Nursing Assistant

Daily Care Routine

Early (AM) care

- Toileting, incontinence care, linen change
- Wash face & hands
- Oral hygiene
- Assist with grooming
- Straighten bed & unit
- Position resident for breakfast

Daily Care Routine

- Morning care after breakfast
  - Oral hygiene
  - Toileting
  - Bathing/shaving/skin care
  - Hair care/dressing
  - Skin care
  - Activity – ROM, ambulation
  - Bed linen change
  - Unit maintenance

Daily Care Routine

- Afternoon Care (Prepare for lunch, dinner)
  - Toileting
  - Wash hands/face
  - Straighten bed/unit
  - Position for meal

Daily Care Routine

- Evening Care (PM, HS)
  - Offer snack
  - Toileting
  - Incontinence care/linen change
  - Wash hands/face
  - Oral hygiene
  - Back rub
  - Assist into sleepwear
  - Straighten bed/unit

Benefits of bathing

- Cleanliness
- Reduce microorganisms
- Promote skin integrity
- Stimulate circulation
- Provide movement & exercise
- Relaxation
- Sense of well-being
- Opportunity for communication & observation

Body areas requiring bathing

- Face
- Axilla
- Hands
- Perineal area
- Any area where skin folds or creases (example – under breasts)

Steps for bathing

- Check with nurse about type of bath
- Procedure manual if special bath
- Identify skin care products to be used
- Check resident’s personal choices
- Collect equipment/provide privacy
- Standard precautions
- Assure comfort – room temp, freedom from drafts, covered
- Use comfortably warm water – change if soapy, dirty, or cold (105 degrees)
- Bathe areas soiled by feces or urine with soap& water – rinse off all soap
- Pat skin dry, encourage resident to help

Safety guidelines for bathing

- Correct water temp
- Use safety equipment
  - Grab bars
  - Emergency call lights
  - Nonskid surfaces
  - Safety belts
- Stay with resident
- Use correct body mechanics

Privacy during bathing

- Close door
- Pull curtain around resident
- Only uncover area being washed

Reportable Observations during bathing

- Color of skin, sclera, lips, nail beds
- Rashes – location & description
- Dry skin, bruising, open areas
- Pale or reddened areas
- Drainage or bleeding
- Swollen legs or feet (edema)
- C/o pain or discomfort
- Skin temperature

Purpose of Oral Hygiene

- Cleanliness of mouth & teeth
- Prevent mouth odor & infection
- Prevent dental disease & tooth loss
- Comfort
- Pleasant taste
- Improve taste of food

When to perform oral hygiene

- Upon awakening
- After each meal
- Bedtime

Special circumstances

- Unconscious –
  - Side-lying to prevent choking & aspiration
  - May use padded tongue blade
- Mouth breather
- Oxygen
- NG tube
- Elevated temperature

Standard Precautions with oral hygiene

- Contact with mucous membranes
- Gums may bleed
- Pathogens may exist in mouth

Examine oral cavity

- Dry, cracked, swollen, blistered lips
- Redness, swelling, sores, white patches in mouth or on tongue
- Redness, swelling, or bleeding of gums
- Observed damage to dentures
- Loose, broken, or chipped teeth
- Resident complaints

Dentures

- Use standard precautions for same reasons as oral hygiene
- To break suction from dentures, push down gently over upper rim of denture
- Put towel or washcloth in sink & fill with 2-3 inches of water to protect dentures\
- Dentures should be stored in denture cup, clearly labeled with name, with cool water covering them.

Nail Care

- Done to prevent infection, injury, & odors
- Easier to clean after soaking in warm, soapy water
- Cut nails with clippers, not scissors & prevent tissue damage
- Don’t trim diabetic resident’s nails
- NEVER trim toenails
- Report any redness or tenderness of fingertips, cuticles, or toes to licensed nurse

Hair Care

- Important for identity & self-esteem
- Should be in style chosen by resident
- Medicinal shampoo
  - Verify order & review procedure for application
  - Standard precautions
- Observations
  - Scalp sores & flaking
  - Lice
  - Patches of hair loss
  - Very dry or oily hair
  - How procedure was tolerated

Shaving

- Important for comfort & self-esteem
- Electric vs safety razors
- Safety razors can cause nicks or cuts
  - Apply shaving cream to soften beard
  - Pull skin taut, shave gently using short & even strokes in direction of hair growth
  - Rinse razor frequently
  - Lather neck & shave upward

Shaving

- Electric razors
  - Check equipment
  - Shave in direction of hair growth for underarms
  - Shave upward from ankle with legs
  - Direct pressure to any nicks & cuts
  - Wash shaved area & dry gently, aftershave lotion

Maintain healthy skin

- Encourage well balanced diet & fluids
- Skin care
  - Bathe, rinse off soap thoroughly
  - Apply lotion as necessary & massage skin
  - Keep skin clean & dry
- Observe high risk residents for potential problems
- Pay close attention to bony prominences
  - Turn & position correctly
  - Keep pressure off of red or irritated areas
- Keep bed free from objects & WRINKLES
- Prevent friction & shearing

Risk Factors for Skin Breakdown

- Mobility/sensory problems
  - Paraplegic or quadriplegic
  - CVA
  - Peripheral vascular disease
  - Bedrest or decreased mobility
  - COPD
  - Decreased sensation

Risk Factors for Skin Breakdown

- Elimination
  - Incontinence
  - Diarrhea
  - Diaphoresis
  - Dehydration
  - Leaking tubes or drainage

Risk Factors for Skin Breakdown

- Fluid status
  - Edema
  - Dehydration
- Nutritional status/body build
  - Obese or thin
  - Poor appetite
  - Nutritional lab values low
  - Poor fluid balance

Risk Factors for Skin Breakdown

- Predisposing factors
  - Circulatory problems
  - COPD
    - Low oxygen level
    - Fowler's position
    - Meds
  - Diabetes
    - Arterial disease & neuropathy
    - Poor circulation & healing
  - Meds like Prednisone
  - Cancer, Anemia
  - Splints, casts, prosthetic devices
  - Age

Conditions leading to decubitus

- Pressure leads to decreased blood flow & nutrition resulting in tissue loss
- Excessively wet or dry skin
- Moving residents causing shearing

Stage I Decubitus ulcer

- Skin is not broken
- Epidermis & dermis are intact
- Erythema that does not resolve within 30 minutes present



Stage II Decubitus Ulcer

- Skin is NOT intact
- Epidermis is damaged, dermis can be involved
- Skin can be blistered, cracked, & open with erythema
- No necrotic or dead tissue present
- Wound bed is moist, pink, painful



Stage III Decubitus ulcer

- Full thickness skin loss
- Epidermis & dermis involved. May have part of dermis left with necrosis
- May or may NOT be painful
- Poss



Stage IV Decubitus ulcer

- Involves subcutaneous tissues – possibly fat, muscle, & bone
- Can see pink healthy cells, necrotic tissue, & eschar
- Wound can tunnel or have undermining in skin surrounding wound
- Risks osteomyelitis

Stage IV Decubitus Ulcer



Prevent & treat pressure sores

- Mobility/sensory
  - Control pressure by egg crates or beds
  - Turn at least every 2 hours
  - Properly support body & limbs
  - Promote active ROM if possible
  - Teach to reposition in w/c frequently
  - Prevent shearing
  - Keep bed linens clean, crumb free, & without wrinkles
  - Watch tubings (foley, oxygen)
  - Remove residents from bedpan or toilet promptly
  - Massage around red area NOT over it
  - Check skin every 8 hours
  - Keep HOB at 30 degrees to avoid sacral pressure

Prevent & Treat Pressure Sores

- Elimination
  - Keep skin clean & dry
  - Apply powder where skin touches skin
  - Watch diaphoresis
  - Check incontinent residents every 2 hours
  - Monitor Attends plastic areas
  - Avoid scrubbing or rubbing when bathing & drying
  - Use blankets & pillows to pad skin

Prevent & Treat Pressure Sores

- Fluid status
  - Elevate limb with edema
  - Monitor TEDS & ace bandages
    - Remove every 8 hours
    - Check skin
    - Watch that edges don’t cut into skin
  - Encourage 1500-2000 cc of fluid per day or as per care plan

Prevent & Treat Pressure Sores

- Nutritional status/body build
  - Encourage & assist with balanced diet
  - Check skin folds with obese resident
  - Monitor bony prominences with thin resident
- Others
  - Monitor casts/bracing/clothing that may cause pressure against skin

Pressure reducing devices

- NOTHING replaces basic nursing care – turn, position, keep dry
- Types of devices
  - Bed cradle – protects toes
  - Sheepskin, heel & elbow protectors
  - Egg crate mattress/alternating pressure
  - Air fluidization beds
  - Trochanter rolls
  - Flotation pads or cushions

Legal Issues

- Duty to keep resident from harm & prevent pressure sores
- Can be sued for allowing resident to get pressure sore & fined by state

Selecting clothing

- Fits well
- Comfortable – especially warmth
- Easy to get on & off
- Neat & attractive, resident choice
- In good condition

Factors limiting ability to dress

- Limitation of movement
  - Brain defect or impairment
  - Weakness or pain
  - Fractures
  - Contractures
  - Paralysis
- Other factors
  - Special equipment – IV, cast, brace
  - Absence of part of a limb
  - Blindness
  - Psychological factors – depression, fear
  - Dementia

Caring for clothing

- Personal property
- Label with resident's name & write on personal belongings list
- Avoid cutting or tearing
- Don't discard
- Store in resident's unit
- Fold neatly or hang on hangers
- Find out who does the laundry
- Assist resident/family in choosing clothing styles that will meet physical needs
- Don't use on another resident

Dressing/Undressing

- Dress can influence feelings of dignity & self-esteem
  - Can also influence perception by others
  - Dressing in street clothes encourages independence in activities and ADLs
  - Dressing in street clothes decreases incontinence
- Guidelines
  - Privacy, encourage independence
  - Allow resident to choose clothing & accessories
  - Remove from strong side first
  - Dress weak side first
  - Be gentle

Frequency of urination

- Amount of fluid ingested
- Personal habits
- Availability of toilet
- Physical activities
- Illness or infection
- Ranges from every 2-3 hours to every 8-12 hours
- Important to keep resident’s routine as normal as possible

Observations about urine

- Color
- Clarity
- Odor
- Amount
- Report the following
  - Urine – cloudy, stones, gravel, sediment
  - Pink or red tint
  - Dark color/concentration
  - C/o urgency, burning, difficulty, pressure, frequency, strong odor

Urinary incontinence

- Inability to control the passage of urine from the bladder
  - Constant dribble
  - Occasional dribble when laugh, cough, sneeze
  - No control
- Causes
  - CNS injury/spinal cord injury
  - Aging
  - Confusion/disorientation
  - Meds
  - Weak pelvic muscles
  - UTI, prostrate problems

Urinary incontinence

- Causes (cont)
  - Prolapsed bladder & uterus
  - Restraints
  - Immobility
  - Unanswered call lights
  - Not having call light in reach
  - Urinary frequency/urgency
  - Failure to toilet frequently

Signs of possible need for toilet

- Restlessness
- Fidgeting
- Pulling at clothes/undressing
- Holding or pointing at genitals
- Crying

Nursing Measures for incontinence

- Record incontinent episodes
- Answer call lights promptly
- Promote normal elimination
- Immediate attention important
  - Embarrassment, shame, anger, frustration, depression
  - Odor development
  - Uncomfortable
  - Major cause for skin breakdown
    - Infection, irritation, redness, rashes
- Avoid disposable briefs – low self esteem, skin irritation, incontinence

Nursing measures

- Record voiding
- Promote normal elimination
- Follow B & B training
- Encourage easy to remove clothing
- Provide good skin care & perineal care
- Dry garments & linens
- Observe for skin breakdown
- Use incontinent products as directed
- Maintain clean, pleasant environment

Urinary catheter

- Plastic or rubber tube used to drain or inject fluid through a body opening
- Indwelling
  - Foley, retention, suprapubic, straight
- Purpose is to drain bladder due to
  - Complete loss of bladder control
  - Urinary retention
  - Before, during, after surgery
  - Too weak or disabled to use bedpan or BSC
  - Prevention of urine contamination on wounds & pressure sores

Complications from catheters

- Bladder infection
- Blockage
- Inserted using sterile technique
- Rules
  - Tubing should not be kinked.
  - Coil tubing on bed
  - Do not pull on tubing
  - Keep drainage bag below level of bladder
  - Drainage bag should be attached to bed frame NOT side rails
  - Never allow bag to touch floor

Rules for catheters

- Catheter should be secured to thigh
- Clean peri area & around catheter with soapy water
- Drainage bag emptied & recorded each shift or as needed
- Report c/o to licensed nurse
- Rules of asepsis, keep drainage system closed
- Check for leaks
- Use separate measuring containers for residents
- Encourage fluids

Bladder training

- Goal is voluntary control of bladder
- 2 basic methods
  - Scheduled use of bedpan, urinal, toilet
  - Clamping of catheter on a scheduled basis

Bowel Movements

- Pattern – each person different
  - Frequency – daily to every 2-3 days
  - Time of day – morning/evening
  - Note
    - Stool shape
    - Size
    - Frequency
    - Color
    - Consistency
    - Amount
    - C/o pain with defecation

Factors affecting BM

- Privacy – fear of others
- Age – problems increase with age
- Diet – need balanced diet, food stimulates
- Fluids- adequate
- Activity – stimulates
- Meds – most tend to constipate
- Personal habits
- Disabilities

Maintain normal elimination

- Prompt response to request for bathroom
- Assist resident to normal position
- Cover for privacy & warmth
- Remain nearby if person weak or frail
- Place signal light & toilet tissue nearby
- Allow person time
- If difficulty – ask what they did at home to help (newspaper, running water)
- Provide peri care as needed
- Offer opportunity at regular intervals

Bowel Training

- Aspects
  - Control
  - Regular pattern
- Methods
  - Suppository
  - Increase fluids
  - Diet
  - Activity
  - Privacy

Ostomy

- Purpose
  - Surgical creation of an artificial opening
    - Most common – colon or small intestine
    - Less common – urinary drainage
  - Urine, feces, flatus pass through opening
  - Can allow for healing of intestine after surgery or disease
  - Temporary or permanent

Ostomy terms

- Stoma – portion of intestine brought to the surface of abdomen to allow for drainage
  - Pink, moist mucous membrane
  - Size & shape are different depending on area of intestine & resident
  - Can bleed when cleaned
- Periostomal skin – skin around stoma, should be clean, intact, & dry
- Appliance – wafer & pouch or bag that protects the skin & collects drainage

Colostom





- Ascending & transverse
  - Like pureed liquid with slightly acidic content
  - Must wear pouch all the time
  - Chew food well with a lot of fluids
- Descending & sigmoid
  - Stool formed and may look “normal”
  - Stool occurs in pattern
  - May irrigate with enema
  - Regular diet
  - May wear small patch & not pouch

Ileostomy

- Continuous liquid –
  - Stool with large acidic content
  - Resident must eat 3 meals per day or it will become liquid
  - 1000 – 1500 cc output each day
  - Empty pouch every 2 – 4 hours or when ½ full
  - Watch skin for irritation
  - Very special diet
  - Watch for fluid & electrolyte problems

Jejunostomy

- Like ileostomy, except not from ileum but from jejunum
- 2000 – 3000 cc output per day
- Hook pouch up to a foley catheter drainage bag to help drainage
- Need IV nutrition to meet nutritional needs as very LITTLE absorption takes place

Ostomy Care

- Equipment
  - Soap & water
  - Bag or pouch
  - Wafer
  - Wash cloth or paper towels
  - Gloves
  - Appliances
    - One piece – wafer & pouch together NOT reusable
    - Two piece – wafer lasting 5 –7 days NOT resuable
      - Pouch can be taken off & emptied, cleaned, & reused multiple times

Emptying ostomy pouch

- Check every 2-4 hours
- Don’t let pouch get more than ½ full
- If reusable, empty & rinse pouch over toilet with water, dry & reapply
- Make sure seal is tight
- Observe contents of bag – color, amount, consistency, odor
- Report c/o discomfort

Ostomy Care

- Skin care
  - Wash skin with soap & water, dry well
  - Shave hair
  - Observe skin around stoma for redness & irritation
- Odor management
  - All stool smells
  - Sprays, tablets, etc to reduce odor

NA role in ostomy care

- Assist with personal hygiene
- Provide privacy
- Change appliances
- Empty ostomy bag
- Provide skin care
- Use universal precautions
- Encourage resident to assist
- Reinforce teaching plan
- Be aware of attitude – privacy, shame, body image

Weight

- Measure of admission & as ordered
- Wears gown or pajamas
- Should urinate before being weighed
- Do routine weights at same time each day
- Upright scale, bed scale, wheelchair

Height

- Use upright scale
  - Paper towel on scale
  - Face away from scale
  - Reading at moveable part of ruler
- Measure in bed
  - Supine position
  - Pencil mark at top of head on sheet
  - Pencil mark even with heels
  - Position on side & measure distance between marks with tape measure

Prosthetic devices

- May be cosmetic, adaptive, restorative
- Artificial limbs – arms & legs
  - Specially fitted for individual resident
  - Ask charge nurse for guidelines
  - Observe ability to participate in ADLS
  - Assist resident to apply
  - Assist with ROM to affected muscles
  - Assist with aids to foster ADL independence
  - Pad brace
  - Stump socks
  - Praise for rehab
  - Skin care at pressure points
  - Observe for c/o pain, numbness, weakness
  - Need PT for non-involved extremity

Contact lenses

- Clean as directed
- Caution due to fragility
- Store according to directions
- Easily lost
- Report –
  - Redness
  - Drainage from eyes
  - C/o of pain or blurred vision

Eyeglasses

- Clean daily & prn
  - Wash with warm water, dry with soft tissue
  - Use special cleaning solution & clothes on plastic lenses (scratch)
  - Check for intact parts & screws
  - Encourage resident to wear
  - Store with caution – protect from breakage & loss
  - Check food trays and bedclothes for hidden glasses
  - Label with resident’s name

Dentures

- Label denture container with name
- Label dentures
- Encourage resident to wear
- Examine for rough surfaces, breaks, cracks
- Handle with care
- Clean thoroughly before storing
- Check food trays, bed linens, wrapped up tissues or napkins for hidden dentures

Hearing aids

- Check battery periodically
- Do not drop
- Do not try to repair
- Apply device to correct ear
- Don’t get hearing aid wet
- Purpose
  - Makes sound louder
  - Can’t restore full, normal hearing
    - Always face resident & speak slowly & clearly

Hearing aid

- Parts
  - Microphone
    - Changes sound waves into electric signals & transmits sound
  - Battery compartment
    - Holds battery
  - Amplifier
    - Uses battery energy to make sound signals strong
  - Earmold
    - Channels sound through ext ear canal to ear drum
  - Cord
    - Connects amplifier to ear mold
  - Off/on switch
    - Controls volume

Hearing aid

- Placement
  - Turn down volume before placing in ear
  - Should be tight but comfortable
- Once in place, turn on & adjust volume
- If c/o whistle or squeal, check ear placement & for crack or break in earmold or wire
- Batteries
  - Right size
  - Test – place hand over hearing aid after turning up volume & you should hear a whistle

Hearing aid

- Caring for
  - Never wash, report to LVN if needs cleaning
  - Never drop
  - Keep away from heat
  - Don’t let moisture in
  - Don’t use hair spray or medical spray – will clog hearing aid
  - Check food trays & linen for lost hearing iads
- Storage
  - Turn battery off when not in use
  - Remove battery from battery case, leave open
  - Label hearing aid & container