inthe**know**
CAREGIVER TRAINING

A Communication Skills Module:
Reporting & Documenting Client Care

COURSE OUTLINE

WHAT HAPPENED TO CAROLINE?

Caroline, a 76-year-old woman arrived at the nursing home to recover from hip surgery that resulted from a fall at home. The routine surgery was done at the hospital without complications.

Upon arrival at the nursing home, an assessment was completed by the nurse, a care plan was written, and the nursing assistant helped Caroline get settled in for her stay.

Orders were written for Caroline to:

- Ambulate to bathroom and in halls three to four times per day.
- Attend therapy sessions and perform hip exercises.
- Wear elastic stockings.
- Continue to perform cough and deep breathing exercises.

After three days, Caroline was doing great. She was well on her way to regaining her independence. But, then something happened.

Caroline removed her elastic stockings for a shower. After the shower, she felt some pain in her leg, but didn't report it and went about her day without the stockings.

That afternoon, the chart indicated that Caroline had no swelling, redness or pain on the affected leg and *that the elastic stockings were on.*

The next morning, Caroline complained of feeling dizzy and was unable to get out of bed. Her vital signs indicated a rapid heart rate and rapid, shallow breathing.

The abnormal vitals were documented correctly, but the nurse was not given an oral report and didn't see the data until later that morning.

When the nurse arrived in the room she found Caroline. . . dead. Caroline had suffered a deep vein thrombosis or DVT (a blood clot in the leg). The DVT became dislodged and traveled to Caroline's lungs.

So, what went wrong? Could this tragedy have been avoided?

Keep reading to learn why accurate and timely documentation is so important. Find out what you can do to make sure something like this does not happen to one of your clients.

WHY IS DOCUMENTATION SO IMPORTANT?

Did you know that in long term care (including home health and nursing facilities), the organization pays *up front* for the care of each client.

- Then, the facility or agency is *reimbursed* for the *specific care* you provide *after* the care has already been provided and documented.

This is different from hospitals which are paid a single payment for each episode of care, regardless of how much care you provide.

- *So who decides how much your workplace will be reimbursed for the care you provide?* **YOU DO!**

Every time you provide care for your client, the activity is ***"scored"*** according to the amount of intervention your client needs.

For example:

Activity	Scoring Criteria	Score
Bathing	Requires no assistance	0
	Requires stand-by assistance	2
	Requires full assistance	3
	Requires full assistance of two caregivers	4

The documentation you provide is reviewed and scored (as above) and sent to Medicare/Medicaid for reimbursement.

The total score determines the clients ***"Assistance Level"*** and also determines how much the company will be reimbursed for the care of that client.

The more ***thorough*** your documentation, the easier it will be for the nurse to score the assistance level of your client.

It's important to note that payment will be made based on the ***daily abilities of the client***. This means payments are based on estimates of the actual staff time it should take to perform the care required by your client.

- Daily abilities are usually assessed over a period of a few days. So, if your client ambulates unassisted one day, but needs help the next—you should report ***exactly*** what happens each day. The care will be reimbursed based on the *highest* level of care needed during the period.

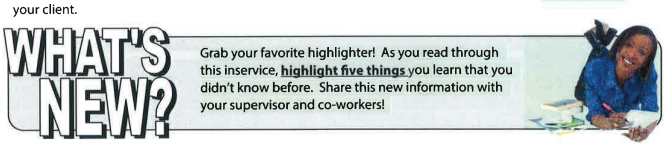
Please Note: If you are providing care for clients without documenting thoroughly and carefully—your employer may not get reimbursed for your work.

In contrast, if you are documenting care that you did not perform, your employer may not get reimbursed, and WILL POSSIBLY be fined for the false records.

Both situations result in a financial loss. And, a loss for your employer is a loss for you, your clients, and your co-workers!

So, this is why it is very important for you to always document:

- ***Thoroughly,***
- ***Accurately, and***
- ***In a timely manner!***



Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!

WHAT DO YOU DOCUMENT?

Whether you write it down or tell someone, your report should include:

Observations

- Observations are the facts and events that you notice as you go about your daily work. (See page three for more about making observations.)

Daily Measurements

- You may be ordered to record your client's:
  - Vital signs.
  - Weight.
  - Intake and Output.
  - Blood sugar level.

Safety Issues

- This includes measures you took to ensure a client's safety and any concerns you have about possible safety hazards in the client's environment.

Client Statements & Complaints

- Document—in their *exact* words—any pertinent statements your clients make about how they are feeling. This may include statements about pain, appetite or emotions.
- Be sure to report complaints. (Again, use the client's exact words.) Complaints help your workplace improve client care and/or find new ways to meet a client's needs.

Unusual Events

- Report anything out of the ordinary that happens while you are with a client. For example, be sure to document if a client refuses care or if the heat in the client's room doesn't work. (Notify your supervisor as soon as possible, too.)

Your workplace should have a list of "approved abbreviations" that you are permitted to use in your documentation.

If you have not seen this list, ask your supervisor for it, today! Using unapproved abbreviations can be dangerous, confusing, and a big time waster!

For example, these two abbreviations were found in actual medical records. Can you figure out what they mean?

1. **THBNCS** yesterday.
2. Patient may get up **AFAWG**.

ANSWERS: *1. There have been no changes since yesterday. 2. Patient may get up As Far As Wire Goes.*

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

MD orders:

"Walk patient in hell," and

"Patient may shower with nurse."

MAKING OBSERVATIONS

- When you observe your clients, you take note of *facts* and *events*. Observations may be *subjective* or *objective*.
  - If a client *tells* you something, it is subjective information and should be written inside quotation marks. (For example, Mrs. Smith states, *"I feel like I'm getting a cold."*)
  - Objective observations include things you can see, hear, smell and feel.

WITH YOUR EYES, YOU CAN SEE A CLIENT'S:

- Daily activities such as eating, drinking, ambulating, dressing, and toileting.
- Body posture.
- Skin color, bruising or swelling.
- Breathing pattern.
- Bowel movement (including the color, amount, and consistency).
- Urine (including color, amount, and frequency).
- Facial expressions (such as smiling, frowning, grimacing, or crying).

WITH YOUR EARS, YOU CAN HEAR A CLIENT'S:

- Raspy breathing.
- Coughing.
- Sneezing.
- Crying or moaning.
- Blood pressure.

WITH YOUR NOSE, YOU CAN SMELL A CLIENT'S:

- Breath.
- Body odor.
- Environment (such as an unusual chemical odor or gas leak).
- Urine.
- Bowel movement.
- Vomit.

WITH YOUR FINGERS, YOU CAN FEEL A CLIENT'S:

- Skin temperature.
- Skin texture.
- Pulse.

REMEMBER: Making observations involves using four senses: sight, hearing, smell and touch. State *objective* observations as facts and write *subjective* observations as statements in quotation marks.

Years ago, charting about clients consisted of short (and rather meaningless) observations such as: *"The patient ate well."* or *"The patient slept well."*

No one expected to read anything of importance in notes written by nurses or caregivers.

In the 1800s, when Florence Nightingale developed theories about nursing documentation, it began to take on more meaning.

More than 100 years later, nurses began to develop their own documentation systems based on *nursing diagnoses.*

- ***Today, nurses, doctors, therapists, and insurance companies rely heavily on documentation you provide to make important decisions about your client!***

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"On the second day the knee was better and on the third day it had completely disappeared."

THE RULES OF GOOD DOCUMENTATION

RULE #1: MAKE IT COMPLETE!

Complete documentation is thorough and follows your workplace policies. *In general, your documentation will be **complete** if you include:*

- The correct date and time.
- The client's correct name.
- The tasks you perform with each client and how the client responds to your care.
- Any changes you notice in a client's condition.
- Any care that was refused by the client.
- Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.)
- Your signature and job title.
- Note: Check with your supervisor about how to complete the specific forms used in your workplace.

RULE # 2: KEEP IT CONSISTENT!

Documentation is consistent when it remains true to:

- The client's care plan.
- Physician and nursing orders.
- The observations that your co-workers have made about the same client.
- Your workplace policies.

*Your documentation will be **consistent** if you:*

- Use workplace-approved medical terms and abbreviations.
- Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why.
- Tell your supervisor right away if you notice changes in a client's condition so that your observations can be shared with other members of the healthcare team. This keeps your co-workers from documenting incorrect information. For example, you take your client's BP and it's suddenly very high. If you don't inform the nurse, she may document that the client's vital signs are normal. This can cause confusion and have a negative effect on client care.
- If you make home health visits, be sure your documentation matches the visit frequency ordered by the physician.

Open the Discussion

Daytime television bombards us with ads from lawyers offering free consultations to look over medical records for errors. This has led to an increase in lawsuits and medical malpractice claims.

These claims are expensive and drive up healthcare costs for EVERYONE!

- Personal access to medical records is a right that cannot be denied.
- Should commercials for lawyers who file malpractice claims be regulated? What about their rights?
- What would you do if you or a loved one suffered an illness or injury as a result of a documentation error?

Share your thoughts with your co-workers and find out how they would solve the problem.

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"She has had no rigors or shaking chills, but her husband states she was very hot in bed last night. "

THE RULES OF GOOD DOCUMENTATION - *continued*

RULE #3: KEEP IT LEGIBLE

Remember, the purpose of documentation is to communicate with other members of the healthcare team. *(If you are the only person who can read your handwriting, your documentation won't communicate anything to anybody!)*

- Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed.")
- Watch your handwriting . . . messy documentation could come back to haunt you in a lawsuit.
- Print with block letters. Cursive handwriting tends to be hard to read and should not be used in a medical chart.

Flow sheets are often used as a quick way to document vital signs, weights, and other tasks. If you use flow sheets, make sure they are legible. Here are a couple of tips:

- Fill out the flow sheet properly. For example, do you circle numbers or words on the flow sheet? Or, are you supposed to make marks like X's or checkmarks?
- Don't try to cram long narrative documentation onto a flow sheet.

RULE #4: MAKE IT ACCURATE

Documentation is accurate when it is true. Your documentation will be ***accurate*** if you:

- Use appropriate medical terms and abbreviations that have been approved by your workplace.
- Use correct spelling and proper English.
- Double check that you've written down the correct client name (and ID number, if required).
- Handle errors correctly.
- Record only the facts...*not* your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you *guess* to be true, like *"Client acts like she's on drugs."* Instead, stick to the facts, like *"Client is unable to stand up without assistance and called me by her mother's name several times."*
- Record what a client tells you by quoting his exact words. For example: If your client says, *"I want my daughter to visit,"* don't put what he said in your own words such as *"client misses his daughter."* That's not really what he said!

Apply what you know

THE ART OF ORAL REPORTS

If you are not comfortable giving oral reports, here's your chance to practice!

- ***Prepare a "shift report" about a client you cared for today. Be sure to include any changes in condition, ongoing orders, new orders, incidents, and any events for which the next shift will need to be prepared.***

In addition to shift reports, you are required to report orally to the nurse in certain circumstances.

- ***Make a list of at least 10 situations that require an immediate oral report in addition to your normal documentation.***

Share your shift report and your list of ten situations with your supervisor for feedback!

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"She slipped on the ice and apparently her legs went in separate directions in early December."

THE RULES OF GOOD DOCUMENTATION - *continued*

RULE #5: FINISH ON TIME!

Documenting on time means writing information down as it happens and turning in your paperwork when it is due. Your documentation will be ***on time*** if you:

- Write information down immediately. For example, if you take a client's vital signs, document them right away. Don't wait until you finish your care and leave the room. The longer you wait, the more likely you are to forget some of the details.
- Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like *"Day Shift."*
- Note the time of your arrival and your departure from each client's home (if you make home health visits).
- Use the proper time format according to your workplace policy. For example, some health care organizations use a twelve hour clock, noting whether it's AM or PM. Others use a twenty-four hour clock—also called military time. Using military time, 6:00 PM is written as 1800.
- Most home health aides are required to document their care on visit notes. If you care for clients in their homes, be sure to complete your visit notes at the time of each home visit. Don't wait until the end of the day to fill out visit notes on all your clients. Be sure to meet the deadlines for turning in your visit notes at the office. (Remember: completing visit notes on time helps you and your workplace get paid!)

WHO CARES ABOUT YOUR DOCUMENTATION?

Your documentation may be read by a number of different people, including:

- Your co-workers and supervisors
- State and/or Joint Commission surveyors
- Researchers
- Quality improvement personnel
- Medicare and insurance company reviewers
- Lawyers and judges

HOW DO YOU HANDLE ERRORS?

1. **What would you do if you left out important information in your client's chart?** *For example, while driving home from work, you suddenly recall something your completely forgot to chart!*
2. **How do you correct a mistake?** *For example, you charted your client's output as 2700mL instead of 270mL.*
3. **What should you do if you notice someone else made a mistake in the chart?** *For example, you notice the nurse documented that the client was NPO when the client was not.*

Share your answers with your co-workers and find out how they would solve the problem.

If you can't answer these questions, ask your supervisor for your official workplace policy on handling errors.

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days."

DOCUMENTATION IN DIFFERENT CLINICAL SETTINGS

ACUTE CARE:

- **Care plans** or **critical pathways** *(used to outline the client's needs).*
- **The Kardex** *(used to chart activities, treatments, and medications).*
- **Progress notes** *(for documenting changes in the client's condition).*
- **Flow sheets** or **graphic forms** *(for tracking vital signs and weights).*

Special Tips For Acute Care Documentation:

- Patients in acute care settings tend to be quite sick. If you are ordered to document vital signs every four hours, it's important to take the vitals—and document the results—on time.
- Remember that sick patients can become sicker in a matter of minutes. And, as they get better, they can be discharged on short notice. It's very important to complete documentation on time.

HOME HEALTH CARE:

- **Plan of care** *(may be known as a "486" which is a special Medicare/Medicaid care plan).*
- **Home health aide care plan** *(outline the assignment for each client).*
- **Daily** or **weekly visit note** *(for documenting care at each visit).*

Special Tips For Home Health Documentation:

- To receive the services of a home health aide, home health clients on Medicare must be homebound—and must need help with bathing. Your documentation should show that your client meets these requirements. However, if your client has already bathed when you arrive, document the reason and tell your supervisor right away.
- Take extra care to keep your documentation confidential—especially in the client's home (where friends or neighbors might see it) and in your car.

LONG TERM CARE:

- **Minimum Data Set or MDS** *(used to evaluate the needs of clients).*
- **ADL checklists** or **flow sheets** *(tracks daily care given to each client).*

Special Tips For LTC Documentation:

- Some LTC residents may need skilled care (which requires *more frequent* documentation). Others receive a lower level of care (which requires *less frequent* documentation).
- A resident's condition may change slowly over time. Always observe and document even slight physical and mental changes.
- Most LTC facilities are required to keep a record of visits and phone calls from family or friends. (The facility may even face a fine if it doesn't comply!) You may be asked to help keep track of your client's visitors and calls.

WRITING AN INCIDENT REPORT

An incident is an unexpected event that often involves an accident or an injury. The injured person may be an employee, a family member, a client, or yourself.

An incident report should include:

- The date and time of the incident.
- The mental and physical condition of the person involved.
- The result of the incident (scratch, broken bone, back injury).
- Actions taken to help the person involved.
- Suggestions for change so the incident does not occur again.

Only include the facts in an incident report. *For example, if Mr. H. reports being hit by Mr. G., but you did not see it happen . . . you would not report "Mr. G. hit Mr. H." You would report "Mr. G. reported being hit by another client."*

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"Bleeding started in the rectal area and continued all the way to Los Angeles."

LEGAL ISSUES

Poor documentation can cause a number of legal problems—especially if a client's chart ends up in the hands of a lawyer.

- It may look like you gave *poor care.* For example, let's say you remember turning your client every two hours as ordered, but you didn't write it down *every* time. A lawyer might say that it's *your* fault the client developed an infected pressure injury.
- It may also look like you neglected specific orders. For example, if you are ordered to take a client's pulse, but you forgot to write it down, you could be accused of neglecting an order and causing harm to the client.

Poor documentation can cause your workplace to be denied payment for the services you provided to your clients.

- For example, let's say you made a home health visit but failed to turn in your visit note. Your workplace could be accused of fraud—even though you made the visit!

Regulations regarding how to properly document client care come from:

- State Boards of Nursing
- The American Nurses Association
- Joint Commission
- CMS (Medicare and Medicaid)
- Workplace policies and procedures.

A WORD ABOUT FALSE DOCUMENTATION

Medical records are legal documents intended as a means to communicate between caregivers. When records are false, great harm and even death may come to the client.

In addition, including false information in a medical record is grounds for a malpractice claim which could cost you and your employer countless hours and a lot of money to defend.

Examples of false documentation include:

- **Charting before you provide care.** *If you get busy and never perform the care you charted, you falsely documented it.*
- **Charting that you provided care that you did not do.**
- **Copycat charting.** *This is charting what the previous shift charted without actually assessing the client or performing the care on the client.*

5 KEY points

1. Documentation is not just pointless busy work. It is a ***legal representation of the care your client receives.***
2. Documentation should include both ***objective*** and ***subjective*** observations you make about the client and the environment while providing care.
3. Always strive to make your documentation ***complete, accurate, legible, consistent,*** and ***on time!***
4. Poor or inaccurate documentation can not only result in legal and *financial trouble* for your employer—but it can result in *harm or death* of a client and cost you *your job.*
5. Be sure to document EVERYTHING you do—even if you also gave an oral report because, ***if it isn't documented—it didn't happen!***

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"She stated that she had been constipated for most of her life until 1989 when she got a divorce."

FINAL DO'S AND DON'TS OF DOCUMENTATION

DO THIS:

- Stick to the facts—because facts speak for themselves. (No one can argue with the facts, but they *can* argue with your opinions!)
- Remain brief and to the point. You don't need to write a "book" about your clients!
- Be specific! For example, it's not very helpful to write *"client ate well."* Writing something like *"client ate 75% of lunch tray"* is much better.
- Avoid documenting the same information about a client day after day. Observe each client carefully and document even small changes.
- If you document directly in your clients' charts, make sure you have the right one before you begin to write!
- Include each client's full name in your documentation since there may be two clients with the same last name.
- If you document a change in a client's condition, be sure to write what you did about it. For example, if you document *"Mr. Ralph Johnson gained 4 pounds since yesterday,"* you should also document that you notified your supervisor. You might write *"Called Jane Doe, RN about weight gain. She said she will talk to doctor."*

DON'T DO THIS:

- Criticize (in a client's chart) the care given by any of your co-workers. Avoid writing about workplace problems like staffing shortages, too.
- Chart for someone else or write down what someone else tells you to say about a client.
- Document a task that you did not do!
- Write with a pencil...always use ink. (And never use "White Out" to cover up a documentation error.)
- Use two different colors of ink for the same entry. Someone might think you came back later to correct your initial charting.
- Use language that sounds like you have negative feelings about a client. For example, instead of writing *"client is drunk,"* stick to the facts by writing *"client's breath smells of alcohol and he is slurring his words."*
- Remove pages from a client's medical record. Each page is a permanent, legal document.
- Mention the name of one client in another client's chart.
- Document your client care ahead of time—even if it never seems to change from day to day.

WHAT I KNOW NOW!

Now that you've read this inservice on documenting client care, take a moment to jot down a couple of things you learned that you didn't know before.

FUNNY QUOTES FROM REAL MEDICAL RECORDS!

"The patient had waffles for breakfast and anorexia for lunch."

COURSE OUTLINE

inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

A Client Care Module:
Helping with Activities of Daily Living

BUILDING A BRIDGE TO INDEPENDENCE

Imagine that life is a series of islands. One island is called the **Island of Dependence.** This is where babies are born, completely dependent upon their parents. Another island is the **Island of Independence.** This is where people go when they have the knowledge, skills and means to take care of themselves.

Traveling from the Island of Dependence to the Island of Independence requires a bridge! Having the skills to perform ***activities of daily living (ADLs)*** makes up the support columns of the bridge. Having the ability to take care of ***instrumental activities of daily living (IADLs***) paves the road and makes the bridge passable.

Sadly, for some people, the bridge is broken.

- A chronic illness in childhood may keep a person from building his bridge.
- A quick cross back may be needed after an illness, fall or accident. It's possible to become *temporarily* dependent, but maintain the ability to return to independence after some hard work.
- And finally, there are those that cross back and become stranded. These are the clients that need your "total care." The longer a person is stranded, the less likely it is that he or she can cross back.

In all cases, your goal is to determine just how much help your client needs to build his bridge toward independence, and then *to do just that*! Some people may only need your encouragement. Others may need your help with "set up." Some may need to work together with you. Others may need you to do all the work! The trick for you is to know the difference!

In this inservice, you'll learn all about the ADLs. You'll explore the different levels of functioning your client may have and how you can help each client maintain or regain independence. Be sure to look for the companion inservice, Helping with IADLs, to learn all about instrumental activities of daily living!

WHAT EXACTLY ARE ADLs AND IADLs?

THE SUPPORT COLUMNS OF THE BRIDGE: *ADLs, or Activities of Daily Living,* are all those basic self-care activities that people without an illness or injury normally do for themselves.

THE ACTIVITIES	WHAT'S EXPECTED?
Bathing & Personal Hygiene	Bathing, showering, washing hair and oral care.
Bowel/Bladder Control and Toilet Hygiene	Recognizing the need to relieve oneself, getting to the bathroom or commode, completing the act and wiping, as needed.
Dressing & Grooming	Putting on and removing clothing, brushing hair, shaving and applying make-up.
Eating	Setting up food, using utensils to bring food to mouth, chewing and swallowing.
Functional mobility	Transfer and ambulation from one place to another while performing activities

THE ROAD THAT MAKES THE BRIDGE PASSABLE: *IADLs, or Instrumental Activities of Daily Living,* are activities that go beyond basic needs. IADLs allow the person to be independent at home and in the community.

THE ACTIVITIES	WHAT'S EXPECTED?
Housework	Keeping one's environment clean, including doing laundry and dishes.
Meal preparation	Planning and preparing healthy meals and snacks.
Taking Medications as Prescribed	Understanding what medications are prescribed, why they are needed, how and when to take them and possible side effects.
Shopping	Navigating around a store, finding desired items and making purchases.
Using the telephone	Locating and dialing a number, then carrying out a conversation with the person called.
Transportation within the Community	Driving, asking a friend or family member to drive or using public transportation to get where needed.

There's More!

In this inservice, you will learn a ***little bit*** about a lot of things!

If you want more, in-depth training on any of the ADLs covered in this lesson, check our catalog for full topics on:

- Bathing Tips
- Toileting Tips
- Handling Incontinence and UTIs
- Dressing & Grooming Tips
- Performing Mouth Care
- Feeding Your Clients
- Mealtime Tips
- Helping Clients with Mobility
- Performing Safe Transfers

Ask your supervisor if these topics are already part of your In the Know library.

If you are a CNA who purchases your own continuing education, many of these topics may be available for online self-study for $8.50/each. Go to www.knowingmore.com to learn more!

WHAT EXCITES YOU?

ROBOT AND FRANK

The award winning film, Robot and Frank (*get it on DVD*) tells a tale of how the adult children of an aging baby boomer hire a robot to keep their father from having to go into a nursing home.

Sound like far-fetched science fiction? It may not be that far from becoming a reality!

Just Google the term "robot caregiver" to learn about all the research and development happening in this budding field!

How do you feel about the idea of robots being involved in human care?

If you could design a robot to care for humans, what would you want it to be able to do?

Do you think your clients would be willing to be cared for by a robot? Why or why not?

FOCUS ON BATHING & ORAL HYGIENE

Bathing is important because it prevents infection, controls body odor, promotes comfort and stimulates circulation. Depending on yours client's abilities and care plan, you may give a:

Full or Partial Bed Bath: Although this is the most "dependent" type of bathing, you can still encourage the client to *assist* as much as possible.

- ***Best Practices:*** *Gather all your supplies ahead of time and have them within reach of the bed. Close any doors or windows to avoid drafts. To ensure both warmth and privacy, cover the client with a light cotton blanket. Uncover, wash and dry only a small part of the body at a time.*

Tub Bath: Tub baths place clients at a high risk for falls, burns and drowning and should be reserved for clients with good posture, balance and mental alertness.

- ***Best Practices:*** *Never give a tub bath unless it is ordered in the client's care plan. Don't attempt to help a client in or out of a tub unless you feel secure about your ability and/or you have the proper equipment (like a lift or slide board). Tub baths can dry the skin, so shouldn't last longer than 20 minutes.*

Shower: A shower is appropriate for the most "independent" clients only. It can be done standing or by using a shower chair, if ordered.

- ***Best Practices:*** *Be sure to place a rubber mat on the shower floor—but don't cover the drain opening. Stand close by, while still providing privacy, if you are unsure of your client's ability to shower independently.*

MOUTH CARE AND ORAL HYGIENE

Having a healthy mouth helps clients feel better, have a heartier appetite and eat a more balanced diet. Depending on yours client's abilities and care plan, you may need to:

Encourage or Remind: Your most independent client may just need a reminder to brush his teeth or take care of his dentures independently.

- ***Best Practices:*** *Remind clients to brush at least once a day using a soft toothbrush. It's even better to brush after every meal!*

Set-up Supplies: A client with mobility problems may need you to set up and arrange her toothbrush, toothpaste, water and towel within easy reach.

- ***Best Practices:*** *If help is needed, wet the toothbrush with water and put the toothpaste on the toothbrush. Provide a basin for the person to spit.*

Total Care: A client who is confused, completely immobile, in a coma or in the end stages of life will need you to perform the oral care tasks for him.

- ***Best Practices:*** *An unconscious person may need oral care every 2 hours. Gently swab the teeth, gums, inside of cheeks and tongue with a soft brush or a "toothette," if available.*

Denture Care: Dentures need to be removed from the mouth, rinsed, brushed with a denture brush and denture paste and soaked over night.

BATHING AND ORAL HYGIENE SKILL CHECK!

GIVING A BED BATH

Use these steps for giving a partial or complete bed bath. A complete bed bath involves washing the entire body. A partial bed bath includes only the face, hands, underarms and perineal area.

What you'll need:

Basin	Towels	Clean clothes
Bath blanket	Mild soap	
Washcloths	Lotion, if desired	

Procedure:

1. Put on clean gloves.
2. Fill a clean basin with warm water that is between 105 and 115 degrees.
3. ***Provide privacy.***
4. Remove client's top linen or bedspread and cover her body with a bath blanket. *(A bath blanket can be any soft, absorbent blanket or towel that covers the entire body.)*
5. Remove the client's clothing, keeping her body covered by the bath blanket.
6. ***Working from head to toe, start at the face.*** Place a dry towel under the head and neck while you gently wash the face with a clean washcloth and water only. *(Soap can dry the face.)*
7. Moving downward, wash the arms, chest, stomach, legs and back. Wash one section at a time and only expose the section being washed. (As you move down the body, move the dry towel to protect the bedding.)
8. ***Use a clean cloth, a fresh basin of water and a new pair of gloves to clean the perineal area last.***
9. Apply lotion if desired.
10. Assist client into a comfortable position, and dress or help the client dress herself.
11. Dispose of supplies and wash your hands.

Please Note: It's always best to allow the client to complete *as much of the process as possible.* This increases a sense of independence and control.

CARING FOR DENTURES

Dentures are expensive and replacing them may mean many trips to the dentist. Without proper care, dentures can become damaged or lead to painful and difficult-to-treat infections of the mouth.

What you'll need:

Washcloth	Soft toothbrush	Mouthwash
Non-abrasive toothpaste	Denture cup	
	Sponge swabs	

Procedure:

1. Wash hands and put on clean gloves.
2. If the client is able, have them remove the dentures and give them to you. If assistance is needed, remove the dentures carefully. Start with the upper denture by gently moving it up and down to break the seal, then gently slide it out of the mouth. Repeat with the bottom denture.
3. Take the dentures to the sink. Line the basin with a washcloth and fill 2 to 3 inches with warm water. This provides a "cushion" for the dentures in the event you drop them while cleaning.

4. Using a soft toothbrush and non-abrasive toothpaste, clean the dentures one at a time. *(Never use regular toothpaste on dentures. It is abrasive and will scratch the surface.)*
5. After brushing the teeth and gum area of the dentures, place them into a clean denture cup filled with cool water.
6. Assist the client with proper oral care using sponge swabs and mouthwash.
7. Dispose of used supplies, drain sink, remove gloves and wash hands.

Don't Forget! Take this opportunity to look into the mouth for any signs of irritation or infection. Report any abnormal observations to your supervisor.

HELPING OUT WITH TOILETING TASKS!

There's no way around this one! Every client has to eliminate! Depending on your client's abilities and care plan, toileting may involve:

Clearing a Safe Path: For clients who are independent and mobile, your only involvement in toileting may be to make sure the path to the bathroom is clear and clutter free!

- ***Best Practices:*** *Remove any area rugs that slide or move. Make sure there are no electrical cords crossing the path. Leave a nightlight on at night to light the way from the client's bed to the bathroom.*

Placing the Client on a Bedpan: Clients who are immobile and cannot get out of bed will need to use a bedpan.

- ***Best Practices:*** *Unless ordered to stay flat, the best position for elimination is sitting upright. It may be helpful to powder the rim of the bedpan to keep skin from sticking or tearing.*

Using a Urinal (for men): Urinals are a handy option for your immobile male clients.

- ***Best Practices:*** *If possible, encourage your clients to sit on the side of the bed to use the urinal. You may have to place the penis inside the urinal and hold the urinal while your client urinates.*

Using a Bedside Commode: For clients who can transfer out of bed with or without help, a bedside commode may be used.

- ***Best Practices:*** *Keep the commode near the bed and clean it after each use to eliminate unpleasant odors. Adjust the legs of the commode so that the client's feet plant firmly on the ground during elimination. Having feet firmly planted makes bowel movements easier.*

For all clients . . .

- Be prepared to answer call bells or requests for help immediately!
- Never make a client wait to use the toilet. It's embarrassing to have an accident and may lead to an unsafe attempt to use the bathroom without assistance.
- Always try to provide privacy during elimination. If your client requires constant supervision, stand just out of sight.
- Avoid hovering, watching and chatting while your client tries to eliminate. This is uncomfortable and may actually prevent elimination.
- Provide toilet tissue or wet wipes and encourage your client to clean the perineal and anal area independently, but always inspect and assist as needed.

CONNECT IT!

WHAT'S NORMAL?

You've been asked to track your client's intake and output and to report to your supervisor if the output is abnormal. See if you can answer these questions about normal outputs:

1. What is a normal urine output for a healthy adult?

_____

2. What would you expect if your client was on a diuretic (water pill)?

_____

3. How many bowel movements a day are normal?

_____

4. What does it mean if the bowel movement is black?

_____

Answers

1. An average adult urinates about 1200-1400ml a day.
2. It would increase urine output.
3. Once a day. But it's also normal to go up to 3 times a day or as little as once every 3 days!
4. There may be bleeding in the upper GI tract.

TOILETING TIME SKILL CHECK!

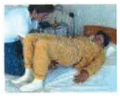
HELPING WITH A BEDPAN

What you'll need:

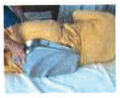
Bedpan	Toilet tissue	Wet wipes

Procedure:

1. Provide privacy.
2. Lower the head of bed.
3. Put on clean gloves before handling bedpan.
4. Place bedpan under client's buttocks.



If client is able, have her lift her buttocks as you slide the pan under her hips.



Or, turn onto side, align bedpan with buttocks and hold in place while turning client back.

5. Remove and dispose of gloves.
6. Raise the head of the bed to place the client in a seated position.
7. Place toilet tissue, wet wipes (for client to clean hands after using toilet tissue) and call bell within reach. *In home health, stand close enough to hear while still providing privacy.*
8. Wait for client to call or signal. Put on clean gloves before returning.
9. If client has used the toilet tissue, proceed to step # 10. If not, help clean the perineal area.
10. Lower the head of the bed.
11. Remove the bedpan, being careful not to spill or splash the contents.
12. Empty contents into a commode (never empty the bedpan or bedside commode into a sink or shower drain).
13. Rinse bedpan and pour rinse into toilet.
14. Place bedpan in designated dirty supply area.
15. Remove and dispose of gloves and wash hands.

CHANGING INCONTINENCE BRIEFS

What you'll need:

Basin and washcloths	Clean briefs
Disposable wipes	Lined Trash Can
Barrier cream	

Procedure:

1. Fill basin with warm water.
2. Place lined trash can next to bed for easy disposal of soiled products.
3. Put on clean gloves.
4. Open soiled brief and fold clean end over the soiled contents (while leaving the brief in place).
5. Initially wipe away as much stool or urine as possible with disposable wipes and discard into lined trash can.
6. Carefully remove soiled (folded) brief and place in lined trash can.
7. Using a clean, wet wash cloth, clean genital area by wiping from *front* to *back*. Use a clean area of the cloth (or a new cloth) for each wipe until all visible incontinence has been removed and area is clean.

8. Dry area and apply barrier cream to buttocks and groin folds.
9. Put clean incontinence brief on client.
10. Remove liner from trash can and dispose of it per your workplace policy.
11. Place washcloths in dirty linen per your workplace policy.
12. Remove gloves and wash hands.

SPOTLIGHT ON DRESSING & GROOMING

Getting dressed and taking care of your appearance seems easy enough! But for people who have physical or mental impairments, dressing and grooming tasks are often difficult to manage alone. That's where you come in. You can help your clients feel good about their appearance by:

Helping Clients Choose Clothing: Clients should be allowed to choose their own clothing, if able. Letting clients choose their own clothing gives them a feeling of being independent and in charge.

Laying Out the Clothing: Clients with dementia or Alzheimer's Disease may have trouble making choices. In this case, you might limit choices to just two items or choose the clothing and lay it out for the person.

Assisting with Dressing: Clients with physical impairments, like paralysis after a stroke or stiff joints from arthritis may need you to assist with dressing. Best choices are items with elastic waistbands and no buttons or zippers.

THE NEXT STEP!

HOW IMPORTANT IS HAIR CARE?

It can be particularly upsetting for an adult child to see his or her mother with a wild-bedhead-hairdo, especially if, in the past, she was a stylish woman who always took special care of her appearance.

What do you do to make sure your client's hair is being properly cared for?

Here are a few tips:

- Most people only need their hair washed once a week. Dry shampoos are a good option for immobile clients and for clients who are confused.
- If your client spends a lot of time lying on her hair in bed, then use a silk pillow case or try having her sleep in a hair net to minimize tangles.
- Women with long hair may need a shorter hairstyle. If a shorter cut is not an option, then braids or an up-do bun can tame a wild style!

DRESSING CLIENTS SKILL CHECK!

No matter what level of support your clients need, the best thing you can do is to encourage participation. This helps them feel confident and in control. It also may help them regain some of the skills they lost.

Procedure

1. Allow client to choose clothing, if possible. If your client can't get to the closet, you might ask "Would you like to wear the red shirt or the blue shirt today?"
2. Place the clean clothes within easy reach.
3. Help client to sit on a chair or the side of the bed.
4. If your client has a weak side, teach her to use her *stronger* arm to slide the clothing off the weak side *first*. Assist only as much as needed. Next, coach your client to use her strong arm to dress the weak side of the body first.
5. If your client is confused, give simple instructions, one at a time. For example, instead of just saying "Take off your pajamas," break it down into smaller steps like "Take off your shirt." "Now take off your pants." And so on.
6. ***Bending down to put on pants or shoes may cause dizziness.*** Help your client put her feet into her pants, pull them up to the knees or higher. Assist her to stand, then help her pull them up as needed.
7. Place shoes close to feet and help slide them on.
8. Place dirty clothes in the appropriate receptacle and wash your hands.

Please Note: If your client becomes fatigued or dizzy while getting dressed, help her sit or lie down before continuing the task.

HELPING CLIENTS EAT

Eating may be difficult for the clients you care for. They may have trouble chewing or swallowing after a stroke. They could feel nauseated from certain medications. Or they may have little or no appetite. Whatever the reason, it's your job to help your clients get the nourishment they need to stay physically and emotionally healthy while remaining as independent as possible.

Just like all ADLs, there are various levels of support. Follow your clients care plan for preparing, serving and feeding foods. Here are some general guidelines to follow with ALL clients:

Sit for Safety! Position your clients so they are sitting up as straight as possible. Feeding a client who is reclining increases the risk of choking.

Prepare and Present! Remove covers from food and open any containers that may be difficult for the client. Check the temperature of the food. Add seasoning if the client requests it and it's allowed. Cut solid foods into smaller, teaspoon-sized pieces.

Take It Step-By-Step. For clients who can feed themselves, but may become confused, give simple step-by-step instructions. For example, you might say "Pick up your spoon." "Now scoop the oatmeal." It's important to remain patient and kind, even if it seems like your client is being difficult.

Take Time to Socialize! For many people, mealtimes are about spending time with family and friends. Sit down with your client. Talk to him, even if it seems like he doesn't understand. Avoid rushing through meals.

Give the Play-By-Play. For clients who need more help, identify each food as you offer it. For example, you might say, "Mr. O'Donnell, here's a bite of chicken." "Now, here's a sip of iced tea."

Always encourage your clients to do as much as possible for themselves. But for clients who cannot feed themselves, here are a few "best practices:"

- Fill a spoon about *half* full and feed the client with the *tip* of the spoon. (Never use a fork!)
- Place the food on the center of the tongue, using a slight *downward* pressure.
- Allow time for your clients to chew and swallow each bite.
- Vary the foods you offer. For example, offer a spoonful of potato and then offer some meatloaf—so your client doesn't fill up on only one kind of food.

THINK ABOUT IT!

WHAT WOULD YOU DO IF . . .

Mr. Watson has had trouble chewing since his stroke a few months ago, but today is his birthday and he begs you to allow him to eat a steak sandwich from his favorite sub shop.

Mrs. Shue is undergoing chemo for cancer. It makes her feel nauseous all the time. She hasn't eaten more than a few crackers in the past 48 hours.

Mr. Suarez is depressed. He comes from a large family where mealtimes are always a celebration. Now that he's sick and elderly, he has to eat alone and he hates it. He tells you he'd just rather not eat at all.

Nothing you serve is ever good enough for Mrs. Johnson. She always finds something to complain about. It's too hot, too dry, too bland and on and on.

PERFORMING SAFE TRANSFERS

Helping clients with transfers and ambulation are important steps on the road to independence. Here are TEN important tips you can follow to keep your client and yourself safe while doing this ADL!

TIP 1: Think before you act! Before you start, be sure you know if the client is physically able to participate in the transfer. If you've never transferred a particular client before, go through the entire transfer in your mind *before* you begin.

TIP 2: Get help if you need it. Be realistic about what you can do safely on your own. Use transfer equipment or a mechanical lift if available. Ask for help if you need it!

In a client's home, a family member may be able to help you or they may need to rent or buy some transfer equipment.

TIP 3: Set the stage. Clear the path where you plan to stand, walk or pivot the client. Place your wheelchair, walker or mechanical lift where it needs to be.

TIP 4: Balance it out. Stand so that your weight is centered over your feet with feet shoulder-width apart. Don't "lock" your knees.

TIP 5: Tighten it up! Pull in your abdominal muscles and tighten your buttocks to support your lower back.

TIP 6: Use your BIG muscles! Bend your knees to help you keep your balance during a transfer. If you need to bend forward, bend from the *hips*, not from the waist.

TIP 7: Don't do the Twist! Plan your transfer so that you don't have to twist your body. Twisting your lower back puts you at risk for muscle strain—or even a more serious back injury.

TIP 8: Get close! Keeping the client close to you helps you use your large muscle groups to do the work and prevents straining the smaller arm and back muscles.

TIP 9: Take a breath test! If you can't lift and breathe at the same time, the client is *too heavy* for you. Ask for help!

TIP 10: Encourage participation! The most important tip of all . . . encourage your client to help as much as possible during the transfer! This will give him the opportunity to use his muscles and joints—and possibly regain some mobility in the future.

SAFE TRANSFERS SKILL CHECK!

TRANSFER A WEIGHT BEARING CLIENT FROM BED TO CHAIR

1. Help the client to sit on the side of the bed.
2. Put on non-skid slippers or shoes.
3. Position the chair near the bed. If the client has a weak side, place the chair on the *stronger* side. If the chair has wheels, be sure to lock them.
4. Now, support the client's knees by putting your knees right in front of them. And, keep the client's feet from sliding by putting your feet in front of his feet. DO NOT LOCK YOUR KNEES!
5. Ask the client to lean forward and push off the bed at the count of three. It's okay for a client hold onto your shoulders or waist, but never your neck!
6. Once client is sanding, turn your body, along with the client.
7. Make sure the chair seat touches the back of the client's legs before he begins to sit. Ask him to reach back for the armrests, if able.
8. Lower the client slowly to the chair seat without rounding your back.

HOW AND WHAT TO DOCUMENT FOR ADLs

When documenting ADLs, two pieces of information are critical—what actually happened and how much you helped:

What actually happened? You must document what the client actually did (not what he or she *might* be capable of doing) even if it varies from day to day or hour to hour. Here are some ways to document how your client performed the ADL:

- **Independent:** The client performed the ADL with no help or supervision from you.
- **Needed Supervision:** You provided oversight, encouragement or cueing during the activity.
- **Limited assistance:** The client was highly involved in the activity but required physical help to move limbs.
- **Extensive assistance:** The client performed part of the activity, but needed weight-bearing support.
- **Total dependence:** The client was unable to perform the activity.

How much did you help? You will need to document exactly how much you helped. This is how Medicare and the insurance companies determine how much to pay for the client's care. Some options are:

- **No setup or physical help from staff:** The client completed the activity with no help from you.
- **Setup help only:** You set up the materials and the client performed the ADL independently.
- **One person physical assist:** You physically assisted the person to complete the ADL.
- **Two or more person physical assist:** You and another co-worker physically assisted the client.

EATING HAS A SEPARATE LANGUAGE!

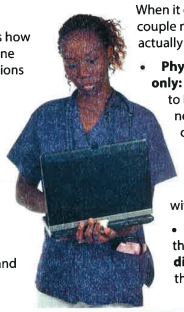
You may be asked to record your client's appetite or to indicate how much of the meal was eaten. Here are a few ways you can estimate this:

- **Refused** to eat or **0%** was eaten.
- **Poor** appetite, less than half eaten, or **25%**.
- **Fair** appetite, half was eaten, or **50%**.
- **Good** appetite, more than half eaten, or **75%**.
- **Excellent** appetite, entire amount, or **100%** eaten.

DETAILS ON TOILETING

In addition to documenting what actually happened (independent, supervision, etc.) and how much you helped, it's also important to document if your client was continent or incontinent during your shift and the number of episodes or movements that occurred.

THERE'S MORE ABOUT BATHING



When it comes to bathing, there are a couple more ways to describe what actually happened. They are:

- **Physical help limited to transfer only:** This is when the client is able to bathe independently, but just needs help getting into and out of the tub or shower.
- **Physical help in part of bathing activity:** This level is for clients who need assistance with some part of bathing.
- **Activity did not occur:** Use this to indicate that the activity **did not happen at all** during the shift.

These documentation terms are standard language for the MDS and OASIS reporting systems used in long term care and home health. Your workplace will have its own system for tracking ADLs that may or may not use these exact terms. It's important to know your workplace policy for documenting ADLs and to follow those guidelines.

FINAL THOUGHTS ON ADLs

If your client's care plan instructs you to provide assistance with ADLs, at any level of functioning, then follow these general guidelines:

Develop a routine with your client. Provide assistance with ADLs at the same time of day the client would normally do that activity. For example, if your client normally likes to get washed and brush her teeth before breakfast, then help her with those tasks at that time.

Include the client in the activity. Ask and encourage clients to participate in personal care and give them time to perform the activity.

Never rush a client through ADLs. Remember, the goal is increase the person's ability to do this task independently. If you rush, or get impatient and do it yourself, you deprive the person of the opportunity to regain this skill. This means you will ALWAYS have to do it!

Give a head start. Set up the items needed for the client to perform the activity independently. For example, put toothpaste on the toothbrush and place it near the client.

Keep it simple. Break complex tasks down into smaller steps. Provide cues for activities to be completed. For example, "Here is the wash cloth. Wash your face." Or, "Pick up the brush and brush your hair."

Use the "hand-over-hand" method. If your client does not respond to your verbal cues, try the hand-over-hand method. You do this by placing your hand *on top of* the client's hand and performing the activity together.

Be patient. Allow your clients to do as much of the activity as possible, even if it takes longer for the task to be completed.

Be positive. Encourage clients who try to do things for themselves. Show them that you are confident in their abilities.

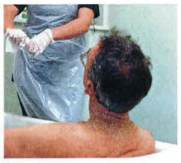
Every effort counts. If a client cannot complete a task after a reasonable amount of time and effort, praise her effort and then complete the task for her.

It's okay to fall short. Never punish clients for not being able to do a task, even if you think they should be able to do it.

Be sure to read part 2 of this inservice. It covers the IADLs, such as housework, meal preparation, taking medications as prescribed, shopping, using the telephone, and transportation within the community.

WHAT I KNOW NOW!

Now that you've read this inservice on helping with ADLs, jot down a couple of things you learned that you didn't know before.



COURSE OUTLINE

inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

A Client Care Module:
Bathing Tips

THE JOYS OF BATHING!

Imagine this: You've had a rough day at work. You're feeling sweaty and tired. You're looking forward to going home and taking a nice hot relaxing shower.

Now, imagine how it would feel if instead of being able to simply hop in the shower, your physical condition required you to:

- Take your clothes off in front of a stranger.
- Hold onto grab bars because you were afraid of falling in the shower.
- Ask for help washing the private areas of your body.
- Stand and shiver while waiting for someone to bring you a towel.

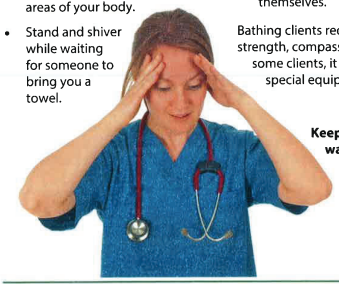
Suddenly, the idea of a nice hot shower doesn't seem so appealing, does it?

Your clients used to be able to take care of their own bathing needs. Now, many of them need your help. And, they probably aren't happy about that!

Being dependent on others for bathing probably makes them feel:

- Old and useless.
- Ashamed.
- Scared about what else they might have to give up doing for themselves.

Bathing clients requires patience, strength, compassion, and skill. For some clients, it may also require special equipment.



Keep reading to learn ways to make bathing a safer, more efficient process for you *and* your clients.

The Purposes of Bathing

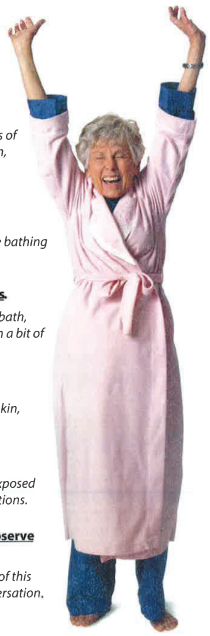
Bathing is important because it:

1. **Cleanses the body by removing dirt and dead skin cells.**

New skin cells continually push older cells toward the surface of the skin. By the time skin cells reach the surface, they are made up of the same lifeless protein as your hair and nails.

2. **Promotes comfort by cooling and refreshing the skin, and relaxing the client.**

Most Americans consider bathing to be a source of comfort. Think of all the products that are available to make bathing a pleasant experience: bubble bath, bath oils, shower gels, etc.



3. **Controls body odor by removing bacteria and germs from the skin.**

Body odor is caused by a combination of sweat and bacteria. The main sources of odor are the armpit, the groin, and the feet. Some foods—such as garlic, cumin, and curry—can cause body odor to linger.

4. **Prevents infection.**

Skin defends the body against injury, infection, and harmful substances in the environment. But, the skin must be clean and intact to do it's job. That's where bathing comes in.

5. **Provides an opportunity for clients to move their muscles and joints.**

By encouraging your clients to do as much as possible for themselves during a bath, you help them remain independent—and provide their muscles and joints with a bit of exercise.

6. **Stimulates circulation.**

Blood flow in the body is increased by warm water, rubbing or massaging the skin, and by moving joints and muscles during the bathing process.

7. **Helps prevent skin breakdown.**

It's especially important to clean the skin of incontinent clients. When skin is exposed to urine and/or stool, the risk increases for developing pressure sores and infections.

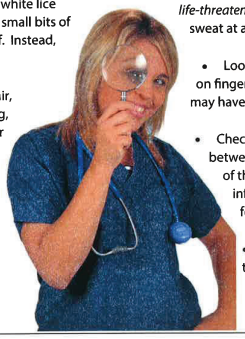
8. **Gives you an opportunity to communicate with the client and to observe his or her body for changes.**

Bathing is the #1 most time-consuming task for all caregivers. Make the most of this time by checking your client's body for changes and by making pleasant conversation. (If your client is unable to speak, try singing or humming instead.)

Making Observations at Bath Time

Bath time gives you a terrific opportunity to observe your clients for physical changes. Keep an eye out for problems and report any changes right away.

- Check the hair and scalp for head lice. (Lice can happen to anyone—no matter how young or old, dirty or clean, rich or poor.) Look for white lice eggs, known as "nits". They look like small bits of dandruff, but do *not* wash or flake off. Instead, they stick *firmly* to strands of hair.
- As you comb or wash your client's hair, observe the scalp for scaling, crusting, irritation, bruises, bleeding, lumps, or large areas of missing hair.
- Look over the whole body, making note of any areas of redness, rashes, bed sores, moles, or other changes in the skin.
- Check the entire body for puffiness or swelling, broken skin, redness, bruises, or bleeding.
- Report any unusual body odors. A strange odor may be a symptom of an illness.
- Watch out for clients who seem to sweat too much, too little, or who tend to sweat a lot at night. There are medical conditions that can cause sweating problems. (In fact, it can be *life-threatening* if a person doesn't sweat at all.)

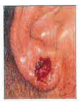


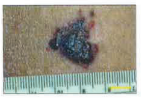
- Look for white or yellow areas on finger and toe nails. Your client may have a nail fungus.
- Check for itching, cracked skin between the toes or on the soles of the feet. These are signs of infections such as "athlete's foot."
- Watch for black warts on the soles of the feet.

Skin cancer is the most common form of cancer. There are one million new cases diagnosed every year. You can watch your clients for signs of skin cancer including:

- Sores that don't heal.
- A mole that changes size and/or has irregular edges.
- A skin growth that changes color, especially if it turns red, white, or blue.
- A mole that becomes tender, itchy, or dotted with black spots.
- A skin growth that crusts over, cracks, or bleeds.

Report any suspicious changes in a client's skin immediately!





Giving Different Types of Baths

Bed Bath

- Encourage the client to assist with the bath as much as possible.
- Gather all your supplies ahead of time and have them within reach of the bed.
- Close any doors or windows to avoid drafts.
- To ensure both warmth and privacy, cover the client with a light cotton blanket. Uncover, wash and dry only a small part of the body at a time.

Sponge or Partial Bath

- A full bath may not be ordered for each of your clients every day. However, a person's face, underarms, buttocks and genital area should be washed daily.
- Follow each client's care plan for a partial bath. For example, Mrs. Smith may be allowed to stand at the sink for her sponge bath, but Mr. Taylor needs to sit on the edge of his bed.

Tub Bath

- Never give a tub bath unless it is ordered in the client's care plan. Tub baths have a high risk for client falls, burns, and chills.
- Encourage clients to use the toilet *before* a bath since warm water may trigger the need to urinate.
- Don't attempt to help a client in or out of a tub unless you feel secure about your ability and/or you have the proper equipment (like a lift or slide board).
- Tub baths can dry the skin, so they shouldn't last longer than 20 minutes.

Shower

- Never give a shower unless it is ordered in the client's care plan. Use a shower chair if ordered.
- Be sure to place a rubber mat on the shower floor—but don't cover the drain opening.

Sitz Bath

- Remember that a sitz bath is meant for soaking the hips and buttocks only. It is often used with clients who have had surgery in the rectal area or who have bladder, prostate, or vaginal infections.
- Some clients may become dizzy after sitting in hot water. When the sitz bath is over, help them stand up and make sure they are steady before they attempt to walk.
- Pat your client's hips and buttocks dry with a soft towel.

Did You Know?

- The early Greeks used blocks of clay or sand to clean dirt off their bodies.
- In 1400 B.C., rich Egyptian women placed a large cone of scented grease on top of their heads every morning. During the day, the grease melted and dripped down their bodies. It covered their skin with an oily shine and bathed their clothes in fragrance.
- In 300 B.C., a number of fancy public baths were built in Rome. They were a popular luxury for wealthy people.
- After the fall of Rome in 467 A.D., bathing became less and less popular, especially in Europe.
- During the Middle Ages, most people lived in filth—because they believed that bathing was dangerous to their health. These unsanitary conditions contributed to the widespread plagues that spread through Europe at that time.

Bathing Clients with Special Needs

Seriously Ill Clients

Clients who are seriously ill, dying, or in pain require some extra "tender loving care" during bathing. Keep these tips in mind:

- Help the client into a comfortable position and complete as much of the bath as possible in that position.
- Proceed slowly if the client is experiencing pain, shortness of breath, or anxiety.
- Schedule the bath for about one hour *after* pain medication has been given to the client.

Confused Clients

Clients with Alzheimer's disease or other conditions that cause confusion need special consideration at bath time. Remember that the confusion may make them:

- Afraid of everyday things like running water, cold tile floors, or soap.
- Overly sensitive to temperature, such as cold drafts or hot water.
- Especially embarrassed about undressing in front of you.

To help make bath time more enjoyable for these clients, try to:

- Set up a routine for bathing...and stick with it.
- Give simple, clear instructions, without arguing.
- Avoid showers for clients who are afraid of running water.
- Fill the tub *before* taking the client into the bathroom.
- Keep the bath water no more than six inches deep.
- Cover the client's upper body with a towel to provide privacy during the bath.
- Play soft music or sing to the client (if he or she finds music soothing).

Disabled Clients

Bathing is more difficult, more time consuming, and more dangerous for people with disabilities. Clients with disabilities may have trouble:

- Keeping their balance while bathing or transferring in and out of a tub.
- Reaching items such as grab bars, soap, or towels.
- Holding on to a bar of soap.
- Opening or closing a faucet.
- Feeling the temperature of the water.

You can help your disabled clients by:

- Following proper bathroom safety procedures. (See page 10.)
- Making sure there is enough light in the bathroom.
- Putting needed items within your client's reach.
- Getting assistance from a co-worker or family member when transferring a client by yourself would be dangerous.

Did You Know?

- The average American takes at least seven baths or showers each week.
- Every day, Americans use 5,506,540 gallons of water for showers.
- Benjamin Franklin brought the first bathtub to the U.S. from Europe. He spent lots of time reading and writing while soaking in the tub.
- Former U.S. President William Howard Taft weighed 332 pounds. He got stuck in the White House tub the first time he used it. A larger one was installed for him!
- Three out of four people wash their bodies from top to bottom in the shower.

Skin Care Products

Soap

- There are many types of soap: plain, medicated, perfumed, or moisturizing. Check your client's care plan to see if a specific type of soap should be used at bath time.
- Question: *When is soap considered a drug?* Answer: *A bar of soap becomes an over-the-counter drug if the manufacturer claims the soap works against dandruff, bacteria, perspiration, or acne.*
- Use mild soap. (HINT: For clients with dry skin, apply soap only to the face, underarms, genital areas, hands, and feet. Clean the rest of the body with warm water only.)
- Rinse soap off with warm water—not hot.

Powder

- You may be asked to apply powder to soothe and cool a client's skin. If so, use only a small amount of powder—and don't mix powder with lotion. This causes the powder to crust and cake on the skin which can irritate the skin.
- Avoid shaking powders in the air. If inhaled, the small powder particles may irritate your client's respiratory tract.

Bath Oil

- Bath oils are used to soften the skin and to keep it from becoming dry. Some are also perfumed.
- Do not add bath oil to a tub bath. (It can make the tub even more slippery and is hard to clean off the surface of the tub.) Instead, if bath oil is desired, apply a light layer to the client's skin *after* the bath.

Deodorant

- There are two kinds of "underarm" products. Both *deodorants* and *antiperspirants* help cover up body odor. However, *antiperspirants* also work to control sweating. Some of these products can cause skin irritation, especially if used immediately after shaving the underarm. Check your clients for rash or other signs of irritation.

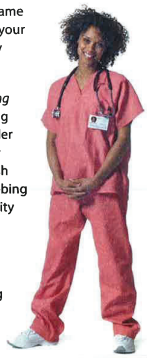
- The earliest soap was made centuries ago by mixing fat with ashes.
- During the Middle Ages, the recipe for making soap was kept top secret. Most people shared the recipe by word of mouth only. If they *had* to write it down, they used a secret code—in case the recipe got into the "wrong" hands.
- The same process used to make soap in the 1800s is used by soap manufacturers today!

Creams & Lotions

- Lotion or cream is used to soften skin and prevent it from drying.
- Encourage your clients to apply lotion themselves—if possible. (This gives them a chance to move their muscles and joints.)
- Before applying lotion, warm it up by rubbing it between your hands.
- Apply lotion gently, especially for elderly clients who have thin, fragile skin.

Bath Time Tips

- Remove any eyeglasses and/or hearing aids before beginning a bath or shampoo. Put them in a safe, dry place.
- Before your start the bathing process, tell your client exactly what you are going to be doing so he or she knows what to expect.
- When working with a bed bound client, be sure to raise the bed to a comfortable working height so you don't strain your back. (Don't forget to lower it again when you are done.)
- Let your supervisor know if you feel a bath is ordered too often or too seldom for one of your clients. In addition, be sure to report if your client needs a different kind of bath. For example, a client who is getting stronger may be able to switch from a sponge bath to a shower. Or, a client who is getting weaker may need to stop taking tub baths.
- Take your clients' suggestions and feelings into consideration. As much as possible, stick to the same bathing routines that your clients had *before* they needed your help.
- Remember that *slowing* the pace of the bathing process may allow older people to do more for themselves. If you rush them, you may be robbing them of the opportunity to remain semi-independent.
- Schedule bathing at the time of day during which your client has the most energy.



- Run cold water through the tub or shower faucet last so that the metal will be cool to the touch.
- Be sure to close doors, pull curtains and pull down blinds to show respect for your client's privacy during bath time.
- If possible, ask a physical or occupational therapist to teach you techniques for making bath time safer for a particular client.
- Praise your clients when they participate in their own personal care. For example, *"Your arm seems stronger today. You were able to scrub your back by yourself."* or *"Your hair looks lovely. You did a great job brushing it."*
- Review the bathing and shampoo policies for your workplace and follow them carefully.

Five Absolutely Vital Things to Know About Taking a Bath

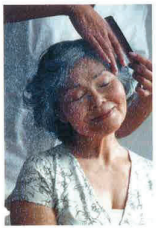
- When you leave a bath to run by itself, the plug jumps just as you leave the bathroom and you return to an empty bath right when the hot water runs out.
- It is physically impossible to turn a tap on or off with your foot.
- The dirt you wash off yourself gathers on the surface of the water and then re-attaches itself to you as you rise to leave.
- A lost bar of soap is ALWAYS behind you.
- However hard you dry yourself, you are still wet when you put on your clothes.

Hair Care Tips

Have you ever joked about having "a bad hair day"? If so, it's because like most people, you feel better about yourself when your hair is clean, trimmed, and attractively styled.

Your clients are probably no different—regardless of their age or health status. You can boost their morale by helping them take care of their hair. Here are some tips:

- Keep your client's hair tangle-free. (Tangled hair can cause pressure sores to develop on the scalp.)
- To remove snarls from hair *before* you shampoo, try gently combing cream rinse through the hair.
- Comb out tangles by beginning at the ends of the hair and working toward the roots.
- Don't remove or comb out braids without your client's permission. Some hairstyles are meant to stay in place for long periods.
- To prevent water from getting in your client's ears, gently insert cotton balls into the outer ear. Protect their eyes from the shampoo by covering them with a washcloth.
- Don't use bar soap to wash your client's hair. Bar soap makes hair rough and tangled.
- You'll get better results if you dilute shampoo with water before applying it to your client's head.
- Warm shampoo between your palms before applying it.
- To reduce the amount of water that gets in a client's face during rinsing, use a wet washcloth to clear shampoo out of the hair.



Did You Know...?

- The average person has 100,000 hairs on his head!
- In a lifetime, the average person produces nearly 600 miles worth of hair!
- A woman from China holds the world record for the longest hair. Her hair grew to be nearly 5.627 meters long.
- Americans can choose from over 600 kinds of shampoo! One brand, Agree, makes at least 13 different kinds of shampoo.

- If you use conditioner on your client's hair, be sure to rinse it thoroughly down the tub drain before helping the person out of the tub. (Conditioner can make a tub extra slippery.)
- Ask your supervisor if you can use *dry* shampoo for your clients who are unable to get out of bed.
- When shampooing a client's hair in bed, place absorbent towels and a waterproof sheet over the client's pillow. For best results, use a shampoo basin or an inflatable sink.
- To avoid spreading germs and/or lice, don't share the following items between clients: combs, brushes, hats, scarves, or hair bands.
- Don't cut, perm, or color your client's hair.
- To prevent accidental burns, don't use a curling iron on your client's hair.
- Don't forget to consult with your clients about how they want their hair styled. And, encourage them to participate in their hair care as much as possible.

Bathing & Infection Control

- If you help a client with toileting right before bath time, don't start the bath while wearing the same pair of gloves. Throw away your dirty gloves, wash your hands, and put on a clean pair of gloves.
- When cleaning a client's eyes, wipe each eye with a different corner of a washcloth. This prevents spreading infection from one eye to the other.
- Change the bath water whenever it:
  - Gets too soapy.
  - Cools off.
  - Becomes contaminated with body secretions.
- Practice standard precautions during the bathing process. For example, wear gloves whenever:
  - Feces and/or urine is present.
  - A client has open sores.
  - You give perineal care.
- Always clean a client's perineal area from front to back to avoid spreading germs from the anal area to the urinary area. (Use a separate, clean washcloth for this part of the bath.)
- Collect soiled towels and washcloths and place them in the appropriate laundry bag or container. Be sure to keep them off the floor. (You may want to review the policy for handling dirty linens at your workplace to find out whether you are required to wear gloves when handling linens.)

Time To Laugh!

Feeling stressed out, Jim decided to take a hot bath. Just as he'd gotten comfortable, the doorbell rang. Jim got out of the tub, put on his slippers and a large towel, wrapped his head in a smaller towel and went to the door. There stood a salesman, wanting to know if Jim needed any brushes. Slamming the door, Jim returned to his bath.

The doorbell rang again. On went the slippers and towels, and Jim headed for the door once more. He took one step, slipped on a wet spot, fell and hit his back against the hard edge of the tub.

Jim struggled into his street clothes and, in great pain, drove to the doctor. After examining him, the doctor said, *"Nothing's broken. But you need to relax. Why don't you go home and take a hot bath?"*

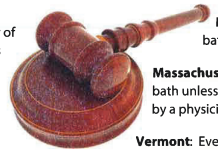
Can You Believe It?

The following laws are real! Some of them are even still "on the books"—although they are not enforced. (At least, we hope not!)

Arizona: Anyone caught stealing a bar of soap must wash himself with it until it's all used up.

California: In Los Angeles, it's illegal to bathe two babies in the same tub at the same time.

Indiana: Bathing in the winter is against the law.



Kentucky: Every citizen in Kentucky is required to take a bath at least once a year.

Maryland: It's illegal to scrub a bathtub no matter how dirty it gets.

Massachusetts: In Boston, it's illegal to take a bath unless you have been ordered to do so by a physician.

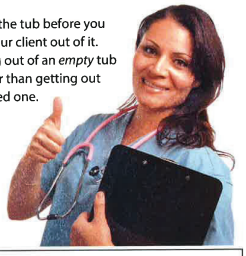
Vermont: Everyone in Vermont is required to take a bath once a week on Saturday night.

Bathing & Safety

- The greatest danger in a bathroom comes when clients get in and out of the tub or shower. The risk of falling is high!
- As you assist clients in and out of the tub or shower, you are at risk for falling, too. Most of these "double" falls happen:
  - At the end of the bath when the client is tired and/or relaxed.
  - If a client's physical condition has worsened.
  - While transferring a client out of a tub—because the client's body, the tub, *and* the floor are wet and slippery.
- Your clients may be *physically* dependent on you for help at bath time. For example, a client with arthritis may not be able to turn the water faucets on and off. A client may also be *psychologically* dependent on you. For example, he or she may be afraid to take a bath alone for fear of falling.

Whether the problem is physical, psychological, or both, keep each client's safety in mind at all times. Try following these tips:

- Wear rubber-soled shoes when assisting clients at bath time.
- If you work in clients' homes—and have access to a cell phone—consider keeping it in the bathroom during bath time. You'll be able to call for help if you and/or the client falls down.
- Make sure there are non-skid mats on the inside *and* the outside of the tub or shower.
- Keep the bathroom well-lit during bath time. Make sure it is well-ventilated, too, so that the room doesn't become too hot. (You—and your client—may become faint in the heat.)
- Remember that older people are more sensitive to heat and cold. Test the temperature of the water before your elderly clients get into the tub or shower. If you use a bath thermometer, it should read between 105 and 110 degrees F. After reading the thermometer, test the water on the inside of your wrist...and consider asking your client to do the same.
- If the bath area is equipped with an emergency call button, make sure your client knows how to use it.
- Never let a client grab onto a towel bar or a soap dish for support. These items are not meant to hold a person's weight and could pull right out of the wall.
- Empty the tub before you help your client out of it. Getting out of an *empty* tub is easier than getting out of a filled one.



- Every year, as many as *seventy* senior citizens die after being burned by hot water in the bathtub.
- If people are exposed to 180 degree water for just one second, they will develop deep third degree burns. Water this hot can also cause someone's skin and toenails to peel off.
- Every day, one American dies from an accident in the bathtub or shower.

Tools & Equipment For Bath Time

Studies have shown that most elderly people with disabilities do not have the necessary safety equipment installed in their bathrooms. For example:

- 68% do *not* have grab bars.
- 80% do *not* have a raised toilet seat.
- 46% do *not* have a non-slip bath mat.

Be sure to notify your supervisor if you notice safety hazards in your client's bathroom!

Transfer Benches

- A transfer bench sits partway outside and partway inside a bathtub. Your client sits on the bench and gradually slides his body inside the tub.

- Transfer benches come in various sizes. Some can be adjusted to different heights. Some have backrests. Most transfer benches have rubberized legs so they may be positioned securely inside the tub.

Grab Bars

- Grab bars come in various designs, including:
  - Horizontal.
  - Vertical.
  - Diagonal.
  - Wrap Around.
- They may be mounted to the wall, floor, ceiling, or tub.

- Some bars have ridges in the metal or are covered with vinyl to make them easier to grab.
- Grab bars don't do any good if they are placed too high or too low for clients to reach. Most people need bars installed in two different positions: one for use in getting in and out of the tub in a standing position; and one for lowering or raising the body from a seated position.

Handheld Showers

- Some clients may benefit from a handheld shower. They may find it easier to clean themselves if they are able to direct the water onto "hard to reach" body parts.

Shower Chairs

- If your clients enjoy taking a shower, but are unable to stand for long periods of time, a shower chair may be the answer.

Other items that may make bath time safer for your clients include:

- Mechanical or hydraulic bath lifts.
- Special adapters for turning on water faucets.
- Long-handled sponges.
- Wash mitts.
- Floor-to-ceiling grab poles.
- Foam faucet protectors (to cushion fixtures in the tub).

Questions & Answers About Bathing

Q: What are some tips for bathing a baby?

A: Make sure you have all your supplies within reach before starting the bath—since you must never leave a baby alone in or near a bath. Use a mild soap and a soft washcloth. Avoid tub baths for a newborn until his cord stump falls off (and circumcision heals). Remember to take time during the bath to hold, cuddle, and talk to the baby.

Q: How does the skin change as we age?

A: As people get older, the skin becomes thinner and develops fine wrinkles. Many people develop "age spots" which look like large freckles. The glands that produce oil become less active, so the skin contains less moisture. Elderly people often have dry, fragile skin that can be torn or injured easily.

Q: Isn't bath time a good time for nail care?

A: Bath time is a great time to clean your client's nails. However, be sure to follow your workplace policy about trimming and filing nails. Some clients, especially diabetics, must have their nails trimmed by a nurse or doctor.

Q: What if I'm ordered to give a bed bath but the client, Mr. Brown, wants to get in the tub?

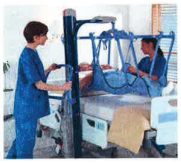
A: You should explain to Mr. Brown that you need to follow your orders as written in his plan of care. Remind him that the plan of care was created with his best interests in mind. Tell Mr. Brown that you will ask your supervisor if the orders can be changed to a tub bath for next time. (Remember, though, that Mr. Brown has the right to *refuse* care. You must not force him to have a bath if he refuses. Be sure to notify your supervisor whenever a client refuses a bath.)

Q: What's the best way to document personal care?

A: Your supervisor can tell you the forms needed to document personal care at your workplace. Many facilities use flow sheets. Home health agencies usually use visit notes. Be sure to document exactly what you did, including: the type of bath provided, the client's level of participation, and anything unusual that you observed.

Q: What's the deal with home health clients on Medicare needing to have a bath?

A: As a home health aide, have you ever heard that you must get your Medicare client "wet" during each visit? Here's the deal: Medicare clients may receive assistance from a home health aide only when they are *acutely* ill. They must have a *temporary* medical problem causing them to need help with their personal care. This personal care must include some type of full or partial bath during every visit or Medicare will not pay for the aide's time. So, if your client refuses a bath or a family member has already done the bath when you arrive, let your supervisor know before you begin your client care. You may be asked to skip your visit that day. (*NOTE*: This "rule" does not apply to Medicare clients receiving *hospice* care.)



COURSE OUTLINE

inthe**know** | CAREGIVER TRAINING
A home care pulse COMPANY

A Safety Module:
Mechanical Lift Use & Safety

NURSE AIDES CARRY A HEAVY LOAD!

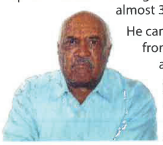
Tamara is a home health aide who visits at least five clients each day. This is a typical line-up of her morning duties:

MR. BARNES suffers from Alzheimer's disease. He has a history of falls and needs help with all aspects of his personal care.

Lately, he has been fixated on going to the bathroom, so Tamara spends a lot of time helping him up and down off the toilet.

Because bathing helps settle Mr. Barnes, his care plan includes a tub bath three times a week. Tamara supports most of his body weight as he gets in and out of the tub.

MR. HOLLOWAY is recuperating from a stroke that left him weak on his left side. A physical therapist is working with him but, for now, Mr. Holloway still requires a wheelchair to get around. Mr. Holloway is quite tall and weighs almost 300 pounds.



He can sit up slightly but needs Tamara's help to transfer from his recliner in the living room to the wheelchair and/or the bed.

Since his stroke, he has been angry at the world because he hates being dependent on others! Often, he fails to cooperate with Tamara in the middle of a transfer.

MRS. JAMESON had surgery recently on her left shoulder and arm. Unfortunately, her right arm has limited strength due to severe arthritis.

So, Tamara has to help Mrs. Jameson sit up from a lying position and then assist her to transfer to her bedside commode.

Even though Mrs. Jameson weighs less than Tamara, the transfers are difficult because the client does not have a hospital bed…and her bed is low to the ground.

LIKE ALL CNAS, TAMARA IS AT RISK!

When a professional athlete is injured during a game, he gets sidelined, but he still gets paid. When a professional nursing assistant gets injured on the job, he or she often has to decide to go home without pay or stay and work through the pain. What would you do if you were injured today?

WOULD YOU BE SIDELINED OR WOULD YOU PLAY INJURED?

If you chose to be "sidelined" and stay home until your injury improved:

- How would you feed your family and pay your bills?
- How would you handle the chronic pain? (Chronic pain often leads to feelings of depression and worthlessness.)
- How would you handle the emotional stress of being off work?

BEING A NURSE AIDE IS RISKY BUSINESS!

- According to the Bureau of Labor Statistics, nearly 80 percent of all injuries to nursing assistants are the result of lifting, pulling, pushing, holding, carrying, and turning clients.
- Every single day in the United States, 9000 healthcare workers sustain a disabling injury while performing work-related tasks.
- You use your body all day long to care for your clients. You go to work every day knowing there is a possibility of getting injured, losing work… and losing pay.

CAN ALL THESE INJURIES BE PREVENTED? FORTUNATELY, YES!

There are a few simple things you can do to prevent a disabling injury. Keep reading to learn more about…

- Using proper body mechanics.
- Types of mechanical lifts and slings.
- The safe and appropriate use of mechanical lifts.

You don't have to be another statistic. Protect your body from injury by working smarter every day! Keep reading to learn how!

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

The Facts

Health care workers have A LOT of work-related back injuries. But the good news is that when you know this fact, you can take steps to prevent back injuries before they ever happen! It's much easier to prevent back problems than it is to treat them or live with them!

- Most nursing assistants who hurt their backs do so while transferring or lifting a client.
- While almost everyone will have back pain at some time in their life, it is more common after age 40.
- Back pain affects the *whole body*. Adults with back pain are often in worse physical and mental health than people who do not have back pain.
- It's impossible to know exactly how many healthcare workers have work-related back injuries because these injuries often go unreported.

SAFETY Alert

A California nursing home resident fell from a Hoyer lift. She suffered a head injury and died nine days later. The cause of the fall was determined to be improper use of a lift.

The sling was not properly placed and the aide who was operating the lift was alone when assistance was required.

While mechanical lifts are designed to make client transfers safer, they can also be dangerous (and even deadly) if not used properly.

Never operate a lift unless you have been properly trained!

IMPORTANT: There are as many as 20 different brands and models of mechanic lifts.

It is essential that in addition to completing this module, you receive **hands-on training for any specific lifting devices you use** in order to operate them safely.

SO, WHAT'S THE BEST WAY?

Like Tamara, chances are you spend a good bit of every day helping your clients move from one place to another. From bed to a chair…from a chair to a commode…and more. So, when lifting, should you:

Bend Your Knees?

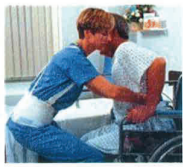
For decades, much attention was focused on preventing injuries during direct client care by using good "body mechanics." As you probably know, this involves learning how to move, hold and position your body (especially your large muscle groups) in order to lift and move heavy loads safely.

This research behind body mechanics was promising and those techniques have been practiced by nurses and nursing assistants for years…but injuries keep happening!

The problem is that all the research into body mechanics was done by moving *mannequins*. The weight of mannequins is fixed and even. Real human bodies are much harder to move. ***While knowing proper body mechanics is important, it's only one piece of the puzzle!***

Wear a Belt?

Back support belts were a "trend" about fifteen years ago…not just in healthcare but in other industries as well. Initially, research seemed to show that they helped protect the back during patient transfers and lifting. But, further studies found that support belts are ineffective for several reasons:



- They can lend a false sense of security, making healthcare workers believe they can lift more weight that they can (or should).
- People tend to rely on the belt to give them the correct posture during lifting, rather than paying attention to body mechanics.
- Often, the belts fit poorly and "ride up" during client care.

Grab a Buddy?

Whenever possible, you should ask for help from a co-worker when you need to lift or transfer a client. Just make sure the team member is "on the same page" as you about how to complete the transfer.

However, did you know that studies have found it takes *at least five minutes longer* to round up several co-workers who are willing to help you transfer a client than it does to use a mechanical lift?

And, if you work in home care, there is generally no one to call for help!

Keep reading to learn why using both proper body mechanics and a mechanical lift is the best—and safest—way to transfer some clients.

KNOW YOUR MECHANICAL LIFTS

ELECTRIC SLING LIFTS

Because the Hoyer brand of sling lift is so common, you may hear an electric lift referred to as a "Hoyer Lift," regardless of its actual brand. (This is similar to how you might call all tissues "Kleenex.")

You may also hear this lift called a "sling lift" or just as a mechanical lift.

This type of lift is used to transfer clients who are completely immobile. They cannot bear weight and cannot sit without support. Using a sling lift takes the burden off the bodies of caregivers like yourself.

How Does it Work?

Electric sling lifts are powered by a re-chargeable battery and/or by being plugged into a standard outlet.

Lifting clients is accomplished by pushing buttons on a hand control.

Some models of electric lifts allow the client to operate the lift independently. (This is helpful for people who live at home and still have good upper body strength.)

Every electric lift, no matter the brand, can be operated manually if a power failure should occur.

Most healthcare facilities prefer electric sling lifts (rather than manual ones). Electric lifts are helpful in home care situations, too, since there is often just one caregiver operating the lift.

MANUAL SLING LIFTS

Just like the electric model, a manual sling lift helps caregivers transfer immobile clients with a minimum of physical effort.

This lift is "manual" because there is no battery or electric power. Instead, there is an hydraulic system that requires the caregiver to "pump" a lever when lifting the client.

Because they don't have electronic parts, manual lifts are cheaper and may be seen more often by home health and hospice aides.

How Does it Work?

Manual sling lifts have hydraulic cylinders, a hand pump and a control valve.

Lifting clients is accomplished by moving the hand pump up and down repeatedly until the client is fully supported by the sling and the boom locks into place.

Manual "Hoyer" lifts have a control valve that is opened gradually to release air and lower the client into place. (This is similar to opening the valve on a blood pressure cuff.)

IMPORTANT! While many sling lifts are referred to as "Hoyer lifts," there are as many as 20 different brands and models of mechanic al lifts. It is essential that in addition to completing this module, you receive hands-on training for any specific lifting devices you use in order to operate them safely.

CONNECT IT!

Whether you work in home health or in a facility, think about the clients you care for who require a mechanical lift.

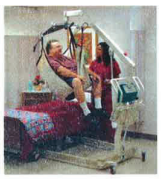
Ask Yourself . . .

- Have I had sufficient training on each of the mechanical lifts I have to operate during my daily client care?
- Do I know how to pick the correct lift and the proper sling for each of my clients?
- Have I performed enough "hands-on" practice lifting healthy volunteers and/or co-workers with mechanical lifts?
- Has a co-worker lifted me in a lift so I know how it feels to be suspended by a sling?

If you answer "no" to any of these questions, inform your supervisor! You require additional training until your answer to each of these questions changes to "yes."

OTHER TYPES OF MECHANICAL LIFTS

HEAVY DUTY LIFTS



Heavy duty "Hoyer" lifts are sometimes called "bariatric" lifts. They are intended for use with clients whose weight exceeds the maximum load for a regular lift.

Some heavy duty lifts are capable of lifting up to 1000 pounds. The legs of the base are extra sturdy and can be widened to make sure the lift remains stable during the client's transfer.

BATH LIFTS

A bath lift, like the one pictured here, is meant to be used to lower a person into the tub…and raise him or her back out again.

Most models are made of materials that won't rust and are resistant to germs.

Bath lifts may be manual or battery operated. Some have reclining backs and/or swivel seats for added ease of use.

STAND ASSIST LIFTS

These devices may be called the "Stand EZ," the "Stella Lift" or just the stand-up lift. Like the Hoyer, there are many makes and models available. You will need hands-on training on the specific device your workplace uses.

Stand-up lifts are used with clients who are able to bear weight and have some upper body strength. These clients can sit unsupported but just need a little help standing up and sitting down.

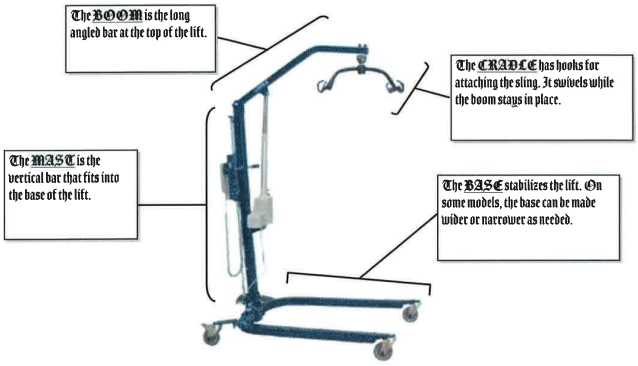
POOL LIFTS

Like bath lifts, mechanical pool lifts help raise and lower people in and out of the water.

Caregivers might see pool lifts in nursing facilities and in private homes.

Some pool lifts are portable and others are mounted to the deck of the pool. They can be used with both swimming pools and hot tubs.

KNOW THE PARTS OF A TYPICAL LIFT



DIFFERENT SLINGS DO DIFFERENT THINGS!

FULL BODY SLINGS, or "hammock" slings, support the whole body. The client's arms are kept inside the sling and the head is usually supported.

This type of sling is used for people who are partially or totally dependent, non-weight bearing or have limited head control.

A **U-SHAPED SLING** supports the back (and sometimes head) of the person being transferred.

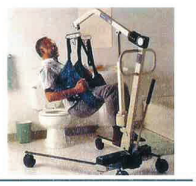
The "sides" of the U serve as straps that wrap around the client's thighs and hook onto the cradle.

"U" slings are fairly simple to take off or put on—even when a client is sitting.

TOILETING SLINGS are made just for the purpose of helping clients use the toilet.

Some allow the client to use his arms—like the one pictured here.

Others are more like full body slings with a hole cut out for toileting purposes.



THINK ABOUT IT!

What would you do if your client became upset, angry, or refused to allow you to use a mechanical lift for transfers? Try these tips to help your clients feel more comfortable:

- Explain everything you are going to do--before you do it. Do this even if you think the client can't hear or understand you.
- Provide privacy. For example, a client may fear the mechanical lift because she's afraid that others will be able to see up her dress.
- Make sure you are completely familiar with any transfer equipment and that you have *practiced* using it. If clients sense that you don't know what you are doing, they are more likely to feel scared.
- Reassure your client that you have checked the equipment to make sure it is working properly and that it will lift him or her safely.

LIFT SAFETY REQUIRES PREPARATION!

Before you go near a client with a mechanical lift, there are a number of things you should do to prepare—so that the transfer is as efficient, comfortable and safe as possible.

CHECK THE CARE PLAN!

- Whether or not your state has adopted laws about safe patient handling, each client's plan of care should let you know how that person needs to be transferred.
- For example, the care plan may state that the client is to be transferred with a Hoyer lift with the assist of TWO people. If this is the case, never try to operate the Hoyer lift by yourself. Plan ahead as much as possible and find a co-worker who can help you with the transfer.
- The care plan (and/or the client's chart) will also tell you how much the client weighs and how much the client can assist with the transfer--so that you can be sure you are using the appropriate lift and sling.

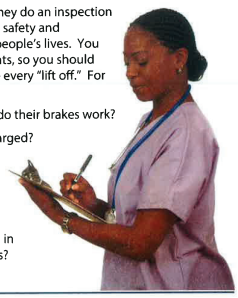
ASK YOURSELF . . .

- Has this client been moved using this lift before? If so, how did it go? Is there anything I can do to improve the experience for the client?
- How much mobility does the client have? How will this impact the lifting procedure?
- How can I minimize any feelings the client may have about loss of dignity and/or privacy?
- If assistance is required, which of my co-workers do I know for sure has been fully trained on the use of this mechanical lift?

DO AN INSPECTION!

Before airline pilots take off in a plane, they do an inspection of their equipment. This is for their own safety and because they are responsible for other people's lives. You are responsible for the lives of your clients, so you should also do an equipment inspection before every "lift off." For example:

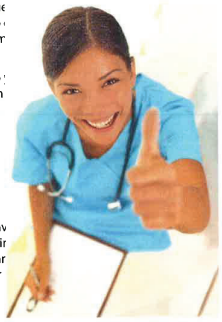
- Are the casters attached firmly and do their brakes work?
- If the lift is electric, is the battery charged?
- Do all of the buttons work on the hand control?
- Is the lift making any strange noises that might indicate trouble?
- How about the sling? Is it clean and in good condition with no frayed areas?



MORE VITAL PREPARATION TIPS

As you complete your "safety inspection" before using a mechanical lift, remember to consider the following:

- ✓ Have you used the spreader bar or control to **set the base legs to the widest possible position**? If not, the lift will be unstable and could tip over during the transfer.
- ✓ Are the **legs locked into position**? If not, they could move closer together once you start moving the lift.
- ✓ Think about **the floor** where you will be moving the lift. Is it even? For example, do you have to move the client from a tile floor to a carpeted floor? If so, make sure the lift you are using is capable of doing this safely.
- ✓ Next, make sure there is **a clear path** for moving the client to where he or she needs to go. (In clients' homes, watch out for children and pets!)
- ✓ Does the lift have **enough room to pivot** and move freely?
- ✓ Will the lift fit though any **doorways** you may encounter?
- ✓ If the lift is a manual model, is the **control valve closed**? The pump won't work if the valve is open…just like a blood pressure cuff won't tighten if the valve is open.
- ✓ If the lift is electric, do you know where the **emergency release** can be found and how to use it? Some models have more than one emergency release. Does yours? If so, which release is the primary one that should be used first?
- ✓ Have you selected **the correct type of sling** for your client and for the lift? Do you know which side of the sling goes next to the client?
- ✓ Is the sling the **correct size** for your client based on height, weight and any mobility issue the sling is too large, the client may slip of it. If the sling is too small, the client m fall out of it.
- ✓ Now that you have the correct sling, do know **how to attach it to the cradle** on the lift? Most "Hoyer-type" lifts have hooks on the cradle to which the sling is attached. Some slings attach to the hooks with chains, some with straps and others with loops. Make sure you are very familiar with how to attach your client's sling!
- ✓ If you work in clients' homes, do you hav **a back up plan** in case a lift stops workir midway through the transfer and you ar on your own. Hopefully, that will never happen, but be sure you make a plan ahead of time, just in case!



THE NEXT STEP!

CARING FOR SLINGS

- If slings are shared between clients, be sure to launder or disinfect between each use.
- Clients on isolation precautions should not share slings.
- Every sling manufacturer provides proper washing instructions. For some, you need to remove metal and/or plastic pieces before washing.
- Be sure to scrub the areas of the sling that touch the client's skin.
- When cleaning slings, avoid bleach, machine drying and ironing.

The time spent cleaning a lift sling provides a good opportunity for checking the status of the sling.

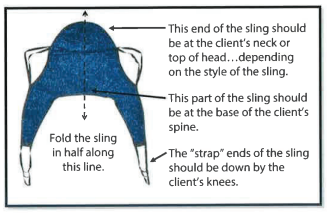
- Look for areas that are frayed, ripped or have holes or loose stitching. If you notice any issues, let your supervisor know…and don't use that sling again.

EIGHT BASIC STEPS TO SAFE LIFTING

1 ARRANGE SLING UNDER CLIENT

As you explain the process to your client, look to see that there are no blankets, sheets or loose clothing that could get in the way during the lifting process.

- Fold the sling lengthwise, making sure any loops or tabs are on the *inside* of the fold. The narrow end of the sling should by the client's head and the long sides of the U-shape down by his knees.
- Center the fold underneath the client's spine—following the same process you would when making an occupied bed.
- When you have rolled the client and unfolded the sling, the opening of the upside-down U should be level with the base of the client's spine.



2 MOVE THE LIFT INTO POSITION

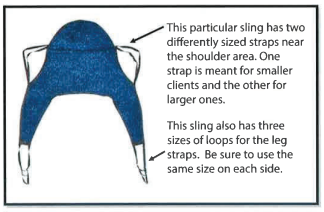
Move the lift so the base is under the client's bed and the lift is as close to the bed as possible.

- Make sure the base legs are locked in the widest possible position.
- Lower the boom so that the cradle is close enough to attach the sling—but not close enough to touch the client.
- Check to see that the cradle is directly above, and parallel to, the client's shoulders.
- Lock the casters so the lift doesn't move as you attach the sling to it.

3 ATTACH THE SLING TO THE LIFT

Most U-shaped slings wrap around the client's thighs and cross between the legs. This helps him feel secure and prevents slipping out of the sling.

- Attach the sling to the cradle with the straps, chains or loops—according the specific manufacturer's instructions.
- If your lift has chains, count the links so that you have the same number attached on both sides of the client.
- The sling may have multiple loops available for attachment. Choose the best loop for his size and comfort—and use the same loop on each side.



4 DO ANOTHER SAFETY CHECK!

This may seem like a waste of time. However, when it comes to safety, patience pays off!

- Double check the position of each strap.
- Look to see that all the loops are on the right hook and that they are fastened firmly in place.
- Are the hooks on the cradle turned so the open end is facing away from the client? This helps prevent injury.
- Observe your client. Is he showing any signs of discomfort? Is his head supported, if necessary?

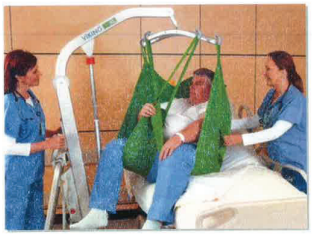
EIGHT BASIC STEPS TO SAFE LIFTING — CONTINUED

5 LIFT THE CLIENT

- Unlock the casters when you are ready to lift the client. This allows the lift to move slightly as it adjusts to the client's weight.
- Raise the boom slowly either by pumping the hand lever (on a manual lift) or pushing the "up" button on an electric lift.
- Lift your client only high enough so that his legs and buttocks clear the bed—usually an inch or two. As you lift, the cradle should level out the client into a sitting position.
- Check to see if the client's weight is centered over the base of the lift and that his knees are slightly higher than his waist.
- Gently guide the client's legs until they are dangling off the side of the bed. As you do, the cradle will swivel so the client faces you.

6 MOVE THE LIFT TO YOUR DESTINATION!

- Using the steering handle, move the lift at a slow, steady pace away from the bed and toward the client's chair.
- Never push or pull on the boom bar while the client is in the sling. This could cause the lift to tip over!
- Never let go of the lift while your client is in it. You need to be in control in case of a sudden shift in weight or an unexpected obstacle, like an uneven floor.
- Be as efficient as possible, without rushing, to limit your client's time in the sling. The longer he is in the sling, the greater the risk for skin tears or abrasions.



7 LOWER THE CLIENT INTO HIS CHAIR

- Move the lift as close as you can to the chair, so that the client's hips are aimed as far back in the chair's seat as possible. Then, lock the casters.
- Lower the client slowly into the chair. For a manual lift, you do this by turning the hydraulic pressure knob no more than one full turn. For an electric lift, you push the "down" button on the hand control.
- As you lower the client, gently push on your client's knees with your other hand. This helps put his hips in the correct position in the chair.
- Avoid supporting your client's weight from underneath his buttocks. This can cause the loops to unhook from the cradle.
- **FOR MANUAL LIFTS:** Before performing a transfer with an actual client, you should already have practiced enough times with this lift to know how much you need to turn the hydraulic pressure knob to lower the client at a safe speed.

8 REMOVE THE SLING!

- Once the client is fully seated in his chair, lower the boom enough to allow you to unhook the sling.
- Gently lift each leg and pull the sling strap out from under the client's thigh.
- Stand in front of the client and assist him to lean forward slightly. Reach around and carefully pull the "U" sling up from behind him.
- As always, make sure your client is comfortable before you leave him.

A FINAL LOOK AT TAMARA . . .

Remember Tamara, the home health aide who was having trouble lifting and transferring three of her clients? Let's look at how she and her clients could benefit from mechanical lifts.

⇒ **Mr. Barnes** suffers from Alzheimer's disease, has a history of falls and needs help with all aspects of his personal care. Tamara spends a lot of time helping him up and down off the toilet and has to help him with a tub bath three times a week.

Both Tamara and Mr. Barnes would benefit most from a **bath lift**. This would make bathing safer for Mr. Barnes and might spare Tamara from a career-ending back injury.

Mr. Barnes may also benefit from a **Stand Assist-type lift**. Tamara decides to check with his family about renting these items.

⇒ **Mr. Holloway** has left-sided weakness after a stroke, needs assistance to sit up in bed and is wheelchair bound. He is quite tall, weighs almost 300 pounds and has been expressing anger at his situation.

Tamara helps him transfer from bed to wheelchair, then to his recliner and so on.

Mr. Holloway would benefit from a **Hoyer lift**. Tamara is going to talk to her supervisor and her agency's social worker to see if one can be obtained.

⇒ **Mrs. Jameson** has upper body weakness due to a recent shoulder operation on one side and chronic arthritis on the other. As a result, she cannot sit up in bed by herself…and her bed is low to the ground. This makes transfers hard on Tamara's back.

It's clear that Mrs. Jameson would also benefit from a **Hoyer-type lift**. Because she is expected to make a full recovery from her surgery, the lift will only be needed *temporarily*. Tamara knows that Mrs. Jameson can't afford a lift, so she asks her supervisor to find out if one can be obtained for Mrs. Jameson.

FINAL TIPS for Using Mechanical Lifts!

- Be sure to follow the manufacturer's instructions for using the lift. Each kind of mechanical lift has specific instructions for how to position and lift the sling.
- Using a lift may need to be practiced *many times* before you feel comfortable doing it on your own with an actual client.
- Many workplace policies prohibit care givers from operating lifts alone. Most policies require at least two caregivers be present while transferring a client with a lift.
- When operating a lift with a partner, one person should operate the lift while the second person guides the client into position.
- If shared, mechanical lifts should be disinfected according to manufacturer guidelines after each use.

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A home care pulse COMPANY

An Infection Control Module:
Infection Control in Home Care

COURSE OUTLINE

GERMS, GERMS, EVERYWHERE!

Marilyn is a home health aide who makes an average of 25 visits to clients' homes each week. And, as anyone who works in home care can tell you, the job is unpredictable! Marilyn knows to "expect the unexpected," but today was especially challenging:

8:30 am: Marilyn visits Mr. Webster who is recovering from a stroke. He has limited mobility and sometimes has trouble getting to the bathroom in time. This morning, Marilyn notices a large urine spot on the carpet and splashes of urine surrounding the toilet.

10:00 am: Mrs. Turner is Marilyn's next client. As part of the plan of care, Marilyn does laundry twice a week. Today, she notices a strong mildew smell coming from Mrs. Turner's old washing machine. After Marilyn finishes the laundry, the clean clothes smell musty.

11:30 am: Next on the schedule is Mrs. Babson who lives with her daughter and young grandchildren. Mrs. Babson gives herself insulin injections for her diabetes. Upon arrival, Marilyn finds three used syringes in the bathroom trash. In fact, she narrowly escapes being stuck with one of the used needles—and hopes that Mrs. Babson's grandchildren didn't get into the trash!

2:00 pm: Now, it's time to visit Mr. Neely, a cheerful old fellow who lives out in the country. He asks Marilyn to fix him a snack. When she opens the drawer to get a spoon, a mouse jumps out! Then, Marilyn notices mouse droppings all over the kitchen counter.

3:30 pm: Marilyn's final visit of the day is with Mrs. Caldwell who recently finished chemotherapy. Mrs. Caldwell has a pet dog, Millie, that she loves dearly. When Marilyn arrives, she finds Mrs. Caldwell in bed, snuggling with Millie. The dog is happily licking Mrs. Caldwell's face and hands.

There's no doubt about it. Infection control in home care can be difficult. Home health aides never know what they might encounter at each visit. So, what are some methods for handling infection control in home care? Let's take a closer look at each of Marilyn's five clients to see how she might deal with her infection control challenges.

GIVE YOURSELF A HAND!

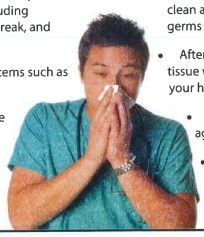
- First of all, as you go through your day, the single most important thing you can do to prevent spreading germs from client to client is to **wash your hands**!
- The key to washing your hands is *not* the kind of soap or the temperature of the water. It's the energy you put into scrubbing your hands. *Friction* gets rid of bacteria—not just soap.
- Use soap and water to wash your hands when they are *visibly soiled*. Be sure to dry your hands with a clean towel or paper towel. Do not use your clients' towels.
- If your hands don't look soiled, you can use an alcohol-based hand rub (about 1/2 tsp). However, remember to cover all surfaces of your hands, fingers and fingernails, and **rub vigorously until hands are completely dry!**
- Teach your clients to *ask* you if you have washed your hands. And then, when they do ask you, don't get defensive. Just be grateful for the reminder!
- Remember **Standard Precautions** apply to *all* clients—because any client might have an infectious disease without even knowing it.

Gloves are great, but wearing them does not take the place of

WHEN SHOULD YOU WASH YOUR HANDS?

Germs are invisible to the eye and, because of this, not many people think about washing their hands throughout the day. Here are a few times when it is **absolutely necessary** to wash your hands thoroughly:

- After lengthy contact with any client.
- Before and after situations in which your hands are likely to be contaminated, including bathroom breaks, your lunch break, and before and after your workday.
- After touching contaminated items such as urine-measuring devices.
- After gloves are removed (since the gloves may have a hole). Bacteria multiplies quickly when your hands are inside gloves.
- Whenever you are preparing food for a client.
- If a client has pets, wash your hands frequently while visiting. Many animals leave invisible germs all around the house that go completely unnoticed!
- If someone in your family is sick, keep your hands as clean as possible all day long, so you don't pass on germs to your clients.
- After sneezing or coughing. Even if you use a tissue when you sneeze, germs can still seep onto your hands.
- When you arrive to see a client, and once again when you leave.
- Before and after you put on gloves.
- Anytime you think it might be a good idea!



BODY FLUIDS & BATHROOMS

Remember Marilyn's first client, Mr. Webster? He is recovering from a stroke and can't move quickly. Unfortunately, Mr. Webster urinated on the carpet on the way to the bathroom. And, because of his stroke, he has trouble with his "aim" when urinating. Marilyn finds splashes of urine on and around the toilet.

For the carpet:

- Blot up as much moisture as you can with paper towels. Then, if available, rub either club soda or a tablespoon of vinegar mixed with hot water into the stain. When the carpet is dry, sprinkle baking soda over the area, rub it in and let it sit for *at least* 15 minutes before vacuuming.
- To remove as much dirt and germs as possible, vacuum the carpet regularly, especially a high traffic area such as the hallway or the "path" between the client's bed and bathroom.
- For best results, move the vacuum *slowly* over the carpet, going back and forth and side to side—seven times for high-traffic areas and three or four times for lighter ones.
- Never use a broom of any kind on the carpet. At best, the dirt is just stirred up and moved around.

In most homes, the carpet is 4,000 times dirtier than the toilet seat!

- If "accidents" are a common problem with one of your clients, suggest that the family buy an enzyme-based carpet cleaner (available at pet stores). The enzymes "eat" the bacteria in urine that cause odor.

To sanitize the bathroom:

- Does your client have a commercial sanitizer such as Lysol on hand? It can be used on every surface in the bathroom except the mirror.
- Be sure to follow your workplace policy about using "homemade" cleaning products. For example, to sanitize bathroom surfaces, the FDA recommends mixing 1 *teaspoon* of chlorine bleach with 1 quart of water. However, if you "make" your own cleaner, don't leave "leftovers" around. Instead, dump out what you don't use.
- Whenever you clean with chemicals, make sure the room is well ventilated so you don't hurt your lungs. And, never combine bleach with another cleaner, even vinegar, as toxic fumes can result.

BEYOND soap & water

Should household surfaces (like bathroom counters and tubs) always be cleaned with an *antibacterial* cleaner? Not necessarily. Regular scrubbing with soaps, detergents, or even plain old vinegar removes many harmful germs.

However, some clients may need you to *disinfect* their environment regularly. Fortunately, there is no solid evidence that using antibacterial cleaners is causing drug resistant strains of bacteria.

Instead, studies show that the widespread misuse of *antibiotics*, not antibacterial cleaners, is to blame for those drug resistant "super bugs."

If you work with a client who wants you to use an antibacterial cleaner, be sure to follow the directions on the container carefully. Some of them need to be left on a surface for *up to two minutes* before being wiped away. (And, remember...diluted bleach needs to stay on a surface for *10 minutes* to disinfect it properly!)

CLEAN & FRESH LAUNDRY

Next, Marilyn visits Mrs. Turner, one of her favorite clients. Mrs. Turner's washing machine still works, but it's pretty old. Today, the laundry smells dirtier after being washed and dried than it did before! Marilyn feels like she wasted her time...and is concerned that Mrs. Turner's bed sheets and clothing may contain mold.

Because washing machines operate by filling with water, they can be great breeding grounds for mold and mildew. If you notice that a client's clean laundry smells of mildew, there are some things you can try:

Be careful not to overload the machine. If there are too many clothes or linens in the machine, the load becomes unbalanced—and slows down the spin cycle. This causes too much moisture to remain in the clothes at the end of the cycle.

Remove the laundry promptly when the wash cycle is finished. If you don't, moisture from the clothes can redeposit itself inside the machine. This can lead to a build up of mold or mildew.

At the end of each wash cycle, leave the door/lid to the washing machine open so that the tub has a chance to dry out. You might also want to gently dry off any rubber seal around the door/lid.

If you notice bad smells in a client's washing machine, try washing an empty "load" with hot water and a mixture of baking soda and vinegar. (Mix 1/2 cup of baking soda to two cups of white distilled vinegar. Add it to the machine when the hot water is rising in the tub.)

Here are some other tips for getting a client's laundry really clean:

- Remember that germs can transfer between contaminated and uncontaminated clothing—and cold or warm water may not get rid of all the germs.
- To "disinfect" laundry, use water that is at least 140 degrees F. Even when using hot water, it's best to wash heavily soiled items separately.
- If a load contains sheets, undergarments, or other items that may be stained with body fluids or feces, save it for your last load. And, if possible, use liquid bleach along with detergent. If your client doesn't want bleach to be used with the laundry, consider disinfecting the washer (after your last load) by running it empty with a cup of bleach added to a cold water wash.
- To keep germs from building up on damp laundry, dry it (or hang it to dry) as soon as the wash cycle is finished.
- Be sure to wash your hands after touching or sorting any dirty laundry—and after transferring wet laundry to the dryer.

DID you KNOW?

- The average load of dirty laundry contains 100 million E. coli bacteria! And, studies have found that more than 60 percent of washing machines are contaminated with fecal matter.
- MRSA, a potentially dangerous staph infection that is resistant to many antibiotics, can be spread by sharing towels.
- Viruses (such as hepatitis A and rotavirus) and bacteria (such as Salmonella) can all cause stomach upsets and diarrhea...and can easily live through the average 28-minute cycle in a dryer. (Using bleach in the wash is your best bet.)

NEEDLE KNOW HOW

Marilyn feels relieved that she wasn't stuck by Mrs. Babson's used insulin needles, but she worries about the young children living in the house. She keeps trying to teach Mrs. Babson not to throw her used syringes in the trash, but the problem continues to happen.

This is a common problem! Every year, eight million Americans use more than three billion needles, syringes and lancets to manage their medical conditions at home. While home health aides are not supposed to handle "sharps," studies have shown that clients often leave used needles and syringes for their aides to dispose of.

Your agency may provide sharps containers for your clients. However, here are some other options for safe sharps disposal:

"Special Waste" Pickup Service. Some communities provide clients with empty sharps containers and then arrange a scheduled pickup when the container is full.

Hazardous Waste Centers. Your community may have a disposal site that accepts household hazardous waste items like used syringes. You can find out by calling the public health and/or trash department in your town.

Drop-Off Collection Sites. In some communities, you'll find specific "sharps" drop-off sites in hospitals, health clinics, pharmacies and/or police stations.

Mail-Back Service. There are companies that will send your client an empty sharps container with instructions on how to mail it back when it is full. Generally, these companies charge a fee based on the size of the sharps container.

Home Needle Destruction Devices. Your client may be interested in buying a device that destroys syringes at home by melting or cutting off the needle...making it safe to throw into the garbage. Be sure to tell your client that any such device should carry the approval of the US Food and Drug Administration (the FDA).

Trash Disposal. Some communities still allow used syringes to be put in the regular trash IF they are not bent, broken or recapped AND they are placed in a puncture resistant container like an empty bleach bottle with a tight cap or 1-pound coffee can with the lid taped closed.

GET creative!

Tap into your experience on the job and come up with at least ONE creative solution to each of the two problems listed on this page:

Despite your warnings, your client continues to flush his used sharps down the toilet. You know that this is unsafe for the workers at the water treatment plant. You decide to:_____

_____

_____

_____

_____

Your client participates in a "mail back" program for sharps disposal, but he keeps the sharps container in the kitchen pantry. You tell him: _____

_____

_____

_____

_____

For more info on safe disposal of sharps in *your* area, check out: www.safeneedledisposal.org

RODENTS, ROACHES & ANTS, OH MY!

Mr. Neely is ready for his afternoon snack. Marilyn gets a big surprise when she opens a kitchen drawer and discovers a mouse! Then, she notices mouse droppings all over the kitchen counter. She has other clients who have problems with ants and cockroaches. In fact, more than once, Marilyn has found a cockroach in her hair after leaving a client's home! **What can be done about household pests?**

RODENTS

Rodents, such as mice and rats, invade homes looking for food, water and warmth. A pair of mice can turn into a "family" of 200 mice within just four months! And, mice can contaminate much more food than they eat. Watch out for:

- Droppings—in kitchen cabinets, pantries, drawers, and bins—and pools of urine. Mice tend to dribble urine as they scamper around.
- Nibble marks or holes in food boxes or containers. Mice are especially attracted to bags of pet food and, surprisingly, bars of soap!
- A musky odor. Mice have a distinctive smell!

One way of discouraging mice from nesting in a home is to dip some cotton balls in peppermint oil and placing them wherever you have seen evidence of

ANTS

Ants are attracted to a variety of foods. To prevent an infestation of ants, you should:

- Keep kitchens and other rooms as free of food as possible. Wipe all kitchen surfaces with soap and water to get rid of spills and grease.
- Keep food tightly sealed or ants can sneak inside.
- Take out the garbage daily and rinse the kitchen garbage container regularly.
- A quick way to get rid of ants is to mix a teaspoon of liquid soap in a spray bottle with one quart of water. Spray the areas where ants are active and wipe up the dead ants. This eliminates the scent trail left by the ants.

ROACHES

Cockroaches are nocturnal insects that look for dark, moist places to hide, such as behind refrigerators and stoves or under sinks. They also hide under floor drains, inside appliance motors, behind wallpaper, and in cracked walls.

If you see a cockroach during the day, it's a good sign that roaches have infested the home. You will probably also see feces that resemble coffee grounds or black pepper. In addition, you may find dead roaches and oval-shaped egg cases throughout the home.

To prevent a roach infestation, do not leave food out overnight, including pet food. Wash dirty dishes and utensils as soon as you are done using them. Clean counters, sinks, and tables with soapy water. And, take your client's garbage out each day.

If you see roaches in a client's home, try vacuuming to reduce the number of insects *and* eggs. Dispose of the vacuum bag in a sealed container. Another "home remedy" is to place a couple of pieces of beer-soaked bread in an empty one-pound coffee can. Put the can in areas known to have roaches.

Be sure to tell your supervisor and/or your agency's social worker about any type of pest infestation in a client's home. Pests can be dangerous, especially for the elderly and people with respiratory problems.

SPIC & SPAN KITCHENS

Pests—like Mr. Neely's mice—can spread a lot of germs around, so Marilyn needs to give the kitchen a good cleaning. Here are some tips that help get a kitchen spic and span!

- When you clean the kitchen, work from *high* to *low*—with the floor being the last surface you clean. (However, if the dirty water used to clean the floor has to be emptied into the kitchen sink, clean the sink last.)
- If possible, use paper towels to clean kitchen surfaces. But, make sure to use them for one task only. If you wipe down one surface and then clean another one with the same towel, you might spread bacteria.
- If you use non-disposable cloths for cleaning, be sure to put them through the washing machine frequently.
- What about sponges? Try this tip: keep them color-coded. Use a blue one to wipe the counter after cutting raw meat. Grab a pink one to wipe the rest of the counter. And use a green one to wash up pots and pans.
- Germs can hide and multiply easily on your client's can opener. Don't forget to clean it regularly with hot, soapy water.
- Another place that germs collect is on a kitchen faucet. As the water runs through the tip of the faucet, it can collect germs and spread them onto your hands, dishes, and/or any food that you rinsing. So, don't forget to clean the faucet—and its tip.
- Do you wash your client's dishes by hand? If so, remember to wash them from cleanest to dirtiest. This means that glassware is first, followed by silverware. Next comes plates and other dishes. Now, check your water. If it's dirty, empty the sink and start with fresh soapy water for the pots and pans.
- Does your client have a sour smelling garbage disposal? If so, it is probably teeming with germs. An easy way to clean it is to put a few tablespoons of baking soda down the drain, followed by three ice cubes. Then turn on the garbage disposal and run *hot* water until the ice is all chopped up.
- Remember that wooden utensils and cutting boards can develop cracks where bacteria can take up residence. (Many experts say that plastic cutting boards are easier to disinfect.)

If a household chemical bothers your skin, eyes, nose, or throat, stop using it.

- Do you work with a client who needs his food blended? If so, you know that blenders can be hard to clean, especially if you can't wash it right away. Try this tip: put a little water in the dirty blender and run it on a low speed. This should loosen any bits of food that have stuck to the sides of the blender.
- Be sure to sweep or vacuum a floor *before* you mop it. Otherwise, any dirt on the floor turns into sticky mud!
- To keep from spreading germs around when you mop, rinse the mop often. If a floor is very dirty, dump the mop water several times and continue with *clean* rinse water.
- When it comes to disinfecting the kitchen, follow your workplace policies about working with chemicals and check out the tips given on page 2 for cleaning with diluted bleach and/or other disinfectants. And, be sure to wear gloves as you work. Doing so will save your skin from repeated exposure to chemicals and keep you from gathering germs under your fingernails.

MORE ON FOOD SAFETY

While mice, roaches, and other pests can spread germs to a client's food, so can pets, kids, and anyone who handles or cooks the food. (The food itself can harbor germs, too!) Here are some infection control tips that relate to food safety.

Remember…you can't always see, smell, or taste the bacteria that cause food-borne illnesses. It takes anywhere from thirty minutes to several weeks to get sick from contaminated food. There are four basic steps to follow to ensure the safety of food, including:

1. **CLEAN**: *Wash hands and surfaces frequently.*

- Wash your hands immediately before and after handling raw meat or poultry or its packaging.
- Raw meat, chicken, and fish do not need to be washed before cooking. (Washing these foods might get rid of some surface bacteria, but it also spreads the bacteria around the kitchen.)

2. **SEPARATE**: *Don't cross-contaminate.*

- When bacteria cross from one food to another through contact with the same surface, it's called cross-contamination.
- Separate raw meat, poultry, and seafood from other food in your grocery cart by putting them in plastic bags.
- Store raw meats on the bottom shelf of the refrigerator so the juices can't drip on other foods.
- Store eggs in their original carton—even if the refrigerator has special "egg holders."
- Don't use the same platters and utensils for meat before and after it's cooked.

3. **COOK**: *Cook foods to proper temperatures.*

- Never serve ground beef if it is still pink inside.
- Cook fish until it is opaque and flakes easily with a fork.
- Cook eggs until they are firm, not runny.
- Bring sauces, soups and gravies to a boil before serving.

4. **CHILL**: *Refrigerate foods promptly.*

- Refrigerate food quickly to keep bacteria from multiplying.
- Make sure the refrigerator is set at 40 degrees and the freezer at 0 degrees.
- Refrigerate food and leftovers within two hours. For quick cooling, put leftovers into *shallow* containers.
- Don't pack a refrigerator too full. Cold air has to be able to circulate to keep food safe.
- Never thaw foods by sitting them out on the counter at room temperature.
- If you must thaw something quickly, cover it with cold water. Change the water every thirty minutes to keep the water cold.
- Food can also be thawed in the microwave, but only if it's going to be cooked immediately after thawing.

According to the CDC, up to 80% of food-borne illnesses happen in homes...not in restaurants.

REMEMBER: Elderly and/or sick people may have less ability to fight off bacteria. So, follow these tips to keep your clients' food free of harmful bacteria.

PETS: THE GOOD, THE BAD & THE UGLY

Mrs. Caldwell has no relatives nearby; her dog, Millie, has become like family to her. Marilyn knows how much she loves that dog, but worries about the spread of infection at a time when Mrs. Caldwell's immune system is compromised.

THE GOOD

There's no doubt about it. Research has proven that pets can have a positive impact on someone's life. For example, caring for a pet can:

- Reduce blood pressure.
- Cut cholesterol levels.
- Decrease feelings of loneliness.
- Increase physical activity.

In addition, dog ownership has been shown to increase the chances of surviving a heart attack. Another study found that older people, living at home, had fewer minor health problems if they had a pet to keep them company.

THE BAD

Pets can be lovable, fun, and treasured members of the family. However, they can also add a lot of work when it comes to keeping a clean house. Here are just some of the challenges they pose:

- Shedding fur and dander.
- Tracking in dirt, mold, and even fleas from outside.
- Creating dirty litter boxes, crates, or cages.
- Having "accidents" in the house.
- Walking on surfaces where food is prepared or served.

THE UGLY

Marilyn is right. People whose immune systems are weakened—due to disease or, like Mrs. Caldwell, chemotherapy—have a higher risk of getting sick from their pets. Other people at risk include:

- Infants and children under five years old.
- The elderly.
- Pregnant women.
- People who have received organ transplants.
- People with HIV/AIDS.

WHAT CAN YOU DO?

Telling a client like Mrs. Caldwell to stay away from her pet is not the answer. When clients are ill, they probably get a lot of emotional comfort from being with their pets. However, you can teach your clients how to protect themselves from infection while still enjoying their pets. For example, they should:

- Wash their hands thoroughly with soap and running water after contact with animals. This is especially important before preparing or eating food.
- Avoid rough play with pets to prevent scratches and bites.
- Have someone else clean up dog droppings, clean the litter box, clean cages or aquariums, or wash pet bedding.
- Be extra cautious around reptiles, baby chicks, ducklings, puppies, and kittens. Young animals are more likely to spread infection.

Be sure that you wash *your* hands after contact with a client's pet, its feces, and/or dog treats. (Some treats may be contaminated with salmonella.)

WHAT DO YOU THINK: FACT OR FICTION?

Fact or Fiction? **Most diseases are spread from germs found on dirty objects such as door knobs, telephones and money.**

ý **Fiction**. While dry surfaces can be temporary homes for germs, most diseases are spread by our hands through person-to-person contact.

Fact or Fiction? **Thousands of germs can live under and around fingernails.**

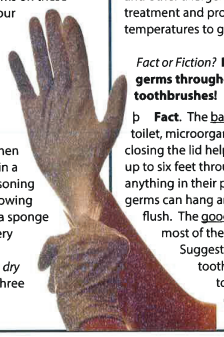
þ **Fact**. Germs can survive by hiding under your fingernails. Don't forget to clean your nails when you wash your hands or use an alcohol hand rub. What about nail polish? If it is freshly applied, it does not increase the number of germs, but chipped polish can hide lots of germs. If you have artificial nails, you run a higher risk of having thousands of "hidden" germs.

Fact or Fiction? **A nurses' station or other workplace desk is much dirtier than a toilet bowl.**

þ **Fact**. Tests showed that the average desktop is home to 400 times more bacteria than a toilet. Why? Because most desktops are cleaned infrequently. While most of the germs found on desktops are harmless, tests have found "live" cold and flu germs on these surfaces. One of the dirtiest spots in your workplace *and* your clients' homes is probably the telephone. If you use a client's home phone, wipe it with an alcohol swab first.

Fact or Fiction? **A kitchen sponge can contain billions of bacteria.**

þ **Fact**. Several studies agree: a kitchen sponge is one of the "germiest" items in a home. The germs that cause food poisoning can be among the billions of germs growing on a sponge. A great way to disinfect a sponge is to put it through the dishwasher every other day. No dishwasher at a client's home? Be sure to allow the sponge to *dry out* between uses and discard it after three weeks.



Fact or Fiction? **To be safe from germs, kitchen sinks need a daily cleaning with bleach.**

ý **Fiction**. Using bleach every day is probably "overkill". Soap and water will do the trick when it comes to getting rid of bacteria. However, if you've been handling raw meat, wash your hands thoroughly and then rinse the sink (including the faucet and handles) with hot, soapy water.

Fact or Fiction? **If your client's favorite bed pillow is from 1975, it is home to billions of bacteria.**

þ **Fact**. However, the bacteria cushioned in a pillow are probably harmless. Pillows (including the stuffing) are not ideal breeding grounds for germs—and a pillowcase provides a barrier the person and the bacteria. Still, for comfort's sake, you might suggest that your clients get new pillows every five years or so. And, in the meantime, change your client's pillowcase as ordered or whenever it becomes soiled.

Fact or Fiction? **Unless bed sheets are washed in hot water once a week, the risk for bed bugs is high.**

ý **Fiction**. Washing sheets cleans them of *dust mites* and other allergens. It takes a professional pesticide treatment and professional laundering at high temperatures to get rid of bed bugs.

Fact or Fiction? **Flushing the toilet can spread germs throughout the bathroom, including on toothbrushes!**

þ **Fact**. The bad news: whenever you flush the toilet, microorganisms are ejected into the air. While closing the lid helps, germs still escape and can travel up to six feet throughout the bathroom, landing on anything in their path—including toothbrushes. These germs can hang around for *at least* two hours after each flush. The good news: when a toothbrush dries, most of the germs will die. Your best bet? Suggest that your clients keep their toothbrushes as far as possible from the toilet or safely tucked in a medicine cabinet.

SOME FINAL TIPS

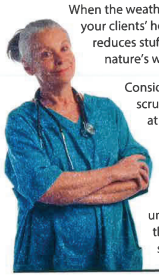
If part of your care plan is to clean the client's living space, try to think outside the box. Germs may be hiding in places you're *not* cleaning. For example, studies show that these common items are usually *dirtier* than a toilet bowl: the kitchen sink, the telephone receiver, doorknobs, the television remote control, and the top of a desk or bedside table.

Remember that a good disinfectant cleaner should state on the container that it kills 99.9% of germs and bacteria. This is different than an "all purpose" cleaner such as Windex or (non-bleach) 409.

One of the best ways to keep carpets and floors germ-free is to take off shoes at the door. (Shoes drag in lots of germs, not to mention toxins and animal feces.) While going shoeless may not be appropriate for you, consider suggesting that your client's family and friends remove their shoes.

Be sure to ask family members and friends to wash their hands before having contact with your client. If they seem offended, tell them that part of your job is to keep their loved one as healthy as possible by promoting proper infection control. Explain that you wash your hands multiple times during your visit with the client.

Do you work with any clients who have compromised respiratory systems from problems such as allergies, asthma, COPD, or cancer? If so, remember that dust, dander, and dust mites can build up in a mattress. When you change their linens, wash their mattress covers, too. No mattress cover on the bed? Simply vacuum the mattress using the upholstery attachment on the vacuum cleaner.



When the weather allows, let some fresh air and sunshine into your clients' homes. The fresh air offers extra oxygen and reduces stuffy odors. And, the heat from the sun is nature's way of killing germs!

Consider keeping a paper gown or a spare set of scrubs in your car. If your clothing becomes soiled at one client's home, you can change before heading to your next visit.

Cut down on the germs in your own home, too, by removing your work shoes before entering your house. Change out of your uniform/scrubs right away and, if soiled, put them in a separate laundry basket. Wash your scrubs in hot water to kill germs.

GOOD to know!

- *You wash your hands frequently according to your workplace policy. And you work hard to keep your scrubs/clothes clean during your visits with clients. So, how is it possible that you could be bringing millions of germs into your clients' homes?*
- *Here's the deal: if you carry a purse and/or a client care bag, germs galore are probably traveling with you from client to client.*
- *Think about it. Many times, a purse ends up touching the same surfaces as the bottom of your shoes, including the floor of restrooms and the floor of your car. It might also sit on chairs in restaurants, kitchen tables, or seats on buses.*
- *According to studies, one in four purses carry E. coli, a bacteria that can cause a serious intestinal illness.*
- *What should you do? Watch where you place your purse and client care bag. Scrub the outside of them regularly. You can use a soapy washcloth, an antibacterial spray, or a disposable wipe. Don't forget to clean the handle or strap, too.*
- *In addition, don't set your purse or client care bag down on any surface where you'll be preparing food or where your client will be eating.*

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A home care pulse COMPANY

COURSE OUTLINE

A Client Care Module:
Handling Incontinence of the Bowel and Bladder

MOM'S CARE GOT COMPLICATED

Tonya lived about 15 minutes away from her mother. Her mother was getting older. She lived alone and was beginning to have health problems. So Tanya became her main caregiver.

Tanya felt completely in control of her mother's care. She took her to doctor's appointments, got her medication refills, made sure she ate well, and even took her to church every Sunday.

One day, Tanya noticed a ***faint smell of urine*** when she entered the home. She asked her mom about it but she didn't get a straight answer. Tanya arranged for a housekeeper to do some cleaning. The housekeeper reported to Tanya that the sheets on the bed were soaked with urine and that there were urine soaked pajamas in the laundry.

Tanya tried to talk to her mom about the problem but it was embarrassing for both of them. She took her to the store to choose between pads and briefs. She made an appointment with the doctor to make sure there wasn't something more serious going on.

Tanya's mom admitted to the doctor that she had problems with urine leakage when laughing and coughing, and that at night, she often couldn't reach the bathroom in time.

The doctor ran some tests and made a few suggestions. She told Tanya's mom to take her afternoon dose of Lasix (a water pill) at 3pm instead of 7pm. She also recommended cutting back on caffeine and doing Kegel exercises. She diagnosed Tanya's mom with ***stress incontinence*** related to weak pelvic floor muscles and ***urge incontinence*** related to her Lasix dose.

Tanya's mom took the doctor's suggestions, but the incontinence didn't improve. Then the urinary tract infections started. After the third UTI, Tanya began to feel overwhelmed by her mother's care. She started looking for a home health nurse to help.

Incontinence is one of the main reason's family caregivers seek professional help with caring for their loved ones. Keep reading to learn more about incontinence and how you can help care for the clients who suffer from it.

IT'S A PRETTY BIG DEAL

Incontinence affects millions of people worldwide. But that's just counting the folks we know about. The real numbers are probably a lot higher because many people are too embarrassed to report the problem or seek help. Here's what we know for sure:

- ***Urinary incontinence*** affects about 25 million American adults and 200 million adults worldwide.
- One in 12 Americans, or approximately 18 million people, is estimated to have ***fecal incontinence***.
- More than half of all residents in nursing homes suffer from one or both types of incontinence.
- Women wait an average of 6.5 years before seeking professional help for their incontinence problems.
- Urinary incontinence is a common ***risk factor for falls***. And falls are a leading cause of injury and death in people aged 65 and older.

SOME TERMS TO KNOW

- **Urinary Incontinence**—The accidental or unwanted loss or leakage of urine.
- **Bowel Incontinence** (aka fecal incontinence)—The accidental or unwanted movement of the bowels. It's the loss of liquid or solid stool at inappropriate times.
- **Continence**—This is the opposite of incontinence. To have control over the urge to urinate or move the bowels until an appropriate time and place can be found.
- **Pelvic Floor**—A group of strong and flexible muscles attached from bottom of the spine to the front of the pelvis. It's often described as a "hammock" because it holds the bladder and other organs in place.
- **Kegel Exercises**—Special exercises that strengthen the pelvic floor. They can help with certain types of urinary incontinence.

WHAT'S NEW? *Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

What Words?

IT'S HARD TO TALK ABOUT IT!

When you work in health care, you HAVE to talk about "pee" and "poo" all the time! But many of your clients are embarrassed to talk about their urinary and bowel incontinence. And they definitely won't use medical terms like "stool" and "urine."

Here are some words you may hear to describe episodes of incontinence:

- Skidmarks
- PeePee
- Wetness in the pants
- Leakage
- Dampness in the underwear
- It leaks out
- I cannot make it to the bathroom
- Going #2 without knowing it

What words have you heard?

_____

_____

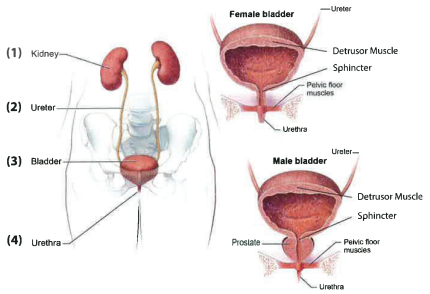
A QUICK QUIZ

Ask your clients, your loved ones, or even yourself these questions.

- Does urine leak out during exercise like walking, climbing stairs, or even getting up from a chair?
- Is there urine leakage when sneezing, laughing, or coughing?
- Is there urine loss on the way to the bathroom?
- How about at night? Does the person wake up during the night to use the bathroom?
- Are trips or places avoided because there may not be a bathroom available?
- Is there a frequent, strong, sudden urge to urinate that can't seem to be controlled?
- Does the person limit the amount she drinks before leaving home so that she doesn't have to worry about finding a bathroom?
- Are pads or diapers being worn to prevent clothes from getting wet?

If you answered "yes" to any of the questions, there may be a problem.

A CLOSER LOOK AT THE URINARY SYSTEM



WHAT DOES THE URINARY SYSTEM DO?

The main function of the urinary system is to flush waste from the body. Fluids in the blood are filtered by the kidneys. Excess water and waste are combined and eliminated in the form of urine.

The pathway:

- (1) Urine is produced in the kidneys. (2) The ureters drain the urine from the kidneys to the bladder where it collects. (3) Urine collects in the bladder until the bladder is full enough to trigger the sensation to urinate. (4) Urine travels from the bladder, through the urethra, to the outside of the body.

WHAT CAN GO WRONG?

1. **Difficulties with the Detrusor Muscle.** Inside the wall of the bladder is a muscle called the detrusor muscle. It helps the bladder expand so it can store urine. This muscle can either become weakened or overactive, both of which can cause incontinence.
2. **Sapped Sphincters.** There are two sets of muscles (called sphincters) that help hold urine in the bladder. The internal sphincter works without conscious effort. The external sphincter is under voluntary control. One or both of these sphincters can become weakened and lead to difficulty "holding" urine.
3. **Problems with the Pelvic Floor.** The pelvic floor is a group of muscles that form a hammock to keep the pelvic organs in the right place. The muscles of the pelvic floor can become weak and start to sag. This can lead to leaking urine or stool when straining, such as coughing, sneezing, laughing or lifting.

TYPES OF URINARY INCONTINENCE

There are two main categories of incontinence: *transient* incontinence and *chronic* incontinence.

- **Transient Incontinence is a temporary or short-term condition that *can* be fixed.** It's usually triggered by an illness like a UTI, a medical problem like a stroke, medications, or constipation. Once the problem is treated, the incontinence goes away.
- **Chronic Incontinence is a long-term condition that can be fixed *most* of the time, but not always.** It's caused by a damaged lower urinary tract and/or a weak pelvic floor.

FIVE TYPES OF CHRONIC INCONTINENCE

1. **Stress Incontinence** is caused by poor pelvic muscle control. Any extra pressure or stress causes urine to leak out.

   Symptoms: Urine leaks out when coughing, laughing, sneezing, exercising, running, jumping, lifting, sitting, and standing.

   The Three Levels of Stress Incontinence

   Mild—urine leaks out during coughing, laughing, straining, and so on.

   Moderate—urine leaks out during walking, rising, or with sudden movement.

   Severe—urine leaks with the slightest activity, like rolling over in bed.

2. **Urge Incontinence** is also called "overactive bladder." The detrusor muscle in the bladder is hyper. Even small amounts of urine can trigger the bladder to "let go!"

   Symptoms: Urge to go is strong and frequent. The bladder can't "hold it" once the urge is felt and it empties right away—before getting to the toilet. Urine loss is moderate to large.

3. **Overflow Incontinence** is caused by weak bladder muscles or a blockage. The bladder is always full and urine dribbles out constantly.

   Symptoms: Bladder never empties. Urine leaks out all the time. There is a weak stream of urine when using the toilet— only small amounts come out even though the bladder is full. The urine doesn't want to come out. Sometimes urine backs up into the kidneys which is dangerous.

4. **Functional Incontinence** means not being able to get to the toilet in time because of problems with moving, thinking, and communicating.

   Symptoms: Memory problems like Alzheimer's disease may prevent timely trips to the bathroom. Physical conditions like severe arthritis can cause delays with walking or removing clothing. Inconvenient bathrooms and poor toilet equipment (lack of handrails or small doorways) can make it difficult for those who need wheelchairs or walkers to get to the toilet in time.

5. **Reflex Incontinence** means there is no urge sensation to urinate. The bladder just empties when full.

   Symptoms: Loss of urine at inappropriate times. Birth defects like spina bifida, a spinal cord injury or surgery can cause loss of sensation to urinate.

A combination of incontinence types is called **Mixed Incontinence**. Women and older adults tend to have both stress and urge incontinence. Men are more likely to have a combination of overflow and urge incontinence.

WHAT ARE THE RISK FACTORS?

Anyone can develop urinary incontinence, but there are certain risk factors that make it more likely. Sometimes, several things combine to cause urinary incontinence.

- For example, a woman may have a history of diabetes, be overweight, and have a severe cough because of smoking. All of these might contribute to her incontinence problem.

PHYSICAL CONDITIONS THAT INCREASE THE RISK:

- **Having had a hysterectomy.** About half of all women who have had a hysterectomy report developing urinary incontinence.
- **Obesity or being overweight.** Extra weight puts pressure on the pelvic floor. This can weaken the muscles and lead to "accidents."
- **Enlarged prostate.** An enlarged prostate can block the urethra, making urine back up into the bladder until small amounts leak out constantly.

DISEASES OR ILLNESSES THAT INCREASE THE RISK:

- **Chronic cough.** A chronic cough that lasts for many years can stretch the pelvic floor and may even make tiny tears in the muscles.
- **Pelvic organ prolapse.** This is when the "hammock" can no longer hold the pelvic organs in place. Up to 60% of women with pelvic organ prolapse also report having urinary incontinence.
- **Diabetes.** Diabetes can lead to nerve damage, which includes the nerves in the bladder and bowel. This causes episodes of incontinence.
- **Parkinson's disease.** The main symptoms of PD are shaking, rigidity (stiffness), slowness, and unsteadiness. These symptoms can make it difficult to make it to the bathroom in time.
- **Alzheimer's disease.** People with AD may not recognize a full bladder. They may forget where the toilet is located or even how to use it.
- **Stroke.** After a stroke, it may be difficult to sense a full bladder—or control it. If speech is affected, they may be unable to communicate their need to use the toilet.

OTHER FACTORS THAT INCREASE THE RISK:

- **Certain Medications.** Taking diuretics (water pills), certain antidepressants, some blood pressure lowering medication, antihistamines (like Benadryl), or hormone replacement therapy (particularly estrogen) increases the likelihood of incontinence.
- **Smoking.** Smoking causes chronic coughing which can damage the pelvic floor. The chemicals in cigarettes are also known to be bladder irritants, which could cause overactive bladder symptoms.

CONNECT IT!

IS AGE A RISK FACTOR?

Becoming incontinent is NOT a normal part of aging. However, there are certain age-related changes that make incontinence more likely. They are:

- Elderly people may feel the need to urinate only when the bladder is almost full. (Most younger people feel the need to "go" when the bladder is only about half full.)
- As people get older, they produce more urine at night—2/3 of the fluids drunk during the day are made into urine at night. So, one or more bathroom trips at night are normal.
- And, as people age, their bladders shrink a bit, so they can't hold as much urine.

Urge incontinence is most common in people over age 60—4 out of every 10 women and 2 out of every 10 men experience it.

Incontinence is one of the major reasons that elderly people are put in nursing homes. It's second only to dementia.

THE NEXT STEP!

DOING KEGEL EXERCISES

If the doctor recommends that your client do Kegel exercises, you can help!

Teach your client to:

1. **Locate the muscle.** To identify the pelvic floor muscles, instruct your client to stop urination in midstream. If she succeeds, she found the right muscles!
2. **Tell her to remember that feeling.** Then, when she's not urinating, instruct her to tighten that pelvic floor muscle, hold the contraction for five seconds, and then relax for five seconds.
3. Have her work up to keeping the muscles ***contracted for 10 seconds, then relaxing for 10 seconds.***
4. **Repeat three times a day.** Aim for at least three sets of 10 repetitions a day.

DIAGNOSIS AND TREATMENT

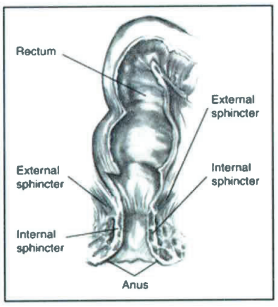
To diagnose urinary incontinence, doctors will do a complete physical exam and may order several kinds of tests, including:

- **Urinalysis.** A urine sample is tested for signs of infection.
- **Cystoscopy.** A tiny camera is used to see the bladder and urethra.
- **Post-void residual measurement.** The doctor checks the amount of leftover urine in the bladder (just after a person voids) using an ultrasound machine.

Treating incontinence depends on what type each person has and how bad the symptoms are. Here are some options:

- **Surgery.** There are many surgeries—some are more complicated than others. In one way or another, these operations support the bladder and urethra or put them back into their original position within the abdomen. Doctors usually do this as a last resort.
- **Medications**. There are many drugs to help control incontinence—too many to list! Some common brand names are: Detrol, Ditropan, Vesicare and Myrbetriq. These drugs relax the bladder muscle. (Estrogen may help women by making the bladder and urethra less sensitive.) Drug therapy may help urge or stress incontinence. It also helps with an overactive bladder.
  - ⇒ **Side effects**—Dry mouth and eyes, headache, constipation, indigestion, blurred vision, changes in heart rhythm, nervousness, and low blood pressure.
- **Biofeedback.** This teaches people how to listen to their bodies and change their habits by using computer equipment and measuring devices. It can be done at home or in the hospital.
- **Behavioral Therapy**. Behavior training programs teach people how to control their bladders and to use the toilet at the right time. These methods include:
  1. **Bladder retraining** to teach normal toileting patterns.
  2. **Scheduled Toileting** to set up timed toileting on a fixed schedule (whether or not the person has to go).
  3. **Habit Training** to match the toileting schedule to a person's needs and habits.
  4. **Prompted Voiding** to make people more aware of their need to urinate and to ask for help from a caregiver.

A CLOSER LOOK AT BOWEL INCONTINENCE



WHEN EVERYTHING WORKS PROPERLY . . .

The digestive system pushes food through the intestines by a series of muscular contractions (called peristalsis). Food passes from the stomach into the small intestine. This is where the nutrients are absorbed. What's left passes into the large intestine (or colon). The colon's job is to store, process, and get rid of waste.

The waste travels to the rectum. ***Nerves*** in the rectum trigger a message to the brain letting the person know the bowel is ready to be emptied. Circular muscles called ***sphincters*** close tightly like rubber bands around the anus until the person is on the commode. Pelvic floor muscles also help keep the stool in the body until the appropriate time to eliminate.

WHAT CAN GO WRONG?

- **Sphincters Stop Working.** There are two sphincters, the external and internal sphincters, that help keep stool in place until it's time to release it. If one or both of the sphincters are damaged , they may not be strong enough to prevent stool from leaking. Childbirth, injury, anal cancer, hemorrhoid surgery, and chronic constipation can all damage the anal sphincters.
- **Nerve Damage.** If the nerves that sense a full rectum are damaged, a person may not feel the urge to go to the bathroom. Childbirth and spinal cord injuries can damage the nerves. In addition, diseases that are known to damage nerves, such as diabetes and multiple sclerosis can also damage the nerves in the rectum and lead to incontinence.

THINK ABOUT IT!

There are three main types of bowel incontinence:

- **Passive incontinence**—Passing stool without any awareness of it at all.
- **Urge incontinence**—Passing stool in spite of attempts to "hold it."
- **Fecal soiling**—Staining of underwear without loss of significant amounts of fecal stool.

Bowel incontinence is further categorized by its severity. The severity is related to:

- The frequency of incontinence
- The type of stool lost
- The volume of stool lost

Think about a client you care for that has bowel incontinence. What type do you think he or she has? What is the severity?

GET OUT!

THINK OUTSIDE OF THE BOX!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

THE PROBLEM: You are caring for Robert, an 84-year-old man who is showing increasing signs of bowel incontinence.

When you suggest the use of adult briefs to Robert, he gets angry and tells you he doesn't need baby diapers.

WHAT YOU KNOW: You know Robert's incontinence is embarrassing to him but you also know it's putting him at risk for other problems.

GET CREATIVE: Think of 3 creative solutions you might try to help Robert with his problem while also helping him maintain his dignity.

TALK ABOUT IT: Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

RISK FACTORS FOR BOWEL INCONTINENCE

Just like urinary incontinence, anyone can have a problem with bowel control. But, whether it's an occasional accident or a chronic problem, certain people have a higher risk of developing bowel incontinence.

DISEASES OR ILLNESSES THAT INCREASE THE RISK:

- **Neurologic conditions.** Diseases or illness that affect the nervous system, such as stroke, multiple sclerosis, spinal cord injury, and spina bifida can increase the risk for bowel incontinence.
- **Dementia and Alzheimer's Disease.** Seniors with dementia or AD are four times more likely to have fecal incontinence than those without.
- **Diabetes.** Complications of diabetes cause nerve damage leading to incontinence.
- **Chronic Bowel Disorders.** People with Crohn's disease, ulcerative colitis, and irritable bowel disease may develop fecal incontinence.

OTHER FACTORS THAT INCREASE THE RISK:

- **Being a woman.** Most studies suggest that women are more likely to suffer from bowel incontinence than men. This is likely due to damage that occurs during childbirth. About 6% of women younger than age 40 report problems and 15% of women older than 65 years are predicted to suffer.
- **Aging.** Losing bowel control is not a normal part of aging, but age-related changes increase the risk. Age-related changes that increase the risk include muscle loss, decreased strength, and decreased mobility.

SOMETIMES, IT'S NOT REALLY INCONTINENCE

Occasionally, you may see uncontrollable leakage of liquid stool in someone who was not previously incontinent. This is common in people with chronic constipation and may be a sign that the person has a fecal impaction.

- A fecal impaction is a large lump of dry, hard stool that remains stuck in the rectum. It is most often seen in patients with long-term constipation or those who over-use laxatives.
- A common sign of fecal impaction is the leakage of watery stool. As the lump of stool sits in the colon, liquid stool begins to build up behind it. Eventually small amounts seep around the impaction and "leak" out.
- Report this symptom right away so that the process of removing the impaction can be started right away.

HOW IS BOWEL INCONTINENCE TREATED?

Treatment for bowel incontinence depends on what is causing it. Some treatment options include the following.

MEDICATIONS.

- **Antidiarrheals.** If chronic diarrhea is the problem, then drugs such as Imodium and Lomotil may help.
- **Laxatives and Stool Softeners.** When chronic constipation leads to bowel incontinence, medications such as Citrucel, Metamucil, and MiraLax may be prescribed.

DIETARY CHANGES

- **Adding Fiber to the Diet.** If constipation is the culprit, the doctor may suggest drinking plenty of fluids and eating fiber-rich foods. If diarrhea is contributing to the problem, high-fiber foods can also add bulk to stools and make them less watery.

OTHER THERAPIES

- **Biofeedback.** With this therapy, people learn how to strengthen pelvic floor muscles, sense when stool is ready to be released, and practice contracting the muscles.
- **Bowel training.** This type of therapy helps the person to establish a regular time to empty his or her bowels, and to find ways of stimulating the bowels to empty.
- **Sacral nerve stimulation (SNS).** The sacral nerves run from the spinal cord to the pelvis and regulate the sensation and strength of the rectal muscles. SNS involves implanting a device that sends small electrical impulses continuously to these nerves to strengthen the muscles.
- **Vaginal balloon.** This treatment involves inserting an inflated balloon into the vagina. The balloon puts pressure on the rectal area, leading to a decrease in the number of episodes of fecal incontinence.

SURGERY

- **Sphincteroplasty.** This procedure repairs a damaged or weakened anal sphincter.
- **Treating rectal prolapse, a rectocele or hemorrhoids.** Surgical correction of these problems will likely reduce or eliminate fecal incontinence.
- **Sphincter replacement.** A damaged anal sphincter can be replaced with an artificial anal sphincter.
- **Colostomy.** This surgery diverts stool through an opening in the abdomen. Doctors attach a special bag to this opening to collect the stool. Colostomy is only considered when other treatments have failed.

TALK ABOUT IT!

IS IT REALLY CONSTIPATION?

Many older adults believe they have to move their bowels every day.

The fact is, you don't have to have a bowel movement every day to be healthy.

So, what's normal?

⇒ It is normal to have a range of 1 to 2 bowel movements per day but it can be as infrequent as every 3 to 4 days.

Here are the signs of true constipation:

- Going more than 3 days without a BM.
- Having lumpy or hard stools.
- Straining to have bowel movements.
- Small, dry, or pellet-like stools.
- Feeling as though you can't completely empty the stool from your rectum.

COMPLICATION: URINARY TRACT INFECTIONS

Chronic urinary tract infections (UTIs for short) are common in people who are incontinent of bowel and/or bladder. Loss of bladder or bowel control can lead to sitting in wet or soiled garments. This can lead to frequent infections.

WHAT IS A UTI?

A UTI is any infection that involves the urinary system. Two common types are:

- **Cystitis.** The most common type of UTI is known as cystitis. This is an infection of the urinary bladder. This is the infection most people think of when they say "UTI."
- **Pyelonephritis.** This infection is commonly referred to as a "kidney infection." It usually results from a bladder infection that travels through the ureter to the kidney.

WHAT ARE THE SYMPTOMS?

- **Urgency.** An urgent need to urinate, with only a few drops of urine to pass.
- **Frequency.** The need to urinate often, usually at least once every hour.
- **Pain.** A burning feeling during urination, or lower abdominal, stomach, or back pain.
- **Abnormal Urine.** Cloudy or blood-tinged urine, or urine with a strong odor. **Fever.** Fever is the body's way of fighting an infection.
- **Nausea and/or vomiting.** If the infection has spread to the kidneys, the person may have nausea, vomiting, and complaints of pain in the lower back.
- **Behavior changes.** You may notice behavioral or mental changes in your elderly clients. Sometimes this is the ***only*** sign that something is wrong. A UTI can cause:
  - Agitation, confusion, and restlessness.
  - Balance problems, dizziness, falls.
  - Lethargy (sleeping more than usual).
  - Decreased appetite.

WHAT CAN YOU DO?

- **Wash your hands** before providing personal care and wear gloves when cleaning the genital area.
- **Change soiled clothing and briefs right away.** Sitting in a soiled brief is the #1 cause of UTIs in people with incontinence.
- **Try putting your client on a "bathroom schedule."** Regular toileting may help incontinent clients avoid accidents (and sitting in soiled clothing).
  - ⇒ Remind clients to void at least every 2 to 3 hours during the day and to completely empty the bladder. "Holding it" increases the risk for incontinence and a UTI.
- **When a client asks for help to get to the toilet, don't delay!** Your promptness may prevent an accident *and* a UTI!
- **Always clean your client carefully after each bowel movement**—wipe front to back to prevent germs in the stool from getting near the urethra.
- **Recognize and report the signs of a UTI right away.** Early recognition of UTI and prompt treatment are essential to prevent recurrent infection and the possibility of complications. Some dangerous complications that may occur include **renal failure** and **sepsis**.

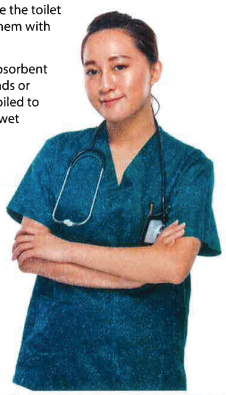
FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. More than half of all residents in nursing homes suffer from either bowel or bladder incontinence. Many suffer from both.
2. Chronic urinary tract infections (UTIs for short) are common in people who are incontinent of bowel and/or bladder.
3. Caring for incontinent clients can be overwhelming. It's one of the main reasons families seek long term care help in the first place.
4. Being incontinent is embarrassing. Be patient and understanding with those who suffer.
5. Depression is a common problem for incontinent people. Watch for and report any signs right away.

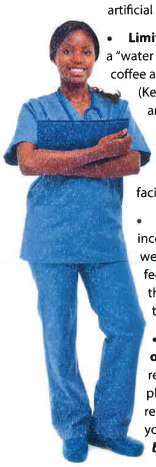
TIPS FOR HELPING INCONTINENT CLIENTS

- **Be patient and understanding with your incontinent clients.** They can't help having accidents. There is a reason behind their urinary problems. Remember that they don't do it on purpose just to annoy you!
- **Try to toilet your client on a regular schedule.** Reminding your client to use the bathroom every two to three hours will prevent "emergencies" and "accidents."
- **Make it safe!** For those clients who can self-toilet, be sure to clear a direct path to the bathroom. It will prevent falls and help them make it there in time!
- **Light the way.** It's a good idea to help your clients prevent falls by placing night lights along the path to the bathroom.
- **Make sure your clients can easily use the toilet**—provide grab bars and a raised toilet.
- **Encourage your clients to wear clothing that's easy to remove!** Suggest elastic waistbands for slacks and skirts and Velcro instead of buttons, snaps, and hooks.
- **Use sign reminders.** For clients with Alzheimer's disease and dementia, hang a sign with the word "toilet" and a picture of a commode on the bathroom door so they know where it's located. You may have to remind them to use the toilet every two to three hours and help them with their clothing.
- **Stay dry.** If your clients must use absorbent products, be sure to change their pads or diapers as soon as they are wet or soiled to prevent skin breakdown. If left in a wet diaper, your client may get rashes, pressure injuries and/or infections like UTIs.
- **Take extra good care of your client's skin.** It's important to wash the skin with a mild soap like Dove after each urine or bowel occurrence.
- **Air it out!** After washing your client, it's best if you let their skin air dry rather than rubbing it with a towel—this will help avoid skin tears and irritation that may cause sores or infection.



FINAL TIPS ON INCONTINENCE

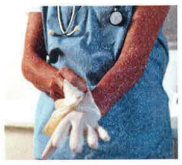
- **Encourage your client to drink plenty of liquids**—at least 6 to 8 glasses of liquid a day. Suggest that they drink throughout the day—not all at once! Too much fluid at one time can stress the bladder.
- **Slow down in the evening.** If nocturia (urination at night) is a problem, remind your client to stop drinking fluids after dinner.
- **Don't stop altogether!** Drinking fewer fluids won't get rid of incontinence. In fact, it may make it worse. It can lead to both UTIs and constipation. (Constipated bowels put pressure on the bladder and make urinary incontinence worse.)
- **Include fiber in the diet.** If you cook for your clients, fix them foods with high fiber content like bran, whole grain breads, fresh fruits and vegetables, and leafy greens.
- **Avoid these foods.** Foods that can make incontinence worse include, alcoholic drinks (wine & beer), soda, citrus fruits & juices, spicy foods, artificial sweeteners, and tomatoes.



- **Limit caffeine intake.** Caffeine is a natural diuretic (like a "water pill") and it irritates the bladder. Drinking a lot of coffee and tea will cause frequent trips to the bathroom. (Keep in mind that caffeine is in chocolate, soft drinks, and some over-the-counter medications, too.)
- **Exercise is important too!** After checking with your supervisor, try exercising with your client. Take a walk around your client's home, within your facility, or even outside.
- **Be aware!** Depression is a common problem for incontinent people. Signs of depression include weight loss or gain, lack of energy, overwhelming feelings of sadness, anxiousness, sleeping more or less than usual, loss of interest in usual activities, and thoughts of suicide.
- **Caring for incontinent clients can be overwhelming.** Remember, it's one of the main reasons families seek long term care help in the first place. Do your best to help your clients, but remember...accidents will happen no matter how hard you try to prevent them. ***Be patient, take a deep breath, and move on!***

WHAT I KNOW NOW!

Now that you've read this inservice on Incontinence, jot down a couple of things you learned that you didn't know before.



COURSE OUTLINE

inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

An Infection Control Module:
Standard Precautions

WILL YOU DO THE RIGHT THING?

You work in a germ factory! Your clients, their environment, and even your co-workers carry, grow and spread germs everywhere. Some of these germs can be serious. And, some can even be deadly.

Because you spend so much time in the germ factory, your chances of being exposed are pretty good. You might pick up a germ by *touching* it, *breathing* it, or by having a *droplet* land on the mucus membrane in your nose or eye.

Once you've been exposed, you may become infected. That's when you actually get sick from the germ. Or, you may never get sick, but unknowingly pass the germ on to someone else who will get sick.

This cycle is known as the ***chain of infection.*** It's a pretty tough cycle to break. But, the good news is . . . there is a proven method to keep yourself and others safe. It's called **Standard Precautions.**

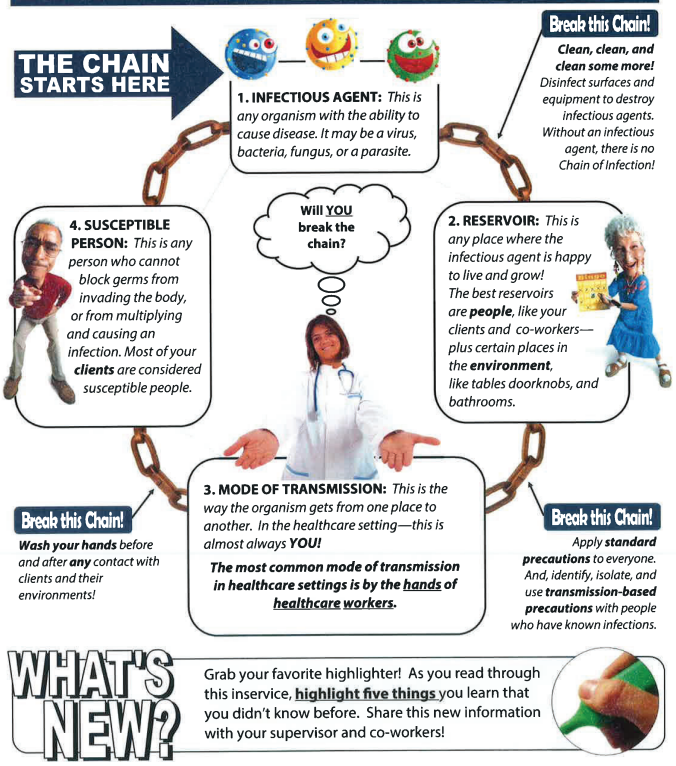
STANDARD PRECAUTIONS are basic infection control guidelines for you to follow as you perform your daily work. Standard Precautions include:

- Washing your hands.
- Using protective equipment like gloves, gowns, and masks.
- Handling infectious waste material properly.

Standard Precautions are written and regulated by OSHA (the Occupational Safety and Health Administration). It is important to remember that ***OSHA regulations are federal law.*** This makes following Standard Precautions guidelines ***mandatory*** within all U.S. healthcare facilities.

Unfortunately, no one is going to follow after you and remind you to wash your hands or put on a gown and gloves before handling bodily fluids. It's completely up to you to **DO THE RIGHT THING** and follow standard precautions to protect yourself and others from infection.

THE CHAIN OF INFECTION



WHAT'S NEW?

Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!

OVERVIEW OF PRECAUTIONS

STANDARD PRECAUTIONS: Standard precautions are the "common sense" infection control guidelines you should follow as you perform your daily tasks with clients. (See detailed the TOP TEN guidelines on page 4.)

Standard Precautions apply to **all** your clients, no matter what their diagnosis—even if they don't seem sick!

Standard Precautions means you ***assume all blood, body fluids, secretions, open wounds, and mucous membranes contain an infection***, and use:

- **Gloves** – As needed, to protect hands your hands.
- **Gowns** – As needed, to protect your skin and clothing.
- **Masks** – As needed, to protect you mouth and nose.

RESPIRATORY HYGIENE AND COUGH ETIQUETTE: This is a fairly new recommendation from the CDC that applies to everyone with a cough or cold symptoms, especially those with fever. It requires that everyone cover their noses and mouths with a tissue or the inside of the elbow when coughing or sneezing, dispose of tissues properly, and perform frequent hand washing.

TRANSMISSION-BASED PRECAUTIONS: These are the guidelines used when a client has a ***highly contagious infection***. Transmission-based precautions include:

PRECAUTION	WHAT EQUIPMENT IS NEEDED?	WHEN IS THIS USED?
Contact Precautions	Gloves and gown must be worn for all contact with the client and the client's environment.	MRSA, VRE, e-coli, pink eye and hepatitis A.
Droplet Precautions	A mask must be worn for all contact within three feet of the client.	Pertussis, flu, strep throat, mumps, and rubella.
Airborne Precautions	A mask must be worn when ever you are in the same room as the client.	Measles, chickenpox, and shingles.
Expanded Airborne Precautions	A fit tested respirator must be worn for all contact with the client.	Tuberculosis (TB), smallpox and SARS

(See detailed descriptions of transmission precautions on pgs. 5-7.)

LOOK HOW FAR WE'VE COME!

- In the 1830s, most people believed that sunlight and *fresh air* killed germs.
- Up until the mid-1800s, surgeons rarely washed their hands or a patient's skin before surgery. Surgical instruments were only *rinsed* and sponges were reused.
- In 1860, Joseph Lister began to spray carbolic acid on surgical wounds, instruments, and dressings. This reduced the number of deaths from surgery.
- Gloves were first used in the early 1900s to protect nurses' hands from chemicals used during surgery. Years later, gloves became a barrier, protecting patients and healthcare workers from infection.
- Until 50 years ago, patients with all different kinds of diseases stayed in the same room or ward.

In another hundred years, people will look back at the way things are done today. What do you think they will consider absurd or crazy about the way we did things in the 2000's?

What changes do you think will happen in this century to improve infection control?

STANDARD PRECAUTIONS TOP TEN LIST

Here are the **TOP 10 STANDARD PRECAUTIONS** guidelines (recommended by the CDC) that you must follow at all times—for *every client* in *every situation*—even if the person doesn't seem sick.

#1. WASH YOUR HANDS! Wash your hands before and after any contact with the client or the client's environment.

- In addition, you must wash your hands before putting on gloves and after taking them off. Wearing gloves is not a substitute for washing your hands.

#2. WEAR GLOVES! Wear gloves when you have to touch blood, body fluids, secretions, excretions, contaminated items, mucous membranes, or any non-intact skin (example: cuts, wounds, stitches).

- Situations when gloves must *always* be worn include mouth care, assisting with toileting, cleaning up spills, cleaning urinals or bedpans, and disposing of waste.
- Remove gloves when finished with the procedure. Never leave the client's care area with dirty gloves on your hands. Avoid touching clean objects, such as doorknobs, light switches, computer keyboards, or your pen while wearing used gloves.

#3. WEAR A GOWN. Wear a disposable gown as needed to protect your skin and clothing from getting splashed with blood or body fluids.

- Wear a *waterproof* gown if you are likely to be heavily splashed with body fluids.
- Remove your dirty gown and wash your hands before leaving the client care area.

#4. WEAR A MASK OR GOGGLES. Wear a mask and eye protection as needed to protect your mucous membranes if you might get splashed or sprayed by blood or body fluids.

- Situations when you might get sprayed or splashed include emptying bedpans and urinals, suctioning, and emptying a catheter bag.

#5. USE GLOVES AND CAUTION WITH SHARPS! Wear gloves and practice extreme care when handling needles, razor blades, or any other "sharp" object.

- Never attempt to re-cap a needle or syringe. If you find one, carefully pick it up and dispose of it in a designated biohazard waste box.
- Always wear gloves when shaving clients.

#6. DISINFECT THE ENVIRONMENT. Routinely clean environmental surfaces, especially frequently touched surfaces like table tops, the remote control, telephone, bed rails, door knobs, and light switches.

#7. DISPOSE OF CONTAMINATED WASTE. Waste containing blood or body fluids is considered a biohazard and should be disposed of according to your workplace policy.

- Put on gloves before handling biohazardous waste. Remove gloves and wash your hands after disposing of biohazardous waste.
- In general, liquids can be flushed through the regular sewer system. Solid wastes, such as soiled wound dressings must be placed in specially marked biohazard bags and removed by professional biohazard waste removal services. Local, state, and federal regulations outline how biohazardous waste is handled in your area.

#8. DISINFECT SHARED CLIENT EQUIPMENT. Carefully clean equipment every time it must be used from client to client, such as thermometers, blood pressure cuffs, bed pans, bedside commodes, walkers, and wheelchairs.

#9. CLEARLY LABEL SPECIMENS. Label all specimens, such as urine, stool, or sputum as biohazardous by placing in a specified biohazard container and sealed bag for transport.

#10. USE A MOUTHPIECE FOR CPR. Use a mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions when performing CPR.

A CLOSER LOOK AT CONTACT PRECAUTIONS

Diseases that are spread by contact transmission are spread by people directly or indirectly touching the germ. **Direct contact** means that the skin of an *infected* person touches the skin of an *uninfected* person. **Indirect contact** means that an uninfected person touches an *object* that has been touched by an infected person.

When a client is on Contact Precautions: Gloves and gown must be worn for all contact with the client and the client's environment.

Studies have shown that in healthcare facilities, the most common way infections are spread is by indirect contact from the hands of healthcare workers!

Here are some examples of contact transmission:

- Without wearing gloves, you change the clothes of a client who has a rash infected with staph germs (MRSA). Then, you bathe your next client without washing your hands and without wearing gloves.
- You wear gloves when you turn a client with scabies, but since the gloves are still dry, you forget to change them for the next client.

FOR CLIENTS ON CONTACT PRECAUTIONS, YOU SHOULD:

- Place clients with contact infections in a private room or with other clients who have the same kind of infection.
- Put on gloves and gown just before you enter the client's room (or home).
- Change your gloves during client care, especially after contact with highly contaminated items.
- Remove the gown right before leaving the area. Place used gowns in a specially marked biohazard laundry or trash bag—even if the gown does not seem soiled. Never reuse gowns for isolation precautions.
- Take your gloves off right before you leave the client's room (or home). Be careful not to touch contaminated items on your way out and wash your hands immediately!
- Avoid taking personal items, like your pen, stethoscope, sweater, or cell phone into the care area of a client on contact precautions. This will keep you from carrying the disease to your home or out into the community.
- Disinfect any client care equipment used on a client with a contact infection.

Open the Discussion

WHAT'S STOPPING YOU?

Take a poll of your co-workers. Ask which of the following situations is the most likely reason they would give for *not* washing their hands.

❑ **Skin Irritation:** The soap is too harsh and damages the skin.

❑ **Supplies are not available:** Sinks are not conveniently located or are not stocked with soaps and towels.

❑ **Urgent or emergency care:** The client needs immediate care, there is no time to wash hands.

❑ **Wearing of gloves:** The belief that if gloves were worn, hands do not have to be washed after client care.

❑ **Not enough time:** High workload and understaffing.

Now, take your findings to your supervisor. There may be an easy solution! For example, if the reason is that the soap is too harsh, a different brand may be tested.

Your employer deserves to know the truth so the situation can be fixed.

A CLOSER LOOK AT AIRBORNE PRECAUTIONS

Some diseases are known to be spread by airborne transmission. This means that the germs that cause these diseases are so tiny that they can float in the air for long periods of time. These germs can also "catch a ride" on dust particles, traveling wherever the dust particles go. So, keep in mind:

- Germs that are spread by airborne transmission can travel across a room or even farther.
- Airborne germs can be helped to spread by things like an electric fan.
- Airborne diseases are often very contagious since the germs can travel a long way and be breathed in by many people.
- **Expanded Airborne Precautions:** Some airborne diseases, like TB and SARS are more difficult to control. It's not enough to just wear a mask. You have to be fitted with a special ***respirator mask*** to care for these clients. And, special air ventilation must be used to prevent the spread of germs outside of the room.

When a client is on Airborne Precautions: A mask must be worn whenever you are in the room with the client.

These precautions are used ***in addition to*** Standard Precautions for clients who have (or might have) airborne infections.

It's important to know if you are immune to certain airborne infections like measles or chickenpox. If you are, you can work with infected clients without worrying about getting the disease yourself. You still have to follow all infection control precautions ordered for that client.

FOR CLIENTS ON AIRBORNE PRECAUTIONS, YOU SHOULD:

- Place them in private rooms or in rooms with patients who have the same diagnosis. Some facilities have rooms with special air filter systems for clients on Airborne Precautions.
- Keep the door to their room closed.
- Wear a special respirator mask when you work with clients who have (or might have) TB.
- Encourage them to cover their nose and mouth with a tissue or the inside of the elbow when sneezing and coughing.
- Put surgical masks on these clients if they need to be around uninfected people for a short period of time.
- Avoid transporting these clients unless at is absolutely necessary. If the client must be moved, cover the mouth with a surgical mask to reduce the risk of spreading germs.

GET OUT!

Thinking outside the box!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **THE PROBLEM:** You are caring for a 79-year-old woman who currently suffers from shingles. She has the itchy rash on her abdomen and back with some smaller patches on her arms and face.
- The nurse has asked you to keep the rash covered as much as possible and has placed the client on airborne precautions.
- **WHAT YOU KNOW:** You know that shingles comes from the virus that causes chickenpox. Since you have never had chickenpox, you know that you may not be immune to it. You also know the client has a new granddaughter who is too young to have gotten vaccinated yet.
- **GET CREATIVE**: Think of **3 creative solutions** you might try so you can provide the best possible care to your client while keeping yourself and your client's granddaughter from getting sick.
- **TALK ABOUT IT:** Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

A CLOSER LOOK AT DROPLET PRECAUTIONS

Some diseases are spread through droplet transmission. These germs fly through the air, but are **too heavy** to float. They drop quickly—and so it's called "droplet" transmission. Because droplets are too heavy to float, they usually don't travel more than three feet. These diseases are commonly spread during coughing, sneezing, and talking. Here are examples of droplet transmission:

- You might be transferring a client with the flu and he sneezes on you. The droplets from the sneeze go in your eyes.
- You are bathing a child with the mumps. She coughs and the droplets from her cough spray up into your nose.

When a client is on Droplet Precautions: A mask must be worn for all contact within three feet of the client.

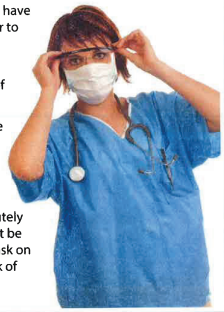
These precautions are used ***in addition to*** Standard Precautions for clients who have (or might have) infections spread by droplets.

Remember that droplets can only travel a *short* distance, but you can get "hit" by many droplets at once because:

- A sneeze zooms out of the nose at over 100 miles per hour!
- A cough sends out an explosion of air going over 60 miles per hour!

FOR CLIENTS ON DROPLET PRECAUTIONS, YOU SHOULD:

- Place them in private rooms or in an area with other clients who have the same disease. (The door to their room may stay open.)
- Wear a surgical mask when working within three feet of the client.
- Put surgical masks on these clients if they need to be around uninfected people for a short period of time.
- Resist moving them from the room unless it is absolutely necessary. If the client must be moved, place a surgical mask on the client to reduce the risk of spreading germs.



CONNECT it now!

Apply what you know

KEEPING EVERYONE SAFE

You work in health care . . . so you understand the importance of standard precautions and you know what to do when a client is on isolation for transmission-based precautions.

Unfortunately, your clients' visitors may not understand the seriousness of the situation.

How would you explain to a visitor the importance of washing hands before and after the visit?

_____

_____

_____

_____

What would you say to a visitor who refuses to wear a gown and gloves when visiting a client on contact precautions?

_____

_____

_____

THE FACTS ABOUT HANDWASHING

Scientists have known for more than 100 years that handwashing helps prevent infection. Yet, people continue to get sick because hands are not washed often enough.

The handwashing procedure at your workplace probably calls for you to wash your hands for 30 to 60 seconds. Yet, studies have shown that most health care workers spend *less than 15 seconds* washing their hands. Why? The reasons given include:

- *"I don't have time to keep washing my hands all the time."*
- *"My skin gets dry if I wash my hands too often."*
- *"There's never a sink around when I need to wash my hands."*
- *"I don't need to wash my hands. I wear gloves."*

ALCOHOL BASED HAND SANITIZERS

In 2002, the CDC approved the use of alcohol based hand rubs in healthcare facilities. These waterless hand sanitizers eliminate some of the problems that health care workers face when taking care of clients.

- Alcohol based hand rubs are faster because you can rub your hands while you are moving between clients.
- Hand rubs are gentler and do not cause the irritation, drying, and cracking you find with hand soaps.

To use: Place a small amount in the palm of one hand. Rub hands together, being sure to cover all surfaces of hands and fingers. ***Rub until hands are dry.***

- Only use waterless hand rubs when hands are *not* visibly soiled. If hands are visibly soiled, always wash with soap and water.

REMEMBER!

- Keep your fingernails clean and short. You should avoid wearing nail polish or artificial nails.
- Do not wear rings or other hand jewelry. The skin underneath will have more bacteria because jewelry can block soap and water from reaching those areas.
- Make sure that you cover any cuts or abrasions with a waterproof dressing.
- Be sure to wash your hands before and after wearing gloves. Wearing gloves does *not* take the place of handwashing.

THINK about it!

ARE YOU ALLERGIC TO YOUR GLOVES?

Latex allergies develop over time with repeated or prolonged exposure. So, while you may not have been allergic to latex in the past, there is a chance you could develop a latex allergy in the future.

Latex contains certain ***proteins*** that cause allergic reactions. At least 10 different proteins have been linked to allergic reactions.

Other chemicals in gloves, known as *accelerators* and *antioxidants* may also cause allergic reactions.

Typical allergic reactions to latex include ***itching, hives, swelling, and runny nose.***

More serious symptoms may involve ***wheezing***, difficulty breathing, nausea, heart palpitations, decreased blood pressure, and ***anaphylactic shock***.

Ask your supervisor for latex-free gloves if you are experiencing a latex allergy.

HANDLING CLIENT CARE EQUIPMENT

Client care equipment includes everything you use during your work with a client such as thermometers, blood pressure cuffs, bath basins, bed pans, bedside commodes, walkers, and wheelchairs.

Carefully clean any equipment that must be used from one client to another. If possible, limit equipment to only a single client. Any "used" client care equipment should be cleaned according to your workplace policy.

- If you work in a facility, you probably use a product like Cavicide® to clean equipment and surfaces. Be sure to read the label and follow the directions carefully. Always wear gloves when using these products to prevent damage to your skin.
- If you work in clients' homes, common products that are available in grocery stores should work. Read the label and look for products that list staph and e-coli among the "germs" it kills.
- Remember that sponges and cleaning rags carry lots of germs. If you "clean" client areas with a dirty sponge, you might just be spreading germs around. Be sure to change your sponge or rag frequently.
- If a client care item is only meant to be used once, be sure to throw it away after using it.
- Dishes and silverware used by clients with bloodborne diseases do not have to be washed separately. Regular dishwashing soap and hot water will kill bloodborne germs.

LINENS AND BEDS

- Do not *shake* dirty client linens. Instead, roll them up and place them in a hamper or bag for cleaning.
- Be careful when you handle dirty linens so that you don't soil your clothes. Hold dirty linen *away* from your body.
- Linen that is soiled with blood and/or other body fluids should be washed according to your workplace policy. It does not have to be washed separately from other laundry.
- In the home, clothing and bedding should be machine washed often and thoroughly. Machine drying instead of hanging (to air-dry) works much better at killing germs.

THE NEXT step!

Apply what you've learned!

WHAT IF YOU ARE EXPOSED?

Ask your supervisor for the written policy and procedure on what you should do if you are exposed to bodily fluids. Then, answer the following questions:

If I am stuck by a used needle, I should:

_____

_____

_____

If I get bodily fluid splashed in my eyes, I will:

_____

_____

_____

If I have been exposed to a client who is later found to have TB, I should:

_____

_____

_____

If I have an open wound, I will:

_____

_____

_____

HANDLING BIOHAZARDOUS WASTE

Biohazardous waste is any waste that has been contaminated with germs that can cause disease. It includes things like:

- Discarded wound dressings.
- Used needles.
- The contents of a bedpan, urinal, or Foley catheter bag.
- Gowns and gloves used on clients with transmission based precautions.

Follow your workplace policies and procedures for disposing of biohazardous waste. Here are some general guidelines:

- Bodily wastes like urine, stool, or vomit can be flushed through the regular sewer system. Be sure to empty contents into the toilet—not the sink or tub.
- Solid wastes should be bagged in an appropriately labeled red plastic biohazard bag.

DISPOSING OF SHARPS

Be extra careful with any client care equipment that might cut or stick you.

- Never recap used needles.
- Use only one hand or a mechanical device and hold the needle with the point away from any part of the body.
- Never remove used needles from disposable syringes by hand.
- Never bend or break needles by hand.
- Used "sharps" must be disposed of in a puncture-resistant container.

In the Home: Official sharps containers are available for sale at most home health supply stores and can be found online.

In some states, it is okay to use a hard plastic container, like a soda bottle or bleach bottle with a screw top lid for sharps disposal. Check the law by contacting your county Department of Health.

Do You Recognize This Symbol? It's the symbol for *biohazardous waste.* Never put your bare hand into a bag or other container marked with this symbol! These containers are used to dispose of used sharps and infectious waste.

It is estimated that each year 385,000 needlesticks happen to healthcare personnel. That's an average of over 1,000 per day!

5 KEY points

Key Points to Remember

1. You work in a germ factory! You are constantly surrounded by germs. Some may be serious, and some may even be deadly.
2. Using **Standard Precautions** is the only proven way to protect yourself and others from germs. It is the only way to break the **Chain of Infection**.
3. Standard Precautions are ***basic infection control guidelines*** for you to follow as you perform your daily work. They include guidelines that require you to wash your hands, use protective equipment like gloves, gowns and masks, and handle infectious waste material properly.
4. Standard Precautions are written and regulated by OSHA. And, ***OSHA regulations are federal law***. This makes following Standard Precautions guidelines ***mandatory*** within all U.S. healthcare facilities.
5. Unfortunately, no one is going to follow you around and make sure you are following standard precautions all the time. It's up to you to **DO THE RIGHT THING** to keep yourself and your clients safe.

FINAL THOUGHTS ON STANDARD PRECAUTIONS

We should all take great care to prevent the spread of illness and infection. With attention to detail and sensible work habits, most infection control-related accidents can be avoided. Here are some important safety reminders:

- Remember to stay focused on what you are doing. Don't let yourself go on "autopilot" because you have done the task so many times before.
- Get enough sleep. Being tired can lead to careless behavior.
- Don't be afraid to ask for help if you need it.
- Don't try to do too many things at once.
- Never take shortcuts when it comes to infection control.
- Avoid thinking that you have nothing to learn about infection control—even if you have been working in health care for years.

TELL YOUR CLIENTS WHY STANDARD PRECAUTIONS ARE IMPORTANT

Some clients may get offended when they see you wearing gloves. They may say something like, *"Oh, you don't need gloves. I don't have anything that's contagious."* Be sure to explain that protective barriers like gloves, gowns, and masks are for their protection as well as yours. Tell them:

- These precautions can prevent the spread of infection from one part of their body to another (cross-contamination).
- That gloves prevent the spread of disease and infection from one client to another.
- That they should insist on the use of *clean* gloves from each of their healthcare workers—and that they should ask all employees who come in their room to wash their hands.

WHY REVIEW BLOODBORNE PATHOGENS EVERY YEAR?

If you've been working in health care for a while, you've probably noticed that you have to review information about Standard Precautions and bloodborne pathogens every year.

Why? It's the law! All healthcare employees are required to participate in an annual review of bloodborne pathogens and Standard Precautions. While it may seem pointless to go over the same information every year, remember that infection control procedures are in place to protect you as well as your clients. So, take the time to read up on Standard Precautions each year.

WHAT I KNOW NOW!

Now that you've read this inservice on standard precautions, take a moment to jot down a couple of things you learned that you didn't know before.

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A Safety Module:
Disaster Planning

COURSE OUTLINE

ARE YOU READY AND WILLING?

As a trained medical professional, you must always be ***ready and willing*** to take action in the event of a disaster. This means that:

- You have been trained in CPR and basic first aid.
- You know how to stay calm and work well under pressure.
- You understand the basic physical and emotional needs of people when they are most vulnerable.

So what will you do if you are suddenly faced with a disaster situation? For example:

- What will you do if the building you work in is hit by a tornado?
- How will you keep your client safe in a home fire?
- Where will you go if a massive hurricane is headed in your direction?
- What will you do after an earthquake has flattened your city?
- What is your workplace procedure for evacuating a whole building full of residents?

If you don't know the answer to these questions, it's time to learn!

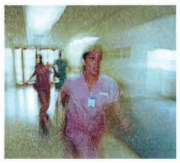
Regardless of the event, disasters have several key elements in common:

- They are usually ***unexpected***, with little or no warning or time to prepare.
- At first, emergency services (like EMTs, fire, and police) may be overwhelmed by demands for their services, leaving you ***in charge of the safety*** of those around you.
- Lives, health, and the environment, are all in ***danger***.

That's why it is critical that you know exactly what to do if disaster strikes. You must be ready and willing to snap into action without delay.

Keep reading to learn how you can be ready for natural disasters like hurricanes, tornadoes, or earthquakes, and other disasters like chemical or radiation exposure. Your preparation and quick action may mean the difference between life and death for many others.

KNOW WHAT IS POSSIBLE



Different hazards threaten different places. Knowing exactly what you need to be prepared for will help you narrow down your priorities.

Before beginning this inservice, you should:

- **Identify the most common disasters that occur in your community.** For example, if you live in an area that is often threatened by hurricanes but does not experience earthquakes, then focus your energy on being prepared for hurricanes!
- **Ask yourself, what's the worse that can happen?** Have a clear understanding of the most *severe* impact a potential disaster may have. For example, a tornado may leave very little damage on one street—and flatten every house on the next street over. It's important to be prepared for the worst!
- **Let history influence the future.** Learn valuable lessons from recent disasters such as hurricane Katrina and 9/11. Remember the devastation and the tragedy of lives lost in past disasters. Think about what went right and what went wrong. Let the lessons learned guide your actions and maybe even decrease the number of injured or dead in the next disaster.

KNOW YOUR WORKPLACE POLICIES

While this inservice functions as a ***general guide*** to planning for a disaster, it is not a substitute for ***your workplace policy*** if disaster strikes while you are on the job!

Your workplace is required by law to have policies and procedures in place that tell you exactly what to do in the event of an emergency or disaster. In addition, your employer is required by law to make sure you have been trained and have had time to practice those policies and procedures.

If you are not familiar with your workplace policies and procedures in the event of a disaster, ask for training TODAY!

Pay close attention to your workplace evacuation plan. If a mandatory evacuation is issued, you must know exactly what is expected of you and you should be prepared to fulfill your role and keep your clients and co-workers out of harm's way.

The Facts

KNOW THE THREATS

- Every U.S. state has experienced tornados, but Texas holds the record with an annual average of 120.
- Every year about 10,000 people, on average, die as a result of earthquakes.
- Hurricane season in the Atlantic and Gulf of Mexico spans from June 1st through November 30th.
- The Department of Homeland Security continues to report that terrorist groups remain focused on major U.S. cities such as New York, Chicago, Los Angeles, and Washington.

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

"An emergency is not the time to plan; it's the time to react, so be informed."

~Tom Ridge,
Secretary of Homeland Security 2003-2005

WILDFIRES!

- A wildfire is an uncontrolled fire, often occurring in forests or fields, which can also destroy homes and farmland.
- Some wildfires are the result of lightning strikes or extreme dry condition, but more than four out of every five wildfires are caused by ***people***.
- Arson and just plain carelessness (like irresponsible smoking and unsupervised campfires) are the biggest causes of wildfires in the U.S.
- An average of 1.2 million acres of U.S. woodland burn every year.
- **INTERESTING FACT:** A large wildfire can actually change the local weather conditions or produce "its own weather."

"Fire takes no holiday."

~Author Unknown

FOCUS ON FIRES IN FACILITIES

Fire can happen anywhere, any time, for a variety of reasons. But, when fire occurs in a facility or home where frail, elderly or sick people live, the consequences can be devastating.

While long-term care facilities are generally safe, the risk for fire remains high because of the types of materials and equipment present in the building.

Every workplace should have a plan so everyone knows what to do in case there is a fire. Please check with your supervisor for your facility's plan.

Here are some things you need to know before going into a facility:

- **KNOW THE FIRE PLAN:** It's not enough to just have a plan in place—facilities are responsible for making sure EVERYONE knows the plan and will know how to react appropriately when the need arises.
- **PARTICIPATE IN FIRE DRILLS:** Your facility should hold routine fire drills on each shift to make sure every employee has a chance to learn the routine. If you have not been involved in a drill, let your supervisor know.
- **LOCATE FIRE ALARMS:** Know the location of any fire alarms in your work area, and learn how to operate them—even in the dark.
- **LOCATE EXTINGUISHERS:** Know the location of portable fire extinguishers in your work area and get training on how to use them.
- **LEARN ABOUT OXYGEN:** Know how to shut off oxygen and other piped gas systems, **if and when** you are told to do so.
- **KNOW THE WAY OUT:** Know the escape routes from your work area and at least two ways to exit (in case one exit is blocked).

PREPARING FOR FIRES IN THE HOME

Clients being cared for at home are at an even slightly higher risk of experiencing a fire because there is little or no inspection or regulation of gases, flammable liquids, and electrical devices.

Making matters worse, clients are permitted to smoke in their own homes without supervision.

Smoking is the leading cause of all residential fire deaths.

Help clients and their families prepare an evacuation plan:

- Draw a rough plan of the home, noting doors and windows that can be used for escape.
- Make sure doors and windows open easily.
- Designate one place to meet outside the home.
- Routinely check smoke alarms. Replace batteries as needed.

A WORD ABOUT PREVENTION: Of all the disasters discussed in this inservice, fire is the only one that you can help prevent! Always be on the lookout for potential fire hazards (smoking, electrical appliances, kitchens) and ***eliminate the risk*** before it becomes an emergency!

FOCUS ON TORNADOS

Tornados are small but powerful cones of wind that spin violently and can travel in excess of 200 miles per hour. ***A tornado can strike any time of the day and any time of year, causing damage that can:***

- Uproot trees.
- Destroy buildings.
- Rip apart roofs.
- Send debris and glass flying.
- Overturn cars and mobile homes.

Fortunately, with today's high-tech radar, weather forecasters can now predict when and where tornados are likely to form and can then warn the public.

PLAN FOR A TORNADO

- **Know the risk for tornadoes in your area.** Tornados can happen anywhere in the U.S., but some areas are at higher risk than others.
- **Identify a safe place to go when a tornado is approaching.** The best shelter from a tornado is somewhere underground. If an underground shelter is not available, plan to go to an *interior* room or hallway on the lowest floor and get under a sturdy piece of furniture.
- **If you are in a mobile home, get out!** No mobile home is safe in a tornado. If you make home visits to mobile homes, locate a sturdy structure nearby that you can get to if a tornado warning is issued.
- **Learn your community's warning system.** Most areas use the Emergency Alert System (EAS) which breaks into television and radio broadcasts. Communities at increased risk may use sirens. If you live in a community that uses sirens, it is critical to learn the siren warning tone to ensure that you recognize the warning when you hear it.
- **Participate in tornado drills.** If you work in a facility, participate in routine tornado drills. If you work in clients' homes, you should conduct your own tornado drills with the family to ensure that all family members know what to do and where to go during a tornado emergency.

DURING A TORNADO:

- **Close all windows and doors.** Damage occurs when wind gets inside a building.
- **Seek shelter.** Move yourself and your clients to an underground shelter, a tornado-safe room, or interior room or hallway on the lowest floor.
- **Tuck and huddle.** Put as much shielding material (such as furniture or blankets) as you can around you and your clients.
- **Wait.** Stay put until you are sure the threat has passed.

AFTER A TORNADO:

- Avoid fallen power lines and immediately report those you see.
- Stay out of damaged areas until you are told that it is safe to enter.
- Turn off utilities, oxygen, or other gas lines to prevent fires.

TALK ABOUT IT!

OPEN THE DISCUSSION!

If you or anyone you know has ever been in a tornado, you know it's an experience that cannot be forgotten.

Let the voice of experience teach the most important lessons!

- ***If you have been in a tornado . . . talk about what it felt like, how you stayed safe, what you learned, and what you would do differently.***
- ***If you have never been in a tornado, ask your co-workers, clients, and family members if they have ever been in one. Find out what lessons they learned from the experience.***

QUESTION:
What is a tornado?

ANSWER:
Mother nature doing the twist!

CONNECT IT NOW!

APPLY WHAT YOU KNOW!

WHAT WENT WRONG?

Think about New Orleans just after Hurricane Katrina.

Nearly 2000 people lost their lives—many of whom were elderly and frail.

Some elderly lived at home without transportation. Others lived in nursing homes without proper evacuation plans.

To make matters worse, government officials did not order a mandatory evacuation until 19 hours before the storm hit.

Then, there were not enough buses to take people out of the city.

Think about the lessons learned and ask yourself :

- *What can I do (including urging city officials to do their part) so that a tragedy like Katrina never happens again.*

Share your thoughts with your co-workers.

FOCUS ON HURRICANES

A hurricane is a violent storm that develops in the tropical Atlantic Ocean from June to November. To be classified as a hurricane, the storm must have winds of 75 miles per hour or more and be accompanied by heavy rains.

HURRICANES CAN:

- Damage or destroy structures.
- Lift and move unstable structures and objects.
- Damage utility and sewage lines.
- Cause floods, especially along coastal communities.
- Make roads impassable.
- Damage cell phone towers.

PLAN FOR A HURRICANE

- **Know the evacuation routes.** Knowing how to get out of the area as quickly as possible when evacuation is ordered is one of the best ways to be prepared.
- **Secure needed supplies.** If you assemble your disaster supply kits as suggested on page 10 of this inservice, you will have everything you need.

JUST BEFORE A HURRICANE:

- Cover windows and glass doors with plywood or close hurricane shutters.
- Place flashlights and a portable radio in easy to find locations and make sure the batteries work.

EVACUATING A FACILITY

Your workplace will have its own evacuation plan, but it may look like this:

- The Administrator or Supervisor will set up a command center and become the "Commander" to direct people to areas needing assistance.
- A shelter for residents will be arranged.
- Residents should be evacuated in an orderly fashion to a predetermined meeting area to board transportation. Evacuate residents in this order:
  1. Residents in immediate danger.
  2. Non-ambulatory or bedridden residents.
  3. Wheelchair bound residents.
  4. Ambulatory residents.
- Medical Records personnel will tag and identify all residents upon evacuation. Medical records will be transported with the resident.
- The Charge Nurse will take the Med Cart to the shelter.
- Housekeeping and Laundry personnel will gather linens and supplies needed for resident care.
- Dietary personnel will gather food and dietary supplies.
- The Social Worker will contact family members to notify them of where residents are being transported.
- Everyone should assist with a last walk through the building to ensure that no one is left behind.

FOCUS ON WINTER WEATHER

Winter storms often involve extremely cold temperatures with snow, freezing rain, wind, or even blizzard conditions that can last for several days.

Winter storms can be deadly—even though most deaths are not directly related to the storm. **Risks to human life include:**

- **Exhaustion and heart attacks:** Caused by overexertion when shoveling or doing other preparations.
- **Hypothermia and frostbite:** It's possible for older Americans to literally freeze to death in their own homes after being exposed to dangerously cold indoor temperatures. Elderly people account for the largest percentage of hypothermia victims.
- **House fires:** These occur more frequently in the winter because of the lack of proper safety precautions when using alternate heating sources (unattended fires, improperly placed space heaters, etc.). Fire during winter storms presents a great danger because water supplies may freeze, and it may be difficult for firefighting equipment to get to the fire.
- **Asphyxiation:** In an effort to get warm, people asphyxiate because of improper use of fuels such as charcoal briquettes or gas stoves which produce carbon monoxide.

IF YOU SUSPECT HYPOTHERMIA:

Take the person's temperature. If it is below 95 degrees Fahrenheit, seek medical care immediately! If medical care is not available, begin to warm the body slowly. Dress the person in dry clothing and wrap him or her in a warm blanket, covering the head and neck. Offer small sips of warm broth.

Warning signs of hypothermia include:

- Uncontrollable shivering.
- Memory loss.
- Disorientation.
- Slurred speech.
- Drowsiness.
- Apparent exhaustion.

DURING A WINTER STORM:

- Stay indoors and dress warmly. Dress elderly clients in layers of loose-fitting, lightweight, warm clothing. When necessary, remove layers to avoid sweating which can lead to chills.
- Provide frequent, small meals and snacks. Food provides the body with energy and energy produces heat. Warm liquids such as warm broth or juices can prevent dehydration.
- Close off unused rooms, stuff towels or rags in cracks under doors and cover drafty windows at night.

GET OUT!

THINK OUTSIDE OF THE BOX!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **The Problem:** You are caring for a 78 year old woman who lives alone—and the weather report shows a massive winter storm is on the way.
- When you arrive at her home, she asks you to do a load of laundry, fix the rubber stopper on her walker, and make sure she has plenty of candles in case the power goes out.
- **What You Know:** These requests are not out of the ordinary, but your focus is on her safety during this approaching storm!
- **Get Creative:** How would you make sure your client is safe during the storm? What are your thoughts on using candles when the power goes out?
- **Talk About It:** Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

FOCUS ON EARTHQUAKES

An earthquake is a sudden and violent shaking of the ground that happens when two blocks of the earth suddenly slip past one another.

Scientist closely monitor the areas where earthquakes are likely to occur, but have not yet found a way to predict when one will happen. Earthquakes can occur any time of the day or night, any time of the year.

Earthquake duration and intensity can vary greatly—lasting from several seconds to several minutes. Aftershocks can go on for days after the main earthquake.

EARTHQUAKES CAN:

- Cause buildings to move off of their foundations or collapse.
- Damage utilities, structures, and roads.
- Cause fires and explosions.
- Cause dam failures that can trigger flash floods.
- Trigger landslides and avalanches or tsunamis.

WHERE DO EARTHQUAKES USUALLY HAPPEN?

- The area along the San Andreas Fault in California
- Western Oregon and Washington
- The Alaskan coast
- The New Madrid Fault Zone in Missouri
- Coastal South Carolina and New England

DURING AN EARTHQUAKE:

- The safest place to be during an earthquake is in a doorway or under a piece of study furniture, away from any windows.
- Take cover close to where you are standing as soon as you begin to feel the shaking. Only move as far as needed to get to a safe place. Most injuries happen when people move more than five feet during the shaking.
- If you are inside a home or building, *stay there.* There is a risk of being hit by falling debris or collapsing walls if you go outside.
- If you are outside when the shaking starts, move quickly away from any building or trees.
- If you are in a car, pull over in an open area—away from any bridges, overpasses, power poles, or buildings. Stay in your car until the shaking stops.
- When the shaking stops, survey the damage and check to see if any clients or co-workers need immediate care.
- Keep in mind, there is a 20 percent chance of an equal or larger aftershock in the two hours following an earthquake.

THINK ABOUT IT!

- Each year, there are about ***500,000*** detectable earthquakes worldwide. 100,000 of those can be felt, and 100 of them cause damage.
- Southern California has about 10,000 earthquakes each year. Most of them are so small that they are not felt. Only about ***15-20*** are greater than magnitude 4.0.
- From 1975 to 1995 only four states in the U.S. ***did not*** have any earthquakes. They were: Florida, Iowa, North Dakota, and Wisconsin.
- Many earthquakes happen on the ocean floor. Big ocean waves can form after a quake resulting in a ***tsunami.***

"It takes an earthquake to remind us that we walk on the crust of an unfinished earth."

–Charles Kuralt

FOCUS ON NUCLEAR POWER PLANTS

Nuclear power plants are closely monitored and regulated, and even though accidents are rare, they are possible.

An accident at a nuclear power plant could cause dangerous levels of radiation to leak into the environment and harm the public in the immediate area.

WHAT IS RADIATION?

Radiation is energy. We are all exposed to a small amount of radiation every day from the sun, x-ray machines, television sets, and microwave ovens.

In small amounts, over a short period of time, radiation is not harmful. However, it can build up over time. The longer a person is exposed to radiation, the greater the risk of serious illness or even death.

If an accident should occur at a nuclear power plant, people may be exposed to radiation through:

- **Absorption** to the body from the cloud and particles left on the ground.
- **Inhalation** of radioactive materials.
- **Ingestion** of radioactive materials.

DURING A NUCLEAR POWER PLANT EMERGENCY:

- **Listen to the warning.** Stay calm and follow the officials' directions.
- **Evacuate if ordered.** Know your community's evacuation route. Stay tuned to the radio while you are evacuating. Keep your car windows closed.
- **If you are not advised to evacuate,** close the doors and windows of the home or building; turn off the air conditioner, ventilation fans, or other air intakes.
- **Go to a basement or other underground area if possible.**

IF YOU THINK YOU HAVE BEEN EXPOSED:

- Remove your clothes and shoes.
- Place exposed clothing in a plastic bag.
- Seal the bag, and place it out of the way.
- Shower thoroughly.

Exposure to intense radiation can cause radiation sickness, a potentially deadly illness that may include a range of symptoms, such as:

- Nausea, vomiting, and diarrhea.
- Headache.
- Fever.
- Dizziness.
- Disorientation.
- Weakness and fatigue.
- Bloody nose.
- Vomiting blood.

THE NEXT STEP!

APPLY WHAT YOU'VE LEARNED

Of all the possible disasters discussed in this inservice, list the top 2 for which you need to be prepared.

1.) _____

2.) _____

Are you prepared today? If not, what do you need to do to get prepared?

_____

_____

_____

Do you know your workplace policy for evacuating clients? If not, learn it today!

Do you have a disaster preparedness kit ready? If not, pack one today! *(See page 10.)*

"In the past, people worked together only when some great disaster threatened."

~Walter Ulbricht

BOMB OR OTHER TERROR THREATS

There are only two reasons a person would call to warn you of a bomb or other terror threat:

1. The caller knows or believes that a threat exists and wants to ***warn*** people to minimize harm. The caller may be the person who placed the device or someone else who has become aware of such information.
2. The caller wants to cause ***anxiety or panic*** and disrupt the normal activities at the facility where the device is supposedly located.

IF YOU RECEIVE A CALL:

- Remain calm.
- Keep the caller on the line and attempt to get as much information as possible.
- Ask the location of the bomb and the time of possible detonation.
- Tell the caller that the building is occupied and that an explosion could cause death or serious injury to innocent people.
- Pay close attention to background noises which may give a clue as to the location of the caller.
- Listen to the voice and make note of whether the caller is male or female, calm or excited, or has an accent or speech impediment.
- Do not talk to other people in the room while you are on the phone, but alert someone near you, in writing, that you are receiving a threat.
- Alert your supervisor and call the police immediately to report the threat.

IF YOU RECEIVE A SUSPICIOUS PACKAGE:

- Remain calm.
- Do not disturb or move the package.
- Move yourself and others to a safe distance.
- Alert your supervisor and call 911.
- Wait for directions from the Emergency Response Coordinator.

A suspicious package may include:

- Excessive postage.
- Handwritten or poorly typed address.
- Incorrect titles.
- Title, but no name.
- Misspellings of common words.
- Oily stains, discoloration, or odor.
- No return address.
- Excessive weight.
- Lopsided or uneven envelope.
- Protruding wires or aluminum foil.
- Ticking sound.
- Marked with restrictive endorsements, such as "Personal" or "Confidential."
- A city or state in the postmark that does not match the return address.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Different hazards threaten different places. Knowing exactly what you need to be prepared for will help you narrow down your priorities.
2. While this inservice functions as a ***general guide*** to planning for a disaster, it is not a substitute for ***your workplace policy*** if disaster strikes while you are on the job!
3. Tornados, hurricanes, and winter weather can all be predicted. Heed the warnings and keep yourself and others safe.
4. Fire is preventable! ***Eliminate the risk*** before it becomes an emergency!
5. Regardless of the particular threat, everyone can benefit from packing a disaster preparedness kit.

ASSEMBLING A DISASTER PREPAREDNESS KIT

Regardless of the particular threat, everyone can benefit from assembling a disaster preparedness kit. This is a sure-fire way to be prepared for ANY emergency!

Gather the following supplies and store them in a canvas bag with a shoulder strap. Check the contents and replace items like food, water, and batteries every six months. It is recommended that you keep enough food and water in the kit to last for ***three days***.

WHAT SHOULD BE IN THE KIT?

- Bottled water: at least two quarts per person per day.
- Non-perishable food: canned goods, granola or energy bars, canned juices or milk, baby food or formula (if a baby is present), pet food (if a pet is present).
- Kitchen items: can opener, knife, matches, plastic bags, plastic eating utensils.
- First Aid Kit including non-prescription drugs like pain relievers, Neosporin, and allergy medicines.
- Small battery operated radio with extra batteries.
- Flashlight with extra batteries.
- Small tool kit: wrench, pliers, screw drivers, duct tape.
- Toilet paper, tissues, moist towelettes.
- One complete change of clothing and shoes (appropriate for the season).
- A small amount of cash.
- Emergency phone numbers.
- An extra set of car and house keys.

IN ADDITION . . .

Place a note on the *outside* of the kit that lists anything you cannot keep stored but that you want to remember to grab in an emergency, such as:

- Prescription medications like insulin (and diabetes supplies), heart medications, dentures, contact lenses, and eye glasses.
- Cell phone, laptop, iPad, and/or GPS.

FINAL THOUGHTS

- Pack an entire emergency preparedness kit for each person and pet in a household or facility.
- Store kits in an easy to find location and be prepared to retrieve kits for those who cannot retrieve their own, such as the very young and the very old.

WHAT I KNOW NOW!

Now that you've read this inservice on disaster planning, jot down a couple of things you learned that you didn't know before.

_____

_____

_____

_____

_____

_____

_____

_____

_____

"Planning is bringing the future into the present so that you can do something about it now."

~ Alan Lakein

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A home care pulse COMPANY

A Risk Management Module:
Client Safety Tips

COURSE OUTLINE

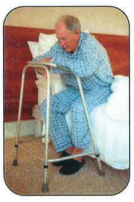
WHERE DID THINGS GO WRONG?

A 68 year old man named John is admitted to the hospital for observation after complaining of chest pain and shortness of breath.

Doctors determine John needs a minor routine surgery to open a blocked artery in his heart.

After the surgery, John is weak and a little dizzy. He pushes the call light for help getting to the bathroom. When no one comes, John tries to go to the bathroom on his own which results in a fall . . . and a broken hip.

Now, John must have surgery to repair his hip and, he can't go home as planned. He must go to a nursing home for rehabilitation.



While at the Nursing Home, John develops an infection at his surgical site. Tests determine it is MRSA. John is placed on isolation precautions and his stay in the nursing home is extended.

Four weeks later, John is discharged home where a home health team takes over his care.

Since John has shown he can safely walk with a walker, and has family close by who can help, the home health worker is only scheduled to visit every other day.

On the first home visit, the Home Health Aide doesn't notice that a latch on John's walker is weak.

Later that night John gets up to for a glass of water. His walker fails, sending him crashing into a side table.

He suffers a head injury and is found the next morning. He is dead.

So, where did things go wrong?

Well, the hospital cured John's heart problem . . . but failed to protect him from falling.

The Nursing Home got John up and back on his feet again . . . but failed to protect him from a terrible infection.

The Home Health team gave John the hope of reclaiming his independence . . . but failed to protect him from faulty equipment.

Keep reading to learn how you can keep your clients safe in these common situations.

WHY SHOULD YOU CARE?

The story you just read about John is fiction. But, what are the chances of it being a reality? Here are some facts:

- ***One in five Americans*** report that they or a family member have experienced a medical error of some kind. This could be a fall, an infection, a medication error, a surgical error, or an equipment malfunction.
- Nationally, this means that there are about 23 million people with at least one family member who experienced an *illness, injury, or even death* while under the care of healthcare professionals.

What if John was your father, your grandfather, or your uncle?

- It is estimated that around **200,000 Americans** die each year as result of these types of errors.
- Preventable injuries like those in John's case cost the economy nearly **$30 billion a year**.

Who do you think should pay for these errors?

- **The Staff:** Should the nurse or aide who failed to answer John's call light in the hospital pay for the hip surgery? Should every employee who ever touched John in the Nursing Home be held responsible for the cost of treating the infection?
- **The Facility:** Should the hospital cover the cost of the hip surgery? Should the nursing home absorb the cost of treating the infection?
- **The Family:** Should John and his family be responsible for the additional charges? Who should pay for the funeral?
- **Medicare or Insurance:** Medicare and insurance companies have the right to refuse to pay.

The Deficit Reduction Act of 2005 required major changes in the way Medicare reimburses the healthcare industry for accidents, infections, and injuries acquired during routine medical care.

MEDICARE NO LONGER REIMBURSES FOR:

- Surgical site infections,
- Catheter-associated urinary tract infections,
- Pressure ulcers, or
- Falls.

In addition to not receiving reimbursement from Medicare for these situations . . . healthcare providers are not allowed to seek payment from the client or family either!

So, who is paying for this? If you think that because you have never been directly billed that you are not paying . . . think again!

- As a society, we pay for these errors through ***increased insurance premiums, staggering medical costs, and tax raises***.
- We all suffer when small community hospitals close because they can no longer afford to operate.

- Nurses and aides suffer when there is not enough money to offer our hardest workers a *decent wage* or an occasional *pay raise.*
- Clients suffer when employers can no longer afford to staff facilities appropriately, leaving everyone ***overworked and stretched to the limit***!

WHAT'S NEW?

Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!

FOCUS ON FALLS

Federal Law requires all healthcare providers to assess each client's risk for falls within the first 14 days of admission and to re-assess risk periodically throughout the duration of care as the client's condition changes. Here are some facts:

- Nearly *one third* of ALL people over the age of 65 will fall each year, sometimes more than once.
- One of the most common (and most costly) injuries suffered from falls is a hip fracture.

Risk factors that determine your client's chance of falling:

- **History of Falls:** At least one fall in the past 12 months.
- **Balance or Gait Problems:** Problems walking or standing without assistance.
- **Multiple medications:** Four or more medications.
- **Certain Diseases:** Parkinson's, Alzheimer's, or Dementia.
- **Muscle Weakness:** Generally, lower body weakness.
- **Continence Problems:** Urgency, frequency, incontinence.

HOW YOU CAN HELP:

- Educate all clients and family members regarding the interventions in place to prevent falls.
- Check on clients with risk factors for falls more frequently. Answer call bells promptly!
- Keep all floors, stairs, and walkways free of clutter. Eliminate throw rugs. Provide skid proof footwear.
- Make use of appropriate assistive equipment (walker, cane, etc.).
- For clients with balance or gait problems, encourage exercises that strengthen the lower body.

  In facilities, clients can participate in group exercise classes or work individually with a physical therapist. Take clients on short walks outside if the weather is suitable or walk around the facility if the weather is bad!

  In the home, clients can join community center exercise or swim classes. Take short walks outside, walk the mall, or even take short walks around the house!
- For clients with bowel or bladder problems, be prepared to be available more frequently, and provide equipment, such as a bedside commode, urinal, bed pan, and incontinence pads.
- Consider using a bed alarm, if available.

WHAT excites YOU?

TAI CHI (pronounced TIE-chee) is a gentle, slow-motion form of ancient Chinese exercise that has recently been proven to reduce falls in the elderly by nearly 50 percent!

Individuals enrolled in Tai Chi exercise programs report:

- Stronger knee and ankle muscles.
- Improved mobility and flexibility.
- Better balance.

Tai Chi is a safe alternative for older adults who cannot otherwise exercise. It is very low impact, does not require any special equipment, and can be done indoors or out.

- *Does your facility offer a Tai Chi class for residents? If so, observe a class one day. Encourage your clients with high risk for falls to join.*
- *If you work with clients in the home, look for a Tai Chi DVD or search your local senior center or YMCA for classes.*

For more information about the benefits of Tai Chi, go to this National Institutes of Health website: http://nccam.nih.gov/health/taichi

FOCUS ON HEALTHCARE-ACQUIRED INFECTIONS

Every time you touch a client or a surface, you potentially pick up disease causing organisms. These organisms can live on you for hours, sometimes days, unless you wash them off.

- In American hospitals alone, healthcare-associated infections account for an estimated **1.7 million** infections and nearly **100,000** deaths each year.
- The cost of caring for individuals with healthcare-associated infections is estimated as high as **$45 billion** dollars every year!

THE SOLUTION IS SIMPLE!

The most important thing you can do to prevent infection is to wash your hands before and after ***any*** contact with clients.

- Use soap and water to wash your hands. Scrub for at least 20 seconds.
- Only use alcohol based hand rubs when your hands are *not* visibly soiled.

SOME MORE WAYS YOU CAN HELP:

- When you have a client on isolation (contact, droplet, or airborne) precautions . . . take the time to find out the nature of the infection. Knowing what organism you are dealing with will help you remember to protect yourself!

- Even when you are crunched for time, no excuse in the world will prevent an infection if you decide not to follow proper precautions.
- It is never okay to enter an isolation room without proper protection . . . even if it's just to pick up a food tray. Wait until you have a few things to do in the room, then put on your gown and gloves and do everything you need to do in the room all at once.
- Never share personal hygiene products, like soap or razors, between clients.
- Equipment that is shared by many clients throughout the day, like shower chairs and mechanical lifts should be disinfected after ***each*** use.

TALK about it!

Open the Discussion

WHAT'S STOPPING YOU?

There are many reasons healthcare workers give for not washing their hands before and after patient care. Here are a few:

- ❑ **Skin Irritation:** The hand cleaners are harsh and damage the skin.
- ❑ **Supplies are not available:** Sinks are not conveniently located or are not stocked with soaps and towels.
- ❑ **Urgent or emergency care:** The client needs immediate care, there is no time to wash hands.
- ❑ **Wearing of gloves:** The belief that if gloves were worn, hands do not have to be washed after client care.
- ❑ **Not enough time:** High workload and understaffing.

Take a poll of your co-workers. Ask which of the situations above is the most likely reason they would give for not washing their hands.

Take your findings to your supervisor. There may be an easy solution! For example, if the reason is that the soap is too harsh . . . a different brand may be tested. If sinks are not conveniently located . . . your employer will want to know so the situation can be fixed.

FOCUS ON ASSISTIVE EQUIPMENT

Assistive equipment is a wonderful addition to your client's care plan. Canes and walkers help clients regain mobility and independence. Grab bars, shower chairs, and raised toilet seats allow clients to use bathrooms privately or with minimal assistance.

But, sometimes, these helpful devices can create more problems than they solve. Here are some facts:

- Injuries related to canes and walkers send **47,000** people a year to the ER.
- Fractures, generally to the hip, are the most common type of injury associated with assistive equipment.

The following is a list of guidelines to follow when inspecting assistive equipment:

- **Check Canes:** If the cane is made of wood, inspect the shaft and handle for cracks, splintering, or weak spots. If the cane is metal, check if all the bolts and screws are present (it should be stable and strong). Check if the rubber tip is present and inspect the shape (it should be even and clean).
- **Check Walkers:** Look at the bolts and screws (all connections should be present and secure). Check for all four of the rubber tips and inspect their shape (rubber tips should be even and clean). If the walker has caster wheels, make sure they are firm, in good shape, and roll smoothly.
- **Check Wheelchairs:** Make sure all bolts and screws are present and secure. Check wheels. Wheels should be firm, smooth, and roll straight without wobbling. Brakes should be firm when engaged, and should completely stop the wheelchair from moving. Check the seat and back rest for rips, tears, or weak spots. Make sure the foot rest and leg rest move easily and sit firmly in the proper position for your client.
- **Grab bars, transfers seats, and commodes:** Grab bars in the home should be professionally installed. Push and pull on grab bars to ensure they are securely attached. Check all connections and rubber stoppers on transfer seats and commodes. Make sure everything is firm and level.

If you discover faulty equipment, follow your workplace guidelines for reporting and requesting repairs.

NEVER ATTEMPT TO REPAIR EQUIPMENT YOURSELF.

Assistive equipment should only be assembled, installed, and repaired by trained professionals!

THINK about it!

RETIRE THOSE RESTRAINTS

In the past, it was common practice to use restraints as a way to *prevent* falls, accidents, or injuries.

Today, however, research has shown that ***restraints have the potential to actually create more problems than they solve***.

For example, restraints have been shown to increase falls, make incontinence worse, lead to dehydration and malnutrition, promote loss of mobility, and lead to the development of pressure sores, muscle weakness, and poor circulation.

Federal law states, *"The resident has the right to be free from any physical or chemical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms."*

So, how do you keep your clients safe when you can't watch them every minute of every day?

- **Get creative! Make a "Top Ten" list of things you can do to keep your clients safe without the use of restraints.**
- ***Share your list with your co-workers and supervisor! Read their "Top Ten" lists!***

FOCUS ON PRESSURE SORES

Pressure Sores, also known as pressure ulcers, bed sores, and decubitus ulcers are a serious cause for concern. A pressure ulcer is any injury to the skin caused by unrelieved pressure. Pressure sores usually develop in clients who are immobile.

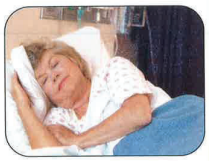
Here are some facts about pressure ulcers:

- Hospitalizations involving patients with pressure ulcers increased by nearly 80 percent in the last decade.
- Nearly 1 million people develop pressure ulcers each year.
- Treatment costs exceed $1.3 billion annually.
- Complication resulting from bed sores include extreme pain and suffering, delayed recovery from other conditions, infection, and death.
- Christopher Reeve, the actor who played "Superman," suffered from pressure ulcers after being paralyzed in a horseback riding accident. ***He died from complications of an infected pressure ulcer.***

REMEMBER: Medicare no longer reimburses for the treatment of bedsores that develop during normal medical care.

HOW YOU CAN HELP:

- Follow the client's care plan for re-positioning. If no plan is stated, re-position every two hours.
- Provide excellent skin care, keeping skin clean, dry, and moisturized. Use powder on areas where skin rubs together.
- Check incontinent clients frequently. Change immediately after soiling to keep stool and urine off the skin.
- Keep linens clean, dry, and free of wrinkles.
- Massage the back during position changes but NEVER rub or massage reddened areas.
- Use pillows to pad boney areas such as knees, elbows, hips, and shoulders.
- Keep heels off the bed by placing a pillow under leg between the calf and ankle.



CONNECT it now!

Apply what you know

BED SORES ARE A FORM OF ABUSE AND NEGLECT

Bed sores are extremely painful and can lead to DEATH!

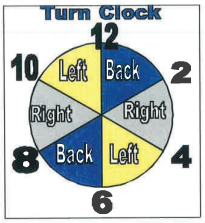
All immobile or bedbound clients should be turned and re-positioned every 2 hours unless there is another order in place.

- ***Does your workplace have a turn clock or other system in place to keep up with the turn schedule?***

  If not, create one! It's easy and you can customize it to each client if you want.

Turn clocks are especially useful for use in home care situations where multiple family members and caregivers contribute to the care of the client.

Here is an example of a turn clock:



FOCUS ON MEDICATION

As a nursing assistant you are probably not involved in actually giving medications unless you have had special training. But, you can monitor clients' medications in the home . . . and you can observe and report any side effects or allergic reactions in clients in the home and in the facility.

- Clients over the age of 65 are twice as likely to need emergency care for problems associated with medications.

There are a few common medications that cause a majority of the problems for older clients. They are:

- Blood thinners - Can cause excessive bleeding or hemorrhage.
- Diabetes medications (insulin) - Can cause LOW blood sugar.
- Heart medicine (Digoxin) - Can cause headache, weakness, and abnormal heart rhythms.

The more you learn about your client's medications and their possible side effects, the easier it will be for you to spot changes and prevent more serious problems.

HOW YOU CAN HELP:

- Have a general idea of what medications your client is on and what the possible side effects may be. Pay special attention to medications that are new to the client.
- Allergy Alert: If you notice that your client is experiencing itching, swelling, or trouble breathing after taking a medication, get help right away! This could be a life-threatening situation.
- Speak to your supervisor immediately if your client has questions, seems confused, or is taking too much or too little of a prescribed medication.
- Tell the nurse right away if your client asks for medication or reports pain. There may be an order in place for a PRN medications (which means it is given "as needed"). Pain medications are often ordered as PRN.
- Let your supervisor know if you see your client taking any over-the-counter medications or dietary herbal supplements. Some supplements can either decrease or increase the effects of certain prescription medications.

THE NEXT step!

Apply what you've learned!

1. Choose a client for whom you currently provide care.
2. Locate the MAR (Medication Administration Record) or ask the nurse for a list of all the medications this client currently takes.
3. Make a list of all the medications and note how often (or at what times) your client takes each medication.
4. Locate a Nursing Drug Guide and look up each drug, or ask the nurse for the main side effects you may see with each medication.
5. Now, take notice of any signs or symptoms your client has that may be from the medication.

THINK ABOUT IT

- **Is your client on any medications that cause drowsiness? How will this effect the way (or time) you provide care?**
- **Are there any medications that cause dizziness or weakness? If so, what special precautions should you be prepared to take?**
- **What do you need to look out for with clients on diuretics (water pills)?**

FOCUS ON FOOD

FOOD PREPARATION SAFETY

- Always wash your hands before handling your client's food!
- If you prepare food in the home for your client, wash all surfaces used for food preparation before and after cooking.
- Clean surfaces with a mixture of one teaspoon of chlorine bleach in one quart of water for a super effective and inexpensive bacteria buster!
- Wash ALL fruits and vegetables before preparing.
- Use two cutting boards, if possible—one for meats and one for fruits and vegetables. If separate boards are not available—clean board with bleach solution when switching between meat and fresh fruit and vegetable preparation.

SPECIAL ORDERS

- Clients with orders for modified consistency diets like pureed foods or thickened liquids have trouble chewing and/or swallowing.
- If you are unsure about what the different consistency orders are supposed to look like, or how to prepare them, ask your supervisor for guidelines or for a demonstration.
- Never serve thickened liquids with a straw!

MEAL TIME SAFETY

- As always, sit facing the client during meals. Socialize, and keep the mood relaxed. Never rush a meal.
- Place clients with trouble chewing or swallowing, in an upright, seated position before feeding. This will prevent choking or aspiration.
- Offer small bites and make sure the mouth is completely empty before offering the next bite.
- Allow client to remain sitting upright for 30 minutes after the meal, if possible. This will promote digestion and prevent choking.

GET OUT!

Thinking outside the box!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **THE PROBLEM:** You are caring for a 73 year old man who is recovering from a stroke. He is regaining his ability to speak but is still having trouble chewing and swallowing. He is on a soft diet with thickened liquids.
- Each time you serve him a meal he becomes angry and refuses to eat. His wife tells you it's because he wants real food, not "baby food."
- **WHAT YOU KNOW:** You know your client's diet is ordered by the doctor and cannot be changed without a doctors order.
- You also know if your client doesn't eat, he may lose weight and his recovery could be impaired.
- **GET CREATIVE:** Think of **3 creative solutions** you might try to get your client to accept his current state of recovery and understand the need for the modified diet.
- **TALK ABOUT IT:** Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

FOCUS ON EMERGENCIES

STAYING SAFE FROM MOTHER NATURE

If you live in an area that commonly experiences weather related emergencies like hurricanes, tornadoes, snow storms, or earthquakes . . . Take some time during the "off season" to help your client get prepared for an emergency.

- In facilities, make sure all clients know where to go and what to do in an emergency. Know the locations of first aid kits and flashlights.
- In the client's home, assemble an emergency preparation kit with flashlight, battery operated radio, first aid supplies, water, perishable foods (enough for 2-3 days), can opener, essential medicines, and medical supplies (like syringes for diabetic clients).
- Check the kit for expired items twice a year.

SAFETY DURING A FIRE

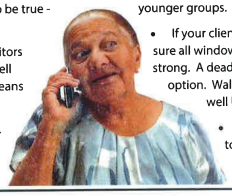
A fire can happen anytime, anywhere! The best way to keep yourself and your clients safe during a fire is to have a plan!

- Remember: People who are elderly, frail, sick, or immobile are at an increased risk of becoming injured or dying in fire because they cannot get out without help. *You must be prepared to help!*
- In facilities, learn the fire emergency plan. Locate all the fire alarms, fire extinguishers, exit signs, and unlocked fire exits. Participate in fire drills.
- In the client's home, help prepare an exit plan, conduct fire drills, test smoke alarms, and replace batteries as needed. Recommend clients keep a fire extinguisher in a convenient location.

FOCUS ON CRIME

About 2 million people over the age of 50 are victims of crime each year. Most crimes against the elderly are financial crimes, like offers to do work that never happens, or identity theft. **Here are some ways you can help keep your client safe from criminals:**

Telemarketers/Solicitors: If you notice your client receives phone calls, visits from sales people, or excessive junk mail with offers that seem too good to be true . . . talk to your client and the family members about saying "No!" If an offer seems too good to be true - it probably is!



- Telemarketers and door-to-door solicitors can be aggressive and demanding. Tell your client it is okay to be firm. No means no!
- Offers of "free gifts" are usually a trap. Tell your client never to send money for an offer of a "free gift."

Identity Theft: Make sure your client knows it is NEVER okay to give personal information over the telephone. Tell your client that legitimate businesses like banks or other reputable companies will never ask for a social security number, bank account or PIN number over the phone.

Violent Crimes: Most elderly people say they fear violent crimes more than any other. Fortunately, violent crimes are not as common among this age group as with younger groups.

- If your client lives in a high crime area, make sure all windows and doors are sturdy and strong. A deadbolt lock on the door is the best option. Walkways and doorways should be well lit at night.
- Clients who live alone should get to know at least one neighbor.

FOCUS ON TRAVEL

If you use your car to drive clients to appointments, shopping trips, church, or on other errands, keeping your clients and yourself safe should be your top priority!

Getting into and out of the car

- The front seat is probably the best option for most clients. It has a larger door and more leg room than the back seat.
- The front seats in most newer cars are equipped with air bags. It is safe for elderly clients to sit in the front with airbags but it is recommended that the seat is pushed as far back as possible and slightly reclined.

Seatbelts

- You and your passenger should wear both the shoulder and the lap belt. The lap belt should fit snuggly under the abdomen (across the hips). The shoulder belt should come over the collar bone and cross the chest. If the seat belt hits the neck, it is too high and should be adjusted.

Cell phones

- Never use your cell phone to talk or text while driving. In some states it is illegal. In all circumstances it is extremely dangerous.

Allow plenty of time

- Avoid feeling rushed by giving yourself plenty of time to get to appointments. When you feel rushed, you are more likely to speed, run through yellow lights, and make unsafe lane changes to pass slower cars.

Drive the speed limit

- Always drive the speed limit. Driving even a few miles over the speed limit dramatically increases the risk of an accident.

Take the scenic route

- One way to slow down and stay safe - and have a little fun too - is to take the scenic route! Avoid major highways and freeways. Take the back roads when time permits! This is a much safer way to transport your precious cargo!

Avoid driving in bad weather

- If possible, ask clients to reschedule appointments or events if the weather is bad. Driving in bad weather is not only stressful - it's dangerous!

5 KEY points

Key Points to Remember

1. Millions of people are injured, or become seriously ill under the care of medical professionals each year. These ***preventable*** situations cost the economy nearly **$30 billion** a year!
2. Your client's ***safety*** should be a top priority. If you are not protecting your client—who will?
3. ***Medicare no longer reimburses for surgical site infections, catheter-associated urinary tract infections, pressure ulcers, or falls.*** Healthcare facilities and the American public are paying the price for these medical mistakes.
4. Falls, infections, equipment related injuries, and pressure sores are almost always preventable! Know your client's risk factors and take precautions before an injury happens.
5. If you ***treat every client the way you would want your family members to be treated*** while under the care of medical professionals . . . you will never have a client fall, or develop an infection, or pressure ulcer!

FINAL TIPS FOR CLIENT SAFETY

FINAL TIP ON FALLS:

- Remember: A falls assessment must be done within 14 days of admission. It's a good idea to know who is responsible for doing your client's falls assessment. You must know your client's fall risk level in order to take the proper precautions. Be sure to report any changes in status to the nurse so the fall risk can be adjusted.

FINAL TIP ON PREVENTING INFECTIONS:

- Wash your hands, wash your hands, wash your hands . . . Then, wash your hands again! The most important thing you can do to prevent infection is WASH YOUR HANDS! You can also teach your client to request ALL caregivers wash their hands before and after care. And, teach family members about the importance of washing hands before and after visits!

FINAL TIP ON EQUIPMENT SAFETY:

- Assistive equipment is available to your client to help encourage safe independence. If the equipment itself is not safe . . . the purpose is LOST! Perform regular inspections of your client's equipment and make sure your client is using the equipment properly.

FINAL TIP ON PRESSURE SORES:

- A client who develops a pressure sore has been neglected in some way. Clients who cannot move independently need to be re-positioned every two hours. Skin should be kept clean and dry and checked at least once a day for reddened areas. If you notice an area of redness, report it immediately so intervention can be started.

FINAL TIP ON MEDICATION:

- Even though you may not be formally trained in medication administration, you can still develop a basic understanding of the common side effects of frequently used medications. Knowing the side effects and reporting any observations you make can save your client's life!

FINAL TIP FOR MEAL TIME:

- Meal times should be fun and relaxing. Never rush a meal! Pay attention to your client's ability to chew and swallow. Report any changes immediately if you think the diet order is not appropriate for your client's abilities. If you have not been trained on how to perform the Heimlich Maneuver on a choking person, ask your supervisor for a demonstration!

WHAT I KNOW NOW!

Now that you've read this inservice on client safety, take a moment to jot down a couple of things you learned that you didn't know before.

inthe**know** CAREGIVER TRAINING
A home care pulse COMPANY

A Patient Rights Module:
Maintaining Confidentiality

COURSE OUTLINE

LOTTI GETS IT ALL WRONG!

Mindy, a nursing assistant, cares for Lotti, a 79 year old woman who suffers from severe arthritis.

While providing care for Lotti one day, the supervising nurse stops by to do a routine assessment. Just before she leaves, Mindy asks the nurse for some information about another client named Phil who she is going to see next.

The nurse and Mindy step into the hallway. They assume no one can hear their conversation as they discuss Phil's condition.

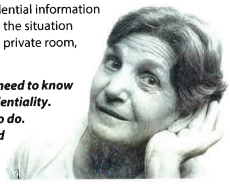
When the nurse and the aide leave, Lotti calls the Pastor at the church that both she and Phil attend. She tells the Pastor that Phil is near death and that he should come for a visit right away. She doesn't tell the Pastor how she got this critical piece of information.

When the Pastor arrives, he offers his condolences to Phil's wife . . . who immediately becomes alarmed and confused.

It turns out that Phil is not near death. In fact his condition is improving. Lotti heard enough of the conversation to identify the client, but got the details all wrong.

The source of information was traced back to the conversation between Mindy and the nurse. Mindy and the nurse were written up and later fined $250 each for HIPAA violations.

While Mindy and the nurse did not know Lotti could hear them, the hallway is *never* a secure place to exchange confidential information about clients. They could have avoided the situation entirely by having the conversation in a private room, behind a closed door.



Keep reading to learn everything you need to know about maintaining your clients' confidentiality. You'll learn what to do and what not to do. And, you'll learn all about the laws and consequences that are in place to protect clients.

WHAT EXACTLY IS CONFIDENTIALITY?

As a healthcare worker, you are trusted each day with confidential information about your clients.

As a nursing assistant, you spend more time with your clients than anyone else on the healthcare team. This helps you develop a close relationship with your clients. Your clients feel safe telling you personal details about their lives and their health because they know you will keep it to yourself.

Now, be honest. Have you ever discussed a client's private information with your family or laughed about a client with a group of co-workers? Most health care workers would probably answer "yes."

Unfortunately, it is easy to break confidentiality if you're not careful. So what exactly *is* confidentiality? **Confidentiality means that:**

- Your clients and your co-workers expect you to keep their personal information to yourself—and you expect the same from them.
- You guard information about your clients ALL THE TIME, even in the privacy of your own home.
- When you keep personal information safe, your clients come to trust you. This trust is an important part of your relationship with your clients.
- Healthcare organizations must *promise* clients that their medical information will be kept safe. This promise is included in the Patient's Bill of Rights in all healthcare facilities. Be sure you understand the Patient's Bill of Rights where you work.

CONFIDENTIALITY VS. PRIVACY

It is easy to confuse confidentiality and privacy. They are very similar, but confidentiality usually applies to medical records and ensuring that information is available only to those who are allowed to see it. For example:

- Maintaining your clients' ***confidentiality*** involves keeping their medical records away from anyone who does not have the right to see them and never discussing their diagnosis with someone who is not a part of their healthcare team.
- Maintaining your clients' ***privacy*** has to do with things like not touching their personal possessions, not listening to their private conversations with others, and not entering their rooms or personal space without their permission.

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

Key Terms

- **Breach of confidentiality** is sharing verbal or written information regarding a client with someone who is *not* on the care team of the client—or who does not have signed permission from the client to have that information.
- **Informed consent** is when a resident or client acknowledges and allows the release of information to other parties. This permission is given by filling out a legal consent form, which becomes part of the resident or client's permanent record.
- Private healthcare information should be available only on a **"Need-To-Know"** basis. This means that each person on the care team should only have access to information that he or she needs to know to carry out the plan of care.

HOW CONFIDENTIALITY IS BROKEN

There are a few common ways that healthcare workers breach confidentiality. See if you can spot the mistakes these nursing aides made:

1. TALKING IN FRONT OF A CLIENT

A client, Mrs. Jones, had been unconscious for several weeks. Two aides, Sally and Mary, were working together to bathe Mrs. Jones. During the bath, Sally told Mary that she overheard the doctor saying Mrs. Jones will die soon.

Never talk about your clients in their rooms, even if they are unconscious or asleep. You don't know what your clients might be able to hear.

2. TALKING TO CO-WORKERS

During a lunch break with five other nursing assistants, Jim told a story about his client, Mr. Smith. Jim said Mr. Smith was very forgetful and kept trying to eat his dinner with a toothbrush instead of a fork. The whole grouped laughed at Jim's story.

Even if it seems like a harmless story, avoid discussing your clients with other employees—unless they are part of the client's healthcare team. And then, do it in private, not at lunch. If Mr. Smith were your father, would you want a bunch of people laughing at him?

3. TALKING TO OTHER CLIENTS

Susan's new client, Mrs. Brown, was a friend of Susan's neighbor. Susan told her neighbor that Mrs. Brown was pretty sick and would probably enjoy a visit.

Even if you mean well, never discuss your clients with anyone outside of work, even your friends and family. They have no business knowing the names or condition of your clients.

4. TALKING TO FAMILY MEMBERS

John had been caring for Mr. Carter for several weeks. Mr. Carter's daughter visited and asked John if her father's blood pressure was okay. John told her that Mr. Carter's pressure had been high recently because Mr. Carter was eating too many salty potato chips.

If a client's family members ask you about the client's condition, it's best to suggest they get information from your supervisor or the doctor. The rule states that you can give information to a person who has a role in taking care of the patient if you believe that releasing the information is in the patient's best interest. However, it's not always easy to determine that on your own.

THEY DID WHAT?

TRUE STORIES OF BREAKS IN CONFIDENTIALITY

- A hospital in Michigan accidentally posted the medical records of thousands of patients on the internet.
- Four hospital workers (including two nurses) in California took pictures of a dying man and posted them on Facebook.
- A children's hospital in California accidentally sent 6 faxes containing private health information to an auto mechanic's shop.
- The health insurance claims forms of thousands of patients blew out of a truck on its way to a recycling center in Connecticut.
- A patient in a Boston area hospital discovered that her medical record had been read by more than 200 of the hospital's employees.

MORE WAYS CONFIDENTIALITY CAN BE BROKEN

5. UNSECURED ELECTRONIC MEDICAL RECORDS (EMR)

Jane works in a facility that uses computer charting. While charting at a mobile laptop station one day, Jane leaves to answer a call bell without closing the client's record and logging out of the system.

Always close the record and log off when you leave a computer or anyone can walk up and read private information about your clients.

6. MEDICAL RECORD LEFT IN PUBLIC PLACE

Sasha works in home health. Before visiting a new client, she receives a report with all the client's information, including name, age, medical condition, and care plan. Sasha makes a stop at a convenience store before going to the client's home and leaves the report in plain view on her passenger side seat.

Never leave charts or papers out in the open where others can see. In facilities, never leave the nurses station with a chart in your hand.

7. SHIFT REPORT SUMMARY THROWN IN PUBLIC TRASH CAN

Robert works in a facility where he receives a shift report summary before each shift. The summary lists the last names of the clients, their room and bed number, and any special care needs they have for the day. The policy at the facility is to shred the report at the end of the shift. One day, Robert forgets to shred it and just tosses it in a trash can in a public restroom on his way out of the facility.

It is never appropriate to dispose of private healthcare information in a public trash can.

8. MEDICAL RECORD "SNOOPING"

A local celebrity was admitted to a nursing home for rehabilitation after a stroke. After about two days in the facility, it was discovered that his electronic medical record had been accessed over 300 times. Since employees had to log in with a password, there was a record of every single person that looked at the chart. Those individuals who "snooped" were written up. The celebrity sued the facility and each individual involved.

Information in the medical record is intended for healthcare workers who "need to know" only. If you are not caring for an individual, you have no business reading the chart.

TALK ABOUT IT!

You are caring for a client who has had a stroke and cannot speak. While you're feeding this client, a woman enters the room and asks how he is doing.

What should you do? You may assume this is a family member and volunteer the information.

- But, what if you find out later that this is a relative the family has tried to keep away from the client?
- Or, what if you learn later that this is a mentally ill person who was in the facility to visit someone else but got confused?

How will you know if it is okay to give information about your client to this person? And, what information can you give?

Discuss your answers with your co-workers and supervisor and find out what they would do.

KNOW THE LAWS, HIPAA AND HITECH

If you've worked in healthcare longer than a minute, you've probably heard of HIPAA (*which stands for **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct*). HIPAA is the law which outlines the privacy rules that protect clients' medical records and information.

This law was developed by the U.S. Department of Health and Human Services and gives clients more control over how their personal medical information is used and to whom it can be given. A client must give authorization before any personal medical information can be given out.

HIPAA guarantees clients the right to:

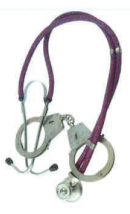
- Privacy.
- Receive a written Notice of Privacy Practices that describes how their information will be used.
- Access and copy their own medical records.
- Fix mistakes or information in their records that is not accurate.
- Request special instructions for how their information is sent to other places.
- Ask for limits on how their information is used and given out.
- Get a list of all non-routine times when their information may be given out.
- Complain about privacy violations to the institution and to the Department of Health and Human Services.

The rules cover all forms of client information, like:

- Names.
- Social Security numbers.
- Addresses and phone numbers.
- Fax numbers.
- Email addresses.
- Medical record numbers.
- Dates of birth.
- Diagnoses.

THEN CAME HITECH!

In 2009, The Department of Health and Human Services introduced The **H**ealth **I**nformation **T**echnology for **E**conomic and **C**linical **H**ealth (HITECH) Act. This Act gives HIPAA more teeth!



HITECH significantly increases the fines that may be issued for violations of the HIPAA rules and encourages quick and decisive action.

Prior to HITECH, fines were limited to $100 for each violation or $25,000 for all identical violations. Now there are tiered ranges of fines, with a maximum penalty of $1.5 million and potential jail time. In addition, individuals who violate privacy laws can no longer claim they "didn't know" a violation occurred.

THE NEXT STEP!

The best way to learn a difficult concept is to learn it well enough to teach it to someone else!

You have a client who is just being admitted. She has many papers to sign, including the HIPAA documents required by all healthcare providers.

She is not sure what it all means and asks you to help explain it to her.

- On a separate sheet of paper, write a simple paragraph, with just 2 to 3 short sentences describing HIPAA to your client.

Share your paragraph with your supervisor to make sure it is correct.

Ask your supervisor how he/she explains HIPAA to clients in a way that is easy to understand.

EXCEPTIONS TO CONFIDENTIALITY

Did you know that there are times when you are <u>not</u> required to keep a client's information confidential? Here are some examples of when you should share information:

- You are caring for a client, Mrs. Adams. A doctor or nurse who has been treating your client asks for information about Mrs. Adams. You are allowed to share information with another healthcare provider who is treating your client.
- Your client, Mr. Johnson, has bruises that he did not have the day before. He had no injury that you know about, and when you ask him about it, Mr. Johnson gives you a suspicious reason for his injury. If you suspect your client is being abused, you should report it to your supervisor or the authorities.
- You are working in a nursing home caring for Mr. Sanders, a client with dementia. One day Mr. Sanders has an argument with another client and you hear him threaten to hit that client. If a client physically threatens to harm you, himself, or anyone else, you should report it to your supervisor.
- Your client, Mrs. Robertson, has been attempting to drive a car when she is unfit to drive. If your client is a danger to others, you should report it to your supervisor.
- You have a client, Mr. Anderson, who is having chest pains. In an emergency, you are allowed to share confidential information about your client with emergency personnel. You should report this to your supervisor and/or follow emergency procedures for your workplace.

CONFIDENTIALITY AND MINORS

In most states, children are considered minors until their 18th birthday. In general, while they are minors, their parents have the right to make decisions about their medical care and to be kept informed about their health and well-being. However, there are exceptions. For example, medical information may be withheld from parents:

- When the parents agree that their child and a healthcare provider may have a confidential relationship.
- When a healthcare provider believes that a child may have been abused or neglected.
- When a child has been declared "independent" from his or her parents—either through court proceedings or by getting married.

The laws covering disclosure of information about minors to their parents vary from state to state. If you are unsure about specific laws in your state, check with your supervisor.

GET OUT!

THINK OUTSIDE OF THE BOX!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **THE PROBLEM:** You are caring for a woman who was just discharged home. During a visit with your new client, a neighbor comes to visit.
- The neighbor tells you she has a friend who gets home visits from your agency. After a few minutes you realize you know her friend. She begins to ask questions about the friend's health.
- **WHAT YOU KNOW:** You know HIPAA laws require you to protect confidentiality. But, you feel this friend is just genuinely concerned.
- **GET CREATIVE:** Think of 3 creative replies you could use to (kindly) let this friend know that you are not at liberty to share any clients' personal information.
- **TALK ABOUT IT:** Ask your co-workers how they would solve this problem.

THINK ABOUT IT!

WHAT YOU DON'T KNOW

Do you think you should be told if a client is HIV positive?

- Do you believe you have the ***right*** to know this bit of private information—especially since you might be providing personal care to this person?

Well, the answer is NO! You don't have the right to know if a particular client is HIV positive.

As healthcare workers, we protect ourselves from contagious diseases like AIDS by using Standard Precautions with EVERY client.

By treating all your clients as if they might have an infectious disease, you can protect yourself without knowing a particular client's HIV status.

HOW DO YOU DO IT?

CONFIDENTIAL DOCUMENTATION

Which of the following do you think "qualifies" as confidential documentation?

- A client's medical record.
- Your client care notes.
- A bulletin board listing each client and his or her diagnosis.
- The results of a co-worker's TB test.
- Your annual job evaluation.
- A client's address and telephone number.
- A copy of a doctor's order.

What's the right answer? THEY ALL ARE! Any personal information about you, your clients, or your co-workers should be kept confidential. This means keeping medical records and personnel files in locked cabinets, locked rooms, or in supervised areas.

CONFIDENTIALLY SPEAKING

Remember to be careful when you are talking about your clients. Before speaking, ask yourself:

- Is what I have to say confidential information?
- Is the person I am speaking to part of the client's healthcare team?
- Am I in a private place or are there other people around me who shouldn't hear what I am saying?
- Am I sharing this information for the client's benefit? Or is it just "gossip"?

What would you do if the following people asked you for information about your client?

- Friends
- Partners
- Family Members

The answer is the same for all — politely ask them to speak to your supervisor. Just being a family member, partner, or friend does give someone the right to have information about your client.

CONFIDENTIALITY IN SMALL TOWNS

Maintaining confidentiality in a small community presents it's own unique set of problems.

People who live in small communities are generally acquainted with everyone else in the area. When people are acquainted in this way, leaks in confidentiality can have serious consequences. For example:

- The local pastor at the church cannot afford to have his church members find out that he is suffering from a damaged liver after years of secret alcoholism.
- The second grade school teacher does not want her current or former students to know she has cancer.
- The man who owns the coffee shop would like to keep his family history of mental illness to himself.

It's important to be even more protective of your clients' confidential health information when you work in a small community.

If you grew up in a small community, you probably already know many of your clients and their families before they even need care. This can lead to a situation where boundaries can easily be crossed.

For example, you grew up with Loretta. You were friends all the way through high school. You spent the night at her house dozens of times. Now Loretta's grandmother is sick, and you are her caregiver.

You run into Loretta in the grocery store and quickly blurt out how happy you are to be able to take care of her grandmother. Loretta's aunt (whom you've never met) is with Loretta and begins asking probing questions about her mother-in-law's health. You provide information without considering confidentiality.

Later that night, you get a call from Loretta who is angry with you for talking about her grandmother to her aunt. It seems there is a family feud going on between the two women that you were not aware of, and now you're caught in the middle of it.

What's worse, you've possibly lost a friend . . . and Loretta's family could actually sue you for violating HIPAA laws.

TIME TO LAUGH!

Here is a quick little tip-a,

'Bout a law that's known as HIPAA.

My advice is to try,

Really hard to comply,

Or else a new one they'll rip ya!

~ Michael Devault

*****

What do you call someone who complains incessantly about HIPAA?

HIPAAchondriac

What do you call urgent HIPAA issues?

HIPAAcritical

What is the disease you get from too much HIPAA?

HIPAAtitis

What do you call someone who is delighted with HIPAA?

HIPAA-go-lucky

~ D. Hager, Paramedic

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Confidentiality involves keeping clients' medical information away from anyone who does not have the right to know it.
2. HIPAA is the law which outlines the privacy rules that protect clients' medical records and information.
3. Your clients feel safe telling you personal details about their lives and their health. They trust that you will keep it to yourself.
4. Healthcare workers who breach confidentiality can be fined, lose their license, and even be put in jail.
5. Your clients' medical information is something they own. You wouldn't take a client's clothes and pass them around to other people. So, don't pass around a client's private information either.

CONFIDENTIALITY Q & A

Q. Why is confidentiality such an important part of your relationship with your clients?

A. Remember that clients have to talk to you about private things such as pain, skin rashes, bowel movements, and urination. Think of how embarrassing it would be if it was announced to everyone at work that you had three loose bowel movements today! You would never want to tell anyone about your bowels ever again. If a client believes he can trust you to keep his information confidential, he will continue telling you how he feels. If you break confidentiality, the client might stop telling you when his condition changes. That could be dangerous for the client!

WHAT WOULD YOU DO IF . . .

Q. Pretend your client, Mr. Brown, tells you that he has fallen down three times in the last few days. He asks you not to tell his daughter or anyone else since he doesn't want to worry anyone. He says he knows he can trust you to keep it a secret. What would you do?

A. You need to tell Mr. Brown that it is your duty to report any changes in his condition to your supervisor. You want him to continue trusting you, but you must tell your supervisor about the falls. Remind Mr. Brown that you want what is best for him and that his safety is your responsibility. Tell him that you will not say anything to his daughter, only to your supervisor. Report the client's condition to your supervisor, but be sure to say that you were not present when he fell. Also, let your supervisor know that Mr. Brown is worried about his daughter finding out. Your supervisor will follow up with the client according to policy.

Q. Let's say that a fellow employee tells you in private that she may have a drinking problem. While there have been no problems with her client care, you are afraid there might be, so you tell your supervisor what she said. Your supervisor fires the employee immediately. Have you broken confidentiality about your co-worker?

A. This is a difficult situation, but, yes, you have broken confidentiality. Your fellow employee could sue you for not keeping the secret, saying you caused her to lose her job. However, you also have a responsibility for keeping clients safe. Instead of telling the supervisor yourself, you might try encouraging the co-worker to talk to the supervisor about her drinking problem. Some workplaces have programs to help employees with drug or drinking addictions. (NOTE TO INSTRUCTOR: Obviously, this is a complex issue. You may want to explore it further based on your workplace policies.)

FINAL CONFIDENTIALITY TIPS!

- Be aware of who is around you whenever you speak about a client. Remember that you are responsible for what you say, and that healthcare workers have been sued for saying the wrong thing at the wrong time!
- All medical information is confidential, especially about a client with HIV. Every state has laws about how to handle HIV information. If you don't know the law in your state, ask your supervisor for more information.
- Think of your clients' medical information as something they own. You wouldn't take a client's clothes and pass them around to other people. So, don't pass around a client's private information either.
- Be careful if you use a cellular telephone during your work day. When you talk on a cell phone, your conversation might be picked up by strangers. Never give a client's full name or address over a cellular telephone.
- If you leave messages about your clients on an answering machine or a voice mail system, be careful what you say. You never know who might hear the message.
- Never leave any charts, papers, or computer screens containing client information visible in public areas. Others may be able to see them.
- If you work at a facility, avoid talking about clients in public areas like the cafeteria or front desk. You never know who may be able to hear you.
- After viewing client information on a computer, don't leave without logging off of the computer first. Also, don't share computer passwords or codes with anyone.
- Do not share personal information about your co-workers with anyone. For example, if Mary covers for Betty one day, she should not tell the client that Betty had to stay home because she's pregnant again and has morning sickness! Don't break confidentiality about your co-workers.

- Always be careful with what you say. For example, Tom was late with his client's bath. He said, *"Sorry. I would have been here sooner, but Mr. Smith had diarrhea and I had to clean him up all over again."* Tom broke confidentiality by talking about Mr. Smith to another client!
- It is important for you to share confidential information with your supervisor if it involves a client's health or well-being. For example, if a client tells you that the right side of his body has gone numb, you do not keep that information secret! Let your supervisor know right away.

WHAT I KNOW NOW!

Now that you've read this inservice on confidentiality, jot down a couple of things you learned that you didn't know before.

COURSE OUTLINE

inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

A Client Care Module:

Understanding Abuse

INNOCENT VICTIMS OF ELDER ABUSE

Meet Joan. Joan really appreciated her grandson for helping her run errands. Michael had always been a sweet boy and seemed to genuinely care for his grandmother. It was the perfect arrangement. He would take her to the bank and wait while she deposited her check. Then he would drive her wherever she needed to do her shopping and other errands.

When the winter weather turned cold, Michael told his grandmother that it would be easier and safer if he just did the errands for her while she stayed warm and cozy at home. Joan didn't think twice about signing her check over to her grandson, who would make her purchases and then deposit the rest into her account.

It took several months to realize that while Michael was doing the shopping, he was also pocketing the rest of Joan's money. When Joan bounced a check for her mortgage, she found all her money was gone.

This is Don. Don desperately wanted to remain in his home—but really needed help with his activities of daily living. He called an agency and quickly decided to hire Mindy, a Certified Nursing Assistant. The agency promised Don that Mindy would be able to meet his basic needs.

Mindy did the best she could, but Don's needs were a bit beyond her experience level. At first, she began to lose patience with how slowly Don moved. Later, she started to shove him—and out of frustration—she began to shout and call him names.

One day, she shoved him off of the toilet because he needed help cleaning himself after a bowel movement. Neighbors heard him crying in pain and called the police.

Don was found lying on the bathroom floor with a broken hip and bruises all over his body in various stages of healing.

Keep reading to learn all about abuse and neglect. In Part 1 of this series, you will read about abuse—how to recognize if someone is being abused, how to report it and even how to prevent yourself from abusing clients. In Part 2 of this series, you'll learn how to recognize, report and prevent neglect.

AN OVERVIEW OF THE PROBLEM

Abuse is a serious problem in our communities and in our institutions. People are most at risk for abuse when they are unable to take care of themselves. Can you name the two groups of people that are least able to care for themselves? ***They are children and the elderly.***

What Exactly is Abuse?

Abuse is some action by a ***trusted*** individual that causes physical and/or emotional harm to the victim. There are a number of different kinds of abuse, including:

- Physical abuse
- Emotional abuse (includes verbal abuse)
- Sexual abuse
- Financial abuse (including identity theft)

Where Does Abuse Happen?

DOMESTIC ABUSE: Abuse can happen in every community around the United States. Every day, there are children and elderly people being abused in their own homes. The abuser is usually a family member, often someone with psychological problems.

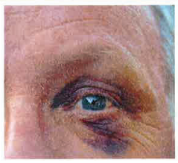
- **IN THE NEWS:** A California man was arrested and charged with kidnapping and abusing his 82 year old grandmother after he got "angry" because she was driving too slowly. He "pounded" on the dashboard and "pushed" her right leg down to make the car go faster. Then he pulled his grandmother out from the driver's seat, "threw" her in the passenger's seat and punched her in the face several times after she tried to leave. Heroin was found in the car. Sadly, the grandmother refused medical attention and even helped her grandson get his sentence reduced.

INSTITUTIONAL ABUSE: Abuse and neglect can also happen in an institutional setting, such as a day care center or a nursing home. Abuse that happens in institutions can go on for a long time without detection. In long term care, staff, visitors and even other residents can be the abusers.

- **IN THE NEWS:** A nursing home in Ohio had its rating drop from 5 stars to 2 stars after a hidden camera caught nurse aides repeatedly abusing a resident. The investigation led to eight employees being disciplined and two aides being convicted.

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*



Key Terms

- **Negligence** involves actions (or failure to take actions) that result in injury to a client.
- **Malpractice** is claimed when a client is injured as a result of negligence, carelessness or lack of skill.
- **Assault** is *threatening* to harm a person. Telling a resident he will be slapped if he soils his clothes is an example of assault.
- **Battery** is *actually* harming a person. Pushing, hitting or even forcing someone to eat are all forms of battery.
- **Domestic Abuse** is abuse by a spouse, intimate partner or family member.
- **Involuntary seclusion** is separating a person from others against the person's will. Confining a client to his room is an example of this type of abuse.

THE FACTS

- A report of child abuse is made every ten seconds.
- More than five children die every day as a result of child abuse.
- Approximately 80 percent of children that die from abuse are under the age of four.
- About 30 percent of abused and neglected children will later abuse their own children, continuing the horrible cycle of abuse.

GET INVOLVED!

If you would like to get involved in preventing child abuse in your community, go to: preventchildabuse.org.

- This program, run by the folks at Prevent Child Abuse America hopes to "engage all people in our society to act to prevent abuse and neglect from ever happening in the first place."

FOCUS ON CHILD ABUSE

Child abuse can happen in any type of family—small, large, rich, poor, white, black, etc. It can also happen to children of all ages.

- Infants and toddlers are more likely than older children to be seriously injured or killed by child abuse.
- Abuse to adolescents can go unrecognized, since teenagers might try to hide the problem.
- Most often, children are abused by their families or guardians, but there are cases of children being abused by day care workers or other caregivers.

ABUSED CHILDREN MIGHT:

- Say they deserve to be punished.
- Act frightened of parents or other adults.
- Get scared when other kids cry.
- Be very quiet or very aggressive.
- Sit and stare into space.
- Be afraid to go home.
- Act much older than they are.
- Try to get attention by being "naughty."
- Try to run away from home.
- Get bad grades at school.
- Attempt suicide.

NEGLECTED CHILDREN MIGHT:

- Beg for or steal food.
- Appear in dirty or torn clothing much of the time.
- Miss a lot of school.
- Act very tired all the time.
- Show no emotion on their faces.
- Talk in a whisper or whine.
- Try to get attention by being "naughty."
- Abuse alcohol or drugs.
- Take on adult responsibilities.
- Talk about being left alone or left "in charge" of younger siblings.

WHO IS AT RISK?

Studies have shown that certain things put children more at risk for abuse. These factors include:

- Living with a parent who has a drug or alcohol problem—or a parent who was abused as a child.
- Living in a family where the parents are having marriage problems.
- Being a "special needs" child, with physical and/or mental disabilities.
- Living with parents who are unemployed or who have money problems.

FOCUS ON ELDER ABUSE

Elder abuse is defined as harm done to persons over the age of 65 by someone who is in a position of being trusted.

- There are two types of elder abuse. *Domestic elder abuse* happens in the person's home. *Institutional elder abuse* occurs in a nursing home or other long term care setting.
- Even if a caregiver is trying to help, it can be considered abusive if they use enough force to cause unnecessary pain or injury to an elderly person.
- We can only guess at the number of elderly who are abused every year. The best estimate is that there are about 5 million cases per year, but authorities say that less than half of them are reported.

Elders don't always report the abuse because they are:

- Afraid that the abuser will find out and be angry.
- Afraid that the authorities might take their family members away.
- Ashamed that their family member is abusing them.

Know the signs! It should send up a red flag if:

- The client is not allowed to speak to you unless another family member is present.
- The client is punished for being incontinent.
- You see family members abusing drugs or alcohol.
- You hear a client being threatened.
- You hear two different stories about how the client got a bruise or other injury.
- A family member refuses to allow you to complete the client's care.

WHO IS AT RISK?

Abuse can happen to anyone. However, there are certain factors that seem to increase the risk of abuse. Elderly people are more likely to be abused if:

- They are physically and/or mentally impaired.
- Their condition is getting worse.
- They are isolated from their family or community.
- They are dependent on others for all their needs.
- Their caregivers are stressed out.
- Their caregivers are not trained for the job of client care.
- Their caregiver is a family member with emotional problems or who is addicted to drugs or alcohol.

What Would You Do?

APPLY WHAT YOU'VE LEARNED

Whistleblowers are heroes who *speak out* when they witness abuse in the workplace, and have the power to make it STOP!

When you observe this behavior, do you tell the truth? Or, do you ignore the situation even though clients may suffer?

WOULD YOU BLOW THE WHISTLE IF...

- One day, you witness a co-worker slapping her client? Would it make a difference if you saw that co-worker slapping other clients previously?
- You overheard your client's adult son tell his mother, "You stink and I can't stand being in the same room with you"?
- You learned that your supervisor was withholding food and medicine from a client because the client was unable to pay for those services?

A CLOSER LOOK AT PHYSICAL ABUSE

Physical abuse is the use of physical force that may cause injury, pain or impairment. Physical abuse includes such things as:

- Striking, hitting, slapping or beating.
- Pushing or shoving.
- Shaking or choking.
- Kicking.
- Hair pulling.
- Pinching or scratching.
- Biting or spitting.
- Burning.
- Using physical restraints inappropriately.
- "Restraining" someone by giving too much medication.
- Taking away all food or water or forcing food.
- Putting someone out, unprotected, in severe weather.
- Using physical punishment.
- Making inappropriate sexual contact.
- Handling someone roughly during client care.

Know the signs! Be prepared to report any of these signs:

- Burns, including cigarette or hot water burns.
- Unexplained bruises, especially those in the shape of a belt or fingers.
- Multiple bruises that are at different stages of healing. (New bruises are red; then they turn blue, then black-purple, then dark green, then yellow.)
- Frequent trips to the emergency room.
- Cuts, scrapes or bite marks.
- Black eyes or broken eyeglasses.
- Signs of sexual assault such as bruises in the genital area, unexplained vaginal bleeding, and bloody or torn underwear.
- Unexplained venereal disease.
- Spots where hair seems to have been pulled out.
- Rope marks, especially on wrists or ankles.

Sadly, physical abuse can easily go unrecognized and unreported. It may be that the victim cannot tell someone what is happening or it may be that witnesses are afraid to speak out.

IN THE NEWS: A nurse in England was found guilty of abusing six residents in a nursing home. All six victims had dementia and could not *tell* their loved ones what was happening. The abuse had apparently gone on for years before several other staff members finally spoke out.

During the trial, one staff member testified that the abusive nurse would tell them, "No one will ever put in a complaint against me because my husband works in admin and he would find out and their life wouldn't be worth living."

Staff members in the home testified that they witnessed the nurse making dementia patients "walk like rag dolls" by kicking their heels from behind. She was also seen screaming at residents and forcing medication and food in their mouths.

TALK ABOUT IT!

HELPING DON

Think about Don from the beginning of this inservice and discuss your answers to these questions with your supervisor and co-workers:

- What do you think went wrong in this situation?
- How could the situation have been prevented?
- Have you ever accepted a client assignment that was beyond your level of experience?
- If yes, how did you handle any difficulties or frustrations that arose?
- Mindy is the type of person who loses her cool under pressure. Have you ever worked with someone like Mindy?
- How would you respond to someone like Mindy if you were to witness an angry outburst or actual physical abuse of a client?

A CLOSER LOOK AT EMOTIONAL ABUSE

Emotional abuse is when someone causes anguish, pain or distress to another person by what they say or do. Emotional abuse includes:

- Insults.
- Threats.
- Intimidation.
- Harassment.
- Yelling or screaming.
- Treating an elderly person like an infant.
- Constant criticism.
- Refusing to listen to someone.
- Giving someone the "silent treatment."
- Humiliation, such as laughing when an elderly client wets their bed.
- Keeping someone away from family, friends or the community.

Know the signs! Watch for and report clients who:

- Seem to be afraid of certain caregivers or family members.
- Are yelled at by family members or caregivers.
- Are made fun of by family members or caregivers.
- Are suddenly very agitated.
- Are suddenly confused or are more confused than usual.
- Talk about being worthless.
- Cry all the time.
- Never seem to get enough sleep.
- Have a sudden change in appetite.
- Have big changes in their weight (either up or down).
- Seem very quiet or just stop talking suddenly.
- Talk about being helpless.
- Seem scared to talk to you about their lives or their health.
- Are angry all the time.

While physical, emotional and sexual abuse are all horrible in different ways, people who are emotionally abused tend to go undiagnosed most often. Victims of emotional abuse (and their loved ones) may not even believe the abuse is happening if there is no "physical" evidence.

IN THE NEWS: In her new book "Breaking the Chains to Freedom," 37 year old Esther Adler describes being married to an emotionally abusive man.

Emotional abuse can be difficult to recognize and prove. Adler recalls being physically abused by her father as a child and says, "but with my husband I couldn't understand I was being abused. I didn't understand why I was hurt and in pain. I couldn't pinpoint it."

She also sends the warning that, "Emotional abusers are often ***liked*** by others." This is why her children "sided" with her husband when she finally decided to file for divorce.

GET OUT!

THINK OUTSIDE OF THE BOX!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **THE PROBLEM:** You are caring for Joan, the elderly woman from the beginning of this inservice.
- After Joan discovers all her money is gone, she confronts Michael. You hear Michael tell Joan that he *deserved* the money and that she should have been paying him anyway.
- You hear Joan crying when Michael threatens to never come back if she tells anyone about the theft.
- **WHAT YOU KNOW:** You know Michael is being emotionally abusive in an attempt to cover up the theft.
- **GET CREATIVE:** What will you do? Think of three ways you may be able to help Joan with this.
- **TALK ABOUT IT:** Share your ideas with your co-workers and supervisor and find out how they would solve this problem.

A CLOSER LOOK AT FINANCIAL ABUSE

Financial abuse includes the theft or misuse of someone's money or property by a trusted individual. This includes the following activities:

- Committing fraud.
- Getting money by lying about why it is needed.
- Forging checks.
- Cashing someone else's check without permission.
- Using someone's ATM card without permission.
- Forcing someone to change his or her will.
- Forcing someone to transfer property.
- Keeping someone away from his or her own home or money.
- Providing healthcare services to a client that are not really needed.
- Promising care in exchange for money and then not following through.

Know the signs! Keep an eye out for clients who:

- Can't pay their bills for housing, food, basic clothing or medications even though they seem like they should have money to do so.
- Get credit card bills for stores they have never been to.
- Suddenly have new "best friends."
- Talk about having to give money to others.
- Seem anxious about—or don't know—where their money is going.
- Have a family member who complains constantly about how much the client's care is costing.
- Have family members who appear suddenly and claim they have a right to the client's money.

Sadly, elder financial abuse is on the rise. In the majority of cases, abusers have a close connection to the victim and take advantage of this connection. Family members, friends, neighbors and caregivers are often the ones committing these crimes.

IN THE NEWS: A man who was a personal live-in caregiver in Canada was recently arrested in connection with a fraud investigation. He is accused of swindling an 84-year-old man who has Alzheimer's disease. It was reported that the caregiver lived with the man for just under a year and, while there, he is alleged to have stolen more than $100,000 by accessing the man's bank accounts. Police believe there may be more victims.

THINK ABOUT IT!

IDENTITY THIEVES, MODERN DAY PICKPOCKETS

The newest form of financial abuse is identity theft. Now, all a thief has to do is gather a few key pieces of a person's identity to rake in tons of stolen money.

Example: An Occupational Therapist in the Midwestern U.S. stole the identity of a patient, then took out nearly $100,000 in loans.

Seniors are at greater risk for identity theft than most people because they:

- Often have more cash and better credit than others,
- Are less technologically savvy, and
- Do not monitor their credit or bank accounts very closely.

How can you help protect your senior clients from identity theft?

What does your workplace do to protect your clients' personal identification? Is it enough?

A CLOSER LOOK AT SEXUAL ABUSE

Sexual abuse is any sexual contact of any kind with a person who has not given consent. Sexual abusers can be family members, medical staff and even other residents. Sexual abuse includes:

- Unwanted touching.
- Rape.
- Sodomy.
- Coerced nudity.
- Sexually explicit photographing.

Know the signs! You should suspect sexual abuse if you see:

- Bruises around the breasts or genital area.
- Unexplained venereal disease or genital infections.
- Unexplained vaginal or anal bleeding.
- Torn, stained, or bloody underclothing.
- A client ***actually being*** sexually assaulted or raped. *(This may seem obvious, but see the true story below.)*

Never be afraid to report if you suspect sexual abuse. If your report is not taken seriously by your supervisor, go up the chain of command. Do whatever is necessary to protect your client from sexual abuse.

IN THE NEWS: Mae Campbell, an 88-year-old Baptist preacher's daughter who suffers from Alzheimer's Disease was sexually abused at least twice while she was a resident in a Kentucky nursing home.

During one incident, Mae was sitting in the hallway, within sight of a nursing supervisor and other staff members, when a male ***resident*** walked up and ejaculated on her face. The nursing supervisor reportedly told the others not to tell anyone and that no harm had been done to Mae.

A few months later, a nurse saw a second male resident with Mae in a room where he had blocked the door. He was nude from the waist down and Mae had semen on her. Again, the nurse was told by the supervisor "to go on and keep working and . . . not to discuss it with anyone," and that "there was no actual harm done to the patient."

An investigation later uncovered that Mae had complained her throat was sore and she had soreness and bruising of her inner thighs. She had also complained of men trying to hurt her. Those complaints were never thoroughly evaluated and no action was ever taken.

The only reason these events were ever uncovered was because a caregiver and a nurse spoke out during an interview regarding the wrongful death of another resident. Mae's family was informed of the abuse and she was taken out of the nursing home.

THE NEXT STEP!

Whether you work in home health or in a facility, think about the clients you care for right now. Ask yourself:

Is it possible that any of my clients are being abused (physically, emotionally, financially, or sexually)?

If so, what are the signs?

What should I do about it?

Who can I go to for support with this issue?

What are the possible consequences if I *don't* get involved?

Talk to your supervisors and co-workers. Find out what they would do.

YOU CAN PREVENT ABUSE

Studies have shown that 93% of caregivers have seen or heard of a client being mistreated by a family member or a co-worker. You and your co-workers have to work together to prevent abuse.

Here is what you can do:

ALWAYS:

- Let your supervisor know if your client's family members seem stressed out. (Abuse is more likely to happen when people are stressed. Your supervisor may have some suggestions for community resources to help the family members.)
- Remember that clients from different cultures may communicate their needs in different ways. Listen to your clients with both your eyes *and* your ears.
- Know your own limits. If you feel overstressed, talk it over with your supervisor.
- Remember that ANGER is just one letter short of DANGER! Breathe deeply and count to ten if you feel yourself losing your temper during client care.
- Tell your supervisor if you find yourself unable to handle a specific client. It may be that more training will help. (For example, an inservice on Alzheimer's disease may help you understand and deal with Alzheimer's client's better.)
- Be a model of professional behavior for your co-workers.

NEVER:

- Keep quiet if the abuser is a co-worker. While it may seem like you are "squealing" on a co-worker, if you stay quiet you could be guilty of neglect yourself. You will be helping both the client and the co-worker if you speak up.
- Take your personal problems out on the clients. Leave your problems at home.
- Let "difficult" clients get the better of you. Treat everyone with kindness, respect and lots of patience!
- Threaten or make fun of a client. Don't appear to approve by just standing quietly by while a co-worker does it either.
- "Freak out" if a client or family member accuses you of abuse when you know you didn't do anything wrong. Discuss the situation with your supervisor, telling him or her all the facts.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Abuse is a serious problem in our communities and in our institutions.
2. The people most at risk for abuse are ***children*** and the ***elderly*** because they often cannot protect themselves from harm.
3. Abuse is some action by a ***trusted*** individual that causes physical and/or emotional ***harm*** to the victim.
4. Whistleblowers are heroes who speak out when they witness abuse in the workplace, and have the power to make it STOP!
5. Caregivers are Mandated Reporters. That means you are *required* to report to the proper authorities if you observe or even just suspect a client is being abused.

HOW DO YOU REPORT ABUSE

CAREGIVERS ARE MANDATED REPORTERS!

A Mandated Reporter is a professional who has regular contact with vulnerable people—and is required to report to the proper authorities if abuse is observed or suspected. You can make reports anonymously, but you can also be charged with negligence for failing to make a report.

When making a report, be prepared to answer the following questions:

- Is the client in immediate danger?
- Is the client in need of emergency medical treatment?
- Does the client have any current medical problems?
- What is the client's current living situation?
- Have you seen or heard yelling, hitting or other abusive behavior?
- Do you know the identity of the abuser?

WHAT WILL HAPPEN NEXT?

- If the situation is an emergency, the authorities forward the report to the police or paramedics.
- The case is assigned to a staff member who contacts the victim. In some states, if the victim is a competent adult, he or she has the right to refuse an investigation.
- If appropriate, the authorities will conduct an investigation of the situation. They may interview health care providers, police, clergy, neighbors, family and friends.
- Based on what the investigation shows, the victim may be moved to a safer location.

If the authorities find that it is safe for the victim to remain in his or her current living situation (or an adult victim refuses to leave), they may arrange for a variety of support, including:

- Mental health assessments.
- Counseling for the victim and/or the abuser.
- Support groups for stressed-out caregivers.
- Legal services such as restraining orders that keep an abuser away from the victim or lawsuits to get back stolen funds.

WHAT I KNOW NOW!

Now that you've read this inservice on abuse, jot down a couple of things you learned that you didn't know before.

COURSE OUTLINE

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A Client Care Module:
Recognizing & Reporting Abnormal Observations

SAVING CARRIE JANE...

Carrie Jane is an 83-year-old woman with a collection of health problems. She has diabetes, high blood pressure, and a permanent colostomy. In addition, she just had hip replacement surgery. You are assigned to care for her during her rehabilitation.

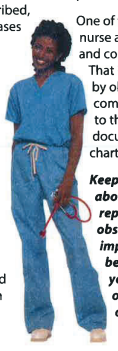
On your first visit with Carrie Jane, you observe a slightly overweight woman with a good understanding of her diabetes and high blood pressure. She eats a healthy diet, takes her medications as prescribed, and is able to manage her diseases effectively.

One week later, Carrie Jane has lost some weight without trying, her energy level is low, her blood sugar level stays high throughout the day, and you notice a reddened, sore area on the top of her foot where the shoe rubs.

You report what you observe right away. The nurse and a dietitian arrive to assess Carrie Jane's diet and medication. A special wound nurse is assigned to prevent the pressure sore on Carrie's foot from progressing.

Your careful observation and reporting have set in motion the intervention needed to keep Carrie Jane healthy while under your care.

Without your careful attention, Carrie Jane's unintentional weight loss would have continued, her elevated blood sugar would have further damaged her body, and the pressure sore that was developing could have progressed to a dangerous wound that may have only been resolved by amputation.



One of the primary roles of a nurse aide/caregiver is to collect and communicate information. That information is collected by observing clients and communicated by reporting to the nurse and/or documenting in the client's chart.

Keep reading to learn more about recognizing and reporting abnormal observations. This important role ensures the best possible outcome for your client when changes or new developments occur.

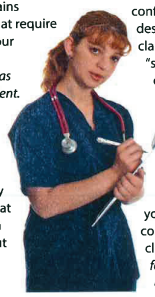
WHO, WHAT, WHEN, AND HOW?

UNDERSTANDING PRIORITY LEVELS

You make observations about clients all day long. But, how do you know *what*, *when*, and *how* to report what you see?

Throughout this inservice, you will read about all sorts of abnormal observations. In order to help you decide the best course of action to take with each observation, they will be grouped according the following priority levels:

- **URGENT:** When you observe something abnormal that falls under this category, you must **STOP** what you are doing and **REPORT** to a nurse or your supervisor right away. Urgent abnormal observations are those that are ***immediately life-threatening.*** They include the ABC's (airway, breathing and circulation problems) and abnormal vital signs.
- **IMPORTANT:** This category contains abnormal signs and symptoms that require you to **REPORT** to the nurse or your supervisor and **RECORD** your observations in the chart *as soon as you complete your task with the client.* This category includes signs and symptoms that require intervention but are *not* immediately life-threatening.
- **SIGNIFICANT:** This third category are those signs and symptoms that should be **RECORDED** in detail in the chart. There is no urgency but these abnormal observations should not be ignored.



A FEW TERMS TO KNOW

TO OBSERVE: This involves paying close attention to the client and the surroundings while gathering information through your eyes, ears, nose, and sense of touch.

TO REPORT: Contacting a nurse or supervisor to verbally describe any *urgent* or *important* observations. If your job requires you to document, your report should always be followed by a detailed entry in the client chart indicating what was observed, the date and time of the observation, and who the observation was reported to (including full name and title).

TO RECORD: Writing a detailed account of the observation in the client's medical chart.

OBJECTIVE OBSERVATIONS: Information that can be seen, heard, smelled, felt, or measured and confirmed by another person. Vital signs, a description of urine (including amount, color, and clarity), or reporting that your client has a "shuffling gait" are all examples of objective observations.

SUBJECTIVE OBSERVATIONS: Pieces of information that cannot be (or were not) observed. They are based on something reported to you by the client. For example, your client reports feeling sad or lonely. You cannot see, hear, smell, or feel the feelings yourself. . . and there is no way to measure or confirm the information. So, you report the client's exact words in the chart: "Client states, *'I feel so lonely since my granddaughter went off to college and can't visit as often.'*"

WHAT'S NEW?

Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!

FOCUS ON VITAL SIGNS

Vital signs (temperature, pulse, respirations, and blood pressure) measure how the vital organs of the body are functioning. Vital organs sustain life. Without properly functioning of vital organs (heart, lungs, brain), life would end.

Your workplace may have a specific policy in place to follow for handling abnormal vitals. Ask your supervisor for this policy. If no policy is in place, here are some general guidelines:

PRIORITY LEVEL: URGENT!

Consider all abnormal vital signs urgent and report immediately to the nurse or supervisor.

NORMAL FINDINGS	ABNORMAL FINDINGS
TEMPERATURE: 97.6°-99.6° F or 36.5°-37.5° C (oral) ***Note:*** Temperatures are usually lowest in the morning and highest in the afternoon. Older adults tend to have lower temperatures than other age groups. Exercise can cause temperature to increase temporarily.	**Greater than 100.4°F** *(Many organizations consider a temperature greater than 100.4°F or 37.8°C to be a fever.)* **Less than 97.2°F** *(A low temp may be normal for your older client, but anything less than 97.2°F or 36.2°C may be a sign of hypothermia.)* Know your workplace ranges.
PULSE: 60-100 beats per minute Regular rhythm, easy to find and count.	**Greater than 100 or less than 60** **Irregular Rhythm** **Bounding** *(forceful)* **Thready** *(weak)*
RESPIRATIONS: 12-20 respirations per minute. Regular rhythm, effortless, quiet.	**Greater than 20 or less than 12.** **Shortness of Breath.** **Retractions** *(skin pulling in at neck and ribs on inspiration)* **Coughing.** **Noisy** *(raspy or wheezing)*
BLOOD PRESSURE: Less than 120 *(top number)* Less than 80 *(bottom number)*	**Hypertension** *(high BP)* **Hypotension** *(low BP)* **Orthostatic Hypotension** *(a drop in blood pressure when changing from a sitting to a standing position)*

THINK about it!

What do you do when your client has abnormal vital signs?

- If your client is in *immediate* distress (no breathing, no pulse), ***call for help (or call 911)!*** DO NOT LEAVE THE CLIENT ALONE.
  - Start CPR (unless a DNR or "do not resuscitate" order is in place).
  - Continue CPR until help arrives.
- If you feel the abnormal vital sign does not match how your client appears . . . then ***recheck*** the measurement to ***confirm*** your initial observation.
- Ask a co-worker to check the client if you are having trouble getting a measurement.
- Use different equipment or take a manual measurement if it seems your equipment may be giving a false reading.
- ***Report*** the abnormal value to the nurse or supervisor right away. Then, ***record*** the value in the chart along with the date, time, name and title of the person to whom you reported.

FOCUS ON PAIN

There are different tools for different pain situations. For example the way you measure pain in a person living with dementia is different from the way you would measure pain in someone being treated for cancer. Use your workplace guidelines for gathering information about pain. If no guidelines are in place, use one of the tools pictured on this page.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

THE VISUAL ANALOG SCALE

Valid for use in clients of any age. Say, "Point to the face that shows how your pain feels right NOW."

No Pain	Minor Pain	Moderate Pain	Severe Pain
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.	Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.	Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.

CHECKLIST OF NONVERBAL PAIN INDICATORS (CNPI)

Valid for use in clients who are non-verbal due to advanced dementia, stroke, or other cognitive impairment. Score a 0 if the behavior was not observed. Score a 1 if the behavior occurred even briefly during activity or at rest.

Pain Indicators	With Movement	At Rest
1. Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)		
2. Facial Grimaces/Winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)		
3. Bracing (Clutching or holding onto furniture, equipment, or affected area during movement)		
4. Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. Rubbing (Massaging affected area)		
6. Vocal complaints: verbal ("Ouch," or "That hurts"; cursing, or protesting ("Stop," or "That's enough.")		
TOTAL SCORE		

FOCUS ON MENTAL STATUS

Mental status is the measure of how well your client functions emotionally, intellectually, and socially.

Keep in mind, you are observing for any ***change*** from what is "*normal*" for your client. If you have a client living with Alzheimer's who is routinely confused and shows impaired judgment, you will not need to report this right away as you would in a client who does not usually have these symptoms.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
APPEARANCE Posture is erect. Dressed and groomed appropriately for weather. Smooth, even body movements.	**Hunched or Stooped** **Curled up in bed** **Disheveled** *(untidy or messy)* **Restless or fidgety movements**
LEVEL OF CONSCIOUSNESS Awake, alert, and aware of your presence in the room.	**Confused** *(slow to respond)* **Lethargic** *(difficult to arouse)* **Coma** *(unable to arouse)*
MOOD Should be appropriate to client's place and condition. Cooperative.	**Flat** *(lacks emotional expression)* **Depressed** *(sad, tearful)* **Anxious** *(worried, nervous)* **Irritable** *(easily angered, annoyed)*
ORIENTATION Aware of ***time*** (day, date, year), ***place*** (present location), and ***person*** (knows own name).	**Disoriented** *(Your client may become confused about the date, but under normal circumstances, should know where and who he is.)*
THOUGHT PROCESSES Conversations make sense. Logical and rational.	**Illogical** *(Ideas are disconnected and run together.)* **Blocking** *(stops in the middle of a thought)*
PERCEPTION Aware of reality.	**Hallucinations** *(sees or hears things that are not really there)*

THINK about it!

WHEN IS MEMORY A PROBLEM?

Normal aging changes the way the brain stores and recalls information.

It's ***normal*** if your elderly client forgets the name of someone she just met or where she put her purse.

It's ***not normal*** when memory affects activities of daily living. For example, your client suddenly has changes in ability to remember how to get dressed or find her way around a familiar place.

- ***Be sure to report any abnormal memory problems affecting your client.***

An elderly man was telling his friend about a new restaurant he and his wife recently visited.

"The food and service were great!" he said.

His friend asked, *"What's the name of the place?"*

"Gee, I don't remember," he said, *"What do you call the long-stemmed flower people give on special occasions?"*

"You mean a rose?" asked his friend.

"That's it!" he exclaimed and turned to his wife and asked, *"Rose, what's the name of that restaurant we went to the other day?"*

FOCUS ON NUTRITION

Nutrition is about more than just eating! It's about providing the right *type* and right *amount* of fuel to support the day-to-day needs of each individual.

Nutrition can be affected by emotions, illness, chemotherapy and radiation, culture, and economics. In addition, nutritional needs change with age and activity level.

One size does not fit all when it comes to "normal" nutrition. However, below you will find a few observations that might be clues that something is abnormal.

PRIORITY LEVEL: SIGNIFICANT!

RECORD *observations in detail in the chart, if required. Most symptoms of abnormal nutrition* ***can*** *be corrected and* ***should not*** *be ignored.*

NORMAL FINDINGS	ABNORMAL FINDINGS
WEIGHT Normal weight for height and age.	**Obese** *(increases BP & blood sugar, hinders mobility, damages joints, and causes many other problems)* **Underweight** *(fuel reserves may be depleted, may lack energy, unable to fight infection or heal wounds)* **Unintentional weight loss** *(a weight loss of 5% or more of body weight over a 30 day period)*
PHYSICAL APPEARANCE Skin is smooth. Eyes are clear and shiny. Tongue is moist, not swollen. Muscles have good tone and strength.	**Skin is dry and flaky** **Eyes are dry, dull, sunken, may be red with sores on the edges** **Tongue is pale, or beefy red, swollen or painful** **Muscle wasting** *(weakness)*
APPETITE Consumes an appropriate amount of food for age and activity level.	**Anorexia** *(unable or unwilling to eat; may be related to medication, illness, pain, or emotional problems)* **Overeating** *(eats in response to stress, emotions, or boredom)*

CONNECT it now!

Apply what you know

You are caring for a 78-year-old woman who is diabetic and receiving radiation treatment for breast cancer.

- You know she has to eat at specific times to regulate her blood sugar. But, the cancer treatments make her nauseated and unable to eat.
- She has lost six pounds in the last week. She also has signs of depression.
- How can you help? ***Think of three creative solutions*** to help with mood, appetite, and unintentional weight loss.
- ***Share your ideas with your co-workers and supervisor.***

He who takes medicine but neglects his diet wastes the skill of his doctors.

~ Chinese proverb

FOCUS ON ELIMINATION

Many older adults mistakenly believe that incontinence, constipation, and hemorrhoids are just part of normal aging, but it's just not true. These are things that can usually be treated or prevented with proper and timely intervention.

Be sure ***YOU*** know what's normal and what's not so you can help your clients understand their bodies a little better. It's important to be able to recognize and report any abnormal elimination observations so intervention can be started.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
URINE OUTPUT Amount: 1200-1400ml per day. Color: Clear to dark yellow. Odor: Light "nutty" odor. No pain or burning. Consistent bladder control.	**Less than 1200ml** *(may be dehydrated or not drinking enough)* **More than 1500ml output** *(may be seen in diabetics or clients on diuretics—"water pills")* **Dark amber urine** *(dehydration)* **Dark red or brown** *(may contain blood)* **Foul Odor** *(may indicate infection)* **Pain or burning with urination** *(may indicate infection)* **New or worsening incontinence** *(may indicate infection)*
BOWEL ELIMINATION Amount: ***Once a day is normal,*** but it can also be normal to go up to ***3 times a day*** or as little as ***once every 3 days***. Shape: Formed, firm. Color: Light to dark brown. No pain or straining.	**Diarrhea** *(frequent, watery stools)* **Constipation** *(no BM in more than 3 days)* **Fecal Impaction** *(Stool forms a large hard ball that client is unable to pass naturally. Watery leakage and cramping pain are common.)* **White or Yellow Stool** *(may be a problem with absorption)* **Black or Red Stool** *(blood in stool)* **Pain or Straining** *(may need to increase fluids or fiber in diet)*

GET OUT!

Thinking outside the box!

Working with clients in the home often requires coming up with creative solutions to unusual problems.

- **THE PROBLEM:** You are caring for a 76-year-old man who lives alone and just needs help with personal hygiene, cooking, and cleaning.
- When you arrive at his house one day, you find a box of laxative pills sitting out on the bathroom counter. You ask him if he has had trouble having a bowel movement. He replies that he normally has a BM every day but didn't have one yesterday so he thought he should take two or three laxative pills.
- **WHAT YOU KNOW:** You know it can be normal for people to go as long as 3 days without a BM. It depends on diet and activity level. You also know overuse or misuse of laxatives can be harmful.
- **GET CREATIVE**: Think of **3 creative solutions** you might suggest to your client to keep him from overusing laxatives in the future.
- **TALK ABOUT IT:** Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

FOCUS ON SKIN

Skin is an organ just like the heart and lungs. In fact, skin is the largest organ of the human body. And, just like you wouldn't ignore an abnormal heart rate or abnormal respirations, you shouldn't ignore wounds, rashes, redness, pain, swelling, or other problems with your client's skin.

Any break in the skin, whether it is a cut, tear, burn, or pressure ulcer, leaves the body vulnerable to infection. Infections in older or ill clients can be deadly.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
COLOR Should be consistent with genetic background. Varies from pinkish to dark brown. May have yellow or olive undertones.	**Pallor or Ashen Gray** *(looks like a "loss of color;" can be a sign of anemia or shock)* **Widespread Redness** **Cyanosis** *(blue colored skin)*
TEMPERATURE Skin should feel warm, with hands and feet slightly cooler.	**Hypothermia** *(temp less than 97.2°F)* **Hyperthermia** *(temp greater than 100.4°F)*
MOISTURE Normal perspiration in response to activity or environment.	**Diaphoresis** *(extreme sweating, soaking though clothing and bedding)* **Dehydration** *(eyes, nose, mouth, and lips look dry and sticky)*
BRUISING No bruising, or normal bruising from occasional bumps.	**Multiple Bruises** *(many bruises in multiple stages of healing may indicate abuse)* **Bruises on face, chest, or abdomen**
PRESSURE ULCERS No signs of pressure ulcers.	**Pressure Ulcer present** *(Know the early signs of a pressure ulcer—see "Stages of Pressure Ulcers to the right. Recognize and report early so treatment can be started.)*

WHAT do you SEE?

STAGES OF PRESSURE ULCERS

Early signs of a pressure ulcer may be pale skin or slightly reddened skin over a bony area.

The client may complain of pain, burning, or tingling.

Stage 1: The skin over a bony area is intact but pink or slightly reddened.

- In a client with dark skin, the skin may appear ashen.
- The client may sense slight itching or mild tenderness.

Stage 2: The skin is red and swollen.

- There will either be a blister or an open area.

Stage 3: The area begins to look like a crater.

- The sore will extend deeper into the skin.

Stage 4: The sore extends deep into the fat, muscle, or bone.

- There may be a thick black scab, called eschar, which is actually dead skin.

FOCUS ON FAMILY AND RELATIONSHIPS

Families come in all shapes and sizes and defining a family as healthy and functional is difficult and subjective. However, there are a few "red flags" or abnormal observations you can be aware of that—when properly reported—may actually prevent needless harm or suffering for your client.

It's important to understand that if you *observe or suspect* your client is being ***abused***, you have an obligation to report that abuse right away. You should get yourself and your client out of harm's way as soon as possible.

PRIORITY LEVEL: SIGNIFICANT!

RECORD *observations in detail in the chart, if required. Personal relationships* ***can*** *be difficult to deal with but* ***should not*** *be ignored.*

NORMAL FINDINGS	ABNORMAL FINDINGS
HEALTHY, FUNCTIONING FAMILY • Power roles are equal; there is respect and trust. • Conversations can be playful and humorous. • Family members listen to each other. • The family is able to admit when help is needed and seeks professional support. • The client is connected to the larger community. Knows neighbors, attends church, and has friends other than family members.	**Dictatorship** *(One caregiver is making all the decisions without input from the client or other family members.)* **Fear or Anxiety** *(The client becomes frightened, fearful, tearful, or withdrawn around certain family members.)* **Anger** *(Every family has a history—and grudges can be held for a long time. But anger can lead to violence or other destructive behavior and should be addressed by a professional.)* **Suspicion** *(Your client may feel suspicious of certain family members. It's important to explore whether this suspicion is rational or irrational.)* **Substance Abuse** *(Any substance abuse by your client or other family member in the home can lead to dangerous, destructive, or harmful behavior.)* **Isolation** *(Clients and families who do not reach out to friends, the community, or professionals when needed will become isolated.)*

5 KEY points

Key Points to Remember

1. It's not enough to just know what is normal or abnormal. You also have to know what's normal for **YOUR** client.
2. Recognizing abnormal signs is only half of the story. Knowing *who, what, and when* to report your observations is the key!
3. You should always have a pen and paper in your pocket to write down important pieces of information. This will make reporting easier.
4. A verbal report should be factual. It should not contain your opinion. Try to use *objective* information as much as possible.
5. Always document the *date* and *time* in addition to the *name* and *title* of the person to whom you reported.

"A family is a unit composed not only of children but of men, women, an occasional animal...and the common cold.

~Ogden Nash

"Families are like fudge—mostly sweet with just a few nuts."

~ Anonymous

FINAL TIPS ON ABNORMAL OBSERVATIONS

SOME ADDITIONAL ABNORMAL OBSERVATIONS

- **Cold or flu Symptoms:** Report any fever, chills, congestion, drainage from eyes or nose, or cough so treatment can be started right away before symptoms worsen.
- **Trouble Sleeping:** Report if your client has trouble *falling* asleep or *staying* asleep. Insomnia is a common side effect of many medications and can often be corrected.
- **Problems with routine ADL's:** You should notice and report if your client is having new or increasing difficulty with activities of daily living. The level of care may need to be increased.
- **Changes in vision or hearing:** Let your supervisor know if your client has any new or worsening vision or hearing problems. Often a trip to the eye or ear doctor is all that is needed.
- **Change in ability to ambulate:** Be sure to report and document if your client is unable to ambulate safely. A physical therapist or new assistive equipment may be needed.
- **New symptoms of one sided weakness:** One-sided weakness is a sign of a stroke. Report this immediately so treatment can be started and damage can be minimized.

FINAL TIPS FOR REPORTING ABNORMAL OBSERVATIONS

- Always carry a pen and paper in your pocket to write down important pieces of information. This will make reporting easier.
- When giving a verbal report to the nurse or your supervisor, be sure to use the client's full name, room number, and even bed number (if applicable) to correctly identify the client.
- Be factual in your reporting. Use objective information as much as possible. Remember, objective information is measurable and can be confirmed. It is not an opinion or a judgment.
- If you are required to document at your workplace, write your observations in the client's chart . . . even if you've given a verbal report to the nurse. Be sure to document the date and time of the observation in addition to the name and title of the person to whom you reported.

Now that you've read this inservice on abnormal observations, take a moment to jot down a couple of things you learned that you didn't know before.

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intheknow A home care pulse COMPANY | CAREGIVER TRAINING

A Communication Module:
Communicating with Individuals Living with Alzheimer's and Dementia

We hope you enjoy this inservice prepared by registered nurses especially for caregivers like you!

About this Course:

This course provides caregivers with important information about the communication needs of clients with Alzheimer's disease or other forms of dementia. It discusses how communication happens normally and how it is affected by Alzheimer's disease. Caregivers will learn how to help clients communicate with them and ways that they can better communicate with their clients. In addition, there is information on how to handle a client's anger, how to answer tough questions and alternative therapies that assist with communication.

Audience: Home Health Aide; Hospice Aide; Nurse Assistant - CNA; Personal Care Aide

Teaching Method: Classroom-based, instructor-led training.

For California, please indicate the teaching method used: ❒ Lecture

❒ Group Discussion ❒ Other (please specify) _____

CE Credit: 1 hour

Evaluation: The learner must achieve 80% or higher on the post-test to receive credit.

Disclosures: The authors, planners and reviewers of this educational activity declare no conflicts of interest with this activity. There are no commercial interests or sponsorships related to this educational activity.

Note to Instructors: Please see the Instructor's Guide for classroom activity suggestions, teambuilding activities, discussion questions, worksheets, quiz answer key, and a post-course survey for learners.

If you have comments and/or suggestions for improving this inservice, email In the Know at feedback@knowingmore.com.

THANK YOU!

COURSE OBJECTIVES

Describe the typical course of events that must take place for communication to be successful.

❖

Describe two things that can make communication challenging for people living with Alzheimer's.

❖

List at least three things you can do to help people living with AD communicate more effectively.

❖

Discuss what you can do to communicate more effectively with your clients living with Alzheimer's disease.

❖

Practice patient and thoughtful communication in your daily work with Alzheimer's clients.

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A Communication Module: **Communicating with Individuals Living with Alzheimer's and Dementia**

COURSE OUTLINE

The Words and Memories Dance and Hide

If you care for clients living with Alzheimer's disease, chances are good that you've had your fair share of communication frustrations.

As the disease progresses, more and more changes in the ability to communicate.

- At first, the words and memories just ***dance away*** for a minute or two and then come back.
- Later, the words and memories seem to ***play hide-and-seek***, but they can usually be found with a little help.
- Eventually, the words and the memories just ***pack up and move out*** of the person altogether.

One of the most important things YOU can do for your clients living with Alzheimer's is to remember that they are an individual with unique life experiences. They had experiences and adventures. They had jobs and families. They contributed to the world in their own special way.

That means that the lost words and memories are far more sad and frustrating to them than they are to you. In fact, the lost words and memories are often the reason behind the dementia-related behaviors you may see in your clients.

And while you may not have any control over your client's abilities or behaviors, your words, the tone of your voice and your calm demeanor can make everything easier for everyone! Keep reading to find out all about how you can communicate effectively with your clients and how you can help them to communicate with you!

This course is recognized by the Alzheimer's Association® for following evidence-based Dementia Care Practice Recommendations in the following topic areas: Alzheimer's and dementia, person-centered care, assessment and care planning, activities of daily living, and behaviors and communication. Learn more about this recognition HERE.

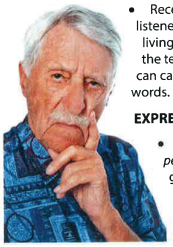
HOW COMMUNICATION HAPPENS

Five critical factors must all work together for communication to be successful. There must be a:

- **SENDER:** The sender is the person who *starts* the communication.
- **MESSAGE:** The message is formed by the sender.
- **MEDIUM:** The sender chooses *how* she will communicate. It may be through speaking, writing, typing or even by using sign language.
- **RECEIVER:** Someone must hear, read or see the message and *understand* its meaning.
- **FEEDBACK:** The receiver must provide feedback that shows the message was understood.

2 WAYS THINGS CAN GO WRONG COMMUNICATION

RECEPTIVE COMMUNICATION CHALLENGES:



- Receptive communication refers to the way a listener *receives* and *understands* a message. A person living with Alzheimer's disease may have damage in the temporal lobe of the brain. Damage in this area can cause changes in the ability to understand spoken words.

EXPRESSIVE COMMUNICATION CHALLENGES:

- Expressive communication refers to *how a person gives a message*. This can be done by gesturing, speaking or writing and can be enhanced by using body language or emotional expressions. A person living with Alzheimer's may have changes in the ability to remember certain words or show the correct emotion. For instance, the person may cry or look sad when they are actually happy.

In a Nutshell: Alzheimer's disease can change a person's ability to understand information (receptive language) and the ability to express information (expressive language).

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

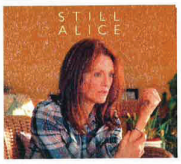
The Facts

Changes in the ability to communicate is often reported as being the most frustrating and difficult problem for people living with Alzheimer's disease (as well as for their family members and their caregivers).

While each person living with Alzheimer's disease is unique, there are a few common communication challenges you may notice.

Common communication challenges may include changes in the ability to:

- Find the right word.
- Speak fluently.
- Understand what others say and/or mean.
- Read and write.
- Show emotions.



COMMUNICATION SLOWLY CHANGES

Alzheimer's disease is a progressive illness. That means the symptoms can get worse over time. This holds true for the person's ability to communicate. It may get worse over time as the disease progresses.

THE "EARLY STAGE" OF AD

The symptoms of the early-stage of Alzheimer's disease come on slowly. A person living with early-stage Alzheimer's disease may look well and may be able to "cover up" the signs of the disease. Communication challenges may start as the person begins to have:

- **Changes in the ability to concentrate.** It may become challenging to focus attention on someone who is speaking—which makes it hard to get the whole meaning of the message.
- **Changes in the ability to remember familiar** names, dates and how things work.

THE "MIDDLE STAGE" OF AD

During the middle-stage of Alzheimer's the individual may continue to have all the signs of the early stage, but now he or she may also begin to experience changes in the ability to:

- Remember familiar words.
- Participate in conversations.
- Follow directions.

SYMPTOMS OF THE "LATE STAGE" OF ALZHEIMER'S DISEASE

People in the late-stage of Alzheimer's disease may experience:

- Changes in both short and long -term memory.
- Worsening changes in ability to speak (but may groan or scream).
- Changes in ability to recognize themselves or others.

WHAT EXCITES YOU?

STILL ALICE

In her book/movie titled, Still Alice, author Lisa Genova provides a stunningly accurate portrayal of one woman's gradual slide into Alzheimer's.

Alice, (played by Julianne Moore) is a mother, wife and doctor who learns she has early onset Alzheimer's disease. As she struggles with what lies ahead, she argues:

"And I have no control over which yesterdays I keep and which ones get deleted. This disease will not be bargained with. I can't offer it the names of the US presidents in exchange for the names of my children. I can't give it the names of state capitals and keep the memories of my husband."

Read the book or watch the movie for deeper insight into living with Alzheimer's disease.

HOW CAN YOU HELP PROMOTE SUCCESSFUL COMMUNICATION?

Depending on the stage and the severity of the disease, your client living with Alzheimer's disease may have changes in the ability to express his or her thoughts and feelings. Here are some ways your can help your client communicate with you and others:

- **Allow more time.** It may take a little longer for your client to find the right words and to get them out. It's important to be patient and show your support through the process. Let your client know you're listening and trying to understand by making eye contact and nodding.
- **Stay present in the conversation.** Listen closely and be careful not to interrupt.
- **Clarify your understanding by repeating back what you heard.**
- **Acknowledge frustrations.** Being unable to communicate can be frustrating and isolating. Try saying, *"I know you want to tell me something important. I'm trying to understand."*
- **Give permission to take a break.** If your client is having trouble communicating, let her know that it's okay. Encourage her to relax and to continue when she's ready.
- **Take a guess.** If the person cannot find a word, try guessing what she is trying to say or ask the person to point or gesture.

- **Manage environmental noise.** Keep distractions such as television and radio at a minimum when talking to your client. This will keep the client focused, and enhance your ability to listen.
- **Never criticizing or correct.** It's not helpful to tell the person he is wrong. Instead, listen and try to find the meaning in what is being said. Repeat what was said if it helps to clarify the thought.
- **Avoid arguing and/or defending yourself.** If your client says something you don't agree with or accuses you of doing something wrong, just let it go! Standing your ground in this situation only makes things worse — and can even increase your client's agitation and make communication more difficult.

CONNECT IT!

Think about a time when you struggled to understand what your client was trying to say.

What was your client saying or doing?

_____

_____

What did he or she really mean?

_____

_____

How did you support your client through the challenge?

_____

_____

What could you have done differently to help?

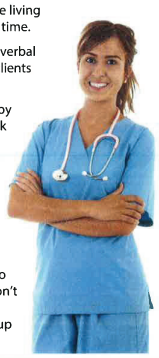
_____

_____

What advice would you give to a new caregiver who is struggling to communicate with someone living with Alzheimer's?

WHAT CAN YOU DO TO COMMUNICATE BETTER WITH YOUR CLIENTS?

- **Approach a client living with Alzheimer's from the front.** Don't speak to them suddenly from behind or you might startle them.
- **Keep your voice low and unhurried.** Use simple, everyday words, but don't use "baby talk."
- **Identify yourself.** Don't be offended if your client doesn't remember you from day to day.
- **Try to stay calm and positive.** If you are feeling stressed or irritable, your mood can easily rub off on someone living with Alzheimer's disease. If you stay calm and positive, your client may "mirror" your good mood.
- **Keep it simple.** Ask one "yes" or "no" question at a time. If the client doesn't answer you, repeat the question using the same words.
- **Give plenty of time to respond.** It can take up to one minute for your AD client's brain to process each sentence you speak.
- **Smile!** Individuals living with Alzheimer's may copy your actions. If you smile, they will smile. If you frown or get angry, so will they!
- **Describe everything.** Be sure to let client living with Alzheimer's know what you are doing—one step at a time.
- **Don't talk in terms of time.** For example, say *"We'll take a walk after lunch."* not *"We'll take a walk in one hour."* People living with Alzheimer's disease may lose their sense of time.
- **Use nonverbal communication.** Try using nonverbal cues such as touching or pointing to help your clients understand what you are saying.
- **Remain respectful.** Be sure to call your clients by name and be respectful, saying things like "thank you," "please," "yes, ma'am" or "no, sir." This helps them feel maintain their sense of dignity.
- **Praise your Alzheimer's clients.** Be generous with positive feedback like *"Good job!"* or *"You're doing great."* or *"You look beautiful today."*
- **Limit choices.** Clients living with Alzheimer's disease may become frustrated very easily. Try to limit offering too many choices. For example, don't say "What do you want soup, a sandwich, or a salad for lunch?" Instead say "Would you like soup or a sandwich for lunch."



THE NEXT STEP!

HONORING PERSONAL PREFERENCES

It's important to always try to honor your client's personal preferences. But how do you do that if he or she can't tell you?

You can ask family members about your client's likes and dislikes, and you can observe your client during routine activities.

If your client appears happy or content (is involved, pays attention, smiles) during an activity, then you can assume your client enjoys it!

Notice how your client seems to feel during:

- Tub baths, showers, or bed baths.
- Watching certain programs (news, cartoons, dramas, comedies).
- Visits from certain family members or friends.
- Listening to music.
- Spending time outdoors.

WHEN COMMUNICATION TURNS ANGRY

Anger can be a common emotion for people living with Alzheimer's disease, particularly in the later stages. It's important to understand that behavior is a form of communication for individuals living with Alzheimer's. It is often used to communicate an unmet need. It is your job to determine the need and how to address it.

While you may not have any control over your client's feelings, you do have control of your own behaviors and how you react to it. *Your behaviors and responses have the potential to turn the anger around!* **Here are some things you can do:**

- **You don't have to be right this time!** Never argue or try to reason with an angry client. This will make the situation worse.
- **Remain calm and comforting.** You are the role model for calm and rational behavior.
- **Help untangle confusing emotions.** Observe body language and help your clients identify their emotions. For example, you might say *"You seem angry, can I help?"*
- **Provide frequent reassurance.** You can say *"I'm here to help,"* and *"Everything is going to be OK."*
- **Remove distractions.** Turn off televisions and radios. Close windows and doors. Dim the lights. Ask visitors to step out for a moment if their presence seems distressing to your clients.
- **Provide time and space.** If your client does not present a danger to himself or to others, watch from a safe distance and allow him to settle on his own.
- **You're not the boss or jailor!** Never scold, punish or make the person feel bad for feeling or expressing anger.
- **NEVER APPLY RESTRAINTS** unless ordered to do so by a doctor.
- **Redirect.** Offer an alternate activity that your client enjoys (such as taking a walk).
- **Get help if you need it.** If your client seems like he may become violent, call for help right away. Get to a safe place if you can. Keep your client as safe as possible and wait for help to arrive.
- **Make mental notes.** Pay attention to the time, what's happening and what may have triggered your client's anger. That way you can avoid similar situations in the future.

TALK ABOUT IT!

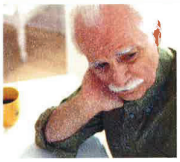
PREVENT COMMUNICATION-RELATED BEHAVIORS

You may not be able to prevent all communication-related behaviors, but there are a few things you can try, such as:

Simplify everyday activities. For example, instead of just saying, *"Put on your shirt,"* start with, *"Your shirt is on the bed."* When your client sees the shirt, say, *"Pick up the shirt."* Then, *"Put your arm in the sleeve,"* and so on.

Keep 'em full and rested! Feeling hungry and/or tired can be confusing sensations to someone who doesn't understand what the feelings mean. Remember, behavior is a form of communication. The person may be trying to communicate an unmet need.

Talk about it with your supervisor and co-workers. Find out what they do!



HANDLING TOUGH QUESTIONS

As your client's disease advances, there may be times when their memories become tangled up in a different time and place. How you respond to these situations can set the tone for a calm transition.

Here are some examples of tough, uncomfortable, and sometimes heartbreaking questions you may get from your clients:

⇒ **"Can you take me to my parents (or spouse)?"**

How do you respond to this request if your client no longer has living parents (or a spouse)? First, try to remember that it will do no good to tell her that her parents (or spouse) have died. In fact, this will only cause her to suffer the grief and loss all over again.

Instead, you might put off the request until the memory passes by saying, *"It's not a good time to travel,"* or *"Let's make a plan to visit next week."*

Another option is to indulge the memory and ask your client to tell you about the person she wants to visit. Allowing her time to reminisce may alleviate the feeling she has of needing to visit them.

⇒ **"Who are you?" or "Do I know you?"**

If the person says this to you, just give your name and ask if it's a good time for you do whatever it was you were there to do (feed, bathe, etc.).

Don't make a big deal about it or dwell on the fact that they don't recognize you. Forgetting people is painful and embarrassing enough for your client.

It's also important to help family members deal with the uncomfortable feelings that come up when their loved one says these words to them. ***Reassure them that the lost memory is a normal part of the disease and has nothing to do with them being unimportant or unmemorable.***

Depression

COULD YOUR CLIENT BE DEPRESSED?

Depression is very common among people living with Alzheimer's, especially in the early and middle stages.

Some symptoms of depression may include:

- Feeling sad or tearful.
- No interest in doing anything.
- Having feelings of worthlessness.
- Being agitated easily.

BUT . . .

Depression in Alzheimer's doesn't always look like depression in other people.

It may be less severe, and it may come and go.

If you see signs of depression, it's important to report it right away, even if it seems mild.

Treatment is available and can make a significant difference in quality of life.

ALTERNATIVES: PETS & COMMUNICATION

Pet therapy can help people living with Alzheimer's disease recover some essential life skills by:

- **Improving short term memory.** Calling the pet by name or asking for a behavior such as "sit" and then rewarding compliance can improve short-term memory.
- **Improving long term memory.** Seeing a pet may trigger the person to remember one of their favorite pets or to reminisce about its favorite toy or trick.
- **Improving communication.** Talking about the pet or to the pet can improve communication skills since pets do not care if the person's speech is clear or their thoughts make sense.
- **Improving the senses.** The sense of smell (puppy breath), touch (the silkiness of a cat's coat), and temperature (the warmth of the animal's head on a lap) can improve environmental awareness and decrease withdrawal. Sight is stimulated when the individual watches the animal move around the room. Listening skills are sharpened when the person tunes in to hear purring or panting. ***Heightened senses improve the ability to communicate!***

You play an important role in assessing the need for a pet in your client's life. A client may benefit from pet therapy if he or she:

- Has few or no outside visitors.
- Seems lonely, depressed or anxious.
- Reminisces frequently about past pets in his or her life.
- Has the physical and mental capacity to pet, stroke, hug, or just sit with an animal without accidentally harming it.

If you notice one or more of these signs in your clients, you can:

- **In facilities**—advocate for pet visitation or animal-assisted therapy programs.
- **In home health**—open the discussion to the possibility of a companion pet, if you think the client is able to handle the responsibility. If pet ownership is not a possibility, look for local groups that provide pet visitation services.

THINK ABOUT IT!

BABY DOLL THERAPY

Want to communicate better with clients living with dementia or Alzheimer's? Why not try "Baby Doll Therapy"?

Research shows that clients living with dementia or Alzheimer's communicate better when holding baby dolls!

Having a "baby" to care for can also be calming and comforting.

- ***Does your workplace use "Baby Doll Therapy" or something similar? If so, is it working?***
- ***Why do you think this type of therapy works so well?***
- ***Some opponents argue that this type of therapy may be upsetting to family members. What are your thoughts?***

ALTERNATIVES: LISTENING TO MUSIC CAN IMPROVE COMMUNICATION

Can a person who has completely stopped communicating in the late stages of Alzheimer's regain the ability to talk and have meaningful conversations? You bet! And music is the key to unlocking the silence.

Plenty of research is going on right now to measure the benefits of using iPods (or other mp3 playing devices) with personalized playlists for people living with dementia or Alzheimer's disease.

- **Listening to preferred music though personal headphones has had a major, positive impact on everyone who uses them.** Many participants in the studies have become happier and more social. And the relationships among staff, residents and family have deepened.

Not convinced? Go to musicandmemory.org and look around. You'll find research on the connection between music and the brain. Or watch the documentary called **Alive Inside** on Netflix.

Here's how you can bring music into your client's world:

- An iPod Shuffle (or similar device) is a good choice since it has very few buttons, no display screen and is easy to learn how to operate.
- Don't have access to an iPod? Ask family members to give their loved ones an iPod (or other mp3 player) as a gift or to donate an older model that is no longer being used.
- Here's another solution. Most smart phones can store and play music through headphones too. Or, you can download free apps like Pandora or Spotify and stream free music through the phone.
- Be sure to include the client and/or the family members in building the playlist. The wrong choice of music can make the whole technique backfire.
- Larger, padded headphones that rest on the sides of the head and ears will be more comfortable than small ear buds that go inside the ears.

Images from Alive Inside documentary.

FIVE KEY POINTS!

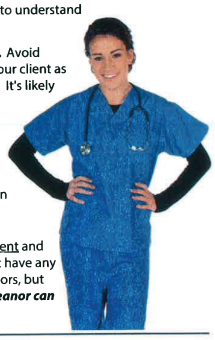
REVIEW WHAT YOU LEARNED!

1. Communicating with client's living with Alzheimer's disease may be one of the most difficult and frustrating parts of your job.
2. While you may not have any control over your client's abilities or behaviors, your words, the tone of voice and your calm demeanor can make all the difference!
3. Alzheimer's disease creates changes in the ability to understand and express thought s and feelings.
4. Behavior is a form of communication for individuals living with AD. It usually arises from an unmet need. It's the caregiver's job to determine the need and address it.
5. Alternative therapies like music, pets and baby dolls are inexpensive and safe options you can try without a doctor's order.

FINAL TIPS FOR COMMUNICATING WITH CLIENTS LIVING WITH AD

Communicating with client's living with Alzheimer's disease may be one of the most difficult and frustrating parts of your job. **Here are a few final tips:**

- **Think about every word you speak.** Use short sentences and ask only one question at a time. This keeps the client focused on one thought at a time.
- **Speak slowly and distinctly.** Repeat key words to prevent confusion.
- **Say it with gestures.** Enhance verbal communication with meaningful gestures to give your client more options to receive information.
- **Give simple but exact instructions.** If your client is capable of participating in his or her own care, you might say, *"point to where it hurts," "open your mouth,"* or *"lift your arm."*
- **Avoid finishing your client's sentences.** Allow your client to complete his own sentences or thoughts. If he gets stuck, ask for permission to help. Say the word or phrase slowly and distinctly if help is requested.
- **Be honest.** Never say you understand if you do not. This may increase frustration and decrease the client's trust in you.
- **Acknowledge frustrations.** Communication challenges can be frustrating and isolating. Watch for signs of depression or helplessness.
- **Stand close by.** Position yourself within the client's line of vision. Your client may need to see your face or lips to understand what you are saying.
- **Assume your client understands you.** Avoid speaking to others in the presence of your client as though he or she understands nothing. It's likely that he does understand, but just can't express that understanding to you.
- **Encourage socializing.** Ask family members to talk to the client even though he may not respond. This decreases the person's sense of isolation and maintains self-esteem.



The Bottom Line: It's important to be patient and remain respectful at all times. You may not have any control over your client's abilities or behaviors, but ***your actions, tone of voice and calm demeanor can make everything easier for everyone!***

WHAT I KNOW NOW!

Now that you've read this inservice on communicating with Alzheimer's clients, jot down a couple of things you learned that you didn't know before.

COURSE OUTLINE

inthe**know** | CAREGIVER TRAINING
A home care pulse COMPANY

A Disease Process Module:
Understanding Dementia

IS IT OR ISN'T IT DEMENTIA?

Meet John. John is a 71-year-old widower with Alzheimer's disease (AD, for short). He lives alone but his two grown sons live close by and visit often. Until recently, John's AD symptoms have been mild, mostly just minor forgetfulness.

Over the past three months, John's sons have noticed a decline in their father's abilities. He seems agitated and can't follow simple instructions. They suggest hiring an Aide to help with bathing and feeding, but John refuses.

One day, John's son receives a call from a neighbor who reports seeing John walking around the yard in just his underwear. When asked about the incident, John slurs and struggles to find the words, "I wanted to go for a walk but I couldn't find the gate to get out of the yard."

And this is Lottie. Lottie is an independent 83-year-old woman who lives at home with her adult granddaughter, Maria. Lottie is mentally sharp and physically strong.

One day. while fixing breakfast, Maria notices her grandmother seems quieter than usual. In fact, she doesn't even answer when Maria asks if she would like tea or coffee. She just glances at Maria, then looks away.

Later, Lottie declines to go on her usual morning walk, even though it is her favorite part of the day. And that afternoon Maria finds her grandmother sitting on the sofa, struggling to get up. She approaches her to help but Lottie shoves Maria out of the way and yells, "You're trying to kill me!"

"I'm not. It's me, Gram. I love you." Maria says. "Leave me alone!" Lottie shouts.

Maria is unsure what to do, so she phones the doctor's office and describes the situation to the nurse.

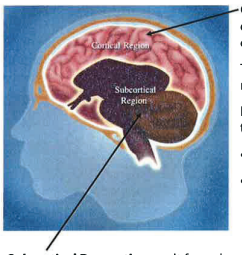
Do you think John and Lottie are showing signs of dementia? Keep reading to learn what dementia is . . . and what it is not! In addition, you will find lots of practical information on how to best care for clients like John and Lottie when they show symptoms of dementia.

WHAT HAPPENS TO THE BRAIN?

Dementia isn't a specific disease—it's a ***group of symptoms***. Depending on the type and the underlying cause, dementia can affect the way a person thinks, functions and the way he or she interacts with others.

What's happening in the brain of someone with dementia?

There are two areas of the brain that, when affected, can cause dementia—the cortical region and the subcortical region.



Cortical Dementias come from a disorder that affects the cerebral cortex, (the *outer* layers of the brain).

This area of the brain plays a critical role in memory and language.

People with cortical dementia typically have:

- Severe ***memory loss***, and
- ***Aphasia*** (the inability to recall words and understand language).

Subcortical Dementias result from damage *deeper* in the brain. People with subcortical dementias tend to show:

- Changes in their ***speed of thinking***, and
- Difficulty ***starting activities***.

Vascular Dementias include damage to ***both parts of the brain***. This type of dementia is common following a series of small strokes.

The most common causes of dementia are Alzheimer's disease and having multiple strokes.

WHAT'S NEW? *Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

The Facts

- At least 25 percent of people over the age of 75, and 40 percent of people older than 80 years of age have some form of dementia.
- Although dementia mainly affects older people, it is ***not a normal part of aging***.
- Worldwide, nearly 8 million new cases of dementia are diagnosed each year. That's one new diagnosis every four seconds!
- The number of people with dementia is expected to nearly double every 20 years, to 65.7 million in 2030 and 115.4 million in 2050.
- Most people with dementia are cared for by loved ones in the home—and the responsibilities can be overwhelming. Caring for a loved on with dementia can be physically, emotionally and financially challenging.

A CLOSER LOOK AT CORTICAL DEMENTIAS

Alzheimer's, Pick's disease, and Creutzfeldt-Jakob disease all affect the cortical region (outer layer) of the brain and cause the characteristic problems with memory and aphasia.

ALZHEIMER'S DISEASE: By far, the most common cause of dementia is Alzheimer's disease—or AD, for short. Alzheimer's disease is an irreversible disorder of the brain.

- Dementia caused by AD usually begins *gradually*. The first sign is often a decline in short term memory.
- Eventually, people with Alzheimer's disease lose the ability to take care of their personal needs—and even become unable to walk.

PICK'S DISEASE: Pick's disease, also called Frontal dementia, is a rare brain illness that causes dementia. The symptoms of Pick's disease are similar to Alzheimer's disease: memory loss, inability to concentrate, changes in behavior, deterioration of language skills and problems performing personal care. However, there are some major differences between Alzheimer's and Pick's disease, including:

- People usually develop Pick's disease before age 70.
- In Pick's disease, behavioral changes—including being socially and sexually inappropriate—are often an early symptom. These behavior problems occur even though the person's memory has not deteriorated.
- Another early symptom of Pick's disease is the inability to speak so that others can understand—even though the memory is intact.

CREUTZFELDT-JAKOB DISEASE (CJD): CJD is a rare condition, affecting about 200 Americans each year. Unfortunately, there is no treatment, and nearly all patients with CJD die within one year.

- In the early stages of CJD, people experience personality changes, impaired memory and lack of coordination. As the disease progresses, the dementia worsens rapidly. People suffering from CJD may also lose the ability to move, speak and even see.
- There is no test for diagnosing CJD, and the only way to confirm a diagnosis of CJD is by doing an autopsy after death. The disease causes the brain to develop holes where nerve tissue used to be, giving the brain a "sponge-like" appearance.

WHAT EXCITES YOU?

WALK AWAY FROM DEMENTIA

A new study from the University of Pittsburgh found that walking about a mile a day, at least six days a week seems to protect against brain shrinkage, which in turn may slow and even prevent dementia.

It shrinks? Yes, indeed!

Brain size tends to shrink in late adulthood and can lead to the onset of dementia.

Why does walking work?

Researchers think that when people walk, their hearts pump more blood to their brains. The increased blood flow to the brain helps keep it healthy by providing nutrients and removing toxic waste products.

So lace up those shoes and get yourself and your clients moving!

A LOOK AT SUB-CORTICAL DEMENTIAS

Dementias that arise from the sub-cortical region (deeper in the brain) include Parkinson's, Huntington's Disease and AIDS dementia complex. These dementias cause changes in personality and a slowing down of thought processes. Language and memory remains largely unaffected.

PARKINSON'S DISEASE: People diagnosed with Parkinson's disease have a shortage of dopamine. This brain chemical controls muscle activities, emotions and thought processes.

- Without dopamine, people with dementia related to Parkinson's disease may have slow or even slurred speech. In addition, people with PD often experience "freezing" or difficulty starting an activity.

HUNTINGTON'S DISEASE (HD): Huntington's Disease is a progressive brain disorder caused by a defective gene.

- This disease causes changes in the central area of the brain which affect movement, mood and thinking skills.

AIDS DEMENTIA COMPLEX (ADC): ADC is a type of dementia that occurs in advanced stages of AIDS. HIV experts believe that dementia in the late stages of AIDS occurs when the virus itself inflames or kills nerve cells in the brain.

- Progression of ADC is different for everyone affected. Symptoms can develop quickly or slowly, but generally affect four different areas of brain function, including: 1) thinking abilities, 2) behavior, 3) coordination and movement and 4) mood.

COMBINED CORTICAL AND SUB-CORTICAL DEMENTIA

VASCULAR DEMENTIA, AKA MULTI-INFARCT DEMENTIA (MID): MID is mental deterioration caused by a series of strokes in the brain. These strokes are more common among men and usually begin after age 70.

- Depending on the part of the brain affected, people may lose specific functions, such as the ability to count numbers or read. People with MID may also have more general symptoms, such as disorientation, confusion and behavioral changes.
- In general, people with MID decline in "steps". Each stroke causes more damage, but, in between strokes, they may experience periods of stability or slight improvement.
- MID is not reversible or curable, but controlling problems like high blood pressure or diabetes may prevent more strokes from happening.

CONNECT IT!

Think about a client you care for right now who suffers from symptoms of dementia.

What symptoms do you see? (problems with memory, thinking, speaking, following instructions, etc.)

_____

_____

_____

Do you know what caused your client's dementia? If not, can you make a guess based on the symptoms you see?

_____

_____

_____

Skip ahead to page 6 and see if you can determine what stage of dementia your client is in.

_____

_____

_____

IS IT DEMENTIA, DELIRIUM OR DEPRESSION?

Dementia can often be mistaken for delirium or depression since the symptoms can be similar or overlapping. Unfortunately, a delayed or missed diagnosis of dementia can delay treatment. Here are some guidelines to help you distinguish between dementia, delirium and depression:

	DEMENTIA	DELIRIUM	DEPRESSION
How does it start?	Slowly, then get's worse over time.	Suddenly.	Suddenly, usually related to a specific event.
How long does it last?	Usually permanent.	A few hours to a few days.	Can come and go, or can be persistent or chronic.
What time of day are symptoms worse?	No change throughout the day.	Worse at night, sleep-wake cycle may be reversed.	May have insomnia.
How is the person's thinking, memory and attention?	Has trouble with judgment and memory. May have trouble understanding simple instructions.	Has trouble with memory and difficulty paying attention.	May complain of memory loss, forgetfulness and inability to concentrate.
What is the person's activity level?	Unchanged from usual behavior.	Activity levels may increase or decrease and may fluctuate throughout the day.	Lack of motivation, tired, restless or agitated.
What does the person's speech sound like?	May struggle to find words.	It may sound like paranoid rambling or may be confused and jumbled.	May be slow to understand and respond during conversations.
How is the person's mood?	Depressed, uninterested in usual activities.	Rapid mood swings, fearful, suspicious.	Extreme sadness, anxiety and irritability.
Are there any delusions or hallucinations?	There may be delusions, but no hallucinations.	The person may see, hear or feel things that are not really there.	The person may have delusions about worthlessness.
Can it be treated?	Rarely. Most dementias get worse over time. (However, treatment may slow down the disease.)	Yes, if the underlying cause is found and treated.	Yes, medication and therapy can help.

WHAT DO YOU THINK? Look back at John and Lottie from the beginning of this inservice module. Try to determine if they are suffering from dementia, delirium or depression. Pay attention to whether the symptoms are gradual or sudden. What does their speech sound like? How is their thinking or memory? Discuss your ideas with your supervisor and co-workers. Find out what they think.

THE THREE STAGES OF DEMENTIA

EARLY STAGE: People in the *early* stage of dementia may show signs of a gradual decline, such as:

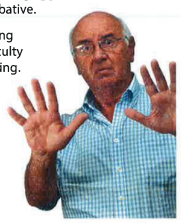
- Becoming more forgetful of details or recent events.
- Misplacing objects frequently.
- Losing interest in hobbies or activities.
- Being unwilling to try new things.
- Showing poor judgment and making poor decisions.
- Taking longer to do routine tasks.
- Repeating themselves during conversations.
- Having trouble handling money.
- Blaming other people for "stealing" from them.
- Becoming less concerned with other people's feelings.

MODERATE STAGE: During the moderate stage of dementia, the problems become more obvious, such as:

- Being very forgetful of recent events.
- Becoming confused about time and place.
- Getting lost in familiar surroundings.
- Forgetting names of friends or family members.
- Seeing or hearing things that are not there.
- Neglecting personal hygiene.
- Forgetting to eat.
- Behaving inappropriately, such as going outside without clothes.
- Wandering.

SEVERE STAGE: People who have severe dementia are in the third stage and need total care. Their symptoms may include:

- Being unable to remember things, even for a few minutes.
- Losing their ability to understand or use speech.
- Being incontinent.
- Showing no recognition of family or friends.
- Needing help with all their personal care.
- Being restless, especially at night.
- Becoming aggressive or combative.
- Having difficulty walking.



THINK ABOUT IT!

DEMENTIA'S TOP 10 WARNING SIGNS

1. New or worsening memory loss.
2. Problems performing everyday jobs.
3. Forgetting simple words.
4. Confusion about time and place/getting lost in familiar locations.
5. Poor or impaired judgment.
6. Problems with abstract thinking.
7. Misplacing items.
8. Rapid mood swings.
9. Changes in personality—such as paranoia or fearfulness.
10. A loss of initiative—may become very passive and avoid social activities.

If you notice these signs developing in your clients, report the situation to your supervisor. Your observation may help them receive an early diagnosis—and treatment— for dementia.

HOW IS DEMENTIA DIAGNOSED?

Currently, there is no one test that spots dementia. However, the ability to diagnose dementia has improved a lot in the past few years. Now, many physicians have enough firsthand experience to allow them to distinguish Alzheimer's disease from other similar conditions in 8 out of 10 patients.

To help them make a diagnosis of dementia, physicians will:

- Perform a thorough physical examination.
- Ask the person to complete a variety of mental status tests, such as the Mini Mental Status Exam (see side bar).
- Look for the signs and symptoms of dementia.
- Try to rule out all the conditions that mimic dementia. This may involve ordering blood work and/or other tests such as CT, PET or MRI scans.

WHAT IS THE MMSE?

The Mini-Mental State Exam (MMSE) is a quick test that looks at the symptoms of dementia. ***Here are a few things the MMSE tests:***

- **ORIENTATION**
  - What is your name?
  - How old are you?
  - What day is it?
  - What season is it?
- **ATTENTION SPAN**
  - "Spell a word such as "WORLD" forward, and then backward."
- **MEMORY**
  - "I'm going to tell you three words. They are Bird, Car and Door. Can you repeat those words back to me?" Then the provide will ask for those words again after 5 minutes.
- **LANGUAGE FUNCTION**
  - The person will be asked to read a sentence out loud, then write a sentence.
- **JUDGMENT**
  - "If you found a driver's license on the ground, what would you do?"

HOW IS DEMENTIA TREATED?

The treatment for dementia depends on what is happening in the brain to cause the symptoms of dementia. If the doctor can pinpoint the cause, the dementia can sometimes be reversed. For example, the doctor may prescribe:

- Vitamins for a B12 deficiency.
- Thyroid hormones for hypothyroidism.
- A change in medicines that are causing memory loss or confusion.
- Medicine to treat depression.

If the dementia cannot be reversed, treatment involves helping the person remain as comfortable and independent as long as possible. The treatment plan may include:

- Counseling or therapy that can teach the person new ways to remain independent.
- Medications like Aricept, Exelon or Namenda. These medicines are generally used to treat Alzheimer's disease, but can also ease some of the symptoms of dementia.
  - **Side effects** of these drugs may include dizziness, headache, confusion, nausea, vomiting and diarrhea.
- Antipsychotics or antidepressants to help control mood or behavior problems.
  - **Side effects** of these medications may include drowsiness, dizziness when changing positions, blurred vision, rapid heartbeat, sensitivity to the sun and skin rashes.

CAN DEMENTIA BE PREVENTED? YOU BET IT CAN!

Remember, the most common causes of dementia are Alzheimer's disease and having multiple strokes. The good news is that there are things that can be done to prevent AD and strokes! Here's what researchers know:

PREVENTING ALZHEIMER'S DISEASE

There are certain factors that put people at risk for developing AD that cannot be changed. For example, you cannot change your age or your genetics.

But, there are other factors that can be controlled!

A growing mountain of evidence now suggests that the same *lifestyle changes* doctors recommend to prevent or control diabetes, heart disease and obesity can also *delay the onset* of Alzheimer's Disease!

HEALTHY DIET: Eating plenty of fruits, vegetables, and whole grains, plus foods that are low in fat and sugar can reduce the risk of many chronic diseases. Now, studies are beginning to suggest this can also reduce the risk of developing AD!

EXERCISE: Researchers know that physical activity is good for the brain as well as the heart and the waistline! One study found that the risk of developing AD was 40 percent lower in people who exercised at least 15 minutes a day, 3 or more times a week!

PREVENTING STROKES (CVAs)

Just like Alzheimer's disease, there are some factors that put people at risk for strokes that cannot be changed, including age, gender, genetics and having had a previous stroke.

But, risk factors that people can control include:

High Blood Pressure—High blood pressure is the most important risk factor for a stroke. Many people believe that because more and more people are being treated for high blood pressure, fewer people are dying from CVAs.

Cigarette Smoking—In recent years, studies have shown that cigarette smoking DOUBLES a person's risk for stroke. Also, the use of birth control pills *combined* with cigarette smoking greatly increases the risk of stroke.

Diabetes—Diabetes is a risk factor for stroke and is strongly related to high blood pressure. While diabetes is treatable, having it increases a person's risk of stroke. In addition, people with diabetes are often overweight and have high cholesterol, increasing their risk even more.

Carotid artery disease—There are arteries in the neck that supply blood to the brain called carotid arteries. A carotid artery that becomes blocked by a blood clot or by cholesterol can result in a stroke.

Heart disease—A diseased heart increases the risk of stroke. In fact people with heart problems have more than twice the risk of stroke as those with hearts that work normally. Atrial fibrillation (rapid beating of the heart's upper chambers) raises the risk for stroke. Heart attack is also the major cause of death among survivors of stroke.

CHALLENGES FOR PEOPLE WITH DEMENTIA:

DEALING WITH CATASTROPHIC REACTIONS

Catastrophic reactions are emotional (and sometimes physical) outbursts that seem inappropriate, irrational and/or "completely out of the blue."

These outbursts can be triggered by a:

- Certain person.
- Memory.
- Sudden change in activity or environment.
- Task that is overwhelming.
- Difficulty expressing a feeling or communicating a need to the caregiver.

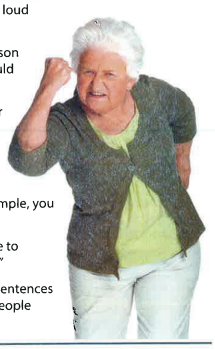
WHY DOES IT HAPPEN?

People with dementia can easily become overwhelmed by routine activities. And making matters worse, the damage in the brain that is typical of people with dementia often leaves the person with ***a limited set of emotions*** to call upon when things get tough.

Panic and anger are the easiest "go-to" emotions when frustration, information overload, or trouble communicating arises.

How you can help . . .

- Pay attention to the "who, what and where" details when catastrophic reactions occur for your client, then try to avoid those triggers.
- Keep distractors that aggravate your client to a minimum—such as televisions or radios on in other rooms, loud telephones and certain people .
- Never argue or try to reason with a person during a catastrophic reaction. This could make the situation worse.
- If your client does not present a danger to himself or to others, observe from a safe distance and allow him to settle on his own.
- Observe body language and help your clients identify their emotions. For example, you might say *"You seem angry, can I help?"*
- Provide frequent reassurance: "I'm here to *help,"* and *"Everything is going to be OK."*
- Always speak in short uncomplicated sentences to avoid confusing or overwhelming people with dementia.



TALK ABOUT IT!

You provide care for Jess, an 83-year-old woman with severe dementia.

When Jess's symptoms first started, her daughter tried to take care of her at home. But the job was too much and the family decided to place Jess in your facility.

For the first few years, Jess's daughter visited several times a week. But now that Jess doesn't recognize her daughter anymore, she only visits once a month because it is just too sad and stressful.

What would/could you say to Jess's daughter to help her remain positive and supportive of her mother in this situation?

Talk to your supervisor, your co-workers, a social worker and even a chaplain to find out what they would say in a situation like this.

CHALLENGES FOR PEOPLE WITH DEMENTIA:

PERSONAL HYGIENE AND PROBLEMS WITH SLEEP

PERSONAL HYGIENE ACTIVITIES

While most of us take getting bathed and dressed for granted, people with dementia can become confused by this rather complex process.

If you think about it, there are probably one hundred small steps involved in washing, brushing your teeth, combing your hair and putting on clothes. Eventually, most people with dementia lose interest in personal hygiene. This may be because they:

- Have forgotten how to dress themselves.
- Don't like feeling out of control.
- Get anxious about being naked.
- Are afraid of getting wet.

How you can help . . .

- Make sure the client's room is warm enough for getting dressed or undressed.
- Provide for your client's privacy.
- Try to use the same location each day for dressing and a *different* spot for undressing.
- Make sure your client's clothes fit comfortably and are not so long the client might trip.
- Simplify the dressing process by offering only a *few* clothing choices.
- If possible—and if your client seems to enjoy it—play calming music during bath time.
- Make sure the bathroom is warm and well-lit.
- Avoid mirrors if your client no longer recognizes him or herself.
- Try to schedule a bath during the time of day that your client is most relaxed.
- Let your client feel the water before getting into the bathtub or shower. Say something like, *"This water feels nice."*
- For additional tips, see the In the Know inservice entitled "Bathing Tips".

PROBLEMS WITH SLEEP

It is not unusual for people with dementia to have sleeping problems. These may come from:

- Confusion about whether it's day or night.
- Frequent need to urinate during the night.
- Depression.
- Pain.
- Leg cramps or "restless legs".
- A disruption in their daily routine.
- Certain medications.
- "Sundowning, " or restlessness, agitation and disorientation, usually at the end of the day.

How you can help . . .

- Try increasing your client's level of activity during the day.
- Limit sugar and caffeine, especially late in the day.
- Keep afternoon and evening hours calm, filled with quiet activities only.
- Close the drapes and turn on the lights well *before* sunset. This cuts down on shadows which can add to confusion.
- Place a night light near the bed.
- Keep daytime clothing hidden at night. Your client may see the clothes and think that it's time to get up and get dressed.
- Some dementia clients enjoy soft music playing near their bed at night.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Dementia isn't a disease—it's a group of symptoms that can affect the way a person thinks, functions and the way he or she interacts with others.
2. The most common causes of dementia are Alzheimer's disease and having multiple strokes.
3. Dementia can often be mistaken for delirium or depression since the symptoms can be similar or overlapping.
4. There are some factors that put people at risk for developing dementia that cannot be changed. But, there are other factors like diet, exercise, diabetes and smoking that can be controlled!
5. During the early stage of dementia, it is best to focus on the person's remaining strengths . . . and not on what he or she is losing.

CHALLENGES FOR PEOPLE WITH DEMENTIA:

DIFFICULTY AT MEALTIMES

A common problem for people with moderate to severe dementia is to have some difficulty at meal time. Why? There are a number of possible reasons, including:

- Changes in appetite—either increased or decreased.
- Forgetting to eat.
- Being frightened by a noisy dining room.
- Confusion about how to use silverware.
- Too agitated to sit for an entire meal.
- Feeling rushed at meal time.
- Distracted by the table setting and/or environment.
- Forgetting how to chew and/or swallow.
- Confusion over too many food choices.

How you can help . . .

- Offer five to six small meals per day, rather than three larger ones.
- Remind your dementia clients that it is meal time.
- Demonstrate how to use silverware or offer foods that can be eaten easily with the fingers.
- Simplify the meal by using just one plate, one piece of silverware and just a few food choices.
- Avoid tablecloths and dishes that are patterned as they may be too distracting.
- Reduce the amount of noise in the dining area to avoid frightening your dementia clients.
- If possible, serve foods that are familiar to your client.
- Check the temperature of foods before you serve them.
- Avoid using foam cups—dementia clients may try to eat them.
- Use bowls rather than plates to make it easier to get food onto a spoon.
- Demonstrate how to chew and say "chew now" in a friendly tone of voice.
- To encourage clients to swallow, stroke them gently on the throat and say, "swallow now".
- Encourage your clients to finish one food completely before moving on to another. (Some people get confused by a change in texture.)
- Give your dementia clients plenty of time to finish their meal.
- Be sure to report any sudden changes in appetite or other eating difficulties. There may be a medical or treatable cause for the problem.

FINAL THOUGHTS ABOUT DEMENTIA CARE

- ***Focus on strengths!*** Most types of dementia cause an inevitable decline of a person's memory, intellect and personality. However, this usually occurs only in the middle to late stages. During the early stage of dementia, it is especially important to focus on the person's remaining strengths . . . and not on what he or she is losing.
- ***Last in, first out!*** For most people with dementia, the things they learned most recently are the most easily forgotten. Allow your clients to focus on what they do remember.
- ***Stimulate, don't overwhelm.*** There is a fine line between providing stimulation to people with dementia and overwhelming them. Get to know each client as an individual so you know what their limits are.
- ***Childlike, not childish.*** People with moderate to severe dementia tend to lose the ability to care for themselves. Just like small children, they need help with eating, dressing, walking and toileting. But, remember, just because some of their needs and behaviors may be childlike, they are not children. Be sure to treat them as adults; don't patronize or "talk down" to them.
- ***Personality Plus!*** Typically, dementia tends to exaggerate personality traits that already existed. For example, someone who was bossy in his younger years may be completely domineering due to dementia. Or, dementia may make a person who was always tidy become obsessed with neatness.
- ***Follow the leader.*** People with dementia tend to take on characteristics of their caregivers and/or family members. For example, a visit from an anxious and irritable spouse can lead to an anxious an irritable client.
- ***All in the family.*** When a loved one has dementia, the whole family is affected—especially if they have primary responsibility for the person's care. Studies have shown that family members of dementia clients have a higher risk of depression, anxiety and even illness.
- ***Change the environment, not the person.*** Watch how your client reacts to different situations throughout their day. If you notice that a noisy dining room seems to trigger a catastrophic reaction, then serve your clients meals someplace quiet.
- ***Try switching shoes!*** As with all clients, try to imagine how you would like to be treated, and talked to, if you were suffering from the confusing symptoms associated with dementia.

WHAT I KNOW NOW!

Now that you've read this inservice on <u>understanding dementia</u>, jot down a couple of things you learned that you didn't know before.

inthe**know**
CAREGIVER TRAINING

A Client Care Module: **Supporting and Guiding Individuals through Dementia-Related Behaviors**

COURSE OUTLINE

DEMENTIA-RELATED BEHAVIORS

Mr. Paxton is 91-year-old man living with Alzheimer's Disease. He lives at home with his wife. They have a regular nursing assistant who comes to help with ADLs and meal times.

One day, Mr. Paxton's wife meets the nursing assistant at the door as she arrives. She tells her that Mr. Paxton has been "really angry" for the past hour. The aide enters the home and finds the living room and kitchen in disarray. There are books, magazines, dishes, picture frames and food thrown everywhere.

Mr. Paxton is standing in the middle of kitchen pointing a bottle of window cleaner at the two women as if it were a handgun.

Ginny is an 82-year-old woman who lives with dementia in a nursing home. She is generally mild-mannered, cooperative and happy.

One day, the nursing assistant notices that Ginny is going back and forth to the bathroom more often than usual. By mid afternoon, she is going about every 10 minutes. Each time she comes back muttering, "Oh dear. Oh my goodness."

The nursing assistant tries to ask Ginny what is wrong but Ginny can't seem to find the right words. She just keeps repeating "Oh no. Oh dear."

As bedtime nears, Ginny becomes panicked. The aide follows her to the bathroom. She sees Ginny sitting on the toilet and wiping, then getting up to look in the toilet. Seeming more panicked by what she sees, Ginny sits back down, wipes and looks again. This cycle goes on for 30 minutes while the aide tries to figure out what is wrong and how to help.

Mr. Paxton and Ginny were both experiencing dementia-related behaviors. Keep reading to learn all about what caused these behaviors and what you can do support and guide people through behaviors like these.

This course is recognized by the Alzheimer's Association® for following evidence-based Dementia Care Practice Recommendations in the following topic areas: Alzheimer's and dementia, person-centered care, assessment and care planning, activities of daily living, and behaviors and communication. Learn more about this recognition HERE.

WHAT EXACTLY ARE DEMNTIA-RELATED BEHAVIORS?

The term "dementia-related behaviors" is used to describe a large group of symptoms associated with dementia and Alzheimer's disease. They include agitation, sleep disturbances, delusions, and hallucinations.

As the disease progresses, many people experience these symptoms in addition to memory loss and other cognitive changes. Underlying medical conditions, environmental influences and some medications can cause behavioral symptoms or make them worse. ***Here are a few triggers that can cause dementia-related behaviors and some of the ways the behavior might appear:***

POSSIBLE TRIGGERS

Too many steps in a single task.
A rushed or upset caregiver.
A new or unfamiliar place.
Doesn't understand what he is being asked to do.
An underlying illness *(infection, flu)*
A change in routine.
Too many choices.
Fatigue.
Pain.
Hunger.
Paranoia or delusions
An unpleasant memory.
Confusing sensory input.
Can't find the right words.
Room is too hot or too cold.
Too much background noise.

COMMON BEHAVIORS

Cursing and name-calling.
Uncontrollable crying.
Persistent weeping.
Hitting or kicking.
Pulling hair.
Biting.
Yelling.
Pacing.
Stomping.
Screaming.
Resisting care.
Hand wringing.
Throwing things.
Trying to "get away."
Ripping out catheters or IVs.

Who's at Risk?

IMPORTANT: Dementia-related behaviors happen because there is **damage** to the parts of the brain that help people communicate and make sense of the world around them. The people who are most at risk of having dementia-related behaviors are those with:

- Dementia
- Alzheimer's Disease
- Traumatic brain injury
- PTSD
- Certain types of strokes

A CLOSER LOOK AT A FEW COMMON TRIGGERS

TOO MANY STEPS IN A SINGLE TASK

Many of the triggers listed on page two are obvious stressors, like being tired, hungry or cold. Other triggers may not be so easy to understand. For example, the first trigger listed is having **"too many steps in a single task."**

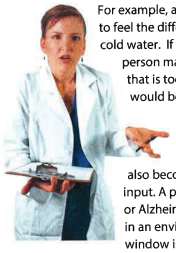
Brushing your teeth may seem simple enough to you—but think of all the mini-steps that go into doing it. Can you imagine, it takes as many as 30 small steps to brush your teeth? They are:

1. Go to the sink.
2. Locate toothbrush.
3. Turn on the water.
4. Wet toothbrush.
5. Turn off the water.
6. Locate toothpaste.
7. Remove cap.
8. Place cap on counter.
9. Apply toothpaste to the brush.
10. Put down the toothpaste.
11. Put brush in mouth.
12. Brush teeth.
13. Spit.
14. Brush tongue.
15. Spit again.
16. Locate a cup.
17. Turn on the water.
18. Fill the cup.
19. Turn off the water.
20. Sip the water.
21. Swish.
22. Spit out the water.
23. Put the cup down.
24. Turn on the water.
25. Rinse tooth brush.
26. Turn off the water
27. Return toothbrush to holder.
28. Recap the toothpaste.
29. Locate a towel.
30. Dry face with towel.

For a person living with dementia or Alzheimer's Disease, 30 steps can be completely overwhelming.

CONFUSING SENSORY INPUT

Another trigger that may not be obvious is ***"confusing sensory input."*** This happens when information coming in through the senses doesn't seem right to the person who is experiencing it.



For example, a person may not be able to feel the difference between hot and cold water. If this is the case, the person may take a bath in water that is too hot. The resulting pain would be confusing and could trigger a dementia-related behavior.

Background noise can also become confusing sensory input. A person without dementia or Alzheimer's can easily function in an environment where the window is open, a TV is on and people are talking in the next room. But, for someone having trouble with sensory input:

- The truck passing by outside may sound like a train barreling toward the building.
- The news anchor on the TV may sound like he is warning the person of impending doom.
- The people in the next room may seem to be discussing how they will escape the danger.

All this confusing input can create terror and panic and lead to dementia-related behaviors.

Research now shows that caregivers like you play a key role in preventing dementia-related behaviors! One study gave specific training to two groups. The first group was just nurses and the second group was just nursing assistants. Each group received training on how to identify, manage and prevent dementia-related behaviors. The results showed that the group with just nursing assistants had the best results in identifying, managing and preventing the behaviors after the training was received. ***Why do you think this is the case? Do you think the results would be different if the whole team received training?***

Good News!

WHEN YOU ARE "IN THE MOMENT". . .

While you may not have any control over what goes on in your client's brain, you do have control of your own behaviors and how you react to clients when they are "in the moment" of a dementia-related behavior. Your behaviors and responses have the potential to ***change the course*** of the event!

Here are some things you can do in the moment to shorten or stop the behavior:

- ***You don't have to be right this time!*** Never argue or try to reason with a client during a dementia-related behavior. This may make the situation worse.
- ***Remain calm and comforting.*** You are the role model for calm and rational behavior.
- ***Help untangle confusing emotions.*** Observe body language and help your clients identify their emotions. For example, you might say "You seem angry, can I help?"
- ***Provide frequent reassurance.*** You can say "I'm here to help," and "Everything is going to be OK." (See more communication tips on page 5.)
- ***Remove distractions.*** Turn of televisions and radios. Close windows and doors. Dim the lights. Ask visitors to step out for a moment if their presence seems distressing to your clients.
- ***Provide time and space.*** If your client does not present a danger to himself or to others, watch from a safe distance and allow him to settle on his own.
- ***You're not the boss or jailor!*** Never scold or make the person feel bad for their actions.
- **NEVER APPLY RESTRAINTS** unless ordered to do so by a doctor.
- ***Distract or redirect.*** Offer an alternate activity that your client enjoys (such as taking a walk).
- ***Get help if you need it.*** If you or your client are in danger, call for help right away. Get to a safe place if you can. Keep your client as safe as possible and wait for help to arrive.
- ***Make mental notes.*** Pay attention to the time, what's happening and where you are when dementia-related behaviors occur for your client, then avoid those triggers. (See the sidebar on this page for more on what to look for.)
- ***When it's safe, do a physical assessment.*** Remember, dementia-related behaviors can be brought on by an underlying (or silent) illness. Once your client has settled down, check for fever, pain, cold symptoms, urinary or bowel problems, and change in level of consciousness. Report any abnormal observations right away so treatment can be started.

CONNECT IT!

WHAT ARE THE CUES AND CLUES?

When you are "in the moment" of a dementia-related behavior with a client, ask yourself these 6 Cues and Clues questions:

1. **WHO** is the person?
2. **WHAT** is the behavior?
3. **WHEN** does it happen?
4. **WHERE** does it happen?
5. **WHY** does it happen?
6. **HOW** can you fix it?

Think about a client who has dementia-related behaviors. Can you answer the first five cues and clues about your client's last event? If so, HOW can you prevent it from happening in the future?

_____
_____
_____
_____
_____

THE NEXT STEP!

DON'T TAKE IT PERSONALLY!

It's hard not to feel hurt when a client lashes out.

You may have been criticized, called horrible names or even physically hurt by a client during a dementia-related behavior, but it's important to remember that it's *usually* not about you personally.

Dementia-related behaviors happen because there is damage to the parts of the brain that help people make sense of the world and communicate their feelings.

Think about the last time you were on the receiving end of a dementia-related behavior.

- What happened?
- How did it make you feel?
- Could it have been prevented?
- Have you forgiven yourself?

COMMUNICATION TIPS THAT CAN HELP

The way you communicate with clients before and during a dementia-related behavior can both decrease and prevent future episodes.

Here are some tips:

- ***Be seen before you are heard.*** Approach clients from the front. Don't speak to them suddenly from behind or you might startle them.
- ***Keep it simple.*** Always speak in short uncomplicated sentences to avoid confusing or overwhelming your client.
- ***Wait for it!*** Ask only one "yes" or "no" question at a time. Calmly repeat the question using the same words if the client doesn't answer you.
- ***Give the play by play.*** Describe what you are doing, one step at a time.
- ***Use nonverbal communication.*** Try using nonverbal cues such as touching or pointing to help your clients understand what you are saying.
- ***Give praise generously.*** Your clients need to hear positive words like "Good job!" or "You're doing great." or "You look beautiful today."
- ***Limit or avoid choices.*** If your client becomes frustrated very easily, then don't give them a choice if there isn't one. For example, don't say "Do you want to take a bath now?" Instead say "It's time for your bath now."

If your client becomes frustrated because he has trouble expressing something to you:

- ***Be patient.*** Allow plenty of time for the client to speak or to complete his thoughts . . . even if he is struggling with words. Avoid trying to guess and finish his sentence.
- ***Write it out.*** If possible, have your client write the word he is trying to express and then have him read it aloud.
- ***Play charades!*** Use gestures or point to objects to help find words or add meaning.

PREVENT DEMENTIA-RELATED BEHAVIORS

You can't prevent every dementia-related behavior, but there are some things you can do to make them less likely for your clients. Here are a few suggestions:

- ***Simplify everyday activities.*** Break even the most routine activities (like putting on a shirt or eating breakfast) into small, manageable steps. For example, instead of just saying, *"Put on your shirt,"* you might start with, *"Your shirt is on the bed."* When your client sees the shirt, you could say, *"Pick up the shirt."* Then, *"Put your arm through the sleeve,"* and so on.
- ***Avoiding rushing.*** When you rush, you deny your client the time he or she needs to figure out what the next step should be. This causes anxiety and can lead to a dementia-related behavior.
- ***Stick to a predictable daily routine.*** Changes can confuse and overwhelm clients who are at risk of having dementia-related behaviors.
- ***Keep em' full and rested!*** Feeling hungry and/or tired can be confusing sensations to someone who doesn't understand what the feelings mean. Avoid these triggers by serving 5-6 small meals and snacks throughout the day and making sure clients get the rest that they need.
    - Sleep needs vary, but many elderly people divide their sleep between daytime naps and nighttime sleep. If your client is having trouble falling asleep or staying asleep at night, try limiting naps to 1 hour (or less) during the day.
- ***Cut back on television viewing.*** The fast-paced visual images and loud sounds can overstimulate your client. Some may not be able to tell the difference between fact and fiction.
- ***Give praise and attention at non-crisis times.*** Loading up on the praise and attention helps your clients realize that they can be in control. It makes it more likely that they will remember how to be calm when a dementia-related behavior occurs.
- ***Talk about stuff before it happens.*** Help ease clients into new or unfamiliar situations by talking about it before it happens. For example, if a new physical therapist is taking over your client's care, talk about it before the first meeting. When the PT arrives, introduce him to your client and explain that "Jim is taking over for Mary."
- ***Healthy body, healthy mind!*** Sometimes the only way to know that your client is getting sick is by experiencing a dementia-related behavior. Watch for early signs of illness, infection or pain and report your observations right away. If you need help identifying signs of illness, infection or pain, ask your supervisor for an inservice on it today!

THINK ABOUT IT!

MILITARY VETS

Dementia-related behaviors are not just for the elderly with dementia and Alzheimer's.

Military veterans returning home with PTSD and traumatic brain injuries can have them too—and they can be much more intense.

A veteran has been trained to use every sense in a way that is much keener than the average civilian, and losing those senses can be devastating. A vet may become extremely agitated if he has trouble:

- Scanning the environment for threats.
- Paying attention to several things at one time, like someone talking while a TV is on.
- Learning and remembering new things.

If you care for military veterans, talk to your supervisor about the best way to support this special population.

Go Ahead and Laugh!

Helping a client deal with a dementia-related behavior is stressful—but it can also be humorous! Sometimes, it's okay to share your funny stories with co-workers.

Humor is an excellent coping strategy for those days when it seems like everything is going wrong!

Using humor and laughter at work can:

- Decrease stress and tension,
- Improve morale, and
- Build stronger teams.

Of course there are a few important rules!

- Never laugh ***at*** the client.
- Never tell inside jokes or funny stories about clients in front of other clients or in a place where you could be overheard (like the cafeteria or elevator), and
- Don't let humor and joking around turn into goofing off that distracts you from your work.

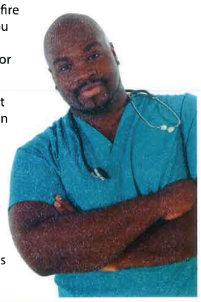
STAYING SAFE DURING AN OUTBURST

Remember, not all dementia-related behaviors will involve violent or aggressive behavior, but it's important to keep yourself safe during those that do. The good news is that you don't have to be a big, strong muscle man to use these strategies to stay safe during an outburst:

- ***Keep calm.*** If you get upset, the anger and aggression may become more intense.
- ***Step back!*** Stand at least an arm's length away from a client who is swinging punches, kicking or otherwise threatening physical harm.
- ***Have a way out.*** Avoid letting the person trap you in a corner or block your exit from the room.
- ***Get out if necessary.*** If you fear for your safety, leave the room and contact your supervisor.
- ***Work in pairs.*** You may need to "buddy up" with another Aide to provide care to clients who are known to become aggressive.
- ***Keep your hands to yourself.*** Avoid touching clients during a dementia-related behavior unless you know from past experience that touching them is safe.
- ***Duck and cover!*** If you know it's coming, get out of the way!
- ***Never hit back.*** It's never okay to hit, kick, pinch or pull your client's hair—even in self-defense.

If you work in the clients' homes, do all of the above, and:

- ***Plan an escape route.*** The first time you enter a home, pretend you are making a plan for fire safety and make note of multiple ways you may be able to get out if necessary. This could be a front or back door, patio door or any first floor windows.
- ***Always carry a cell phone with you.*** Don't count on there being a working landline in the home. Have your phone charged and ready to use in your pocket at all times.
- ***Lock yourself up.*** If you can't get away from a violent client, lock yourself in a room, bathroom or closet with your cell phone and call for help. A "caregiver in a closet" may seem absurd, but it's much safer than trying to fend off a client who is out of control.



AN A-B-C-D APPROACH TO DEMENTIA-RELATED BEHAVIORS

Pulling it all together: This A-B-C-D approach is a generalized action plan to help guide the ongoing management of dementia-related behaviors. If your workplace doesn't already have a plan in place to handle dementia-related behaviors, this is a great tool to use for getting started!

A

ACTIVATING EVENT *(the "trigger")*. Every dementia-related behavior requires the healthcare team to do a thorough investigation to establish the trigger.

It's important to determine when and where the behavior occurred, what the person was doing immediately before the behavior occurred, and what the environment was like at the time (noise, lighting, temperature, etc.)? In addition, a physical assessment (when it's safe) should be done to check for fever, UTI, constipation, or other illnesses like cold, flu and stomach problems.

Learn more about triggers on pages 2 and 3 of this inservice.

B

BEHAVIORS *(the dementia-related behavior)*. People living with dementia, Alzheimer's Disease, stroke and some traumatic brain injuries have trouble making sense of the world around them—combined with difficulty communicating their feelings.

This combination may lead the person to act out inappropriately to situations that seem completely normal to a person without the illness. Some people will react with anger toward others—including physical and/or verbal aggression.

Caregivers have the highest risk of being injured by a client during a dementia-related behavior. All behaviors should be reported and documented. This is not to get the client "in trouble" but to help protect other caregivers in the future. Every possible step should be taken to protect caregivers from clients who are known to become aggressive.

C

COMMUNICATION *(the caregiver's response)*. No one can derail every dementia-related behavior, but everyone can learn a few communication techniques that may bridge the gaps between confusion and understanding for clients who are at risk.

Communication includes body language, tone of voice and spoken words. With the power of communication, caregivers can help clients make sense of confusing stimuli and help them express themselves more accurately.

Learn all about communication techniques on page 5 of this inservice.

D

DEVELOP A PLAN *(the prevention strategy)*. It's always better to prevent a problem than it is to react to one in the moment. That's why it's so important to come up with a plan to help your clients avoid dementia-related behaviors before they happen.

Each client will have a different plan based on their specific triggers. But all plans should include a strategy to keep clients from being overwhelmed, overstimulated and over tired. In addition, preventing illness and infections can help prevent dementia-related behaviors.

Learn some specific prevention strategies on page 6 of this inservice.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. The term "dementia-related behaviors" is used to describe a large group of symptoms associated with Alzheimer's disease.
2. Dementia-related behaviors occur when the person is unable to cope with or communicate during an actual or imagined stressful situation.
3. You can't control what goes on in your client's brain, but you can control your own behaviors and how you react to clients when they are "in the moment" of a dementia-related behavior.
4. Your calm behaviors and positive responses have the potential to change the course of a dementia-related behavior!
5. Every dementia-related behavior requires the healthcare team to do a thorough investigation to determine the trigger and develop a prevention plan.

WHAT ABOUT MR. PAXTON AND GINNY?

Remember Ginny and Mr. Paxton from the beginning of this inservice? What do you think was happening in each of these situations?

MORE ABOUT MR. PAXTON

By asking questions, the caregiver learned that Mr. Paxton had been watching television alone in the living room when the dementia-related behavior began. His wife found him ducking behind his recliner, throwing magazines into the middle of the room and yelling something she didn't understand. She tried to get him to stop but he only got angrier.

When the caregiver asked what he was watching just before the behavior started, the wife thought it was one of the usual game shows he liked to watch. After they calmed Mr. Paxton and helped him to lie down for a nap, they began to clean up the mess. As they were cleaning, a special report broke into programming on the TV that was still on in the living room. The newscaster apologized for the second interruption that morning. It was a report about unrest in a foreign country and the possibility of a civil war.

That's when the caregiver and Mrs. Paxton understood what happened. Mr. Paxton had spent many years in the military and even fought in the Korean War. Hearing that report must have triggered some sort of fear or anxiety in him. In his mind, he was defending himself in a war zone.

The caregiver and Mrs. Paxton came up with a plan to limit television, particularly around the news hours, and to be sure to monitor all television viewing so that nothing upsetting or confusing would trigger another problem.

WHAT ABOUT GINNY?

After Ginny's nursing assistant witnessed the bizarre bathroom behavior, she knew exactly what to do. Ginny had a history of recurrent urinary tract infections and suffered from occasional constipation. The nursing assistant knew that one or both of those issues could be causing Ginny to seem so worried about her toileting activities.

The nursing assistant reported the behavior and her thoughts about a possible UTI and/or constipation to the nurse. The nurse did a physical assessment of Ginny and determined that she was indeed constipated. She administered a stool softener and followed up with a call to the doctor for lab orders to check for a urinary tract infection.

The labs came back positive for a UTI and antibiotics were started. In less than 48 hours, Ginny was back to her normal, mild-mannered, cooperative and happy self.

The nurse and the nursing assistant made a plan to monitor Ginny's toileting routine more closely so that any changes would be caught sooner—before Ginny could work herself into a dementia-related behavior.

FINAL THOUGHTS

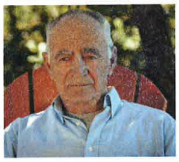
If you care for people who have dementia, Alzheimer's Disease, traumatic brain injury or those who have suffered a stroke, chances are you have witnessed a dementia-related behavior. If you haven't yet—you will!

- Dementia-related behavior happen because there is damage to the parts of the brain that help people communicate and make sense of things.
- You can't change the fact that clients with this type of damage to the brain will have trouble coping with real (or imagined) stressors, but you can change the way you respond—and that can make all the difference!
- Always model calm and positive behavior around your clients. If you are feeling stressed or irritable, your mood can easily rub off on a client. If you can stay calm and positive, your client may "mirror" your good mood.
- Stay plugged in and be creative! Prevention strategies that worked today may not work tomorrow. And, there is no one-size-fits-all solution that will work with every client.
- During a dementia-related behavior, it's important to understand that your client is confused, frightened, does not feel safe, and cannot reason or make sense of his/her environment. Your job is to restore the feeling of safety and to help untangle confusing emotions.

- Being able to identify the triggers that cause problem behaviors for your clients is the most important part of managing dementia-related behaviors. It's the only way you can prevent a problem before it arises.
- Remember, every dementia-related behavior requires a thorough investigation into the ***who, what, when, where, why,*** and ***how*** of the event. This investigation not only helps identify triggers and develop a prevention plan, but it also serves as a way to document the behavior so that other caregivers can be made aware of the potential for danger (if one exists) and can take steps to protect themselves from harm.
- Even on a "good" day, your job is extremely hard. Tossing a few dementia-related behaviors in on top of everything else you have to handle can really take a toll on your body, mind and soul. At the end of your shift, always take time to ***relax***, ***laugh*** a little and ***take care of yourself!***

WHAT I KNOW NOW!

Now that you've read this inservice on dementia-related behaviors, jot down a couple of things you learned that you didn't know before.



COURSE OUTLINE

inthe**know** A home care pulse COMPANY | CAREGIVER TRAINING

A Client Care Module: **Safe Environments for People Living with Dementia or Alzheimer's Disease**

IT'S AN ONGOING CHALLENGE

There are more than five million Americans currently living with Alzheimer's Disease. By 2050, the number is expected to increase to 14 million. So, if you don't already provide care for someone living with AD (or other type of dementia)—you will soon!

Alzheimer's disease is a progressive and irreversible brain disorder that can slowly destroy memory and thinking skills .

- "Progressive" means it gets worse over time.
- "Irreversible" means it causes cells to waste away and never return.
- And currently, there is no way to prevent, cure or slow Alzheimer's disease.

As a caregiver, you face the ongoing challenge of adapting the environment—on an ongoing basis—to keep the person safe as changes in the brain occur.

Here are two guiding principles to keep in mind:

⇒ **PREVENTION IS THE KEY!** It can be difficult to predict the behavior changes you may see in a person living with Alzheimer's disease. Things may be typical and routine one day, then completely different the next. Just remember, it's much easier to *prevent* an accident than it is to deal with the emergency and the aftermath of it.

⇒ **BE READY TO ADAPT AND CHANGE!** Trying to change unwanted behaviors in a person living with dementia or AD is difficult. *Instead, it is more effective to change the environment.* There are changes you can make in the environment to decrease the hazards and stressors that lead to behavioral and functional challenges. This inservice is full of tips and tricks you can use to change the environment in a way that meets the challenges that come with having Alzheimer's or dementia.

This course is recognized by the Alzheimer's Association® for following evidence-based Dementia Care Practice Recommendations in the following topic areas: Alzheimer's and dementia, person-centered care, assessment and care planning, activities of daily living, and behaviors and communication. Learn more about this recognition HERE

FOCUS ON PREVENTING FALLS

People living with dementia or Alzheimer's disease have a much higher risk of falling. Most falls in this group are related to changes in vision, perception, gait, and balance.

Some studies indicate that the fall rate for people living with dementia or AD is as high as 60 percent. Another study showed that the average person living with Alzheimer's will fall at least four times during the course of the illness.

The most likely outcome of a fall is a **broken hip**. Broken hips are painful—and they require surgery and follow-up physical therapy, all of which are made more difficult by the symptoms of AD and dementia.

Fortunately, there are things you can do to make the environment safer and decrease the risk of falls for your client. **Here are a few things you can do:**

- Encourage your clients to wear shoes that are suitable for walking, instead of loose slippers or socks. Shoes with low-heels and light, non-skid soles are the best. Also, make sure that any laces are tied tightly.
- Make sure that all rugs are tacked down tightly. Loose rugs can be very dangerous and are easy to trip over.
- Make sure that all loose cords are tucked under furniture or placed where they will not be tripped over.
- Wipe up any spills on the floor immediately. A wet floor is very slippery and could easily cause a fall.
- Make sure the client's area is well lit during the day and has a nightlight during the night.
- Keep the client's living environment free from clutter, especially on the floor. Anything, including magazines, newspapers, or shoes could easily be tripped over.
- Make sure your clients have a clear path to walk through their homes or personal areas. Many times, large furniture can obstruct a path, making it hard for them to move about with ease.
- Check stairways for anything that may be a safety hazard. Nearly ten percent of falls happen while going up or down the stairs. Poor lighting, clutter, and low visibility could cause this type of fall. Assist your clients to climb stairs as necessary.
- ***Confused clients may need to be coaxed into following the rules that keep them safe.*** For example, you may need to sit down with the client and convince him to agree to call for help as needed or you may even have him repeat, "I will call for help before getting up to walk."
- **Be patient!** And be prepared to remind your client every day, every shift, or even every hour to ask for help when needed.
- In clients' homes, you may need to develop a checklist for the client and family to go through once a week. The check list may include items such as:
  - **When you walk through a room, do you have to walk *around* furniture?** If so, move the furniture so your path is clear.
  - **Are there any throw rugs on the floor?** If yes, remove.
  - **Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?** If so, pick them up.
  - **Do you see any wires or cords in the walking path?** If yes, tuck them away or remove completely.
  - **Don't hesitate to involve the family.** Family and loved ones will welcome the responsibility and appreciate the opportunity to help! No one wants to see a loved one suffer an injury from a fall.

WHAT EXCITES YOU?

Some homemade assistive devices may help make things safer and less frustrating for people living with AD. Here are some creative ways you can help your client without buying an expensive assistive device:

- Add suction cups to the bottom of bowls or dishes to keep them from sliding around during meals.
- Make a toothbrush or pencil easier to grasp by twisting a large rubber band around it. Or, use the foam from a foam hair roller.
- Try tying a ribbon to your client's zipper for a "homemade" zipper pull!

What assistive devices have you created? Does your client need something now that you can create?

Share your ideas with your co-workers and supervisor and find out how they solve common problems with creative assistive devices!

STAYING SAFE WITH ASSISTIVE DEVICES

Assistive equipment can be a great help in preventing falls. Canes and walkers help clients regain mobility and independence. Grab bars, shower chairs, and raised toilet seats allow clients to use bathrooms privately and independently.

Sometimes, these helpful devices can create more problems than they solve. Here are some facts:

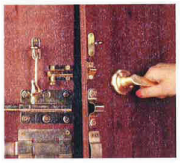
- Injuries related to canes and walkers send 47,000 people a year to the ER.
- Fractures, generally to the hip, are the most common type of injury associated with assistive equipment.

Assistive equipment cannot help prevent falls if it is not in good working condition. Here is what you should look for:

- **Check Canes:** If the cane is made of wood, inspect the shaft and handle for cracks, splintering, or weak spots. If the cane is metal, check if all the bolts and screws are present (making the cane stable and strong). Check if the rubber tip is present and inspect the shape (which should be even and clean).
- **Check Walkers:** Look at the bolts and screws (to see that all connections are present and secure). Check for all four of the rubber tips and inspect their shape (which should be even and clean). If the walker has caster wheels, make sure they are firm, in good shape, and roll smoothly.
- **Check Wheelchairs:** Make sure all bolts and screws are present and secure. Check wheels. Wheels should be firm, smooth, and roll straight without wobbling. Brakes should be firm when engaged and should stop the wheelchair from moving at all. Check the seat and back rest for rips, tears, or weak spots. Make sure the foot and leg rests move easily and sit firmly in the proper position for your client.
- **Grab bars, transfers seats, and commodes:** Grab bars in the home should be *professionally* installed. Push and pull on grab bars to ensure they are securely attached. Check all connections and rubber stoppers on transfer seats and commodes. Make sure everything is firm and level.

If you discover faulty equipment, follow your workplace guidelines for reporting and requesting repairs. **NEVER ATTEMPT TO REPAIR EQUIPMENT YOURSELF.** Assistive equipment should only be assembled, installed, and repaired by trained professionals!

PROTECT CLIENTS FROM WANDERING



Wandering is when a person strays into unsafe places and can be harmed. The most dangerous form of wandering is elopement in which the confused person leaves an area and does not return.

There are two types of wandering:

- **Goal-Directed Wandering.** In goal-directed wandering, the person appears to be searching for someone or something. The person may also be looking for something to do and may make gestures as if performing a familiar task.
- **Non-Goal Directed Wandering.** In non-goal directed wandering, the person may appear to wander without a purpose or may be unable to state or remember the purpose.

Know the signs! An individual may wander off if he or she is:

- Anxious or worried.
- Frustrated or bored.
- Experiencing unmet needs, such as hunger, thirst, constipation, inactivity, need to use the toilet, fatigue, pain or environmental discomfort, such as uncomfortable seating, mattresses, and lighting.

Here's how you can help:

- **Address any unmet needs.** Offer a snack, a drink, or a trip to the bathroom.
- **Encourage physical activity** to curb restlessness, promote relaxation, and prevent boredom.
- **Label everything!** A person living with Alzheimer's may forget where she is, even inside her own home. Post signs or photos on the doors to the bathroom, bedroom, and kitchen to provide a visual cue of where she is in the environment.
- **Take a walk!** Periodically take your client for a walk around the living space, even if the person has lived there for years. Chat as you go, saying things like, "There's the bathroom," and "We're walking into the kitchen now."
- **Plan in advance to prevent wandering.** If your client tends to wander at the same time every day, a planned activity at that time could eliminate the problem. Think of simple chores the person may be able to do, such as folding laundry or setting the table for dinner.

If wandering outdoors is an issue:

- Store coats, shoes, and keys out of sight.
- Install alarms and locks. (See sidebar for more on locks and alarms.)
- Place curtains over doors or make them invisible with paint or wallpaper that matches the surrounding walls. A mirror or a stop sign on the door can also help.
- Talk to the family about having your client wear a GPS tracking device that can send electronic alerts about his or her location if wandering away is an issue.

CONNECT IT!

LOCKS AND ALARMS: WHAT'S AVAILABLE?

LOCKS: Hook & eye latches and slide bolts can be purchased for a few dollars at any hardware store.

There are also hook & eye latches that have a spring-loaded catch that makes it even harder to open.

Sliding windows can be locked with clamps or dowels placed in the tracks to limit how far they can be opened.

ALARMS: Pressure-release alarms are pads or mats that go under the mattress or on the chair seat. They sense changes in weight and pressure.

Motion detectors can alert you to nighttime wandering that goes beyond the bathroom or bedroom.

Shakers are alarms for caregivers who are hard of hearing. They vibrate the bed or pillow to signal nocturnal activity.

THE NEXT STEP!

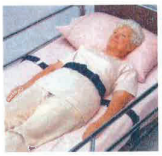
For each of the scenarios below, think of a few ways to keep the client safe—without using restraints.

- Mr. Williams has lost a lot of weight and tends to slide right out of his favorite "easy chair." He has been found on the floor with bruises more than once.
- Mrs. Brown enjoys walking around her fenced backyard, but her gait is unsteady. Her home care aide has trouble getting all her work done because she is constantly having to watch Mrs. Brown so she doesn't fall down.
- Mr. Harrison has dementia. He tends to get up at night by himself and has been found urinating in the hallway (because he can't find the bathroom).

Share your ideas with your supervisor and co-workers!

ALTERNATIVES TO RESTRAINTS

All this talk of falls, assistive devices, and wandering may have you thinking about how nice it would be to have some sort of "restraint" to keep the person safe. *But restraints can be more of a safety hazard than a safety measure.* For example, when used with confused clients, restraints have been known to increase agitation and confusion—increasing the risk of an injury.



- **Please Note:** Restraints can never be used to discipline a client or to make things easier for a healthcare worker. They must be medically necessary and must have a doctor's order.

Here are some alternatives you can try:

- Use cushions and/or wedges to keep clients from sliding out of chairs. Place the cushion under their thighs to keep them from slipping and to help them maintain proper posture while seated.
- If possible, use a chair alarm (such as a sensor on the seat) for a client who shouldn't get up without assistance.
- In facilities, keep the client close to the nurse's station or other area where he or she can be observed easily.
- Create a special (safe) area with lots of interesting activities to occupy your client's time and attention.
- Seat clients at a table with an activity that interests them to keep them from wandering and/or from sliding out of their chair.
- Physical therapy may be a good alternative to restraints. For example: Mr. Smith is restrained because he has an unsteady gait and tends to fall. He has been wearing a vest restraint to keep him from getting up. But if he received physical therapy to strengthen his legs, he might be able to walk without falling and would no longer need restraints. (And remember that restraints keep clients inactive. Inactivity causes muscles and joints to weaken. This makes clients *less* safe than before the restraints were used. So keeping Mr. Smith in a restraint will just make him weaker and weaker!)
- Play soothing music. Studies have shown that music relaxes clients who tend to wander or be agitated.

IMPORTANT:

If you can't change a client's behavior, then change the environment. For example, think about a curious toddler who gets into everything. We don't put him in a high chair for eight hours a day to keep him safe! Instead, we change his environment—we put gates on stairways and locks on cabinets. Think about your clients the same way. Instead of restraining them, make their living area safe.

MAKING THINGS SAFE IN THE KITCHEN

The kitchen can be a confusing and dangerous place for people living with Alzheimer's disease or dementia. There are things that can cut, burn, choke, and poison your client in the kitchen. That's why it's especially important to be vigilant about keeping your clients safe in this room!

Here are a few things you can do:

- Install safety latches on cabinets and drawers.
- Lock and/or hide matches, knives, scissors, and small appliances with sharp blades, such as food processors and blenders.
- Install safety knobs and an automatic shut-off switch on the stove.
- Keep a night-light in the kitchen.
- Keep all condiments such as salt, sugar, or spices hidden if you see the person with Alzheimer's using excess amounts. Too much salt, sugar, or spice can be irritating to the stomach or cause other health problems.
- Remove or lock the "junk drawer." Small items such as batteries, matches, or other small objects may pose a choking or poisoning risk.
- Remove artificial fruits and vegetables or food-shaped kitchen magnets, which might appear to be edible.
- Insert a drain trap in the kitchen sink to catch anything that may otherwise become lost or clog the plumbing.
- Consider disconnecting the garbage disposal to eliminate the risk of injury or damage if an object (or a person's hand) goes into the disposal.

ELIMINATING POTENTIALLY POISONOUS HAZARDS

People can be poisoned by taking too much prescription or non-prescription medication, ingesting household chemicals, or by eating spoiled foods.

Post the toll-free poison control number (1-800-222-1222) by every telephone in the home.

- If prescription or nonprescription drugs are kept in the kitchen, store them in a locked cabinet.
- Store ALL cleaning supplies in a locked cabinet.
- Consider placing a latch on the refrigerator if the client tends to forage for food (and if there is a potential for spoiled food to be left in the refrigerator).
- Never use a food-related container to store cleaning supplies. Cleaning products that are clear can be mistaken for water, and those that are brightly colored can look just like juice.
- Do not store flammable liquids in the kitchen. Lock them in the garage or in an outside storage unit.

If you think your client may be poisoned, you should try to determine the source of the poison. Then, get help quickly. For a poison victim, the most important time is the first hour or two.

Here are a few other important steps to take:

- See if there's any obvious source of poison.
  - Do you notice any unusual odor?
  - Are there empty medicine bottles near the victim? Can you see solid pills in the victim's mouth?
- If you suspect chemical poisoning—from a household cleaner—do not induce vomiting. Call the Poison Control Center Hotline. You will be given clear instructions on what to do.

GET OUT!

THINK OUTSIDE OF THE BOX!

Mr. Parker has a diagnosis of middle-stage Alzheimer's disease. Most days, he let's you know when he feels the need to go to the bathroom. Occasionally, he forgets.

When you enter his room on this day, you find him just after he has had a bowel movement in the drawer of his night stand. He is wiping himself with a corner of the drapes.

What do you do?

Here are a few suggestions:

- Stay calm!
- Take him to the shower to clean him up.
- Once he's clean and settled, decontaminate the nightstand and drapes!

What else could you do in this situation? Come up with a plan of your own to handle this type of situation.

MAKING THINGS SAFE IN THE BATHROOM

Did you know . . . there are nearly 200,000 bathroom accidents per year. ***This makes the bathroom the most dangerous room for your clients.***

While you may not have to physically take all of your clients with Alzheimer's or dementia to the bathroom, there are a few things you can do to make the bathroom a safer place for everyone.

Here are a few things you can do:

- Never leave a person alone in the bathroom if he or she shows changes in the ability to make safe choices.
- Inspect towel bars, toilet paper holders, and soap dishes regularly to be sure they are securely fastened. Clients may grab onto any of these to steady themselves or to try to prevent a fall.
- If no grab bars are in place, ask your supervisor to request installation. A towel bar is not a suitable or safe grab bar.
- An elevated toilet seat or a bedside commode placed over the toilet seat (without the bucket) may enable clients to continue to use the bathroom independently.
- Use a plastic shower stool and a handheld shower head to make bathing easier.
- Throw rugs should have non-skid or rubber backing to keep them from sliding around on the floor.
- Clean up any water spills or leaks immediately to prevent slippery surfaces.
- Change burned out light bulbs right away. The bathroom should be well lit, with a light switch located near the door.
- A night light will help your client locate the bathroom at night.
- Make sure all outlets are grounded to protect against electric shock. Look for an outlet with 3-prong plug receptacles and a "reset" button.
- Keep electrical appliances away from water!
- Just like the kitchen, you can install safety latches on cabinets and drawers.
- If prescription or nonprescription drugs are kept in the bathroom, store them in a locked cabinet.
- Remove cleaning products from under the sink.
- If the door to the bathroom has a lock, you may want to remove or disable it. A person living with dementia could accidentally lock himself in the bathroom and then not be able to get back out.

FIRE PREVENTION AND SAFETY

It is always important to have a plan of action in place in case of fire or other disasters for ALL clients. But it's especially important when you are caring for someone living with Alzheimer's or dementia.

People with AD or dementia are particularly vulnerable because their impairments in memory and reasoning severely limit their ability to keep themselves safe in crises.

Here are some steps to take to <u>prevent</u> fires:

- Do not leave the person alone with an open fire in the fireplace.
- If your client smokes, monitor lit cigarettes closely.
- Keep matches and cigarette lighters out of reach and out of site.

Are you prepared for an emergency? If not, here's how you do it:

- **IN FACILITIES:** Know the plan! It's not enough to just have an evacuation plan in place—most organizationd are responsible for making sure EVERYONE knows the plan and will know how to react appropriately when the need arises.
- **IN CLIENT HOMES**, you can **help clients and their families prepare an evacuation plan by following these guidelines:**
  - ⇒ Draw a rough plan of the home noting doors and windows that can be used for escape.
  - ⇒ Make sure doors and windows open easily.
  - ⇒ Designate one place to meet outside the home.
  - ⇒ Conduct a drill a couple of times each year so everyone is familiar with the routine.
  - ⇒ Routinely check smoke alarms. Replace batteries as needed.

If a fire break out, follow these R.A.C.E. guidelines :

- **<u>R</u>escue:** Move clients who are in immediate danger away from smoke or flames first.
- **<u>A</u>larm:** Pull the fire alarm. If you are working in a facility, report the fire according to the facility's policies and procedures. If you are in a client's home, call 911.
- **<u>C</u>onfine:** Close the doors and windows of client(s) rooms behind you to slow the spread of smoke and flames. Don't open doors without checking for heat. If the door is hot, it means there is fire on the other side. Opening a hot door can injure you and cause the fire to spread.
- **<u>E</u>xtinguish:** Fight the fire ONLY if it is small and contained (such as a wastebasket or a frying pan) and ONLY if you have been trained to operate a portable fire extinguisher.

THINK ABOUT IT!

Careless smoking is the leading cause of fire-related deaths. For people with AD, the risk is even greater.

Here are some ways to keep smokers safe:

- Discourage smoking by placing cigarettes, matches, lighters, and ashtrays out of direct sight. This may help the person forget about smoking altogether.
- Always supervise clients while they are smoking.
- Large, deep ashtrays with water in the bottom can ensure the fire goes out when the smoker is finished.
- Place a cookie sheet under the ashtray to prevent the cigarette and its hot ashes from falling onto furniture or clothing.
- Never allow smoking in bed or near oxygen.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Alzheimer's disease is a progressive, irreversible brain disease that can slowly destroy memory and thinking skills.
2. As a caregiver, you face the ongoing challenge of adapting the environment—on an ongoing basis—to keep the person safe as changes in the brain occur.
3. Making the environment safe—before an accident happens—is the key to minimizing danger.
4. Fortunately, there are changes you can make in the environment to decrease the hazards and stressors that lead to behavioral and functional challenges for people with dementia.
5. The bottom line: If you can't change a client's behavior, then change the environment.

SAFETY WITH CARS AND DRIVING

Driving demands good judgment, quick reflexes, and split-second decision making. These are all skills that may diminish as Alzheimer's disease or dementia progresses. While losing the independence to drive is one of the most devastating losses for older adults, it's an important safety measure for the person living with Alzheimer's as well as other drivers on the road.

If your client has already lost the privilege to drive:

- Keep keys hidden and/or out of sight.
- Keep the car parked in a garage or out of sight, if possible.
- Disable the car by removing the distributor cap or battery.

Visit **alz.org/driving** for more information on making the decision to take away driving privileges and working with families to make the right choice for each client.

GUN SAFETY

Recent events in the U.S. have brought much attention to the debate over how to balance gun rights with gun safety. Most of the focus in the media is on how to keep children safe. But what about older adults? And when a senior has Alzheimer's disease or dementia, what should the family do?

Just like the freedom to drive must be restricted or taken away, the freedom to own and operate firearms also must be addressed as the symptoms of Alzheimer's disease or dementia worsen.

⇒ One survey determined that a firearm is present in 6 out of 10 homes that have a family member with dementia, and 44.6 percent of those homes reported that the gun was loaded.

If your client has a gun in the house, there are special precautions you will need to take:

- Work with the family to make sure all firearms are in a locked cabinet, vault, safe, or storage case.
- Install trigger locks on any firearms in the home.
- Hide the keys to any trigger locks or gun cabinets in a place far away from the gun and cabinet.
- Make sure all firearms are unloaded when not in use.
- Lock ammunition in a separate place.
- If locking the gun is not an option, ask the family to remove it from the living space altogether.
- If the family is unable, unavailable, or unwilling to help, ask for help from local law enforcement.

FINAL THOUGHTS ON SAFE ENVIRONMENTS

Many of the safety recommendations made in this module focus on the client's changes in ability to think and to make safe choices. **Here are some things you can do to help with challenges related to the five senses:**

VISION

- Create color contrast between floors and walls to help the person see depth. Floor coverings are less visually confusing if they are a solid color.
- Mark the edges of steps with brightly colored strips of tape.

SMELL

- Install smoke detectors and check them frequently. The person living with Alzheimer's disease may not smell smoke or associate it with danger.
- Keep refrigerators clear of spoiled foods.

TOUCH

- Place a sign on the oven, coffee maker, toaster, crock-pot, iron, and other potentially hot appliances that says DO NOT TOUCH or STOP! VERY HOT.
- Unplug appliances when not in use.
- Use a thermometer to tell you if bath water is too hot or too cold.
- Remove furniture or other objects with sharp corners or pad the corners to reduce potential for injury.

TASTE

- Remove or lock up medicine cabinet items such as toothpaste, perfume, lotions, shampoos, rubbing alcohol, and soap, which may look and smell like food to the person with Alzheimer's.
- Keep the toll-free poison control number (1-800-222-1222) by the telephone.
- Keep pet litter boxes inaccessible to the person with Alzheimer's disease. Do not store pet food in the refrigerator.

HEARING

- Avoid excessive noise in the home such as having the stereo and the TV on at the same time.
- Be sensitive to the amount of noise outside the home and close windows or doors, if necessary.
- Avoid large gatherings of people in the home if you know the person becomes agitated or distressed in crowds.
- If the person wears a hearing aid, check the batteries and functioning often.

WHAT I KNOW NOW!

Now that you've read this inservice on <u>safe environments</u>, jot down a couple of things you learned that you didn't know before.