing bowel problems (constipation, diarrhea)
  - Dealing with treatment side effects
  - Psychological and social needs
  - Spiritual needs
  - Sexual needs
- Anger, fear, and depression are common. Some surgeries are disfiguring. The person may feel unwhole, unattractive, or unclean. The person and family need support.
- Talk to the person. Do not avoid the person because you are uncomfortable. Use touch and listening to show that you care.
- Spiritual needs are important. A spiritual leader may provide comfort.

Immune System Disorders
- The immune system protects the body from microbes, cancer cells, and other harmful substances. It defends against threats inside and outside the body.

HIV/AIDS
- Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV). The virus is spread through body fluids—blood, semen, vaginal secretions, rectal fluids, and breast-milk. HIV is not spread by air, saliva, tears, sweat, sneezing, coughing, insects, casual contact, closed mouth or social kissing, or toilet seats.
- Persons with AIDS are at risk for pneumonia, tuberculosis, Kaposi's sarcoma (a cancer), nervous system disorders, mental health disorders, and dementia.
- To protect yourself and others from HIV, follow Standard Precautions and the Bloodborne Pathogen Standard.
- Review Box 43-4, Caring for the Person With AIDS, in the Textbook.
- Older persons also get AIDS. They get and spread HIV through sexual contact and intravenous (IV) drug use. Aging and some diseases can mask the signs and symptoms of AIDS. Older persons are less likely to be tested for HIV/AIDS.

Skin Disorders—Shingles
- Shingles is caused by the same virus that causes chicken pox. A rash or blisters can occur. Pain is mild to intense and itching is a common complaint.
- Shingles is most common in persons over 50 years of age. Persons at risk are those who have had chicken pox as children and who have weakened immune systems. Shingles lesions are infectious until they crust over.
- Treatments include anti-viral and pain-relief drugs. A vaccine is not available.

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CHAPTER 43 REVIEW QUESTIONS

Circle the BEST answer.

1. A person with cancer may need all the following *except*
   a. Pain relief or control
   b. Avoidance by you
   c. Fluids and nutrition
   d. Psychological support
2. Which statement about HIV is *false?*
   a. HIV is spread through body fluids.
   b. Standard Precautions and the Bloodborne Pathogen Standard are followed.
   c. Older persons cannot get and spread HIV.
   d. Older persons are less likely to be tested for HIV/AIDS.
3. The immune system defends against threats inside and outside the body.
   a. True
   b. False
4. Shingles lesions are not infectious.
   a. True
   b. False

Answers to these questions are on p. 517.

CHAPTER 44 NERVOUS SYSTEM AND MUSCULO-SKELETAL DISORDERS

Nervous System Disorders

Stroke

- Stroke is also called a brain attack or cerebrovascular accident (CVA). It is the third leading cause of death in the United States. Review Box 44-1, Stroke: Warning Signs, in the Textbook.
- The effects of stroke include:
  - Loss of face, hand, arm, leg, or body control
  - **Hemiplegia**—paralysis on 1 side of the body
  - Changing emotions (crying easily or mood swings, sometimes for no reason)
  - Difficulty swallowing (dysphagia)
  - Aphasia or slowed or slurred speech
  - Changes in sight, touch, movement, and thought
  - Impaired memory
  - Urinary frequency, urgency, or incontinence
  - Loss of bowel control or constipation
  - Depression and frustration
  - Behavior changes
- The health team helps the person regain the highest possible level of function. Review Box 44-2, Stroke Care Measures, in the Textbook.

Parkinson's Disease

- Parkinson's disease is a slow, progressive disorder with no cure. Persons over the age of 50 are at risk. Signs and symptoms become worse over time. They include:
  - *Tremors*—often start in 1 finger and spread to the whole arm. Pill-rolling movements—rubbing the thumb and index finger—may occur. The person may have trembling in the hands, arms, legs, jaw, and face.
  - *Rigid, stiff muscles*—in the arms, legs, neck, and trunk.
  - *Slow movements*—the person has a slow, shuffling gait.
  - *Stooped posture and impaired balance*—it is hard to walk. Falls are a risk.
  - *Mask-like expression*—the person cannot blink and smile. A fixed stare is common.
- Other signs and symptoms that develop over time include swallowing and chewing problems, constipation, and bladder problems. Sleep problems, depression, and emotional changes (fear, insecurity) can occur. So can memory loss and slow thinking. The person may have slurred, monotone, and soft speech. Some people talk too fast or repeat what they say.
- Drugs are ordered to treat and control the disease. Exercise and physical therapy improve strength, posture, balance, and mobility. Therapy is needed for speech and swallowing problems. The person may need help with eating and self-care. Safety measures are needed to prevent falls and injury.

Multiple Sclerosis

- Multiple sclerosis (MS) is a chronic disease. The myelin (which covers nerve fibers) in the brain and spinal cord is destroyed. Nerve impulses are not sent to and from the brain in a normal manner. Functions are impaired or lost. There is no cure.
- Symptoms usually start between the ages of 20 and 40. Signs and symptoms depend on the damaged area. They may include vision problems, muscle weakness in the arms and legs, and balance problems that affect standing and walking. Tingling, prickling, or numb sensations may occur. Also, partial or complete paralysis and pain may occur.
- Persons with MS are kept active as long as possible and as independent as possible. Skin care, hygiene, and range-of-motion (ROM) exercises are important. So are turning, positioning, and deep breathing and coughing. Bowel and bladder elimination is promoted. Injuries and complications from bedrest are prevented.

Head Injuries

- Traumatic brain injury (TBI) occurs from violent injury to the brain. Common causes include falls, traffic accidents, violence, sports, explosive blasts, and combat injuries. Review Box 44-3, Traumatic Brain Injury: Signs and Symptoms, in the Textbook.
- Disabilities from TBI include cognitive problems, sensory problems, communications problems, and emotional problems.

Spinal Cord Injury

- Spinal cord injuries can permanently damage the nervous system. Common causes are motor vehicle crashes, falls, violence, sports injuries, alcohol use, and cancer and other diseases.
- The higher the level of injury, the more functions lost.
  - Lumbar injuries—sensory and muscle function in the legs is lost. The person has **paraplegia**—paralysis and loss of sensory function in the legs and lower trunk.
  - Thoracic injuries—sensory and muscle function below the chest is lost. The person has paraplegia.

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- ◦ Cervical injuries—sensory and muscle function of the arms, legs, and trunk is lost. Paralysis in the arms, legs, and trunk is called **quadriplegia** or **tetraplegia.**
- Review Box 44-4, Care of Persons With Paralysis, in the Textbook.

Musculo-Skeletal Disorders

Arthritis

- Arthritis means joint inflammation.
- *Osteoarthritis (degenerative joint disease).* The fingers, spine (neck and lower back), and weight-bearing joints (hips, knees, and feet) are often affected. Treatment involves pain relief, heat applications, exercise, rest and joint care, weight control, and a healthy life-style. Falls are prevented. Help is given with activities of daily living (ADL) as needed. Toilet seat risers are helpful when hips and knees are affected. So are chairs with higher seats and armrests. Some people need joint replacement surgery.
- *Rheumatoid arthritis.* Rheumatoid arthritis (RA) causes joint pain, swelling, stiffness, and loss of function. Joints are tender, warm, and swollen. Fatigue and fever are common. The person does not feel well. The person's care plan may include rest balanced with exercise, proper positioning, joint care, weight control, measures to reduce stress, and measures to prevent falls. Drugs are ordered for pain relief and to reduce inflammation. Heat and cold applications may be ordered. Some persons need joint replacement surgery. Emotional support is needed. Persons with RA need to stay as active as possible. Give encouragement and praise. Listen when the person needs to talk.

CHAPTER 44 REVIEW QUESTIONS

Circle the BEST answer.

1. The person had a stroke. Care includes all the following *except*
   a. Place the call light on the person's strong side
   b. Re-position the person every 2 hours
   c. Perform ROM exercises as ordered
   d. Place objects on the affected side
2. The person with hemiplegia
   a. Is paralyzed on 1 side of the body
   b. Has both arms paralyzed
   c. Has both legs paralyzed
   d. Has all extremities paralyzed
3. The person with multiple sclerosis should be kept active as long as possible.
   a. True
   b. False
4. The person has paralysis in the legs and lower trunk. This is called
   a. Quadriplegia
   b. Paraplegia
   c. Hemiplegia
   d. Tetraplegia
5. Fever is a common symptom of osteoarthritis.
   a. True
   b. False

Answers to these questions are on p. 517.

CHAPTER 45 CARDIOVASCULAR, RESPIRATORY, AND LYMPHATIC DISORDERS

Cardiovascular Disorders

- *Hypertension.* Hypertension (high blood pressure) occurs when the systolic pressure is 140 mm Hg or higher or the diastolic pressure is 90 mm Hg or higher. Narrowed blood vessels are a common cause. Review Box 45-1, Cardiovascular Disorders: Risk Factors, in the Textbook.
- *Coronary artery disease (CAD).* In CAD, the coronary artery become hardened and narrow and the heart muscle gets less blood and oxygen. The most common cause is atherosclerosis, or plaque buildup on artery walls. Complications of CAD are heart attack, irregular heartbeats, and sudden death. CAD complications may require cardiac rehabilitation, which consists of exercise training and education, counseling, and training for life-style changes.
- *Angina.* Angina is chest pain. It is caused by reduced blood flow to part of the heart muscle. Chest pain is described as tightness, pressure, squeezing, or burning in the chest. Pain can occur in the shoulders, arms, neck, jaw, or back. The person may be pale, feel faint, and perspire. Dyspnea is common. Nausea, fatigue, and weakness may occur. Some persons complain of "gas" or indigestion. Rest often relieves symptoms in 3 to 15 minutes. Chest pain lasting longer than a few minutes and not relieved by rest and nitroglycerin may signal heart attack. The person needs emergency care.
- *Myocardial infarction (MI).* MI also is called *heart attack, acute myocardial infarction (AMI),* and *acute coronary syndrome (ACS).* Blood flow to the heart muscle is suddenly blocked. Part of the heart muscle dies. MI is an emergency. Sudden cardiac death *(sudden cardiac arrest)* can occur. Review Box 45-2, Myocardial Infarction: Signs and Symptoms, in the Textbook.
- *Heart failure.* Heart failure or congestive heart failure (CHF) occurs when the heart is weakened and cannot pump normally. Blood backs up. Tissue congestion occurs. Drugs are given to strengthen the heart. They also reduce the amount of fluid in the body. A sodium-controlled diet is ordered. Oxygen is given. Semi-Fowler's position is preferred for breathing. Intake and output (I&O), daily weight, elastic stockings, and range-of-motion (ROM) exercises are part of the care plan.
- *Dysrhythmias.* Dysrhythmias are abnormal heart rhythms. Rhythms may be too fast, too slow, or irregular. Dysrhythmias are caused by changes in the heart's electrical system. Some abnormal rhythms are treated with a pacemaker.
- *Viral hemorrhagic fevers (VHFs).* VHFs are a group of illnesses caused by viruses. *Ebola* is a severe and deadly VHF caused by the *Ebolavirus.* Signs and symptoms can appear 2 to 21 days after exposure and include fever greater than 101.5°F, severe headache, muscle pain, weakness, diarrhea and vomiting, abdominal pain, and hemorrhage. The virus is contagious and is spread through direct contact with blood or body fluids, contaminated objects, and infected animals. The health team must prevent the spread of infection.

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Hand hygiene, Standard Precautions, Transmission-Based Precautions, and the Bloodborne Pathogen Standard are followed. Special training is needed to care for such patients and for donning and removing personal protective equipment (PPE).

Respiratory Disorders

Chronic Obstructive Pulmonary Disease

- Two disorders are grouped under chronic obstructive pulmonary disease (COPD). They are chronic bronchitis and emphysema. These disorders obstruct airflow. Lung function is gradually lost.
- *Chronic bronchitis.* Bronchitis means inflammation of the bronchi. Chronic bronchitis occurs after repeated episodes of bronchitis. Smoking is the major cause. Smoker's cough in the morning is often the first symptom of chronic bronchitis. Over time, the cough becomes more frequent. The person has difficulty breathing and tires easily. The person must stop smoking. Oxygen therapy and breathing exercises are often ordered. If a respiratory tract infection occurs, the person needs prompt treatment.
- *Emphysema.* In emphysema, the alveoli enlarge and become less elastic. They do not expand and shrink normally when breathing in and out. Air becomes trapped when exhaling. Smoking is the most common cause. The person has shortness of breath and a cough. Sputum may contain pus. Fatigue is common. The person works hard to breathe in and out. Breathing is easier when the person sits upright and slightly forward. The person must stop smoking. Respiratory therapy, breathing exercises, oxygen, and drug therapy are ordered.

Asthma

- In asthma, the airway becomes inflamed and narrow. Extra mucus is produced. Dyspnea results. Wheezing and coughing are common. So are pain and tightening in the chest. Asthma usually is triggered by allergies. Other triggers include air pollutants and irritants, smoking and second-hand smoke, respiratory tract infections, exertion, and cold air. Asthma is treated with drugs. Severe attacks may require emergency care.

Pneumonia

- Pneumonia is an inflammation and infection of lung tissue. Bacteria, viruses, and other microbes are causes.
- High fever, chills, painful cough, chest pain on breathing, and rapid pulse occur. Shortness of breath and rapid breathing also occur. Cyanosis may be present. Sputum is thick and white, green, yellow, or rust-colored. Other signs and symptoms are nausea, vomiting, headache, tiredness, and muscle aches.
- Drugs are ordered for infection and pain. Fluid intake is increased. Intravenous (IV) therapy and oxygen may be needed. The semi-Fowler's position eases breathing. Rest is important. Standard Precautions are followed. Isolation precautions are used depending on the cause.

Tuberculosis

- Tuberculosis (TB) is a bacterial infection in the lungs. TB is spread by airborne droplets with coughing, sneezing, speaking, singing, or laughing. Those who have close, frequent contact with an infected person are at risk. TB is more likely to occur in close, crowded areas. Age, poor nutrition, and human immunodeficiency virus (HIV) infection are other risk factors.
- Signs and symptoms are tiredness, loss of appetite, weight loss, fever, and night sweats. Cough and sputum production increase over time. Sputum may contain blood. Chest pain occurs.
- Drugs for TB are given. Standard Precautions and isolation precautions are needed. The person must cover the mouth and nose with tissues when sneezing, coughing, or producing sputum. Tissues are flushed down the toilet, placed in a BIOHAZARD bag, or placed in a paper bag and burned. Hand-washing after contact with sputum is essential.

CHAPTER 45 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement about angina is *false?*
   a. Angina is chest pain.
   b. The person may be pale and perspire.
   c. Rest often relieves the symptoms.
   d. You do not report angina to the nurse.
2. A person has heart failure. You do all of the following *except*
   a. Measure intake and output
   b. Measure weight daily
   c. Promote a diet that is high in salt
   d. Restrict fluids as ordered
3. Which position is usually best for the person with pneumonia?
   a. Semi-Fowler's
   b. Prone
   c. Supine
   d. Trendelenburg's
4. A bacterial infection in the lungs is
   a. Asthma
   b. Bronchitis
   c. Tuberculosis
   d. Emphysema

Answers to these questions are on p. 517.

CHAPTER 46 DIGESTIVE AND ENDOCRINE DISORDERS

Digestive Disorders

Gastro-Esophageal Reflux Disease (GERD)

- GERD occurs when stomach contents flow back up into the esophagus. Drugs to prevent stomach acid production or to promote stomach emptying may be ordered. Life-style changes include limiting smoking and alcohol, losing weight, eating small meals, wearing loose belts and clothing, and sitting upright for 3 hours after meals.

Vomiting

- These measures are needed.
  - Follow Standard Precautions and the Bloodborne Pathogen Standard.

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- Turn the person's head well to 1 side. This prevents aspiration.
- Place a kidney basin under the person's chin.
- Move vomitus away from the person.
- Provide oral hygiene.
- Observe vomitus for color, odor, and undigested food. If it looks like coffee grounds, it contains undigested blood. This signals bleeding. Report your observations.
- Measure, report, and record the amount of vomitus. Also record the amount on the intake and output (I&O) record.
- Save a specimen for laboratory study.
- Dispose of vomitus after the nurse observes it.
- Eliminate odors.
- Provide for comfort.

Hepatitis

- Hepatitis is an inflammation of the liver. It can be mild or cause death. Signs and symptoms are listed in Box 46-1, Hepatitis, in the Textbook. Some people do not have symptoms.
- Protect yourself and others. Follow Standard Precautions and the Bloodborne Pathogen Standard. Isolation precautions are ordered as necessary. Assist the person with hygiene and hand-washing as needed.

Endocrine Disorders

Diabetes

- In this disorder the body cannot produce or use insulin properly. Insulin is needed for glucose to move from the blood into the cells. Sugar builds up in the blood. Cells do not have enough sugar for energy and cannot function.
- Diabetes must be controlled to prevent complications. Complications include blindness, renal failure, nerve damage, and damage to the gums and teeth. Heart and blood vessel diseases are other problems. They can lead to stroke, heart attack, and slow healing. Foot and leg wounds and ulcers are very serious.
- Good foot care is needed. Corns, blisters, calluses, and other foot problems can lead to an infection and amputation.
- Blood glucose is monitored for:
  - *Hypoglycemia*—low sugar in the blood.
  - *Hyperglycemia*—high sugar in the blood.
- Review Table 46-1 in the Textbook for the causes, signs, and symptoms of hypoglycemia and hyperglycemia. Both can lead to death if not corrected. You must call for the nurse at once.

CHAPTER 46 REVIEW QUESTIONS

Circle the BEST answer.

1. A person is vomiting. You should do all of the following *except*
   a. Follow Standard Precautions and the Bloodborne Pathogen Standard
   b. Keep the person supine
   c. Provide oral hygiene
   d. Observe the vomitus for color, odor, and undigested food
2. A person with diabetes is trembling, sweating, and feels faint. You
   a. Tell the nurse immediately
   b. Tell the nurse at the end of the shift
   c. Tell another nursing assistant
   d. Ignore the symptoms
3. All of the following are signs and symptoms of hepatitis *except*
   a. Itching
   b. Diarrhea
   c. Skin rash
   d. Increased appetite

Answers to these questions are on p. 517.

CHAPTER 47 URINARY AND REPRODUCTIVE DISORDERS

Urinary System Disorders

Urinary Tract Infections (UTIs)

- UTIs are common. Catheters, poor perineal hygiene, immobility, and poor fluid intake are common causes.

Prostate Enlargement

- The prostate grows larger as a man grows older. This is called benign prostatic hyperplasia (BPH). The enlarged prostate presses against the urethra. This obstructs urine flow through the urethra. Bladder function is gradually lost. Most men in their 60s and older have some symptoms of BPH.

Kidney Stones

- Kidney stones (calculi) are most common in white men 40 years of age and older. Bedrest, immobility, and poor fluid intake are risk factors. Review the list of symptoms on p. 752 in the Textbook.
- Stones vary in size from grains of sand to golf ball–sized.

Kidney Failure

- In kidney failure (renal failure) the kidneys do not function or are severely impaired. Waste products are not removed from the blood. Fluid is retained.
- Acute kidney failure is sudden. Blood flow to the kidneys is severely decreased. Causes include severe injury or bleeding, heart attack, heart failure, burns, infection, and severe allergic reactions.
- With chronic kidney failure the kidneys cannot meet the body's needs. Hypertension and diabetes are common causes. Infections, urinary tract obstructions, and tumors are other causes. Review Box 47-3, Chronic Kidney Disease: Signs and Symptoms, in the Textbook.

Reproductive Disorders

Sexually Transmitted Diseases

- A sexually transmitted disease (STD) is spread by oral, vaginal, or anal sex. Some people do not have signs and symptoms or are not aware of an infection. Others know but do not seek treatment because of embarrassment. Standard Precautions and the Bloodborne Pathogen Standard are followed.

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CHAPTER 47 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Older persons are at high risk for urinary tract infections.
   b. Skin irritation and infection can occur if urine leaks onto the skin.
   c. Benign prostatic hypertrophy may cause urinary problems in women.
   d. Some people may not be aware of having a sexually transmitted disease.
2. An STD is spread by oral, vaginal, or anal sex.
   a. True
   b. False
3. A person with an STD always has signs and symptoms.
   a. True
   b. False

Answers to these questions are on p. 517.

CHAPTER 48 MENTAL HEALTH DISORDERS

- The whole person has physical, social, psychological, and spiritual parts. Each part affects the other.
- **Stress** is the response or change in the body caused by any emotional, physical, social, or economic factor.
- **Mental health** means the person copes with and adjusts to every-day stresses in ways accepted by society.
- **Mental disorder** is a disturbance in the ability to cope with or adjust to stress. Behavior and function are impaired. *Mental illness, emotional illness,* and *psychiatric disorder* also mean mental disorder.

Anxiety Disorders

- **Anxiety** is a vague, uneasy feeling in response to stress. The person may not know the cause. The person senses danger or harm—real or imagined. Some anxiety is normal. Review Box 48-1, Anxiety: Signs and Symptoms, in the Textbook.
- Coping and defense mechanisms are used to relieve anxiety. Review Box 48-2, Defense Mechanisms, in the Textbook.
- Some common anxiety disorders are panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder.
- *Panic disorder.* **Panic** is an intense and sudden feeling of fear, anxiety, terror, or dread. Onset is sudden with no obvious reason. The person cannot function. Signs and symptoms of anxiety are severe.
- *Phobias.* **Phobia** means an intense fear. The person has an intense fear of an object, situation, or activity that has little or no actual danger. The person avoids what is feared. When faced with the fear, the person has high anxiety and cannot function.
- *Obsessive-compulsive disorder (OCD).* An **obsession** is a recurrent, unwanted thought, idea, or image. **Compulsion** is repeating an act over and over again. The act may not make sense but the person has much anxiety if the act is not done. Some persons with OCD also have depression, eating disorders, substance abuse, and other anxiety disorders.
- *Post-traumatic stress disorder (PTSD).* PTSD occurs after a terrifying ordeal. The ordeal involved physical harm or the threat of physical harm. Review Box 48-3, Post-Traumatic Stress Disorder: Signs and Symptoms, in the Textbook. Flashbacks are common. A **flashback** is reliving the trauma in thoughts during the day and in nightmares during sleep. He or she may believe that the trauma is happening all over again. Signs and symptoms usually develop about 3 months after the harmful event. Or they may emerge years later. PTSD can develop at any age.

Schizophrenia

- **Schizophrenia** means split mind. It is a severe, chronic, disabling brain disorder that involves:
  - *Psychosis*—a state of severe mental impairment. The person does not view the real or unreal correctly.
  - *Hallucinations*—seeing, hearing, smelling, or feeling something that is not real.
  - *Delusion*—a false belief.
  - *Delusion of grandeur*—an exaggerated belief about one's importance, wealth, power, or talents.
  - *Delusion of persecution*—the false belief that one is being mistreated, abused, or harassed.
  - *Thought disorders*—trouble organizing thoughts or connecting thoughts logically.
  - *Movement disorders*—include agitated body movements; repeating motions over and over; and sitting for hours without moving, speaking, or responding.
  - *Emotional and behavioral problems*—normal functions are impaired or absent, including losing motivation or interest in daily activities, being unable to plan, lacking emotions, neglecting personal hygiene, and withdrawing socially.
  - *Cognitive problems*—trouble paying attention, understanding, or remembering information.
- The person with schizophrenia has problems relating to others. He or she may be paranoid. The person may have difficulty organizing thoughts. Responses are inappropriate. Communication is disturbed. The person may withdraw. Some people regress to an earlier time or condition. Some persons with schizophrenia attempt suicide.

Bipolar Disorder

- The person with bipolar disorder has severe extremes in mood, energy, and ability to function. There are emotional lows (depression) and emotional highs (mania). This disorder is also called manic-depressive illness. This disorder must be managed throughout life. Review Box 48-4, Bipolar Disorder: Signs and Symptoms, in the Textbook. Bipolar disorder can damage relationships and affect school or work performance. Some people are suicidal.

Depression

- Depression involves the body, mood, and thoughts. Symptoms affect work, study, sleep, eating, and other activities. The person is very sad.

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- Depression is common in older persons. They have many losses—death of family and friends, loss of health, loss of body functions, and loss of independence. Loneliness and the side effects of some drugs also are causes. Review Box 48-5, Depression in Older Persons: Signs and Symptoms, in the Textbook. Depression in older persons is often overlooked or a wrong diagnosis is made.

Substance Abuse Disorder

Alcoholism

- Alcohol affects alertness, judgment, coordination, and reaction time. Over time, heavy drinking damages the brain, central nervous system, liver, kidneys, heart, blood vessels, and stomach. It also can cause forgetfulness and confusion. Alcoholism is a chronic disease. Alcoholism can be treated but not cured. Alcohol recovery, support programs, and drugs are used to help the person stop drinking. The person must avoid all alcohol to avoid a relapse.
- Alcohol effects vary with age. Even small amounts can make older persons feel "high." Older persons are at risk for falls, vehicle crashes, and other injuries from drinking. Mixing alcohol with some drugs can be harmful or fatal. Alcohol also makes some health problems worse.

Suicide

- **Suicide** means to kill oneself.
- Suicide is most often linked to depression, alcohol or substance abuse, or stressful events. Review Box 48-7, Suicide Risk Factors, in the Textbook.
- If a person mentions or talks about suicide, take the person seriously. Call for the nurse at once. Do not leave the person alone.

Care and Treatment

- Treatment of mental health disorders involves having the person explore his or her thoughts and feelings. This is done through psychotherapy and behavior, group, occupational, art, and family therapies. Often drugs are ordered.
- The care plan reflects the person's needs. The physical, safety and security, and emotional needs of the person must be met.
- Communication is important. Be alert to nonverbal communication.

CHAPTER 48 REVIEW QUESTIONS

Circle the BEST answer.

1. A person may not know why anxiety occurs.
   a. True
   b. False
2. Panic is an intense and sudden feeling of fear, anxiety, terror, or dread.
   a. True
   b. False
3. A person with an obsessive-compulsive disorder has a ritual that is repeated over and over again.
   a. True
   b. False
4. A person talks about suicide. You must do the following *except*
   a. Call the nurse at once
   b. Stay with the person
   c. Leave the person alone
   d. Take the person seriously
5. Which statement about depression in older persons is *false?*
   a. Depression is often overlooked in older persons.
   b. Depression rarely occurs in older persons.
   c. Loneliness may be a cause of depression in older persons.
   d. Side effects of some drugs may cause depression in older persons.
6. Which statement is *false?*
   a. Communication is important when caring for a person with a mental health disorder.
   b. You should be alert to nonverbal communication when caring for a person with a mental health disorder.
   c. The care plan reflects the needs of the person.
   d. The focus is only on the person's emotional needs.

Answers to these questions are on p. 517.

CHAPTER 49 CONFUSION AND DEMENTIA

- Changes in the brain and nervous system occur with aging. Review Box 49-1, Nervous System Changes From Aging, in the Textbook.
- Changes in the brain can affect **cognitive function**—memory, thinking, reasoning, ability to understand, judgment, and behavior.

Confusion

- Confusion has many causes. Diseases, infections, hearing and vision loss, brain injury, and drug side effects are some causes.
- When caring for the confused person:
  - Follow the person's care plan.
  - Provide for safety.
  - Face the person and speak clearly.
  - Call the person by name every time you are in contact with him or her.
  - State your name. Show your name tag.
  - Give the date and time each morning. Repeat as needed during the day and evening.
  - Explain what you are going to do and why.
  - Give clear, simple directions and answers to questions.
  - Break tasks into small steps.
  - Ask clear, simple questions. Allow time to respond.
  - Keep calendars and clocks with large numbers in the person's room. Remind the person of holidays, birthdays, and other events.
  - Have the person wear eyeglasses and hearing aids as needed.
  - Use touch to communicate.
  - Place familiar objects and pictures within the person's view.
  - Provide newspapers, magazines, TV, and radio. Read to the person if appropriate.

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- Discuss current events with the person.
- Maintain the day-night cycle.
- Provide a calm, relaxed, and peaceful setting.
- Follow the person's routine.
- Do not re-arrange furniture or the person's belongings.
- Encourage the person to take part in self-care.
- Be consistent.

Dementia

- **Dementia** is the loss of cognitive function that interferes with routine personal, social, and occupational activities.
- Dementia is not a normal part of aging. Most older people do not have dementia.
- Some early warning signs include problems with language, dressing, cooking, personality changes, poor or decreased judgment, and driving as well as getting lost in familiar places and misplacing items.
- Alzheimer's disease is the most common type of permanent dementia.

Alzheimer's Disease

- Alzheimer's disease (AD) is a brain disease. Memory, thinking, reasoning, judgment, language, behavior, mood, and personality are affected.

Signs of AD

- The classic sign of AD is gradual loss of short-term memory. Warning signs include:
  - Asking the same questions over and over again.
  - Repeating the same story—word for word, again and again.
  - Forgetting activities that were once done regularly with ease.
  - Losing the ability to pay bills or balance a checkbook.
  - Getting lost in familiar places. Or misplacing household objects.
  - Neglecting to bathe or wearing the same clothes over and over again. Meanwhile, the person insists that a bath was taken or that clothes were changed.
  - Relying on someone else to make decisions or answer questions that the person would have handled.
- Review Box 49-5, Signs of Alzheimer's Disease, in the Textbook for other signs of AD.

Behaviors

- The following behaviors are common with AD.
  - *Wandering*. Persons with AD are not oriented to person, place, and time. They may wander away from home and not find their way back. The person cannot tell what is safe or dangerous.
  - *Sundowning*. With sundowning, signs, symptoms, and behaviors of AD increase during hours of darkness. As daylight ends, confusion, restlessness, anxiety, agitation, and other symptoms increase.
  - *Hallucinations*. The person with AD may see, hear, or feel things that are not real.
  - *Delusions*. People with AD may think they are some other person. A person may believe that the caregiver is someone else.
  - *Paranoia*. The person has false beliefs and suspicion about a person or situation.
  - *Catastrophic reactions*. The person reacts as if there is a disaster or tragedy.
  - *Agitation and aggression*. The person may pace, hit, or yell.
  - *Communication changes*. The person has trouble expressing thoughts and emotions.
  - *Screaming*. Persons with AD may scream to communicate.
  - *Repetitive behaviors*. Persons with AD repeat the same motions over and over again.
  - *Rummaging and hiding things*. The person may search for things by moving things around, turning things over, or looking through something such as a drawer or closet. The person may hide things, throw things away, or lose something.
  - *Changes in intimacy and sexuality*. The person with AD may depend on and cling to his or her partner or may not remember life with or feelings for his or her partner. Sexual behaviors may involve the wrong person, the wrong time, and the wrong place. Persons with AD cannot control behavior.

Care of Persons With AD and Other Dementias

- People with AD do not choose to be forgetful, incontinent, agitated, or rude. Nor do they choose to have other behaviors, signs, and symptoms of the disease. The disease causes the behaviors.
- Safety, hygiene, nutrition and fluids, elimination, and activity needs must be met. So must comfort and sleep needs. Review Box 49-10, Care of Persons With AD and Other Dementias, in the Textbook.
- The person can have other health problems and injuries. However, the person may not recognize pain, fever, constipation, incontinence, or other signs and symptoms. Carefully observe the person. Report any change in the person's usual behavior to the nurse.
- Infection is a risk. Provide good skin care, oral hygiene, and perineal care after bowel and bladder elimination.
- Supervised activities meet the person's needs and cognitive abilities.
- Impaired communication is a common problem. Avoid giving orders, wanting the truth, and correcting the person's errors.
- Always look for dangers in the person's room and in the hallways, lounges, dining areas, and other areas on the nursing unit. Remove the danger if you can.
- Every staff member must be alert to persons who wander. Such persons are allowed to wander in safe areas.

The Family

- The family may have physical, emotional, social, and financial stresses. The family often feels hopeless. No matter what is done, the person only gets worse. Anger and resentment may result. Guilt feelings are common.
- The family is an important part of the health team. They may help plan the person's care. For many persons, family members provide comfort. The family also needs support and understanding from the health team.

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CHAPTER 49 REVIEW QUESTIONS

Circle the BEST answer.

1. Cognitive function involves all of the following *except*
   a. Memory and thinking
   b. Reasoning and understanding
   c. Personality and mood
   d. Judgment and behavior
2. When caring for a confused person, you do the following *except*
   a. Provide for safety
   b. Maintain the day-night schedule
   c. Keep calendars and clocks in the person's room
   d. Ask difficult-to-understand questions and give complex directions
3. Which statement about dementia is *false?*
   a. Dementia is a normal part of aging.
   b. The person may have changes in personality.
   c. Alzheimer's disease is the most common type of dementia.
   d. The person may have changes in behavior.
4. When caring for persons with AD, you do the following *except*
   a. Provide good skin care
   b. Talk to them in a calm voice
   c. Observe them closely for unusual behavior
   d. Allow personal choice in wandering

Answers to these questions are on p. 517.

CHAPTER 51 SEXUALITY

Sex and Sexuality

- Sexuality involves the whole person. Illness, injury, and aging can affect sexuality.

Sexuality and Older Persons

- Love, affection, and intimacy are needed throughout life. Older persons love, fall in love, hold hands, and embrace. Many have intercourse.
- Reproductive organs change with aging. Frequency of sex decreases for many older persons.
- Sexual partners are lost through death, divorce, and relationship break-ups. Or a partner needs hospital or nursing center care.

Meeting Sexual Needs

- The nursing team promotes the meeting of sexual needs.
- Review Box 51-1, Promoting Sexuality, in the Textbook.

The Sexually Aggressive Person

- Some persons want the health team to meet their sexual needs. They flirt or make sexual advances or comments. Some expose themselves, masturbate, or touch the staff. This can anger and embarrass the staff member. These reactions are normal.
- Touch may have a sexual purpose. You must be professional about the matter.
  - Ask the person not to touch you. State the places where you were touched.
  - Tell the person that you will not do what he or she wants.
  - Tell the person what behaviors make you uncomfortable. Politely ask the person not to act that way.
  - Allow privacy if the person is becoming aroused.
  - Discuss the matter with the nurse. The nurse can help you understand the behavior.
  - Follow the care plan. It has measures to deal with sexually aggressive behaviors. They are based on the cause of the behavior.

Protecting the Person

- The person must be protected from unwanted sexual comments and advances. This is sexual abuse (see Chapter 5 in the Textbook). Tell the nurse right away.
- No one should be allowed to sexually abuse another person. This includes staff members, patients, residents, family members or other visitors, and volunteers.

CHAPTER 51 REVIEW QUESTIONS

Circle the BEST answer.

1. A resident touches you in a sexual way. You should do the following *except*
   a. Ask the person not to touch you
   b. Discuss the matter with the nurse
   c. Tell the person what behaviors make you uncomfortable
   d. Yell at the person immediately
2. Unwanted sexual comments and advances are forms of sexual abuse.
   a. True
   b. False

Answers to these questions are on p. 517.

CHAPTER 54 BASIC EMERGENCY CARE

Emergency Care

- Rules for emergency care include:
  - Know your limits. Do not do more than you are able.
  - Stay calm.
  - Know where to find emergency supplies.
  - Follow Standard Precautions and the Bloodborne Pathogen Standard to the extent possible.
  - Check for life-threatening problems. Check for breathing, a pulse, and bleeding.
  - Keep the person lying down or as you found him or her.
  - Move the person only if the setting is unsafe. If the scene is not safe enough for you to approach, wait for help to arrive.
  - Perform necessary emergency measures.
  - Call for help.
  - Do not remove clothes unless necessary.
  - Keep the person warm. Cover the person with a blanket, coat, or sweater.
  - Re-assure the person. Explain what is happening and that help was called.
  - Do not give the person food or fluids.
  - Keep on-lookers away. They invade privacy.
- Review Box 54-1, Emergency Care Rules, in the Textbook for more information.

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Basic Life Support for Adults

- Cardiopulmonary resuscitation (CPR) supports breathing and circulation. It provides blood and oxygen to the heart, brain, and other organs until advanced emergency care is given. CPR is done if the person does not respond, is not breathing, and has no pulse.
- CPR involves:
  - *Chest compressions*—the heart, brain, and other organs must receive blood. Chest compressions force blood through the circulatory system.
  - *Airway*—the airway must be open and clear of obstructions. The head tilt–chin lift method opens the airway.
  - *Breathing*—air is not inhaled when breathing stops. The person must get oxygen. The person is given breaths by a rescuer inflating the person's lungs.
  - *Defibrillation*—ventricular fibrillation (VF, V-fib) is an abnormal heart rhythm. Rather than beating in a regular rhythm, the heart shakes and quivers. The heart does not pump blood. The heart, brain, and other organs do not receive blood and oxygen. A *defibrillator* is used to deliver a shock to the heart. This allows the return of a regular heart rhythm. Defibrillation as soon as possible after the onset of VF (V-fib) increases the person's chance of survival.

Hemorrhage

- Hemorrhage is the excessive loss of blood in a short time. It can be internal or external.
- Internal bleeding cannot be seen but can cause pain, shock, vomiting of blood, coughing up blood, cold and moist skin, and loss of consciousness. Follow the Emergency Care Rules in Box 54-1 in the Textbook; this includes activating the Emergency Medical Services (EMS) system; keeping the person warm, flat, and quiet until help arrives; and not giving fluids.
- To control external bleeding:
  - Follow the Emergency Care Rules in Box 54-1 in the Textbook. This includes activating the EMS system.
  - Do not remove any objects that have pierced or stabbed the person.
  - Place a sterile dressing directly over the wound. Or use any clean material.
  - Apply firm pressure directly over the bleeding site. Do not release pressure or remove the dressing.
  - Bind the wound when bleeding stops.

Fainting

- Fainting is the sudden loss of consciousness from an inadequate blood supply to the brain.
- Warning signals are dizziness, perspiration, and blackness before the eyes. The person looks pale. The pulse is weak. Respirations are shallow if consciousness is lost. Emergency care includes:
  - Have the person sit or lie down before fainting occurs.
  - If sitting, the person bends forward and places the head between the knees.
  - If the person is lying down, raise the legs.
  - Loosen tight clothing.
  - Keep the person lying down if fainting has occurred. Raise the legs.
  - Do not let the person get up quickly.
  - Help the person to a sitting position after recovery from fainting.
- Provide Basic Life Support (BLS) if there is no response or breathing.

Seizures

- You cannot stop a seizure. However, you can protect the person from injury.
  - Follow the Emergency Care Rules in Box 54-1 in the Textbook.
  - Do not leave the person alone.
  - Lower the person to the floor.
  - Note the time the seizure started.
  - Place something soft under the person's head.
  - Loosen tight jewelry and clothing around the person's neck.
  - Turn the person onto his or her side. Make sure the head is turned to the side.
  - Do not put any object or your fingers between the person's teeth.
  - Do not try to stop the seizure or control the person's movements.
  - Move furniture, equipment, and sharp objects away from the person.
  - Note the time when the seizure ends.
  - Make sure the mouth is clear of food, fluids, and saliva after the seizure.
  - Provide BLS if the person is not breathing after the seizure.

Concussion

- Head injuries can be minor or serious and life-threatening. A concussion results from a bump or blow to the head or jolt to the head or body. The head and brain move quickly back and forth.
- Symptoms can last for days, weeks, or longer. Symptoms include difficulty thinking and concentrating, headaches, fuzzy or blurred vision, nausea and vomiting, sensitivity to noise or light, feelings of tiredness or low energy, irritability and sadness, mood swings, and more or less sleep than usual.
- The following danger signs signal the need for emergency care:
  - Headache that gets worse or does not go away
  - Stiff neck
  - Weakness, numbness, or decreased coordination
  - Nausea or vomiting more than once
  - Slurred speech
  - Very sleepy; drowsy; cannot be awakened
  - One eye pupil is larger than the other
  - Convulsions or seizures
  - Cannot recognize people, places, or things
  - Increased confusion, restlessness, or agitation
  - Unusual behavior
  - Loss of consciousness
- Follow the Emergency Care Rules in Box 54-1 in your Textbook. This includes activating the EMS system.

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CHAPTER 54 REVIEW QUESTIONS

Circle the BEST answer.

1. During an emergency, you do all of the following *except*
   a. Perform only procedures you have been trained to do
   b. Keep the person lying down or as you found him or her
   c. Let the person become cold
   d. Re-assure the person and explain what is happening
2. During an emergency, you keep on-lookers away.
   a. True
   b. False
3. Which statement about fainting is *false?*
   a. If standing, have the person sit down before fainting.
   b. If sitting, have the person bend forward and place his head between his knees before fainting occurs.
   c. Tighten the person's clothing.
   d. Raise the legs if the person is lying down.
4. During a seizure, you do the following *except*
   a. Turn the person's body to the side
   b. Place your fingers in the person's mouth
   c. Note the time the seizure started and ended
   d. Turn the person's head to the side
5. The symptoms of a concussion are gone within 24 hours.
   a. True
   b. False

Answers to these questions are on p. 517.

CHAPTER 55 END-OF-LIFE CARE

Attitudes About Death

- Attitudes about death often change as a person grows older and with changing circumstances.

Culture and Spiritual Needs

- Practices and attitudes about death differ among cultures.
- Attitudes about death are closely related to religion. Many religions practice rites and rituals during the dying process and at the time of death.

Age

- Adults fear pain and suffering, dying alone, and the invasion of privacy. They also fear loneliness and separation from loved ones. Adults often resent death because it affects plans, hopes, dreams, and ambitions.
- Older persons usually have fewer fears than younger adults. Some welcome death as freedom from pain, suffering, and disability. Death also means reunion with those who have died. Like younger adults, they often fear dying alone.

The Stages of Dying

- Dr. Kübler-Ross described 5 stages of dying. They are:
  - *Stage 1: Denial.* The person refuses to believe he or she is going to die.
  - *Stage 2: Anger.* There is anger and rage, often at family, friends, and the health team.
  - *Stage 3: Bargaining.* Often the person bargains with God or a higher power for more time.
  - *Stage 4: Depression.* The person is sad and mourns things that were lost.
  - *Stage 5: Acceptance.* The person is calm and at peace. The person accepts death.
- Dying persons do not always pass through all 5 stages. A person may never get beyond a certain stage. Some move back and forth between stages.

Comfort Needs

- Comfort is a basic part of end-of-life care. It involves physical, mental and emotional, and spiritual needs. Comfort goals are to:
  - Prevent or relieve suffering to the extent possible.
  - Respect and follow end-of-life wishes.
- Dying persons may want to talk about their fears, worries, and anxieties. You need to listen and use touch.
  - *Listening.* Let the person express feelings and emotions in his or her own way. Do not worry about saying the wrong thing or finding the right words. You do not need to say anything.
  - *Touch.* Touch shows caring and concern. Sometimes the person does not want to talk but needs you nearby. Silence, along with touch, is a meaningful way to communicate.
- Some people may want to see a spiritual leader. Or they may want to take part in religious practices.

Physical Needs

- As the person weakens, basic needs are met. The person may depend on others for basic needs and activities of daily living (ADL). Every effort is made to promote physical and psychological comfort. The person is allowed to die in peace and with dignity.

Pain

- Some dying persons do not have pain. Others may have severe pain. Always report signs and symptoms of pain at once. Pain management is important. The nurse can give pain-relief drugs. Preventing and controlling pain is easier than relieving pain.

Breathing Problems

- Shortness of breath and difficulty breathing (dyspnea) are common end-of-life problems. The semi-Fowler's position and oxygen are helpful.
- Noisy breathing (death rattle) is common as death nears. This is due to mucus collecting in the airway. The side-lying position, suctioning by the nurse, and drugs to reduce the amount of mucus may help.

Vision, Hearing, and Speech

- Vision blurs and gradually fails. Explain what you are doing to the person or in the room. Provide good eye care.
- Hearing is one of the last functions lost. Always assume that the person can hear.
- Speech becomes difficult. Anticipate the person's needs. Do not ask questions that need long answers.

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Mouth, Nose, and Skin

- Frequent oral hygiene is given as death nears.
- Crusting and irritation of the nostrils can occur. Carefully clean the nose.
- Skin care, bathing, and preventing pressure ulcers are necessary. Change linens and gowns whenever needed.

Nutrition

- Nausea, vomiting, and loss of appetite are common at the end of life. The doctor can order drugs for nausea and vomiting.
- Some persons are too tired or too weak to eat. You may need to feed them.
- As death nears, loss of appetite is common. The person may choose not to eat or drink. Do not force the person to eat or drink. Report refusal to eat or drink to the nurse.

Elimination

- Urinary and fecal incontinence may occur. Give perineal care as needed.

The Person's Room

- The person's room should be comfortable and pleasant. It should be well lit and well ventilated. Remove unnecessary equipment.
- Mementos, pictures, cards, flowers, and religious items provide comfort. The person and family arrange the room as they wish.

The Family

- This is a hard time for family. The family goes through stages like the dying person. Be available, courteous, and considerate.
- The person and family need time together. However, you cannot neglect care because the family is present. Most agencies let family members help give care.

Legal Issues

- *Advance directives.* Advance directives give persons rights to accept or refuse treatment. The advance directive is a document stating a person's wishes about health care when that person cannot make his or her own decisions.
- *Living wills.* A living will is a document about measures that support or maintain life when death is likely. A living will may instruct doctors not to start measures that promote dying or to remove measures that prolong dying.
- *Durable power of attorney for health care.* This gives the power to make health care decisions to another person. When a person cannot make health care decisions, the person with durable power of attorney can do so.
- *"Do Not Resuscitate" (DNR) order.* This means the person will not be resuscitated. The person is allowed to die with peace and dignity. The orders are written after consulting with the person and family.
- You may not agree with care and resuscitation decisions. However, you must follow the person's or family's wishes and the doctor's orders. These may be against your personal, religious, and cultural values. If so, discuss the matter with the nurse. An assignment change may be needed.

Signs of Death

- There are signs that death is near.
  - Movement, muscle tone, and sensation are lost.
  - Abdominal distention, fecal incontinence, nausea, and vomiting are common.
  - Body temperature rises. The person feels cool, looks pale, and perspires heavily.
  - The pulse is fast or slow, weak, and irregular. Blood pressure starts to fall.
  - Slow or rapid and shallow respirations are observed. Mucus collects in the airway. This causes the death rattle that is heard.
  - Pain decreases as the person loses consciousness. Some people are conscious until the moment of death.
- The signs of death include no pulse, no respirations, and no blood pressure. The pupils are dilated and fixed.

Care of the Body After Death

- Post-mortem care is done to maintain a good appearance of the body.
- Moving the body when giving post-mortem care can cause remaining air in the lungs, stomach, and intestines to be expelled. When air is expelled, sounds are produced.
- When giving post-mortem care, follow Standard Precautions and the Bloodborne Pathogen Standard.

CHAPTER 55 REVIEW QUESTIONS

Circle the BEST answer.

1. Which statement is *false?*
   a. Adults fear dying alone.
   b. Older persons usually have fewer fears about dying than younger adults.
   c. Adults often resent death.
   d. All adults welcome death.
2. Persons in the denial stage of dying
   a. Are angry
   b. Bargain with God
   c. Refuse to believe that they are dying
   d. Are calm and at peace
3. When caring for a person who is dying, you should do the following *except*
   a. Listen to the person
   b. Talk about your feelings about death
   c. Provide privacy during spiritual moments
   d. Use touch to show care and concern

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4. When caring for a dying person, you provide all of the following *except*
   a. Eye care
   b. Oral hygiene
   c. Good skin care
   d. Physical exercise
5. When giving post-mortem care, you should wear gloves.
   a. True
   b. False
6. A document that states a person's wishes about health care when that person cannot make his or her own decisions is a
   a. Living will
   b. Advance directive
   c. Durable power of attorney for health care
   d. "Do Not Resuscitate" order

Answers to these questions are on p. 517.

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Practice Examination 1

This test contains 75 questions. For each question, circle the BEST answer.

1. A nurse asks you to give a person his drug when he is done in the bathroom. Your response to the nurse is
   A. "I will give the drug for you."
   B. "I will ask the other nursing assistant to give the drug."
   C. "I am sorry but I cannot give that drug. I will let you know when he is out of the bathroom."
   D. "I refuse to give that drug."
2. An ethical person
   A. Does not judge others
   B. Avoids persons whose standards and values are different from his or hers
   C. Is prejudiced and biased
   D. Causes harm to another person
3. You smell alcohol on the breath of a co-worker. You
   A. Ignore the situation
   B. Tell the co-worker to get counseling
   C. Take a break and drink some alcohol too
   D. Tell the nurse at once
4. A person's call light goes unanswered. He gets out of bed and falls. His leg is broken. This is
   A. Neglect
   B. Emotional abuse
   C. Physical abuse
   D. Malpractice
5. Your mom asks you about a person on your unit. How should you respond?
   A. "She is walking better now that she is receiving physical therapy."
   B. "I'm sorry but I cannot talk about her. It is unprofessional and violates her privacy and confidentiality."
   C. "Don't tell anyone I told you but she is getting worse."
   D. "She has been very sad recently and needs visitors."
6. You are going off duty. The nursing assistant coming on duty is on the unit with you. A person puts her call light on. Your response is
   A. "I'm ready to go. I will let you answer that light."
   B. "I've been here all day so I am not answering that light."
   C. "No one helped me answer lights when I came on duty."
   D. "I will answer that light so you can get organized for the shift."
7. When recording in the medical record, you
   A. Write in pencil
   B. Spell words incorrectly
   C. Use only center-approved abbreviations
   D. Record what your co-worker did
8. You are answering the phone in the nurses' station. You
   A. Answer in a rushed manner
   B. Give a courteous greeting
   C. End the conversation and hang up without saying good-bye
   D. Give confidential information about a resident to the caller
9. A person who was admitted to the nursing center yesterday does not feel safe. You
   A. Are rude as you care for the person
   B. Ignore the person's requests for information
   C. Show the person around the nursing center
   D. Act rushed as you care for the person
10. A person is angry and is shouting at you. You should
    A. Yell back at the person
    B. Stay calm and professional
    C. Put the person in a room away from others
    D. Call the family
11. When speaking with another person, you
    A. Use medical terms that may not be familiar to the person
    B. Mumble your words as you talk
    C. Ask several questions at a time
    D. Speak clearly and distinctly
12. To use a transfer or gait belt safely, you should
    A. Ignore the manufacturer's instructions
    B. Leave the excess strap dangling
    C. Apply the belt over bare skin
    D. Apply the belt under the breasts
13. When you are listening to a person, you
    A. Look around the room
    B. Sit with your arms crossed
    C. Act rushed and not interested in what the person is saying
    D. Have good eye contact with the person
14. When caring for a person who is comatose, you
    A. Make jokes about how sick the person is
    B. Care for the person without talking to him or her
    C. Explain what you are doing to him or her
    D. Discuss your problems with the other nursing assistant in the room with you
15. You need to give care to a person when a visitor is present. You
    A. Politely ask the visitor to leave the room
    B. Do the care in the presence of the visitor
    C. Expose the person's body in front of the visitor
    D. Rudely tell the visitor where to wait while you care for the person
16. A person tells you he wants to talk with a minister. You
    A. Ignore the request
    B. Tell the nurse
    C. Ask what the person wants to discuss with the minister
    D. Tell the person there is no need to talk with a minister
17. When you care for a person who has a restraint, you
    A. Observe the person every 15 minutes
    B. Remove the restraint and re-position the person every 4 hours
    C. Apply the restraint tightly
    D. Apply the restraint incorrectly

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18. As a person ages
    A. The skin becomes less dry
    B. Muscle strength increases
    C. Reflexes are faster
    D. Bladder muscles weaken
19. A person you are caring for touches your buttocks several times. You
    A. Tell the person you like being touched
    B. Ask the person not to touch you again
    C. Tell the person's daughter
    D. Tell the person's girlfriend
20. You are transporting a person in a wheelchair. You
    A. Pull the chair backward
    B. Let the person's feet touch the floor
    C. Push the chair forward
    D. Rest the footplates on the person's leg
21. You cannot read the person's name on the identification (ID) bracelet. You
    A. Tell the nurse so a new bracelet can be made
    B. Ignore the fact that you cannot read the name
    C. Ask another nursing assistant to identify the person
    D. Tell the family the person needs a new ID bracelet
22. The universal sign of choking is
    A. Holding your breath
    B. Clutching at the throat
    C. Waving your hands
    D. Coughing
23. A person is on a diabetic diet. You
    A. Serve the person's meals late
    B. Let the person eat whenever he or she is hungry
    C. Sometimes check the tray to see what was eaten
    D. Tell the nurse about changes in the person's eating habits
24. With mild airway obstruction
    A. The person is usually unconscious
    B. The person cannot speak
    C. Forceful coughing often does not remove the object
    D. Forceful coughing often can remove the object
25. To relieve severe airway obstruction in a conscious adult, you do
    A. Abdominal thrusts
    B. Back thrusts
    C. Chest compressions
    D. A finger sweep
26. Faulty electrical equipment
    A. Can be used in a nursing center
    B. Should be given to the nurse
    C. Should be taken home by you for repair
    D. Should be used only with alert persons
27. A warning label has been removed from a hazardous substance container. You
    A. May use the substance if you know what is in the container
    B. Leave the container where it is
    C. Take the container to the nurse and explain the problem
    D. Tell another nursing assistant about the missing label
28. A person's beliefs and values are different from your views. What should you do?
    A. Refuse to care for the person.
    B. Delegate care to another nursing assistant.
    C. Tell the nurse about your concerns.
    D. Tell the person how you feel.
29. You find a person smoking in the nursing center. You should
    A. Ignore the situation
    B. Tell the person to leave
    C. Tell another nursing assistant
    D. Ask the person to put out the cigarette and show him or her where smoking is permitted
30. During a fire, the first thing you do is
    A. Rescue persons in immediate danger
    B. Sound the nearest fire alarm
    C. Close doors and windows to confine the fire
    D. Extinguish the fire
31. A person with Alzheimer's disease has increased restlessness and confusion as daylight ends. You should
    A. Try to reason with the person
    B. Ask the person to tell you what is bothering him or her
    C. Provide a calm, quiet setting late in the day
    D. Complete the person's treatments and activities late in the day
32. To prevent suffocation, you should
    A. Make sure dentures fit loosely
    B. Cut food into large pieces
    C. Make sure the person can chew and swallow the food served
    D. Ignore loose teeth or dentures
33. When using a wheelchair, you should
    A. Lock both wheels before you transfer a person to and from the wheelchair
    B. Lock only 1 wheel before you transfer a person to and from the wheelchair
    C. Let the person's feet touch the floor when the chair is moving
    D. Let the person stand on the footplates
34. A person begins to fall while you are walking him or her. You should
    A. Try to prevent the fall
    B. Ease the person to the floor
    C. Let the person fall to avoid injury to yourself
    D. Tell the nurse at the end of the shift
35. A person has a restraint on. You know that
    A. Restraints are used for staff convenience
    B. Death from strangulation is a risk factor from using a restraint
    C. Restraints may be used to punish a person
    D. A written nurse's order is required for a restraint
36. Before feeding a person, you
    A. Tell the other nursing assistant
    B. Go to the restroom
    C. Wash your hands
    D. Tell the nurse

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37. When wearing gloves, you remember to
    A. Wear them several times before discarding them
    B. Wear the same ones from room to room
    C. Wear gloves with a tear or puncture
    D. Change gloves when they become contaminated with urine
38. When washing your hands, you
    A. Use hot water
    B. Let your uniform touch the sink
    C. Keep your watch at your wrist
    D. Keep your hands and forearms lower than your elbows
39. You need to move a box from the floor to the counter in the utility room. You
    A. Bend from your waist to pick up the box
    B. Hold the box away from your body as you pick it up
    C. Bend your knees and squat to lift the box
    D. Stand with your feet close together as you pick up the box
40. The nurse asks you to place a person in Fowler's position. You
    A. Put the bed flat
    B. Raise the head of the bed between 45 and 60 degrees
    C. Raise the head of the bed between 80 and 90 degrees
    D. Raise the head of the bed 15 degrees
41. You accidentally scratch a person. This is
    A. Neglect
    B. Negligence
    C. Malpractice
    D. Physical abuse
42. You positioned a person in a chair. For good body alignment, you
    A. Have the person's back and buttocks against the back of the chair
    B. Leave the person's feet unsupported
    C. Have the backs of the person's knees touch the edge of the chair
    D. Have the person sit on the edge of the chair
43. You need to transfer a person with a weak left leg from the bed to the wheelchair. You
    A. Get the person out of bed on the left side
    B. Get the person out of bed on the right side
    C. Keep the person in bed
    D. Ask the person what side moves first
44. A person tries to scratch and kick you. You should
    A. Protect yourself from harm
    B. Argue with the person
    C. Become angry with the person
    D. Ignore the person
45. When moving a person up in bed
    A. Window coverings may be left open so people can look in
    B. Body parts may be exposed
    C. Ask the person to help
    D. Ask the person to lie still
46. For comfort, most older persons prefer
    A. Rooms that are cold
    B. Restrooms that smell of urine
    C. Loud talking and laughter at the nurses' station
    D. Lighting that meets their needs
47. Call lights are
    A. Placed on the person's strong side
    B. Answered when time permits
    C. Kept on the bedside table
    D. Kept on the person's weak side
48. A nurse asks you to inspect a person's closet. You
    A. Tell the nurse you cannot do this
    B. Inspect the closet when the person is in the dining room
    C. Ask the person if you can inspect his or her closet
    D. Tell the nurse to inspect the closet
49. When changing bed linens, you
    A. Hold the linens close to your uniform
    B. Shake the sheet when putting it on the bed
    C. Take only needed linens into the person's room
    D. Put used linens on the floor
50. To use a fire extinguisher, you
    A. Keep the safety pin in the extinguisher
    B. Direct the hose or nozzle at the top of the fire
    C. Squeeze the lever to start the stream
    D. Sweep the stream at the top of the fire
51. When doing mouth care for an unconscious person, you
    A. Do not need to wear gloves
    B. Give mouth care at least every 2 hours
    C. Place the person in a supine position
    D. Keep the mouth open with your fingers
52. A person is angry because he did not get to the activity room on time because a co-worker did not come to work. How should you respond to him?
    A. "It's not my fault. A co-worker called off today and we are short-staffed."
    B. "I'm sorry you were late for activities. I will try to plan better."
    C. "I am doing the best I can."
    D. "I'm just too busy."
53. You are asked to clean a person's dentures. You
    A. Use hot water
    B. Hold the dentures firmly and line the basin with a towel
    C. Wrap the dentures in tissues after cleaning
    D. Store the dentures in a denture cup with the person's room number on it
54. When bathing a person, you notice a rash that was not there before. You
    A. Do nothing
    B. Tell the person
    C. Tell the nurse and record it in the medical record
    D. Tell the person's daughter
55. When washing a person's eyes, you
    A. Use soap
    B. Clean the eye near you first
    C. Wipe from the inner to the outer aspect of the eye
    D. Wipe from the outer aspect to the inner aspect of the eye
56. When giving a back massage, you
    A. Use cold lotion
    B. Use light strokes
    C. Massage reddened bony areas
    D. Look for bruises and breaks in the skin

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57. You need to give perineal care to a female. You
    A. Separate the labia and clean downward from front to back
    B. Separate the labia and clean upward from back to front
    C. Wear gloves only if there is drainage
    D. Only use water
58. When giving a person a tub bath or shower, you
    A. Do not give the person a call light
    B. Turn the hot water on first, then the cold water
    C. Stay within hearing distance if the person can be left alone
    D. Direct water toward the person while adjusting the water temperature
59. A person is on an anticoagulant. You
    A. Use a safety razor
    B. Use an electric razor
    C. Let him grow a beard
    D. Let him choose which type of razor to use
60. A person with a weak left arm wants to remove his or her sweater. You
    A. Let the person do it without any assistance
    B. Help the person remove the sweater from his or her right arm first
    C. Help the person remove the sweater from his or her left arm first
    D. Tell the person to keep the sweater on
61. When talking with a person, you should call the person
    A. "Honey"
    B. By his or her first name
    C. By his or her title—Mr. or Mrs. or Miss
    D. "Grandpa" or "Grandma"
62. A person has an indwelling catheter. You
    A. Let the person lie on the tubing
    B. Disconnect the catheter from the drainage tubing every 8 hours
    C. Secure the catheter to the lower leg
    D. Measure and record the amount of urine in the drainage bag
63. A person needs to eat a diet that contains carbohydrates. Carbohydrates
    A. Are needed for tissue repair and growth
    B. Provide energy and fiber for bowel elimination
    C. Add flavor to food and help the body use certain vitamins
    D. Are needed for nerve and muscle function
64. You are taking a rectal temperature with an electronic thermometer. You
    A. Insert the thermometer before lubricating it
    B. Leave the privacy curtain open
    C. Insert the thermometer 1 inch into the rectum
    D. Insert the thermometer ½ inch into the rectum
65. A person has a blood pressure (BP) of 86/58 mm Hg. You
    A. Report the BP to the nurse at once
    B. Record the BP but do not tell the nurse
    C. Ask the unit secretary to tell the nurse
    D. Retake the BP in 30 minutes before telling the nurse
66. On which person would you take an oral temperature?
    A. An unconscious person
    B. The person receiving oxygen
    C. The person who breathes through his or her mouth
    D. A conscious person
67. When caring for a person who is blind or visually impaired, you
    A. Offer the person your arm and have the person walk a half step behind you
    B. Do as much for the person as possible
    C. Shout at the person when talking with him or her
    D. Touch the person before indicating your presence
68. You are caring for a person with dementia. You
    A. Misplace the person's clothes
    B. Choose the activities the person attends
    C. Send personal items home
    D. Let the family make choices if the person cannot
69. When providing rehabilitation and restorative care for a person, you
    A. Can shout or scream at the person
    B. Can hit or strike the person
    C. Can call the person names
    D. Discuss your anger with the nurse
70. While bathing a person, you
    A. Keep doors and windows open
    B. Wash from the dirtiest areas to the cleanest areas
    C. Encourage the person to help as much as possible
    D. Rub the skin dry
71. When a person is dying
    A. Assume that the person can hear you
    B. Oral care is done every 5 hours
    C. Skin care is done weekly
    D. Re-position the person every 3 hours
72. A person is on intake and output. You
    A. Measure only liquids such as water and juice
    B. Measure ice cream and gelatin as part of intake
    C. Measure intravenous (IV) fluids
    D. Measure tube feedings
73. A person has been on bedrest. You need to have the person walk. What will you do first?
    A. Help the person move quickly.
    B. Have the person dangle before getting out of bed.
    C. Have the person sit in a chair.
    D. Walk with the person as soon as he or she gets out of bed.
74. Your ring accidentally causes a skin tear on an elderly person. You
    A. Tell yourself to be more careful the next time
    B. Tell the nurse at once
    C. Do nothing
    D. Hope no one finds out
75. To protect a person's privacy, you should
    A. Keep all information about the person confidential
    B. Discuss the person's treatment with another nursing assistant in the lunch room
    C. Open the person's mail
    D. Keep the privacy curtain open when providing care to the person

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Practice Examination 2

This test contains 75 questions. For each question, circle the BEST answer.

1. You can refuse to do a delegated task when
   A. You are too busy
   B. You do not like the task
   C. The task is not in your job description
   D. It is the end of the shift
2. Mr. Smith does not want life-saving measures. You
   A. Explain to Mr. Smith why he should have life-saving measures
   B. Respect his decision
   C. Explain to Mr. Smith's family why life-saving measures are needed
   D. Tell your friend about Mr. Smith's decision
3. You are walking by a resident's room. You hear a nurse shouting at a person. This is
   A. Battery
   B. Malpractice
   C. Verbal abuse
   D. Neglect
4. When communicating with a foreign-speaking person, you
   A. Speak loudly or shout
   B. Use medical terms the person may not understand
   C. Use words the person seems to understand
   D. Speak quickly and mumble
5. To protect a person from getting burned, you
   A. Allow smoking in bed
   B. Turn hot water on first, then cold water
   C. Assist the person with drinking or eating hot food
   D. Let the person sleep with a heating pad
6. To prevent equipment accidents, you should
   A. Use 2-pronged plugs on all electrical devices
   B. Follow the manufacturer's instructions
   C. Wipe up spills when you have time
   D. Use unfamiliar equipment without training
7. To prevent a person from falling, you should
   A. Ignore call lights
   B. Use throw rugs on the floor
   C. Keep the bed in a high position
   D. Use grab bars in showers
8. You need to wash your hands
   A. Before you document a procedure
   B. After you remove gloves
   C. After you talk with a person
   D. After you talk with a co-worker
9. You need to move a person weighing 250 pounds in bed. You
   A. Do the procedure alone
   B. Keep the privacy curtain open
   C. Ask the person to lie still
   D. Ask for assistance from at least 2 other staff members
10. When transferring a person from a bed to a wheelchair, you never
    A. Ask a co-worker to help you
    B. Use a transfer or gait belt
    C. Have the person put his or her arms around your neck
    D. Lock the wheels on the wheelchair
11. When making a bed, you
    A. Keep the bed in the low position
    B. Wear gloves when removing linens
    C. Raise the head of the bed
    D. Raise the foot of the bed
12. To give perineal care to a male, you
    A. Use a circular motion and work toward the meatus
    B. Use a circular motion and start at the meatus and work outward
    C. Wear gloves only if there is drainage
    D. Use only water
13. A person with a weak left arm wants to put on his or her sweater. You
    A. Let the person do it without any assistance
    B. Help the person put the sweater on his or her right arm first
    C. Help the person put the sweater on his or her left arm first
    D. Tell the person to keep the sweater off
14. A person has an indwelling catheter. You
    A. Let the drainage bag touch the floor
    B. Keep the drainage bag higher than the bladder
    C. Hang the drainage bag on a bed rail
    D. Have the drainage bag hang from the bed frame or chair
15. A person needs to eat a diet that contains protein. Protein
    A. Is needed for tissue repair and growth
    B. Provides energy and fiber for bowel elimination
    C. Adds flavor to food and helps the body use certain vitamins
    D. Is needed for nerve and muscle function
16. Older persons
    A. Have an increased sense of thirst
    B. Need less water than younger persons
    C. May not feel thirsty
    D. Seldom need to have water offered to them
17. A person is NPO. You
    A. Post a sign in the bathroom
    B. Keep the water pitcher filled at the bedside
    C. Remove the water pitcher and glass from the room
    D. Provide oral hygiene every day
18. A person drank 3 oz of milk at lunch. He or she drank
    A. 30 mL
    B. 60 mL
    C. 90 mL
    D. 120 mL
19. When feeding a person, you
    A. Offer fluids at the end of the meal
    B. Use forks
    C. Do not talk to the person
    D. Allow time for chewing and swallowing
20. You need to do range of motion (ROM) to a person's right shoulder. You
    A. Force the joint beyond its present ROM
    B. Move the joint quickly
    C. Force the joint to the point of pain
    D. Support the part being exercised

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21. A person has a weak left leg. The person should
    A. Hold the cane in his or her left hand
    B. Hold the cane in his or her right hand
    C. Hold the cane in either hand
    D. Use a walker
22. To promote comfort and relieve pain, you
    A. Keep wrinkles in the bed linens
    B. Position the person in good alignment
    C. Talk loudly to the person
    D. Use sudden and jarring movements of the bed or chair
23. A person is receiving oxygen through a nasal cannula. You
    A. Turn the oxygen higher when he or she is short of breath
    B. Fill the humidifier when it is not bubbling
    C. Check behind the ears and under the nose for signs of irritation
    D. Remove the cannula when the person goes to the dining room
24. You accidentally dropped a mercury glass thermometer and broke it. You
    A. Tell the nurse at once
    B. Put the mercury in your pocket
    C. Pick up the pieces of glass with your hands
    D. Touch the mercury
25. When taking a person's pulse, you
    A. Use the brachial pulse
    B. Take the pulse for 30 seconds if it is irregular
    C. Tell the nurse if the pulse is less than 60
    D. Use your thumb to take a pulse
26. You are counting respirations on a person. You
    A. Tell the person you are counting his or her respirations
    B. Count for 1 minute if an abnormal breathing pattern is noted
    C. Report a rate of 16 to the nurse at once
    D. Count for 30 seconds if an abnormal breathing pattern is noted
27. You are taking blood pressures on people assigned to you. An older person has a blood pressure (BP) of 158/96 mm Hg. You
    A. Report the BP to the nurse at once
    B. Finish taking all the blood pressures before telling the nurse
    C. Retake the BP in 30 minutes before telling the nurse
    D. Ask the unit secretary to tell the nurse about the BP
28. When would you take a rectal temperature?
    A. The person has diarrhea.
    B. The person is confused.
    C. The person is unconscious.
    D. The person is agitated.
29. A person has been admitted to the nursing center recently. You
    A. Look through his or her belongings
    B. Ignore his or her questions
    C. Speak in a gentle, calm voice
    D. Enter the person's room without knocking
30. When taking a person's height and weight, you
    A. Let the person wear shoes
    B. Have the person void before being weighed
    C. Weigh the person at different times of the day
    D. Balance the scale every 6 months
31. A person is bedfast. To prevent pressure ulcers, you
    A. Re-position the person at least every 3 hours
    B. Massage reddened areas
    C. Let heels and ankles touch the bed
    D. Keep the skin free of moisture from urine, stools, or perspiration
32. A person has a hearing problem. When talking with the person, you
    A. Keep the TV or radio on
    B. Shout
    C. Face the person
    D. Speak quickly
33. When caring for a person who is blind or visually impaired, you
    A. Place furniture and equipment where the person walks
    B. Keep the lights off
    C. Explain the location of food and beverages
    D. Re-arrange furniture and equipment
34. You are caring for a person with dementia. You
    A. Share information about the person's care
    B. Share information about the person's condition
    C. Protect confidential information
    D. Expose the person's body when you provide care
35. When caring for a confused person, you
    A. Call the person "Honey"
    B. Do not need to explain what you are doing
    C. Ask clear, simple questions
    D. Remove the calendar from the person's room
36. A person with Alzheimer's disease likes to wander. You
    A. Keep the person in his or her room
    B. Restrain the person
    C. Argue with the person who wants to leave
    D. Exercise the person as ordered
37. Restorative nursing programs
    A. Help maintain the lowest level of function
    B. Promote self-care measures
    C. Focus on the disability, not the person
    D. Help the person lose strength and independence
38. When caring for a person with a disability, you
    A. Focus on his or her limitations
    B. Expect progress in a rehabilitation program to be fast
    C. Remind the person of his or her progress in the rehabilitation program
    D. Deny the disability
39. After a person dies, you
    A. Can expose his or her body unnecessarily
    B. Can discuss the person's diagnosis with your family
    C. Can talk about the family's reactions to your friends
    D. Respect the person's right to privacy

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40. You enter a person's room and find a fire in the wastebasket. Your first action is to
    A. Remove the person from the room
    B. Close the door
    C. Call for help
    D. Activate the fire alarm
41. You leave a person lying in urine and he or she develops a bedsore. This is
    A. Fraud
    B. Neglect
    C. Assault
    D. Battery
42. A nurse asks you to place a drug and a sterile dressing on a small foot wound. You
    A. Agree to do the task
    B. Ask another nursing assistant to do the task
    C. Politely tell the nurse you cannot do that task
    D. Report the nurse to the director of nursing
43. You observe a person's urine is foul-smelling and dark amber. Your first action is to
    A. Tell the other nursing assistant
    B. Tell the person
    C. Tell the nurse
    D. Record the observation
44. A daughter asks you for water for her mom. Your response is
    A. "I am not caring for your mom. I will get her nursing assistant for you."
    B. "I do not have time to do that."
    C. "That's not my job."
    D. "I will be happy to do that."
45. A person has a restraint on. You
    A. Observe the person for breathing and circulation complications every 30 minutes
    B. Know that unnecessary restraint is false imprisonment
    C. Use the most restrictive type of restraint
    D. Know that restraints decrease confusion and agitation
46. The nurse asks you to place a person in the supine position. You
    A. Elevate the head of the bed 45 degrees
    B. Elevate the foot of the bed 15 degrees
    C. Place the person on his or her back with the bed flat
    D. Place the person on his or her abdomen
47. The most important way to prevent or avoid spreading infection is to
    A. Wash hands
    B. Cover your nose when coughing
    C. Use disposable gloves
    D. Wear a mask
48. You are eating lunch and a nursing assistant begins to gossip about another person. You
    A. Join the conversation and talk about the person
    B. Remove yourself from the group
    C. Tell your roommate about the gossip you heard at lunch
    D. Tell another nursing assistant about the gossip you heard
49. When moving a person up in bed, you should
    A. Raise the head of the bed
    B. Ask the person to keep his or her legs straight
    C. Cause friction and shearing
    D. Ask a co-worker to help you
50. A person is on a sodium-controlled diet. This means
    A. Canned vegetables are omitted from his or her diet
    B. Salt may be added to food at the table
    C. Large amounts of salt are used in cooking
    D. Ham is eaten regularly
51. Elastic stockings
    A. Are applied after a person gets out of bed
    B. Should not have wrinkles or creases after being applied
    C. Come in 1 size only
    D. Are forced on the person
52. While walking, the person begins to fall. You
    A. Call for help
    B. Reach for a chair
    C. Ease the person to the floor
    D. Ask a visitor to help
53. Before bathing a person, you should
    A. Offer the bedpan or urinal
    B. Partially undress the person
    C. Raise the head of the bed
    D. Open the privacy curtain
54. When taking a rectal temperature with an electronic thermometer, you insert the thermometer
    A. ½ inch
    B. 1½ inches
    C. 2 inches
    D. 2½ inches
55. Touch
    A. Is a form of nonverbal communication
    B. Is a form of verbal communication
    C. Means the same thing to everyone
    D. Should be used for all persons
56. You may share information about a person's care and condition with
    A. The staff caring for the person
    B. The person's daughter
    C. Your family members
    D. The volunteer in the gift shop
57. A person tells you he or she has pain upon urination. You
    A. Tell the nurse
    B. Let the nurse document this information
    C. Ask the person to tell you if it happens again
    D. Tell the person's son
58. A person's culture and religion are different from yours. You
    A. Laugh about the person's customs
    B. Tell your family about the person's customs
    C. Ask the person to explain his or her beliefs and practices to you
    D. Tell the person his or her beliefs and customs are silly
59. You need to wear gloves when you
    A. Do range-of-motion exercises
    B. Feed a person
    C. Give perineal care
    D. Walk a person

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60. An older person is normally alert. Today he or she is confused. What should you do?
    A. Ask the person why he or she is confused.
    B. Ignore the confusion.
    C. Check to see if the person is confused later in the day.
    D. Tell the nurse.
61. While walking with a person, he tells you he feels faint. What do you do first?
    A. Have the person sit down.
    B. Call for the nurse.
    C. Open the window.
    D. Ask the person to take a deep breath.
62. You are asked to encourage fluids for a person. You
    A. Increase the person's fluid intake
    B. Decrease the person's fluid intake
    C. Limit fluids to meal times
    D. Keep fluids where the person cannot reach them
63. Communication fails when you
    A. Use words the other person understands
    B. Talk too much
    C. Let others express their feelings and concerns
    D. Talk about a topic that is uncomfortable
64. During bathing, a person may
    A. Decide what products to use
    B. Be exposed in the shower room
    C. Have visitors present without his or her permission
    D. Have no personal choices
65. People in late adulthood need to
    A. Adjust to increased income
    B. Adjust to their health being better
    C. Develop new friends and relationships
    D. Adjust to increased strength
66. When measuring blood pressure, you should do the following except
    A. Apply the cuff to a bare upper arm
    B. Turn off the TV
    C. Locate the brachial artery
    D. Use the arm with an intravenous (IV) infusion
67. You find clean linens on the floor in a person's room. You
    A. Use the linens to make the bed
    B. Return the linens to the linen cart
    C. Put the linens in the laundry
    D. Tell the nurse
68. When doing mouth care on an unconscious person, you
    A. Use a large amount of fluid
    B. Position the person on his or her side
    C. Do the task without telling the person what you are doing
    D. Insert his or her dentures when done
69. When brushing or combing a person's hair, you
    A. Cut matted or tangled hair
    B. Encourage the person to do as much as possible
    C. Style the hair as you want
    D. Perform the task weekly
70. When providing nail and foot care, you
    A. Cut fingernails with scissors
    B. Trim toenails for a diabetic person
    C. Trim toenails for a person with poor circulation
    D. Check between the toes for cracks and sores
71. An indwelling catheter becomes disconnected from the drainage system. You
    A. Reconnect the tubing to the catheter quickly without gloves
    B. Tell the nurse at once
    C. Get a new drainage system
    D. Touch the ends of the catheter
72. Urinary drainage bags are
    A. Hung on the bed rail
    B. Emptied and measured at the end of each shift
    C. Kept on the floor
    D. Kept higher than the person's bladder
73. A person needs a condom catheter applied. You remember to
    A. Apply it to a penis that is red and irritated
    B. Use adhesive tape to secure the catheter
    C. Use elastic tape to secure the catheter
    D. Act in an unprofessional manner
74. For comfort during bowel elimination
    A. Have the person use the bedpan rather than the bathroom or commode if possible
    B. Permit visitors to stay
    C. Keep the door and privacy curtain open
    D. Leave the person alone if possible
75. You are transferring a person with a weak right side from the wheelchair to the bed. You
    A. Place the wheelchair on the left side of the bed
    B. Place the wheelchair on the right side of the bed
    C. Keep the person in the wheelchair
    D. Ask the person what side moves first

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Skills Evaluation Review

Each state has its own policies and procedures for the skills test. The following information is an overview of what to expect.

- To pass the skills evaluation, you will need to perform 5 of all the skills available.
- To pass the skills evaluation, you must perform all 5 skills correctly.
- A nurse evaluates your performance of certain skills. Having someone watch as you work is not a new experience. Your instructor evaluated your performance during your training program. While you are working, your supervisor evaluates your skills.
- Mannequins and people are used as "patients" or "residents," depending on the skills you are performing. Speak to the person as you would a patient or resident.
- If you make a mistake, tell the evaluator what you did wrong. Then perform the skill correctly. Do not panic.
- Take whatever equipment you normally take to or use at work. Wear a watch with a second hand. You may need it to measure vital signs and check how much time you have left.

Before and During the Procedure

- Hand-washing is evaluated at the beginning of the skills test. You are expected to know when to wash your hands. Therefore you may not be told to do so. Follow the rules for hand hygiene during the test.
- Before entering a person's room, knock on the door. Greet the person by name and introduce yourself before beginning a procedure. Check the identification (ID) or the photo ID to make certain you are giving care to the right person.
- Explain what you are going to do before beginning the procedure and as needed throughout the procedure.
- Always follow the rules of medical asepsis. For example, remove gloves and dispose of them properly. Keep clean linens separated from used linens.
- Always protect the person's rights throughout the skills test.
- Communicate with the person as you give care. Focus on the person's needs and interests. Always treat the person with respect. Do not talk about yourself or your personal problems.
- Provide privacy. This involves pulling the privacy curtain around the bed, closing doors, and asking visitors to leave the room.
- Promote safety for the person. For example, lock the wheelchair when you transfer a person to and from it. Place the bed in the lowest horizontal position when the person must get out of bed or when you are done giving care.
- Make sure the call light is within the person's reach. Attaching it to the bed or bed rail does not mean the person can reach it.
- Use good body mechanics. Raise the bed and over-bed table to a good working height.
- Provide for comfort.
  - Make sure the person and linens are clean and dry. The person may have become incontinent during the procedure.
  - Change or straighten bed linens as needed.
  - Position the person for comfort and in good alignment.
  - Provide pillows as directed by the nurse and the care plan.
  - Raise the head of the bed as the person prefers and allowed by the nurse and the care plan.
  - Provide for warmth. The person may need an extra blanket, a lap blanket, a sweater, socks, and so on.
  - Adjust lighting to meet the person's needs.
  - Make sure eyeglasses, hearing aids, and other devices are in place as needed.
  - Ask the person if he or she is comfortable.
  - Ask the person if there is anything else you can do for him or her.
  - Make sure the person is covered for warmth and privacy.

Skills

Ask your instructor to tell you which of the following skills are tested in your state. Place a checkmark in the box in front of each tested skill so it will be easy for you to reference. The skills marked with an asterisk (*) are used with permission of National Council of State Boards of Nursing (NCSBN). These skills are offered as a study guide to you. The word "client" refers to the resident or person receiving care. You are responsible for following the most current standards, practices, and guidelines in your state.

The steps in boldface type are critical element steps. Critical element steps must be done correctly to pass the skill. If you miss a critical element step, you will not pass the skills evaluation. For example, you are to transfer a client from the bed to a wheelchair. You will fail if you do not lock the wheels on the wheelchair before transferring the person. An automatic failure is one that could potentially cause harm to a person. Your state may mark critical element steps in another way—underline or italics. If your state has one, review the candidate's handbook.

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❑ **Hand Hygiene (Hand-Washing) (Chapter 16)*

1. Addresses client by name and introduces self to client by name
2. Turns on water at sink
3. Wets hands and wrists thoroughly
4. Applies soap to hands
5. **Lathers all surfaces of wrists, hands, and fingers, producing friction for at least 20 (twenty) seconds keeping hands lower than the elbows and the fingertips down**
6. Cleans fingernails by rubbing fingertips against palms of the opposite hand
7. **Rinses all surfaces of wrists, hands, and fingers, keeping hands lower than the elbows and the fingertips down**
8. Uses clean, dry paper towel/towels to dry all surfaces of hands, wrists, and fingers then disposes of paper towel/towels into waste container
9. Uses clean, dry paper towel/towels to turn off faucet then disposes of paper towel/towels into waste container or uses knee/foot control to turn off faucet
10. Does not touch inside of sink at any time

❑ **Applies One Knee-High Elastic Stocking (Chapter 35)*

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Client is in supine position (lying down in bed) while stocking is applied
4. Turns stocking inside-out, at least to heel
5. Places foot of stocking over toes, foot, and heel
6. Pulls top of stocking over foot, heel, and leg
7. Moves foot and leg gently and naturally, avoiding force and over-extension of limb and joints
8. **Finishes procedure with no twists or wrinkles and heel of stocking (if present) is over heel and opening in toe area (if present) is either under or over toe area**
9. Signaling device is within reach and bed is in low position
10. After completing skill, washes hands

❑ **Assists to Ambulate Using a Transfer Belt (Chapter 19)*

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. **Before assisting to stand, client is wearing shoes**
3. Before assisting to stand, bed is at a safe level
4. Before assisting to stand, checks and/or locks bed wheels
5. **Before assisting to stand, client is assisted to sitting position with feet flat on the floor**
6. Before assisting to stand, applies transfer belt securely at the waist over clothing/gown
7. Before assisting to stand, provides instructions to enable client to assist in standing including prearranged signal to alert client to begin standing
8. Stands facing client positioning self to ensure safety of candidate and client during transfer. Counts to three (or says other prearranged signal) to alert client to begin standing
9. On signal, gradually assists client to stand by grasping transfer belt on both sides with an upward grasp (candidate's hands are in upward position), and maintaining stability of client's legs
10. Walks slightly behind and to one side of client for a distance of ten (10) feet, while holding onto the belt
11. After ambulation, assists client to bed and removes transfer belt
12. Signaling device is within reach and bed is in low position
13. After completing skill, washes hands

❑ **Assists With Use of Bedpan (Chapter 24)*

1. Explains procedure speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before placing bedpan, lowers head of bed
4. Puts on clean gloves before handling bedpan
5. **Places bedpan correctly under client's buttocks**
6. Removes and disposes of gloves (without contaminating self) into waste container and washes hands
7. After positioning client on bedpan and removing gloves, raises head of bed
8. Toilet tissue is within reach
9. Hand wipe is within reach and client is instructed to clean hands with hand wipe when finished
10. Signaling device within reach and client is asked to signal when finished
11. Puts on clean gloves before removing bedpan
12. Head of bed is lowered before bedpan is removed
13. Avoids overexposure of client
14. Empties and rinses bedpan and pours rinse into toilet
15. After rinsing bedpan, places bedpan in designated dirty supply area
16. After placing bedpan in designated dirty supply area, removes and disposes of gloves (without contaminating self) into waste container and washes hands
17. Signaling device is within reach and bed is in low position

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❑*Cleans Upper or Lower Denture (Chapter 22)

1. Puts on clean gloves before handling dentures
2. Bottom of sink is lined and/or sink is partially filled with water before denture is held over sink
3. Rinses denture in moderate temperature running water before brushing them
4. Applies toothpaste to toothbrush
5. Brushes surfaces of denture
6. Rinses surfaces of denture under moderate temperature running water
7. Before placing denture into cup, rinses denture cup and lid
8. Places denture in denture cup with moderate temperature water solution and places lid on cup
9. Rinses toothbrush and places in designated toothbrush basin/container
10. Maintains clean technique with placement of toothbrush and denture
11. Sink liner is removed and disposed of appropriately and/or sink is drained
12. After rinsing equipment and disposing of sink liner, removes and disposes of gloves (without contaminating self) into waste container and washes hands

❑*Counts and Records Radial Pulse (Chapter 29)**

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Places fingertips on thumb side of client's wrist to locate radial pulse
3. Counts beats for one full minute
4. Signaling device is within reach
5. Before recording, washes hands
6. **After obtaining pulse by palpating in radial artery position, records pulse rate within plus or minus 4 beats of evaluator's reading**

❑*Counts and Records Respirations (Chapter 29)†

1. Explains procedure (for testing purposes), speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Counts respirations for one full minute
3. Signaling device is within reach
4. Washes hands
5. **Records respiration rate within plus or minus 2 breaths of evaluator's reading**

❑*Dresses Client With Affected (Weak) Right Arm (Chapter 23)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Asks which shirt he/she would like to wear and dresses him/her in shirt of choice
4. While avoiding overexposure of client, removes gown from the unaffected side first, then removes gown from the affected side and disposes of gown into soiled linen container
5. **Assists to put the right (affected/weak) arm through the right sleeve of the shirt before placing garment on left (unaffected) arm**
6. While putting on shirt, moves body gently and naturally, avoiding force and over-extension of limbs and joints
7. Finishes with clothing in place
8. Signaling device is within reach and bed is in low position
9. After completing skill, washes hands

❑*Feeds Client Who Cannot Feed Self (Chapter 27)

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Before feeding, candidate looks at name card on tray and asks client to state name
3. **Before feeding client, client is in an upright sitting position (75–90 degrees)**
4. Places tray where the food can be easily seen by client
5. Candidate cleans client's hands with hand wipe before beginning feeding
6. Candidate sits facing client during feeding
7. Tells client what foods are on tray and asks what client would like to eat first
8. Using spoon, offers client one bite of each type of food on tray, telling client the content of each spoonful
9. Offers beverage at least once during meal
10. Candidate asks client if they are ready for next bite of food or sip of beverage
11. At end of meal, candidate cleans client's mouth and hands with wipes
12. Removes food tray and places tray in designated dirty supply area
13. Signaling device is within client's reach
14. After completing skill, washes hands

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**Count for 1 full minute.
†Count for 1 full minute. For testing purposes you may explain to the client that you will be counting the respirations.

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❑*Gives Modified Bed Bath (Face and One Arm, Hand, and Underarm) (Chapter 22)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Removes gown and places in soiled linen container while avoiding over exposure of the client
4. Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water
5. Puts on clean gloves before washing client
6. **Beginning with eyes, washes eyes with wet washcloth (no soap), using a different area of the washcloth for each stroke, washing inner aspect to outer aspect, then proceeds to wash face**
7. Dries face with towel
8. Exposes one arm and places towel underneath arm
9. Applies soap to wet washcloth
10. Washes arm, hand, and underarm, keeping rest of body covered
11. Rinses and dries arm, hand, and underarm
12. Moves body gently and naturally, avoiding force and over-extension of limbs and joints
13. Puts clean gown on client
14. Empties, rinses, and dries basin
15. After rinsing and drying basin, places basin in designated dirty supply area
16. Disposes of linen into soiled linen container
17. Avoids contact between candidate clothing and used linens
18. After placing basin in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands
19. Signaling device is within reach and bed is in low position

❑ Makes an Occupied Bed (Client Does Not Need Assistance to Turn) (Chapter 21)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Lowers head of bed before moving client
4. Client is covered while linens are changed
5. Loosens top linen from the end of the bed
6. Raises side rail on side to which client will move and client moves toward raised side rail
7. Loosens bottom used linen on working side and moves bottom used linen toward center of bed
8. Places and tucks in clean bottom linen or fitted bottom sheet on working side and tucks under client
9. Before going to other side, client moves back onto clean bottom linen
10. Raises side rail then goes to other side of bed
11. Removes used bottom linen
12. Pulls and tucks in clean bottom linen, finishing with bottom sheet free of wrinkles
13. Client is covered with clean top sheet and bath blanket/used top sheet has been removed
14. Changes pillowcase
15. Linen is centered and tucked at foot of bed
16. Avoids contact between candidate's clothing and used linens
17. Disposes of used linens into soiled linen container and avoids putting linens on floor
18. Signaling device is within reach and bed is in low position
19. Washes hands

❑*Measures and Records Blood Pressure (Chapter 29)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Before using stethoscope, wipes bell/diaphragm and earpieces of stethoscope with alcohol
3. Client's arm is positioned with palm up and upper arm is exposed
4. Feels for brachial artery on inner aspect of arm, at bend of elbow
5. Places blood pressure cuff snugly on client's upper arm with sensor/arrow over brachial artery site
6. Earpieces of stethoscope are in ears and bell/diaphragm is over brachial artery site
7. Candidate inflates cuff between 160 mm Hg to 180 mm Hg. (If beat heard immediately upon cuff deflation, completely deflate cuff.) Re-inflate cuff to no more than 200 mm Hg.
8. Deflates cuff slowly and notes the **first sound** (systolic reading), and **last sound** (diastolic reading) (If rounding needed, measurements are rounded **UP** to the nearest 2 mm of mercury)
9. Removes cuff
10. Signaling device is within reach
11. Before recording, washes hands
12. **After obtaining reading using BP cuff and stethoscope, records both systolic and diastolic pressures each within plus or minus 8 mm Hg of evaluator's reading**

❑*Measures and Records Urinary Output (Chapter 27)

1. Puts on clean gloves before handling bedpan
2. Pours the contents of the bedpan into measuring container without spilling or splashing urine outside of container
3. Measures the amount of urine at eye level with container on flat surface
4. After measuring urine, empties contents of measuring container into toilet

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5. Rinses measuring container and pours rinse water into toilet
6. Rinses bedpan and pours rinse into toilet
7. After rinsing equipment, and before recording output, removes and disposes of gloves (without contaminating self) into waste container and washes hands
8. **Records contents of container within plus or minus 25 mL/cc of evaluator's reading**

❑*Measures and Records Weight of Ambulatory Client (Chapter 32)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Client has shoes on before walking to scale
3. Before client steps on scale, candidate sets scale to zero
4. While client steps onto scale, candidate stands next to scale and assists client, if needed, onto center of the scale; then obtains client's weight
5. While client steps off scale, candidate stands next to scale and assists client, if needed, off scale before recording weight
6. Before recording, washes hands
7. **Records weight based on indicator on scale. Weight is within plus or minus 2 lbs of evaluator's reading (If weight recorded in kg, weight is within plus or minus 0.9 kg of evaluator's reading)**

❑*Positions on Side (Chapter 18)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before turning, lowers head of bed
4. Raises side rail on side to which body will be turned
5. Slowly rolls onto side as one unit toward raised side rail
6. Places or adjusts pillow under head for support
7. Candidate positions client so that client is not lying on arm
8. Supports top arm with supportive device
9. Places supportive device behind client's back
10. Places supportive device between legs with top knee flexed; knee and ankle supported
11. Signaling device is within reach and bed is in low position
12. After completing skill, washes hands

❑*Provides Catheter Care for Female (Chapter 25)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before washing checks water temperature for safety and comfort and asks client to verify comfort of water
4. Puts on clean gloves before washing
5. Places linen protector under perineal area before washing
6. Exposes area surrounding catheter while avoiding overexposure of client
7. Applies soap to wet washcloth
8. **While holding catheter at meatus without tugging, cleans at least four inches of catheter from meatus, moving in only one direction (i.e., away from meatus) using a clean area of the cloth for each stroke**
9. **While holding catheter at meatus without tugging, rinses at least four inches of catheter from meatus, moving only in one direction, away from meatus, using a clean area of the cloth for each stroke**
10. While holding catheter at meatus without tugging, dries at least four inches of catheter moving away from meatus
11. Empties, rinses, and dries basin
12. After rinsing and drying basin, places basin in designated dirty supply area
13. Disposes of used linen into soiled linen container and disposes of linen protector appropriately
14. Avoids contact between candidate clothing and used linen
15. After disposing of used linen and cleaning equipment, removes and disposes of gloves (without contaminating self) into waste container and washes hands
16. Signaling device is within reach and bed is in low position

❑ Provides Fingernail Care on One Hand (Chapter 23)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Before immersing fingernails, checks water temperature for safety and comfort and asks client to verify comfort of water
3. Basin is in a comfortable position for client
4. Puts on clean gloves before cleaning fingernails
5. Fingernails are immersed in basin of water
6. Cleans under each fingernail with orangewood stick
7. Wipes orangewood stick on towel after each nail
8. Dries fingernail area
9. Candidate feels each nail and files as needed
10. Disposes of orangewood stick and emery board into waste container (for testing purposes)
11. Empties, rinses, and dries basin
12. After rinsing basin, places basin in designated used supply area
13. Disposes of used linens into used linens container

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14. After cleaning nails and equipment and disposing of used linens, removes and disposes of gloves (without contaminating self) into waste container and washes hands
15. Signaling device is within reach

❑*Provides Foot Care on One Foot (Chapter 23)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before washing, checks water temperature for safety and comfort and asks client to verify comfort of water
4. Basin is in a comfortable position for client and on protective barrier
5. Puts on clean gloves before washing foot
6. Client's bare foot is placed into the water
7. Applies soap to wet washcloth
8. Lifts foot from water and washes foot (including between the toes)
9. Foot is rinsed (including between the toes)
10. Dries foot (including between the toes)
11. Applies lotion to top and bottom of foot, removing excess (if any) with a towel
12. Supports foot and ankle during procedure
13. Empties, rinses, and dries basin
14. After rinsing and drying basin, places basin in designated dirty supply area
15. Disposes of used linen into soiled linen container
16. After cleaning foot and equipment, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands
17. Signaling device is within reach

❑*Provides Mouth Care (Chapter 22)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before providing mouth care, client is in upright sitting position (75–90 degrees)
4. Puts on clean gloves before cleaning mouth
5. Places clothing protector across chest before providing mouth care
6. Secures cup of water and moistens toothbrush
7. Before cleaning mouth applies toothpaste to moistened toothbrush
8. **Cleans mouth (including tongue and surfaces of teeth) using gentle motions**
9. Maintains clean technique with placement of toothbrush
10. Candidate holds emesis basin to chin while client rinses mouth
11. Candidate wipes mouth and removes clothing protector
12. After rinsing toothbrush, empty, rinse, and dry the basin and place used toothbrush in designated basin/container
13. Places basin and toothbrush in designated dirty supply area
14. Disposes of used linen into soiled linen container
15. After placing basin and toothbrush in designated dirty supply area, and disposing of used linen, removes and disposes of gloves (without contaminating self) into waste container and washes hands
16. Signaling device is within reach and bed is in low position

❑*Provides Perineal Care (Peri-Care) for Female (Chapter 22)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before washing checks water temperature for safety and comfort and asks client to verify comfort of water
4. Puts on clean gloves before washing perineal area
5. Places pad/linen protector under perineal area before washing
6. Exposes perineal area while avoiding overexposure of client
7. Applies soap to wet washcloth
8. **Washes genital area, moving from front to back, while using a clean area of the washcloth for each stroke**
9. **Using clean washcloth, rinses soap from genital area, moving from front to back, while using a clean area of the washcloth for each stroke**
10. Dries genital area moving from front to back with towel
11. **After washing genital area, turns to side, then washes and rinses rectal area moving from front to back using a clean area of washcloth for each stroke. Dries with towel**
12. Repositions client
13. Empties, rinses, and dries basin
14. After rinsing and drying basin, places basin in designated dirty supply area
15. Disposes of used linen into soiled linen container and disposes of linen protector appropriately
16. Avoids contact between candidate clothing and used linen
17. After disposing of used linen, and placing used equipment in designated dirty supply area, removes and disposes of gloves (without contaminating self) into waste container and washes hands
18. Signaling device is within reach and bed is in low position

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❑*Transfers From Bed to Wheelchair Using Transfer Belt (Chapter 19)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Before assisting to stand, wheelchair is positioned along side of bed, at head of bed, facing the foot, or foot of bed facing head
4. Before assisting to stand, footrests are folded up or removed
5. Before assisting to stand, bed is at a safe level
6. **Before assisting to stand, locks wheels on wheelchair**
7. Before assisting to stand, checks and/or locks bed wheels
8. **Before assisting to stand, client is assisted to a sitting position with feet flat on the floor**
9. Before assisting to stand, client is wearing shoes
10. Before assisting to stand, applies transfer belt securely at the waist over clothing/gown
11. Before assisting to stand, provides instructions to enable client to assist in transfer including prearranged signal to alert when to begin standing
12. Stands facing client, positioning self to ensure safety of candidate and client during transfer. Counts to three (or says other prearranged signal) to alert client to begin standing
13. On signal, gradually assists client to stand by grasping transfer belt on both sides with an upward grasp (candidates hands are in upward position) and maintaining stability of client's legs
14. Assists client to turn to stand in front of wheelchair with back of client's legs against wheelchair
15. Lowers client into wheelchair
16. Positions client with hips touching back of wheelchair and transfer belt is removed
17. Positions feet on footrests
18. Signaling device is within reach
19. After completing skill, washes hands

❑*Performs Modified Passive Range-of-Motion (PROM) for One Knee and One Ankle (Chapter 30)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Instructs client to inform candidate if pain is experienced during exercise
4. Supports leg at knee and ankle while performing range of motion for knee
5. Bends the knee then returns leg to client's normal position (extension/flexion) (AT LEAST 3 TIMES unless pain is verbalized)
6. Supports foot and ankle close to the bed while performing range of motion for ankle
7. Pushes/pulls foot toward head (dorsiflexion), and pushes/pulls foot down, toes point down (plantar flexion) (AT LEAST 3 TIMES unless pain is verbalized)
8. **While supporting the limb, moves joints gently, slowly, and smoothly through the range of motion, discontinuing exercise if client verbalizes pain**
9. Signaling device is within reach and bed is in low position
10. After completing skill, washes hands

❑*Performs Modified Passive Range-of-Motion (PROM) for One Shoulder (Chapter 30)

1. Explains procedure, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Privacy is provided with a curtain, screen, or door
3. Instructs client to inform candidate if pain is experienced during exercise
4. Supports client's upper and lower arm while performing range of motion for shoulder
5. **Raises client's straightened arm from side position upward toward head to ear level and returns arm down to side of body (flexion/extension) (AT LEAST 3 TIMES unless pain is verbalized). Supporting the limb, moves joint gently, slowly, and smoothly through the range of motion, discontinuing exercise if client verbalizes pain**
6. **Moves client's straightened arm away from the side of body to shoulder level and returns to side of body (abduction/adduction) (AT LEAST 3 TIMES unless pain is verbalized). Supporting the limb, moves joint gently, slowly, and smoothly through the range of motion, discontinuing exercise if client verbalizes pain**
7. Signaling device is within reach and bed is in low position
8. After completing skill, washes hands

❑ Performs Passive Range-of-Motion of Lower Extremity (Hip, Knee, Ankle) (Chapter 30)

1. Washes hands before contact with client
2. Identifies self to client by name and addresses client by name
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Provides for client's privacy during procedure with curtain, screen, or door
5. Positions client supine and in good body alignment
6. Supports client's leg by placing one hand under knee and other hand under heel
7. Moves entire leg away from body (performs AT LEAST 3 TIMES unless pain occurs)

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8. Moves entire leg toward body (performs AT LEAST 3 TIMES unless pain occurs)
9. Bends client's knee and hip toward client's trunk (performs AT LEAST 3 TIMES unless pain occurs)
10. Straightens knee and hip (performs AT LEAST 3 TIMES unless pain occurs)
11. Flexes and extends ankle through range-of-motion exercises (performs AT LEAST 3 TIMES unless pain occurs)
12. Rotates ankle through range-of-motion exercises (performs AT LEAST 3 TIMES unless pain occurs)
13. **While supporting limb, moves joints gently, slowly, and smoothly through range-of-motion to point of resistance, discontinuing exercise if pain occurs**
14. Provides for comfort
15. Before leaving client, places signaling device within client's reach
16. Washes hands

❑ *Performs Passive Range-of-Motion of Upper Extremity (Shoulder, Elbow, Wrist, Finger) (Chapter 30)*

1. Washes hands before contact with client
2. Identifies self to client by name and addresses client by name
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Provides for client's privacy during procedure with curtain, screen, or door
5. Supports client's extremity above and below joints while performing range-of-motion
6. Raises client's straightened arm toward ceiling and back toward head of bed and returns to flat position (flexion/extension) (performs AT LEAST 3 TIMES unless pain occurs)
7. Moves client's straightened arm away from client's side of body toward head of bed, and returns client's straightened arm to midline of client's body (abduction/adduction) (performs AT LEAST 3 TIMES unless pain occurs)
8. Moves client's shoulder through rotation range-of-motion exercises (performs AT LEAST 3 TIMES unless pain occurs)
9. Flexes and extends elbow through range-of-motion exercises (performs AT LEAST 3 TIMES unless pain occurs)
10. Provides range-of-motion exercises to wrist (performs AT LEAST 3 TIMES unless pain occurs)
11. Moves finger and thumb joints through range-of-motion exercises (performs AT LEAST 3 TIMES unless pain occurs)
12. **While supporting body part, moves joint gently, slowly, and smoothly through range-of-motion to point of resistance, discontinuing exercise if pain occurs**
13. Before leaving client, places signaling device within client's reach
14. Washes hands

❑ *Makes an Unoccupied (Closed) Bed (Chapter 21)*

1. Washes hands
2. Collects clean linens
3. Places clean linens on a clean surface
4. Raises the bed for good body mechanics
5. Puts on gloves
6. Removes linens without contaminating uniform. Rolls each piece away from self
7. Discards linens into laundry bag
8. Moves the mattress to the head of the bed
9. Applies mattress pad
10. Applies bottom sheet, keeping it smooth and free of wrinkles
11. Places the top sheet and bedspread on the bed, keeping them smooth and free of wrinkles
12. Tucks in top linens at the foot of the bed. Makes mitered corners
13. Applies clean pillowcase with zippers and/or tags to inside of pillowcase
14. Lowers the bed to its lowest position. Locks the bed wheels
15. Washes hands

❑* *Donning and Removing PPE (Gown and Gloves) (Chapter 16)*

1. Picks up gown and unfolds
2. Facing the back opening of gown, places arms through each sleeve
3. Fastens the neck opening
4. Secures gown at waist making sure that back of clothing is covered by gown (as much as possible)
5. Puts on gloves
6. Cuffs of gloves overlap cuffs of gown
7. **Before removing gown, with one gloved hand, grasps the other glove at the palm, removes glove**
8. **Slips fingers from ungloved hand underneath cuff of remaining glove at wrist, and removes glove turning it inside out as it is removed**
9. Disposes of gloves into designated waste container without contaminating self
10. After removing gloves, unfastens gown at neck and at waist
11. After removing gloves, removes gown without touching outside of gown
12. While removing gown, holds gown away from body, without touching the floor, turns gown inward and keeps it inside out
13. Disposes of gown in designated container without contaminating self
14. After completing skill, washes hands

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❑ *Performs Abdominal Thrusts (Chapter 13)*

1. Asks client if he or she is choking
2. Stands behind the client
3. Wraps arms around client's waist
4. Makes a fist with one hand
5. Places thumb side of fist against the client's abdomen
6. Positions fist in middle above navel and well below sternum (breastbone)
7. Grasps fist with other hand
8. Presses fist and other hand into client's abdomen with quick upward thrusts
9. Repeats thrusts until object is expelled or client becomes unresponsive

❑ *Ambulation With Cane or Walker (Chapter 30)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Locks bed wheels or wheelchair brakes
3. Assists client to a sitting position
4. **Before ambulating, puts on and properly fastens non-skid footwear**
5. Positions cane or walker correctly. Cane is on the client's strong side
6. Assists client to stand, using correct body mechanics
7. Stabilizes cane or walker and ensures that client stabilizes cane or walker
8. Stands behind and slightly to the side of client on the person's weak side
9. Ambulates client at least 10 steps
10. Assists client to pivot and sit, using correct body mechanics
11. Before leaving client, places signaling device within client's reach
12. Washes hands

❑ *Fluid Intake (Chapter 27)*

1. Observes dinner tray
2. Determines, in milliliters (mL), the amount of fluid consumed from each container
3. Determines total fluid consumed in mL
4. Records total fluid consumed on intake and output (I&O) sheet
5. Calculated total is within required range of evaluator's reading

❑ *Brushes or Combs Client's Hair (Chapter 23)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Collects brush or comb and bath towel
3. Places towel across client's back and shoulders or across the pillow
4. Asks client how he or she wants his or her hair styled
5. Combs/brushes hair gently and completely
6. Leaves hair neatly brushed, combed, and/or styled
7. Removes towel
8. Removes hair from comb or brush
9. Before leaving client, places signaling device within client's reach
10. Washes hands

❑ *Transfers a Client Using a Mechanical Lift (Chapter 19)*

1. Assembles required equipment; performs safety check of slings, straps, hooks, and chains
2. Checks client's weight to ensure it does not exceed the lift's capacity
3. Asks a co-worker to help
4. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
5. Provides for privacy during procedure with curtain, screen, or door
6. Locks the bed wheels
7. Raises the bed for proper body mechanics
8. Lowers the head of the bed to a level appropriate for the client
9. Stands on one side of the bed; co-worker stands on the other side
10. Lowers the bed rails if up
11. Centers the sling under the client following the manufacturer's instructions
12. Ensures that the sling is smooth
13. Positions the client in semi-Fowler's position
14. Positions a chair to lower the client into it
15. Lowers the bed to its lowest position
16. Raises the lift to position it over the client
17. Positions the lift over the client
18. Attaches the sling to the sling hooks and checks fasteners for security
19. Crosses the client's arms over the chest
20. Raises the lift high enough until the client and sling are free of the bed
21. Instructs co-worker to support the client's legs as candidate moves the lift and the client away from the bed
22. Positions the lift so the client's back is toward the chair
23. Slowly lowers the client into the chair
24. Places client in comfortable position, in correct body alignment
25. Lowers the sling hooks and unhooks the sling
26. Removes the sling from under the client unless otherwise indicated. Moves lift away from client
27. Puts footwear on the client
28. Covers the client's lap and legs with a lap blanket
29. Positions the chair as the client prefers
30. Places signaling device within client's reach
31. Washes hands

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❑ *Provides Mouth Care for an Unconscious Client (Chapter 22)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Provides for privacy during procedure with curtain, screen, or door
3. Washes hands
4. Positions client on side with head turned well to one side
5. Puts on gloves
6. Places the towel under the client's face
7. Places the kidney basin under the chin
8. Uses swabs or toothbrush and toothpaste or other cleaning solution
9. Cleans inside of mouth including the gums, tongue, and teeth
10. Cleans and dries face
11. Removes the towel and kidney basin
12. Applies lubricant to the lips
13. Positions client for comfort and safety
14. Removes and discards the gloves
15. Places signaling device within the client's reach
16. Washes hands

❑ *Provides Drinking Water (Chapter 27)*

1. Washes hands
2. Assembles equipment—ice, scoop, pitcher, cup, straw
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Uses the scoop to fill the pitcher with ice; does not let the scoop touch the rim or inside of the pitcher
5. Places scoop in appropriate receptacle after each use
6. Adds water to pitcher
7. Places the pitcher, disposable cup, and straw (if used) on the over-bed table, within the person's reach
8. Before leaving, places signaling device within client's reach
9. Washes hands

❑ *Provides Perineal Care for Uncircumcised Male (Chapter 22)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Provides for privacy during procedure with curtain, screen, or door
3. Washes hands
4. Fills basin with comfortably warm water
5. Puts on gloves
6. Elevates bed to working height
7. Places waterproof pad under buttocks
8. Gently grasps penis
9. Retracts the foreskin
10. Using a circular motion, cleans the tip by starting at the meatus of the urethra and working outward
11. Rinses the area with another washcloth
12. Returns the foreskin to its natural position
13. Cleans the shaft of the penis with firm, downward strokes and rinses the area
14. Cleans the scrotum
15. Pats dry the penis and the scrotum
16. Cleans the rectal area
17. Removes the waterproof pad
18. Lowers the bed
19. Removes and discards the gloves
20. Washes hands
21. Before leaving, places signaling device within client's reach

❑ *Empties and Records Content of Urinary Drainage Bag (Chapter 25)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Washes hands
3. Puts on gloves
4. Places a paper towel on the floor
5. Places the graduate on the paper towel
6. Places the graduate under the collection bag
7. Ensures that the bag is below the bladder and the drainage tube is not kinked
8. Opens the clamp on the drain
9. Lets all urine drain into the graduate—does not let the drain touch the graduate
10. Closes and positions the clamp
11. Measures urine
12. Removes and discards the paper towel
13. Empties the contents of the graduate into the toilet and flushes
14. Rinses the graduate
15. Returns the graduate to its proper place
16. Removes the gloves
17. Washes hands
18. Records the time and amount on the intake and output (I&O) record
19. Provides for client comfort
20. Places the signaling device within reach of client

❑ *Applies a Vest Restraint (Chapter 15)*

1. Obtains the correct type and size of restraint
2. Checks straps for tears or frays
3. Washes hands
4. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
5. Provides for privacy during procedure with curtain, screen, or door
6. Makes sure the client is comfortable and in good alignment
7. Assists the person to a sitting position
8. Applies the restraint following the manufacturer's instructions—the "V" part of the vest crosses in front

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9. Makes sure the vest is free of wrinkles in the front and back
10. Brings the straps through the slots
11. Makes sure the client is comfortable and in good alignment
12. Secures the straps to the chair or to the movable part of the bed frame
13. Uses a secure knot that can be released with one pull
14. Makes sure the vest is snug—slide an open hand between the restraint and the client
15. Places the signaling device within the client's reach
16. Washes hands

❑ *Performs a Back Rub (Massage) (Chapter 31)*

1. Washes hands
2. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
3. Provides for privacy during procedure with curtain, screen, or door
4. Raises the bed for good body mechanics
5. Lowers the bed rail near the candidate, if up
6. Positions the person in the prone or side-lying position
7. Exposes the back, shoulders, upper arms, and buttocks
8. Warms the lotion
9. Rubs entire back in upward, outward motion for approximately 2 to 3 minutes; does not massage reddened bony areas
10. Straightens and secures clothing or sleepwear
11. Returns client to comfortable and safe position
12. Places the signaling device within reach
13. Lowers the bed to its lowest position
14. Washes hands

❑ *Positions a Foley Catheter (Chapter 25)*

1. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
2. Washes hands
3. Puts on gloves
4. Secures catheter and drainage tubing according to facility procedure
5. Places tubing over leg
6. Positions drainage tubing so urine flows freely into drainage bag and has no kinks
7. Attaches bag to bed frame, below level of bladder
8. Washes hands

❑ *Applies a Cold Pack or Warm Compress (Chapter 38)*

1. Washes hands
2. Collects needed equipment
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Provides for privacy during procedure with curtain, screen, or door
5. Positions the client for the procedure
6. Covers cold pack or warm compress with towel or other protective cover
7. Properly places cold pack or warm compress on site
8. Checks the client for complications every 5 minutes
9. Checks the cold pack or warm compress every 5 minutes
10. Removes the application at the specified time—usually after 15 to 20 minutes
11. Provides for comfort
12. Places the signaling device within reach
13. Washes hands

❑ *Positions for an Enema (Chapter 26)*

1. Washes hands
2. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
3. Provides for privacy
4. Positions the client in Sims' position or in a left side-lying position
5. Covers client appropriately
6. Provides for comfort
7. Places the signaling device within reach
8. Washes hands

❑ *Positions Client for Meals (Chapter 27)*

1. Washes hands
2. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
3. If the person will eat in bed:
   a. Raises the head of the bed to a comfortable position—usually Fowler's or high-Fowler's position is preferred
   b. Removes items from the over-bed table and cleans the over-bed table
   c. Adjusts the over-bed table in front of the person
   d. Places the client in proper body alignment
4. If the person will sit in a chair:
   a. Positions the person in a chair or wheelchair
   b. Provides support for the client's feet
   c. Removes items from the over-bed table and cleans the table
   d. Adjusts the over-bed table in front of the person
   e. Places the client in proper body alignment
5. Places the signaling device within reach
6. Washes hands

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❑ *Takes and Records Axillary Temperature, Pulse, and Respirations (Chapter 29)*

1. Washes hands before contact with client
2. Identifies self to client by name and addresses client by name
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Provides for client's privacy during procedure with curtain, screen, or door
5. Turns on digital oral thermometer
6. Dries axilla and places thermometer in the center of the axilla
7. Holds thermometer in place for appropriate length of time
8. Removes and reads thermometer
9. Records temperature on pad of paper
10. **Recorded temperature is within required range**
11. Discards sheath from thermometer
12. Places fingertips on thumb side of client's wrist to locate radial pulse
13. Counts beats for 1 full minute
14. Records pulse rate on pad of paper
15. **Recorded pulse is within required range**
16. Counts respirations for 1 full minute
17. Records respirations on pad of paper
18. **Recorded respirations are within required range**
19. Before leaving client, places signaling device within client's reach
20. Washes hands

❑ *Transfers Client From Wheelchair to Bed (Chapter 19)*

1. Washes hands before contact with client
2. Identifies self to client by name and addresses client by name
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Provides for client's privacy during procedure with curtain, screen, or door
5. Positions wheelchair close to bed with arm of wheelchair almost touching bed
6. Before transferring client, ensures client is wearing non-skid footwear
7. Before transferring client, folds up footplates
8. Before transferring client, places bed at safe and appropriate level for client
9. **Before transferring client, locks wheels on wheelchair and locks bed brakes**
10. a. *With transfer (gait) belt:* Stands in front of client, positioning self to ensure safety of candidate and client during transfer (for example, knees bent, feet apart, back straight), places belt around client's waist, and grasps belt. Tightens belt so that fingers of candidate's hand can be slipped between transfer/gait belt and client
    b. *Without transfer belt:* Stands in front of client, positioning self to ensure safety of candidate and client during transfer (for example, knees bent, feet apart, back straight, arms around client's torso under arms)
11. Provides instructions to enable client to assist in transfer, including prearranged signal to alert client to begin standing
12. Braces client's lower extremities to prevent slipping
13. Counts to three (or says other prearranged signal) to alert client to begin transfer
14. On signal, gradually assists client to stand
15. Assists client to pivot and sit on bed in manner that ensures safety
16. Removes transfer belt, if used
17. Assists client to remove non-skid footwear
18. Assists client to move to center of bed
19. Provides for comfort and good body alignment
20. Before leaving client, places signaling device within client's reach
21. Washes hands

❑ *Applies an Incontinence Brief (Chapter 24)*

1. Washes hands before contact with client
2. Identifies self to client by name and addresses client by name
3. Explains procedure to client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible
4. Starts with scale balanced at zero before weighing client
5. Chooses correct brief and size per facility instructions
6. Provides privacy for the resident
7. Elevates bed to comfortable working height
8. Puts on gloves
9. Places waterproof pad under client, asking client to raise buttocks or turning the client to the side
10. Loosens tabs on each side of the product
11. Turns the client away from you
12. Removes the product from front to back, rolling the product up and placing the product into trash bag
13. Opens the new brief, folding it in half, length-wise along the center, and inserts it between the client's legs from front to back; unfolds and spreads the back panel
14. Turns the client onto his or her back, with the product under buttocks with top of absorbent pad aligned just above the buttocks crease
15. Grasps and stretches the leg portion of front panel to extend elastic for groin placement
16. Rolls ruffles away from groin
17. Snuggly places bottom tabs angled toward abdomen on both sides
18. Places top tabs on each side angled toward bottom tabs
19. Removes gloves
20. Washes hands
21. Covers client appropriately and provides for comfort
22. Places signaling device within reach

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After the Procedure

After you demonstrate a skill, complete a safety check of the room.

- The person is wearing eyeglasses, hearing aids, and other devices as needed.
- The call light is plugged in and within reach.
- Bed rails are up or down according to the care plan.
- The bed is in the lowest horizontal position.
- The bed position is locked if needed.
- Manual bed cranks are in the down position.
- Bed wheels are locked.
- Assistive devices are within reach. Walker, cane, and wheelchair are examples.
- The over-bed table, filled water pitcher and cup, tissues, phone, TV controls, and other needed items are within reach.
- Unneeded equipment is unplugged or turned off.
- Harmful substances are stored properly. Lotion, mouthwash, shampoo, after-shave, and other personal care products are examples.

After the Test

- Celebrate—you have completed the competency evaluation! The length of time for you to get your test results varies with each state. In the meantime, try to relax. Continue your daily routine and be the best nursing assistant you can be.

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