

Revised
**Fundamentals of
Caregiving**

**Facilitator's
Guide**

Second Edition
July 2005
Updated May 2009



ADSA Aging & Disability
Services Administration

Using the Facilitator's Guide

Your Facilitator's Guide has instructions for teaching the course. Review the material thoroughly and become familiar with the Learners Guide, the Resource Directory, the Common Diseases and Conditions sections, the course techniques, and exercises prior to teaching the course.

Facilitator's Guide set-up

Your Facilitator's Guide has been formatted with the Learner's Guide page appearing on the left. The right-hand side the page is for additional instructions on how to teach the Learner's Guide page, if any are needed. Page numbers for the Facilitator's Guide appear only on the right-hand page.

The exception to this formatting rule is when several Learner's Guide pages appear consecutively with no instructor's notes needed. In these cases, another Learner's Guide page also appears on the right-hand side of the page.

Course Overview

The content of the Revised Fundamentals of Caregiving curriculum is based on the required knowledge and skills outlined for basic caregiver training in WAC 388-112-0055.

The WAC defines the following core knowledge and skills. The caregiver will be able to:

- understand and use effective interpersonal and problem solving skills with the resident, family members and other care team members;
- take appropriate action to promote and protect resident rights, dignity, and independence;
- take appropriate action to promote and protect the health and safety of the resident and the caregiver;
- correctly perform required personal care tasks while incorporating resident preferences, maintaining the resident's privacy and dignity, and creating opportunities that encourage resident independence;
- adhere to basic job standards and expectations.

Course Schedule

Classroom times



Times allocated above for each module are guidelines. Some amount of variation is expected due to things such as class size or the number of questions a class may have on a particular subject. See the Facilitator Guide for specifics of how much time has been allocated for Module Reviews, Module Scenarios, and required exercises.

Course Schedule

DAY 1	Time	Skills
Module 1 – Course Introduction	30 Min.	
Module 2		
Lesson 1 - The Client	15 Min.	
Lesson 2 - Client Rights	2 Hours 35 Min.	
Module 3 – The Caregiver	1 Hour 40 Min.	
Module 4		Hand Washing Putting On and Taking Off Gloves
Lesson 1 – Infection Control	2 Hours	

DAY 2	Time	Skills
Module 4		
Lesson 2 – Blood Borne Pathogens	1 Hour 10 Min.	
Module 5 – Mobility	2 Hours 5 Min.	
Module 6 – Basic Communication	45 Min.	
Module 7		
Lesson 1 – Skin Care	1 Hour 35 Min.	Body Mechanics Transfer Helping a Client Walk Turn and Reposition a Client in Bed
Lesson 2 – Body Care	1 Hour 25 Min.	

DAY 3	Time	Skills
Module 7 (continued)	2 Hours 40 Min.	
Lesson 2 – Body Care - Continued		
Module 8		
Lesson 1 - Nutrition	1 Hour 30 Min.	
Lesson 2 – Food Handling	45 Min.	
Module 9 – The Process of Elimination	2 Hours 5 Min.	Mouth Care Clean and Store Dentures A Shave with Safety Razor Fingernail Care Foot Care Bed Bath Assist Client with Weak Arm to Dress Put Knee-High Stocking on Client Passive Range of Motion Assist a Client to Eat Assist Client with Pericare Assist Client with Use of Bedpan Catheter Care Assist Client with Condom Catheter Care

DAY 4	Time	Skill
Module 10		
Lesson 1 – Self Directed Care and Nurse Delegation	20 Min.	
Lesson 2 – Medications	1 Hour 30 Min.	
Module 11		
Lesson 1 – Self Care and the Caregiver	1 Hour 30 Min.	
Lesson 2 – Grief and Loss	20 Min.	Assisting with Medications
Test Review	20 Min.	
Written Exam	1 Hour	
Skill Demonstration Testing	2 Hours	

Course Structure

Overview

The course structure is developed around six key elements, including:

1. Learner's Guide content and activities;
 2. Skill demonstrations;
 3. Skill stations;
 4. DOC teams;
 5. Module Reviews; and
 6. Module Scenarios.
-
1. The **Learner's Guide** is the student's textbook and includes all of the course content and activities.
 2. **Skills demonstrations** give students a clear, visual, step-by-step demonstration of the proper procedure for completing a skill.
 3. **Skill stations** are practice areas set up in the classroom where all the needed supplies to perform a personal care task have been gathered and are available for students to practice skills.
 4. **DOC Teams** (doer, observer, client) give students the opportunity to take turns practicing the skill, experiencing what it is like to be the recipient of care, and practicing observation skills and peer teaching with other students. DOC teams are used with skill stations, Module Scenarios, study teams, and during skills demonstration testing at the end of the course.
 5. **Module Reviews** are practice quizzes at the end of each module. Module Reviews reinforce the major points in the module, lets the instructors know if students understand the materials, and gives the instructor the opportunity to clarify or review particular topics. Module Reviews also ease test anxiety as students become familiar with the testing format and feel better prepared to take the written test.
 6. **Module scenarios** reinforce and give students practice in:
 - problem solving in common caregiving situations;
 - understanding how caregiving is impacted by a client's disease and/or condition;
 - performing the selected skill correctly while demonstrating respectful communication and attention to client rights.

Module Scenarios are **mandatory** and are completed after the Module Reviews in Modules 5, 7 (after lessons one and two), 9, and 10.

Working with students

1. Learner's Guide content and activities

It is expected that the content on the Learner's Guide page will be covered with the students. How much depth to cover in each section varies.

Highlighted material in the Facilitator's Guide must be covered thoroughly. For non-highlighted material, follow any specific instructions found on the right-hand page. If no further instruction is given, summarize the main points of the section for students.

2. Skill demonstrations

Demonstrating skills is more than just "showing" students how to do something. Teaching a new skill requires a well thought out process that includes an overview of the skill, demonstrating the skill, reviewing the skill with a student volunteer, and time for students to practice.

- **Step 1: Introduce the skill**

Give a clear and brief overview of the task or skill you will demonstrate. Build a bridge for the students so they understand why it is important that they know how to perform the skill correctly.

- **Step 2: Tell them how...**

Go through each step in the proper sequence, demonstrating and explaining the mechanics of each step. This allows the student to see the steps from start to finish and gives them a good visual of the entire procedure. Make sure all students can see the skill being demonstrated.

- **Step 3: Review....**

Ask for a volunteer to demonstrate how to do the new skill or task in front of the group. Before beginning, review the steps once again. This process helps students see common mistakes made when first beginning to learn the skill. It also reinforces that it isn't as easy as it looks to do it yourself.

- **Step 4: Practice....**

Allow students to practice in skill stations.

3. Skill stations

Setting up skill stations

A bed, chair, hand washing facility, wheelchair, mannequin, and other supplies for teaching all of the personal care tasks must be in the classroom.

The supplies needed for each skill station will change depending on which skills are taught and practiced during that portion of the day. Set skill stations up prior to students needing to use them.

Skill stations should be set up so DOC teams can rotate through different stations during skills practice. For example, supplies for mouth care, denture care, and shaving may be at one station with foot care, fingernail care, and bed bath at another station. This helps reduce the amount of supplies required (though for larger classes you likely need more than one skill station with the same equipment) and helps keep the DOC teams focused.

How many skills you wish to demonstrate before you have the students practice in skill stations is left to your discretion. Keep in mind, students can only retain so much new information at one time. It is recommended that you demonstrate several skills and then allow students to practice.

Students need to practice soon after a skill demonstration. It is recommended that you not demonstrate a skill at the end of one day without allowing students to practice that skill before they go home.

4. DOC Teams

A DOC team is comprised of three students with distinct roles.

- **D-Doer** - The person who takes the role of the caregiver and performs the selected care task.
- **O-Observer** – The person who observes, helps make sure tasks are done correctly, and offers feedback to the **doer**.

Note: Besides making sure the doer performs the physical aspects of the skill correctly, the observer should be instructed to watch for and provide feedback on the communication/client rights skills noted at the bottom of each Skills Demonstration Checklist (found at the back of the Learner's Guide starting on page 326).

- **C-Client** – The person who takes the role of the client.

Setting up DOC teams

Assign students to the DOC team. It is recommended that you do not put more than one limited English speaking person in each DOC team. Don't put people who know each other well together.

When first introducing the DOC teams to students, explain the different roles and why they are being used during the course. Explain each DOC team member must practice each role. Roles should not be switched until each Doer has successfully completed the assigned skill.

Instructor role during skills practice

Your role during the skills station practice time is to monitor the students and make sure:

- students are performing the skills correctly;
- the groups stay focused;
- each team member takes on each role; and
- questions are answered.

5. Module Reviews

Explain to students that Module Reviews are completed individually. Students should treat the Module Review as a "quiz" – although they will not be turned in and graded.

Give students a timeline for completing each Module Review (noted in the Facilitator's Guide). If the majority of students are done at the end of the allotted time, review the answers. You do not have to wait for every student to complete the review before proceeding. Make sure each student participates.

Watch to see which students may be struggling (see ESL notes on next page). This lets you know who might need extra help during the class and perhaps during the written test.

Instructor option: You may choose to let the students do the Module Reviews as an “open-book”. If you do so, tell the students to do as much as they can from memory before opening their Learner’s Guide. Let them know the final written test will not be open book.

ESL and low literacy learners

Pair students up and have one student read questions out loud to the other student or have students work together in their DOC teams. If a translator is available, have the translator read the questions to the student.

Remind students that the final written test can be read to them if that would be helpful.

Processing the Lesson Review

Once the majority of students have finished, go through each question and ask for a volunteer to report his/her answer. Make sure the answers are correct. Have students correct any incorrect answers in their own Learner’s Guide.

Allow time for questions or clarification of incorrect answers. If students appear confused about any of the content, review that topic in more depth before moving on to the next Module.

6. Module Scenarios

Completing the “Research” and “Problem Solve” steps

Group the students in their DOC teams. Instruct students to:

- read through the module scenario;
- review the highlighted disease(s) in the Common Diseases and Conditions section; and
- work through the specific steps called out in “Problem Solve”.

Remind students there may be more than one problem within the scenario and there is not “one” right answer.

Completing the “Demonstrate” skill

Once the research and problem solving steps are completed, have students practice the skill with their DOC team.

Group Discussion on the Problem Solving

Ask the groups to identify what problem they selected to focus on, the solution they picked, and why.

This normally generates a lively discussion – which is also an important learning experience for students. It helps reinforce that there are always a variety of factors influencing what is happening with a client, different perceptions of “what” the problem is, and many ways to solve similar situations.

Large group skill demonstration (by one team)

Select **one group** or ask for one team to volunteer to demonstrate the skill.

Give the assigned team a minute to choose who will demonstrate. They should then perform the assigned demonstration in front of the class.

Teaching techniques

Adult learners learn best from a blend of approaches that appeal to a variety of learning styles. RFOC uses a variety of techniques designed for adult learners to enhance student learning, participation, and to stimulate interaction.

The following is a brief description of the methods and techniques used throughout the course. The Facilitator's Guide uses these icons to alert you to the recommended technique for that particular section.



Instructor note: provides added information/expectations.

Lectures highlight key points and provide information so student's can grasp the content.



Skills demonstrations give students a clear, visual, step-by-step sequence of the proper procedure for completing a skill.



Exercises give students an opportunity to take a more in-depth look at specific topics.



Exercises documented in the Facilitator's Guide are mandatory and should be taught as documented.

Optional Exercises

Optional exercises have been included in the Facilitator's Guide and can be used or modified (if time permits) to reinforce key points in the module. Optional exercises do not replace the mandatory exercises.



Guided Discussions allow the instructor to lead the class in the discussion of a topic while assuring there is structure and order to how the discussion evolves.



Discussions are developed by using planned questions or statements. Guided discussions provide the opportunity for all students to participate in the exchange of ideas.

Brainstorming is a tool that encourages spontaneous, uninhibited thought. It enables students to look at old familiar situations and see new perspectives.



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Services Administration

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Module 1

Course Introduction

Lesson 1

Introduction



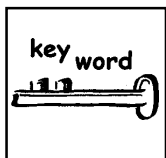
30 Minutes

Personal Care Skills Covered

None



Icons to help guide you



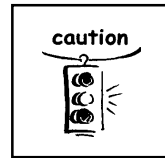
A word to remember



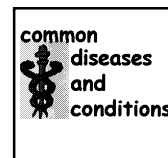
Something to report



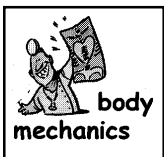
See the Resource Directory



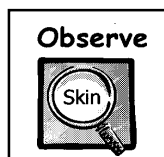
Beware or be careful



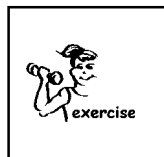
See the Common Diseases section



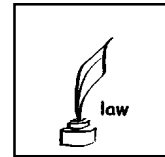
Use proper body mechanics



Observe skin



Classroom exercise



Something in the law



Be alert and respectful



Each module begins with a Module Preview Page. Module Preview Pages are a quick snapshot of the lessons in the module and lists any personal care tasks that will be covered.

1. Review the Module Preview Page with the class.
2. Review each of the **icons** at the bottom of the page. When you come to an icon in the text during the first morning, remind the students about the icons.

Module 1

Introduction

Successfully
Completing
the Course



What you will learn in this lesson:

1. What this course covers.
2. How to successfully complete this course.
3. Ground rules for the course.
4. Learning styles.

key word



Learning styles

Definition

The way a person uses his/her physical senses to learn



Each lesson includes a Lesson Preview Page. Lesson Preview Pages are a quick snapshot of the learning outcomes covered in the module and any key words that appear in the content that may be unfamiliar to students.

1. Review the Lesson Preview Page at the beginning of each lesson.
2. Tell students to refer back to the Lesson Preview Page if they come across a key word they don't understand or to the Glossary starting on page 279 if they see a word/term that is unfamiliar to them.



The first time a key word appears in the text of the Learner's Guide, the word is bolded and italicized and the key word icon appears in the sidebar. The definition is not included again in the text.



Welcome!

Welcome to the Revised Fundamentals of Caregiving class. This course is a very practical and basic class in caregiving.

You are an important part of this class. We want you to leave the class confident of your knowledge and skills to provide quality care.

You need to be fully committed to the class. This lesson will give you the vision and tools for successfully completing the course.



Directions: Use the questions below to interview the student sitting next to you. Make sure this is someone you do **not** know. You will each be given one minute to interview the other person. After both interviews are completed, you will introduce your neighbor to the class.

1. What is your name? _____
2. What is your favorite color? _____
3. What languages do you speak? _____
4. What is your favorite activity or hobby? _____
5. Where do you work as caregiver? _____

Learner's Guide

Your Learner's Guide is your workbook for the entire course. Make sure to:

- bring it everyday;
- write notes in it to help you remember important items;
- use it to follow along with the instructor during class.

There are three other sections in the back of your Learner's Guide: the Resource Directory, Glossary, and the Common Diseases and Conditions.

The Resource Directory includes reference information and resources that will be useful to you in the class and in the future. The Glossary includes definitions of words that may be new to you. The Common Diseases and Conditions section includes diseases and conditions commonly seen with many clients.

Successfully Completing the Course



■ Student Introductions Exercise



10 Minutes

Purpose:

- provides an icebreaker, team builder, and a non-threatening way to introduce students to each other.

1. Review the directions to the exercise.
2. Proceed with the interviews.
3. Once everyone is done, give students 15 seconds to complete their introduction.

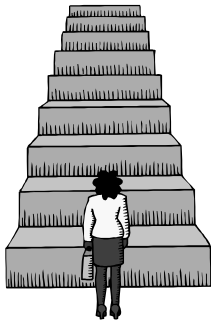


Reinforce the time limit - this is a brief introductory exercise.



■ The Learner's Guide

1. Have students turn to the table of contents at the beginning of the Learner's Guide.
2. Give a general overview of each of the modules and the breadth of material the class will cover.
3. Introduce students to each of the other sections of the Learner's Guide explaining what types of information they can find:
 - Resource Directory - page 212
 - Glossary - page 279
 - Common Diseases and Conditions - page 296
 - Skill demonstration checklists - page 326



How the class is taught

Students are very involved during the entire training. You will actively take part in and practice what you are learning. This will be accomplished through:

- class and small group discussions;
- short instructor lectures;
- study teams;
- personal care skills practice in skill stations;
- module reviews and module scenarios.

Learning Goals

There are **5 major learning goals** in this course. By the end of the course, you will be able to:

1. Understand what is required and expected of you in your job.
2. Know how and why it is important to protect a client's rights.
3. Use good communication and problem solving skills with a client, family members, and other care team members.
4. Protect the health and physical safety of a client and yourself.
5. Correctly provide personal care and other authorized tasks while:
 - understanding how a client wants things done and doing tasks that way;
 - honoring a client's privacy, dignity, and differences;
 - encouraging a client to do as much as he/she can.

Successfully completing the course

To successfully complete this course, you are required to attend all classes and pass a written test and skill demonstration test.

Written test

The written test will help you and the instructor know whether you have learned the key points in the course. By following the tips for successfully completing this course (see next page) and completing the Module Reviews, you should be prepared to pass the written test.

Skill demonstrations

Skill demonstrations will help you and the instructor know whether you can do the personal care tasks and other important caregiving skills taught during the class. You will be given plenty of time in class to practice these skills.



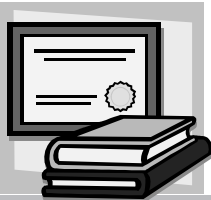
■ Learning Goals

1. Go through each goal one at a time.
2. For each goal, ask how achieving this goal helps a caregiver provide quality care.

8

tips for successfully completing this course

1. Be rested and ready to learn.
2. Keep outside demands/distractions out of the classroom.
3. Ask questions if you don't understand something.
4. Be on time and attend every class.
5. Listen and take notes during lectures and skill demonstrations.
6. Watch demonstrations carefully and use practice time wisely.
7. Take an active role in study teams and discussions.
8. Be committed to getting the most out of the class.



Training certificate

A Revised Fundamentals of Caregiving Training Certificate will be given to all students who pass the written test and skill demonstration test for this course.

Keep your Revised Fundamentals of Caregiving Training Certificate with other important records. **You will need it if you change jobs. It proves that you successfully completed the class.**

Additional training requirements

Completing this course is only one of your caregiver training requirements. You must attend at least **ten (10) hours of approved continuing education each year**. This requirement begins the next calendar year after the year you complete Revised Fundamentals of Caregiving.

Continuing education is caregiver related training designed to keep your skills and knowledge current. Continuing education must be on a topic relevant to the care needs of the client and the care setting. Topics may include, but are not limited to, client rights, personal care, mental illness, dementia, developmental disabilities, depression, medication assistance, communication skills, or medical conditions.

Proof of completion of these continuing education hours is required.

See pages 212-213 in the Resource Directory for a summary of training requirements.

You have **120 days** from the time you start your job to complete this training.



resources

Ground Rules

If you can't make a class

You will be expected to attend every class. If an emergency comes up, speak with your instructor at a break or lunch.

If extra support is needed

If you need help with writing, reading, understanding English, **or have any other problems**, let the instructor know at the first break.

Presenting yourself for class.

Dress as you would for your job.

Learning Styles



Each one of us has a way of learning that feels more natural and easy.

Identifying your own natural **learning style** helps you understand how to get information in ways that work best for you.



To help determine your learning style, in the shaded, boxed column, put:

"O" next to the statement if it is **Often** true for you;

"S" next to the statement if it is **Sometimes** true for you; or

"R" next to the statement if it is **Rarely** true for you.

_____	_____	Written directions are easier for me to follow than someone explaining something to me.
_____	_____	I like to write things down or take notes to look at later.
_____	_____	I can easily understand and follow directions on maps.
_____	_____	I can understand a news article better if I read it rather than hear it on the tv or radio.
_____	_____	
_____	_____	I can remember more about a subject if I hear it rather than read it.
_____	_____	I usually need someone to explain graphs, diagrams, or visual directions to me.
_____	_____	I can follow verbal directions better than written ones.
_____	_____	I can spell better by repeating the letters out loud rather than by writing the word down.
_____	_____	
_____	_____	I learn best if I am allowed to try something new.
_____	_____	I enjoy working with my hands.
_____	_____	I can remember best by writing things down several times.
_____	_____	I use a lot of gestures when I talk and am well coordinated.
_____	_____	

Module 1

Introduction



You must use the optional exercise on Learning Styles below or do a guided discussion (see Facilitator Guide page 15) to help students understand the different learning styles.

No matter which option you choose, highlight the things students with different learning styles can do to learn better in the class.



■ Learning Style Inventory Exercise

Optional

Purpose:

- allows student to identify his/her own style;
- gives student a better understanding of what helps him/her learn best.

How to do the Learning Styles Exercise

1. Review the directions. Tell students they have 5 minutes to complete the written part of the exercise.
2. Let students know they will not have to share their answers with others - and to be truthful in their responses.
3. Remind students to put their answers in the shaded, boxed column.

Scoring the inventory

1. Students should assign the following scores for each of their responses.

Often true = 5

Sometimes true = 3

Rarely true = 1

2. Add and record the total for each of the three sections.

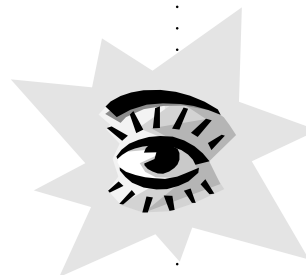
<u>5</u>	<u>O</u>	Written directions are easier for me to follow than someone explaining something to me.
<u>1</u>	<u>R</u>	I like to write things down or take notes to look at later.
<u>3</u>	<u>S</u>	I can easily understand and follow directions on maps.
<u>3</u>	<u>S</u>	I can understand a news article better if I read it rather than hear it on the tv or radio.
<u>5</u>	<u>O</u>	A good way for me to remember something is to picture it in my head.
<u>17</u>		

3. Explain the **highest section score** is the student's primary learning style. Tied scores may indicate a student's ability to learn comfortably using more than one learning style.
4. Explain that section one is sight, section two is hearing, and section three is touch.
5. Go to the next page and review with students more about each learning style.

The three primary learning styles use the senses of sight, hearing, and touch.

People who learn best by **sight**:

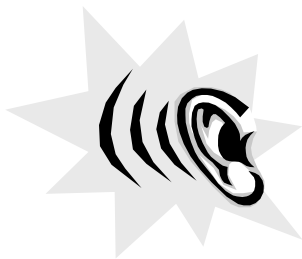
- learn best when they can “see” what has to be done or understood.
- remember what they have seen easier than what they hear;
- remember people’s faces better than their names.



Helpful hints

- A visual picture of what needs to be done is helpful to you. Ask the person to “show” you rather than tell you.
- Take notes so that you have something to “look at” later.
- Picture in your head what it is you want to remember.
- If you have to read something, use colorful highlighters or underline important points. Then, go back and review what you have highlighted to reinforce learning.

Although you may have one main learning style, you also learn in other ways.



People who learn best by **hearing**:

- learn best by listening and asking questions;
- like to hear verbal instructions;
- are great listeners;
- will remember what someone said to them easier than the person’s name or face;
- enjoys talking but often needs quiet in order to concentrate.

Helpful hints

- Ask others to “tell” you the important things you need to know.
- If you receive written instructions, say them out loud to yourself.
- Talk things out with others.
- If you have to learn from a book or article, underline the important points and then go back and read them out loud.

People who learn by **touch**:

- learn best when they are able to **do** what has to be done or understood;
- may ignore the written directions when learning a procedure and just try to figure it out;
- remember people by what they did.



1. Ask students if they have ever bought anything that says, "assembly required". Ask students to reflect on how they would go about assembling that object.

Ask:

- Q:** How many of you just dump it all out and start putting it all together?" These are the feeling learners.
- Q:** How many of you read all the instructions first and then put it together with the picture? These are the sight learners.
- Q:** How many of you have to either read the instructions out loud to your selves or have someone read them to you? These are the hearing learners.

Using this knowledge for the class

2. Explain to students:

- Touch learners will find it helpful to write things down during the lectures and will retain more during the skills demonstration when they have hands on practice.
- Sight learners should follow along in the book during the lectures and will learn skills best by carefully watching the demonstrations.
- Hearing learners will absorb what they hear in the lecture but may need to talk through each step of a skill.

Ask for
information in ways
that work best for
you.

Helpful hints

- When given verbal or written instructions, you may not feel comfortable until you have a chance to actually “do it”.
- Make sure to take the time and understand ALL the important steps and pieces to what you are learning.
- Use your finger or a bookmark to follow along while reading.
- Move around as much as possible when learning or thinking about new things.

Smell and taste

The **senses of smell or taste** are not often the primary way in which people learn. The sense of smell is one of the oldest and most primitive of the senses and often is a strong trigger for memory - not learning. The sense of taste often triggers an emotional reaction.

Working with other people

If you find you are confusing or frustrating to someone else, often the other person’s learning style is different than yours. Change what you are doing or saying to better match how **the other person** learns and understands!

If you find yourself confused or frustrated, ask for the information in a way that works best for you.



Module 2

The Client and Client Rights

Lesson 1

The Client



15 Minutes

Lesson 2

Client Rights



2 hours 15 minutes

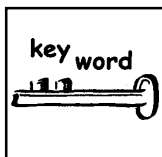
20 Minutes - Module Review

Personal Care Skills Covered

None



Icons to help guide you



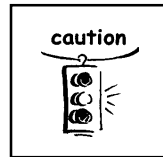
A word to remember



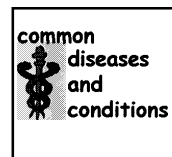
Something to report



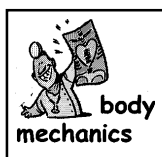
See the Resource Directory



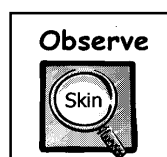
Beware or be careful



See the Common Diseases section



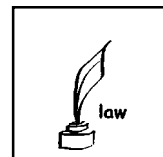
Use proper body mechanics



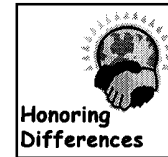
Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 2

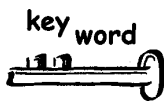
Lesson 1 - The Client



The Client

What you will learn in this lesson:

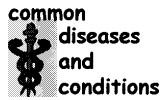
1. General overview of clients.
2. How a client gets a care plan and services.
3. The types of personal care services a client may receive.
4. Working with a client as an individual.
5. Common changes associated with aging.
6. Importance of honoring differences in caregiving.



Definition

Adult family home	Residential, neighborhood home licensed to care for 2-6 people
Assessment	Gathering information to determine what help a client needs
Boarding home	Larger, residential facility licensed to care for 7 or more people
Care plan	A written plan that outlines everything the care team is to do to support a client
Care setting	Where a client lives (adult family home, boarding home, or in-home)
Care team	Everyone who provides care and services for a client, including professionals, relatives, and the person receiving care
Developmental Disability	A condition beginning before the age of 18, that is expected to last a person's lifetime and substantially limits him/her in some of these areas: self-care; communication; learning; mobility; self-direction (e.g. mental retardation, cerebral palsy, and autism)
DSHS plan of care	A plan of care (care plan) written by a DSHS representative for a DSHS client.
Personal care services	Tasks done to help a client with his/her activities of daily living

The Client



See the Common Diseases and Conditions section on page 306 for more information about clients living with a developmental disability.



The person you provide care for may be called a client, care recipient, consumer, employer, or resident. In this course, we have used client to represent any of these.

A client is 18 years old or older and needs help because of an injury, disease, a chronic condition, or **developmental disability**. In 2004, 35,000 adults received help through the Department of Social and Health Services (DSHS) to pay for long-term care services. Of these adults:

- 61% were women;
- 11% were men and women with a developmental disability;
- 33% were between the ages of 18-59 and 63% were 60 or older;
- 84% were white, and the other 16% including African American, American Indian, Korean, Vietnamese, Filipino (and many others);
- 85% of clients spoke English, with other languages spoken including Russian, Spanish, Vietnamese and Korean (and many others).

Where a client lives

A client wants to live in a **care setting** that offers him/her as much independence as possible. The three care settings where a client may live, include:

- an **adult family home**;
- a **boarding home**; or
- the client's own home or apartment.



In 2004, 67% of the people receiving services lived in their own homes, 18% lived in an adult family home or boarding home, and 15% in nursing homes.

A client's care team

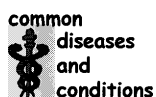
The **care team** includes the client and everyone involved in his/her care. The care team can include family, friends, doctors, nurses, caregivers, social workers, and case managers. The role of the care team is to support the well-being of the client.



A client's disease or condition

The most common diseases or conditions DSHS clients have include:

- heart disease;
- dementia;
- arthritis;
- diabetes;
- stroke;
- neurological problems;
- mental illness; or
- a respiratory condition.



These and other common diseases and conditions and their possible impact on a client will be discussed throughout the rest of the class. See the Common Diseases and Conditions section starting on page 296 for more information.

Module 2 - Lesson 1

The Client

Page 12

■ A client's disease or condition

1. Review content.



2. Ask students to volunteer what disease and/or conditions the client he/she is caring for is living with.

3. Ask students to talk about:

- how the condition impacts the client's personal care requirements,
- what he/she did to learn about the client's disease/condition,
- what additional things he/she does to support the client in maintaining independence.



The importance of the client's disease or condition impacting care is reinforced throughout the curriculum. Set a good foundation!

Aging and health

As a caregiver, you need to be aware of common changes associated with aging so you can:

- encourage a client to get medical treatment when necessary;
- know when to report an issue or concern;
- become more aware of your own beliefs about aging/disability and how they can impact the care you provide.

Everyone experiences some changes in their body as they age. Many of the body's functions go through a common and normal process of change. **Aging is not a disease.** There is a difference between getting older and being sick.

People age at different rates and in different ways. Genes, life-style, nutrition, stress, exercise, mental outlook, and disease can all affect the rate of aging. Adapting to the changes associated with aging allows most older adults to live full and independent lives in their older years. See page 214 in the Resource Directory for more information on healthy aging.



Common Changes Associated With Aging

Eyesight - loss of peripheral (side) vision and decreased ability to judge depth. Decreased clarity of colors (for example, pastels and blues). Need for more light. Glare is harder to tolerate.

Hearing - loss of hearing, especially high pitched sounds. Decreased ability to distinguish sounds when there is background noise and words get harder to separate.

Smell and taste - decreased ability to smell and taste.

Touch and Smell - decreased sensitivity to pain, touch, temperature extremes.

Kidneys and Bladder - increased frequency in urination. Both shrink and become less efficient.

Bones - somewhere around age 35, bones lose minerals faster than they are replaced. Height may decrease, bones may weaken with an increased risk of fracture, posture may get worse.

Heart - thickens with age. Pumps less efficiently.

Lungs - somewhere around age 20, lung tissue begins to lose its elasticity, and rib cage muscles begin to shrink. Breathing gets less deep and ability to cough is decreased.

Muscles - muscle mass declines, especially with lack of exercise.

Skin - skin is thinner and gets more dry and wrinkled. It heals more slowly.

Nails - grow more slowly and get thicker.

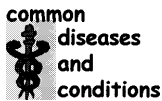
Digestion - some vitamins are absorbed more slowly, digestive system slows down. Constipation may be more of a problem.

Nervous system - reflexes get slower, less steady on feet and falling may become a problem. Sleep gets lighter and may wake up more at night.



■ Common Changes Associated With Aging

1. Select several of the listed common changes of aging.
2. Ask students to comment on:
 - the types of things he/she may see in an aging client,
 - what the client may be experiencing (both + and -) because of it, and
 - things he/she may need to report.



Memory and aging

Forgetfulness can be part of aging. Usually beginning in early middle age, most people have some experience forgetting names, appointments, or things like where they left their keys.

Memory loss is **not** a normal part of the aging process and is different from being forgetful. Memory loss can include:

- not being able to remember important events (e.g. family weddings, familiar people, or places);
- forgetting how to do familiar tasks (e.g. opening a door with a key);
- repeating phrases or stories in the same conversation;
- difficulty making choices.

Memory loss is linked to certain diseases and can be permanent such as with Alzheimer's disease. Memory loss can also be temporary and caused by illnesses, reactions to medications, depression, and/or stress. In these cases, memory loss can be treated and reversed.

See the Common Diseases and Conditions section page 303 for more information on reversible and irreversible dementia.

Myths regarding aging

Myths are commonly believed but false ideas. Although by definition myths are untrue, they can still influence our attitudes and behavior. Many myths surround older people and the aging process (e.g. all older people get sick, are lonely/sad, senile, unproductive, or end up in nursing homes).

These myths become harmful if they stop people from getting the help and/or support needed to adjust to the physical changes associated with aging. This can happen when people do not understand what is normal and treatable or, based on false myths, assume nothing can be done.

As a caregiver, be alert to possible situations that need to be evaluated and addressed by a client's health care provider. Encourage a client to seek professional medical advice when needed. Document and report any concerns you may have about a client to the appropriate person in your care setting.



It is also important to take a closer look at any myths **you** may believe about older people or someone living with a disability. Unquestioned beliefs can impact the way you talk, look at, and/or do things for a client.

How a DSHS client gets services

When a person needs assistance or care, a case manager gathers information from the client, other care team members, and medical records to complete an **assessment**. The client and case manager work together to decide what **personal care services** will help the client to live as independently as possible.



The case manager assesses for each task:

- how much a client can do on his/her own;
- the level of support needed from others to complete the task;
- who will do the task;
- how the client wants to have the task done.



This assessment is completed using an interactive, computerized Comprehensive Assessment Reporting and Evaluation (CARE) tool. Using the collected information, a plan of care or **DSHS care plan** is generated.



What a client's plan of care is called can be different in each care setting. In this course, we have used care plan to represent anything that documents a client's plan of care. When specific reference needs to be made to the plan of care completed by a DSHS representative, it is referred to as the DSHS care plan.

Once the DSHS care plan has been completed, the case manager arranges for the needed services and authorizes payment for paid care providers.

The case manager is responsible for keeping the client's DSHS care plan up to date. He/she makes changes to the DSHS care plan if a client's needs change and services need to be added or are no longer needed.

Care plans for clients not receiving state-funded services

Caregivers working in a boarding home or adult family home may also be providing care for clients who do not receive state-funded services. Although an assessment is still required for that client, there will be no DSHS care plan or DSHS case manager involvement. The type of care plan available and what a caregiver will see and use depends on the boarding home or adult family home. Talk with your supervisor if you have any questions.

See pages 40-43 for more information on how to use a care plan in your job as a caregiver.

Case managers or social workers work for either the Area Agencies on Aging (AAA), Home and Community Services (HCS), or the Division of Developmental Disabilities (DDD)



The care plan is introduced here to explain who and how it is developed for a DSHS client. The focus should remain on the client and his/her relationship with a case manager.

The care plan and how a caregiver uses it to understand his/her job is taught in Module 3.

Module 2

Lesson 2 -Client Rights



Client Rights

Abuse and
Mandatory Reporting

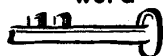
Restraints

Problem Solving

What you will learn in this lesson:

1. Basic state and federal client rights laws.
2. Advance Directives.
3. The Long-Term Care Ombudsman Program.
4. Adult abuse, abandonment, neglect, and financial exploitation.
5. Your responsibility as a mandatory reporter.
6. Understanding the types and risks of restraints and safer alternatives.
7. Problem solving and its importance in caregiving.

key word



Definition

Abandonment	Leaving or deserting a person without a way or ability to care for themselves
Abuse	A willful action or inaction that leads to harm
Confidential	Not revealing any personal information
Grievance	A formal complaint
Incapacitated	Unable to act, respond (e.g. a person unable to make decisions about his/her care)
Mandatory reporter	A person required by law to report suspected abuse, neglect, or financial exploitation of a vulnerable adult
Ombudsman	A person who advocates for the rights of clients in long-term care facilities

A client does not give up his/her basic human rights when they start receiving services or move to a community care setting.

To safeguard these basic freedoms, federal and state “client rights” laws have been established to help make sure a client maintains independence, self-respect, and dignity.

In-home client rights

Federal and state laws give the client the right to:

- be told before services begin that these rights exist and what they are;
- take part in choosing, planning, and changing any services he/she receives;
- voice a ***grievance*** about services or lack of services without fear of punishment;
- have his/her clinical and personal records kept confidential;
- have his/her property treated with respect;
- interpreter/translation services at no cost and without significant delay;
- live free from abuse and physical or chemical restraints;
- an administrative hearing when he/she does not agree with a decision regarding benefits (DSHS clients only).

In addition, clients living in a community care setting, also have the right to:

- choose his/her activities, schedules, health care, clothing, and hairstyle.
- interact with people both inside and outside the facility including family, friends, his/her doctor or other health care providers, or an Ombudsman;
- refuse treatment, medications, or services;
- manage his/her financial affairs;
- send and receive unopened mail;
- access to a telephone and privacy while using it;
- privacy, including within his/her room and during personal care;
- have his/her own personal property (as space permits and where it does not violate the rights, health, or safety of other clients);
- be able to stay at the facility and not be transferred or discharged (unless certain conditions are met);
- examine the most recent survey or inspection reports, including any plans of correction.

Client Rights



■ Client Rights

1. Review content.



2. Ask students to reflect on client rights from a client's position. What might be happening in a client's life that makes these basic rights even more important?

3. Select several rights for both in-home and community care settings.



4. For each right selected, ask students to brainstorm things that happen in "real-life" that can make it challenging for a caregiver to support this right.

5. Brainstorm ways caregivers can deal with the real-life pressure AND support a client's rights in these situations.

Freedom of choice

Freedom of choice is important to most clients. The loss of home, housework, job, strength, and/or health can limit a client's sense of freedom and independence.

Protect and safeguard a client's freedom to choose what and how he/she wants things done.

A client's well-being depends on continuing to make decisions about his/her own daily routines.

The client will have a life long routine for how he/she likes personal care tasks done. Ask about and respect the client's choices. Unless the client asks you to do something inappropriate or unsafe, his/her wishes should be followed.

The client is the person to decide and choose:

- when and how services are delivered;
- when and what to eat;
- when to go to bed and when to get up;
- what clothing to wear and hairstyle (even if it isn't what you would choose);
- how to spend his/her leisure time.



Balancing a Client's Right of Choice and Safety

As a caregiver, you cannot follow your client's choices at all costs. If a client's choice places his/her safety or well-being at risk or somehow could cause harm to others, use the following guidelines.



1. **Explain** to the client why you are concerned.
2. **Offer safe alternatives** that could meet what the client wants and allows the choice to remain his/hers.
3. **Report** your concerns to the appropriate person in your care setting, if you can't negotiate a safe solution.
4. **Document** your concerns, what you did, and who you reported it to.



If you are concerned that a client's actions put him/her in immediate danger to themselves or others, call 911.



■ Balancing a Client's Right of Choice and Safety

1. Review content.
2. Review with students what constitutes "immediate danger" and when it is and is not appropriate to call 911.



The issue of balancing client choice and safety is discussed here and is returned to at several different points of the curriculum. Set a strong foundation.



1. Select one of the following brief situations or make up some of your own.
2. After reading the situation, ask students to volunteer an appropriate response to the client using the steps outlined for balancing choice and safety.

Situation 1: You are working as an Individual Provider for Ann. Ann is unsteady on her feet when she walks. She has a quad cane but doesn't like to use it at home. When walking in the house, Ann grabs and uses the furniture to steady herself. You are afraid she is going to fall.

Situation 2: You are working in an adult family home with Sam who has refused to bathe for several days. Sam is on the schedule to have a shower or bath this morning and again says he doesn't want it. Besides the obvious smell coming from Sam, he has had serious skin problems in the past.

As a caregiver, you come to know very private and **confidential** information about your client.

A client has a legal right to expect that his/her medical, financial, personal matters, and records will be kept private and confidential - unless the information is needed by another care team member. Your professional relationship with a client is based on this right to confidentiality.



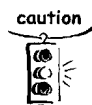
Confidentiality



All care team members are bound by confidentiality laws and professional ethics. When there is a need to share confidential information with other care team members, make sure you:

- share only what is needed and in the best interest of the client;
- do not gossip;
- do not have the discussion in a public area where others may overhear.

Your client has a legal right to their medical, financial, and personal matters and records being kept private.



You may not share confidential information with others outside of the care team without written permission from your client.

If you are asked to share confidential information by someone outside of the care team, tell the person it would be best if he/she asked the client directly. If the person keeps on, explain you cannot talk about the client's private affairs.



Do not talk about a client outside of work - even if you don't use a client's name. Even in casual conversations, a client's privacy can be jeopardized.

In Washington State, all adults have a right to make their own decisions about medical care. The following is a summary of the types of decisions a client can make.

A Client's Right to Make Health Care Decisions

Informed consent

Health care providers are required to give the client enough information to make an informed decision about health care treatments, including:

- the nature of the treatment;
- reasonable alternatives;
- the relevant risks, benefits, and uncertainties related to each alternative.



■ Confidentiality

1. Review content.



2. Select one of the following brief situations below or make up some of your own.

3. After reading the situation, ask the students to offer an appropriate caregiver response to ensure the client's private information is kept confidential.

Situation 1: You are an Individual Provider. One day while you are working, the client's sister is visiting from out of town. She pulls you aside and asks you to fill her in on how her sister is "really" doing.

Situation 2: You are a caregiver working at a boarding home. While walking down the corridor, you see a friend of your client. The friend comes up to you and says, "I hear Mary had a really bad night. Do you think she is getting worse?"

Situation 3: Your shift at an adult family home is about to start and you run in to a co-worker who has been working all day. Your co-worker tells you Joe has been sad because his son did not come for a visit this afternoon. She then goes on to say, "Can you believe the way his son treats him?"

Advance Directives



The right to refuse treatment

A client has a legal right to refuse treatment, medications, or services. As a caregiver, you (or other care team members) cannot force a client to do anything – even if you think it is in his/her best interest.

If you are concerned that a client's refusal of treatment, medications, or services is putting him/her in jeopardy, use the steps found on page 18 for balancing a client's right of choice and safety (explain your concerns, offer safe alternatives, report, and document).

For more information about a client refusing to take medication, see page 190.

Who else can make decisions for a client

There are things a client can do "in advance" to legally make sure others know his/her wishes regarding health care (both physical and/or mental) if he/she becomes unable to make these decisions.

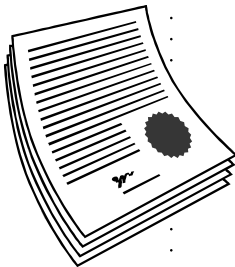


Advance directives:

- help make sure a client's wishes are known and followed;
- take effect when the client loses his/her ability to make decisions or authorizes another person to make decisions;
- can only be made and cancelled by the client.

There are several types of advance directives in Washington State, including:

- Living Wills or Health Care Directives;
- Durable Power of Attorney for Health Care and Power of Attorney;
- Do Not Resuscitate (DNR) or Code/No Code Determination;
- Anatomical gift.



Living Wills

A Living Will is a legal document that outlines a client's desire to receive or withhold life sustaining procedures if he/she is unable to make his/her own decision. Living Wills are written specifically to doctors and other health care professionals where a doctor provides oversight of a client's care.

Durable Power of Attorney for Health Care

A Durable Power of Attorney for Health Care identifies another person (usually a family member or close friend) to make medical decisions for another person. It may include specific treatment instructions the person would want or not want. Depending on how it is written, a Durable Power of Attorney may be active while the person is able to make his/her own decisions or become active (or remain in place) when the person loses the ability to make his/her own health care decisions.

Power of Attorney (POA)

A client may legally identify another person to act on his/her behalf at their direction via a POA. Unlike the Durable Power of Attorney for Health Care already discussed, the POA is no longer active when the client becomes incapacitated.

Do Not Resuscitate (DNR) or Physician Orders for Life-Sustaining Treatment (POLST)

A DNR is a request not to have cardiopulmonary resuscitation (CPR) if a client's heart stops or if he/she stops breathing.

Washington State is implementing the use of the new POLST form to communicate a person's wishes regarding life-sustaining treatment identified in any advanced directives. See the Resource Directory page 216 for a sample of the form. Previously completed and signed EMS-No CPR forms will continue to be honored.

Emergency personnel and advance directives

In an emergency, you need to know if a client has advance directives and where they are located.

If you are an Individual Provider (IP), **you must call 911* even if you know a client has a Living Will, DNR/No Code, or POLST form** that states they don't want life-sustaining treatment. Make sure you know where a client's advance directives are so you can give them to the Emergency Medical Technicians (EMTs) when they arrive. It must be the original - not a copy.

* If a client is receiving hospice services, the hospice plan of care should include who to call in an emergency. It may or may not be 911. This is something to know about and plan for in advance. See page 210 for more information about working with hospice.

If you work in an adult family home or boarding home, there may be another person at your facility designated and specially trained to handle medical emergencies. Find out what policies you are to follow where you work.



Legally incapacitated

A person may be or become **incapacitated** and not have the ability to make health care decisions. This can be the result of an accident, illness, or disability.

If a person is incapacitated, a family member (or a friend, care facility, or case manager) may petition the court to appoint a legal guardian for him/her. After a detailed process and review, the judge signs papers appointing a guardian. Guardians are charged to act on the person's behalf (follow client's wishes for care) and make decisions that reflect the values and needs of the person.



Long-Term Care Ombudsman Program



A guardian may also be appointed to oversee other things besides health care decisions including managing the property, income, and finances of the client. If your client has a guardian, you may need to know how and when to contact him/her. This will depend on the type of guardianship and care setting where you work.

The purpose of the Washington State Long-Term Care Ombudsman Program is to protect the client and promote quality of life for people living in licensed, long-term care facilities.



An *ombudsman*:

1. Advocates for the rights of clients in long-term care facilities.
2. Works with clients, families, and facility staff to meet the needs and concerns of the people living there.
3. Provides a way to get complaints and concerns heard and resolved.
4. Monitors laws, regulations, and policies that affect clients.
5. Provides public education to promote a better understanding about the use of long-term care facilities.

The following people can use the Ombudsman Program:

- clients in an adult family home, boarding home, or nursing home;
- relatives and friends of the client;
- administrators and staff of an adult family home, boarding home, or nursing home;
- any group or individual with concerns about client welfare at an adult family home, boarding home, or nursing home.

For more information or to find your local Ombudsman offices, visit www.ltcop.org or call 1-800-562-6028.

Washington Protection and Advocacy System (WPAS)

WPAS is a federally-funded program mandated to protect the rights of people with disabilities. The WPAS mission is to advance the dignity, equality, and self-determination of people with disabilities. They provide free advocacy services to people with disabilities, including:

- disability rights information and referrals;
- problem solving strategies for disability issues;
- community education and training;
- legal services for disability discrimination or violation of rights.

Contact WPAS at 1-800-562-2702 or visit www.wpas-rights.org.



Check with your local Ombudsman office for any additional resources to use in the class. Many local offices are willing to send a guest speaker to the class or provide booklets or videos that are very helpful to students.

All people share a responsibility to keep vulnerable adults safe from harm. Intentionally harming a vulnerable adult - or causing a vulnerable adult to be afraid of being harmed - is considered **abuse**.

By Washington State Law, a vulnerable adult is a person:

- 60 or older who is not able to care for him/herself because of a functional, mental, or physical disability; or
- 18 or older who:
 - lives in an adult family home, boarding home, or nursing home; or
 - receives personal care services in their own home; or
 - has a developmental disability; or
 - self directs a personal aide to provide care; or
 - is incapacitated.

Abuse



Any adult receiving services is considered a vulnerable adult.

There is no single pattern for what causes abuse or who may be harmed. Abuse happens to men and women from all ethnic backgrounds and social positions. What is known, includes:

- the abuser is often (though not always) a family member or spouse;
- abuse takes place both in private homes and community care settings;
- vulnerable adults who are frail, ill, disabled, or mentally impaired can be at a higher risk.



Families and abuse of a vulnerable adult

Family situations that can contribute to abuse are:

- a history of violence within the family;
- social isolation of the vulnerable adult;
- changes in living situations and relationships;
- a vulnerable adult's growing or continued frailty and/or dependence;
- additional emotional and financial stresses;
- emotional or psychological problems;
- drug or alcohol problems.

Possible signs of abuse

As a caregiver, it is essential that you know and look for possible signs of abuse. It can be one sign or a combination of signs that makes you suspect something is wrong. Use your observation skills and stay alert to what you see and hear.

Watch and/or listen for:

- any sign of a problem;
- what the client is telling you;
- a nagging feeling that something isn't right;
- things that do not have an explainable cause;
- explanations for injuries or behavior that don't seem to make sense.



- **Abuse and Mandatory Reporting**
- **Families and abuse of a vulnerable adult**

1. Review content.



There are many myths and mistruths regarding the patterns and perpetrators of abuse. This section and the information above it was included to increase student awareness of what is currently known.

Caregivers snapping from burnout and harming a client (a common myth) does not account for a significant % of those who abuse vulnerable adults - but it does happen. A caregiver is more likely to abuse a vulnerable adult if he/she is a family member and any of the items listed as things contributing to abuse are present.

Caregiver stress issues will be addressed in Module 11.

Abuse, like any form of violence, is never an acceptable response to any problem.

Different forms of abuse

There are different forms of abuse, including:

Physical abuse -- intentionally causing pain, suffering, and/or injury to a vulnerable adult.

Sexual abuse -- any unwanted sexual contact.

Mental abuse -- intentionally causing mental or emotional pain or distress to another person.

Neglect -- when a person who has responsibility for providing care to a vulnerable adult refuses or fails to provide important basic life necessities or fails to take action to prevent harm or pain to a vulnerable adult.

Financial exploitation -- improperly and/or illegally using or stealing a vulnerable adult's things, property, or money.

Abandonment -- when a person who has responsibility for providing care to a vulnerable adult deserts or leaves him/her without basic life necessities.

Physical Abuse

Examples include slapping, pinching, choking, kicking, shoving, giving medications inappropriately, or using physical restraints.

Signs of



- bruises, black eyes, welts, cuts
- broken or fractured bones
- untreated injuries in various stages of healing
- unexplained injuries
- broken eyeglasses/frames
- sudden change in behavior or unexplained withdrawal from normal activity
- signs of being restrained (bruising or unexplained marks on wrists, rope burn)
- vulnerable adult downplays injuries
- vulnerable adult is reluctant to go to a doctor or changes doctors often
- vulnerable adult reports being harmed

Sexual Abuse

Examples include unwanted touching, rape, sodomy, forced nudity, taking sexually explicit pictures, or sexual harassment.

Signs of



- bruises around the breasts or genital area
- genital infections, vaginal or anal bleeding
- difficulty walking or sitting
- torn, stained, or bloody underclothing
- vulnerable adult refuses to bathe
- vulnerable adult reports being sexually abused

Mental Abuse

Examples include intimidation or threats, ridiculing, harassment, yelling, belittling, swearing, anger, or isolating a vulnerable adult from family, friends, or regular activities.

Signs of



- being emotionally upset, agitated, or anxious
- unusual behaviors (sucking, biting, rocking)
- being extremely withdrawn or fearful
- nervousness around certain people
- depression or nightmares
- vulnerable adult reports being mentally abused

Neglect

Examples include not providing basic items such as food, water, clothing, a safe place to live, medicine, or health care, etc.

Signs of



- untreated injuries, health, or dental problems
- vulnerable adult does not have the right type of clothing for the season
- lack of food
- hazardous, unsanitary, or unsafe living conditions (i.e. no heat, no running water)
- animal or insect infestation
- empty or unmarked medicine bottles or outdated prescriptions
- loss of eyeglasses, dentures, or other assistive devices
- untreated pressure sores
- soiled clothing or bed
- vulnerable adult is dirty or smells of urine or feces
- vulnerable adult reports neglect

Financial Exploitation

Examples include illegally withdrawing money out of another person's account, forging checks, or stealing things out of the house.

Signs of



- putting additional names on bank signature card
- unauthorized ATM withdrawals
- missing checks
- sudden changes of a will or other financial documents
- using or taking a vulnerable adult's property or possessions without permission
- unpaid bills
- telemarketing scams - where trickery, scare tactics, or exaggerated claims are used to get a vulnerable adult to send money
- unexplained transfer of assets to others (e.g. stocks, bonds, deeds, titles)
- sudden appearance of previously uninvolved relatives claiming money and/or possessions
- vulnerable adult reports exploitation

Abandonment

Examples include deserting a vulnerable adult in a public place, leaving a vulnerable adult at home without the means of getting basic life necessities, or a caregiver working in a client's home who quits without notice.

Signs of



- vulnerable adult is left in a public place without the means to care for his/her self
- vulnerable adult is left alone at home and not able to care for his/her self safely
- caregiver does not show up to provide needed care resulting in an unsafe situation for the vulnerable adult
- caregiver quits without notifying case manager, supervisor, the vulnerable adult or the vulnerable adult's contact
- vulnerable adult reports abandonment

Caregivers are among the people that Washington State Law (RCW 74.34) lists as **mandatory reporters** of suspected abuse. The list includes:

- health care professionals and other professional groups;
- individual providers;
- employees of:
 - ◆ boarding homes;
 - ◆ adult family homes;
 - ◆ nursing homes;
 - ◆ home care agencies.

As a caregiver, by law **you are required to report immediately to DSHS if you have reason to believe** a vulnerable adult is being harmed. Your responsibilities as a mandatory reporter continue whether you are at work or not (24-hours a day, 7 days/week) and include **any** vulnerable adult - not just your client(s).

Mandatory Reporting



caution



If you suspect physical or sexual assault, you are also required to report it to law enforcement. If you think a vulnerable adult may be in danger or needs urgent help, **call 911. Then report it to DSHS.**

It is critical that caregivers take their role as mandatory reporters seriously. For every case of abuse reported, national statistics point to as many as four cases that go unreported. This means the majority of vulnerable adults being harmed continue to suffer - often without any way of getting help.

You can't let anything stop you from reporting. If you do, **you are breaking the law** and could be risking someone's life or continued suffering if he/she is being harmed.

If you suspect abuse - report it.

Calling in a report

- You **do not need anyone else's permission** to report (including the client and/or your supervisor).
- You **do not need proof to make a report.**
- If you report in good faith and it turns out there was no abuse, you cannot be blamed or get in trouble.
- Your name will be kept confidential (unless there is a legal proceeding, you give permission to release your name, or where the law requires the release of your name to law enforcement or a licensing agency).
- Your name will not be given out to the client.



■ You can't let anything stop you from reporting

1 . Review some of the common reasons people give for not reporting.

- I am not 100% sure.
- Someone else will call.
- It probably isn't even happening.
- The client will get mad.
- I will get the person in trouble.



2. For each item, have students talk about the reasons this is a common reaction people have.

3. Have students brainstorm what to say to a person in this situation to overcome his/her fear and report the abuse.



It is a gross misdemeanor for a mandatory reporter to knowingly fail to make a report. People **are** being prosecuted for failing to report.

Two divisions within DSHS are responsible for taking reports of suspected abuse of vulnerable adults, Adult Protective Services (APS) and the Complaint Resolution Unit (CRU).

Call Adult Protective Services (APS) if:

- you have reason to believe a vulnerable adult **living in his/her own home** is being abused.

Call the Complaint Resolution Unit (CRU) if:

- you have reason to believe the vulnerable adult **living in an adult family home, boarding home (including assisted living), or nursing home** is being abused.

APS NUMBERS

ADULT PROTECTIVE SERVICES (APS) NUMBERS

Region 1

1-800-459-0421

Spokane, Grant, Okanogan, Adams,
Chelan, Douglas, Lincoln, Ferry,
Stevens, Whitman, and Pend Oreille

Region 2

1-877-389-3013

Yakima, Kittitas, Benton, Franklin,
Walla Walla, Columbia, Garfield, and
Asotin

Region 3

1-800-487-0416

Snohomish, Skagit, Island, San
Juan, and Whatcom

Region 4

206-341-7660

King

Region 5

253-476-7212

Pierce

360-473-2192

Kitsap

Region 6

1-877-734-6277

Thurston, Mason, Lewis, Clallam, Jefferson, Grays
Harbor, Pacific, Wahkiakum, Cowlitz, Skamania,
Klickitat, and Clark

CRU NUMBER

COMPLAINT RESOLUTION UNIT (CRU) NUMBER STATEWIDE

1-800-562-6078

When you report, you will be asked to tell what you know about:

- the name, address, and age of the person you suspect is being harmed;
- what you think is happening, when it started, and if it continues to be a problem;
- who you think is doing the harm;
- the names of anyone else who may have some information about the situation;
- your name, address, and the best time to reach you, so you can be contacted for any questions.

Any form of abuse is a clear sign that the people involved need help - immediately.

Self neglect

A client may refuse or fail to adequately care for his/her own health, well-being, or safety. This is called self-neglect. Self-neglect is often due to a vulnerable adult's declining physical or mental health, isolation, depression, some type of dementia, or drug or alcohol dependency.

Although caregivers are not mandatory reporters of self-neglect, it is encouraged that you:

- be aware and stay alert for signs of it;
- keep the appropriate people in your care setting informed of your concerns;
- call in a report if you suspect a vulnerable adult is self neglecting.

Signs of



Self-neglect

- not enough food or water;
- hazardous, unsafe, or unsanitary living conditions;
- inappropriate and/or inadequate clothing;
- inadequate medical care, not taking prescribed medications properly.

Helping a self-neglecting adult

If appropriate, help the vulnerable adult to:

- figure out what is happening and why;
- make and keep medical appointments;
- get involved in an old hobby;
- attend social functions;
- get other family members or professionals (e.g. a case manager) involved.

Restraints



RCW 70.129.120 states a client has the right to be free from physical and/or chemical restraints in a boarding home or adult family home.

For specific rules about restraints in adult family homes, see WAC 388-76-605.

All individuals have a humane and legal right to live free of restraints.

As a caregiver, there are 3 things you need to understand about restraints:

1. The types of restraints that have been used in the past.
2. The risks associated with using restraints.
3. Safe alternatives to be used with clients instead of restraints.

There were 3 types of restraints used in the past:

- **physical** restraints - anything used to prevent or limit movement or access to one's body;
- **chemical** restraints - drugs not required to treat medical symptoms used to control mood, mental state, or behavior; or
- **environmental** restraints - locked rooms or barriers which confine a person to a specific space.

Examples of physical restraints include:

- a tie, belt, or vest used to keep a client from getting out of a bed or a chair;
- clothing a client cannot independently remove, such as a top that buttons in the back to stop a client from taking it off;
- a reclining or lounge chair, couch, or bed the client can't get out of;
- bed rails that cannot be independently lowered;
- "lap buddies" in a wheelchair.

Other physical restraints can include:

- holding a person's hand down against his/her will;
- a "bear hug" used to restrict a person's movements;
- holding a person's legs or arms to prevent him/her from getting out of bed.

Examples of **chemical restraints**

Any medication or substance (even if prescribed by a doctor) may be a chemical restraint if it is given:

- when there are no symptoms or indications for its use;
- in too large of doses;
- for the convenience of staff;
- without appropriate or enough monitoring.



Examples of environmental restraints include:

- locking someone in a room;
- seclusion rooms.



When do things become a restraint?

Whether or not something is a restraint can depend on the intent of how something is used or done. For example, you have a client who enjoys sitting in his favorite recliner but is unable to get out of it without help.

The chair would **not** be considered a restraint if he was closely monitored while in the chair and a caregiver was readily available to help him when he wants to get out.

The chair could be considered a restraint if a client is put in the chair for the convenience of the caregiver, not monitored, and the client is unable to get out of it when he wants.

Risks associated with restraints

The most common reasons given in the past for using restraints were to prevent injuries or control potentially dangerous behavior. The truth about restraints is they do **NOT**:

- decrease falls or prevent injuries;
- make clients feel more secure and protected;
- prevent lawsuits or malpractice claims; or
- make caregiving more efficient and less worrisome for staff.

The risks of using restraints outweigh the largely unsupported claims of safety.

The **physical risks** of using physical restraints can include:

- increased incontinence and/or chronic constipation;
- pressure sores and other risks of immobility;
- injury or possible death from a client trying to remove or get out of a restraint.

The **emotional risks** of using physical restraints can include:

- increased feelings of hopelessness, fear, depression, anger, and humiliation;
- changes in behavior, mood swings; and
- reduced social contact, loss of independence.

The **risks associated with chemical restraints** can include:

- increased agitation and confusion;
- oversedation (being tired and groggy all the time);
- dizziness, increased risk of falls, and hip fractures.

Restraints must not be used.



3-5 Minutes



■ Beliefs About Restraint Use

Purpose:

- to help identify and correct mistaken beliefs students may have regarding the use of restraints.



1. Ask students to give some examples of times they have seen restraints used. Give your own examples if the students do not come up with any (e.g. to keep the person from falling out of bed, to keep a person from sliding down in a wheelchair).

2. Ask the students to discuss possible reasons the restraints were used (e.g. to prevent the person from injuring him/herself or to stop a problem behavior).



3. Ask students to brainstorm some of the negative outcomes that could happen with the use of restraints in those situations.

4. Have students brainstorm ways to handle the same situations without restraints.

Reinforce:

- any unchallenged beliefs about restraint use needs to be updated with current information;
- the more we have learned about the use of restraints—the stronger the case becomes for never using them.

Alternatives to restraints

Restraints are not the answer. Less restrictive methods are equally effective without the risks associated with the use of restraints. Any thought to restrain a client should instead trigger an investigation and understanding of what is causing the behavior or problem. Care strategies should then be put in place to address the individual needs of the client without the use of restraints.

Some examples of alternatives to restraints are listed below. Depending on the circumstances, you may want to talk with professionals specializing in the development of programs to help resolve specific behavior and/or safety concerns identified.

Examples of physical alternatives include:

- assessment for pain and medications used properly for pain relief;
- massage to soothe and calm an agitated or anxious person;
- use of wheelchairs that are in good working order and correct size.

Examples of activities include:

- structured daily routines;
- walking or pacing in a safe area such as an enclosed courtyard;
- organized physical exercises;
- greater reliance on available family or friends for direct supervision;
- using an activity board that fits on a client's lap;
- music;
- reading.

Examples of environmental modifications include:

- door buzzers;
- bracelet alarms;
- chair alarms;
- signs, yellow barrier tape;
- visual barriers such as large plants (that do not block entrances/exits or in any way cause other safety concerns);
- exit alarms;
- increased or decreased lighting as needed for a client;
- reduced level of noise.



■ **Alternatives to Restraints continued**

1. Review content.
2. Offer one of your own examples of successful alternatives highlighting the positive impact on the client.
3. Ask students to give examples of alternative solutions they have seen or used.

There are four steps used to successfully solve problems, including:

1. Understanding the problem.
2. Brainstorming possible solutions.
3. Picking a solution, planning, and doing it!
4. Getting feedback about how it worked.

By becoming more aware of these steps, you can use them to solve problems that come up at work.

Step #1 – Understanding the problem

What causes you to think there's a problem? Gather information and think about what is happening. Get to the root cause of the problem.

Stop and identify:

- what is happening?
- when is it happening?
- with whom is it happening?
- **why** is it happening?



Use the "Why" technique for getting to the root cause of any problem. Ask "why" the problem exists. Repeat "why" four more times. By the fifth "why" you should be at the root cause of the problem.

Things to remember

- Remain open-minded.
- Be as specific as possible.

Things to avoid

- Trying to solve a problem before having a good understanding of what the problem is.
- Reacting to a problem instead of logically sorting through it.
- Focusing on a symptom of a problem not the cause.

Problem solving with others

Each person involved needs to share his/her perspective and perception of the problem. The goal of this sharing is to reach a common agreement of what the problem is. It works best if the problem is viewed as something to solve together, not a battle to be won. Often, a problem will get redefined or even resolved as it is discussed.

2

Step #2 – Brainstorming possible options/solutions

To get to the best solution consider many possible options. One of the best ways to do this is brainstorming. If the problem involves others, have them involved with brainstorming ideas as well. Come up with as many solutions as possible. Even silly ideas can be the seeds of a great solution.



The problem solving model was included at the end of this module to reinforce the importance of problem solving in potential abuse situations.

Set a good foundation. The importance of problem solving in caregiving will be stressed throughout the remainder of the course.

3

Things to remember

- Be creative when coming up with your options.
- Don't stop with the first couple of options - keep thinking.
- Respect all ideas. This is not the time to evaluate them.

Things to avoid

- Only using the more obvious solutions; not being creative.
- Only thinking of a one or two options.

Step #3 – Picking a solution/option, planning, and doing it!

Look at the positives and negatives of each option before making a decision. Pick what you think is the best option and plan out how you are going to do it. It may be that the best choice is obvious or that you will have to decide which solution has the best chance of solving the problem.

Things to remember

- Think about the resources you have available (time, money, desire of others, energy it will take to get it done).
- Think through how the plan and solution will affect other people.
- The client's preferences and needs.

Things to avoid

- Selecting the easiest solution because it is the easiest.
- Not thinking about the outcome of the plan and solution.
- Not thinking through all of the steps.

Problem solving with others

When solving a problem involves other people, agree on what criteria will be used to decide which solution to try. This could include taking a vote and letting the majority rule, agreeing the entire group must reach consensus, evaluating and rating each idea against a set list of criteria, or even tossing a coin.

Pick an option/solution that is fair and beneficial to everyone and focuses on the best solution. This will help the group avoid a contest of wills where the strongest person wins. Make sure everyone is clear about what steps or actions he/she needs to take to resolve the problem. Each person needs to be committed to taking these actions.

4

Step #4 – Getting feedback

The final step of problem solving involves getting feedback. Ask yourself and the people involved how the solution is working. If changes need to be made, look at the brainstormed options and try a different solution.

Things to avoid

- Assuming the problem will always stay solved once the plan is put in to action.



1. True ☒ False A client's doctor is responsible for making any changes to the client's care plan.
2. ☒ True False A possible sign of neglect could include a vulnerable adult living in unsafe or unsanitary living conditions.
3. A client has a legal right to: (circle the correct answer)
 - a. Tell a caregiver what to wear.
 - b. Wear another person's clothing.
 - c. **Choose what to wear.**
4. When is a caregiver mandated to report abuse of a vulnerable adult? (Circle the correct answer).
 - a. **Any time the caregiver suspects abuse.**
 - b. After getting his/her supervisor's permission.
 - c. After getting the client's permission.
5. When confidential information must be shared with **other care team members** about a client, you must: (circle the correct answer)
 - a. Get the client's written permission before you do so.
 - b. **Only share what is needed and in the client's best interest.**
 - c. Only talk about it outside of the work setting.
6. True ☒ False Caregivers can make a client take his/her medications if it's life-threatening not to do so.
7. There is a medical emergency, 911 has been called, and your client has advance directives. Individual providers must: (circle the correct answer)
 - a. **Give them to the EMT when they arrive.**
 - b. Only give them to the EMTs if they ask for them.
 - c. Give them to the EMTs if they remember to.

8. Put the number of the correct definition next to the term it defines.

Term	Definition
<u>2</u> Financial exploitation	1. Intentionally causing pain, suffering, and/or injury to a vulnerable adult
<u>3</u> Abandonment	2. Using or stealing a vulnerable adult's things, property, or money
<u>4</u> Neglect	3. A person who has responsibility for providing care deserting or leaving a vulnerable adult without basic life necessities
<u>1</u> Abuse	4. Failing to provide important basic life necessities or taking action to prevent harm or pain

■ Module Review



20 Minutes

1. Explain to students the **purpose** of the Module Reviews.
 - A tool to help make sure everyone understands the material and to determine where further work is needed.
 - Highlights and reinforces the major points in each module.
 - Familiarizes students with the testing format – easing test anxiety and helping them prepare for the written test.
2. Explain to students how to complete a Module Review.



See page Intro-5 of the *Course Structure and Teaching Techniques* for detailed instructions on completing a Module Review.

The Client and Client Rights module has the largest number of Module Review questions. This module covers a lot of important information and a significant number of learning outcomes. Since the Module Review is new to students, it also takes them a bit longer. The rest of the Module Reviews are shorter.

9. Since Mr. Rogers hired another caregiver a month ago, he has given her \$800 to fix her car, \$725 for a dental crown, and has "misplaced" his checkbook. What should you do? (Circle the correct answer).
- a. **Call and report it to DSHS.**
 - b. Talk to the new caregiver about it.
 - c. Call Mr. Roger's family and tell them.
10. A client asks you to do something you feel puts his/her safety at risk. You should: (Circle the correct answer)
- a. **Explain why you are concerned and offer a safer alternative.**
 - b. Tell the client you won't do it and politely walk away.
 - c. Do what the client asks without questioning it.
11. Mr. Stevens has Alzheimer's disease and continually finds ways to get outside and wander off. You should: (Circle the correct answer)
- a. Block him from the door when you see him go near it.
 - b. **Encourage the use of an exit alarm where he lives.**
 - c. Let him go. He has the right to do what he wants.
12. ☒ True ☐ False A possible sign of physical abuse could include a vulnerable adult with a suspicious injury refusing to see a doctor.
13. True ☒ False Restraints should be used to keep a client from falling out of bed.

Do not do the exercise until directed by your instructor.



Mrs. Jones is a 78 year old client with Dementia and Chronic Obstructive Pulmonary Disease (COPD). She has difficulty understanding why she needs to use her oxygen tank and pulls out her tubes several times daily. She is usually cooperative when caregivers re-insert the tubes. Today, when Michael, another caregiver at the boarding home, goes to assist her, she looks away, cries, and screams that she doesn't want him near her.

Understanding the problem

What causes you to think there's a problem? Remember to think about:

- what is happening
- when it is happening
- with whom is it happening
- why it is happening.

In one sentence, describe what you think the problem is that needs to be solved.



Problem Solving and Mandatory Reporting



15-20 Minutes

Purpose:

- to highlight the importance of understanding a problem before trying to solve it;
- to reinforce the complexity and importance of staying alert to signs of abuse.

1. **Divide students into pairs** and tell them to:
 - read through the exercise, and
 - the information on page 303 on Dementia and and page 302 on COPD.
2. Tell pairs to discuss the “what, when, with whom, and why” questions. After a brief discussion (2-3 minutes), they should agree on and write down a one sentence description of the problem.
3. Have the teams share their sentence description of the problem explaining the “what, when, with whom, and why” they used to come to an understanding of the problem. Write these on the board or flip chart.



Let the students know there isn't one “right” answer. The students will come up with a variety of potential issues - all of which may or may not be true. Is there really enough information to know what is going on with Mrs. Jones? There may be many explanations for her behavior, including possible abuse by Michael.

Reinforce that it is important to have a good understanding of a problem and gather sufficient information before attempting to solve situations that arise in caregiving.

Relating it back to abuse and mandatory reporting

Relate these issues and concerns to the topic of abuse and mandatory reporting.

- Q:** Did any group question whether to report possible abuse?
- Q:** What signs may cause a caregiver to have reason to believe abuse may be happening?
- Q:** What information would you report in this case if you did suspect abuse?



Module 3

The Caregiver

Lesson 1

The Caregiver



1 Hour 30 Minutes

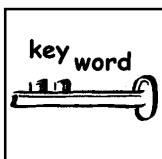
10 Minutes - Module Review

Personal Care Skills Covered

None



Icons to help guide you



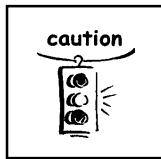
A word to remember



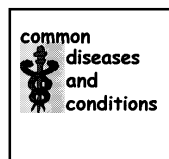
Something to report



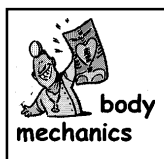
See the Resource Directory



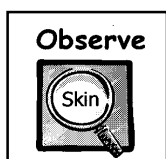
Beware or be careful



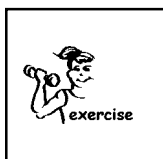
See the Common Diseases section



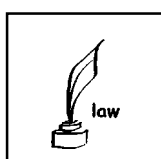
Use proper body mechanics



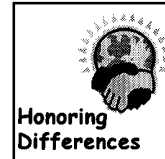
Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 3 - Lesson 1

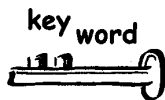


The Caregiver

Basic Job Responsibilities

What you will learn in this module:

1. A caregiver's basic job responsibilities.
2. Benefits for the caregiver and client in having a caregiver available.
3. Using the DSHS care plan to understand your basic job responsibilities.
4. The importance of respecting a client's need for privacy and dignity, and supporting a client's independence.
5. How to document and report changes in a client's condition.
6. Responding to emergencies.



Definition

Activities of daily living (ADL)	Everyday personal care activities
Advocating	To speak up or take action
Assessment Details	A section of a DSHS care plan that describes the client's strengths, limitations, and care task preferences, and provides specific caregiver instructions
Baseline	What is "normal" for a client at a certain point in time
Cultural background	The attitudes and behavior characteristics of a particular social group or organization
Instrumental activities of daily living (IADL)	Routine tasks performed around the home or in the community
Professional	Exhibiting a courteous, conscientious, and businesslike manner in the workplace
Professional boundaries	Appropriate limits in a job relationship
Service Summary	A section of a DSHS care plan that documents contact information, caregivers' schedules, and the client's goals

The role of the caregiver is full of challenges and rewards. There will be few other jobs in your lifetime where what you do so dramatically impacts another human being. The many positive benefits of caregiving include:

- feelings of positive self-worth, purpose, and meaning;
- confidence that a client is getting the best care;
- pride in successfully coping with difficult life situations;
- feeling closer to another person as a result of helping;
- increased patience and inner strength;
- a stronger sense of who you are and enjoyment out of life.



The Caregiver

See the Resource Directory page 215 for more information on a caregiver's role in different care settings.



How a client benefits from having a caregiver

As a caregiver, you support a client's ability to live as independently and safely as possible. You support a client's:

- social, physical, and emotional well-being;
- ability to have choice and control over his/her environment;
- ability to have control over decisions about what services he/she receives, when, and how services are given.

Your **4 basic job responsibilities** as a caregiver are to:

- 1. Provide personal care**, including:
 - understanding how a client wants things done and doing tasks that way;
 - honoring a client's privacy and dignity;
 - encouraging a client's independence;
 - honoring a client's differences.
- 2. Know, take pride in, and perform your role as a member of the care team**, including:
 - observing changes in a client's physical, emotional, and mental health.
 - knowing when and what to document and/or report to the appropriate care team member(s).
- 3. Follow a high standard of professional conduct.**
- 4. Respond to day-to-day situations and emergencies** without supervision (if necessary).

Basic Job Responsibilities

A caregiver provides personal care, support, and assistance to another person.

■ **Basic Job Responsibilities**

1. Review each of the 4 caregiver responsibilities highlighting for each item:
 - why this is important for the client;
 - why this is important to them as a caregiver.



Reinforce that these 4 basic job responsibilities are a caregiver's "job description".

Providing Personal Care



Basic job responsibility

1

In this course, we have used care plan to represent anything that documents a client's plan of care.



Understanding and using a care plan

A care plan outlines your caregiving responsibilities. The DSHS plan of care (care plan)* is made up of two sections: the **Service Summary** and the **Assessment Details**.

* This section is written for caregivers using the DSHS care plan. Caregivers providing care for non state-funded clients should refer to the boarding home or adult family home care plan.

The Service Summary of a DSHS care plan gives you an overview of your caregiver responsibilities and what you and other members of the care team will be providing to support the client. The Service Summary also has contact information for other care team members, a list of any advance directives a client may have, and any other people involved in making decisions for a client.

In the Assessment Details, a case manager will document the client's needs, strengths, limitations, preferences, any special equipment necessary, and specific caregiver instructions for each needed task. Many tasks also include a section with specific instructions containing "Do's and Don'ts" for the caregiver. Read through everything carefully.

The types of services you may see in a DSHS care plan

The type of personal care services a client receives will vary depending on where the client lives, the services he/she needs, and what the client is financially eligible to receive.

Activities of Daily Living (ADLs) a client may need help with include:

Bathing: taking a full-body bath/shower, sponge bath, or transferring in/out of tub/shower.

Bed mobility: moving to and from a lying position, turning side to side, and positioning his/her body while in bed.

Body care: passive range of motion, applications of dressings and ointments or lotions to the body, pedicure to trim toenails and apply lotion to feet. Body care excludes foot care for clients who are diabetic or have poor circulation and changing bandages or dressings when sterile procedures are required.

Dressing: putting on, fastening, and taking off all items of clothing, including a prosthesis.

Eating: eating and drinking, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

Locomotion in room and immediate living environment: moving between locations in a room and immediate living environment.

Locomotion outside of immediate living environment, including outdoors: moving to, and returning from, more distant areas. Locomotion outside immediate living environment includes moving to and returning from a patio or porch, backyard, the mailbox, or the next-door neighbor, etc.

Medication management: the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

Toilet use: using the toilet room, commode, bedpan, or urinal, transferring on/off toilet, cleansing, changing pad, managing an ostomy or catheter, and adjusting clothes.

Transfer: moving between surfaces, e.g. to/from bed, chair, wheelchair, standing position.

Personal hygiene: maintaining personal hygiene, including combing hair, brushing teeth, applying makeup, washing/drying face, hands, menses care, and perineum.

Instrumental activities of daily living

Instrumental activities of daily living (IADLs) your client may need help with include:

Meal preparation: preparing meals (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals).

Ordinary housework: performing ordinary work around the house (e.g., doing dishes, dusting, making bed, tidying up, laundry).

Essential shopping: shopping to meet a client's health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for his/her health, maintenance, or well-being. This includes shopping with or for a client.

Wood supply: supplying wood (e.g., splitting, stacking, or carrying wood) when the client uses wood as the sole source of fuel for heating and/or cooking.

Travel to medical services: traveling by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment. This includes a client driving a vehicle or traveling as a passenger in a car, bus, or taxi.

Managing finances: paying bills, balancing a checkbook, managing household expenses. Although you may see this listed on a DSHS care plan, this task is normally done by family or friends of the client. DSHS does not pay caregivers to assist with managing finances except for clients of the Division of Developmental Disabilities (DDD).

Telephone use: receiving or making telephone calls, including the use of assistive devices such as large numbers on telephone, amplification as needed.

key word





The following scale is used by a case manager to communicate the client's ability to complete each personal care task.

Independent: no help or supervision required.

Supervision: oversight of client required (monitoring, encouragement or cueing).

Limited Assistance: client is highly involved in the task, but needs some physical help in guided maneuvering of limbs or other non-weight bearing assistance.

Extensive Assistance: client requires weight bearing or full assistance from caregiver during **part** of task.

Total Dependence: client requires caregiver to do all of the task.



See pages 218-235 in the Resource Directory to see a sample DSHS care plan.

Care settings and care plans

Individual Providers (IPs) should receive a copy of the DSHS care plan. If you are an IP and do not have a copy, ask your employer (the client) or call the case manager.

If you work for a home care agency, the full care plan is normally kept at the home office. Many home care agency caregivers receive part of the care plan or a list of their assigned personal care tasks.

Adult family home and boarding homes with DSHS clients use the DSHS care plan as a starting point for developing their own negotiated service agreement or negotiated care plan.

This negotiated care plan has more details about the client's care preferences. This negotiated care plan is what caregivers normally see and may be kept in a notebook or as part of the client's records.



See page 236 in the Resource Directory to see a sample negotiated care plan.

Understanding client preferences

No care plan has all the details you will need to do your job. You still need to talk with the client about EACH task you are assigned to do.





Care Plans

Purpose:

- To highlight for students the important types of information available in a care plan and how to use it to understand their job.



5 Minutes



Please remember the DSHS training certificate covers all care settings. Students should leave the training understanding there are a variety of different care plans they might see and the major types of information they will need to know from it and use.

IPs need to have a solid understanding of the DSHS care plan and what to look for and use.

Reviewing the Assessment Details

1. Have students turn to the Resource Directory pages 218.
2. Ask students to look through the care plan and find:
 - the client's diagnosis (page 219)
 - What types of medication assistance the client needs (page 220)
 - What ADLs the client needs assistance with (pages 221-229)
 - Specific skin care instructions Do's and Dont's and when to report (page 228)
3. Ask students to look on page 227 and review each section with them through page 229.

This section gives a good overview of all of the types of information caregivers need to read and understand from a care plan about ADLs.

Reviewing the Service Summary

1. Ask students to look through pages 233-235 and find:
 - The emergency contact (page 233)
 - Who the informal provider is (page 233)
 - What the assigned task for the informal provider is (page 233).
2. Have students turn to page 236 and look briefly at the negotiated plan of care.



Remind students that the care plan is different for each client and depends on his/her care needs. The page numbers listed in this sample relate only to this example.

Follow up

Periodically, go back and make sure care tasks are still being done the way the client wants them to be. By asking again, you make sure you understand the client's current wishes and keep doing the tasks the way that works for him/her.



Clients who have trouble speaking, can't speak at all, or have other ways of communicating (e.g. sign language, assistive devices, gestures) still have preferences that are important to understand.



Depending on where you work, the case manager or supervisor is a good resource to talk with about how best to communicate directly with the client. If a client is unable to communicate at all, a family member or friend will be authorized as the client's contact and can give you more detailed information. His/her name and telephone number is listed in the Service Summary. There will also be information in the Assessment Details regarding communication with that client.

Knowing what your caregiver job isn't

The client or a family member may ask you to do things that are not on the care plan (e.g. lawn care or cleaning up after others in the house). Say "no" to these requests. Do so nicely. If the client continues to expect you to do something not on the care plan, encourage him/her to talk with the DSHS case manager or your supervisor. Tasks need to be listed in the care plan before you can do them.

How you provide personal care requires great sensitivity and understanding. The term "personal" is a reminder that you are helping with tasks that are normally done in private.

View your caregiving role from a client's perspective. Most people would prefer to wash, groom, and care for themselves. Needing help with personal care can make a client feel a variety of very vulnerable emotions. A client may:

- feel uncomfortable having anyone, especially a stranger, help with these tasks;
- not want to talk about "private" things;
- feel his/her independence and sense of self-worth is threatened.

Privacy

One way to be sensitive to a client is to honor his/her privacy when you perform any personal care. Always:

- close windows, curtains, and doors;
- knock before entering a room with a closed door;
- keep the client's body covered;
- provide privacy for a client to do as much self-care as possible.

Respecting a Client's Privacy and Independence

■ Respecting a Client's Privacy and Independence

1. Review content.



2. Discuss what needing help with personal care can be like for a client.

Ask:

Q: How easy is it for you to ask for help?

Q: What are some of the emotions that come up when you HAVE to have someone do something for you?

Q: How easy would it be to ask a stranger/family member to do something for you?

Q: What are some of the reasons it can be uncomfortable for a client to have someone help with personal care?

Q: How might this impact a client's need for respect for his/her privacy and independence?

Supporting other forms of privacy

Everyone needs private time to think and deal with problems, losses, or simply to enjoy a quiet moment.

- Respect a client's need to get away. Be sensitive to a client's emotional need for privacy or quiet solitude.
- Make sure the client has privacy when visiting or talking on the phone with family and friends or reading his/her mail.



Support a client's independence

Anything that helps a client maintain mobility, social connections, and feelings of self-worth, can be physically and emotionally therapeutic. Find ways to support the client's independence as much as possible, including:

- allowing the client a chance to do things him/herself as much as possible.
- being patient. Do not rush or let getting your "work done" take priority over supporting a client's independence.
- encouraging the client to make little steps so he/she doesn't get discouraged.
- providing plenty of encouragement and positive feedback.
- encouraging the use of any assistive device(s).



Honoring Differences



- **Supporting other forms of privacy**
- **Support a client's independence**



1. Ask students to brainstorm any additional ways they can think of to honor a client's privacy.
2. Ask students to brainstorm any "real-life" issues that come up that may stop a caregiver from remembering this important aspect of providing care.
3. Ask students to discuss ways they can remember to honor a client's privacy.
4. Use the same process for supporting a client's independence.



2 Minutes



Honoring Differences

Purpose:

- To demonstrate that our life experiences, values, and beliefs influence how we view other people and impacts our interactions;
 - To reinforce the need to see past our assumptions and appreciate the uniqueness of each person.
1. Direct students to look at the pictures in the exercise on page 46. Ask them to consider the following questions and answer them silently to themselves:
 - Is this person ... happy/sad?
 educated?
 healthy/ill?
 married/single?
 - Do they speak another language?
 - What is their job?
 - Were they born in the U.S.?
 2. Tell students that you will re-visit the exercise after the lecture.

Each person is a unique and worthwhile individual. This uniqueness comes from a lifetime of experiences influenced by such things as his/her:

- **cultural background;**
- religious upbringing and beliefs;
- gender;
- sexual orientation and/or marital status;
- economic status;
- social groups;
- physical, mental, and/or sensory disability.

All of these factors combine and influence:

- how a person sees the world;
- what he/she believes in and values;
- what he/she considers acceptable ways to look and act;
- what he/she considers "normal".

Bias

Your reactions and feelings towards others - especially those different from what you consider "normal" - happen automatically based on beliefs and values learned from your own upbringing (culture). Hidden biases can influence how you talk, look at, and do things for a client.

It is important to be aware of and question how your beliefs and values impact your dealings with others. Differences are neither good nor bad. It is how you react to them that is the key.

Stay alert for signs that unquestioned biases are impacting your actions with a client, including:

- negative judgments about a client's choices, lifestyle, etc.;
- viewing a client's cultural preferences as unimportant;
- being impatient or not open-minded about a client's needs;
- making jokes or fun of a client.

Just as you may have hidden biases, clients may as well. These biases may influence how he/she talks, looks at, and responds to you as a caregiver. You have a right to be treated respectfully, too.

See page 266 of the Resource Directory for some tips on how to communicate effectively if you feel you are being treated disrespectfully.

Getting to know a client

When another person is viewed as different, we tend to stress the differences and overlook the similarities. Differences can also create bridges and other worlds to explore.

Honoring Differences

key word
1.1.1





■ Honoring Differences

1. Review content.
2. Tell students to reflect back on the Honoring Differences exercise on page 44.
3. Share the following information with the class:

The Woman:

76 years old
Retired physician
Very healthy
Single all her life
Speaks one language
Born in Germany

The Man:

53 years old
Unemployed
Very healthy
Widowed
Speaks two languages
Born in the U.S.



Ask:

Q: How many of your answers were “right?”

Q: What assumptions did you make?

Q: How did you come to these assumptions?

Q: Do we normally take the time to test the assumptions we are making about other people?
Should we?

Q: How aware are you in everyday life to making assumptions about others?

Q: What kinds of problems can arise when we aren’t aware of the assumptions we make about clients? Do clients make assumptions about caregivers?



Use the last two questions to lead to covering the topic of “bias”.

■ Bias

1. Review content.
2. Read out loud the following statement that appears in the Learner’s Guide.

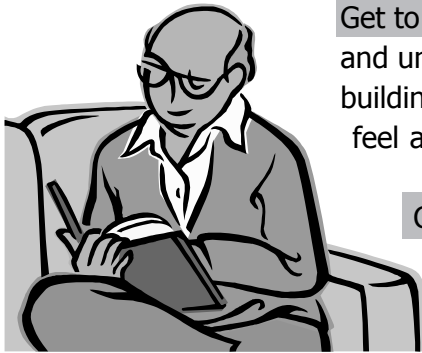
“Differences are neither good nor bad. It is how you react to them that is the key.”



3. Have students brainstorm the types of ways people react to differences.

Q: What are some things that lead people to react in these ways? (e.g. fear, insecurity, not being aware of their biases)

4. Have students brainstorm ways they can learn to be more open and aware of reacting to differences.



Get to know your client as a unique individual. A genuine effort to learn about and understand another person with an open mind goes a long way towards building trust and respect. It will also have a real impact towards making a client feel appreciated and accepted.

Getting to know a client also tells you what he/she considers respectful and appropriate behavior. This helps you avoid unintentionally offending a client or other misunderstandings - especially when you first begin working together.

To learn more about your client, ask questions of other care team members and pay attention to any clues from how he/she acts, dresses, relates to others, and/or items of importance displayed in his/her room or home.

You can also ask questions of the client directly. Be aware that a client may have a different view of what types of questions are respectful and appropriate.



Caregiver as Part of a Care Team

2

Basic job responsibility

Observing changes



As a caregiver, you are an important part of the care team. Caregivers often spend more time with a client than other care team members and are better able to observe day-to-day changes.

Two important caregiver roles in a care team are to:

1. Watch for changes in a client's physical, emotional, and mental health.
2. Know when and what to document and report to the appropriate care team member(s).

To effectively observe changes in a client, compare what you know of the client's **baseline** to what you currently see. A baseline is often called a client's customary range of functioning. Good sources of baseline information include the client, the client's care plan, other care team members, and a client's health care provider.

Make **regular observations** a part of your routine and get to know the client. Stay alert and pay attention to any change in a client's baseline. Changes can include an improvement or a decline in a client's condition.

- Listen to what the client tells you about how he/she is feeling or any pain being reported. Allow the client to complete what they have to say.
- Use your senses when observing a client (sight, hearing, smell, and touch), as well as your intuition or "gut".

See the next page for the types of changes to look for in a client.

What you see	<p>Physical changes</p> <ul style="list-style-type: none"> • Skin change (color, rashes, open areas) • Swelling of extremities • Marked changes in activity level • Decline in a client's ability to do tasks <p>Mobility</p> <ul style="list-style-type: none"> • Change in how client moves (e.g. leans to one side, ability to stand, more unsteady on feet) • Begins to limp or bumps into things • Falls or injuries <p>Ability to breathe</p> <ul style="list-style-type: none"> • Short of breath, gasping for air, difficulty talking • Breathing is slow or rapid <p>Appearance</p> <ul style="list-style-type: none"> • Change in hygiene habits or physical appearance • Unkempt or dirty clothing • Appears anxious, tense, afraid, or depressed • Change in level of consciousness <p>Bathroom habits</p> <ul style="list-style-type: none"> • Constipation or diarrhea • Frequent urination or urine of strange color • Not urinating after drinking • Urine or blood stains <p>Eating</p> <ul style="list-style-type: none"> • Increase or decrease in appetite • Losing/gaining weight - clothing or belts loose or tight • Any indication a client is not eating or has difficulty eating • Difficulty with swallowing
What you hear	<ul style="list-style-type: none"> • Coughing, noisy breathing • Crying, moaning • Talking to self or objects or others not in the room • Slurred speech, difficulty speaking or finding words • Client tells you about a change he/she is having • Client talks of loneliness and/or suicide
What you feel/ touch	<ul style="list-style-type: none"> • Skin temperature and moisture • Bumps or lumps under skin
What you smell	<ul style="list-style-type: none"> • Bad breath • Unusual odor from urine or stool • Odor from cut or sore

■ Observing changes

1. Review several examples from each category of the types of changes a caregiver should look for.
For each example, highlight:
 - the need to use all of your senses to observe changes.
 - why and what a caregiver might need to know about a client's disease/condition as it relates to these symptoms.
 - how to relate the change to baseline and determine when something is significant to report.



■ Be a people watcher

Optional



Assign steps 1-4 below before a break when students will be out of the classroom.

1. Have class break into teams of 3-5 people. Each team is to decide on a person or group of people they wish to observe for a period of 1-2 minutes (e.g. out a window in the classroom, a grocery store, mall, a busy street, a facility).

The rules of the exercise are:

- the person(s) being observed are not to know they are being watched or disturbed in any way.
 - students should not discuss their observations with other team members.
2. Once the observation is complete, students are to take 1-2 minutes and write down what they observed. This should be as soon as they can after making their observations.
 3. Once each team member has had a chance to write down their observations, ask team members to:
 - share with each other their observations and compare notes;
 - identify what they saw in common and what they saw differently.
 4. Ask:



Q. Did students see different things?

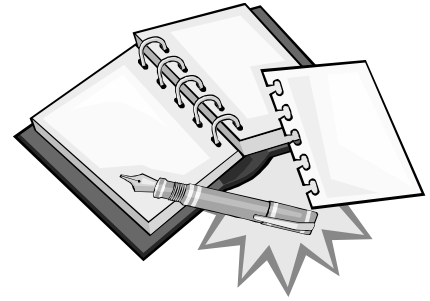
Q. (assuming they did) What are some of the reasons each person saw something different?

Q. How does this impact the need to write observations objectively?

Documenting Observations

Documenting is keeping a written record of any changes or concerns about a client, including a:

- change in a client's condition or baseline;
- sign or symptom of possible importance;
- concern about a client's behavior or a specific incident or event.



Having a written record helps you:

- see patterns of changes;
- remember details that could be important to another care team member;
- give more accurate information;
- not rely solely on your memory.

Care settings and documentation

The kind of documentation that you do depends on where you work.

For in-home workers, no documentation is officially required unless you are doing nurse delegated tasks. However, it is highly recommended that you keep a log in a notebook of your observations.

If you work in a boarding home or an adult family home, there are specific procedures on how, when, and what you are to document. Make sure you understand your responsibilities regarding documentation.

Objective versus subjective documenting

What you document should be objective. To document objectively means you write down the facts exactly as you observed or noticed them with your senses. The goal is to describe the specific behavior or changes you observed about the client and/or his/her mood. Your documentation should also include the facts as the client described them to you. When documenting something the client has told you, write down the client's exact words.

Subjective documenting means you write down your opinion or interpretation of what you observed. Opinions are less useful in documentation because biases and emotions can influence how you interpret what you see. You may not have all of the facts, the medical knowledge, or an understanding of what the client is experiencing. For these reasons, **subjective documentation should be avoided.**

There may be times when you are asked to give your opinion about a change or observation. If you are asked for your subjective opinion about a client, always start with the objective facts that led to your conclusion.



Objective documentation



3-5 Minutes

Purpose:

- to give students practice identifying the difference between objective and subjective observation and documentation.
1. Write the following pairs of statements (or use your own) up on the board or read them out loud. Have students decide which sentence is objective and which is subjective.
 2. For the subjective sentences, ask the students to volunteer suggestions for how the behavior could be described more objectively. An example of a more objective statement is listed after the statements in parenthesis.

Mrs. Smith was very upset today. (subjective)
Mrs. Smith spoke in a loud voice. (objective)
(Mrs. Smith said she was sad and disappointed that her daughter didn't visit today.)

Mr. Smith said he has a headache. (objective)
Mr. Smith appeared ill. (subjective)
(Mr. Smith felt warm when I touched his forehead.)

Mrs. Smith called me by her daughter's name today. (objective)
Mrs. Smith seemed confused. (subjective)
(Mrs. Smith asked the same question three times within 5 minutes.)

Mr. Smith was drunk today. (subjective)
Observed two empty scotch bottles in Mr. Smith's room. (objective)
(Mr. Smith smelled of alcohol and his speech was slurred.)

Documentation guidelines

- Set aside a specific time for writing notes. A regular routine helps ensure that your observations are documented promptly and the information is accurate.
- Make sure your handwriting is readable and use a blue or black pen.
- Make sure your notes are complete. Include the date and time of when you are documenting your observations and sign your notes.
- Address the following information:



WHEN... date and time you observed the change, behavior, or incident.

WHAT... happened - writing down the objective facts.

WHERE... you observed this happening.

HOW... long and often it happened.

WHO... was present, involved, or notified about what was happening.

WHAT... action you took and the outcome.

Poor documentation example

Monday afternoon. Yelling in bathroom. Trapped herself in and is really angry.

Good documentation example

10/11/04, 4:30 P.M. Heard Mrs. Smith in the bathroom yelling "Let me out". Found Mrs. Smith's bathroom door locked. Used key to unlock the door. Mrs. Smith said she was scared about being locked in the bathroom.

Signed Ms. Careful Caregiver

The documentation in the last example gives a complete, factual picture of what happened. The caregiver wrote what she observed and heard, what Mrs. Smith said about her situation, and what she did to respond. The documentation is also dated and signed.

There comes a point where a change in a client's baseline, or other concerns you may have, need to be reported to the appropriate person in your care setting.

For in-home clients, report changes to the case manager. If you work in a boarding home or an adult family home, there will be communication procedures on how, when, what, and to whom you are to report. If these procedures are unclear to you, ask your supervisor to explain them.

Reporting

Reporting Guidelines



The following are some guidelines for when to report to the client's case manager or your supervisor. Use any documentation notes you have to report what you observed. Document afterwards what you have reported and to whom.

- You have worries or questions about changes in a client's condition.
- The client develops a new problem and has personal care needs that are not being met.
- The client is getting better and no longer needs help with some of the tasks you are doing.
- You have suggestions or know of additional resources that would add to a client's quality of care or independence.
- You are unable or uncomfortable doing the tasks outlined in the care plan.
- You are asked to perform tasks **not** outlined in the care plan and cannot resolve this with the client.
- The client continues to refuse services.

Professional Conduct



How you present yourself is your statement about who you are to others. See below for a list of important qualities of being a **professional** caregiver.

Basic job responsibility

3

Professional

- Demonstrate integrity in word and action
- Take pride in doing the best job possible
- Continually strive to learn and improve
- Stay focused on what has to be done and getting it done
- Be a positive, flexible, team player
- Be responsible
- Communicate clearly and openly
- Leave your personal problems at home
- Do not make private arrangements with clients for services
- Maintain professional boundaries
- Do not accept tips, borrow, or lend money
- Do not use the client's phone for personal calls

Respectful

- Be polite
- Listen
- Honor and place value in a person
- Call a client by name
- Keep things private
- Provide choice and privacy
- Use appropriate language

Reliable

- Show up to work on-time – all the time
- Do what you say you are going to do
- Set realistic expectations of what you can do
- Organize your time to complete all necessary tasks



Remind students that when they see this icon, there is something that needs to be reported to the appropriate person in his/her care setting.

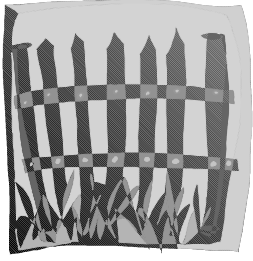


■ Professional Conduct

1. Review content.
2. Review several of the bulleted items listed under each category.



3. Ask the students to brainstorm consequences of not acting in this manner in their:
 - relationship with the client;
 - relationship with other care team members; and
 - sense of accomplishment and self-worth.



Professional boundaries include setting and maintaining appropriate limits in your relationship with a client. Just as good fences make good neighbors, clear professional boundaries allow for a safe, trusting, and ethical connection between you and a client.

Professional Boundaries key word

Setting clear boundaries as a caregiver helps you:

- manage your relationship with a client and other care team members;
- keep a healthy physical and emotional distance between you and a client;
- keep your identity as a caregiver clear;
- know what, how, and when to allow others into your personal space.

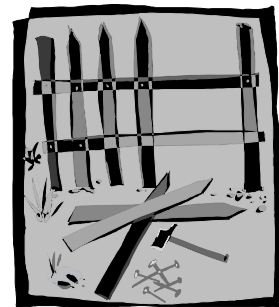
Many caregivers find it hard to keep the boundaries of a professional relationship with a client. This can happen because caregivers:

- are people who like helping others and find it difficult to say “no”;
- enter into very private aspects of a client’s life;
- work in a home or other home-like residential setting;
- can become emotionally attached to a client as “family-like” bonds develop.

Warning signs

Not having professional boundaries between you and a client interferes with your ability to provide quality care. Some of the warning signs that professional boundaries may be in question include:

- frequently thinking about the client away from work;
- spending your free time with a client;
- sharing personal information or work concerns with a client;
- giving special attention to one client over another;
- keeping secrets with a client;
- taking gifts or money from a client;
- giving a client your home telephone number.



Maintaining a healthy, professional boundary

The best way to maintain a healthy, professional boundary between you and a client is to view caregiving as your job. Viewing caregiving as a job helps you create a needed balance between your work and home life. Having a variety of interests and relationships outside of work is also important.

A family member or close friend employed as an Individual Provider has different challenges in establishing a “professional” relationship with a client. See the Resource Directory page 237 for more tips and information on establishing a working relationship as a family caregiver.

See the Resource Directory page 239 for tips on maintaining positive professional relationships, and the Resource Directory page 240 for tips on communicating professionally with your supervisor or employer.





■ Professional Boundaries

1. Review content.



2. Ask students to brainstorm the types of situations/problems that arise when caregivers don't keep clear boundaries (e.g. higher possibility of burnout, not supporting a client's independence).



■ Warning signs

1. Review content.



2. Ask students to look at each of the warning signs and discuss why it leads to problems with the caregiver/client relationship.

3. Have students list any additional warning signs they see within themselves or others.



In a survey of successful, long-term caregivers, viewing caregiving as a job was the most important way to maintain clear, professional boundaries. Stress this important boundary with the class.

Remind students that many tools to help caregivers address these issues will be talked about later in the course (Module 11).

Caregiving as a Professional Job

There are three important considerations to caregiving as a professional job, including:

- attendance;
- job performance;
- appearance.

Taking responsibility in these three areas are other ways to build trust with clients and other care team members and to take pride in the work you are doing.



Attendance

People need to be able to count on you to come to work when scheduled and on-time. This means having your home life organized so that things like child care and dependable transportation have already been arranged.

There are times when things go wrong in spite of your planning. When you are not able to go to work or will be late, call your employer as soon as possible. Know who to call and keep the phone number where you can easily find it.

If you know ahead of time you need time off, let your employer know about your plans as soon as possible. This gives your

employer or the case manager a chance to arrange for coverage while you are away. Not calling when you are unable to get to work or not showing up may be considered abandoning a client. Besides inconveniencing or even putting a client in danger, you can get into legal trouble for abandonment.

When you are sick

You should not go to work if you have a contagious illness (e.g. chicken pox, fever, flu, diarrhea). It puts the client at risk of getting sick. If you are unsure if you may be contagious, contact your health care provider and get his/her medical opinion. Follow your health care provider's instructions and/or use your best judgment when making a decision to go to work.

Your personal problems can interfere with your job duties. Leave them at home.

If you can't go to work, call your employer as soon as possible. Have a backup plan worked out ahead of time with your employer.

Performance

While you are at work, focus on your job. Make sure you have a good understanding of what you are to do and complete all of your assigned duties.

Do not let your personal problems interfere with your job duties.

Getting organized

Keep a daily routine. Come up with a system that works for you and the client, and keep it simple. When you arrive at work, get an idea of what you are supposed to do that day and how long it will take. Make yourself a task “to-do” list. A written list will help keep you on track and get everything done. Here are some tips for organizing your “to-do” list.

- ☐ List your activities in terms of importance. That way, if some less important things don’t get done, it can be shifted to another day.
- ☐ Figure out when you work most efficiently. Do priority tasks then.
- ☐ Do similar activities at the same time. This saves time going back and forth between unrelated tasks.
- ☐ Provide for more time than you think you will need. This makes your schedule flexible enough to allow for the unexpected. Remember, there will be times you need to be flexible and change the routine.



If you fail to plan,
you plan to fail!

Appearance

Take pride in your appearance and use the following guidelines when getting ready for work.

- | | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Hair | Your hair should be clean, neat, and pulled back out of your face. |
| Jewelry | Make sure your jewelry will not get in the way when you are providing care tasks. |
| Shoes | Wear shoes that you can work in (e.g. no high heels, loose shoelaces). |
| Clothing | Wear clean, comfortable clothing that you can move in. |
| Perfume | Many people have allergies or are sensitive to odors. Be thoughtful and aware. Avoid wearing too much perfume or fragrance. |
| Fingernails | Fingernails should be clean, filed smoothly, and short enough not to injure yourself or others (e.g. scratching, cutting, pinching). |
| Hygiene | Remember the importance of daily oral and body hygiene. |



We have to do the best we can. This is our sacred human responsibility.
Albert Einstein

Responding to Situations and Emergencies

4

Basic job responsibility



Safety Habits that Prevent Accidents



Handling Emergencies



Module 3 - Lesson 1

The Caregiver

Page 54

There are four ways you will provide for a client's safety and well-being:

1. Follow up on any concerns or problems you observe.
2. Practice good safety habits that help prevent accidents.
3. Be aware of environmental hazards and take precautions where you work.
4. Be prepared to recognize and handle emergencies.

Follow up

Take the time to follow up on any concern or problem you see happening with a client. Always talk to the client or other care team members if you see a problem, read any notes other care team members may have written, or take action to help resolve a situation.

Following up can also mean **advocating** for a client. As a caregiver, this includes alerting others (including the client) that:

- a client has additional personal care needs that are not being met;
- you are aware of other services available in the community that may be helpful for a client;
- you know of additional equipment or assistive devices that would give a client more independence;
- a client has certain preferences that are not being followed.

Checklist for home safety and environmental hazards

Practicing good safety habits that prevent accidents gives a client a sense of physical security. Look in the Resource Directory pages 241-243 for safety tips, page 244 for safety tips for clients that are cognitively impaired, and 245 for safety with environmental hazards.

In an emergency, you may be the only person to provide or get help.

Ask questions, plan, and think about handling emergencies soon after you begin working. Statistics show that many kinds of emergencies occur during a person's first weeks or months on the job. From day one, make emergency awareness and preparedness a priority.

Emergency planning in your care setting

When working in an adult family home or boarding home, ask your supervisor about the policies and procedures for responding to work place emergencies.

When working in a client's home, discuss the emergency procedures and evacuation plan the client wants you to use. If no formal emergency procedures exist, use the information provided in the Resource Directory on pages 246-248 to work together and develop plans and procedures.

Talk about emergency planning with the client, a member of his/her family, the case manager, or a trained community emergency response person. This is particularly important when a client needs help to evacuate. Refer to the client's care plan for further instructions and information.

Calling 911 for help in an emergency

The appropriate "first" response to a fire, medical, or police emergencies depends on the situation. In almost all cases:

- Make sure the client is safe before you do anything else.
- **Call 911 for help in any situation** you think might be an emergency or problem. When calling 911:
 - briefly describe the problem;
 - give your address and the nearest major street or intersection;
 - stay on the phone and follow the directions of the emergency operator.

You will also want to know who to contact once the emergency has been handled. IPs can check on the client's Service Summary for people's names and telephone numbers. If working in an adult family home or boarding home, check with your supervisor about where these numbers may be kept or if you are the person to make the call. See page 21 of the Learner's Guide for a reminder of what to do about advance directives.

Response to a fire

Planning ahead and knowing how to respond to a fire is important to you and the client's safety. You will want to know the location of telephones, flashlights, and the emergency evacuation procedures, etc.

The appropriate "first" response to a fire emergency often depends on the situation. In general, follow the guidelines listed below.

- Always get your client to safety before you do anything else.
- Call 911 and report the fire - use a cell phone or a neighbor's phone.
- Stay as low as possible when exiting, there is less smoke closer to the floor.

If you discover a fire, use the word R.A.C.E. to remind you of the safest way to respond.

R = Rescue.	Remove everyone from the immediate vicinity.
A = Alarm.	Sound an alarm or call for assistance.
C = Confine the area.	Close doors and windows in the area.
E = Extinguish.	Extinguish the fire if it is confined to a small area and if you feel confident to do so.

See the Resource Directory pages 249-251 for fire safety and prevention information.

Keep emergency information next to the telephone including the address and cross street of the client's home or care facility.





Check with your local fire department or on the Internet for brochures or fact sheets to supplement this section.

Caregivers in adult family homes and boarding homes should be reminded to know the facility's procedures and follow them.



Module 3 Module Review

1. To support a client's independence when helping with personal care, you should encourage the client to: (circle the correct answer)
 - a. **do as much as he/she can.**
 - b. try big, new things every day.
 - c. not use assistive devices.
2. When providing personal care, honor a client's need for privacy: (circle the correct answer)
 - a. **Every time you provide care.**
 - b. When you can take the time.
 - c. If the client asks for it.
3. ☒ True False The best way to maintain a healthy, professional boundary between you and a client is to view caregiving as your job.
4. True ☒ False A client's care plan has **all** of the information you need to do your job.
5. To effectively observe changes in a client, compare his/her baseline to: (circle the correct answer)
 - a. **What you see, hear, smell, or feel.**
 - b. Other client's behaviors.
 - c. Their last visit to the doctor.
6. The following statement is a(n) ... objective observation.

subjective observation.

"Mrs. Smith was out of control all afternoon."
7. In **most** emergencies, your **first** response should be to: (circle the correct answer)
 - a. Check the care plan.
 - b. **Make sure the client is safe.**
 - c. Report to your case manager/supervisor.
8. Changes in a client's baseline should be reported when you: (circle the correct answer)
 - a. Have time.
 - b. Feel like it.
 - c. **Are concerned.**
9. ☒ True False Your own beliefs and values can influence how you provide care.

Module 3
Module Review



10 Minutes



■ Putting On & Taking Off Gloves

1. Demonstrate skill.
2. Refer students to the diagram on page 67 of the Learner's Guide as a good visual reminder of the proper steps.



Putting on and taking off gloves is a **mandatory** skill that must be practiced and tested for each student prior to the end of the course.



Module 4

Infection Control

Lesson 1

Infection Control



2 Hours

Lesson 2

Infectious Diseases



1 hour

10 Minutes - Module Review

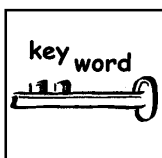
Personal Care Skills Covered

Handwashing

Putting on and taking off gloves



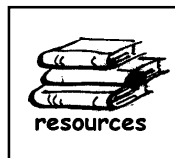
Icons to help guide you



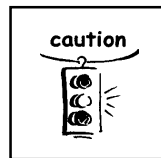
A word to remember



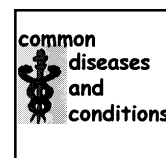
Something to report



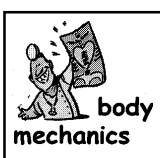
See the Resource Directory



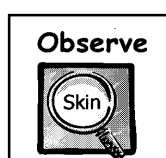
Beware or be careful



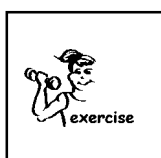
See the Common Diseases section



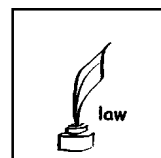
Use proper body mechanics



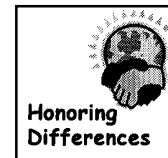
Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 4 - Lesson 1

Infection Control

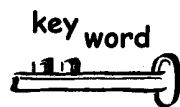


Infections and
How They Spread

Infection Control
Techniques

What you will learn in this lesson:

1. What infections are and how they spread.
2. Four major infection control techniques.
3. Symptoms of infection, what to look for and do.
4. Adult immunizations that help to control the spread of infection.



Definition

Bacteria	Microscopic organisms (germs) which can cause disease
Contaminated	An area or thing with a lot of germs, dirty
Contagious	Easily spread
Disinfecting	Using a bleach solution or another disinfectant to kill germs
Germ	Tiny, microscopic organism
Immunizations	A medical treatment given to protect against a particular infection or disease
Immune system	A collection of cells, chemical messengers, and proteins that work together to protect the body from pathogens
Infection	Growth of harmful germs in the body
Infectious	Easily spread, capable of causing infection
Infection control	Stopping germs from spreading and causing infection
Pathogen	Any germ causing disease
Virus	The smallest known living disease-producing organism

Infections and How They Spread



2,000 bacteria will fit on the head of a pin.



Understanding infections

A germ can be a **bacteria**, **virus**, or fungus. There are millions of germs present all the time in healthy human beings. Many germs are not harmful. Some germs are harmful and cause illness or disease.

Any disease causing germ is called a **pathogen**. Not all pathogens are **infectious**. Only pathogens that can be spread from one person to another or from the environment to a person are considered infectious.

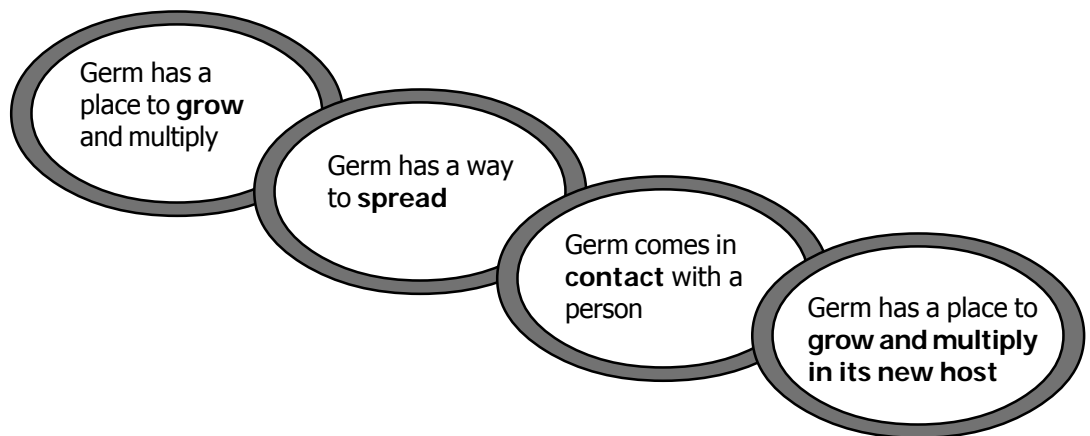
There are hundreds of different kinds of pathogens that cause illnesses from the common cold, flu, pneumonia, and diarrhea to diseases such as HIV/AIDS, TB, and Hepatitis A and B.

The spread of infection

Understanding how germs grow and spread is an important step in learning to control the spread of **infection**.

For infections to spread, **all** of the following conditions must occur:

- the germ has to be able to **grow** and multiply;
- there has to be a way for the germ to **spread** from one person to another or from the environment to a person;
- the germ has to come in **contact** with a person's body (e.g. a wound);
- the germ has to be able to **grow and multiply in its new host**.



For germs to grow and multiply

Different types of pathogens grow and multiply in a variety of places including, inside the body or on the skin, in food, or in the environment (e.g. soiled clothing or tissues, sponges, bathroom).

The 5 conditions germs need to grow and multiply include:

1. **Moisture** - germs grow well in moist areas.
2. **Heat** - germs multiply in warm temperatures.
3. **Air** - most germs need oxygen in the air to live.
4. **Food** - germs need food to survive. Food for a germ is protein.
5. **Darkness** - the absence of natural light encourages germ growth.

How germs spread

Germs must have a way to get out of the place where they have grown and multiplied and a way in to infect something or someone else. The four ways infections are spread include:

1. **Direct contact** -- the spread of an infection through direct body contact of secretions or body fluids from one person to another.
2. **Indirect contact** -- coming into contact with something an infected person has used or touched (used tissues, bedding, clothing, or drinking from a glass used by a person with an infection).
3. **Droplet spread** -- coming into contact with a drop of moisture coming from secretions containing germs (when a person sneezes or coughs). Droplets must have enough force to propel them towards another person.
4. **Airborne spread** -- coming into contact with a germ traveling on dust particles (e.g. TB. See the Common Diseases and Conditions section page 325 for more information about TB).



common
diseases
and
conditions

key word

Germs growing and multiplying in a new host

Our **immune systems** are designed to fight off infection. A weak immune system means the body has a harder time killing pathogens - allowing germs to grow and multiply.

A client can be at greater risk of infection when his/her immune system is weakened due to:

- poor nutrition
- dehydration
- stress and fatigue
- chronic disease or certain medications
- thinning of the skin
- poor personal hygiene habits

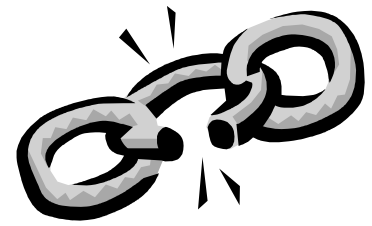
As a caregiver, encourage a client to do what he/she can to keep his/her immune system as strong as possible. This includes:

- making healthy choices in diet, fluid intake, and exercise;
- getting plenty of rest;
- maintaining good personal hygiene habits - including taking good care of his/her teeth;
- reducing stress;
- getting **immunizations**;
- seeing a doctor regularly.

key word

Infection Control

Think of all of the conditions required for the growth and spread of infection as a chain. As in any chain, it is only as strong as its weakest link.



As a caregiver, **your job is to break this chain wherever and whenever you can.**



Most infections are spread through direct or indirect contact. **Infection control** techniques focus on killing or blocking direct or indirect contact with germs so they can't cause harm.

There are four important infection control practices for caregivers, including:

1. Hand washing.
2. Wearing gloves.
3. Cleaning and disinfecting the environment.
4. Keeping up with needed immunizations.

Handwashing



As a caregiver, you have constant direct and indirect contact with the client and things in the environment. With every thing or person you touch, more and more germs build up on your hands. Your hands quickly become a source for the spread of infection.

Hand washing is the single most important thing you can do to control the spread of infection.

When to Wash Your Hands

Before

- ☐ contact with a client
- ☐ starting work
- ☐ eating
- ☐ preparing food
- ☐ putting on gloves

After

- ☐ contact with a client
- ☐ using the restroom
- ☐ removing gloves or protective clothing
- ☐ contact with body fluids
- ☐ contact with **contaminated** items
- ☐ blowing nose, sneezing, coughing
- ☐ cleaning
- ☐ smoking
- ☐ handling pets





■ Infection Control

1. Review content.
2. Take 2-3 diseases (e.g. flu, HIV, Hepatitis A) and walk students through the chain highlighting:
 - where the pathogen grows and what it needs to multiply;
 - how it gets out of the body;
 - how it is transmitted;
 - how it gets into the next host;
 - the types of things that make a person susceptible.

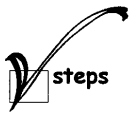


3. Have students brainstorm ways caregivers can break the link of infection for these diseases (e.g. washing their hands, disinfecting the kitchen, etc.)

There are key, important steps to perform when doing any personal care task. Use the word S.W.I.P.E.S. to remember what they are.

- S** Gather **supplies** before starting the task.
- W** **Wash** your hands before contact with a client.
- I** **Identify** yourself by telling the client your name.
- P** **Provide privacy** throughout care with a curtain, screen, or door.
- E** **Explain** what you are doing to the client.
- S** **Scan** the area to be sure everything is back in place after the task is done.

Skill: Hand Washing



1. S.W.I.P.E.S.
2. Make sure supplies are within easy reach so that no contaminated surface is touched throughout the task.
3. Turn on warm water at sink.
4. Wet hands and wrists thoroughly.
5. Apply skin cleanser or soap to hands.
6. Lather all surfaces of fingers and hands, including above the wrists, producing friction, for at least 20 seconds, keep fingers pointing down.
7. Thoroughly rinse all surfaces of hands and wrists.
8. Use clean, dry paper towel to dry all surfaces of hands, wrists, and fingers. *
9. Use clean, dry paper towel or clean, dry area of paper towel to turn off faucet.
10. Dispose of used paper towel(s) in wastebasket immediately after shutting off the faucet.

* Germs can grow quickly on cloth towels. If paper towels are not available and you must use cloth towels, launder them frequently.

A waterless hand sanitizer is another alternative that can be used if it is available and the care setting where you work allows its use.



Hand Washing

1. Demonstrate handwashing. Refer students to the diagram on page 64 of the Learner's Guide as a good visual reminder of the proper steps.



Handwashing is a **mandatory skill** that must be practiced and tested for each student prior to the end of the course.

See page Intro-4 in the *Course Structure and Teaching Techniques* for more information on how to effectively demonstrate a skill.



Handwashing

Optional

1. Put a small amount of Glo Germ on each student's hands.
2. Have them wash according to the proper handwashing procedure.
3. Use a black light to let students see how good a job they did with their hand washing technique in removing the Glo Germ.
4. Remind students that areas that show up are germs that can be spread. This will point out areas of their hand washing technique that require more work.

6 Steps to Proper Handwashing

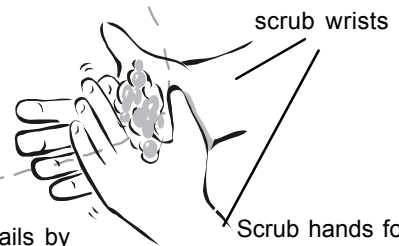
- 1) Make sure you have everything you need at the sink.



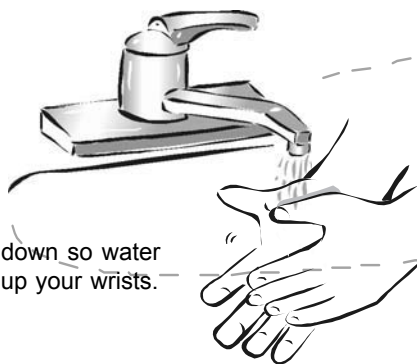
- 2) Turn on warm water.
Completely wet hands and wrists.

Keep warm water running while washing your hands.

- 3) Rub palms together to make lather and produce friction. Scrub between fingers and entire surface of hands and wrists.



- 4) Rinse hands and wrists.



Point fingers down so water does not run up your wrists.

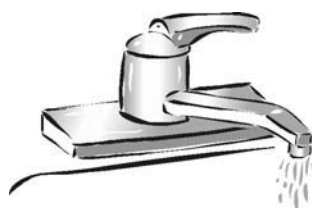
Clean fingernails by rubbing the tips of your fingers against your palms.

Scrub hands for at least 20 seconds.

- 5) Dry hands with clean towel.



Avoid touching faucets and sink.



- 6) Use a clean, **dry** paper towel to turn off the faucet. Use hand lotion if available, to prevent chapping.

Many caregivers do not wash their hands as often as they should.

“My hands don’t look dirty”

It is impossible for the human eye to see germs. Just looking at your hands will not tell you whether they are really “dirty”. You need to know when to wash your hands **based on the activities** you do as a caregiver.

“I don’t have time”

The few extra minutes it takes is well worth the benefits to you and the client. Make hand washing a part of your regular routine so you automatically build time for it into your schedule.

“Washing my hands so often dries them out”

Use moisturizing soap and lotion to prevent chapping and dry hands.

Gloves provide a protective barrier between you and a client. **Wearing gloves** keeps you from spreading germs from one person to another.

Household gloves should be worn when you are doing any general household cleaning.

Wash your hands
**based on the
activities** you do
as a caregiver.

Wearing gloves

Disposable Gloves MUST be Worn, When You:

- ☐ have direct skin contact with blood, body fluids, or mucous membranes;
- ☐ handle things contaminated with germs such as tissues, disposable undergarments, or soiled clothing or linens;
- ☐ provide first aid;
- ☐ have contact with a client that has an open wound;
- ☐ clean-up body fluids;
- ☐ assist a client with toileting or other personal care tasks.
- ☐ have a cut, scrape, chapped hands, or dermatitis, etc.

Disposable gloves:

- need to be made of the appropriate material, usually latex or vinyl;
- should not be peeling, cracked, discolored, or have punctures or tears;
- should be thrown away after each use;
- should be changed between tasks if they have become contaminated with germs (e.g. body fluids).

Skill: Putting On & Taking Off Gloves



Putting On Gloves

1. S.W.I.P.E.S.
2. Wash hands before contact with gloves.
3. Check each glove for holes or other deterioration before using.
4. Grasp glove at cuff and pull onto other hand.
5. Grasp other glove at cuff and pull onto other hand.
6. Check to make sure glove is snugly fit over each finger.

Taking Off Gloves

1. With one gloved hand, grasp the other glove just below the cuff.
2. Pull glove down over hand so it is inside out.
3. Keep holding removed glove with gloved hand and crumple it into a ball.
4. With two fingers of bare hand, reach under the cuff of the second glove.
5. Pull the glove down inside out so it covers the first glove.
6. Throw gloves away.
7. Wash hands as final step.

Latex allergies

Most disposable gloves are made of latex. According to the Centers for Disease Control and Prevention, about 20% of health care workers are allergic to latex.

The best way to prevent a reaction to latex is to switch to non-latex gloves or change to non-powdered latex gloves if the powder is the problem for you.

Infection control through the eyes of a client

Infection control practices can stop or limit touch and direct contact between a caregiver and a client. As a caregiver, you need to be sensitive to a client's possible reaction to their use. Wearing gloves, using any barrier, and the need to wash your hands before and after contact with a client, can make him/her feel dirty or contaminated, lonely or isolated, and/or can interfere with a client's need for connection and emotional support.

This cannot stop you from using them. It may help to talk with the client about it and let them know why these practices are important to his/her health and well-being.

How to Remove Gloves Safely

Assume that all used gloves are contaminated. When you remove them, follow these steps so that the outside of the gloves do not touch your bare skin.

1) With one gloved hand, grasp the other glove just below the cuff.

2) Pull the glove down over your hand so it is inside out.

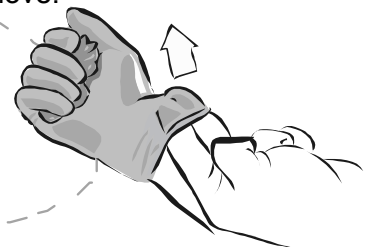


3) Keep holding the glove with your gloved hand and crumple it into a ball.



Danger: do NOT touch bare hand to dirty glove.

4) With two fingers of the bare hand, reach under the cuff of the second glove.



5) Pull the glove down inside out so it covers the first glove.



6) Both gloves are now inside out. You can throw them away safely.

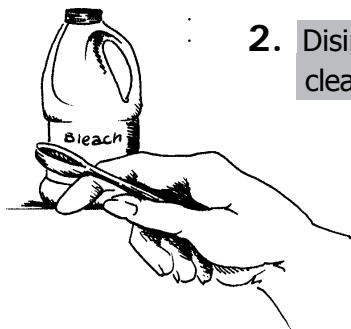


7) Wash your hands.

Cleaning and Disinfecting



One teaspoon bleach to one gallon of water makes a good disinfectant.



An area or thing is considered “clean” when it has been cleaned and properly disinfected. An area or thing with a lot of germs is considered contaminated or dirty. For example used sheets, dirty dishes, worn clothing, and areas such as bedrooms and bathrooms are considered contaminated. **Control germs by keeping your work area “clean”.**

General cleaning and disinfecting guidelines

Cleaning and disinfecting are not the same. Cleaning with soap, water, and scrubbing removes dirt and some germs. **Disinfecting** with a bleach solution or another disinfectant kills additional germs on surfaces.

There are 2 steps to clean and disinfect any surface.

1. Clean and scrub the surface with soap and water;
2. Disinfect the area with a bleach solution or a commercial, household cleaning solution.

One teaspoon bleach to one gallon of water makes a good disinfectant solution. Use the solution within 24 hours.

More detailed information about cleaning and disinfecting a kitchen properly is covered starting on page 155.

See the Resource Directory on pages 252-254 for guidelines and tips for properly cleaning and disinfecting other major areas of a house.

Immunizations

Another way to keep you and your client healthy is for everyone to keep immunizations up to date.

Check with your employer to see if any immunizations are available through your work. Check with your doctor to make sure you have the immunizations you need. Encourage a client to also follow his/her doctor’s recommendations for what immunizations he/she needs.

Types of common immunizations

- Tetanus/Diphtheria - every ten years or if injured
- Flu shots - yearly
- Pneumonia shot - once (lifetime)
- Hepatitis A - a series of 2 shots, 6 months apart
- Hepatitis B - a series of 3 shots



Even with good infection control practices, you or a client can still get an infection. As a caregiver, staying alert for signs of infection will help you know when to report a change or concern about a client or if **you** may be sick and should not go to work.

Observing and Reporting if a Client has an Infection

Keep in mind:

- many people with a germ causing illness have no symptoms;
- a person can be highly contagious before symptoms develop;
- symptoms of infection may be specific to just one part of the body (e.g. an infected wound or incision or a urinary tract infection).

Stay alert to the following general signs of infection. If you see these symptoms in a client, report it to the appropriate person where you work.



General signs of infection

- ☐ Fever, chills, sweating
- ☐ Nausea
- ☐ Dizziness
- ☐ Headache
- ☐ Thirst
- ☐ Feeling lousy, weak
- ☐ Decline in overall well-being

- ☐ Pain
- ☐ Redness and/or swelling
- ☐ Areas on the body that are hot to touch
- ☐ Increased breathing and pulse rates
- ☐ Hot, dry skin, and rash
- ☐ Confusion
- ☐ Tired

Module 4 - Lesson 2

Blood Borne Pathogens

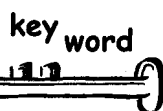


More About Blood
Borne Pathogens

HIV/AIDS

What you will learn in this lesson:

1. Common blood-borne diseases.
2. How blood borne pathogens are spread.
3. The need for and how to use Standard Precautions.
4. An in-depth look at HIV/AIDS.



Definition

Blood borne pathogen

Disease causing germs that spread through contact with blood

Hepatitis (B and C)

Viral infections of the liver

HIV/AIDS

Disease that attacks the immune system, preventing the body from fighting infection

Standard Precautions

Accepted practices used to prevent pathogens being spread through the blood, body fluids, non-intact skin, or mucous membranes

Transmitted

The process of passing something from one person or place to another

As a caregiver, you may come in contact with a client's blood or body fluid. This presents a small risk of exposure to **blood borne pathogens**. As a caregiver, you need to know:

- common types of blood borne diseases;
- how blood borne diseases can and cannot be spread;
- how to use **Standard Precautions** to protect yourself and a client;
- what to do if you are exposed to blood or body fluids.

Blood borne diseases

The three most common blood borne diseases caused by blood borne pathogens are Hepatitis B, Hepatitis C, and HIV/AIDS. Syphilis and the West Nile Virus are also caused by blood borne pathogens.

Hepatitis B (HBV) is a viral infection that infects the liver. It is a more common infection and more contagious than HIV. Approximately 90% of adults infected with HBV will recover. Some people exposed to HBV may not have any symptoms. A vaccine is available to prevent infection with HBV. Talk to your doctor about whether you should have this vaccine.

See page 256 of the Resource Directory for a sample of a hepatitis B consent form.

Hepatitis C (HCV) is also a viral infection of the liver but causes chronic inflammation with possible scarring (cirrhosis) and causes permanent liver damage. HCV is not as easy to contract as HBV, but is still more infectious than HIV. The majority of people who become infected with HCV remain infected and become chronic carriers of the virus. There are no vaccines currently available.

Both HCV and HBV can be spread through contact with dried blood.

See the Common Diseases and Conditions section page 312 for more information about Hepatitis B and C, as well as A, D, and E.



Human Immunodeficiency Virus (HIV) is a virus that damages the immune system of an infected person. There is no vaccine against HIV. HIV will be covered in more detail in this lesson.

More About Blood Borne Pathogens



How Blood Borne Pathogens are Spread in the Workplace

Blood borne pathogens **CAN** be spread by:

- a needle stick or other puncture wound
- helping a client who is bleeding
- changing linens that are contaminated by blood or other body fluids
- helping to clean up blood, vomit, urine or feces
- changing a dressing or bandage with blood that has oozed from a wound
- contact with broken skin (chapped, weeping, or dermatitis)
- contact with mucous membranes (mouth, nose, and eyes)

Blood borne pathogens **can NOT** be spread by:

- providing care for a client with a blood borne disease when standard precautions are used
- sharing eating utensils, plates, or glasses
- sharing bathrooms
- through the air
- hugging or shaking or holding hands

Standard Precautions

Standard Precautions are used any time you may come in contact with a client's blood, body fluids, broken skin, or mucous membranes. Standard Precautions must be used **whether or not you think a client may have a blood borne disease.**



Standard Precautions can include:

- using a protective barrier between you and the blood or body fluids (e.g. gloves, a face mask or goggles, and/or a gown);
- cleaning and disinfecting any surfaces contaminated with blood or body fluids;
- following special laundry procedures;
- properly disposing of contaminated waste;
- handling needles or other sharp objects correctly.



Standard Precautions are used in addition to other routine infection control practices any time there is a risk of exposure to blood or other body fluids.

Protective barriers

Gowns or aprons should be worn when there is a potential for splashing or spraying of blood or body fluids onto your body and clothing from a client.

Masks and goggles should be worn when there is a potential for exposure of blood or body fluids to your mouth, nose and/or eyes.

Cleaning and disinfecting

Any surface contaminated with body fluids or blood should be cleaned and disinfected immediately. Gloves must always be worn as well as any other protective barriers that the situation calls for. Use paper towels for clean up if possible. Dispose of contaminated materials properly (see below).

Special laundry procedures

Although the risk of exposure from soiled laundry is very small, laundry soiled with body fluids or blood should be treated as contaminated. Always:

- wear gloves;
- put contaminated items in a leakproof, plastic bag or covered hamper until ready to wash;
- handle as little as possible and do not shake items out;
- avoid holding soiled items against your clothing;
- wash items with a detergent and/or bleach according to the manufacturer's directions;
- keep soiled and clean linen separate;
- wash your hands after you are done.



See page 255 of the Resource Directory for tips on how to do laundry.



Proper disposal of contaminated waste

All contaminated items should be placed in a heavy-duty plastic bag, tied shut, and placed in a second plastic bag before putting in the trash can. Label the bag "contaminated".

Normal trash pickup is generally an appropriate way to dispose of contaminated waste.

Handling needles or other sharp objects

Disposable syringes and needles, blades, and other sharp items should be placed in a puncture-resistant container after use. Regulations vary by county regarding how to dispose of the container, so check with your local Health Department or your supervisor if you are unsure. Special containers can be purchased from a pharmacy.



- **Protective barriers**
- **Cleaning and disinfecting**

1. Review contents.



2. **Demonstrate** how to properly clean up a blood or body fluid spill. This should include the proper procedure, standard precautions required, and the supplies needed to clean and disinfect surfaces.



Students are not expected to practice this skill - but understanding how to do it correctly is important. The purpose of the demonstration is to give students a good visual demonstration of the proper steps and reinforce the need for standard precautions any time they clean up blood or body fluids.

Exposure to Blood Borne Diseases

Kind of exposure	What to do
Your eyes are splattered with blood or body fluids.	Flush immediately with water for at least five minutes. Rinse under clean running water.
Blood or any body fluids get into your mouth .	Rinse your mouth with a 50/50 mix of hydrogen peroxide and water. Then rinse with plain water. Get medical attention for further action.
Both eyes and mouth are exposed .	Immediately rinse both as recommended above and get medical attention for further action.
A needle stick or puncture wound .	Wash thoroughly with soap and water or pour a small amount of hydrogen peroxide on the wound. Get medical attention for further action.
Any bite, scratch, or lesion that may have had blood or body fluid exposure.	<p>Wash the area thoroughly with soap and water or pour a small amount of hydrogen peroxide on the wound.</p> <p>Cover the wound with a sterile dressing. Get medical attention for further action.</p>

Reporting exposure to blood borne diseases

If you are exposed to another person's blood or other potentially infectious materials (OPIM), check with your employer or supervisor for the procedures in your care setting. If you work in a client's home, call your physician to discuss your exposure.

You can also request HIV testing of the source individual. If the source individual does not want to be tested, assistance from the local health officer can be requested, provided the:

- request is made within 7 days of the exposure;
- health officer determines that a "substantial exposure" has occurred. The health officer may make the determination that testing is unnecessary;
- exposure occurred on the job.

See page 257 in the Resource Directory for further information about risk after exposure and follow up and reporting of exposure.

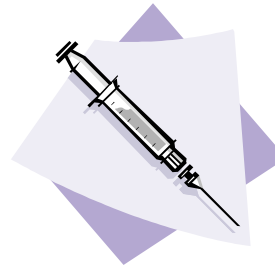


How HIV is spread

HIV is **transmitted** when infected blood, semen, vaginal fluids, or breast milk enter the body through the mucous membranes of the anus, vagina, penis (urethra), or mouth, or through cuts, sores, or abrasions on the skin.

HIV is spread by:

- having unprotected vaginal, anal, or oral sex with an infected person. Unprotected sex is sexual intercourse without consistent and correct condom use.
- using or being stuck with a needle or syringe that has been used by an infected person, including tattoo needles or ink and body piercing needles.
- sharing of drug paraphernalia. The paraphernalia that carries the potential of transmission are the syringe-needle, "cooker", cotton, and/or rinse water. Sharing these items (sometimes called "works") may transmit the virus. Sharing works also has the potential to transmit hepatitis C.
- giving birth. Women with HIV infection can pass the virus to their babies during pregnancy or childbirth.
- breast feeding. Infected moms can pass the virus to their babies through their breast milk.
- receiving blood. The risk of infection through blood transfusions has been practically eliminated since 1985 when careful and widespread screening and testing of the blood supply for evidence of HIV became standard practice



See page 72 for more information on how a blood borne pathogen like HIV may be spread in a caregiving environment.

Anyone who is infected with HIV can transmit the virus. Being infected means the virus is in your body and will be there for the rest of your life. You can infect others if you engage in behaviors that can transmit HIV. You can infect others even if you feel fine, have no symptoms of illness, or don't even know you are infected.

When a person is exposed to HIV

Once a person is exposed to HIV, the virus enters the blood and attaches to certain white blood cells, called T-cells. The role of T-cells is to signal other cells to produce antibodies to fight off pathogens. Producing antibodies is a critical function of our immune system.

With the HIV virus attached to the T-cells, the antibodies produced to fight the HIV virus are unable to do so. Over time, HIV progressively destroys the T-cells and therefore the body's immune system - leaving the person vulnerable to unusual infections, cancer, and other life-threatening disease.

HIV/AIDS



The highest concentrations of the HIV virus are in the blood, semen, vaginal fluid, and breast milk.

**The CDC Information
Line is
1-800-CDC-INFO.
(1-800-232-4636)**

Symptoms of HIV/AIDS

Early symptoms of HIV may include tiredness, fever, diarrhea, enlarged lymph nodes, loss of appetite, or night sweats.

People with HIV infection can develop many different health problems. These include severe pneumonia, several forms of cancer, damage to the brain and nervous system, and extreme weight loss.

Acquired Immune Deficiency Syndrome (AIDS)

According to the Centers for Disease Control and Prevention (CDC), AIDS begins when a person with HIV infection has a T-cell count below 200 or has one of numerous opportunistic infections and cancers that occur in the presence of HIV infection. Once diagnosed with AIDS, the diagnosis does not change back to HIV if a person's T-cell count goes back above 200.

All people diagnosed with AIDS have HIV, but not all people with HIV have reached an AIDS diagnosis. Medical treatment can delay the onset of AIDS. Without treatment, there is an average of ten years between the time a person is infected with HIV and the start of the symptoms of AIDS.

To stay healthy for as long as possible, it is important for the person to learn his/her HIV status and get treatment as soon as possible. Early detection will allow an infected person to get the treatment needed to take better care of his/her immune system. New drug therapies have been able to sustain the health of a person who has been infected.

Diseases Associated with HIV/AIDS

Common diseases related to HIV/AIDS are called "opportunistic infections" because they are able to attack the body due to the person's weakened immune system. These infections usually pose little or no threat to persons with healthy immune systems. For people diagnosed with HIV/AIDS, these infections may cause one or more of the following diseases.

Pneumocystis carinii Pneumonia – a severe lung infection characterized by dry cough and shortness of breath.

Kaposi's Sarcoma - a skin cancer that causes raised, brownish/purplish lesions on the face, hands, or other areas.

Toxoplasmosis - a disease that invades tissue and may seriously damage the central nervous system, common symptoms may include fever, headaches, confusion and/or seizures.

Cryptococcosis - a disease caused by a fungus, characterized by lesions or abscesses in the lungs, tissue, joints or brain.

Cryptosporidiosis - a bowel infection caused by a water-borne parasite which causes severe diarrhea, dehydration and weakness.

Candidiasis - an infection caused by a fungus, characterized by a white, filmy coating of the mouth, esophagus, vagina, or lungs.

Mycobacterium avium-complex (MAC) – infection of the gastrointestinal tract which can rapidly spread to the liver, lymph nodes, and bone marrow. Causes weakness, abdominal pain, fever, and wasting (loss of 10% or greater body weight within 30 days).

HIV-associated Dementia - mild to severe damage to the brain and central nervous system causing confusion, memory loss, motor control problems, mood swings, poor concentration, and personality changes.

Treatment

The treatment focus for HIV/AIDS is on medications that slow the virus and on treating the associated diseases. There is still no cure for HIV/AIDS.

There are a number of anti-viral drugs that have been approved to treat HIV/AIDS but the use of these drugs is usually complicated and they have many side effects. There is work being done on new versions of medications and simpler once-a-day dosages.

Research is also being done on ways to make the immune system stronger and on developing a vaccine.

Every local health department should have a person you could contact for HIV/AIDS case management to help an individual find medical or community resources to meet his/her needs.

Look in the Resource Directory page 258 for contacts in your local area.

Testing for HIV/AIDS

Any person exposed to the blood or body fluids of another person may need to be tested for HIV/AIDS. If you work in an adult family home or boarding home, follow the protocol where you work! If you work in a client's home, call your physician to discuss the need for testing.

The window period

Tests for HIV look for antibodies to HIV. The test will not be positive until enough antibodies are present in the blood for the test to find them. After infection with HIV, it can take up to 3 months for HIV antibodies to develop.



The time period between when a person is actually infected with HIV and when antibodies to HIV can be detected in a test is called the window period.

Different people take different amounts of time to develop antibodies after being infected. Most people take between 2-12 weeks after becoming infected to produce enough antibodies to show up on the test. In rare cases, it may take as long as 6 months.

Being tested

According to the CDC, you should be tested for HIV as soon as possible after exposure to get a baseline. You will need to be retested during the next several months. Check with your doctor or talk with the staff where you were initially tested for what works in your situation. You must give informed consent for HIV testing, either verbally or in writing, and that consent must be documented.



People may test for HIV at home, at public health departments, through their medical provider, and at family planning or sexually transmitted disease clinics. Testing usually involves drawing a small amount of blood, or providing a saliva or urine sample.

Confidential or anonymous testing

Testing can be either confidential or anonymous. Confidential testing means the results of the test are kept private to all but the person being tested and the health care worker who provides the test and/or medical care to the person. With confidential testing, the person gives his or her real name. Health care providers must also submit a confidential report of positive HIV tests results to local public health officials (see reporting on next page).

Anonymous testing means that the clinic keeps no record of the person's name. They use only a code to process records and blood specimens. Anonymous testing cannot be used in cases of occupation exposure.

Counseling

Pre-test prevention counseling is required only for people at increased risk for HIV infection or for those who request it.

Counseling topics are based on recommendations from the CDC, including risk assessment for getting or transmitting HIV, help in setting behavior change goals and risk reduction strategies, and offering referrals.

Post-test prevention counseling must be offered. Only people who test positive must be provided counseling. In this case, the person is referred to the local health department or other community organizations providing this service.

Reporting

AIDS and symptomatic HIV have been reportable conditions in Washington State since 1984 and 1993 respectively. Starting in 1999, asymptomatic HIV also became reportable.

Providers must report HIV and AIDS cases within three working days of diagnosis.

Positive results obtained through anonymous testing are not reportable. However, when HIV positive patients are seen for health care, or tests are obtained, the health care provider and labs must report the case.

Federal law also requires that states take action to require that a "good faith effort" be made to notify all spouses of HIV-infected persons.



Law against discrimination (RCW Chapter 49.60)

HIV infection and AIDS are medical conditions that are considered disabilities under the Washington State Law Against Discrimination, Chapter 49.60 RCW and the Federal Americans with Disabilities Act.

This means it is illegal to discriminate against someone who has or is **believed** to have AIDS or who is HIV-infected. The areas covered in law are:

- employment;
- rental, purchase, or sale of apartment, house, or real estate;
- places of public accommodation (restaurants, theaters, etc.);
- health care, legal services, home repairs, and other personal services available to the general public;
- applying for a loan or credit card, or other credit transaction;
- certain insurance transactions.

Look in the Resource Directory page 259 for more information about HIV and employment protection.



Difficult realities

Persons with HIV/AIDS and their families and friends face a multitude of very difficult realities. Even with antiviral drugs, persons with AIDS still die prematurely. Persons who are HIV-infected can live 10-12 years or more before developing symptoms, but have to deal with complicated medication schedules and numerous medical appointments.

The infections and cancers that are often part of AIDS can disfigure the body. 90% of all adults with AIDS are in the prime of their life and are not prepared to deal with all of the losses associated with the HIV/AIDS. Many people living with, or working with, people with AIDS have to deal with a succession of losses.

Losses

HIV often produces many losses, which may include the loss of:

- physical strength and abilities;
- mental abilities;
- income and savings;
- health insurance;
- housing, personal possessions, including pets;
- emotional support from family, friends, co-workers, religious and social institutions;
- job;
- independence and privacy;
- social contacts/roles;
- self-esteem
- friends, who may pass away from HIV/AIDS

Psychological Suffering

Infection with HIV, causes distress for those who have HIV and for those who care for them. Physical weakness and pain can diminish a person's ability to cope with the psychological and social stresses. Often, grief shows up in physical symptoms, including depression, anxiety, insomnia and the inability to get pleasure from normal daily activities. Some people with HIV/AIDS think about suicide, some attempt suicide, and some kill themselves.

Some of the feelings common for people with HIV/AIDS may include:

- that life, as they knew it, is gone forever;
- disbelief, numbness, and inability to face facts;
- fear of the "unknown" and developing AIDS;
- rejection by family, friends, and co-workers;
- guilt about the disease, about past behaviors, or about the possibility of having transmitted it to others;
- sadness, hopelessness, helplessness, withdrawal, and isolation;
- anger at the disease, at the prospect of a lonely, painful death, at the discrimination that usually accompanies the disease, and at the lack of effective and affordable treatment.

Often the feelings experienced by the caregiver will mirror those of the person with AIDS. Caregivers may experience the same isolation as the person with HIV infection. Finding a support system, including a qualified counselor, can be just as important for the caregiver as for the person who has HIV/AIDS. Support from co-workers can be especially important.



10 Minutes

1. True ☒ False Most infections are spread through the air.
2. HIV can be spread by: (circle the correct answer)
 - a. Holding hands or hugging.
 - b. **Having unprotected sex.**
 - c. Sharing utensils or drinking glasses..
3. To effectively kill germs on surfaces, you must: (circle the correct answer)
 - a. Clean with soap and water only.
 - b. Disinfect and then clean with soap and water.
 - c. **Clean with soap and water and then disinfect.**
4. True ☒ False Only use Standard Precautions if you think a client has a blood borne disease.
5. True ☒ False It is only mandatory to wash your hands if they look dirty.
6. ☒ True False Some people with an infection have no symptoms.
7. A caregiver's job is to break the chain of infection: (circle the correct answer)
 - a. **Whenever and wherever you can.**
 - b. When it is part of the care plan.
 - c. When you have extra time.
8. The **most** important thing you can do to control infection is to (circle the correct answer):
 - a. Cover your mouth.
 - b. **Wash your hands.**
 - c. Get a flu shot.
9. ☒ True False There are laws that protect a person living with HIV/AIDS against discrimination.
10. Blood borne pathogens can be spread by: (circle the correct answer)
 - a. Sharing a bathroom.
 - b. Coughing or sneezing.
 - c. **Cleaning up blood.**
11. True ☒ False The only time you must wear disposable gloves is to clean up blood or body fluids.
12. When cleaning any surface with blood, always wear: (circle the correct answer)
 - a. **Gloves.**
 - b. Goggles.
 - c. An apron.
13. HIV test results are: (circle the correct answer)
 - a. **Kept confidential.**
 - b. Given to your employer.
 - c. Available on-line.



Module 5

Mobility

Lesson 1

Mobility



1 hour 30 Minutes

5 Minutes - Module Review

30 Minutes - Module Scenario

Personal Care Skills Covered

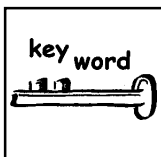
Body mechanics

Helping a client walk

Transfer from bed to chair/wheelchair



Icons to help guide you



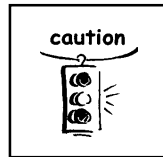
A word to remember



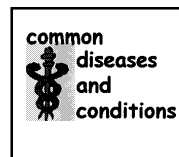
Something to report



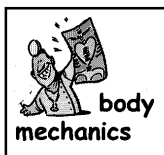
See the Resource Directory



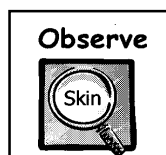
Beware or be careful



See the Common Diseases section



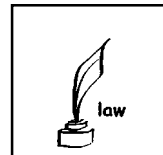
Use proper body mechanics



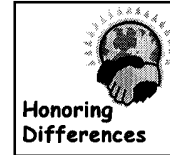
Observe skin



Classroom exercise



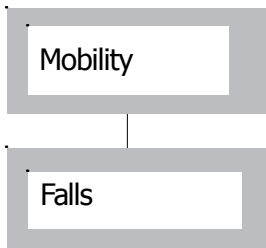
Something in the law



Be alert and respectful

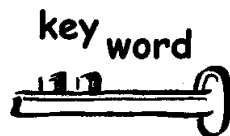
Module 5 - Lesson 1

Mobility



What you will learn in this lesson:

1. Using proper body mechanics to prevent injury.
2. Proper techniques and assistive devices for helping a client walk and transfer.
3. Why falls are a concern for clients, how to prevent falls, and what to do if a client has fallen.



Definition

Assistive devices	Equipment that helps a person perform a task and maintain or regain independence
Body mechanics	A way of lifting to prevent injury
Mobility	Ability to move about
Positioning	How a person is placed when sitting or lying
Transfers	Moving a person from one place to another
Transfer belt/gait belt	A belt worn around the client's waist to aid in transfers and walking
Transfer board	A flat board that enables a person to slide from one level surface to another

Any time you help lift or move a client, use proper **body mechanics** to prevent stress and injury to your spine.

Body Mechanics



Proper Body Mechanics

- ❑ **Before** lifting or moving a thing or person, **test the weight** of the load and make sure you can move it safely. Do not lift it alone if it seems too heavy.
- ❑ **Spread your feet about shoulder width apart with one foot in front of the other** to provide a good base of support.
- ❑ **Bend at the knees** instead of the waist.
- ❑ **Keep your back as straight** as possible.
- ❑ **Bring the load as close to your body** as you can.
- ❑ **Lift with your legs**, using your stronger set of buttock and leg muscles.
- ❑ **Keep your back, feet, and trunk together and do not twist at the waist.** If it is necessary to change your direction when upright, shift your feet and take small steps. Keep your back and neck in a straight line.
- ❑ **Pull, push, or slide objects** instead of lifting when possible.



Encouraging and helping a client to stay mobile greatly impacts his/her physical and emotional well-being.

Many things can limit a client's **mobility**, including:

- balance problems;
- vision problems;
- hearing loss;
- pain;
- medication;
- certain disabilities;
- reduced sense of touch.

Common problems that can occur when a client becomes less mobile include:

- pressure ulcers;
- urinary problems;
- constipation;
- increased stress on the heart;
- muscle weakness.

In addition, becoming less mobile can bring on feelings of helplessness, depression, and anxiety as a client's independence is reduced.

Mobility





Demonstrate proper body mechanics - reinforcing

- how to avoid common mistakes, and
- consequences of improper body mechanics.



Students are expected to use proper body mechanics when performing personal care tasks that require lifting.

Reinforce when body mechanics are necessary to properly perform a personal care task and monitor students when students are practicing these skills.



Remind students that this icon is used in the course to remind students of when proper body mechanics are required in a task.

Transfers



- **Transfers** are very personal. A client knows what works and doesn't for him/her and will have a definite opinion about how he/she wishes to be transferred.
- Talk with the client about his/her preferences before you do any transfers.
- Be clear and confident with your directions. This helps the client feel more comfortable and secure.



Skill: Transfer Client From Bed To Chair/Wheelchair

1. S.W.I.P.E.S.
2. Position chair/wheelchair close to bed with arm of the wheelchair almost touching the bed.
3. Fold up or remove footrests.
4. Lock wheels on wheelchair.
5. Assist client to roll toward side of bed.
6. Supporting the client's back and hips, assist client to a sitting position with feet flat on the floor.
6. Assist client to put on non-skid footwear.
7. Put on transfer belt, if necessary.
8. Assist client to scoot toward edge of bed.
9. With transfer (gait) belt:
 - Stand in front of client.
 - Grasp belt.
10. Without transfer belt:
 - Stand in front of client.
 - Place arms around client's torso under client's arms.
11. Brace client's lower extremities with your knees to prevent slipping.
12. Alert client you will begin transfer on the count of 3.
13. On signal, assist client to stand.
14. Assist client to pivot to front of wheelchair with back of client's legs against wheelchair.
15. Flex your knees and hips and lower the client into the wheelchair.
16. Have client hold onto armrests for support.
17. Reposition client with hips touching the back of the wheelchair and good body alignment. Remove transfer belt, if used.
18. Position client's feet on footrests.
19. Wash hands as final step.





■ Skill: Transfer Client From Bed To Chair/Wheelchair

1. Demonstrate skill.

All students are expected to practice the skill in a DOC team.

Transfers are a **mandatory skill** that must be practiced and tested for each student prior to the end of the course.



See page Intro-4 in the *Course Structure and Teaching Techniques* for detailed information on how to set up skill stations.

See page Intro-5 in the *Course Structure and Teaching Techniques* for detailed information on setting up a DOC team.

Assistive devices used for transfers

A **transfer belt** is a belt made of sturdy webbing or twill with a buckle or clasp on it. The transfer belt is placed around a client's waist and used to help a client transfer or walk. A transfer belt is recommended for clients who need help to transfer.



A transfer belt can be purchased at a local medical equipment supplier. Medical coupons may be available for DSHS clients to cover the purchase of a transfer belt. Encourage the client to check with his/her case manager or talk with your supervisor. If you do not have a store purchased transfer belt, you can use a regular wide belt with a clasp.

The following are **general tips** to remember when **using a transfer belt**.

- Place the belt around the client's clothing, not his/her bare skin.
- The belt should be snug but not too tight. You should be able to comfortably put the flat of your hand under the belt.
- Make sure a woman's breasts are not caught under the belt.

Transfer boards improve a client's ability to transfer with less assistance. Transfer boards work well for clients that can use their arms to scoot from one side to the other.



caution



Safety with transfers

If the client cannot help with the transfer at all, you need special training and/or adaptive equipment (i.e. a Hoyer Lift) to lift and move him/her. Depending on where you work, talk with your supervisor or the client's case manager about how to get this special training.

The client should never put his/her arms around your neck during a transfer. It can pull you forward, make you lose your balance, and/or hurt your back.

If you feel a strain in your lower back, stop the transfer and get help.



The following are **general tips** to remember when **helping a client to sit on the side of a bed**.

- Make sure the client is not too close to the edge of the bed.
- Instruct the client to bend his/her knees with their feet flat on the bed and to roll onto their side towards you. Watch closely.
- Have the client bring his/her legs off the bed and push up with their arms to a sitting position.
- Encourage the client to use hip walking if able (scooting forward one hip at a time) when scooting towards the edge of a bed.
- Assist the client, if needed, by placing one arm under her/his shoulder and your other arm over his/her thighs. Swing the client's legs off the bed.

The following are **general tips** to remember when **using a drawsheet to lift**.

- Lifting a client with a drawsheet requires two people. Use a draw sheet (a regular sheet folded in half) placed under the person between his/her knees and shoulders.
- Roll up each side of the draw sheet to the client lying in bed, and then lift the client up in bed. Be careful not to drag the client's heels.
- If the client is able, he/she can also assist by bending his/her knees and pushing up while the caregivers use the drawsheet.

The following are **general tips** to remember when **transferring a client from a wheelchair into a car**.

- Position the car away from the curb so the client stands on level pavement, or have the car close to the curb so the client will not have to step down onto the pavement from the curb.
- Have the car door open.
- Position the car seat as far back as possible. The front passenger seat is preferred.
- Make sure the wheelchair is in the locked position.
- Have the client put his/her right hand on the car door.
- Have the client use his/her left hand to push off on the wheelchair to a standing position.
- Have the client turn, face the door, and place his/her left hand on the seat back or door frame and sit down sideways onto the seat.
- Have the client turn in the seat and assist him/her, if needed, in placing one, then the other foot, in the car.
- Reverse this process if transferring the client out of car.
- Non-friction upholstery such as vinyl or leather helps the client to slide easily. A large, plastic garbage can liner can also be used to make it easier for the person to slide.
- Avoid parking the car on an incline.
- Have the car engine off—put the car in park with brakes set.



See the Resource Directory page 261 for more information on wheelchair safety.

Helping a client walk includes helping steady the client while he/she is walking, assisting with difficult parts of walking (e.g. climbing stairs), and helping with assistive devices (e.g. walkers).

Helping a Client Walk

Skill: Helping a Client Walk



1. S.W.I.P.E.S.
2. Put on and properly fasten non-skid footwear on the client.
3. Stand in front of and face client.
4. Brace the client's lower extremities.
5. With transfer (gait) belt:
 - Place belt around the client's waist and grasp the belt while assisting client to stand.
 - Walk slightly behind and to one side (weaker side, if any) of client for the full distance, while holding onto the belt.
6. Without transfer belt:
 - Place arm around client's torso while assisting client to stand.
 - Walk slightly behind and to one side (weaker side, if any) of client for the full distance with arm supporting client's back.
7. Assist client to where he/she is going and remove transfer belt, if used.
8. Wash hands as final step.



The following are **general tips** to remember when **helping a client walk**.

- Clarify with the client where he/she wants to go and assess the client's abilities before assisting the client to walk.
- Before assisting a client to stand, encourage him/her to:
 - lean forward;
 - use a rocking motion as momentum (if able);
 - move his/her legs off the bed;
 - push forward with his/her arms from the bed (if able).
- Keep the client's body as straight as possible when lifting.
- If a client has a weak leg, brace your knee against it as the client stands.
- Once the client is standing, encourage him/her to:
 - stand a few minutes and stabilize his/her balance before walking;
 - stand straight, look forward, and keep a measured, smooth rhythm;
 - use his/her glasses and/or hearing aids;
 - avoid wearing skirts, robes, etc., that fall below the ankles.
- Clear pathways of clutter.



Never help a client stand by pulling on his/her arms. Never put your hands under the client's armpits when assisting a client to stand.



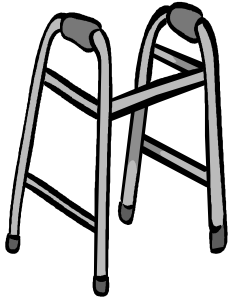
■ Skill: Helping a Client Walk

1. **Demonstrate skill.** Students are expected to practice the skill with their DOC team.



Since Helping a Client Walk is part of the Module Scenario, you can wait and have students practice the skill then - or have them practice right after your demonstration.

If you have students practice now, it is still expected that one group will still demonstrate the skill after the Module Scenario research, problem solving, and discussion.



The following are **general tips** when **helping a client climb stairs**.

- The client should **step up with his/her stronger leg first**.
- Stand behind the client when he/she is going up stairs.
- The client should **step down with the weaker leg**.
- Stand in front or at the side of the client when he/she is going down stairs.
- For safety, the client should always use a handrail.
- A transfer belt can also be used for support.

Assistive devices used for helping a client walk

Clients who can bear some weight on their legs but are unsteady and/or need help with balance use walkers.

The following are **general tips** for helping a client **use a walker**. Encourage the client to:

- pick up - do not slide - the walker;
- not lean into the walker;
- place his/her weight on the stronger leg and hands;
- not pull on the walker when standing up.

Straight canes are for balance and are not designed to bear weight. The client must be able to bear weight on both legs and hold the cane.

The following are **general tips** for helping a client **use a cane**.

- The cane should be used on the client's strong side.
- The cane goes forward first, followed by the weaker leg and then the stronger leg.
- Stand on a client's weaker side (if they have one).

Crutches provide support and stability when a client can only bear weight on one foot.

The following are **general tips** for helping a client **use crutches**.

- The crutches should be adjusted to the client's height.
- The crutches should have heavy, rubber suction tips.

Braces provide specific support for weakened muscles or joints or immobilize an injured area. The brace should be custom-made for the individual.



Observe



The following are **general tips** to remember when a client **has a brace**.

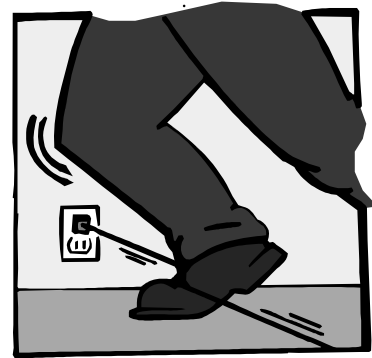
- The client may need protective padding.
- There may be a prescribed schedule for use and rest.
- Monitor closely for skin irritation or breakdown.

Falls are a major health problem for older adults and can be of concern for people with certain developmental disabilities.

Falls

Fall statistics

- Approximately 75% of the falls in older adults occur in and around the home. The majority of these falls occur while walking or just turning around.
- Each year, 25% of people 65-74 years old that live in the community fall. The rate increases to over 35% among those 75 years and older.
- Older women experience significantly more falls than older men until age 75, when men and women fall at about the same rate.
- 50% of elderly persons who fall do so repeatedly.
- Unsteady shoes increase the risk of hip fractures 6 times.



Things that lead to falls

Many things can lead to falls for a client, including:

- vision and hearing problems
- impaired balance or awareness
- reduced strength
- alcohol or drug abuse
- seizures
- medications
- poor hydration or nutrition
- slowed reaction time

For people 65 and older, 50-75% of falls happen in or around the home.

National Center for Injury Prevention and Control

Consequences of a fall

There are many consequences of a fall for a client, including injury, fear, and loss.

Injury

- Falls result in approximately 200,000 hip fractures in older adults each year. Half of these people remain disabled.
- Other injuries often include fracture to the wrist, shoulder, or spine.
- Over 50% of all fatal falls involve people 75 years and older.

Fear and loss

Many clients fear falling (especially if they have fallen before) or lose confidence in their ability to move around safely. This fear can:

- limit his/her daily activities;
- increase his/her feelings of dependence, isolation, and depression;
- lead to a loss of mobility.

Fall Prevention



There are a great number of simple and practical things that can be done to reduce the risk of falling for a client. Report concerns you have about a client falling to the appropriate person where you work.

Encourage a client to:

- have routine eye exams and wear his/her glasses;
- have routine hearing exams and wear his/her hearing aides;
- do strengthening or balance exercises*;
- use a walker or other needed assistive devices;
- exercise*;
- get up slowly after sitting or laying down;
- reduce fall hazards in the home;
- have medications reviewed by his/her doctor.

* A client may require an individualized program designed by a doctor.

Footwear

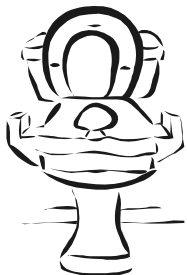
All clients should have sturdy walking shoes that support the foot. Shoes that tie or supportive sneakers with thin, non-slip soles and velcro fasteners to adjust for swelling of the feet are best. Slippers and jogging shoes with thick soles should be avoided.

Fall Prevention Tips

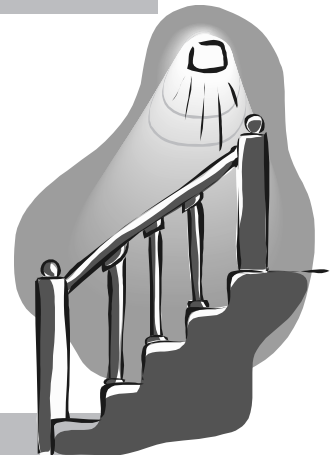


- Keep walkways clear - especially to the bathroom.
- Remove throw rugs and any other things a client may trip over.
- Rooms and stairs should be free of clutter.

- All rooms should have good lighting, especially hallways and stairs.
- Stairs should have a strong hand rail.
- Vary the colors at floor level so you can see where steps and edges are.
- Use nightlights in a client's room, in the hallway and in the bathroom.
- Avoid long robes, loose-fitting slippers and high heeled shoes.
- Keep things used most often on lower kitchen cabinet shelves.



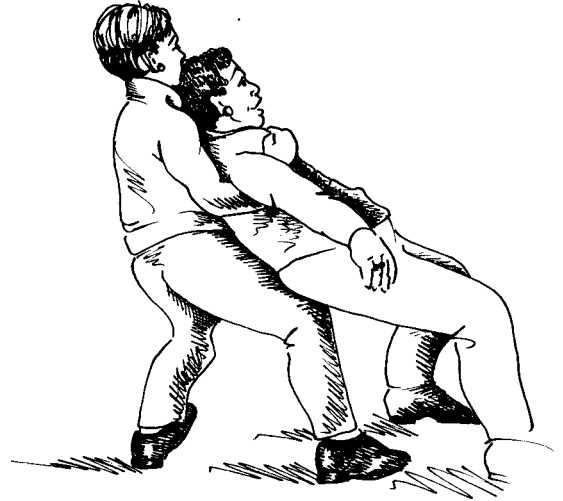
- Use hand rails in tubs and next to toilets.
- Use hand grips to help steady.
- Use safety toilet seats to make standing and sitting easier.
- Use mats in showers and tubs.



What to do if you see a client falling

Follow these steps if you see and can get to a client who is falling.

1. Don't try to stop the fall. You could both be injured.
2. Try to support the client's head and gradually ease the client onto the floor.
3. Keep your back straight, position your feet for a wide base of support. Flex at the knees and hips as you lower the client to the floor.
4. If you are behind the client, gently let him/her slide down your body.



What to do if a client has fallen on the floor

Follow your facility or agency policy about responding to falls. Below are recommended steps to take.

1. Ask the client how he/she feels.
Keep in mind, that most people are embarrassed and may want to get up or tell you everything is fine even if he/she is hurt. Observe the person carefully.
2. If the client says he/she feels **unhurt and comfortable getting up**, observe him/her carefully as he/she does so.

Depending on where you work, you may be expected to assist the client back to his/her pre-fall position. Follow your employer's policies and procedures. If the client has trouble getting up, you can help steady him/her, but **do not lift** him/her up.

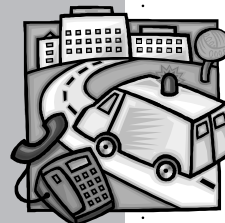
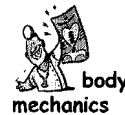
If the **client is injured**, your role is to get the client medical help. Individual providers should call 911. Caregivers in adult family homes or boarding homes should know and follow their employer's emergency policies and procedures.

Make the client as comfortable as possible and keep him/her warm by covering with a blanket until the EMTs or other medical help arrives.

Do not give the client anything to drink or move him/her.

3. Document and report the fall to the appropriate person where you work.

Know your facility or agency policy about responding to falls before something happens.





■ What to do if you see a client falling

1. Demonstrate skill.



Students are **not** expected to practice the skill.



Module 5 Module Review

1. ☒ True ☐ False If you see a client falling, do not try to stop the fall.
2. True ☒ False A transfer belt is **only** used if the client needs extensive help to transfer or walk.
3. During a transfer, do not have a client put his/her arms on your: (circle the correct answer)
 - a. **Neck.**
 - b. Shoulders.
 - c. Hips.
4. True ☒ False There is little you can do as a caregiver to reduce the risk of a client falling.
5. When helping a client to walk, you should walk slightly behind a client and on: (circle the correct answer)
 - a. His/her stronger side.
 - b. **His/her weaker side.**
 - c. Either side, it doesn't matter.
6. If a client has fallen and **is injured**: (circle the correct answer)
 - a. Lift him/her to a chair or bed.
 - b. **Get him/her medical help.**
 - c. Give him/her a glass of water.
7. Proper body mechanics mean you lift with your: (circle the correct answer).
 - a. Back.
 - b. Abdomen.
 - c. **Legs.**



Mrs. Johnson is an 89-year-old client living with congestive heart failure (CHF) and high blood pressure (hypertension). You have just come in her room and she is sitting in her recliner. She tells you that she got dizzy, fell a while ago, and climbed into the chair. She tells you she is not injured and asks you not to tell anyone she fell. She would like some help getting into her bed now.

RESEARCH:

Review the information on page 301 for CHF, page 314 for hypertension, and pages 91-93 for falls.

PROBLEM SOLVE:

1. Identify what problem(s) a caregiver needs to address in this situation.
2. Pick one problem and brainstorm ways to solve it. Pick a solution.
3. How does this impact how a caregiver provides care?

DEMONSTRATE

One group will demonstrate for the class the proper way to assist Mrs. Johnson out of her chair and assist her to walk to her bed.

Module Review



5 Minutes



20-30 Minutes

■ Module Scenario

1. Review with students the purpose of the module scenario. **Module scenarios** reinforce and give students practice in:
 - problem solving in common caregiving situations;
 - understanding how caregiving is impacted by a client's disease and/or condition;
 - performing the selected skill correctly while demonstrating respect towards a client and his/her rights.



See page Intro-6 in the *Course Structure and Teaching Techniques* for detailed information on how to do the Module Scenarios.

Transfers should be practiced in a skill station **before** beginning the Module Review and Module Scenario.



Module 6

Communication

Lesson 1

Basic Communication



40 Minutes

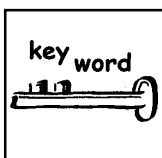
5 Minutes - Module Review

Personal Care Skills Covered

None



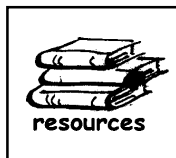
Icons to help guide you



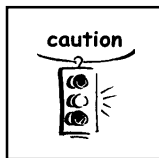
A word to remember



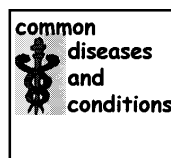
Something to report



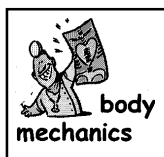
See the Resource Directory



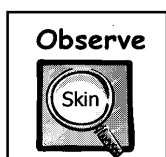
Beware or be careful



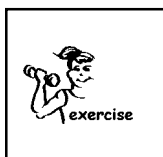
See the Common Diseases section



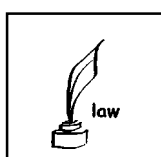
Use proper body mechanics



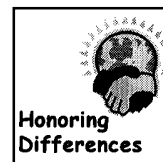
Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 6 - Lesson 1

Basic Communication



Managing your
Communication

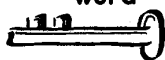
Active Listening

Managing Challenging
Communication

What you will learn in this lesson:

1. How to effectively manage your communication.
2. The importance and use of body language.
3. How to make sure your message is received correctly.
4. How to be an effective, active listener.

key word



Active listening

Definition

A way of listening that focuses entirely on the other person and makes sure you understood what was said

Body language

What you communicate via gestures, posture, facial expression, and eye contact

Feedback

A reaction or response to something

Good communication plays an essential role in developing and maintaining a positive relationship with a client and other care team members. Being a good communicator helps you:

- effectively and respectfully engage and connect with a client;
- communicate in ways that avoids problems, misunderstandings, and/or confusion;
- build trust and respect;
- get the information you need to do your job;
- problem solve effectively;
- ask for what you need.

Everything about you communicates something to others. It is impossible not to communicate, even if you are not talking. Your **body language** communicates messages to others. 90% of the messages you send to others are through your body language and tone of voice.

You are probably unaware of the impact of all of the messages you send to others through your body language. This can be the source of many communication problems in your relationships at work and home.

All of the things you communicate through your body language are lifelong habits. Becoming more self-aware of your body language and tone of voice is the first step in identifying and changing any communication habits that may not be working for you.

Body language communicates your emotions and the inner meaning behind your words to others. Emotions are difficult to cover up. Others pick up on any strong emotions you may be feeling - even if you **think** you are doing a good job of hiding them. It only takes an instant for things like a flash of anger, boredom, or disrespect to get communicated.

Effective use of body language in caregiving

Make sure your body language communicates respect and engages a client.

Gestures

Your gestures should create a feeling of openness and not be distracting.

- Use relaxed, smooth, and open-palm gestures.
- Avoid gestures that communicate tension or disrespect (e.g. tapping your feet, drumming your nails, swinging your legs).

Managing Your Communication

Body Language



Over **90%** of what you communicate is through body language and tone.



■ Body Language



In this module, photos have been used instead of clip art. This was done intentionally to provide you with good, visual, examples to use when covering the content for each section.

For example, the picture on page 97 can be used to start a discussion on the importance of body language. Below are some sample discussion questions.



Q: What is the woman's body language communicating?

Q: Where do these impressions come from?

Q: If this person told you everything was just fine, would you believe her? Why not?

Q: If, as a caregiver, your body language looked like this, how engaged and respected do you think the client would feel?



Posture

- Hold yourself in a way that looks natural, approachable, and confident.
- Stand at a comfortable distance away from a client (about an arm's length). The amount of distance that is comfortable depends on the person. If in doubt, ask!



Facial expressions

- Use pleasant, calm, open facial expressions.
- Match your facial expressions to your spoken words.
- Smile (if appropriate).

Check yourself frequently during the day to see how much tension you feel in your face. If you notice tightness or stress there, the chances are you may be stressed, upset, or tense. Your facial expressions could easily be communicating these emotions to others. Relax the muscles in your forehead and around your eyes and mouth. Taking several deep breaths can be a good, calming tool.

Eye contact

Good eye contact helps you connect to another person, show your sincerity and openness, and keep another's attention. Avoiding eye contact, in this culture, can make you seem not interested in the other person.

- Make direct eye contact with a client (if appropriate for his/her culture).
- Whenever possible, sit or stand at the same eye level of the person you are talking to.





Sample discussion questions

Q: What does this man's expression communicate?

Q: How would you feel about asking this person for help?

Q: Do you think the client would feel respected and would want to engage with this person?



Q: What messages are being communicated here?

Q: Do you think the client would feel respected and would want to engage with this person?

Effective use of your spoken words

Make sure the words you use and how you speak them helps you respectfully engage and connect with a client.

Words

- Think about what you want to say before you speak.
- Use simple words and common terms you are sure the client understands.
- Make one point at a time.
- Avoid rambling - make your points sharp and clear.
- Clearly pronounce each word without mumbling.
- Avoid using slang words or swearing.

You don't always have to use words. At times, saying nothing can be the best thing. A simple caring gesture can be the best message you can communicate.

Tone of Voice

- Use a respectful and calm tone.
- Do not speak to a client with tones you would use with a child.
- Use the mid range of your voice.

Pace of Speaking

- Your pace should be determined by the speed the other person can understand and process what you are saying. Often, though not always, a client may need you to speak slowly as he/she may need more time to process information. When in doubt, ask. "Am I going too fast? I will be happy to slow down".

Volume

- The client should be able to hear you easily without straining.
- Do not speak too loudly. It can be seen as being pushy or irritating.

Matching your body language with what you say

What you say is considered believable and trustworthy when your words, body language, and how you say something all communicate the same thing. When your messages don't match, the listener may become confused or suspicious. You can be viewed as untrustworthy and hurt your working relationship with a client or other care team members.



Effectively Engaging a Client

- ☐ Gestures and facial expressions create a feeling of openness and respect
- ☐ Posture looks natural, approachable, and confident
- ☐ Eye contact is appropriate
- ☐ Words chosen are thoughtful and understandable by the client
- ☐ Voice tone is calm, with pace and volume appropriate to the client
- ☐ Body language matches message

■ Matching your body language with what you say



Q: This person is your coworker, and you have just asked her if she has time right now to help you with something. She says "yes, no problem". Would you believe her? Why not?

Q: What other messages might this woman's body language be communicating?



Effectively Engaging a Client



5 Minutes

Purpose:

To help students understand the importance communication plays in demonstrating respecting and engaging a client.

1. Tell the class that you will be playing the role of a caregiver and demonstrating different interactions between a caregiver and a client.
2. Tell the class to look at the "Effectively Engaging a Client Checklist" as you demonstrate each interaction and ask them to pay attention to these different aspects of communication.
3. After each demonstration, lead a guided discussion (see below).

Instructor demonstrates:

- Crossed arms, tapping foot, hurried speech, telling the client that they need to hurry and move along.
- Elevate voice, infantile talking, calling the client sweetie or dear, and patting the client's head.
- Smiling, open body language, relaxed.



Q: Referencing the checklist, what were some of the things you observed?

Q: How would these types of messages affect the client? quality of care provided?

Q: How engaged and respected do you think the client would feel if this is what was being communicated?



The communication skills needed to effectively engage a client is something that should be reinforced throughout the remainder of the course. The student's will see important communication and client rights skills listed in the Skills Demonstration Checklists at the back of the Learner's Guide starting on page 326.

Students should use this list as a reminder to observe and provide feedback to each other when practicing personal care tasks in skill stations and performing the module scenarios.

Making Sure Your Message Has Been Understood



Feedback is the mirror of communication.

For you to communicate effectively with a client or other care team members, the other person needs to get your message the way you meant it. There are three ways to make sure your message is understood correctly. You need to:

1. Pay attention to how your message was received (**feedback**).
2. Communicate in ways that work best for the client.
3. Try again if it looks like the client didn't get the message the way you meant it.

Feedback

To know if the client has gotten the message the way you meant it, you have to look for feedback.

- Watch a person's body language. Are you seeing a puzzled look or a nod of understanding? Body language gives you important feedback. Good observation skills are important here.
- Ask for it. "Was that clear?" "Did you understand all that?"
- Pay attention to the other person's verbal response. Does it match the type of response you expected? Does it match what his/her body language is communicating to you?

Communicating in ways that work best for the other person

You learned earlier in the course that we use our physical senses to take in information when we learn (learning styles). We also use our physical senses (sight, hearing, touch) to understand the messages sent by other people.

Find out what your client's learning style is so you can tailor how and what you communicate in the way that works best for him/her. This helps you avoid miscommunication, confusion, and creates good rapport.

To learn what a client's learning style may be:

- listen for the words and phrases he/she uses;
- pay attention to how the client handles new information. Do they want to write it down, try it, read it, hear it, etc.?
- ask him/her directly, "would it be better if I wrote this down for you or should I remind you before I leave"?

Communication tips

Some clients may have a disability that makes certain parts of communication challenging. See the next page for some specific tips for working with clients whose disability might make certain parts of communicating challenging.

Communicating with a client who has difficulty...

Hearing

- Get the client's attention verbally or by touch (e.g. tap the person gently on the shoulder or arm).
- Face the client directly and keep your hands away from your face. Make sure there is enough light so the client can easily see your face.
- Speak slowly and carefully form your words.
- Use short, simple sentences.
- Reduce background noise and distraction as much as possible.
- Use gestures and facial expressions to help explain yourself.
- Check to make sure the client has understood what you said before moving on.
- Avoid chewing gum.



People over the age of sixty-five rank hearing loss as one of the most limiting of health problems. Yet, 60% of people who need hearing aids don't get them. See the Resource Directory page 262 for more information on how to encourage a client to get a hearing test or wear his/her hearing aids.

Communicating with a client who has difficulty...

Speaking

- Ask questions in a way that lets the client respond with one word, hand gestures, or a nod of the head.
- Watch the lips of the client to see if you can pick up any additional clues.
- Reduce background noise and distraction.
- Use pictures or props. Keep paper and pencil handy.
- Be patient. If you do not understand, ask again.
- Limit the amount of time of your conversations so you don't tire the client.

Communicating with a client who is living with a...

Cognitive impairment

- Speak slowly in a calm, soft, low, tone of voice.
- Ask one question at a time and wait for the response.
- Use exact, positive statements and phrases.
- Use simple, one step directions.
- Show how to do a task as well as explain it.
- Provide cues to help with transitions (e.g. "In five minutes, we'll be going to lunch").
- Reinforce information with pictures or other visual images.
- Include the client in your conversations, if appropriate. Never talk as though the client is not there.
- Remember, a person who has cognitive limitations is often very sensitive to your body language and tone. Keep your negative emotions in check.



There is a lot of information packed in these lists. Select and review several bullets. Encourage students to read through it again later.

Communicating with a client who is living with a ... Disability

- Treat the person as you would any other adult.
- Don't be afraid to ask questions when you're unsure of what to do.
- Just be yourself. Use a normal tone of voice and body gestures. Relax. Don't be embarrassed if you happen to use common expressions such as "Do you want to take a walk," or "I wish you could have seen it?" that might relate to a person's disability.
- Don't talk down to a person with disabilities. Gauge the pace, complexity, and vocabulary of your speech according to his/hers.
- If you have trouble understanding, don't nod or pretend that you do understand. Ask the person to repeat what he/she has said. If, after trying, you still cannot understand the person, ask him/her to write it down or find another way to communicate.
- Don't assume because someone has a disability, he/she needs help. The fastest way to find out if someone needs assistance, is to ask them. If he/she does want help, ask how before you act.
- Speak and ask questions directly to the person with a disability, not to another person who may be accompanying the person.
- When referring to a person's disability, be mindful of the language that you use. Talk about or refer to the person first - not a label. Say "person with a disability" rather than "a disabled person".
- If a conversation will last more than a few minutes and the person needs to sit or uses a wheelchair, sit down or kneel to communicate at eye level.
- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. Shaking hands with the left hand is also fine.



Active Listening

When listening to others, rate how often you do the following.

	Never	Sometimes	Often	Always
1. Daydream or think about other things instead of listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Think about what you're going to say instead of listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Judge what the person is saying instead of listening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Interrupt or talk over the person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Let your emotions get in the way of hearing the other person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Stop what you are doing to listen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Give the person your complete attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Make sure your body language shows you are listening (make eye contact, nod your head, lean towards the person)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Make sure you fully understood what the person has said	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 6 - Lesson 1

Basic Communication



■ Active Listening



3-5 Minutes

Purpose:

- to increase student's awareness of their own listening abilities/skills and where he/she may need to work at becoming a better active listener.



The checklist has been included as a self-assessment tool. Give students time to complete the checklist during this part of the lesson. Encourage students to be as honest with their answers as possible. Do not ask or expect students to share their answers.

1. Have students complete the survey.
2. Explain to students that they will be referencing it again later in the module.

Listening requires more than hearing words. It requires a desire to understand another human being, an attitude of respect, and a willingness to stay open to seeing things from another's point of view.

Active listening helps you:

- stay focused on the other person;
- have a better chance of understanding his/her message correctly;
- avoid misunderstandings;
- better understand what you are asked to do;
- connect with another person;
- show and receive respect.

Active listening takes energy, practice, and concentration. Listen with your whole self actively involved. Pay attention to both the content and the feelings of the person speaking.

The following are seven keys to becoming an effective active listener.

1. **Stop Talking!** You can't listen and talk at the same time.
2. **Put yourself in the other person's place.** Put yourself in the client's shoes and try to understand what he/she feels - not what **you** think he/she should think or feel. Don't assume that you know what the client is going to say. Fully understand what the other person is saying before you jump to your own conclusions or judgments.
3. **Show the person you want to hear them.** Face the other person - keeping good eye contact. Keep an open posture. Nod your head. Add comments that let the client know you are listening. For example, "I see." "Mm hmm." "Oh, really?" Make sure your body language continues to show interest throughout the conversation.
4. **Give the person your full attention.** Stop what you are doing and show the client you are interested in hearing what he/she has to say. Stay present during the conversation. Do what you can to limit distractions. Ask the client's permission to turn off the TV, close the door, or take a breath and stop what you're doing.
5. **Be patient and respectful.** Don't interrupt. Give the client time to finish before you jump in. Let the conversation be at the client's pace - not yours.

Active Listening



People are more likely to talk with you and let you help them if they feel you truly listen and understand them.

6. Watch your own emotions. If you have a strong emotional reaction to what you hear, be extra careful to listen carefully. Take a deep breath and relax. When you are emotional, you can miss critical parts of what is being said to you. Stay aware of your body language. You are likely to send negative messages if you are upset.

7. Make sure you understood the message. As a listener, there will be times when you are confused or not sure you fully understood what the speaker said. Here are some effective ways to verify or check things out.

Restating: In your own words, restate the client's basic ideas to test your understanding. This will help make sure you got the message as it was intended. You don't have to agree with what the client has said in order to do this effectively.

Clarifying: Ask questions and get more information if you don't understand something. Don't wait and risk your confusion growing into a larger misunderstanding. "I am confused by this point..." "I need more information to understand what you have said..."

Empathizing: If the client is upset, use your own words to acknowledge his/her feelings. "I can see you are frustrated..."

Anything that blocks good communication is a barrier to communication. The following are some common areas where caregivers may experience communication problems with the client or other care team members.

Environmental Barriers

Environmental barriers are things in the surroundings that in some way don't encourage communication. Environmental barriers can include:

- noise from a loud TV, radio, etc.;
- interruptions, such as other people walking in and out of the room or answering a telephone call in the middle of a conversation;
- physical problems such as it being too hot or cold or poor ventilation.



If we were supposed to talk more than we listen, we would have two mouths and one ear.

-Mark Twain



■ Active Listening (continued)

1. Review content.
2. Have students go back to their active listening survey (on page 102 of the Learner's Guide) and reflect on how they responded.
3. Reinforce to be an effective active listener, the goal for:
 - questions 1-5 is to be able to respond sometimes or never.
 - questions 6-9 is to respond often or always.
4. Ask for volunteers to share any "aha's" they had about their listening skills - both positive and needing work. Reinforce that reflecting on these areas help indicate where they can improve their active listening skills.

Ways to overcome environmental barriers, include:

- Limit distractions as much as possible. Request politely the person turn down the TV or not answer the phone when you are having a conversation.
- Plan a different time to talk when there are fewer distractions, interruptions, or more privacy.
- Dress for the environment. It is difficult to concentrate when you are physically uncomfortable.

Conversational Bad Habits

Conversational bad habits are habits that immediately stop or interfere with good communication. Three common conversational bad habits are imposing your point of view, advising, and avoiding. These habits need to be avoided when working with a client or other care team members.

Imposing your point of view is when you override the speaker. The other person often ends up feeling defensive and misunderstood. You impose your point of view by:

judging - "This wouldn't have happened if you weren't so..."

name-calling - "You stupid jerk, why..."

ordering - "Go do this right now""

threatening - "If you don't do this, I will make sure..."

using offensive words - "^*(&^*"

Advising is when you automatically step in to solve the person's "problem". This can be particularly harmful when you offer a solution without being asked to give one or when you don't have a complete understanding of the problem. Even when you mean well, the other person can end up feeling resentful or put down. Avoid saying things like, "If I were you, I would..." or "You should have thought before you did ..."

Avoiding is when you sidestep a conversation because you are uncomfortable or just don't feel the need to talk about something. Changing the subject or drawing attention to yourself are ways of avoiding a conversation. Avoid saying things like, "Let me tell you about something similar that happened to me"... or "Well, enough about that, did you see that show on TV last night"?



When you are arguing with a fool, make sure he isn't doing the same thing.

- Unknown

■ Barriers to Effective Communication continued



1. Have students list any barriers to effective communication where they work.
2. Have students brainstorm effective ways to eliminate these barriers.

Managing Challenging Communication



Although conflict with others can be uncomfortable, conflict itself isn't always bad. Conflict can be positive when it helps people:

- clarify important problems and issues;
- resolve a problem;
- release emotions in a healthy way;
- come to a place of trust and understanding.

However, unresolved or poorly handled conflict or problems can be damaging, and in certain cases, even dangerous to you or a client's emotional and/or physical well-being.

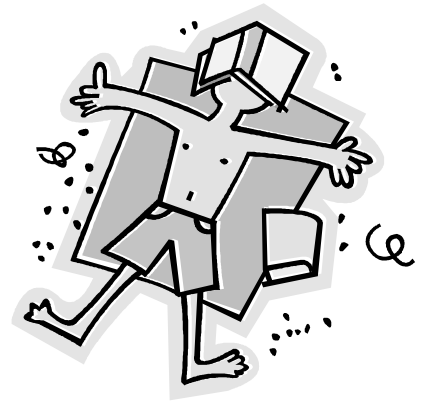
Dealing with difficult behaviors

Difficult behaviors in others can make your life miserable if you let them. Since you can't change the other person, learn to focus on changing the way you react to them.

One important goal when dealing with difficult behaviors in others is to remain calm and balanced. There are a variety of ways to do this. Practice them so you can use them successfully when they are needed most.

To remain calm and balanced when faced with difficult behaviors:

1. Train yourself to recognize when you are reacting. Then, make a conscious choice how you want to respond.
2. Use the tools you have practiced (see below and on the next page for some examples).
3. Practice a gentle assertiveness on your own behalf. Standing up for yourself avoids a buildup of resentment, hurt, or angry feelings.



Getting back to calm and balance

When faced with negativity, our natural response is to react with negativity. To stop negative reactions, try:

- staying focused on achieving what you want.
- breathing deeply.

A woman is like a tea bag. You never know how strong she is until she gets into hot water.

— Eleanor Roosevelt.

Good communication and active listening skills help in conflict or problem situations.



This would be one excellent place to introduce and use the deep breathing exercise found on page 202 of the Learner's Guide.

- being patient with yourself. Look at each difficult exchange as a lesson in how to deal with others.
- focusing on the **behaviors** that are difficult, **not the person**.
- repeating a positive phrase to yourself (e.g. "I am calm and centered").
- imagining a scene, person, or experience that gives you a feeling of calm.
- remembering that you have options, such as asking for politeness or leaving the room/area.
- remaining quiet until you feel yourself centered and balanced.

Tips for dealing with specific difficult behaviors

Some caregivers may be in situations where a client's behavior becomes difficult. Difficult behaviors can include things like a client becoming angry or violent, sexually inappropriate, or disrespectful towards you.

This may be caused by several factors, including:

- his/her disease or condition;
- side-effects of medication;
- environmental factors (e.g. too much noise or distractions);
- your way of communicating with a client.

See the Resource Directory pages 264-266 for tips on handling these types of difficult behaviors.



"In the middle of difficulty lies opportunity."
— **Albert Einstein**



Module 6 Module Review



5 Minutes

1. ☒ True ☐ False Your body language communicates respect when your facial expressions and gestures are open and relaxed.
2. True ☒ False Most of what you communicate is through the words you speak.
3. To communicate effectively with a client, he/she needs to: (circle the correct answer)
 - a. Like what you have to say.
 - b. Understand what you said the way you meant it.**
 - c. Sit close to you when you are talking.
4. When faced with difficult behaviors from others, it is best to: (circle the correct answer)
 - a. React in a similar manner.
 - b. Remain calm and balanced.**
 - c. Defend yourself at all costs.
5. To be an effective active listener: (circle the correct answer)
 - a. Stay focused on the task you are doing.
 - b. Stop what you are doing and focus on the speaker.**
 - c. Focus on what you want to say while the speaker is talking.
6. A client is upset and you are not sure you have understood what he is telling you. You should: (circle the correct answer)
 - a. Let it go. If it is important it will come up again.
 - b. Restate his basic ideas in your own words to test your understanding.**
 - c. Tell him you aren't going to listen until he calms down.
7. To make sure what you say communicates respect and engages the client, you should: (circle the correct answer)
 - a. Think about what you want to say before you speak.**
 - b. Say whatever comes to your mind.
 - c. Say what you think the client wants to hear.
8. ☒ True ☐ False Offering a solution to a client's problem without being asked can be a barrier to good communication.
8. True ☒ False Your body language has little impact on how a client reacts to you.



Module 7

Skin and Body Care

Lesson 1

Skin Care



1 Hour 5 Minutes

30 Minutes - Module Scenario

Lesson 2

Body Care



Day 2

1 Hour 25 Minutes

Day 3

2 Hours

10 Minutes - Module Review

30 Minutes - Module Scenario

Personal Care Skills Covered

Turn and Reposition a Client

Mouth Care

Clean and Store Dentures

Shaving With a Safety Razor

Fingernail Care

Foot Care

Bedbath

Assist Client with Weak Arm to Dress

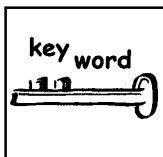
Put Knee-High Elastic Stocking on Client

Passive Range of Motion - Shoulder

Passive Range of Motion - Knee and Ankle



Icons to help guide you



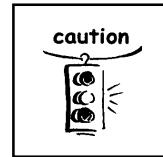
A word to remember



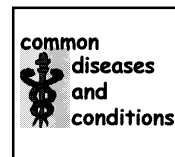
Something to report



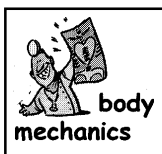
See the Resource Directory



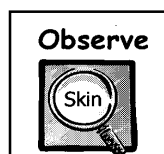
Beware or be careful



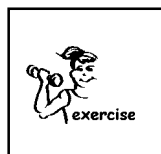
See the Common Diseases section



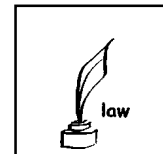
Use proper body mechanics



Observe skin



Classroom exercise



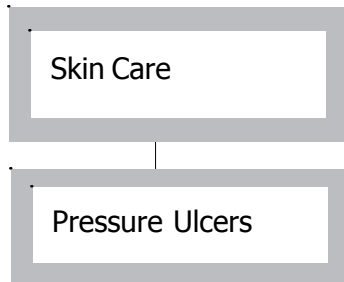
Something in the law



Be alert and respectful

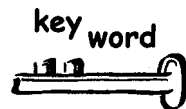
Module 7- Lesson 1

Skin and Body Care



What you will learn in this lesson:

1. A caregiver's role in client skin care, including:
 - promoting healthy skin;
 - routinely observing a client's skin;
 - knowing the types of skin problems to look for;
 - documenting and reporting skin problems immediately.
2. What pressure ulcers are and how to help prevent them.



Definition

Nurse Delegation	When an RN delegates nursing tasks to qualified NACs or NARs
Pressure ulcers or Pressure sores	Skin breakdown or injury caused by pressure that damages the skin and underlying muscle
Pressure points	Places on the body where the bone causes the greatest pressure on the muscles and skin
Self-Directed Care	When an in-home client directs an Individual Provider to help him/her with health related tasks
Skin breakdown	Any break in the skin, creating a risk for infection and further injury
Sterile dressing	A protective, bacteria-free, covering put on an injury

The four important caregiving roles in client skin care include:

1. Promoting healthy skin.
2. Routinely observing a client's skin.
3. Knowing the types of skin problems to look for.
4. Documenting and reporting problems immediately.

Skin is the first line of defense a client has to heat, cold, and infection. Skin changes as we age and sometimes because of a chronic illness. These changes can lead to the:

- skin becoming thinner and dryer - tearing easier and not healing as easily;
- loss of the layer of fat just below the skin, decreasing the ability to stay warm;
- sweat glands losing the ability to cool in heat;
- loss of the ability to feel pain, heat, or light touch.

There are five ways to help a client keep his/her skin healthy.

1. Keep skin clean.

- Keep skin, nails, hair, and beards clean.
- Set up a routine bathing schedule.
- When bathing, use warm, **not hot** water and **mild** soaps. Monitor water temperature to avoid burns for any client who has lost the ability to feel heat.
- Take extra care to make sure skin folds are clean and dry for clients who are obese. Skin folds hold bacteria, dirt, and old skin cells.
- In-between baths, clean the skin as soon as you see something on it.

2. Keep the skin dry.

- Use pads or briefs that absorb urine and keep moisture away from the skin for clients with incontinence. Use a cream or ointment as further protection for the skin.
- Avoid using "blue pads" or disposable waterproof underpads that can hold moisture on the skin. A waterproof **cloth** pad that can be laundered and reused is a good alternative.

3. Use moisturizing creams and lotions.

- Gently apply lotion to dry skin regularly.

A caregiver can apply:

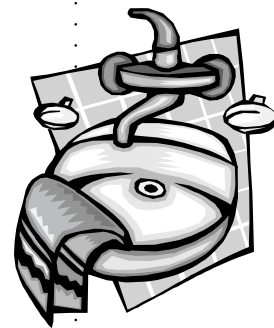
- non-prescribed ointments or lotions (e.g. dandruff shampoo or body lotion to prevent drying of skin);
- or change a bandaid in response to a first-aid situation.

A caregiver can **NOT**:

- change **sterile dressings**;
- apply a prescribed lotion or ointment used to treat a condition (unless under **Nurse Delegation** or **Self-Directed Care**).

Skin Care

Promoting Healthy Skin Care




4. Encourage good nutrition.

- Diet contributes a great deal to healthy skin. Encourage a client to eat a healthy, well-balanced diet and to drink plenty of fluids (unless on a fluid restriction). See pages 135-142 for more detailed information about good nutrition and page 148 for more information about getting enough water.

5. Encourage mobility.

- Encourage a client to stay as mobile as possible.
- Encourage activities or exercise that help increase circulation.

Skin Problems a Caregiver May See	
Type of Problem	What is it?
Pressure Ulcers (or Bed Sore) 	Skin breakdown or injury caused by pressure and/or weakened skin that damages the skin and underlying muscle.
Stasis/Venous Ulcers	A chronically open area, caused by poor circulation of the blood in the veins. Early symptoms are a rash or a scaly, red area and itching. The skin around the ulcer becomes a discolored reddish-brown. This occurs most often on the lower legs and feet.
Arterial Ulcers	Round open areas on the feet and lower leg due to lack of blood flow to the legs.
Rashes and Infections	Most rashes are raised, red, bumpy areas on the skin that are often itchy. Skin infections are a break in the skin, like a scratch, where bacteria have spread and caused an infection.
Burns	Skin that is damaged by fire, sun, chemicals, hot objects or liquids, or electricity. Burns are classified according to how deeply the skin is damaged. 1 st degree burns are when the skin is reddened and maybe swollen and tender. 2 nd degree burns usually have blisters, intense redness, pain and swelling. 3 rd degree burns are the most serious and involve all layers of the skin.
Skin Cancer/Lesions	Abnormal growth on the skin that usually doesn't spread and is treatable. A more dangerous kind of skin cancer is melanoma. Melanomas are irregularly shaped and may be described as a "strange mole" or a mole that is changing. If a client has a strange mole, encourage him/her to contact their doctor.

Observe a client's skin whenever you are doing personal care. Look at the client's skin at least once a day.

Observe



What to Look For

- ☐ Redness or other changes in coloring
- ☐ Swelling
- ☐ Changes in temperature (warm or cold)
- ☐ A break in skin
- ☐ Rashes, sores, or a gray or black scab over a pressure point
- ☐ Odor
- ☐ Pain

Observing any of these signs could be an indication of a skin problem and should be reported to the appropriate person in your care setting.

What causes pressure ulcers

Immobility is the number one cause of pressure ulcers. When a person sits or lies in a position too long without moving, the weight of his/her body puts pressure on the skin and muscle. The pressure can be from a bone pressing against another part of the body or from a mattress or chair. This unrelieved pressure cuts off blood supply to the skin. Without a blood supply, the skin - and eventually the muscle under it - dies and a pressure ulcer forms.

The amount of pressure needed to cause a pressure ulcer ranges from a small amount of pressure for a long time to high pressure for a short time.

Pressure ulcers can also be caused when the skin is weakened by:

- friction;
- too much moisture on the skin;
- dryness and cracking;
- age;
- irritation by urine or feces;
- lack of good nutrition and/or drinking enough fluids;
- certain chronic conditions or diseases - especially those that limit circulation.

High risk for pressure ulcers

Clients who are fully or partially immobile or with weakened skin are at high risk for getting a pressure ulcer. This includes clients:

- in wheelchairs or who spend a lot of time in a chair or bed;
- who have had a pressure ulcer in the past;
- who are paralyzed;
- who have unmanaged incontinence;
- with poor nutrition or dehydration;
- with a chronic illness, like diabetes, that decreases circulation;
- with cognitive impairments that make him/her forget to move;
- who have a decreased ability to feel sensation;
- who are obese or too thin.





■ High risk for pressure ulcers

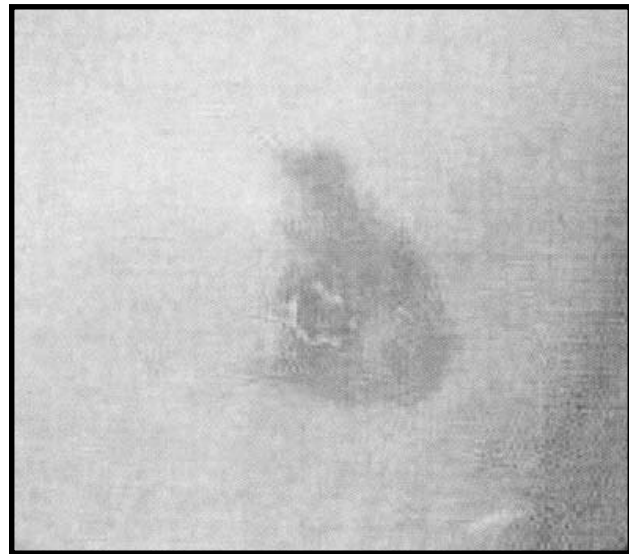
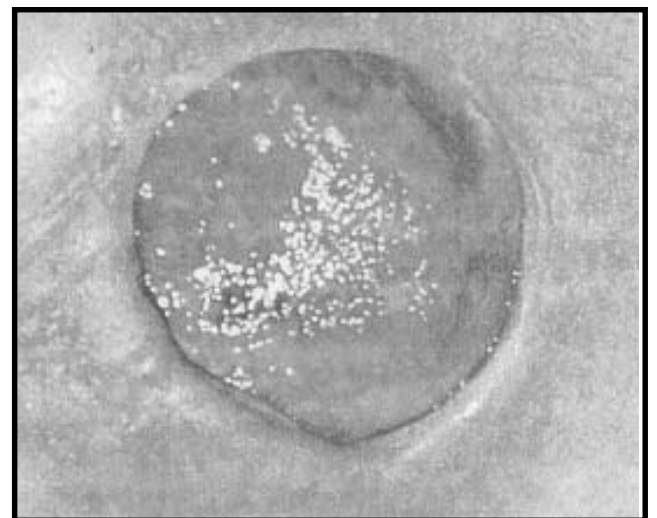
1. Review content.
2. Explain **why** each situation might put a client at risk for a pressure ulcer. Highlight any aspects of promoting healthy skin care that help to prevent pressure ulcers in each area.

What pressure ulcers look like

What a pressure ulcer looks like depends on how severe it is. The first signs of a pressure ulcer include:

- redness on unbroken skin lasting 15-30 minutes or more in people with light skin tones. For people with darker skin tones, the ulcer may appear red, blue, or purple. If in doubt, compare the area to the other side of the client's body.
- any open area - it may be as thin as a dime and no wider than a Q-tip.
- an abrasion/scrape, blister, or shallow crater.
- texture changes - the skin feels "mushy" rather than firm to the touch.

A pressure ulcer can sometimes look like a gray or black scab. Beneath the scab is a pressure ulcer. If you notice a scab over a **pressure point**, report it to the appropriate person in your care setting. Do not remove the scab. If a pressure sore is beneath it, this could cause damage or lead to infection.





■ What pressure ulcers look like

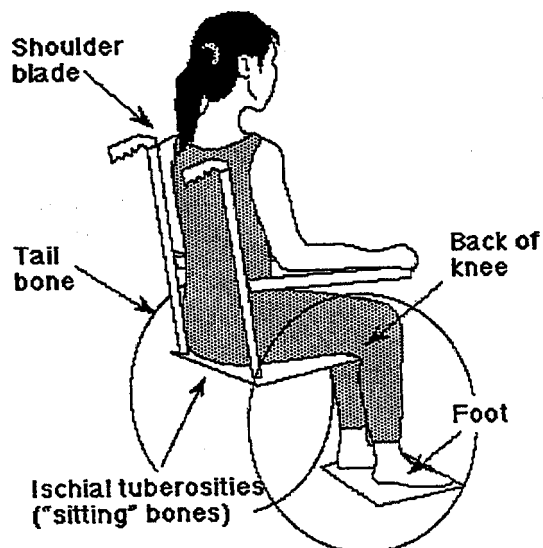
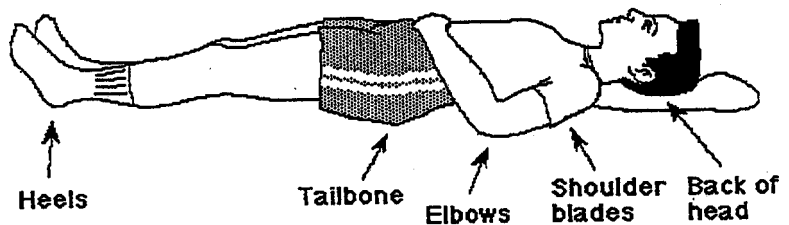
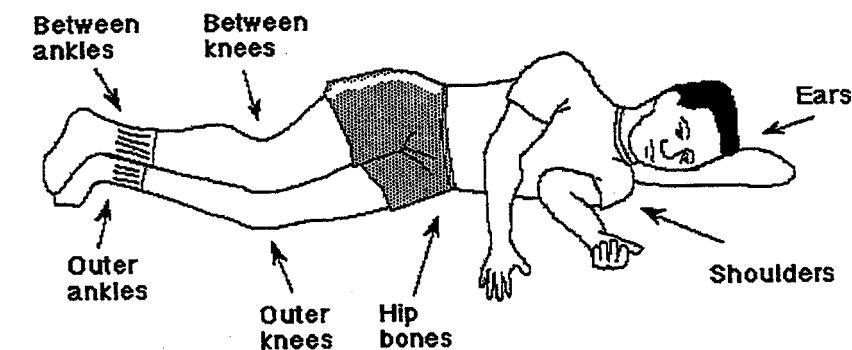
1. Review content.



Color pictures are the most helpful visual aide for students. Supplement the pictures here with your own.

Pressure points

Pressure points are likely areas for pressure ulcers.



What to do if you see a problem

Anytime you see redness on unbroken skin or feel heat in the area lasting 15-30 minutes or more - especially at a pressure point:

- reposition the client off of the red area immediately to remove pressure from the area.
- **report it** to the appropriate person where you work. Make sure you know ahead of time who to report to about this kind of situation. Document your concerns.



Do not:

- massage the area or the skin around it.
- use a heat lamp, hair dryer, or "potions" that could dry out the skin more.

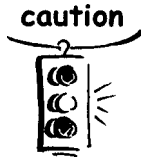
■ Pressure Points

1. Review each of the different possible pressure points. Clearly note on your own or a volunteer's body exactly where each of the pressure points would be.
2. Ask students to brainstorm what can happen that would be a problem for several of the major pressure points (e.g. someone sleeping on his/her hipbone);
3. Ask students to brainstorm things they could do or use to help prevent pressure in these situations.



Changing a Client's Position

A client needs to change position frequently to protect his/her skin. A pressure ulcer can start in as little as one to two hours for clients in bed and unable to move. Clients who sit in chairs and can't move can get pressure ulcers in even less time because the pressure on the skin is greater.



A client confined to bed should change position **at least every 2 hours**. A person confined in a chair or wheelchair should shift his/her weight in the chair at least **every 15 minutes for 15 seconds** and change position at least **every hour**.

Preventing friction to the skin

Friction is caused when skin is rubbed against or dragged over a surface. Even slight rubbing or friction on the skin may cause a pressure ulcer - especially for those clients with weakened skin.

Special care by a caregiver must be made when transferring and positioning a client. A client must always be:

- lifted - not dragged when transferring;
- positioned in a chair or bed correctly so he/she cannot slide down;
- positioned on smooth linen or clothing.

Skill: Turn and Reposition a Client in Bed



1. S.W.I.P.E.S.
2. Bend client's knees.
3. Before turning client, move client's body towards self.
4. Place your hands on the client's hip and shoulder and gently roll the client over on his/her side away from you.
5. Position client in proper body alignment:
 - head supported by pillow;
 - shoulder adjusted so client is not lying on arm and top arm is supported;
 - back supported by supportive device;
 - top knee flexed, top leg supported by supportive device with hip in proper alignment.
6. Cover client with top sheet.
7. Remove gloves (if used) and wash hands as final step.





Skill: Turn and Reposition a Client in Bed

- 1. Demonstrate skill. Students are expected to practice the skill at a skill station.**



Highlight the need for proper body mechanics.

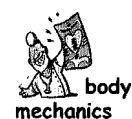
Reinforce what "proper" body alignment is in a bed **AND a chair**.

Since repositioning is part of the Module Scenario for this lesson, you can wait and have students practice the skill then - or have them practice before you do the Scenario.

If you have students practice now, it is still expected that one group will demonstrate the skill after the Module Scenario research, problem solving, and discussion steps.

The following are **general tips** to remember when **repositioning a client**.

- Make sure there is room to roll the client.
- Tell the client to look in the direction they are being rolled.
- Do not roll the client by pulling or pushing on his/her arm.



Skin care tips for positioning a client confined to a bed or chair

- A special mattress that contains foam, air, gel, or water may be used. A doctor or the case manager can help the client get special equipment. Check the mattress daily to make sure it is working properly.
- Do not use donut-shape cushions. They reduce blood flow and cause tissue to swell. This increases the risk of a client getting a pressure ulcer.
- Choose a position that spreads weight and pressure most evenly.
- Use pillows or wedges to keep knees or ankles from touching each other.
- Place pillows under the client's legs from mid-calf to ankle to keep a client's heels off the bed if a client can't move at all.
- Never place pillows directly behind the knee. It can affect blood circulation and/or increase the risk of blood clots.
- Be cautious about raising the head of a bed. This puts more pressure on the tailbone and allows the client to slide, possibly causing a pressure ulcer. Lying flat can be a problem for clients who have difficulty breathing. If this is the case, the head of the bed should not be raised at more than a 30° angle, unless necessary for breathing.
- Avoid positioning a client directly on the hipbone when he/she is lying on their side. Tuck pillows behind a client's back when in this position.



Mr. Bernard is a 44-year-old client who had a stroke (CVA) six months ago. The results from the stroke have left Mr. Bernard depressed. He has weakness on his left side and needs help with many care tasks including positioning himself in bed. Since this morning, Mr. Bernard has refused to get out of bed and has stayed in the same position for several hours.

RESEARCH:

Review page 321 on stroke (CVA) and page 305 for depression. Review information on pages 113-117 on pressure ulcers and changing a client's position.

PROBLEM SOLVE:

1. Identify what problem(s) a caregiver needs to address in this situation.
2. Pick one problem and brainstorm ways to solve it. Pick a solution.
3. How does this impact how a caregiver provides care?

DEMONSTRATE

One group will demonstrate for the class repositioning Mr. Bernard in his bed, making sure to avoid pressure on areas at risk for skin break down.



■ Skin care tips for positioning a client confined to a bed or chair

1. Review content.



2. **Demonstrate** proper placement of pillows and proper positioning of a client if the head of the bed must be raised. **Students are not expected to practice skill.**



20-30 Minutes

Module Scenario



Lesson 2 of this module should not be started until after the completion of the Module Scenario.

Module 7- Lesson 2

Skin and Body Care



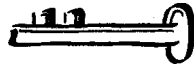
Personal Hygiene

Assisting a Client to Dress

What you will learn in this lesson:

1. Your role in helping a client perform personal hygiene, bathing, body care, and getting dressed.

key word



Definition

Body care

Helping the client with exercises, skin care, and changing dry bandages

Personal hygiene

Cleaning and grooming of a person, including care of hair, teeth, dentures, shaving, and filing of nails

Range of motion

How much a joint can move



Time has been allocated on both days 2 and 3 for this lesson to allow students enough time to practice all of the skills.

In addition, instructors may choose to use some of the practice time to test or finish testing students on the mandatory skills of handwashing, putting on and taking off gloves, and transfer. Students not being tested should be busy practicing in their DOC teams on the new skills you have covered.

Things to keep in mind about timing, demonstrations, and student practice

Students:

- need to be able to practice a skill as soon as possible after watching a demonstration;
- reach a certain saturation point after watching many demonstrations in a row;
- find it difficult to retain what they have seen if they watch a series of skills demonstrated and leave for the day before being able to practice.

It is recommended that you demonstrate and have students practice **a small subset** of skills on Day 2.

If any DOC team finishes early, encourage students to also go back and practice any of the other skills they have learned thus far in the course.

See page Intro-5 in the *Course Structure and Teaching Techniques* for a list of instructor responsibilities during skills practice.

Personal hygiene is a very important part of helping to keep a client's skin and body healthy. Being well-groomed is also an important psychological and physical boost for most people. This lesson covers the personal hygiene tasks you may be asked to help a client do.

Personal Hygiene



Mouth care

Proper care of the mouth and teeth supports a client's overall health and helps prevent mouth pain, eating difficulties, speech problems, digestive problems, tooth decay, and gum disease.

To help prevent decay and gum disease, teeth should be brushed twice a day with fluoride toothpaste (if available). It is even better to brush after every meal. Teeth should be flossed at least once a day to clean between the teeth where the brush misses.

Watch for, document, and report any sore areas in the mouth, changes in tissue, complaints a client may have in eating comfortably, or anything unusual inside the client's mouth.

See the Resource Directory page 267 for more information on gum disease, dry mouth, and oral cancer.



Skill: Mouth Care



1. S.W.I.P.E.S.
2. Ensure client is in an up-right sitting position.
3. Put on gloves.
4. Place towel across client's chest before providing mouth care.
5. Moisten toothbrush or toothette and apply toothpaste.
6. Clean entire mouth (including tongue and all surfaces of teeth), with brush or toothette, using gentle motions.
7. Assist client to rinse his/her mouth.
8. Hold basin to client's chin.
9. Wipe client's lips and face, and remove towel.
10. Dispose of soiled linen in soiled linen container.
11. Clean and return toothbrush, toothpaste, etc. to proper storage.
12. Remove gloves and wash hands.



■ Skill: Mouth Care

1. **Demonstrate skill.** Students are expected to practice the skill at a skill station.

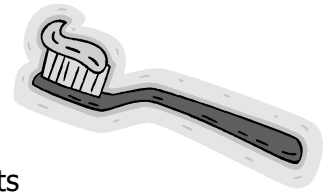


Students are expected to practice **all of the skills** in this lesson at skill stations with their DOC teams.

See pages Intro 4 - Intro 5 in the *Course Structure and Teaching Techniques* for more detailed information and recommendations on skills demonstrations and clustering skills in skill stations.

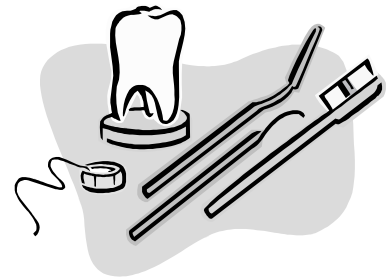
The following are **general tips** when helping a client with **mouth care**.

- When assisting with brushing, use short, circular movements, gently brushing the teeth with a massaging motion around each tooth. Make sure to work in a pattern so no teeth are missed.
- A soft bristle toothbrush is recommended by dentists and should be replaced when the bristles get worn (normally every three months).
- Make sure you have good light and can see what you are doing.
- Be careful not to touch the toothbrush bristles or any oral health item to other surfaces such as the counter, the sink, your bare hands, etc.
- Do not contaminate faucets, drawer handles, or other surfaces by touching with gloves that have been in contact with the client's mouth.
- If a client has difficulty grasping a toothbrush, make the handle bigger with a sponge, rubber ball or adhesive tape. An electric toothbrush may be easier to manage than a manual brush in this case.
- Toothettes, moistened gauze pads, or "Oral-B Brush-Ups" may not clean the teeth completely and can push food further into the spaces between the teeth. These products are useful in cleaning mouth tissues when the client has no or just a few teeth, or for a client who is unable to open his/her mouth.



The following are **general tips** when helping a client with **flossing**.

- Start with a strand approximately 18 inches long.
- Use a prethreaded flosser or floss holder (a great assistive device), or wrap the floss around the middle finger of both hands.
- Use your thumbs and forefingers to control the floss.
- Gently ease the floss between the client's teeth using a gentle back and forth motion.
- Carefully rub up and down, gently moving the floss from under the gum line to the top of the tooth. Keep the floss against the tooth so you don't injure the gums.
- If a client has not flossed before or recently, the gums may bleed when you floss. If the client has heavy deposits on his/her teeth, it may be difficult to get the floss between his/her teeth.



Denture Care

Like natural teeth, dentures must be properly cared for to last. If the client does not have any teeth or wears dentures, gums and mouth should be brushed and cleaned at least twice daily.

Watch for, document, and report any problems a client may have with dentures such as discomfort, trouble eating, speech problems, complaints of the dentures not fitting correctly, sore spots under or around the denture, or odor.



Skill: Clean and Store Dentures



1. S.W.I.P.E.S.
2. Put on gloves.
3. Line sink/basin with a towel/washcloth or by filling it with water.
4. Obtain dentures from client or gently remove them from client's mouth if he/she is unable to do so. Take the lower denture out first, then the upper denture.
5. Rinse dentures in cool running water before brushing them.
6. Apply toothpaste or denture cleanser to toothbrush.
7. Brush dentures on all surfaces.
8. Rinse all surfaces of denture under cool, running water.
9. Rinse denture cup before putting dentures in it.
10. Place dentures in clean denture cup with solution or cool water.
11. Return denture cup to proper storage.
12. Clean and return supplies and equipment to proper storage.
13. Dispose of sink liner.
14. Remove gloves and wash hands.

The following are **general tips** when helping a client with **denture care**.

- Allow dentures to soak overnight (or for several hours, depending on dentist's recommendations or the client's preference).
- Inspect dentures for cracks, chips, or broken teeth.
- Dentures can chip, crack, or break even if only dropped a few inches. They are also slippery. Take extra care to avoid dropping them.
- Place clean dentures on clean surfaces, such as the denture cup after it is rinsed.
- Avoid hard-bristled toothbrushes that can damage dentures.
- Do not put dentures in hot water - it can warp them.

- Do not soak dentures in bleach water. Bleach can remove the pink coloring, discolor the metal on a partial denture, or create a metallic taste in a client's mouth.
- Ask the client what denture cleaning product he/she uses. Hand soap, mild dishwashing liquid, or special denture cleaners are all acceptable. Do not use powdered household cleaners that are too abrasive.
- Don't let dentures dry out - they lose their shape.
- Never soak a dirty denture. Always brush first to remove food debris.



Skill: The Shave (With Safety Razor)

1. S.W.I.P.E.S.
2. Put on gloves.
3. Ask client if he/she wears dentures. If so, make sure they are in his/her mouth.
4. Wash face with warm, wet washcloth.
5. Apply shaving lather to the area you are going to shave.
6. Hold razor securely.
7. Hold skin taut with free hand and shave with smooth even movements in the direction of hair.
8. Rinse safety razor in warm water between strokes to keep the razor clean and wet.
9. Shave sides first, then nose and mouth.
10. Wash, rinse, and dry face.
11. Clean equipment and put away.
12. Remove gloves and put in appropriate container.
13. Wash hands as final step.

Observe



The following are **general tips** when helping a client with **shaving**.

- Do not press down hard or move the razor/shaver too fast over a client's face.
- Shave the most tender areas of the face (the neck area below the jawbone) first and then move up to the tougher areas of the face between the ears, nose, and mouth.



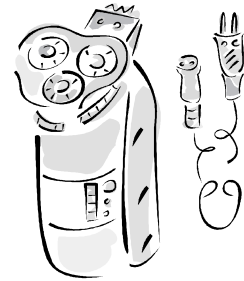
Clients taking blood thinning medication should be encouraged to use an electric razor.

Module 7 - Lesson 2

Skin and Body Care

If using an electric razor,

- Clean the shaver's screen and cutter regularly. It is good to clean a shaver after every third shave, and best after every shave.
- All electric razors are not the same. It takes time for a client's face to adjust to using a different brand electric shaver.



Nail care

Nail care includes both fingernails and toenails. Nail care may be a part of the bath routine.



If a client has a circulatory problem or diabetes, **you may not cut the client's toe or fingernails.**

Skill: Fingernail Care



1. S.W.I.P.E.S.
2. Put on gloves.
3. Put water in bowl. Test water temperature to make sure it is safe and comfortable before placing client's fingers in water. Adjust if necessary.
4. Place water at a comfortable level for client.
5. Put client's fingers in water and allow to soak.
6. Dry client's hand including between fingers. Pat, don't rub dry.
7. Clean under nails with orange stick. Wipe orange stick on towel after each nail.
8. Groom nails with file or emery board.
9. Finish with nails smooth and free of rough edges.
10. Empty, rinse, wipe water bowl, and return to proper storage.
11. Dispose of soiled linen properly.
12. Remove gloves and wash hands.

The following are **general tips** when helping a client with **fingernail care**.

- Sawing back and forth with an emery board and going too deep into the corners can split and weaken nails. Go from side to side in one direction or file each nail tip from corner to center.
- Cuticles act as a barrier to infection. Do not clip them.
- Apply a moisturizing cream or lotion to the hands and cuticles after you are done.



Skill: Foot Care



1. S.W.I.P.E.S.
2. Put on gloves.
3. Put water in basin. Test water temperature. Ensure it is safe and comfortable before placing client's feet in water. Adjust if necessary.
4. Put the client's foot completely in the water.
5. Supporting foot and ankle properly throughout procedure, remove foot from water, wash entire foot, including between toes, with soapy washcloth.
6. Rinse and then dry entire foot, including between toes. Pat, don't rub dry.
7. Gently clean dirt out from under nails using orange stick.
8. File or cut nails, straight across, as needed with clippers or emery board.
9. Put lotion in your hand and massage lotion on client's entire foot. Remove excess (if any) with towel.
10. Assist client to replace socks and shoes.
11. Empty, rinse, wipe bath basin, and return to proper storage.
12. Remove gloves and wash hands.

Observe



The following are **general tips** when helping a client with **foot care**.

- Inspect your client's feet regularly for changes in color (especially redness), temperature, blisters, cuts or scratches, cracks between the toes, or other changes. Document and report any swelling or redness you notice around the area.
- Monitor minor cuts and keep them clean.
- Do not put lotion in-between the toes - the lotion causes moisture that promotes fungal growth.
- Do not cut down the corners of a client's toenails or dig around the nail with a sharp instrument.
- Never cut the nails too short as this may cause ingrown toenails.
- After cutting, file the nails downwards.
- Cuticles act as a barrier to infection. Do not clip them.

Bathing

A bath leaves all of us feeling refreshed and in a more relaxed frame of mind. A bath serves other important purposes for a client, including it:

- cleans the skin;
- stimulates circulation;
- provides movement and exercise;
- provides an opportunity to observe the client's skin.

Observe



How often baths should be given depends on the client's physical condition, age, skin type, and personal wishes. Bathing can take place in a tub, shower, in a bed, or as a sponge bath. Baths given in the tub may be more enjoyable for the client if he/she is able to do so.

Older people and some people with chronic illnesses have less skin oil and perspiration. Therefore, they may not need a daily bath or may only need a sponge bath.

Bathing equipment

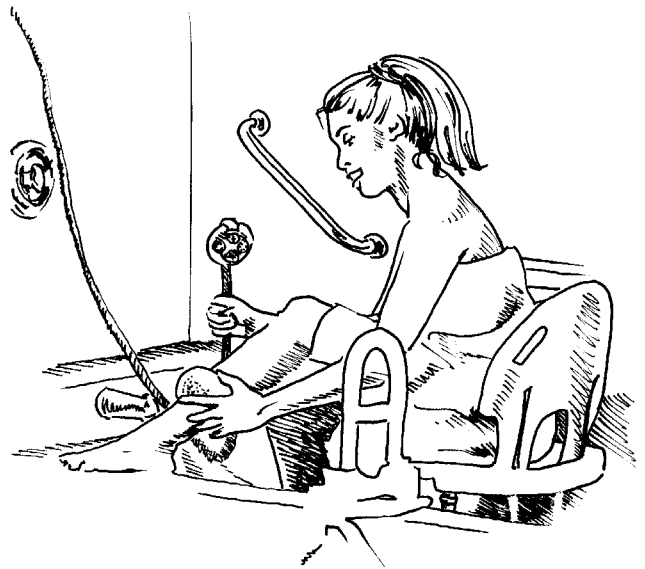
Ideally, the bathroom should have the following equipment:

- bath mat;
- bath bench;
- hand held shower;
- grab bars in the right places.

If the bathroom does not have these items, talk with the appropriate person where you work to find out how a client can get needed equipment.

The following are **general tips** when helping a client with a **bath**.

- When assisting with a bath, start at a client's head, work down and complete his/her front first, unless the client has another preference.
- Use less soap - too much soap increases skin dryness.
- Fragile skin requires a very gentle touch.
- Make sure the lighting is good.
- Make sure the bathroom is warm and without drafts.



Skill: Bedbath



1. S.W.I.P.E.S.
2. Put on gloves.
3. Remove or fold back top bedding. Keep client covered with bath blanket or top sheet.
4. Remove client's gown/sleep wear.
5. Test water temperature and ensure it is safe. Adjust if necessary. Replace the water at anytime it gets soapy, cool, or dirty.
6. Wet washcloth (no soap) and begin with the eyes. Use a different area of the washcloth for each eye, washing inner to outer corner.
7. Wash the rest of the face, ears, and neck, using soap (if the client prefers).
8. Rinse. Dry areas with a towel – pat, don't rub.

Observe



9. Expose one arm and place a towel underneath it. Support the client's arm with the palm of your hand underneath the client's elbow. Wash the client's arm, shoulder, and armpit. Rinse and pat dry.
10. Place the client's hand in the water basin. Wash the client's hand, rinse, and pat dry. Repeat with the other arm and hand.
11. Wash, rinse, and pat dry the client's chest and abdomen.
12. Uncover one of the client's legs and place a towel lengthwise under the foot and leg. Bend the knee and support the leg with your arm. Wash the leg, rinse, and pat dry.
13. Slide the client's foot in to the water basin. Wash the client's foot, rinse and pat dry. Repeat with the other leg and foot.
14. Assist the client to turn on his/her side, away from you. Place a bath blanket or towel along side his/her back.
15. Wash the client's back and buttocks, rinse and pat dry.
16. Assist the client to his/her back. Provide privacy and let the client perform his/her own perineal care (Assisting with this will be covered later).
17. Assist client to get dressed.
18. Assist the client to get up, or assist in a comfortable position if remaining in bed.
19. Remove bedding that may have gotten wet.
20. Empty, rinse, wipe bath basin and return to proper storage.
21. Place soiled clothing and linen in proper container.
22. Remove gloves and wash hands.

You may also be asked to help a client with a shower instead of a bath. This can include helping get the client into a shower, washing body parts a client can't reach, assisting the client out of the shower, and getting dried and dressed.

The following are **general tips** when helping a client with a **shower using a bath bench**.

- Make sure the floor is dry when assisting someone in or out of a shower.
- Make sure all equipment is secured and locked before assisting someone on or off of the equipment.
- Encourage the client to do as much as he/she can.
- If help is needed, make sure to move body parts gently and naturally, avoiding force and over-extending limbs and joints.
- When assisting a client off a bath bench, make sure the person is dried off well so he/she doesn't slip.
- Look for skin problems, especially at pressure points and feet.

Clients who need assistance with dressing often have difficulty doing things that require small finger movements like buttoning, zipping, putting on socks, and/or lacing up shoes.

Clients who have had a stroke or are paralyzed for other reasons are likely to have had some rehabilitation and instruction on how to dress.

Assistive devices for dressing

There are many helpful tools to assist a person to dress independently. Your job may be to assist the client in using these tools to get dressed. Examples of common tools are:

- velcro in place of buttons or shoelaces.
- zipper pulls attached to a zipper's metal tab to give the client added leverage in closing and opening the zipper. A large paper clip can also be used.
- extended shoehorns that allow the client to get on his/her shoes without bending over.

Types of clothing

Certain types of clothing also can make it easier for the client to get dressed, including:

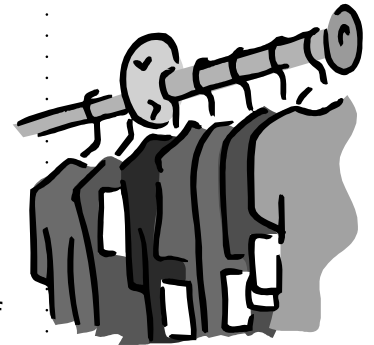
- pants and skirts that pull on;
- items that fasten in front including front-fastening bras, blouses, shirts, and pants;
- clothes made of fabric that stretches, such as knits;
- velcro fasteners and large, flat buttons that are easier to open and close.



Observe



Assisting a Client to Dress



Client choice in clothing

Choosing clothing is a very personal statement. Clients need to choose what they want to wear. It may not be what you would choose, but if the clothing is appropriate for the weather, clean, and in good repair, do not interfere with the client's choice.



A client's clothes need to fit correctly. Clothes that are too loose or tight can be a sign of a change in the client's condition or a safety problem and should be reported to the appropriate person in your care setting.

Skill: Assist Client with Weak Arm to Dress



1. S.W.I.P.E.S.
2. Ask client what he/she would like to wear.
3. Remove client's gown/sleep wear while protecting privacy.
4. Assist client to put the weak arm through the correct sleeve of the shirt, sweater, or slip.
5. Assist client to put strong arm through the correct sleeve.
6. Assist client to put on skirt, pants, shirt, or dress, and non-skid footwear.
7. Puts on all items, moving client's body gently and naturally, avoiding force and over-extension of limbs and joints.
8. Finish with client dressed appropriately (clothing right side out, zippers/buttons fastened, etc.) and seated.
9. Place gown in soiled linen container.
10. Wash hands.

Observe



The following are **general tips** when helping a client **get dressed**.

- Make sure the room is warm and comfortable.
- Encourage the client to do as much of the dressing as he/she can. Assist with what client is unable to do. Be very patient if it takes longer.
- Be gentle. Do not overextend a client's limbs or use force to get clothing on.
- Once the client is dressed, check and make sure his/her shoelaces are tied, buttons done, zippers up, and shirt tails tucked in.
- If your client wears dentures, eyeglasses, hearing aids, etc., make sure he/she has them.
- Wear gloves if there is a chance you will come in contact with blood or body fluids.

Elastic stockings

Clients with poor circulation to the feet or swelling due to fluid in the tissue (edema), may wear elastic stockings.

When assisting with this task, make sure to watch for any changes in skin color, temperature, swelling, or open areas on the legs. Document and report changes or abnormal skin conditions.

Observe



Skill: Put Knee-High Elastic Stocking on Client

1. S.W.I.P.E.S.
2. Have client elevate leg(s) 15 minutes.
3. Turn stocking inside out, at least to heel area.
4. Place foot of stocking over toes, foot, and heel moving client's foot and leg naturally, avoiding force and over-extension of limb and joints.
5. Pull top of stocking, over foot, heel, and leg.
6. Make sure stocking is smooth, with no twists or wrinkles, and is not too tight over the client's toes.
7. Wash hands.

The following are **general tips** when helping a client with **elastic stockings**.

- Encourage the client to have you assist with putting on elastic stockings first thing in the morning.
- Encourage the client to let you put the stockings on while he/she is in bed.
- Make sure that the heel of the stocking is in the correct place.
- Make sure to check the stockings frequently for wrinkles after the client is dressed. Wrinkles in the stockings can cause the client's skin to breakdown and lead to a pressure ulcer.

Observe



Passive range of motion exercises

Passive range of motion exercises help keep a client's joints flexible and strong, reduce stiffness, and/or increase the range of motion in a specific area.



Skill: Passive Range of Motion for One Shoulder



1. S.W.I.P.E.S.
2. While supporting the limb through the following exercises, move joint gently, slowly, and smoothly through the range of motion to the point of resistance. Stop if pain occurs.
3. Support client's arm at elbow and wrist, while performing range of motion for shoulder.
4. Raise client's straightened arm toward ceiling, back towards the head of bed and return to a flat position. Repeat at least 3 times.
5. Move client's straightened arm away from client's side of body toward head of bed, and return client's straightened arm to midline of client's body. Repeat at least 3 times.
6. Place client's flexed elbow at client's shoulder level, rotate forearm toward head of the bed and rotate forearm down toward hip. Repeat at least 3 times.
7. Wash hands.

Skill: Passive Range of Motion for One Knee and Ankle



1. S.W.I.P.E.S.
2. While supporting the limb through the following exercises, move joint gently, slowly, and smoothly through the range of motion to the point of resistance. Stop if pain occurs.
3. **Knee.** Support client's leg at knee and ankle while performing range of motion for knee.
4. Bend the knee to the point of resistance and then return leg flat to bed. Repeat at least 3 times.
5. **Ankle.** Support foot and ankle while performing range of motion for ankle.
6. Keeping the client's foot on bed, push/pull foot toward head and push/pull foot down, toes point down (as if pushing down or letting up on a gas pedal in a car).
7. Repeat at least 3 times.
8. Wash hands.



The following are **general tips** when helping a client with **passive range of motion exercises**.

- Encourage the client to relax during the exercises.
- Perform each exercise slowly and consistently. Do not start and stop mid-range.
- If the muscle seems especially tight, slowly pull against it. Gentle, continuous stretching on a muscle will relax it.
- Stop if you see signs of pain on a client's face or the client reports feeling pain.
- Depending on where you work, additional training may be required before helping a client with full passive range of motion exercises.



It is expected that all personal care tasks will be practiced by students in their DOC teams before doing the Module Review and the second Module Scenario.



10 Minutes

1. True ☒ False Dehydration is the leading cause of pressure ulcers.
2. ☒ True ☐ False To position a client correctly in a bed, choose a position that spreads weight and pressure evenly.
3. A client confined to a bed must change position every: (circle the correct answer)
 - a. 1 hour.
 - b. 2 hours.**
 - c. 3 hours.
4. Clients at high-risk for pressure ulcers are people: (circle the correct answer)
 - a. that smoke.
 - b. with unmanaged incontinence.**
 - c. with food allergies.
5. To help keep a client's skin healthy, encourage him/her to: (circle the correct answer)
 - a. Use underpads that hold moisture on the skin.
 - b. Eat a well-balanced diet and drink plenty of fluids.**
 - c. Take a bath daily using plenty of hot water.
6. ☒ True ☐ False Wrinkles in elastic stockings can lead to a pressure ulcer.
7. Anytime you see redness on a client's unbroken skin lasting 15-30 minutes or more - especially at a pressure point: (circle the correct answer)
 - a. Remove pressure from the area immediately.**
 - b. Increase pressure to the area immediately.
 - c. Do nothing - but watch it closely for the next few hours.
8. When helping with passive range of motion exercises, move the joint gently to the point of: (circle the correct answer)
 - a. Pain.
 - b. Resistance.**
 - c. Comfort.
9. To take good care of a client's dentures, always soak them in: (circle the correct answer)
 - a. Bleach.
 - b. Hot water.
 - c. Cool water.**
10. True ☒ False When helping a client with a bedbath, replace the water every 2 minutes.



Mr. Stevens is a 78 year old client living with diabetes. Today when helping him with foot care, you notice two new sores on his feet. He asks you to clip his toenails and clean and bandage the sores. He tells you not to worry about the sores, that they are just part of his diabetes.

RESEARCH:

Review page 308 about diabetes.

PROBLEM SOLVE:

1. Identify what problem(s) a caregivers needs to address in this situation.
2. Pick one problem and brainstorm ways to solve it. Pick a solution.
3. How does this impact how a caregiver provides care?

DEMONSTRATE

One group will demonstrate for the class foot care.



20-30 Minutes



Module 8

Nutrition and Food Handling

Lesson 1

Nutrition



1 Hour 30 Minutes

Lesson 2

Food Handling



35 Minutes

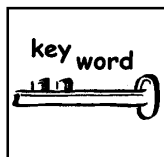
10 Minutes - Module Review

Personal Care Skills Covered

Assisting a Client to Eat



Icons to help guide you



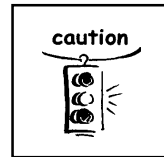
A word to remember



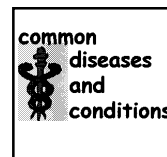
Something to report



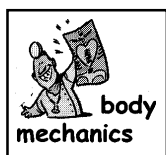
See the Resource Directory



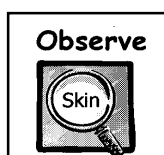
Beware or be careful



See the Common Diseases section



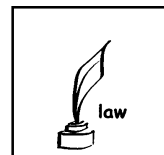
Use proper body mechanics



Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 8 - Lesson 1

Nutrition



Nutrition Basics

Assisting a Client
with Eating

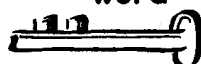
Special diets

Water, the Forgotten
Nutrient

What you will learn in this module:

1. The basics of nutrition.
2. How to read food labels and use them to make healthy food choices for shopping and meal planning.
3. Signs of poor nutrition and when to report.
4. How to assist a client with eating.
5. Special diets a client may require.
6. The importance of knowing whether a client has any food allergies.
7. The importance of hydration to a client's health.

key word



Definition

Allergy	High sensitivity and reaction to certain substances (e.g. certain foods, pollen, bee sting)
Dehydration	Not enough fluid in the body
Dysphagia	Difficulty swallowing
Nutrition	The body's process of taking in and using food
Nutrients	Any substance plants or animals need to live and grow

As a caregiver, your role in meal preparation is to understand the basics of good **nutrition** and encourage your client to make healthy food choices. This can include helping a client:

- plan meals and shop;
- prepare or assist a client in fixing a meal;
- clean up after meals.

Healthy food choices are especially critical for a client. Good nutrition can:

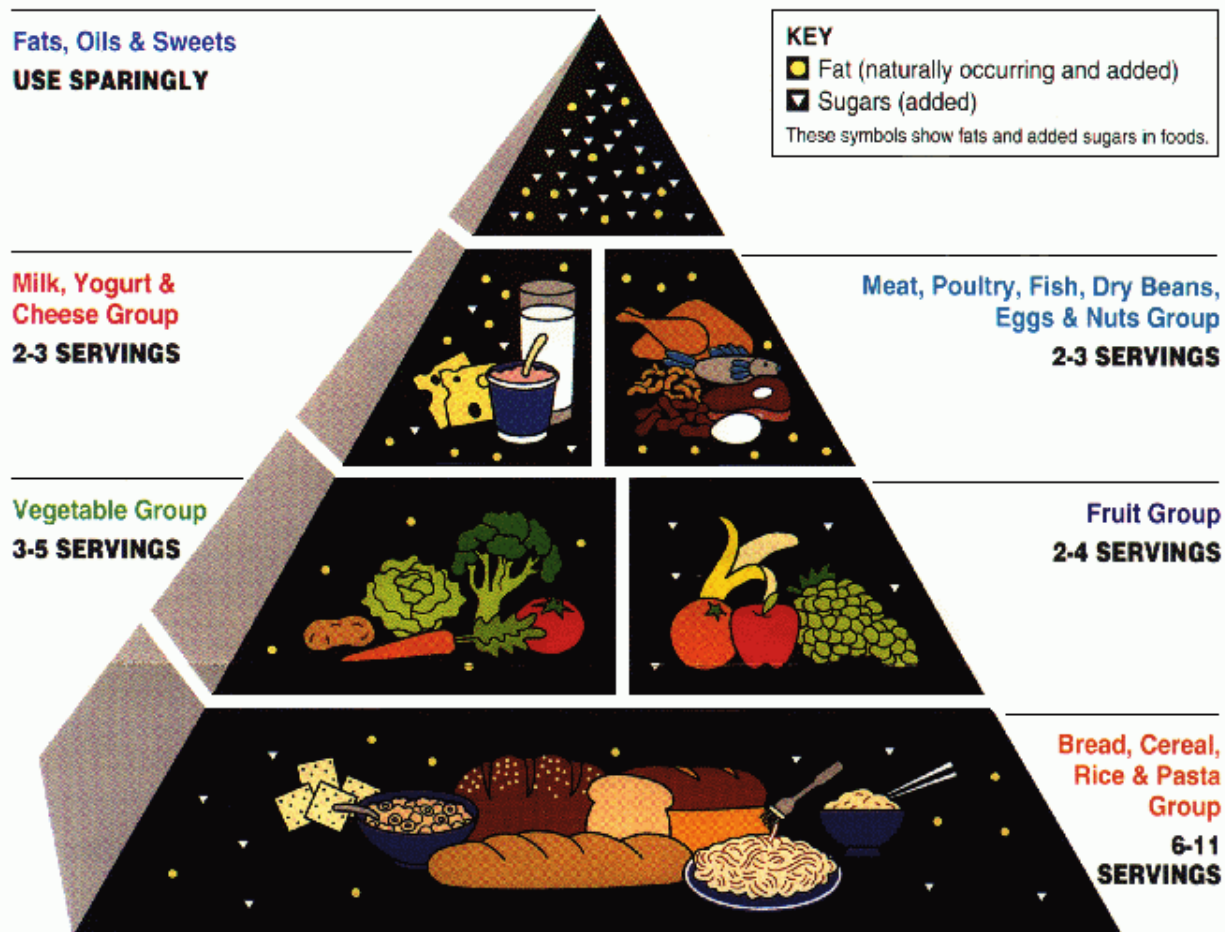
- increase overall health and energy - prolonging independence;
- prevent or control certain diseases (e.g. diabetes, osteoporosis, heart disease, high blood pressure, cancer, tooth decay);
- reduce bone fractures.

A healthy diet means choosing a variety of healthy foods and setting limits to how much and how often less healthy foods are eaten. The United States Department of Agriculture (USDA) Food Pyramid shows with pictures the types of food (groups) people should eat and in what quantities each day.

Nutrition Basics



The Food Pyramid (Pyramid)





The learning outcomes associated with the module are related to caregivers understanding nutrition so if they are required to shop and/or prepare meals, they will be able to go into a store and know how to choose and prepare healthier foods using food labels, basic nutrition guidelines, and the food pyramid.

Students are not expected to become experts in nutrition. Content on Learner's Guide pages 136-141 (up to the Meal Planning and Shopping section) has been included so the student has a basic understanding of what to look for (see above) and has reference materials during and after the course.

Although the emphasis of the module is on the client, good nutrition is also important for caregivers. The need for caregivers to make healthy food choices for good self-care is referenced in Module 11 (Self Care and the Caregiver). Remind students of how important this information is for them.

The Pyramid shows a range of servings for each food group. The number of servings needed depends on a person's age, sex, weight, and how active he/she is. By knowing a client's recommended calorie intake and activity level, you can assist the client to figure out approximately how many servings of each food group he/she needs daily. *

		Activity Level		
	Age	Sedentary	Moderately Active	Active
Female	19-30	2000	2000-2200	2400
	31-50	1800	2000	2200
	51+	1600	1800	2000-2200
Male	19-30	2400	2600-2800	3000
	31-50	2200	2400-2600	2800-3000
	51+	2000	2200-2400	2400-2800

Calories	About 1,600	About 1,800	About 2,000	About 2,200
Grain Group servings	5	6	6	7
Vegetable Group Servings	4	5	5	6
Fruit Group servings	3	3	4	4
Milk Group Servings	3	3	3	3
Meat Group	5 oz.	5 oz.	5 1/2 oz.	6 oz.

What counts as a serving?

Bread, Cereal, Rice, and Pasta Group (Grains Group) - whole grain and refined

- 1 slice of bread
- About 1 cup of ready-to-eat cereal
- 1/2 cup of cooked cereal, rice, or pasta

Vegetable Group

- 1 cup of raw leafy vegetables
- 1/2 cup of other vegetables - cooked or raw
- 3/4 cup of vegetable juice

Fruit Group

- 1 medium apple, banana, orange, pear
- 1/2 cup of chopped, cooked, or canned fruit
- 3/4 cup of fruit juice

Milk, Yogurt, and Cheese Group (Milk Group)

- 1 cup of milk or yogurt
- 1 1/2 ounces of natural cheese (such as cheddar)
- 2 ounces of processed cheese (such as American)

Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts Group (Meat and Beans Group)

- 2-3 ounces of cooked lean meat, poultry, or fish
- 1/2 cup of cooked dry beans or 1/2 cup of tofu counts as 1 ounce of lean meat
- 2 1/2 ounce soyburger or 1 egg counts as 1 ounce of lean meat
- 2 tablespoons of peanut butter or 1/3 cup of nuts counts as 1 ounce of meat

Module 8 - Lesson 1



■ **Personal Food Diary - Optional**

Purpose:

- to increase student's awareness of the importance of the food pyramid for both themselves and the client.

1. Have each student individually write down all of the foods he/she ate yesterday.
2. Using the Pyramid, students should put each listed food in the proper food group.
3. Have students determine how many servings per food group they had yesterday.

4. Ask:



Q: Did you meet the minimum requirements for each food group?

Q: If not, what changes can you make?

Q: What did you learn about your eating habits when matching your diet to the Pyramid?

Q: In thinking about your client(s), what did you learn about his/her/their eating habits?

Four basic nutrition guidelines help provide the **nutrients** needed for good health without getting too many calories, saturated fat, cholesterol, sugar, sodium, or alcohol. To make healthy food choices, most people should eat foods:



Low in ... Saturated Fat
Salt
Empty Calories



High in ... Fiber

Fats help the body absorb certain vitamins, provide energy, and protect the body and organs from injury. While fat is important, we only need a small amount. Over time, too much fat leads to weight gain. Certain types of fat can increase the risk of heart problems, stroke or complications in people with diabetes.

As a caregiver, you need to be aware of the:

- different types of fat and which is better for you and your client;
- amount and type of fat to use in healthy cooking;
- importance of choosing and preparing foods lower in saturated fat.

Unhealthy fats

Saturated fat, trans fat, and foods already high in cholesterol (liver, other organ meats and egg yolks) are more likely to cause problems. A diet high in these types of fats can raise blood cholesterol levels and should be eaten in small amounts.

Saturated fats are solid at room temperature and found mostly in foods from animals and a few plants. Trans fats are created when liquid vegetable fats or oils are hardened.

Four Basic Nutrition Guidelines



Fats

Watch for the word “hydrogenated” to help spot trans fats.

Where Fats are Found

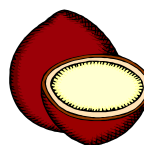
Saturated fats from animals

- meat
- lard
- the skin and fat of chicken
- butter, cream, milk, cheeses, ice cream



Saturated fats from plants

- coconut oil
- palm oil



Trans fats are found in

- vegetable shortenings
- some margarines
- crackers
- cookies and other commercial bakery products
- snack foods



Healthier fats

Unsaturated fats (oils) do not raise blood cholesterol.

Unsaturated fats are normally plant oils that are liquid at room temperature including:

- canola, olive, peanut, corn, soybean, and safflower oil;
- sesame and sunflower seeds and oils.



Unsaturated fats can also be found in most nuts, olives, and fatty fish like salmon or tuna. Use unsaturated fats instead of saturated fats - but still in moderation.

Fat intake per day

Aim for a total fat intake of 30% of total calories each day (or less). Only 10% of total fat intake should be from saturated fats. Trans fats should be limited as much as possible. Clients with heart problems, stroke, or diabetes may be on a low fat diet.



Total Daily Calories	Saturated Fat in grams	Total Fat/Day in grams
1,600	16 or less	53 or less
1,800	18 or less	60 or less
2,000	20 or less	67 or less
2,200	22 or less	73 or less

Tips to reduce saturated fats

- **Choose low fat dairy food** such as skimmed or semi-skimmed milk, low fat yogurt, cheese, ice cream, and pudding.
- **Choose lean meat or skinless chicken** and trim all visible fat before cooking.
- **Use low fat cooking methods** such as grilling, barbecuing, stir-frying, dry roasting, or poaching.
- **Skim the fat** off the top of cooled gravies, sauces, soups, or stews.
- **Cook with unsaturated oils and spreads** like olive or canola oils.
- **Choose tomato based sauces** rather than creamy sauces. Avoid creamy style soups.

Sodium helps to maintain the body's water balance, blood pressure, and prevent dehydration. Too much sodium can lead to high blood pressure.



Most of us eat too much salt. A great deal of salt is added during food processing. Even if salt is not added while cooking or at the table, your client could still be getting too much salt in his/her diet.

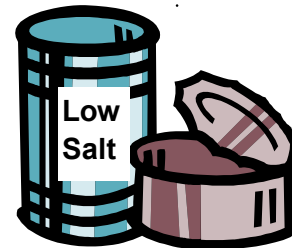


Salt intake per day

The Dietary Guidelines for Americans recommends a goal of 1500 mg of sodium per day with no more than 2,300 mg for healthy adults. Sodium intake may be lower for your client depending on his/her health. Clients with congestive heart failure or high blood pressure most likely will be on a low salt diet.

Tips to reduce sodium

- Look for and use sodium-free, low, reduced, light in sodium, or no salt added processed foods.
- Compare the level of salt in processed foods - the amount can vary widely between brands.
- Choose fresh, frozen, or canned vegetables and meats without salt added.
- Be "spicy" instead of "salty" when cooking. Flavor foods with a variety of herbs, spices, lemon, lime, or vinegar.
- Avoid the salt shaker or fill it with a herb substitute instead.
- Choose fewer canned, ready-cooked, or boxed meals such as noodle casseroles or rice dishes.
- Limit highly salted foods such as corned beef, bacon, luncheon meats, pickles, chips, crackers, pretzels, or preserved meats.



Look for these phrases on food labels

On Label

Sodium-free

Very low sodium

Low sodium

Light in sodium

Reduced sodium

No salt added, unsalted, or salt free

Sodium per Serving

5 mg or less

35 mg or less

140 mg or less

at least 50% less sodium than regular version

at least 25% less sodium than regular version

5 mg or less

Empty Calories

Carbohydrates (sugars and starches) supply the body with energy in the form of glucose. Sugars can be found naturally in foods or added to foods. Added sugars often supply calories but few or no nutrients (empty calories).

Choose carbohydrates wisely. Choose foods in the basic food groups (fruits, vegetables, grains, and milk). Limit the amount of foods with large amounts of added sugars. Empty calories make it difficult to consume enough nutrients without gaining weight.



See the Resource Directory pages 268-270 for more information on adding more fruits and vegetables into your diet.



See the Common Diseases and Conditions section on page 308 for more information about diabetes, carbohydrates, and diet.

Fiber

Dietary fiber is the part of foods we eat that cannot be digested. Fiber, also known as bulk or roughage, can help lower blood cholesterol and prevent heart disease, digestive problems, or digestive diseases. Fiber can also help to prevent or control constipation and/or hemorrhoids.

Looking to the Pyramid for fiber intake

Fiber is found in fruits, vegetables, whole grains, nuts, legumes (lentils and beans).

Bread, Cereal, Rice, and Pasta Group

- Choose whole-grain breads and cereals with “whole wheat flour,” “stone-ground whole wheat flour” or “100 percent whole wheat flour” as the first ingredient.
- Experiment with different whole grains such as couscous, barley, bulgur, quinoa, and kasha in salads, soups, and casseroles to increase fiber.

Fruit and Vegetable Group

- Eat fruits such as apples, pears, bananas, berries, melon, or oranges. Peels and seeds in fruits increase fiber.
- Eat vegetables such as carrots, sweet potatoes, broccoli, spinach, or green beans.
- To keep the fiber content of vegetables high, eat them raw or steamed just until tender and leave the skins on.
- Add dried fruits to cereal, muffins, and quick breads to increase fiber.

Look for these phrases on food labels

On Label	Dietary Fiber
Good Source of Fiber, Contains Fiber, Provides Fiber	3 to less than 5 grams
High Fiber, Rich in Fiber, Excellent Source of Fiber	5 grams or more

Meat, Poultry, Fish, Dry Beans, Eggs, and Nut Group

- Add beans, peas, and lentils to soups, stews, salads, and rice dishes. Substituting beans for meat will provide fiber and lower fat intake.
- Nuts are a good source of fiber but are also high in “good” fat so should be eaten in moderation.

Fiber intake per day

20 to 35 grams of fiber are recommended per day. Most people can get the recommended amount of fiber by eating five servings of fruit and vegetables daily.

Clients should check with their doctor before increasing or decreasing dietary fiber. Fiber intake may need to be limited for adults with certain medical problems such as diverticulitis or increased for clients who have chronic constipation.

Fiber should be increased in the diet slowly. Increasing fiber too fast can cause bloating and gas. Since fiber absorbs water, it is also important to drink plenty of fluids when increasing dietary fiber or taking fiber supplements like Metamucil or Citrucel.

Foods Rich in Fiber



Food	Serving Size	Fiber
All Bran	1/3 cup	8.5 g
Raisin Bran	1 cup	5 g
Whole-wheat spaghetti	1 cup	4 g
Corn on the cob	1 ear	6 g
Baked yam	1	7 g
Large carrot	1	2 g
Banana	1	4 g
Strawberries	1 cup	4 g
Apple with skin	1	3 g
Baked beans	1 cup	8 g
Kidney beans	1 cup	7 g
Split pea soup	1 cup	5 g
Baked potato with skin	1	3 g
Broccoli	1 cup	4 g
Dried figs	3 average	10 g
Pear	1 small	4 g
Prunes	5	4 g

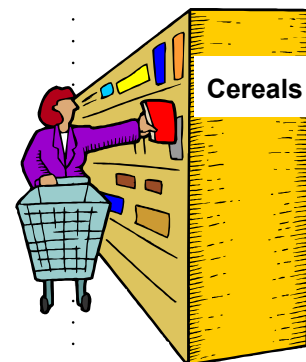
As a caregiver, your role may vary in how you help a client prepare meals and shop for food. The suggestions listed below assume that you are doing both activities for a client. If that is not the case, encourage your client to use the information if it is helpful to him/her.

Planning nutritious, good tasting meals ahead of time helps you better organize your time, make fewer trips to the store, save money, and serve a better variety of healthy foods.

Plan out meals five to seven days in advance. Start by planning the main dish and work out from there. Use the Food Pyramid and include enough foods from each food group. When meal planning, consider:

- what foods the client prefers;
- any leftovers that need using up;
- what's in the freezer or the cupboard;
- what's on sale this week or any coupons you have;
- how much time you will have to cook or the client's abilities if he/she will be cooking for him/herself.

Meal Planning and Shopping



Always eat before you go shopping.



■ **Fiber**

Optional

Purpose:

- To determine if a student's personal food choices include adequate fiber; and
- To help student's know if a client has enough fiber in his/her diet.

1. Have students return to the previous exercise where they wrote down what they ate yesterday.
2. Have students highlight which foods were high in fiber.
3. Ask students how many met their daily fiber requirement.



4. Have students brainstorm how to add high fiber alternatives into their diet and that of their client(s).



20 Minutes



Meal Planning

Purpose:

- To give students practice in gathering needed information from a client to prepare appropriate meals.

1. Divide students into pairs.
2. Refer students to the sample client care plan on pages 229 and 233 in their Learner's Guide.
3. Using the information there, pairs must plan breakfast, lunch, and dinner for that client. The plan must meet all of the daily requirements from the Food Pyramid and incorporate any special diet considerations found in the care plan.

Review

4. Ask for students to volunteer how they incorporated each of the food groups into the day. Make sure to keep in mind the client and whether or not any of the food would be something that client should not have or be able to eat.



Check any recipes you are using and make sure you have the needed ingredients. Write down any items you don't have and will need to buy at the store. Once you have your list for the week, it's time to go shopping.

A person's background influences the types of food he/she normally eats and likes. Respect and get to know a client's food preferences.

Food Labels

Read the "Nutrition Facts" food label on packaged foods to compare the amount of fat, sodium, calories, and other nutrients in similar products. This can help you choose foods that have less fat, sodium or calories, and more vitamins, minerals, and fiber.

Not all foods have food labels (e.g. fresh fruits, meats). The most popular fruits, vegetables, and some meats should have their nutritional information, similar to a food label, posted in the grocery store near where the food is displayed.

Nutrition Facts		
Serving Size 3/4 cup (30g)		
Servings Per Container 11		
Amount Per Serving		
Calories 100	Calories from Fat 11	
		% Daily Value*
Total Fat 1%		1%
Saturated Fat 0g		0%
Cholesterol 0mg		0%
Sodium 200 mg		8%
Total Carbohydrate 24g		8%
Dietary Fiber 3g		10%
Sugars 5g		
Other Carbohydrate 16g		
Protein 2g		
Vitamin A 100%	Vitamin C 100%	
Calcium 25%	Iron 100%	
* Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs:		
Calories:	2,000	2,500
Total Fat	< 65g	80g
Sat Fat	< 20g	25g
Cholesterol	< 300mg	375mg
Total Carbohydrate	300g	375g
Dietary Fiber	25g	30g
Calories per gram:		
Fat 9	Carbohydrate 4	Protein 4

Nutritional facts are based on one serving. Serving size is NOT necessarily a recommended serving size or the amount a person normally eats. Pay attention to the actual serving size and the number of servings in the package.

The "% of Daily Value" tells you what percentage of the recommended daily intake are contained of that nutrient in each serving. These daily values are based on a 2,000 calorie diet and must be modified if the client eats more than one serving or eats more or less than 2,000 calories each day.

For saturated fat and cholesterol, choose foods with a **low** % Daily Value.

For total carbohydrates and dietary fiber choose foods with a **high** % Daily Value.

For protein, choose foods with a **high** % Daily Value.

This information is the current recommended daily intake for each of the nutrients listed and is printed on every food label as a reference.

Module 8 - Lesson 1

Nutrition

■ Food Labels

1. Bring in several food products with food labels, including several “healthy” products and several products high in fat, empty calories, etc.

2. For each product, ask:

Q: Is this a healthy food choice? If so, what are the healthy qualities in this food?

Q: If not, what are the unhealthy qualities in this food?

3. Ask students to brainstorm some healthier alternatives.

4. Do this for each of the food labels you bring in.

Optional



■ Food Labels and Meal Planning combined

Another exercise that has proven successful is to collect a large quantity of food labels with the product on them. Since the activity takes hundreds of labels, have co-workers, friends, and family help gather them for you.

Have students use these food labels to plan a days worth of meals for a client. You can assign different groups different types of meals to plan (e.g. low-fat, low-salt, etc.)

Ingredients

Somewhere on the product label will be a list of the product's ingredients listed in decreasing order by weight.

To choose foods low in saturated fat or total fat, limit the use of products that list any fat or oil as the first three ingredients or that list many fat or oil ingredients. If your client is watching his/her sodium intake, do the same for sodium or salt.

The ingredients list can also be used to check if a specific ingredient is in the food or product. This is especially important if a client has allergies (see page 146) or other reasons to avoid particular items.

Poor nutrition occurs when a person's body is not getting enough nutrients. This can be because of diet, digestive problems, dental problems, or a medical condition.

A client with poor nutrition can have a decreased ability to resist infection, recover from illness, surgery or other treatments, and heal wounds.

Warning Signs of Poor Nutrition

- Unintended weight loss (e.g. clothing that is now too big)
- Eats less than half of meals and snacks
- Constant fatigue or dizziness
- Depression, loneliness, grief
- Confusion

Other Factors That Can Lead to Poor Nutrition

- Problems chewing, mouth pain, or dentures that don't fit
- An upset stomach, constipation, bloating, or gas
- Living alone
- Taking multiple medications
- Substance abuse
- No appetite

See the Resource Directory page 271 for more information on helping a client who has difficulty chewing or has no appetite.

Poor Nutrition





Report poor nutrition

Talk with a client if you have concerns about his/her nutrition. If after your conversation(s) you are still concerned, talk with the client's case manager or your supervisor. He/she can work with the client to decide whether to consult a dietitian, speech pathologist, dentist, occupational therapist, or the client's health care provider.

Getting more information

Senior Nutrition Programs are available in most geographic areas and help older people with nutrition problems. Contact or encourage the client to call for assistance or a referral to a dietitian for some help.

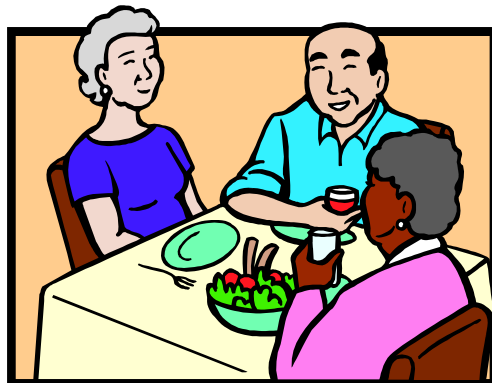
Assisting a Client with Meals

The social importance of meals

The social importance of mealtime can be just as important to the client's well-being as the food he/she eats.

Make mealtime a pleasant experience by:

- planning the menu with the client;
- arranging the place setting and food so that it looks attractive and is easy for the client to reach and eat;
- sitting down with the client whenever possible;
- making sure the client is sitting comfortably;
- helping only when help is asked for;
- offering food at an unrushed pace;
- taking the time to make eating a highlight of the day.



Client preference

Include the client in meal planning. Find out what your client likes and can eat. People eat more when they like the food.

Balancing choice with safety

If a client chooses not to make healthy food choices or follow a special diet, you **cannot** force him/her. Follow the steps outlined on page 18 if you are concerned that a client's safety or well-being is at risk (explain your concerns, offer safe alternatives, report, and document your concerns and what you did).

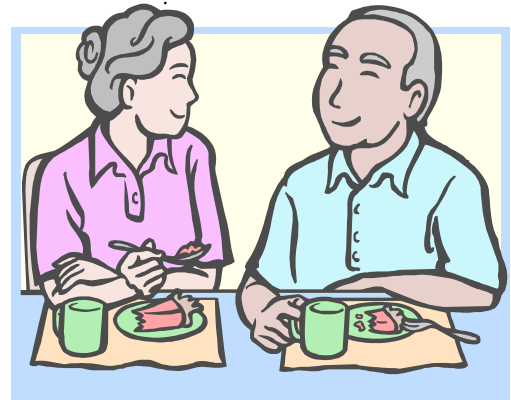
Skill: Assisting a Client to Eat



1. S.W.I.P.E.S.
2. Assist client to put on clothing protector or cover, if needed.
3. Ensure client is in an upright, sitting position.
4. Sit at client's eye level.
5. Offer the food in bite-size pieces - alternating types of food offered.
6. Make sure the client's mouth is empty before offering the next bite of food or sip of beverage.
7. Offer a beverage to the client during the meal.
8. Talk with the client throughout meal.
9. Wipe food from client's mouth and hands as necessary and at the end of the meal.
10. Remove clothing protector if worn and dispose of in proper container.
11. Remove leftover food.
12. Wash hands as final step.

The following are **general tips** when helping a client to **eat**.

- Never feed a client who is lying down, reclining, or very sleepy.
- Make sure the client's head is forward and his/her chin is down.
- Put a small amount of food on the spoon or fork.
- Give the client plenty of time for chewing and swallowing. Never rush.
- Tell the client what food is on the fork or spoon before putting it in his/her mouth.
- Treat the client as an adult not a child.
- The client should remain upright for at least 20 - 30 minutes after finishing a meal.



Assistive devices to help with eating

Many assistive devices can help maintain a client's independence while eating including silverware with built-up handles to make them easier to grasp, two handled cups, straws, a divided plate or a plate with a rim (makes it easier to "scoop" food onto the eating utensil).

Skill: Assisting a Client to Eat



- 1. Demonstrate skill. Students are expected to practice the skill at a skill station in their DOC teams.**

Special Diets

A client may have a special diet due to a disease, condition, medication, or food allergy. A special diet can limit or increase the intake of certain foods or how foods must be prepared.

It is important for you to understand how and why the nutrition therapy is needed and what foods should be added or avoided in food preparation.



caution A client should have a doctor's or dietitian's prescription before you make changes to a client's normal diet. If you do not have the specific information you need, alert the case manager or your supervisor depending on the care setting where you work.



Foods that cause the most allergies include milk, soy, eggs, wheat, peanuts, nuts, fish, and shellfish.

Food allergies

Some people have allergies to food that can be serious and can cause sudden, life threatening reactions. Even a small amount of food can make the person sick. Symptoms of an allergic reaction to a food can be a tingling or itching sensation, hives, swelling of the mouth or throat, eyelids, face, lips, and tongue, abdominal pain, diarrhea, nausea, vomiting, difficulty breathing, light headedness, or loss of consciousness.

A client with a food allergy must avoid any source of the food. A client's safety can depend on safe preparation steps in the kitchen (e.g. paying close attention to the ingredient list on food labels). Make sure to talk with the client about any food allergies he or she has.



It is a medical emergency if a person develops any type of serious or whole-body reaction, even hives, after eating food he or she is allergic to. As in any other emergency with a client, call 911 or follow the emergency and reporting procedures where you work.



Dysphagia

A special diet will be required if a client has a condition called dysphagia. People likely to have dysphagia include clients who have had a stroke, certain diseases (Parkinson's, MS, certain cancers), dementia, some individuals with developmental disabilities, and people who are on certain medications.

Warning signs of dysphagia include:

- taking a long time to begin a swallow or needing to swallow 3-4 times for each bite of food;
- coughing, frequent throat clearing, lack of a gag reflex, or weak cough (before, during, or after a swallow);

- difficulty controlling liquids in the mouth or drooling out of the front or side of the mouth;
- pocketing food in mouth (storing food in the cheek), spitting food out, or refusing to eat,
- unintentional weight loss;
- fullness or tightness in the throat or chest or a sensation of food sticking there.

Report any of these signs to the case manager or your supervisor if the client has not already been diagnosed with dysphagia.



Caring for a client with dysphagia

If a client you are caring for has dysphagia, your role is to help make sure he/she gets adequate nutrition and to protect against food or fluid getting into his/her airway and lungs.

Clients with dysphagia will have a prescribed special diet. Depending on the severity of the condition, the consistency of foods and liquid must be changed to make it easier and safer for the client to eat or drink (e.g. making foods soft and easy to swallow or thickened or thinned to prevent choking).

You may also be asked to work directly with the client's health care provider to understand how to prepare food correctly. This depends on the care setting where you work.

The diet modifications required should be noted in the DSHS care plan or check with your supervisor. See the Resource Directory pages 272-273 for more specific suggestions on how to modify food for a client with dysphagia and some general tips on helping a client with dysphagia eat.



Problems caused by dietary mistakes

A small number of dietary mistakes made by a caregiver result in serious harm or the death of a client, including:

- a very high dose of sodium (salt) to a client who has congestive heart failure and is on a severe sodium restriction. A high dose of sodium may lead to fluid in the lungs and serious consequences.
- some food and drug interactions. Be certain that medications your client is taking do not require any food restrictions.
- an individual with dysphagia given a food or beverage that is not appropriately modified.

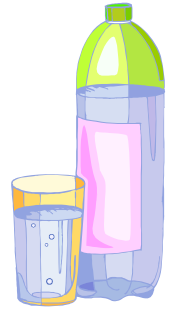


Any time you are in doubt about anything related to a client's diet, get help from the appropriate person in your care setting.

Water, the Forgotten Nutrient

Water is another important nutrient needed by our bodies. Without water, we'd be poisoned to death by our own waste products. Water is essential for:

- digesting food;
- carrying nutrients and oxygen to every cell in the body;
- cooling the body;
- breathing;
- lubricating joints.



Dehydration



Encourage a client not to wait until he/she is thirsty to drink.

Dehydration can be caused by losing too much fluid, not drinking enough water or fluids, or certain medications. A common cause of dehydration is loss of fluids through vomiting, diarrhea, and/or high fever.

Dehydration can be mild, moderate, or severe. When severe, dehydration is a life-threatening emergency. Many factors can affect how quickly a client becomes dehydrated including heat, medications, diet, how active he/she is, and body size.

Too many people - including many clients and caregivers - are not getting enough water/fluids each day. The thirst sensation tends to decline as we age, making it harder for older adults to realize more fluids are needed.

Warning Signs of Dehydration

- Prolonged vomiting or diarrhea
- Thirst
- Dry or sticky mouth, cracked lips
- Headache
- Fatigue
- Dizziness

- Confusion
- Heavy perspiration
- Fever
- Dark urine
- Constipation
- Leg cramps



Report any of these symptoms to the appropriate person in your care setting.

Lack of water is the #1 trigger of daytime fatigue.



Water intake recommendations

Adults need at least 6 to 8 glasses of fluid each day. Fluids can be taken in many forms, such as water, fruit juice, milk, soups, coffee, tea, or soft drinks. Decaffeinated drinks are good choices. Offer fluids frequently throughout the day. It is also a good idea to keep a glass of water by a client's chair or bed.

Since most fruits and vegetables are mostly water, eating five a day will also help with hydration.

Module 8 - Lesson 2

Food Handling



Food Borne Illness

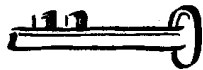
Good Food Handling
Practices

Kitchen Cleaning
and Disinfecting

What you will learn in this lesson:

1. What food borne illness is and what causes it.
2. How to prevent food borne illness by using safe food handling practices, including:
 - how to safely prepare, thaw, and store food;
 - how to prevent cross-contamination;
 - cleaning and disinfecting food contact surfaces.

key word



Definition

Cross-contamination

When germs from raw or contaminated food get into other foods that are not cooked or reheated before they are eaten

Danger zone

A zone of temperatures where germs grow quickly when potentially hazardous food is kept at those temperatures

Food borne illness (FBI)

Any illness caused by eating contaminated food



A reminder. Even if the content of this section is not relevant to your care setting, the training certificate covers all care settings. A caregiver (and the clients he/she will care for) may need the information in the future.

Food-Borne Illness



Food-borne illness (FBI) is any illness caused by eating contaminated food. Symptoms of FBI can include vomiting, diarrhea, fever, and stomach cramping.

An older person or someone with a chronic illness can be at a higher risk of a FBI because his/her immune system is not as strong to fight it. Extra care is needed. Certain foods are more likely to cause FBI in people at higher risk including undercooked meat or eggs, raw oysters, sprouts, and unpasteurized milk or juices.

You must have a good understanding of what causes FBI and know how to prevent it.

Causes of Food-Borne Illness (FBI)

Bacteria - the most common germ that causes FBI. Almost always, food with enough bacteria to cause FBI looks and smells fine. In some cases, bacteria can make a food turn color or smell.

Viruses - germs that cause FBI through direct contact or airborne spread with food.

Parasites - tiny worms or bugs that live in fish and meat.

Chemicals - insect bait, household cleaners, or other chemicals that come in contact with food.

Pesticides, chemical additives - pesticides used in growing crops that are still on the food or chemicals added to enhance shelf-life or color.

Fungi, including molds and yeast - molds are furry looking spots or areas on the surface of foods. Yeasts look like round, dot-shaped patches and are not harmful on their own but can change the food's environment so that harmful bacteria grows.

Common Germs Causing Food-Borne Illness

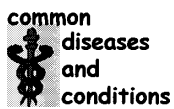
Hepatitis A - virus passed through contaminated food, water, or contact with a person who is currently infected with the disease. See the Common Diseases and Conditions section page 312 for more information on hepatitis A.



E. coli - bacteria found in feces.

Norovirus - highly contagious virus passed through contaminated food, water, or contact with a person who is currently infected with it. Commonly referred to as the stomach flu.

Salmonella - bacteria found in dairy foods, poultry, or eggs.

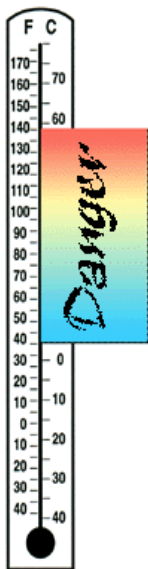


Refer students to the Common Diseases section for more information about hepatitis A if if you didn't cover it in your discussion of hepatitis B and C in Module 4.

You have already learned that your hands can look clean but have germs on them or a food can smell and look fine but contain enough germs to cause a FBI. Since you cannot always see or smell what is safe, safe food handling practices are needed.

There are four required safe food handling practices, including:

1. Prepare food safely.
2. Store food safely.
3. Prevent ***cross-contamination***.
4. Clean and disinfect surfaces that food touches.



The Danger Zone

Bacteria, or other germs, do not grow when the temperature of food is colder than 41° F or hotter than 140° F.

Germs grow quickly in foods left at temperatures between 41° F and 140° F. Keep potentially hazardous foods out of this "***Danger Zone***".

Potentially hazardous foods

Beef, lamb, seafood, pork, poultry, and stuffing are examples of potentially hazardous foods. These are all foods that are moist or damp and have protein. Refried beans, cooked rice, and baked potatoes also grow germs quickly if left in the Danger Zone.

When getting ready to prepare food:

- wash your hands (at least 20 seconds from start to finish).
- take the food to be fixed out of the refrigerator, stove, freezer, etc. Only take out what you will be preparing immediately. This is especially important when preparing potentially hazardous foods.

Cooking

Kill germs with heat by cooking them above the Danger Zone at 140° F or more. Different foods must reach different temperatures to be safe.

Poultry, stuffed foods or stuffing, casseroles, all raw animal products cooked in a microwave, all reheated potentially hazardous food.	165° F (for 15 seconds)
Hamburger, sausage	155° F (for 15 seconds)
Eggs, fish, beef, pork	145° F (for 15 seconds)
Vegetables or Packaged ready-to-eat foods that will be hot held (foods kept hot until served)	140° F

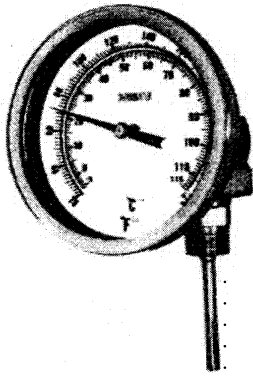
Safe Food Handling Practices



Prepare Food Safely



The FDA food code specifies the 20 seconds as a requirement anytime food is to be handled.



Metal stem thermometers

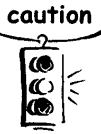
You will need a special, metal stem thermometer to check if the food is done all the way inside. Place the metal stem thermometer in the center of the food to measure the inside, or internal, temperature of the food.

Clean the metal stem thermometer with hot, soapy water between each use.

For foods cooked in a microwave, stir and turn the dish while it cooks. This makes sure the food cooks to the same temperature in every part. Check the food with a metal stem thermometer before you serve it.

Thawing frozen foods

Never thaw food at room temperature, on a counter, or in warm water. These methods let harmful bacteria grow quickly to high, possibly unsafe numbers. The inside of the food may be at a safe temperature, but the outside could be perfect for bacterial growth.



There are 3 safe ways to thaw foods. Plan ahead to allow enough time to do it right!

1. Use the **refrigerator** to thaw the food. It may take longer, but this is the best and safest way.
2. Thaw the food **under cool, running water** - never under warm or hot water.
3. Use a **microwave** and follow the manufacturer's defrosting instructions.



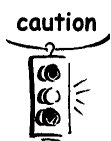
Special consideration for cold salads

Potato, pasta, macaroni, egg, and chicken salads have to be cold enough to keep germs from growing. When you make these foods, all ingredients should be cooked and then chilled to below 41° F before mixing ingredients and serving.

Reheating

When you reheat food:

- only reheat food that has been safely prepared and refrigerated promptly.
- reheat it quickly (within one hour) to 165° F;
- use the burner on a stove, microwave, oven, or a double boiler;
- stir the food to be sure that all parts of it are hot;
- use a metal stem thermometer to check the temperature;
- leftovers should be reheated only once - and eaten within 2 days of being stored properly in the refrigerator.



Take care in eating or serving food heated in the microwave. Food heated in the microwave can continue to heat up for some time after it is taken out of the microwave and can cause burns.

Cooling leftovers

Bacteria can grow quickly in cooling food. It is important to cool food quickly through the Danger Zone.

- Put all meats and other hot food in the refrigerator as quickly as you can. Do not let food sit at room temperature for more than 30 minutes.
- Divide large portions of food into shallow pans (no more than 2 inches deep) and put on the top shelf of the refrigerator. Don't stack or cover the pan while the food is cooling. Cover the pan after the food is 41° or colder.
- Liquids can also be cooled by placing a container with the food in an ice bath and stirring until the temperature is under 41°F. More ice should be added when the ice melts. Then cover and put it in the refrigerator.
- Never try to cool food that is more than four inches thick. For example, cut a large, cooked roast into smaller pieces to cool.

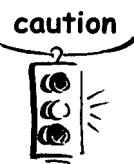
Do not let food sit at room temperature for more than 30 minutes.

A refrigerator should be set at 40° F or lower. Freezers should be set at 0° F. Measure the temperature with a metal stem thermometer. Fish, shellfish, poultry, milk, and red meat will stay fresh longer if kept below 40° F. Seafood will keep longer at 30°F.

Store Food Safely

Storing foods in the refrigerator

- After shopping, put away the groceries that need to be refrigerated or frozen right away.
- Don't overpack the refrigerator. Air must be able to circulate freely in order to chill foods effectively and prevent warm spots.
- Don't store perishables, such as eggs, in the refrigerator door. Because the door is opened frequently, its temperature is generally higher than the rest of the refrigerator and may not be safe.



Washing your hands for at least 20 seconds and cooking and cooling foods safely are the most essential safe food handling practices.



Prevent Cross-Contamination

See page 68 for a reminder on how to properly clean and disinfect a surface.

Store dry foods safely

To store foods safely:

- store foods in clean, leak proof containers with an airtight lid. Store so you can use older food first. "First in, first out" is a good rule to follow.
- cover, label, and date dry, refrigerated, or frozen foods.
- do not store food in galvanized cans or containers with metal coatings because some foods can "pull off" the metal which can cause poisoning.
- plastic bags should be the kind approved for food use.
- keep all foods off the floor.
- store foods away from cleaners and poisons.
- use utensils with bulk foods. Tongs and scoops work well.
- foods which are extremely sweet, like jams and jellies, are usually not a problem because the high sugar content prevents bacteria from growing. However, these foods can get moldy if they are very old or had a bad lid seal. If this happens, throw it away.

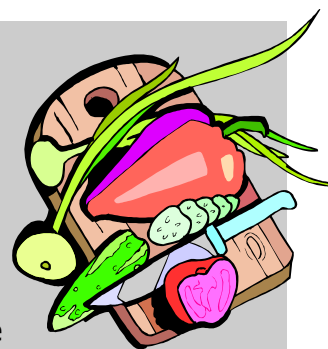
As a caregiver, your role is to help prevent cross-contamination.

Raw meat and cross-contamination

- Wash your hands between handling raw meat and foods that will not be cooked before eating.
- Don't let raw meat, fish, or poultry drip onto foods that will not be cooked before serving in the refrigerator.
- Store raw meat, fish, and poultry in leak-proof containers on the lower shelves of the refrigerator.
- Never store foods that will not be cooked before serving in the same container as raw meat, fish, or poultry.

Cutting surfaces and cross-contamination

- Cut food on a hard surface made of a non-porous material with no cracks or holes where germs can collect. This type of surface is easier to disinfect.
- Always use separate cutting surfaces for meats, fish, and poultry.
- Fruits, vegetables, and bread can be cut on the same surface.
- Wash, rinse, and disinfect the cutting surface and all the utensils and knives every time you finish cutting raw meat, fish, or poultry, finish with a job, or are going to prepare a different food.
- Use a cutting surface you can put through the dishwasher, if possible. Nylon and acrylic are both dishwasher safe.



Dishes and utensils

- Avoid putting your hands directly in or on the food.
- Use utensils to mix food. If you must use your hands, wash them carefully. Use gloves if possible.
- Use a clean spoon or fork to taste food. Do not reuse it until you clean and disinfect it.
- Use dishes and utensils that are in good condition. Cracked wooden spoons or chipped dishes are good places for germs to grow.

Germs are easily moved from one surface to another. Make sure the kitchen, especially the areas and things used to prepare food, are properly cleaned and disinfected.

Clean and disinfect all surfaces food touches

- When cleaning, basic good personal hygiene is important.
- The kitchen should be well-ventilated.
- Kitchen countertops, appliances, the inside of the refrigerator, sinks, dining table and chairs, and floors should be kept free from food particles and cleaned and disinfected regularly.
- Clean spills from the microwave, stove, or oven after each use.
- Clean the can opener often. Germs collect and grow there. Wipe off can lids before opening to remove dust, etc.
- Use separate clean cloths or paper towels for drying hands.
- Use separate cloth or paper towels for wiping up spills from the floor.
- A sponge spreads germs. Use paper towels if possible. Throw the paper towel away after cleaning each surface to help stop cross-contamination.
- Wash all towels, cloths, and sponges often.
- Replace sponges every few weeks.
- Mops should not be rinsed out in the kitchen sink.

Clean and Disinfect Surfaces Food Touches

See page 68 for a reminder on how to properly clean and disinfect a surface.

Dangerous bacteria grow easily in places that stay damp, such as kitchen sponges, dishcloths, sink drains, and faucet handles.

Washing dishes

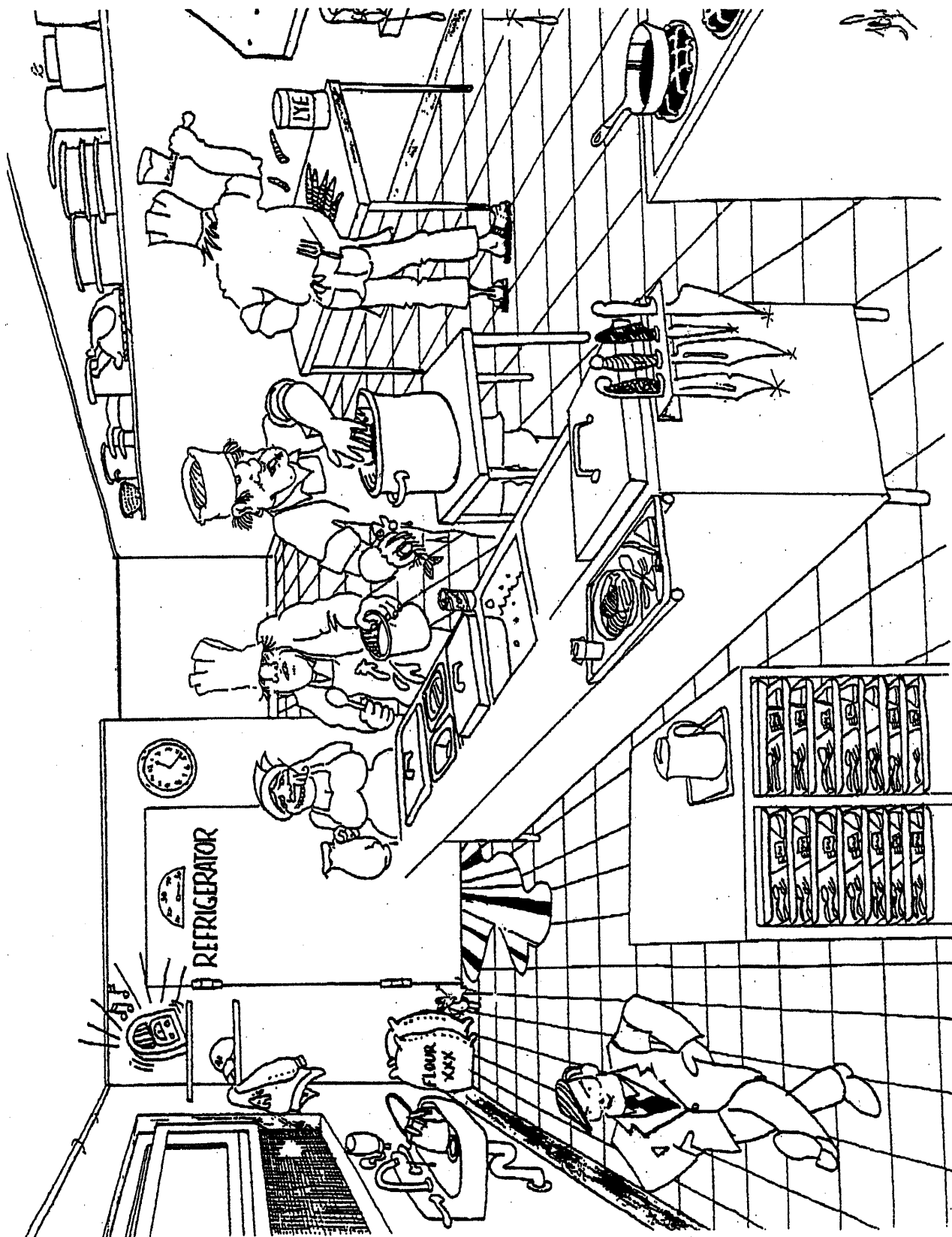
Dishwashers are the safest way to wash dishes. If a dishwasher is not available, use this four step method of washing dishes by hand.

1. Wash dishes with detergent.
2. Rinse in hot water.
3. Disinfect with bleach water in the sink (one teaspoon bleach to one gallon of water).
4. Air dry the dishes. Do not use a towel to dry them.

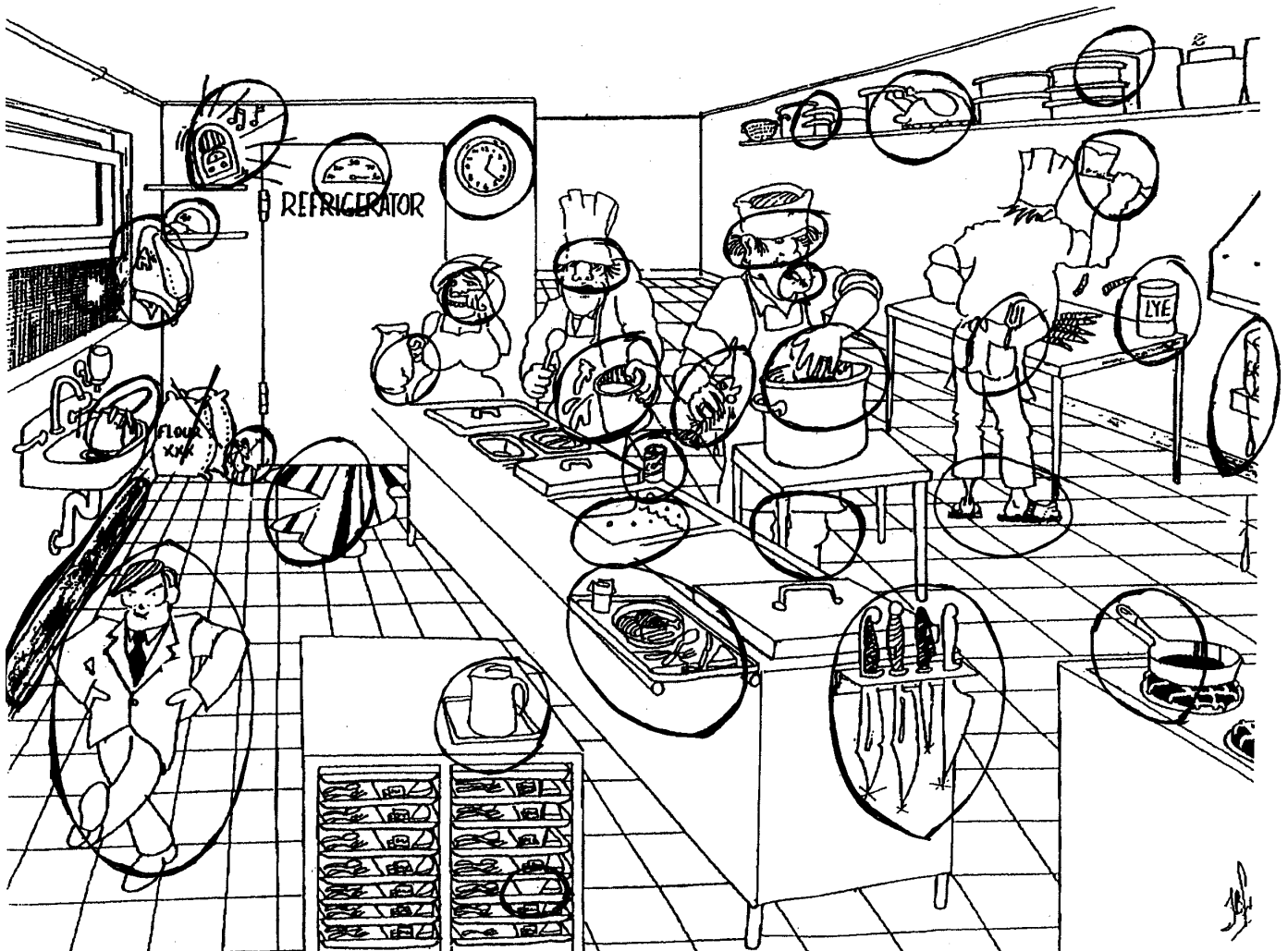


After cleaning

- Keep pots, pans, and utensils off of the floor.
- Put cups and glasses away upside down on clean surfaces. When you pick them up again, do not touch the rims.
- When you put away eating utensils, touch only the handles.



1. Have students find and circle any problems they see in the picture with safe food handling.
2. Set a timelimit of 3 minutes.
3. Have students volunteer their answers.





1. True ☒ False Only water counts towards a client's needed daily intake of fluids.
2. If a client is on a special diet, you need to know: (circle the correct answer)
 - a. Whether the client's family likes the diet.
 - b. What special foods or preparation is needed.**
 - c. Whether the diet has worked for others.
3. A nutrition food label is used in meal planning and shopping to help you: (circle the correct answer)
 - a. Decide if you will like the taste of the food.
 - b. Compare and choose healthy foods.**
 - c. Know if it is something the client likes.
4. True ☒ False The warning signs of poor nutrition in a client are difficult to observe.
5. A healthy diet means choosing a variety of healthy foods and: (circle the correct answer)
 - a. Never eating less healthy foods.
 - b. Setting limits on eating less healthy foods.**
 - c. Eating healthy foods a few days a week.
6. The safest way to thaw foods is to use the following: (circle the correct answer)
 - a. Counter.
 - b. Refrigerator.**
 - c. Hot water.
7. To prevent cross-contamination of food, always use separate cutting surfaces for: (circle the correct answer)
 - a. Bread or baked goods.
 - b. Fruits and vegetables
 - c. Meat, fish, and poultry.**
8. ☒ True ☐ False Food borne illness is caused by eating contaminated food.
9. True ☒ False To be safe, a refrigerator should be set to 0 degrees.
10. True ☒ False The number of daily servings needed from each of the food pyramid groups is the same for every person.
11. Germs grow quickly when left in temperatures between the danger zone at (circle the correct answer)
 - a. 0 and 100 degrees.
 - b. -10 to 120 degrees.
 - c. 41 - 140 degrees.**
12. ☒ True ☐ False Foods must be reheated to 165 degrees.
13. The most important safe food handling practices are: (circle the correct answer)
 - a. Washing your hands and cooking and cooling foods safely.**
 - b. Shopping for and preparing nutritious foods.
 - c. Using an oven mitt when handling hot foods or meats.



Module 9

The Process of Elimination

Lesson 1

The Process of Elimination



1 hours 30 Minutes

5 Minutes - Module Review

30 Minutes - Module Scenario

Personal Care Skills Covered

Assist Client with Pericare

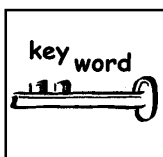
Assist Client with Use of Bedpan

Catheter Care

Assist Client with Catheter Care



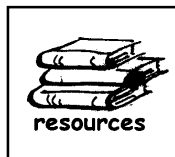
Icons to help guide you



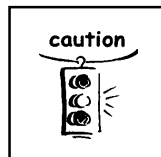
A word to remember



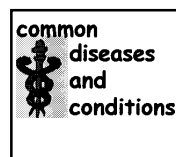
Something to report



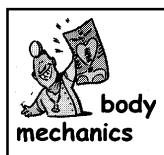
See the Resource Directory



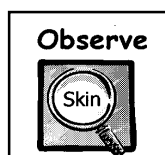
Beware or be careful



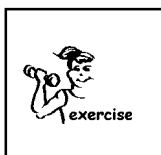
See the Common Diseases section



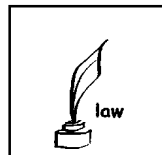
Use proper body mechanics



Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 9 - Lesson 1

The Process of Elimination



Bowel and Bladder
Function

Problems with
Urinary Function

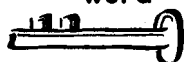
Assisting with
Toileting

Problems with Bowel
Function

What you will learn in this lesson:

1. How to promote good bowel and bladder functioning for a client.
2. Problems with bowel and bladder functioning, causes, signs, what can help, and what to report.
3. Assisting with toileting, including:
 - common toileting assistive equipment;
 - incontinence products;
 - pericare, colostomy, and catheter care.

key word



Definition

Colostomy	An opening on the surface of the abdomen where the bowel is opened and redirected to the outside of the body
Pericare	Cleansing of the genital and anal areas of the body
Urinary catheter	A tube inserted into the bladder to drain urine
Urinary incontinence	The inability to control bladder functions

When overseeing a client's bowel and bladder function, your job as a caregiver is to:

- have an understanding of what is and is not normal bowel and bladder function for a client;
- encourage the client to make choices to maintain good urinary and bowel function;
- know what to document and report to the appropriate person in your care setting if there are problems in this area.

Bowel & Bladder Function

The following are general guidelines for what is normal and not normal urinary and bowel function.

Urinary Function

Normal

- Emptying the bladder about every 3-4 hours during the day (6-8 times in 24 hours)
- Getting up once at night to empty the bladder

Not normal

- Getting up more than twice at night to empty the bladder
- Experiencing urine leakage or wetting accidents (incontinence)
- Pain or burning during urination
- Emptying the bladder more than 8 times a day
- Frequent, sudden, strong urges to go to the bathroom
- Blood in urine

Bowel Function

Normal

"Normal" bowel function varies greatly among people. Having a bowel movement is considered normal if it is:

- At least once every 1-3 days
- Formed, but not hard
- Without excessive urgency (needing to rush to the toilet)
- With minimal effort and no straining
- Without the need of laxatives

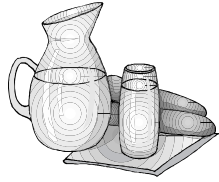
Not normal

- Straining or difficulty passing stool
- Stool is dry or hard; has blood and/or mucus
- Crampy, abdominal pain
- Constipation
- Diarrhea
- Bloating and/or gas
- Changes in bowel habits
- Continual need for laxatives
- Blood in stool

Tips for maintaining good urinary and bowel function

Many of the recommendations for maintaining good urinary and bowel function are identical to making healthy choices for overall health and well-being.

Encourage a client to take the following steps.



Get plenty of fluids

Drink 6-8 cups of fluid per day, more when the weather is hot or when exercising. Cut down on alcohol and beverages containing caffeine (tea, coffee, soda).

Make healthy food choices

Fiber is especially important to good bowel function.

Stay active and fit to the extent possible

Physical activity speeds the movement of food through the digestive system.



Relax

Don't strain to empty the bladder or bowel or sit on the toilet too long.

Talk to a doctor

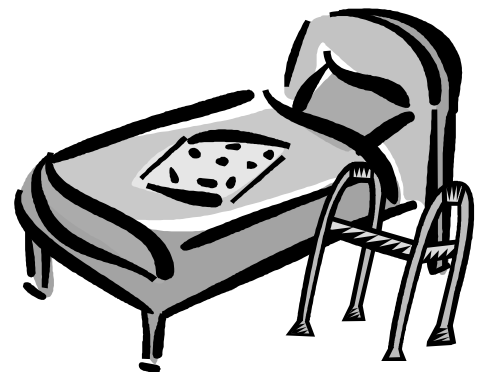
Encourage a client to see his/her doctor whenever there are changes or concerns about urination or bowel habits.

Stick to the client's toileting routines

Encourage a client not to ignore his/her body's signals and to go to the bathroom when he/she has the "urge" to go. Learn what the client's usual pattern is so you have time to assist and recognize when there are changes from a client's normal toileting.

Make sure the environment supports a client's routine

- Keep the path to the bathroom clear and free of clutter.
- Keep assistive devices, such as a walker or cane, nearby.
- Place a night light in the bathroom or leave a light on.
- Place a commode, urinal, or bedpan at the bedside if the client is unable to get to a bathroom.





■ Tips for good urinary and bowel function

1. Review content.



2. Ask students to brainstorm ways to respectfully learn what the client's usual toileting pattern is.

3. Ask students to brainstorm **how** each of these items assist a client in maintaining good urinary and bowel function.

Urinary tract infections (UTI)

A urinary tract infection is caused when bacteria invades the urinary system and multiplies, leading to an infection. Women are affected more frequently than men.

Urinary Tract Infections (UTI)

Common Causes

- A habit of waiting too long to urinate
- Prostate enlargement (men)
- Neurological problems that affect bladder emptying, including spina bifida and multiple sclerosis
- Diabetes
- Sexual activity (women)
- Post menopause in women
- Multiple pregnancies
- Not keeping the areas around the urethra, vagina, and anus clean and dry
- Wiping from the back towards the front
- Something in the urinary tract that stops the flow of urine (e.g. a kidney stone)

Signs or Symptoms

- Unexplained confusion or agitation
- An intense urge to urinate followed by passing only a small amount of urine
- A painful, burning feeling in the area of the bladder or urethra during urination
- Urine that is milky, cloudy, or reddish due to the presence of blood
- Urine that has an unpleasant odor
- Feeling "lousy" or weak
- Unexplained lower back pain
- Bladder spasms/pain
- Fever, chills, sweating
- Nausea
- Uncomfortable pressure above the pubic bone in women, and a feeling of fullness in the rectum in men



Urinary tract infections are easiest to treat if caught before they become severe or spread beyond the bladder into the kidneys. Report any of these signs immediately to the appropriate person in your care setting.

Urinary incontinence

Urinary incontinence is a symptom of a problem in the urinary system.

Common causes include:

- urinary tract or vaginal infections;
- side effects of medicine;
- constipation;
- blocked urethra due to an enlarged prostate in men;
- weakness of the muscles holding the bladder in place;
- an overactive bladder muscle;
- some types of surgery;
- spinal cord injuries;
- diseases involving the nerves and/or muscles (multiple sclerosis, muscular dystrophy, polio, or stroke).



Most urinary incontinence is treatable.

There are two main types of urinary incontinence.

Stress incontinence - loss of urine when the person coughs, laughs, strains, lifts, etc. It is a problem of weakness in the pelvic muscles. This is the most common kind of incontinence.

Urge/reflex incontinence - a strong, sudden need to urinate followed by an instant bladder contraction and involuntary loss of urine. There is often not enough time between the urge to urinate and the urination.

Help for urinary incontinence

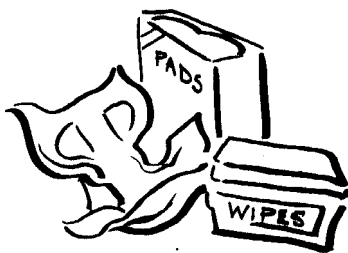
Incontinence is difficult for many people to talk about. Too many people, including many clients, still believe it is a part of normal aging and there is nothing that can be done about it. This is not the case. The majority of those affected by urinary incontinence can be cured or at least the symptoms improved. Although success rates in treating incontinence are high, only a small number of people get help.

For many, incontinence also affects their emotional, psychological, and social well-being. Many people are afraid to participate in normal daily activities that might take them too far from a toilet.

A client should be encouraged to talk with his/her doctor and find out what is causing the problem. Sometimes simple changes in diet or changing certain medications can cure incontinence. More frequently, treatment involves a combination of medicine, bladder training or pelvic floor exercises, and/or absorbent products.

When to report a problem

Make sure to report any problems with incontinence to the appropriate person in your care setting - especially if this is a new problem for a client.



Incontinence products

There are many products on the market to help a client manage urinary incontinence, including disposable pads, briefs, and/or moisture barrier creams. Do not refer to these products as diapers.

A client may prefer certain products, so know the client's preferences.

Assisting with incontinence products

Urine and stools are very irritating on the skin. Always help a client as soon as help is requested or routinely check to make sure help is not needed. Take the opportunity to observe the client's skin and report any problems you may see.



Problems with Bowel Function



Disposal and laundry

When disposing of incontinence products:

- wear gloves;
- empty urine and stool into the toilet;
- put the pads, briefs, or wipes and your gloves in a garbage bag;
- secure the bag and take it out to the trash immediately;
- deodorize the room, as needed.

Constipation

Constipation is caused when the stool moves too slowly through the bowel and too much water is absorbed by the body. This makes the stools hard, dry, and difficult for all or any part of the stool to be passed. Constipation is a common concern for many clients.

Constipation

Common Causes

- Some medications
- Not enough fluid and/or fiber in the diet
- Over use of laxatives
- Lack of exercise or immobility
- Anxiety, depression, or grief
- Changes in life or routine
- Diseases such as diabetes, Parkinson's disease, multiple sclerosis, and spinal cord injuries
- Conditions like diverticulosis or hemorrhoids
- Ignoring the urge to have a bowel movement
- Problems with the colon or rectum

Signs or Symptoms

- Bowel movements less frequently than is normal for the individual or less than 3 times per week
- Feces that are hard or clay-like
- Straining
- Pain before, during, or after having a bowel movement
- Passage of small amounts of feces or inability to pass feces
- Abdominal discomfort, bloating, nausea, feelings of fullness
- The need for a bowel movement but can't follow through
- Blood in stool or consistent change in stool color

Help for constipation

The cause of the constipation needs to be identified so the right treatment can be planned. In many cases, diet and lifestyle changes (increasing fiber, water, and physical activity levels) help to relieve symptoms and prevent constipation.

You may be asked to assist with a bowel program individually designed for a client and/or to use specific equipment. The client, a family member, or a health professional should train you on any individualized services.



When to report a problem

Change in a client's bowel habits can be a sign of a serious illness. Do not let the client go more than one to two days past his/her regular bowel movement pattern without reporting the problem to the appropriate person.

Blood in the stools or a consistent change in the color of the stool is of particular concern. Stools that have blood in them often appear black and sticky. Be aware that iron supplements, beets, blackberries, blueberries, or dark green vegetables can change stool color temporarily.

Fecal impaction

A fecal impaction is a very unpleasant and dangerous situation for the client. The client may or may not have an urge to pass stool. Clients who have chronic constipation are at the greatest risk.



Report these symptoms to the appropriate person immediately:

- sudden, watery diarrhea (especially for clients with chronic constipation);
- frequent straining with passage of liquid or small, semi-formed stools;
- abdominal cramping or discomfort;
- pain in the rectal area;
- lack of appetite or nausea;
- increased confusion and/or irritability;
- fever;
- unusual odor to breath.

Diarrhea

Diarrhea occurs when the stool moves too fast through the intestinal system and not enough water is removed from the stool before being passed.

Diarrhea	
Common Causes <ul style="list-style-type: none"> • A virus or bacterial infection • Food borne illness • Anxiety, stress • Side-effect of a medicine • Over use of laxatives • Too much fiber • Intestinal conditions (e.g. colitis, Crohn's disease, diverticulosis) • Food intolerances (e.g. lactose) or certain foods (e.g. beans, prunes, orange juice) • A dramatic change in diet • Excessive alcohol or caffeine usage 	Signs or symptoms <ul style="list-style-type: none"> • An urgent need to use the bathroom • Loose, frequent, watery, stools • Cramping or abdominal pain • Bloating • Nausea • Fever

Help for diarrhea

A possible dangerous side effect of diarrhea is dehydration. Clear liquids (water, diluted fruit juices, sports drinks, broth, and teas) help to keep the client hydrated. Heat can be applied to the abdomen to help relieve pain, cramps, and tenderness. It is best to avoid dairy products (milk, butter, creams, and eggs) which can make diarrhea worse. Ask the appropriate person in your care setting what the client should eat when having diarrhea.

Assist the client in keeping the skin around the rectal area very clean, if needed. Liquid stool is very irritating and can cause the skin to break down.



When to report a problem

Report to the appropriate person in your care setting if the client has diarrhea. Watch for and report immediately:

- severe pain in the abdomen or rectum;
- fever;
- blood in the stool;
- signs of dehydration (see page 148);
- diarrhea lasting more than 2-3 days.

When the client has diarrhea, report the type of stool (contents, odor, color) and frequency of stool to the appropriate person in your care setting. Documenting and recording the bowel movements makes it easier when reporting.

Colostomy care

Clients with Crohn's disease, colorectal cancer, diverticular disease, or a serious injury to the colon may require a **colostomy**. A bag is attached to the skin over the opening (stoma) to collect stool as it empties from the bowel. A colostomy may be permanent or temporary, depending upon the reason it was needed.

A client manages his/her colostomy in his/her own way. In an in-home setting, a caregiver can assist the client with colostomy care if his/her employer self-directs his/her care or if the task is delegated under nurse delegation. Special training is needed to do this task. In adult family homes or boarding homes, colostomy care must be a nurse delegated task.

Observe the skin for redness and/or irritation, and report and document any problems to the appropriate person in your care setting.

Observe



key word



Observe



Assisting with Toileting



The DSHS care plan will outline what kind of toileting assistance the client needs. Assistance may include:

- cueing and reminding;
- helping the client to and from the bathroom;
- helping the client transfer on and off and use the toilet or assistive equipment;
- undoing a client's clothing, pulling down clothing, and refastening clothing correctly when he/she is done;
- **pericare**;
- emptying the bedpan, urinal, or commode into the toilet;
- assisting with pads, briefs, or moisture barrier cream;
- performing routine colostomy or catheter care.

Privacy, dignity, and independence

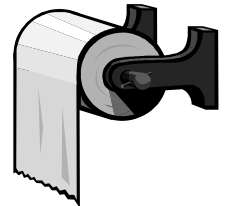
Toileting is a very private matter. No matter how routine it may become for you, it is a very vulnerable and defenseless time for a client. A reassuring attitude from you can help lessen feelings of embarrassment for the client.

When assisting a client with toileting, do everything you can to give the client privacy and maintain his/her dignity. This can include things like:

- looking the other way for a few moments;
- leaving the room (if it is safe to do so),
- allowing the client extra time to do what he/she can,
- being patient when a request for your time comes when you are busy with other things.

The following are **general tips** when assisting a client with **toileting**.

- Assist the client as much as possible into a normal, sitting position.
- If assisting with a transfer to a toilet or assistive device, make sure the item is stable or locked down before beginning the transfer.
- Put anything the client requires within easy reach (e.g. toilet paper or soap to wash up afterwards).
- If assisting with wiping, move from front to back and wear gloves.



Pericare

A client will want to do his/her own pericare if possible. Providing privacy and preserving the client's dignity are very critical if help is needed by the client.

Skill: Assist Client with Pericare



1. S.W.I.P.E.S.
2. Test water temperature and ensure that it is safe and comfortable before washing, and adjust if necessary.
3. Put on gloves.
4. Expose perineal area, making sure that the client's privacy is maintained.
5. Gently wash entire perineal area with soapy washcloth, moving from front to back, while using a clean area of the washcloth or clean washcloth for each stroke.
6. Rinse entire perineal area moving from front to back, while using a clean area of the washcloth or clean washcloth for each stroke.
7. Gently dry perineal area, moving from front to back and using a blotting motion with towel.
8. Wash, rinse, and dry buttocks and peri-anal area without contaminating perineal area.
9. Dispose of linen in proper containers.
10. Empty, rinse, wipe basin, and return to proper storage.
11. Remove and dispose of gloves without contaminating self after returning basin to storage.
12. Wash hands.

Observe



The following are some **general tips** when helping a client with **pericare**.

- Put down a pad or something else to protect the bed before beginning the task.
- Stay alert for any pain, itching, irritation, redness, or rash in this area. Report any concerns to the appropriate person in your care setting.
- Alcohol-free, commercial wipes may be preferred by a client instead of a washcloth and soap.
- If the client is incontinent, protect him/her from the wet incontinent pad by rolling the pad into itself with the wet side in and the dry side out. Remove the pad and use a clean, dry pad.





■ Skill: Assist Client with Pericare

1. Demonstrate skill using a mannequin. Students are expected to practice it in skill stations. Some parts can be simulated.
2. Cover the general tips during the skill demonstration.

· **Using other assistive equipment**

· While it is preferable to use the toilet in the bathroom, that is not always possible. Assistive equipment, such as a bedpan, commode, or urinal may be used by a client. The client's Case Manager or your supervisor can assist the client in getting assistive equipment when it is needed.

· Clients not able to get out of bed may have to use a bedpan.

Skill: Assist Client with Use of Bedpan



1. S.W.I.P.E.S.
2. Before placing bedpan, lower head of bed.
3. Place bedpan correctly under client's buttocks (standard bedpan: position bedpan so wider end of pan is aligned with the client's buttocks. Fracture pan: position bedpan with handle toward foot of bed). Have client bend knees and raise hips (if able).
4. Raise head of bed after placing bedpan under the client.
5. Put toilet tissue within client's reach.
6. Ask client to let you know when he/she is finished.
7. Lower head of bed before removing bedpan.
8. Put on gloves before removing bedpan.
9. Remove bedpan and empty contents into toilet.
10. Provide pericare, if needed.
11. Rinse bedpan, pouring rinse water into toilet. Return to proper storage.
12. Assist client to wash hands and dispose of soiled washcloth or wipe in proper container.
13. Remove gloves and wash hands.

Observe



· The following are some **general tips** when helping a client with a **bedpan**.

- Always help the client as soon as requested.
- Put a protective pad on the bed before the client uses the bedpan.
- If the pan is cold, warm it with warm water.
- Once the client is done, keep the bedpan level so it doesn't spill.



■ **Skill: Assist Client with Use of Bedpan**

1. **Demonstrate skill.** Students are expected to practice the skill in at a skill station.
2. Cover the general tips during the skill demonstration.



Commode

For clients who cannot get to the toilet in a bathroom, a commode can be very helpful. A commode is a portable chair with arms and a backrest with the seat open like a toilet and a bucket under the seat.

The bucket needs to be emptied, cleaned, and disinfected after each use. Putting a little water, liquid soap, or a very small amount of bleach water in the empty bucket makes it easier to clean the bucket after use.

Urinal

A urinal is used by a man as a container to urinate in when he is unable to get to the toilet. It is easier to use if the client is standing or sitting.

Do not leave the urinal in place for a long period of time. It can cause skin breakdown. Empty, clean, and disinfect the urinal after each use.



Portable urinal

Urinary catheters

Catheters are tubes that drain urine into a bag. A client may have a catheter because of:

- urinary blockage;
- a weak bladder unable to completely empty;
- unmanageable incontinence;
- surgery (used to drain the bladder during and after surgery);
- skin breakdown (allows skin to heal or rest for a period of time).

Internal catheters

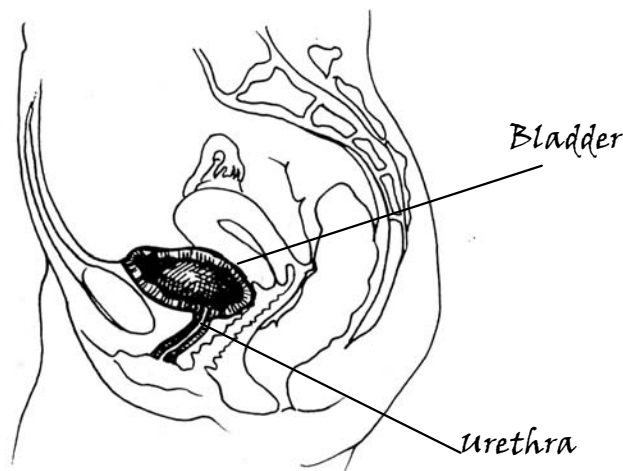
There are three types of catheters that go directly into the bladder to drain urine.

1. **Straight** (in and out catheter).

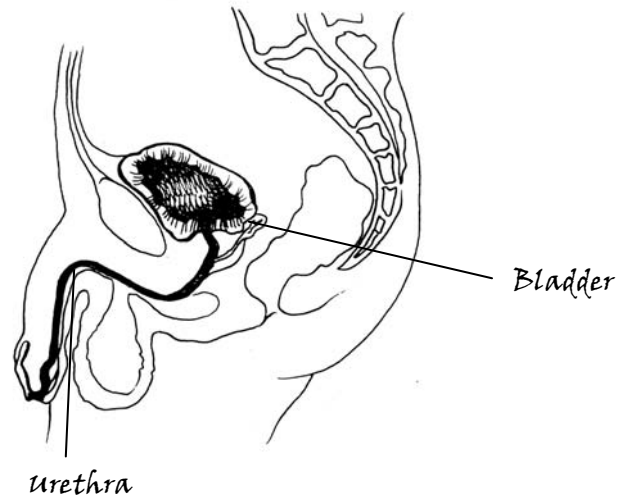
The straight catheter is inserted into the bladder, urine is drained, and then the catheter is removed.

If a caregiver is to insert this type of catheter, the task needs to be delegated to the caregiver under nurse delegation or by the in-home client under self-directed care. The task must be documented in the DSHS care plan and special training is required.

Catheters



Female



Male

2. Indwelling Suprapubic catheter.

The indwelling suprapubic catheter is a straight tube with a balloon near the tip. It is placed directly into the bladder through a hole made in the abdomen just above the pubic bone. The balloon is inflated with a normal saline solution after the catheter has been placed in the bladder and keeps the catheter from falling out.

3. Indwelling/Foley urethral catheter.

The indwelling urethral catheter is also a straight tube with a balloon near the tip but is inserted through the urethra. Caregivers may be asked to clean the tubing or empty the urinary drainage bag (see next page).

For either the Suprapubic or Foley catheter, the catheter attaches to tubing that drains the urine into a urinary drainage leg bag or overnight bag. The leg bag is attached to the leg, thigh, or calf. An overnight drainage bag hangs on the bed or chair.

This catheter can be left in place for one to two months if there are no problems. It can be removed and replaced with a new one once the old one is removed.



Caregivers are not allowed to insert or replace indwelling catheters. Caregivers may be asked to change the urinary drainage bag (see next page).

Skill: Catheter Care

1. S.W.I.P.E.S.



2. Test water in basin. Determine if water temperature is safe and comfortable before washing, and adjust if necessary.

3. Put on gloves before contact with linen and/or client.

4. Expose area surrounding catheter only.



5. Place towel or pad under catheter tubing before washing.

6. Avoid tugging the catheter.

7. Apply soap to wet washcloth.

8. Hold catheter near opening where it enters the body to avoid tugging it.

9. Clean at least four inches of the catheter nearest the opening, moving from the opening downwards away from the body, using a clean area of the cloth for each stroke.

10. Rinse at least four inches of the catheter nearest the opening, moving from the opening downwards away from the body, using a clean area of the cloth for each stroke.

11. Make sure there are no kinks in catheter tubing.

12. Dispose of linen in proper containers.

13. Empty, rinse, wipe basin and return to proper storage.

14. Remove and dispose of gloves without contaminating self after returning basin to storage.

15. Wash hands.

The following are **general tips** when helping a client with **catheter care**.

- Make sure the bag is kept lower than the bladder.
- Make sure the catheter is always secured to the leg to prevent tugging of the tube.
- When emptying the urinary catheter bag, be sure the end of the bag doesn't touch anything. This helps stop germs from entering the bag.
- In some care settings, you may be asked to measure the amount of urine in the bag.

Make sure to observe and report if:

- the urine appears cloudy, dark-colored, or is foul smelling;
- there isn't much urine to empty (as compared to the same time on other days);
- an in-dwelling catheter comes out;
- pain, burning, or irritation.





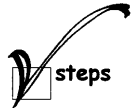
■ Skill: Catheter Care

1. **Demonstrate skill.** Students are expected to practice the skill at a skill station.
2. Cover the general tips during the skill demonstration.

External/condom catheter

External catheters are for men and are designed to fit over a man's penis. The condom catheter is made up of a sheath (or condom) attached to a tube that leads to a drainage bag. The condom is held onto the penis with tape or other sticky material.

Skill: Assist Client with Condom Catheter Care



1. S.W.I.P.E.S.
2. Put gloves on.
3. Expose genital area only.
4. Wash and dry penis carefully, cut long hairs.
5. Observe skin of penis for open areas.
6. If sores or raw areas are present, do not apply condom.
7. Put skin adhesive over penis.
8. Roll condom catheter over penis area.
9. Attach condom to tubing. Check that tip of condom is not twisted.
10. Check that tubing is one inch below tip of penis.
11. Remove gloves and wash hands.



The following are **general tips** when helping a client with **condom catheter care**.

- Condom catheters can be difficult to keep in place and should be changed regularly.



Making a homemade condom catheter out of a regular condom and tubing is not recommended.



■ **Skill: Assist Client with Condom Catheter Care**

1. **Demonstrate skill using a mannequin. Students are expected to practice it in skill stations. Some parts can be simulated.**
2. Cover the general tips during the skill demonstration.



1. ☒ True ☐ False Dehydration can be a dangerous side-effect of diarrhea.
2. True ☒ False Bowel function is usually the same for each person.
3. A client with what condition is at the greatest risk of fecal impaction? (Circle the correct answer)
 - a. High blood pressure.
 - b. Diabetes.
 - c. **Chronic constipation.**
4. ☒ True ☐ False When assisting with catheter care, always clean from the opening downwards away from the body.
5. True ☒ False Incontinence is just a part of aging and few medical treatments are effective.
6. Which of the following help to control symptoms or prevent constipation? (Circle the correct answer)
 - a. Decreasing physical activity.
 - b. **Increasing fiber and water intake.**
 - c. Over use of laxatives.
7. ☒ True ☐ False Unexplained confusion can be a symptom of a urinary tract infection.
8. How long should you wait before reporting a change in a client's normal bowel movement pattern?
 - a. Less than 24 hours.
 - b. **1-2 days.**
 - c. 3-4 days.
9. To maintain good urinary and bowel function, encourage a client to: (Circle the correct answer)
 - a. Read the paper on the toilet to relax.
 - b. Change his/her toileting routine each week.
 - c. **Stay as physically active as he/she can.**



Mrs. Crump is a 52-year-old client living with Parkinson's disease and Down Syndrome. She has a difficult time getting to the bathroom in time and is often incontinent. Today she was incontinent in the dining room and will not let you assist her with changing her clothes.

RESEARCH

Review page 318 about Parkinson's disease and page 306 for Developmental Disabilities.

PROBLEM SOLVE

1. Identify what problem(s) a caregiver needs to address in this situation.
2. Pick one problem and brainstorm ways to solve it. Pick a solution.
3. How does this impact how a caregiver provides care?

DEMONSTRATE

One group will demonstrate for the class the proper way to assist a person with peri-care.

Module Review



5 Minutes

Module Scenario



20 - 30 Minutes



Module 10

Medications and Other Treatments

Lesson 1

Self Directed Care and Nurse Delegation



20 Minutes

Lesson 2

Medications



50 Minutes

10 Minutes - Module Review

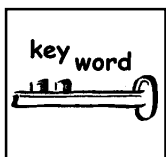
30 Minutes - Scenario

Personal Care Skills Covered

Assisting with Medications



Icons to help guide you



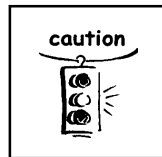
A word to remember



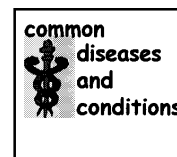
Something to report



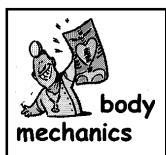
See the Resource Directory



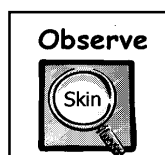
Beware or be careful



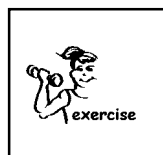
See the Common Diseases section



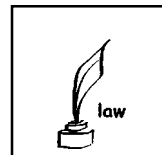
Use proper body mechanics



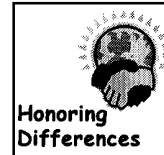
Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 10 - Lesson 1

Self-Directed Care and Nurse Delegation

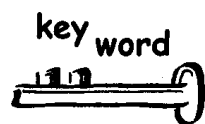
Self-Directed Care

Nurse Delegation



What you will learn in this lesson:

1. Self-Directed Care.
2. Nurse Delegation.



Definition

None



Self-Directed Care

A Washington State law protects the rights of a client living in his/her own home to direct an Individual Provider (IP) to do health care tasks he/she can no longer physically do. These are health care tasks that a caregiver **would not otherwise be allowed to do** (e.g. placing a pill in the client's mouth or assisting with an injection).

Self-directing these additional care tasks gives a client the freedom to direct and supervise his/her own care. It allows him/her to continue to live at home rather than move to a care facility, where a licensed nurse would have to perform the task(s).

Self-directed care rules

The law allows only clients living in their own home to self-direct care tasks and only to an IP. In-home clients who have a home care agency worker or clients living in an adult family home or boarding home are **not** allowed to self-direct their care.

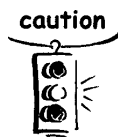
The specific roles and responsibilities of the client, IP and case manager are outlined in law.

Client responsibilities include:

- informing his/her health care provider that task(s) will be self-directed to the caregiver;
- informing the case manager of his/her desire to self-direct certain tasks and providing the necessary information that must be documented in the DSHS care plan;
- Training, directing, and supervising the IP in performing the task(s).

IP responsibilities include:

- deciding if you are comfortable providing the self-directed care task;
- getting trained by the client to do the task(s);
- performing the task(s) according to the instructions from the client.



If you are uncomfortable performing a self-directed health care task, talk with the client about it. If you and the client cannot reach an agreement on what to do, contact the case manager for help.

IPs are not allowed to do a self-directed care task **not** listed on the DSHS care plan. The case manager has to be involved and the DSHS care plan needs to be updated to include the task **before** it can be done.

Self-Directed Care key word



Case manager responsibilities include:

- documenting the self-directed care tasks in the DSHS care plan, including what is to be done and who is doing it;
- providing the IP and the client with a copy of the DSHS care plan with the self-directed care tasks listed;
- updating the DSHS care plan, as needed.

Nurse Delegation



Nurse Delegation is a Washington State law that allows a licensed Registered Nurse (RN) to train a qualified Nursing Assistant to do specific health care tasks for a client. These tasks are different than the standard personal care tasks and without nurse delegation a caregiver would not be allowed to do them.

Nurse Delegation allows a client to continue to stay where he/she is living and still get the care he/she needs.

The requirements for Nurse Delegation are written in law. **Only** Nursing Assistants - Certified (NAC) or Nursing Assistants - Registered (NAR) can do delegated tasks.

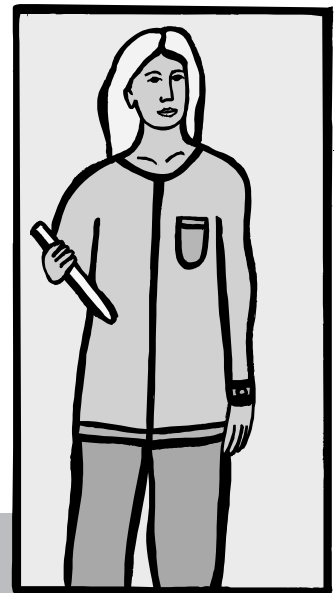
Nurse Delegation training requirements

Training requirements include:

1. All Nursing Assistants must successfully complete the *Nurse Delegation Training for Nursing Assistants* course **before** accepting a delegated task.
2. **NARs** must successfully complete *Revised Fundamentals of Caregiving* or another state-approved basic caregiving curriculum **before** accepting a delegated task.

NARs who are also a RN, LPN, Medicare Certified Home Health Aide, Occupational Therapist, or Physical Therapist may take *Modified Revised Fundamentals of Caregiving* or another state-approved modified basic caregiving curriculum.

NACs must complete the *Modified Revised Fundamentals of Caregiving* course or another state-approved modified basic caregiving curriculum within 120 days of employment. It is not necessary to complete this course before performing a delegated task.



Complaints or concerns about nurse delegation can be called into DSHS at 1-800-562-6078.

After the training has been successfully completed, the Nursing Assistant must take direction from the RN who is supervising him/her in performing these tasks.

Module 10 - Lesson 1

Self Directed Care and Nurse Delegation

Types of tasks that must be delegated

The following are examples of tasks that must be delegated, including:

- administration of oral, topical, inhaled medications, and drops;
- administration of enemas or suppositories;
- inserting a straight catheter using a clean technique;
- tube feedings;
- blood glucose monitoring;
- simple dressings;
- colostomy care.

Types of tasks that may NOT be delegated

There are certain tasks written in law that **cannot** be delegated even to trained Nursing Assistants, including:

- injectable medications (other than insulin);
- sterile procedures;
- maintenance of central IV lines;
- tasks requiring nursing judgment.

When not to do a delegated task

You cannot do a delegated task if you:

- have not completed the training (see previous page);
- are not a NAR or NAC;
- are being asked to do a task that cannot be delegated; or
- are not comfortable doing the task.

Talk with your supervisor or get the client's case manager involved to resolve any of these situations.

The difference between Self-Directed Care and Nurse Delegation

The difference between these programs can be confusing. The following chart describes the main differences between these programs.



	Self-Directed Care	Nurse Delegation
Who trains and supervises you on the task itself?	Client	RN
Where can it be done?	In-home only	All care settings
Caregiver requirements	IP, not home care agency worker	Must be Nursing Assistant (Registered or Certified)

Module 10 - Lesson 2

Medications



Medication Assistance
and Medication

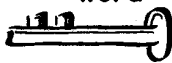
The Five Rights

More on Medications

What you will learn in this lesson:

1. The caregiver's role in medication assistance and medication administration.
2. The five rights of medication.
3. What to document and report regarding medications.
4. Medication side-effects.
5. What to do if a client doesn't want to take his/her medications.

key word



Definition

Medication route

The way a medication is taken

Side-effects

A secondary and usually undesirable effect of a drug or therapy

Medications are powerful substances that can treat, cure, or help control an illness, relieve symptoms like pain, and prevent disease. Medications include:

- **prescriptions** which must be ordered by a health care professional (doctor, nurse practitioner, physician's assistant, or dentist);
- **over the counter (OTC) medications** which anyone can purchase without a prescription at the store.

Your role as a caregiver may be to assist a client in taking medication. Very specific rules are written in law as to what a caregiver can and cannot do. The DSHS care plan will detail exactly what tasks you are asked to do in this area.

Medication Assistance and Medication Administration



Medication assistance and medication administration

Medication assistance is helping the client to take his/her own medication. Medication assistance does not require nurse delegation. Caregivers can assist with medications, as long as the client:

- is aware he/she is taking a medication;
- can put the medication into his/her mouth; or
- apply it to his/her own skin.

Medication assistance includes:

- reminding or coaching the client to take a medication;
- opening the medication container;
- handing the medication container or enabler to the client;
- placing the medication in the client's hand;
- crushing, cutting, or mixing a medication (only if a pharmacist or health care provider determines it is safe);
- steadying or guiding a client's wrist so he/she can apply drops, sprays, lotions, or ointments.

Medication assistance can **not** include:

- forcing a client to take his/her medication or hiding medication in something, such as food, in order to get the person to take it.

Medication administration is putting the medication into a client's mouth or applying it to his/her eyes, ears, or skin. Medication administration is required when:

- a client is unaware that he/she is taking medication;
- a client is physically unable to take or apply his/her medication;
- professional nursing or medical judgment is needed to determine whether the client needs to take the medication.

Who can administer medications

Only caregivers that fall into one of the categories listed below can administer a medication.

- RN, LPN;
- Family member;
- IP where an in-home client self-directs the task;
- NAR/NAC who has been nurse delegated the task;
- Caregivers in licensed boarding homes to a client who cannot physically administer his/her own medication but can direct the task to be done.



Comparing Medication Assistance to Medication Administration

Task	Task is considered:	
	Medication Assistance	Medication Administration
Filling a medication organizer (e.g. medisets)		X*
Opening containers, handing container to client	X	
Pouring liquid medication into a container and handing to client	X	
Putting medication in client's hand	X	
Crushing, cutting, or mixing medication (only if a pharmacist or other health care provider determines it is safe).	X	
Putting medication in a client's mouth or applying to skin		X
Steadying or guiding a client's wrist	X	
Injecting medications (other than insulin)		X*
Assisting with PRNs when professional judgement is needed		X*
Changing a sterile bandage		X*

* Tasks cannot be delegated.

Storage of medications

In-home clients can store medications as they choose. Encourage the client to keep medications out of the reach of children or pets, in its original container, and to store them in a cool, dry spot.



The rules for storing medications is set in law for boarding homes and adult family homes. Ask your supervisor about the rules if you work in one of these care settings.

Documentation

There are no specific documentation rules for in-home clients. For IPs, it is good practice to document:

- any drug reactions, possible **side-effects**, and/or changes observed;
- if a client continues to refuse to take a medication.



The rules for documenting medication assistance and medication administration have been set in law for boarding homes and adult family homes. Check with your supervisor. Agency workers should follow agency guidelines.

Module 10 - Lesson 2

Medications



The second to the last line in the chart comparing medication assistance to administration mentions PRNs. A caregiver's role with PRNs is covered on page 187 of the Learner's Guide. You can either cover what PRNs are here or wait and cover it later. If you wait, make sure to remind students of the rules regarding medication assistance at that time.

There are five rights that guide your actions anytime you help a client with medications including: right medication, client, amount, route, and time.

Medication names

All medications have a generic and product name. The generic name is given by the manufacturer before the Food and Drug Administration (FDA) approves the medication and gives information about the chemical makeup of the medication (e.g. ibuprofen).

The product name is the brand name used by a specific manufacturer when they sell the product. The name is owned by the manufacturer and cannot be used by any other company (e.g. Motrin or Advil for ibuprofen).

Medications packaging

Medication is packaged in a variety of ways, including:

- pill bottles or bottles with droppers;
- bubble packs or bingo cards;
- medication organizers, like medisets and weekly pill boxes;
- unit dose packaging with each dose packaged separately. Keep unit-dose packages wrapped until ready to use so the label stays with the medication.

All medications should be in a labeled medicine bottle or labeled container. The following information should always be on the medicine label:

- | | |
|------------------------|--------------------------------|
| • client's name | • expiration date |
| • medication name | • schedule |
| • doctor's name | • strength |
| • pharmacy name/number | • directions on use |
| • dosage | • quantity in the prescription |
| • route | • number of refills |

There may also be a special warning label that provides more information on the use of the medication, for example: *Medication should be taken with food.*

If the medicine is put in a separate container (not allowed in an adult family home or boarding home unless you are a nurse or pharmacist), it should always be labeled to include the:

- | | |
|-------------------|-------------------|
| • Client's name | • Route |
| • Medication name | • Expiration date |
| • Dosage | • Schedule |

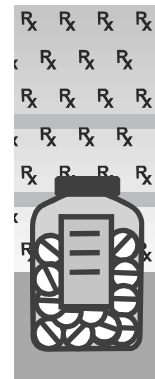
Reading the label

Read the label to make sure:

- the client's name is on the container;
- the medication is not expired;
- you verify the correct time, dosage, route and that you are aware of any special instructions for this medication (e.g. needs to be taken with food).

Five Rights

1. Right Medication





Bring in and show students a variety of different medication packages.



Read the label when you:

1. Take it from the shelf or drawer where it is stored.
2. Open the container or transfer it to an enabler.
3. Replace the bottle or package.

2. Right Client

Always identify the client. It is your responsibility to make absolutely certain you know who the client is before you assist him/her with medication. Stay with each client until he/she takes the medicine.

3. Right Amount

Know the correct dosage symbols and abbreviations for medications. Be sure that the amount the client takes matches the amount on the label.



Commonly Used Abbreviations for Medications

a	Before	mEq	Milliequivalent
ac	Before meals	noc, noct	Nocturnal
@	At	NPO	Nothing by mouth
bid	2 times a day	OD	Right eye
c	With	OS	Left eye
cc	Cubic centimeter, same as ml	OU	Both eyes
cm	Centimeter	p	After
dc	Discontinue	pc	After meals
elix	Elixir	po	By mouth
gm	Gram	prn	As needed
gtt	Drop	q	Every
gtts	Drops	qd	Every day
hs	Bedtime	qid	4 times a day
IU	International units	qod	Every other day
Kg	Kilogram	q4h	Every 4 hours
L	Liter	qhs	Every bedtime
mcg	Microgram	s	Without
mg	Milligram	tid	3 times a day
ml	Milliliter, same as cc	u	Unit
mm	Millimeter		

The most common **medication routes** are:

- **oral** - taken by mouth. This includes tablets, capsules, powders, syrups, mouthwashes, and more.
- **topical** - applied to the skin or mucous membranes. These include creams, lotions, ointments, skin patches, or ear and eye drops.
- **suppositories** - inserted into the rectum or vagina.
- **aerosol medications** - inhaled through the nose or mouth.
- **injected** - by piercing the skin with a needle and putting the medication into a muscle, fat tissue, under the skin, or into a vein.



Regularly scheduled medications are taken at certain times of the day. Usually, there is some flexibility in the “window of time” when the medication can be taken. For example, a medication to be taken at 9 am. may be okay to take anywhere between 8:30 to 9:30 am.

The regular schedule will be determined by the client, the doctor, and/or the nurse. The schedule should be clear so you can assist the client at the right time.

Check the medication record or medicine container for the correct time for the medication. Refer back to the list on page 186 to make sure you know the correct abbreviations for times.

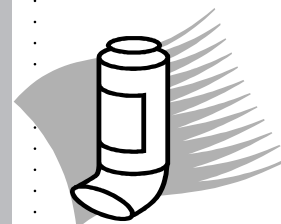
PRNs

PRN medications (Latin for Pro Re Nata) are medications taken on an “as needed” basis.

You **may assist** the client if there are specific, **written** directions to follow and the client indicates he/she needs the medication.

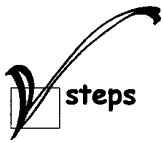
You **may not assist** the client with PRN medications when professional judgment is required to decide if the medication is needed or when the client is not able to determine what is needed (unless you are an RN, LPN, or family member).

4. Right Route



5. Right Time

Skill: Medication Assistance



1. S.W.I.P.E.S.
2. Remind the client it is correct, scheduled time to take his/her prescribed medication.
3. Take the medication container from where it is stored, look at the label, and verify the 5 Rights—medication, client, amount, route, and time.
4. Open the container, look at the label and verify the 5 Rights again.
5. Hand the correct dosage to the client, hand the open container to the client, or transfer the medication to an enabler.
6. Offer the client a full glass of fluid (for oral medications).
7. Observe and make sure the medication is taken.
8. Close the medication container and put it back in the appropriate place. Read the label and verify the 5 Rights once again.
9. Document that the client has taken the medication. If he/she has not, document that as well.
10. Wash hands.

The following are **general tips** when assisting a client with **oral medications**:

- Ask the client to sit up when taking oral medicine to make it easier to swallow.
- If the client cannot sit up and is lying in bed, help him/her roll to the side to make swallowing easier.



More on Medications

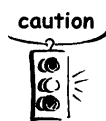


When medications are not taken as prescribed

It is considered an error when the medication is not given according to the directions. This includes any error related to the “five rights” including wrong time, wrong medication, wrong client, wrong dose, wrong route, or any other mistake.

Reporting errors

While we all try not to make mistakes, sometimes it happens. Immediately report errors you discover to your supervisor or the delegating nurse (if there is one). IPs (or the client, if able) should immediately call the client’s pharmacist or doctor to make sure the medication error will not harm the client.



Pay close attention and make sure you understand what you are to do when assisting with medications. Check with the appropriate person in your care setting when in doubt about anything to do with assisting with medications.



■ Skill: Medication Assistance

1. **Demonstrate skill.** Students are expected to practice the skill.



Since this is the only skill in this module and is called out in the Module Scenario, you can wait and have the students practice it when working on the Module Scenario.

Medication side-effects

A medicine can interact with other medicines, food, alcohol, OTC medications, and/or herbs. This drug interaction may increase or decrease the effectiveness and/or the side-effects of the medicine being taken. The likelihood of a drug interaction occurring increases as the number of medications being taken by a client increases.

Read the label and insert that comes with a medication and stay alert to special instructions, anything that should be avoided (e.g. food), and/or possible side-effects of the drug.



Symptoms of Possible Medication Side-Effects

- | | |
|-------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Confusion and other memory problems | <input type="checkbox"/> Rash, hives, itching |
| <input type="checkbox"/> Dizziness, difficulty walking, increased falls | <input type="checkbox"/> Diarrhea, constipation |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Upset stomach or vomiting | <input type="checkbox"/> Loss of energy |
| <input type="checkbox"/> Changes in eating, sleeping patterns | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Chills | |

Report any of these symptoms to the proper person in your care setting.



Clients should also be encouraged to:

- give his/her doctor and pharmacist a complete list of all of the drugs he/she is using including OTC medications, vitamins, food supplements, and herbal remedies;
- inform his/her doctor when medications are added or discontinued or about changes in lifestyle;
- ask his/her doctor or pharmacist about the most serious or frequent drug interactions with the medications she/he is taking;
- get all prescribed and OTC medications at the same pharmacy or drug store so the pharmacist can maintain an up-to-date list of all medications a client is taking and check for potential problems.



Vitamin supplements and herbs

Many vitamins and herbs interfere with medications that people take or can cause serious side-effects in individuals with certain medical problems. Encourage a client to talk with his/her doctor and/or pharmacist before taking any vitamins or herbs.

When a client doesn't want to take medication

Individuals have the right to refuse to take their medications. If a client refuses to take a medication, try to find out why and help solve any concerns or problems.

Below are some common reasons and suggestions for how to work with clients who may not want to take a medication.

REASON	SUGGESTION
Unpleasant taste	<ul style="list-style-type: none"> • Provide crackers or juice afterwards to help cover up any bad taste. • Put the medication in jelly (if appropriate and the client is aware it is there). • Many pharmacies now offer flavoring that can be added to bad-tasting medicines. • Use an ice cube to numb the taste buds just before the individual takes the medication. • Suggest that the client or the family try to get a different form of medication, a different medication from the prescribing doctor, or report this to the nurse for a solution, if one is available.
Unpleasant side effect	<ul style="list-style-type: none"> • Suggest that the client ask the doctor about changing the schedule, (e.g. before bedtime), changing medication, or treating the side effect.
Lack of understanding	<ul style="list-style-type: none"> • Provide simple reminders on what the name of the medication is and what the medication does. For example, "This is Lasix, your water pill."
Denial of need for medication	<ul style="list-style-type: none"> • Remind the client about the purpose of the medication, but do not argue. For example, "Alma, you take your heart medication every day to keep your blood pressure down." If appropriate, get support from a family member. It may help to show a client something written by the doctor.



If there is no solution to why a client doesn't want to take the medication and/or he/she continues to refuse to do so, report this to the appropriate person in your care setting. Document that the client did not take the medication, why, and who you notified according to the rules for where you work.



A client's background and/or culture can impact his/her view on the use of medications versus other types of treatments and/or therapies. Encourage the client to share any concerns with his/her health care provider.



1. Put an "X" in the appropriate column.

	Medication Assistance	Medication Administration
Putting medication in a client's mouth or applying to skin		X
Placing a medication in a client's hand	X	
Using professional nursing judgment about a medication		X
Steadying or guiding a client's wrist	X	
Reminding or coaching a client to take medication	X	

2. ☒ True ☐ False The likelihood of a drug interaction occurring increases as the number of medications being taken by a client increases.
3. The window of time a medication can normally be safely taken is within: (circle the correct answer)
- 1-2 hours of the prescribed time.
 - 3-4 hours of the prescribed time.
 - 30 minutes of the prescribed time.**
4. True ☒ False ☐ Only clients living in an adult family home or boarding home can self-direct care tasks to a caregiver.
5. The following care tasks can **not** be done by a caregiver under nurse delegation. (circle the correct answer)
- Tube feedings.
 - Injecting medications (other than insulin).**
 - Colostomy care.
6. A caregiver can assist a client with PRN medications, when there are clear, written directions and: (circle the correct answer)
- The client requests it.**
 - Nursing judgment is required.
 - You have time to help.
7. True ☒ False ☐ What needs to be documented regarding medication is up to the caregiver in an adult family home or boarding home.



10 Minutes

Module 10
Module Review



8. The wrong medication was given to a client by mistake. Your **first** action must be to: (circle the correct answer)
- a. Watch for side-effects.
 - b. Report it immediately.**
 - c. Offer the correct medication.
9. When assisting with medications, you must read the medication label and verify it is the correct time, dosage, and route: (circle the correct answer)
- a. The first time you give it to a client only.
 - b. Every time you assist giving the medication.**
 - c. When you think about it and have time.
10. True False Only report a client's continued refusal to take a medication if you think it will harm him/her.

Module Scenario



Mr. Gaines is a 67-year-old client living with arthritis and cancer. His current chemotherapy treatment has left him quite weak. Today he has asked you to open a bottle that contains a new vitamin supplement he has heard will cure his type of cancer.

RESEARCH

Review page 296 about arthritis and page 299 for cancer.

PROBLEM SOLVE

1. Identify what problem(s) a caregiver needs to address in this situation.
2. Pick one problem and brainstorm ways to solve it. Pick a solution.
3. How does this impact how a caregiver provides care?

DEMONSTRATE

One group will demonstrate for the class the proper way to assist a person with medication.



20-30 Minutes



Module 11

Self Care and the Caregiver

Lesson 1

Self Care and the Caregiver



1 hour 30 Minutes

Lesson 2

Grief and Loss



10 Minutes

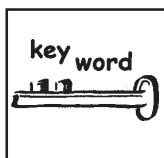
5 Minutes - Module Review

Personal Care Skills Covered

None



Icons to help guide you



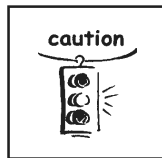
A word to remember



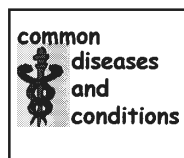
Something to report



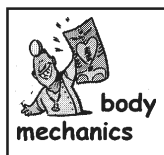
See the Resource Directory



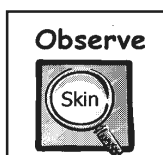
Beware or be careful



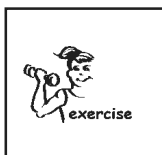
See the Common Diseases section



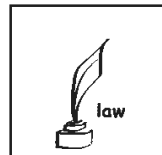
Use proper body mechanics



Observe skin



Classroom exercise



Something in the law



Be alert and respectful

Module 11 - Lesson 1

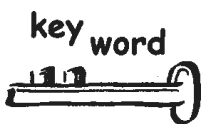
Self Care and the Caregiver



Self Care

What you will learn in this module:

- 1. Good self care practices for caregivers.
- 2. Warning signs of caregiver stress and burnout.
- 3. How to set limits.
- 4. Finding positive outlets for your emotions.
- 5. Learning ways to relax.
- 6. Successfully making healthy lifestyle choices.



Definition

Burnout	A state of physical, emotional, and mental exhaustion
Stress	Any situation or thought that makes you feel frustrated, angry, or anxious

There are many positive, life giving rewards to caregiving (see page 39). On the other hand, caregiving can take a lot out of you. It can be physically and emotionally demanding, stressful, and energy draining work. Most caregivers also have other life pressures and responsibilities.

All of this adds up to a lot of expectations and demands on one person. Caregivers can be so busy caring for others that they often neglect their own emotional, mental, physical, and spiritual health. Just as you need to fill up your car before it runs out of gas, caregivers need to continually refuel the body, mind, and spirit.

Good self care for caregivers includes:

- Recognizing and reducing stress in your life;
- Setting limits;
- Finding positive outlets for your emotions;
- Learning to relax;
- Making healthy choices in diet;
- Getting enough sleep and physical activity.

Does “doing it all” also include taking care of you? Ask yourself the following questions and think about how well you are taking care of your own needs.

Yes No

- ☐ ☐ Do you take better care of others than you do yourself?
- ☐ ☐ Do you try to “do it all” even when it isn’t realistic?
- ☐ ☐ Do you ignore or down play your own feelings or health problems?
- ☐ ☐ Do you have a hard time saying “no”?
- ☐ ☐ Is it hard for you to ask for help?
- ☐ ☐ Is finding time for yourself always something you will do tomorrow?

If you answered yes to several of the questions above, you may need to look at how well you are taking care of yourself.

Recognize early warning signs of stress

Stress is a normal part of every day life. Although small amounts of stress can keep you alert and motivate you to take action, too much stress for long periods of time is hard on your body, mind, and spirit.

Under stress, your body goes on high alert. Essential body functions, like respiration and heart rate, speed up. Less essential functions, such as the immune system, shut down. This puts you at greater risk for infections, certain diseases, depression, or anxiety.

Self Care



key word
stress

■ Self Care



The checklists have been included as a tool to help students assess their current and potential issues with self care. Give students time to complete the checklists during the lesson.

Encourage students to be as honest with their answers as possible. Do not ask or expect students to share their answers.



1. Once students have completed the checklist, have students brainstorm why several “yes” answers could potentially be an issue for a caregiver.

Reduce Stress in Your Life

Stress itself isn't harmful. It's your **reaction** to what is causing the stress that can be harmful.

Recognize early warning signs of stress

To give yourself the best chance of reducing stress in your life, you should:

1. Recognize what normally causes YOU stress.
2. Stay alert to early warning signs that you are stressed.
3. Take action early to reduce the stress.

1. What causes you stress

Stress often begins when events feel beyond or out of your control. What is stressful for you may or may not be stressful to others. There are no right or wrong answers - just your own internal feelings.



Below are some common feelings and stress causing factors that caregivers report as stressful. Check off any that are possible causes of stress for you.

- ☐ I feel overwhelmed most of the time.
- ☐ It feels like everything is out of my control.
- ☐ I feel trapped.
- ☐ I feel alone with all the responsibility for too many things.
- ☐ I don't feel valued for what I do.
- ☐ I feel guilty that I am not doing enough - no matter what I do.
- ☐ I often feel sad or depressed.
- ☐ I am angry or resentful at not getting enough help from others.
- ☐ I feel helpless to change the situation.
- ☐ (other) _____
- ☐ (other) _____

Other stress causing factors ...

- ☐ A client's or co-worker's negative behavior or attitude.
- ☐ Problems outside of work.
- ☐ Not enough money.
- ☐ (other) _____
- ☐ (other) _____

2. Warning signs of stress

Once you have a better idea of what can cause you stress, get a sense of how much stress you are feeling. Stay alert to early warning signs that things are getting out of balance. Family or friends can also be a good source of feedback.

Warning Signs of Stress

Physical

- Muscle tension
- Stiff neck or back pain
- Cold/sweaty hands
- Tired all the time
- Tension headaches
- Indigestion or diarrhea
- High blood pressure - chest pain
- Ulcers
- Rapid heart rate
- Grinding of teeth

Emotional/Mental

- Feelings of hopelessness, depression, guilt, anxiety, apathy, or fear
- Impatience
- Nervousness
- Mood swings
- Short-tempered
- Panic

Behavioral

- Changes in eating or sleeping patterns
- Forgetfulness
- Having a hard time making a decision
- Withdrawing from former activities or spending less time with friends
- Problems with relationships (marriage, friends, children)
- Inability to rest or relax

Caregiver *burnout*

Caregiver burnout can happen when too much stress continues for too long and little or no action has been taken to replenish the mind/body/spirit.

The warning signs of burnout are similar to the warning signs of stress - just intensified (see above). Caregivers who are burned out report that they feel like there is "nothing left". Beyond the physical exhaustion, there is often a loss of hope, purpose, and meaning. There are no emotional or physical reserves left to continue on as before - the gas tank is now empty.

The following are behaviors that may put you at risk for caregiver burn out. Check off the ones that may be true for you.

Yes No

- | | | |
|--------------------------|--------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | I take on more than I can realistically do. |
| <input type="checkbox"/> | <input type="checkbox"/> | I skip breaks, lunch, or other free time. |
| <input type="checkbox"/> | <input type="checkbox"/> | I don't take vacations – even when I need one. |
| <input type="checkbox"/> | <input type="checkbox"/> | It is hard for me to ask for help - even when I need it. |
| <input type="checkbox"/> | <input type="checkbox"/> | It is not easy for me to seek out emotional support from others. |
| <input type="checkbox"/> | <input type="checkbox"/> | I don't make or keep needed medical appointments. |
| <input type="checkbox"/> | <input type="checkbox"/> | I usually don't take the time to eat right or exercise. |
| <input type="checkbox"/> | <input type="checkbox"/> | I don't get enough sleep. |
| <input type="checkbox"/> | <input type="checkbox"/> | I find myself drinking more or using drugs to "cope". |

If you checked "yes" for several statements, you may want to look at the possibility that you may now or in the future be a candidate for caregiver burnout.

key word





- **Warning Signs of Stress**
- **Caregiver burnout**

1. Review content.



- Q. What is it about caregiving that leads to burnout?
- Q. What stops you from doing what you need to do to avoid burnout?
- Q. How can not taking good care of yourself impact a client?

Taking Action to Reduce Stress

The need to reduce stress is not surprising to most caregivers. The reality is that making the needed lifestyle changes is often easier said than done.

There are common barriers to many caregivers carving out the time, making it a priority, or having the resources and energy to take the steps to refuel their body/mind/spirit, including:

- feelings of guilt or selfishness for taking time away from others;
- pressure from loved ones to keep things the way they are;
- being too overwhelmed or too tired to take positive action;
- fear of failing or lack of confidence in making the change;
- not knowing or using stress reducing techniques;
- lack of money;
- procrastinating or postponing taking the needed steps.

Tips for making successful behavior changes

To make positive life-style changes, you need to feel confident in your ability to change and see the importance and benefit to you and/or your loved ones. Here are three important tips for making positive changes in your life.

1. Be honest with yourself about your capabilities and goals

Set specific, realistic short-term and long-term goals. Shoot for small changes and start slowly. You are more likely to be successful taking it one, small, baby step at a time. Unrealistic goals set you up to feel frustrated or defeated and are likely to cause you to give up.



2. Get help

Create a support system. Looking for and accepting help is one of the best tools you have in making a successful change. Find people who will encourage and support you in sticking with your goals. Talking with a person who has already been through what you are experiencing is always helpful. Don't assume others can read your mind and know what you need. Be specific and ask for what you want. If that person can't give it to you, find someone who can!



3. Reward yourself

Create your own reward system and give yourself encouragement along the way. Celebrate every success, no matter how small. Be patient - don't expect immediate results. Feel good about the steps you are making and don't beat yourself up. If you slip and go back to old behaviors, don't give up. Tomorrow is another day to try again.



10 Minutes

■ **Setting a personal goal**

Purpose:

- To help students define and commit to one small action towards better self-care.
- To reinforce the essential steps normally needed to successfully make lifestyle changes.

1. Instruct students to individually reflect and choose one small goal that would help them take better care of themselves.
2. Have students individually define one or two small steps they could take towards that goal.
3. Have students individually define one or two problems or obstacles that may arise that might stop them from taking these steps.
4. Pair students up.
5. Have students share with each other their goal and potential obstacles. Working as a team (support system), brainstorm some possible solutions to the problems/obstacles.
6. Have students decide what reward they will give themselves for committing to taking this small step.



Setting Limits

Your time and energy are limited resources. One of the first actions you can do to reduce stress and prevent burn out is to recognize you have the right to meet your own needs and set realistic limits to what you can and can't do for others. Often, caregivers forget that they have a choice of saying "no" in many areas of their lives.

The following are certain behaviors that are difficult for many caregivers to do regarding setting limits. Check off the ones that may be true for you.

Yes No

- | | | |
|--------------------------|--------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | It is hard for me to say "no". |
| <input type="checkbox"/> | <input type="checkbox"/> | I find it hard to find the time to enjoy fun things. |
| <input type="checkbox"/> | <input type="checkbox"/> | I would rather do things myself than ask others to help. |
| <input type="checkbox"/> | <input type="checkbox"/> | I would rather do things for other people than for myself. |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel guilty or selfish when I try to set limits. |
| <input type="checkbox"/> | <input type="checkbox"/> | It is not easy for me to tell others when I need time for myself. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am afraid others will be angry if I tell them I can't do something. |
| <input type="checkbox"/> | <input type="checkbox"/> | I usually don't set limits and end up feeling resentful of others. |
| <input type="checkbox"/> | <input type="checkbox"/> | I set limits but then back down too easily. |
| <input type="checkbox"/> | <input type="checkbox"/> | People rarely take me seriously when I do try to set limits. |

If you answered yes in several of the boxes, you may want to look at your skills at setting limits. Not setting healthy limits can lead to stress, possible burnout, frustration, and often anger and resentment.

How to set limits

To set limits, you first have to be realistic with yourself about what you can and can't do. Slow down and understand where you stand. Think before you automatically say "yes". The following are some questions to help you sort through what you can and can't do.

- Are you clear about what you are being asked to do?
- Are you interested in what you are being asked to do?
- Do you realistically have the time to add this activity to your schedule without creating yourself unnecessary stress?
- Are you looking for the approval from others by saying yes and not thinking about what is best for you?
- What is your "gut" reaction for what is best for you?
- What will happen if you say "no"?

If you are not sure how you feel about it, let the other person know you need some time to think it over (unless it is an emergency). For example, "I need some time to think this over, I will get back with you later this afternoon."

Communicating your limits

When you want to say “no”:

- Actually use the word “no” when telling another person you can’t do something.
- Use “I” statements without making excuses. No excuses are necessary. You have a basic right to say “no.”
- Be brief. Long explanations are not needed and tend to sound like excuses.
- Make sure your body language matches what you are saying. Often people unknowingly nod their heads and smile when saying “no”.
- Plan ahead. If you know a situation is brewing, plan what you will say in advance.
- You may have to say “no” several times before the person hears you. Just repeat your “no” calmly.
- Offer alternatives if they exist and are within your limits. “I am unable to do what you have asked, but I can do...”

Practice, Practice, Practice

Saying “no” gets easier with practice. Start with small steps and with people or situations outside of your family and work. For example, say “no” to the telemarketer that calls or to the clerk at the grocery store who asks if you want to donate money to charity.

When you build up to saying “no” to family and friends, remember they may not be used to you setting limits. Be prepared for resistance or denials in your ability to stick to “no”. This is a common human reaction to change. It doesn’t mean that what you are doing is wrong or that you should feel guilty. Stick to your limits if it is in your own best interest. However, it is always possible to change your mind if your circumstances change.



Finding Positive Outlets for Your Emotions

It is a normal part of caregiving to feel a variety of strong emotions. It is important to admit to these feelings and deal with them in a constructive manner. For example:

- **Talk to a trusted friend.** Problems are often easier to face and deal with when they can be talked over with an understanding and non-judgemental friend. Talking can help you vent your emotions, clarify your feelings, feel connected to others, and ease pressure and emotional stress.

Don't assume that people know or understand your situation or your need for help. Explain it to them. By communicating regularly and expressing your needs, you make it possible for friends and family to offer emotional support.

- **Join a support group** for caregivers or talk with your supervisor or other caregivers. Such groups can be extremely valuable in providing a safe place to share personal experiences and feelings with others who are in similar circumstances. In a support group, you can hear and share coping strategies and help others while helping yourself.

Contact your local Area Agency on Aging, senior center, or local hospital to find a caregiver support group in your area.



Remember when talking through your feelings with trusted friends or a support group to keep client information confidential.

- **Keep a journal.** Write down your thoughts and feelings. Journaling can help provide perspective and can serve as an important release for your emotions.

Stay involved in activities that “feed” your mind/body/spirit

There are a variety of positive ways people use to relax, de-stress, and refuel their mind/body/spirit including:



- hiking;
- gardening;
- reading a book;
- spending time with friends;
- listening to music;
- meditation;
- doing yoga;
- visualizing a comforting scene;
- laughter.

Find what works for you. Staying socially connected and involved with activities and people that bring you pleasure is essential for good self care. Establish a routine and schedule times for such activities each week.



- **Finding Positive Outlets for Your Emotions continued**
- **Stay involved in activities that “feed” you**

1. Review content.
2. Have students volunteer any additional positive ways they have found to deal with strong emotions.

Relaxation Techniques

Other ways to relax involve using relaxation techniques. One easy and helpful technique is an exercise that promotes deep breathing.

When stressed, our breathing becomes shallow and rapid. Deep breathing involves deliberately learning to slow your breathing rate and breathe from the diaphragm. There are many benefits to deep breathing, it:

- lowers blood pressure;
- relaxes the muscles;
- slows your heart and respiration rate;
- prevents stress from building up;
- reduces general anxiety;
- increases your energy level.



Deep breathing technique

1. Either stand up or lie down, whatever is most comfortable and appropriate at the moment. You may also want to close your eyes.
2. Place one hand right below your belly button.
3. Inhale slowly and deeply through your nose, starting from your diaphragm.
4. Count slowly to four as you inhale.

Note: Your abdomen should push up into your hand. Your chest should move only slightly. If your chest moves noticeably when you inhale or your hand over your abdomen doesn't move, you're probably still breathing from your chest.

5. Pause and exhale slowly through your nose to a count of four.
6. Repeat two more times.



If you have high blood pressure, glaucoma, heart, or cerebral problems, avoid holding your breath.

Progressive Muscle Relaxation (PMR)

PMR is another commonly used relaxation and stress reduction technique. PMR teaches you to relax your muscles. Through practice, you can use PMR at the first signs of tension, anxiety, or stress to relax.



Before practicing PMR, check with your health care provider if you have a history of serious injuries, muscle spasms, or back problems.



■ Deep breathing technique

1. **Demonstrate the deep breathing technique.** Students are expected to practice it at least once during the training.



One or both of these relaxation techniques can be introduced and used early and throughout the training. For example, they are a great way to get students focused after an activity or before testing.

PMR technique

1. Sit in a chair or lay in bed. Get as comfortable as possible—no tight clothes, no shoes, and don't cross your legs. Take a deep breath.
2. Focus on a specific muscle group (feet, hands, face, etc.).

A standard practice is to move from each foot and leg up through the abdomen, chest, each hand, arm, neck, shoulders, and face.

3. Inhale and tense or squeeze as hard as is comfortable the selected muscle for eight seconds.

Done properly, the tension will cause the muscles to start to shake and you will feel mild discomfort. If you feel pain - stop or don't squeeze as hard. Be careful with the muscles in your feet and your back.

4. Exhale and release the muscles quickly - letting them become loose and limp. Let all the tightness and pain flow out of the muscles. Stay relaxed for fifteen seconds and then move to the next muscle.

Getting enough rest

Most people need about seven to eight hours of sleep each day. See the Resource Directory page 274 for more information on getting a good night's sleep.



Making healthy choices for physical activity

Many people think being physically active means playing sports or going to a gym and getting hot and sweaty. When in reality, there is now strong scientific evidence that moderate physical activity – like taking a brisk walk for thirty minutes each day most days of the week – is enough to see real health benefits and prevent certain diseases.

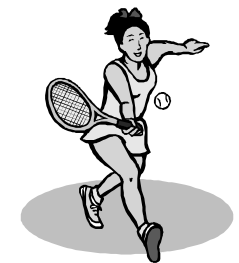
Staying physically active can help you:

- prevent heart disease and stroke;
- lower your blood pressure and cholesterol;
- boost the immune system;
- promote healthy blood sugar levels;
- improve your mood and the way you feel about yourself
- decrease depression;
- increase your energy and alertness;
- sleep better;
- reduce stress and anxiety.

How much exercise is enough?

Your doctor can help determine the best answer for you.

For the greatest overall health benefits for many people, 30 minutes of physical activity most days of the week and some type of muscle strengthening activity at least 2 times a week is the standard.



Healthy Choices in Sleep, Physical Activity, and Diet





■ PMR technique

1. Demonstrate the PMR technique. Students are expected to practice it at least once during the training.

Tips for starting or maintaining physical activity

Staying active works best when you:

- Match your interests and needs. Choose an activity you enjoy enough to do enthusiastically. A wide range of options should be considered in planning activities. Alternate new activities with old favorites to keep things fresh.
- Get a family member or friend to do the activity with you.
- Make time for it and schedule it each day.
- Remember that something is better than nothing. Shoot for shorter, more frequent sessions rather than the occasional prolonged session.
- Make use of everyday routines. Take the stairs instead of the elevator, use a rake rather than a leaf blower, walk or bike to the corner store instead of driving, or do stretching exercises while watching TV.



General exercise guidelines

- Warm up and cool down; stretch both before and after you exercise. Always ease into an activity for the first five minutes, and slow down the pace for the last five minutes instead of stopping suddenly.



See the Resource Directory 275-277 for some examples of stretching exercises.

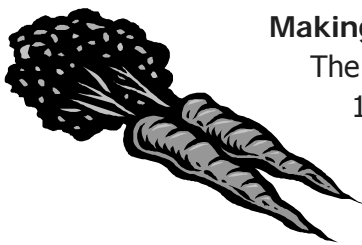
- Start with as little as ten minutes of exercise a day and increase gradually to thirty minutes plus for maximum benefits.
- Exercise at a comfortable pace. For example, while jogging or walking briskly you should be able to hold a conversation. You are exercising too hard if you do not feel normal again within ten minutes following exercise, if you have difficulty breathing, or feel faint during or after physical activity.
- Wear shoes that fit and clothes that move with you.
- Drink plenty of fluids.



Always check with your doctor before starting any exercise program.



See the Resource Directory page 278 for some information and tips on encouraging a client to keep physically active.



Making healthy choices for nutrition

The information contained in Module 8 - Nutrition, pages 134-143, will help you have a better understanding of how to make healthy choices in what you eat.

Tips for starting or maintaining a healthy diet

- Change what you eat one meal at a time.
- Planning is as important as willpower! Plan meals and snacks and then buy the foods you need for the week.
- Eat on a regular schedule to control your appetite.
- Choose smaller portions.
- Eat out less often.
- Take meals and healthy snacks to work.
- Remove temptations from the house.
- When you eat, focus on the food and enjoy it. Don't eat too fast, watch television, or read a book while eating.
- Know the difference between emotional and physical hunger.

Value the role you play as a caregiver

Finally, be proud of what you are doing and accomplishing. Since sometimes the demands and challenges of caregiving are overlooked by others, it is even more crucial that **you** take pride in your work. Be assured that you are performing an essential and very difficult job. You deserve recognition for what you do. If the recognition is not available from those around you, find ways to acknowledge and reward yourself.



Caregiving as a profession

As the number of people requiring care continues to rise, the demand for skilled, professional caregivers and professional healthcare providers (e.g. nurses, doctors, social workers, case managers) far exceeds the supply.

Depending on your current situation and career goals, you may wish to explore becoming a Nursing Assistant Certified (NAC) or pursue becoming a healthcare provider.

For more information about becoming a NAC, call the Washington State Department of Health at: (360) 236-4700.



- **Value the role you play as a caregiver**
- **Caregiving as a profession**

1. Review content.



2. Ask students to brainstorm and list things that give them a sense of pride in what they do.

Module 11 - Lesson 2

Loss and Grief



Loss and Grief

What you will learn in this module:

1. The types of losses a client or a caregiver may experience.
2. The grieving process.
3. Symptoms of grief.
4. How to be present when others are grieving or facing death.

key word



Grief

Definition

A reaction to a loss



All of us experience many different kinds of losses, disappointments, setbacks, and heart-breaks in our lives. Loss can include the death of a loved one or other losses like the loss of a job, relationship, pet, or dream. How strongly we react to the loss depends on how important the person or thing was in our lives and the number and timing of the losses that have occurred.

Loss and Grief

As a caregiver, it is important to be sensitive to a client who may be experiencing loss. Depending on the client's circumstances, these can include loss of:

- home and personal possessions
- physical abilities
- relationships, social activities
- income, financial security
- feeling of purpose and meaning
- privacy
- control
- hopes for the future
- self esteem
- independence

It is also important for you to be aware of the losses you personally may experience as a caregiver. A client's losses can also trigger strong emotional reactions in you.

Family caregivers, as well as non-related caregivers, can also experience loss seeing a person's condition worsen or when facing the person's death.

Grief is a normal reaction to loss. Each of us grieves in our own way. How we grieve can be affected by our culture, gender, and the circumstances surrounding the loss.

Symptoms of grief

Grief is not limited to just our emotions. Grief can also impact your thoughts, physical body, relationships, and create spiritual turmoil.



... joy and sorrow are inseparable. . . together they come and when one sits alone with you . . . remember that the other is asleep upon your bed.

- Kahlil Gibran



■ Loss and Grief

■ Symptoms of grief

1. Review content.
2. Ask students the following questions.



- Q: What are some of the ways your caregiving may be impacted if a client is grieving?
- Q: What are some helpful things you, as a caregiver, might do to support a grieving client?



■ Loss



5 Minutes

Purpose:

- To increase students' understanding and empathy for people who have suffered losses and the impact it has on their life.

1. Ask students to take out a piece of paper. Have them divide and tear the paper into 3 equal pieces.
2. Have students write one thing that is important to them on each piece of paper (e.g. health, family, vision, car, money, pets)
3. Once students are done writing, have them individually hold the three pieces of paper like playing cards in front of them - so that they can see what is written and no one else can.
4. Have students turn to their neighbor and randomly pick one piece of paper from each other's hand. Explain that they are not to look at the paper but simply to place it face down in front of their neighbor.
5. Explain to students that they have just lost that item.....forever....and are not getting it back.
6. Repeat one more time until students are left with one piece of paper.



Use these group discussion questions or add your own.

- Q: How did it feel to think about losing these items?
- Q: What happens to people when there are losses from all different parts of their lives?
- Q: How does this exercise relate to what a client may have experienced?
- Q: How might this impact how you provide care?

Possible Symptoms of Grief

Physical Symptoms:

- Lack of energy or exhaustion
- Difficulty sleeping or sleeping a lot
- Headaches
- Upset stomach
- Lack of appetite or weight gain
- Restlessness
- Heart pounding
- Shortness of breath
- Tightness in the throat
- Numbness

Spiritual Symptoms:

- Feeling cut off or angry at a higher source or questioning faith

Thought Symptoms:

- Forgetful
- Inability to concentrate
- Distracted or preoccupied
- Confused
- Loss of the perception of time
- Difficulty with making decisions

Relationship Symptoms:

- Withdrawing from others
- Increased dependence
- Over sensitivity
- Lack of interest
- Relationship difficulties
- Lowered self esteem

Emotional Symptoms:

- Self blame
- Fear or anxiety
- Guilt
- Crying
- Loneliness
- Disbelief
- Denial
- Relief
- Panic
- Helplessness
- Depression
- Anger or irritability
- Mood swings

The process of grieving

Grieving is a process. It is a journey and not a destination. Grief does not proceed in a fixed order any more than life itself does. Many and varying degrees of emotions and reactions appear, disappear, only to reappear again.

A key for moving through the grieving process is to acknowledge, feel, and express all of the emotions and reactions brought on by grief-related changes.

Be a good listener to yourself. Let yourself feel your emotions. What you feel is valuable information. Try to understand what your feelings are telling you. Be patient. Everyone grieves in his/her own way and time.

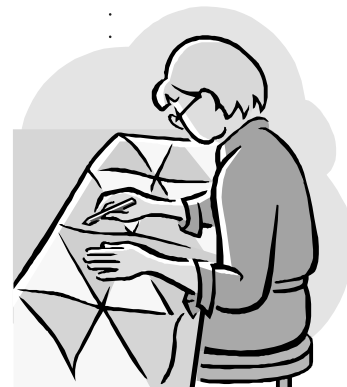


Grief rituals

It is important to find ways to stay healthy and keep functioning as you move through the grief process. See pages 195-204 for some examples of how to take care of yourself as you would in any other stressful life situation.

The use of a favorite ritual or practice is one way to create some closure for your loss. Some rituals people have used include:

- creating a memory book or quilt;
- planting a special flower, tree, bush;
- attending the funeral, wake, or memorial service;
- writing a letter to the person who has died;
- giving a donation to a favorite charity;
- having a celebration of the person's life;
- lighting candles;
- making an oversized card for the family with staff writing about special times.



Being present with others grieving or facing death

It is common for caregivers to be surrounded by others grieving from a variety of losses or to care for a client approaching death. It can be difficult to know what to say or not to say in these situations. Try not to avoid or side step the conversation. There are no easy or right ways to talk about grief or death and many people avoid it.

There is no better gift you can give another human being than to be open and present with him/her during this time. A client wishing to talk about death or other painful losses may need to:

- be reassured he/she is not alone;
- know that someone cares enough to listen;
- discuss important memories or learnings from his/her life;
- have help coping with fears and intense emotions;
- find ways to say good-bye to you and others.

Be available

Give the person time to talk. Don't take over. Let the person know that you are available to listen and willing to talk. Since knowing what to say isn't always easy, here are a few suggestions:

- "If you want to talk about this, I am here for you."
- "I can't really fully understand what you are feeling, but I can offer my support."
- "You are important to me."
- "I wish I knew the right thing to say, but I care and I am here if you need me."



Feel and express your own feelings

Be yourself. Many people try to hide their own feelings because they don't want to upset the person who is facing significant loss or death. Most of the time it is helpful and appropriate to let the other person know you are sad and concerned for them.



Remember everyone is different

People express their thoughts and emotions in a variety of ways. Avoid making and communicating judgments about how a person should be feeling.

In some cultures, it is not acceptable to talk about dying or show grief. Be aware of any cultural differences a person may have that impact his/her relationship with loss and death.

Sometimes saying nothing is the right thing to do. Just listening can be the best thing to help a client work through his/her feelings.

Hospice care

Some clients who are believed to have no more than six months to live may choose and be eligible for hospice care. Hospice care is designed to relieve or decrease pain and control other symptoms. The focus is no longer on curing the disease. The goal of hospice care is to help make sure the person's last days are spent with dignity and quality, surrounded by the people he/she loves.

Hospice care can be given in the client's home, a hospital, adult family home, boarding home, nursing home, or a private hospice facility.

If hospice becomes involved in a client's care, the hospice nurse will work with the care team to develop a hospice care plan. If hospice will be an added service, the case manager or your supervisor needs to be involved to make sure the DSHS care plan is updated.

Depending on where you work or your relationship with the client, how involved you are with the hospice care plan will vary. You are still an important part of the client's care.



5 Minutes

Module 11
Module Review



1. True ☒ False The process of grieving normally follows a fixed, orderly course.
2. ☒ True ☐ False Caregiver burnout is normally caused by too much stress for too long without taking steps to refuel the body/mind/spirit.
3. To effectively communicate “no” when setting limits with others: (circle the correct answer)
 - a. Give a long explanation for why you can’t do something.
 - b. **Use the word “no” and repeat it if necessary.**
 - c. Offer a good excuse for why you can’t do it.
4. True ☒ False A high amount of stress builds your immune system.
5. Friends and family are telling you stress is becoming a problem in your life. When should you take steps to reduce it? (circle the correct answer)
 - a. **As soon as possible.**
 - b. In a few months.
 - c. No action is necessary.
6. True ☒ False Good self care includes taking really good care of everyone but yourself.
7. True ☒ False Grief only impacts a person’s emotions.
8. This afternoon a client has just learned of the death of a close friend. You should: (circle the correct answer)
 - a. Tell them all about your own experiences with loss.
 - b. **Let the person know you care and are available to listen.**
 - c. Avoid any conversation about it for a few days.
9. ☒ True ☐ False To successfully make a change in your life-style, (e.g. eating better, getting more exercise) set realistic goals and start slowly.
10. To set healthy limits with others, you first have to be realistic about what? (circle the correct answer).
 - a. Whether the person will accept it.
 - b. **What you can and can’t do.**
 - c. What is best for the other person.