

# **Assisted Living Facility Direct Care Staff Training Instructor Guide**

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COMMONWEALTH OF VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

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# Assisted Living Facility Direct Care Staff Training

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## Orientation

This curriculum is based upon section 22 VAC 40-72-250 C of the Standards for Licensed Assisted Living Facilities which requires that, for facilities licensed for both residential and assisted living care, within the first 30 days of employment all direct care staff [*except Virginia-certified nursing aides; graduates of Virginia Board of Nursing accredited institutions for nursing assistants, geriatric assistants or home health aides; graduates of department-approved education curricula for nursing assistants, geriatric assistants or home health aides; or licensed health care professionals acting within the scope of the requirements of their profession*] shall enroll in and successfully complete within two (2) months of employment a training program consistent with Virginia Department of Social Services (VDSS) requirements.

This curriculum meets the requirements of 22 VAC 40-72-250 C 5, as the department-approved assisted living facility offered training.

### **Trainer Credentials and Expectations**

This training must be provided by a currently Virginia-licensed healthcare professional acting within the scope of the requirements of his or her profession.

The instructor shall:

- Make the course interesting and enjoyable.
- Deliver course content in a language and manner that can be easily understood by the participants. Explain any jargon that may be used to make sure the students understand and to expand each student's knowledge base.
- Strictly follow the methods of instruction provided in the curriculum including class discussions, training exercises, games, etc. Each of these methods of instruction was establish to vary the method of delivery and to increase learning potential.
- Use facility-developed policies and procedures when available.
- Provide trainees with a certificate upon completion of the training. The certificate should include the trainee's name, dates training was completed, total hours of training (40 hours is required), trainer's name and credentials, curriculum used (DSS curriculum is the only approved one), and name of training institution/location.

## Student Expectations

Before beginning to teach the curriculum, the instructor should review with the students the expectations below:

- Be an active participant in all class discussion and activities
- Be willing and eager to learn
- Attend all classes and arrive on time
- Accept each other's point of view. Values and beliefs that are not like yours are okay and it is important to respect others personal views. Think about other people's feelings and be respectful:
  - Be respectful
  - No teasing
  - No insulting others
  - "Vegas Rule" – What your classmates share with you about them stays in the classroom.
- Respect the privacy of people that you describe or discuss. Do not identify residents, family members, colleagues, etc. by name. You might consider saying, "I know someone who..."
- Ask questions. If you have a question, it is likely that a classmate has a similar question.
- Throughout this curriculum you will hear phrases such as, "encourage resident to do as much as he or she can to maintain self-esteem and independence", "encourage resident to be as independent as possible", or "encourage resident to do as much as possible to maintain independence." These phrases should not be presumed to mean make the resident do these tasks without supervision or assistance. These statements mean that the residents should be approached in a supporting manner so that a certain level of independence is achieved and/or maintained. How this message is received may be perceived differently by residents and family members and may be perceived as a negative "do it yourself" attitude. Know your resident well and learn what technique works for him or her in a positive manner. This "independence" may require breaking the task down into multiple steps, spending additional time with the resident, and positively motivating the individual. A soothing and comforting tone of voice will assist in this process.

## **Expected Outcomes of the Class**

Upon completion of this course, each student should know the items listed below. The instructor should review the list with the class prior to beginning the curriculum.

- How to improve the quality of life for residents in an assisted living community.
- How to assist residents with personal care and to notice if the resident's physical, mental, or cognitive condition has changed.
- How to assist the residents in remaining as independent as possible.
- How to respect and protect resident rights.
- How to prevent or minimize the occurrence of adverse outcomes for the residents.
- How to work well as a team member and carry out activities that support the Individualized Service Plan (ISP).
- How to be more sensitive to the emotional and social needs as well as individual differences of residents, their families, colleagues, and the community.
- How to communicate well with staff, residents, and residents' family members and friends.
- How to use proper terminology in long-term care and focus on person-centered care.

## Instructor Guide

Welcome to the Direct Care Staff training curriculum. Only individuals that meet the VDSS requirements may be an instructor for this course. An instructor must be a licensed health care professional acting within the scope of the requirements of his profession as stated in § 22 VAC 40-72-250. If you do not meet this requirement, you are not permitted to train off this curriculum and any student receiving this training by you will not have a valid Certificate of Training.

There are a number of symbols used throughout this curriculum. Each symbol denotes an exercise that needs to be conducted or a statement that should be made. These exercises/statements should be completed at the point in the curriculum when the symbol is reached and should not be done at a later point in time. The symbol key is as follows:



denotes Instructor Notes/Handout(s)-these sections should be specifically followed as they provide the instruction on how each group question or student activity should be conducted.



denotes a Student Activity-these are group activities and/or instructor demonstrations.



denotes a group question/class participation – this is a question that should be directed to the class. The instructor should wait for the responses from the class, provide acknowledgement of responses, and proceed with the curriculum.

§ denotes a State regulation – when this symbol is seen, a statement needs to be made to the class that the section/statement being described is a Virginia Department of Social Services Regulation and must be met for regulatory compliance. Regulations are subject to change. It is the instructor's responsibility to review the regulations for any updates prior to each time teaching this curriculum.



denotes Skill Checklist – this checklist must be properly completed under the trainer's supervision prior to completing the chapter.

There are “Objectives and Expected Outcomes of Chapter” at the beginning of each chapter. Review each item with the class prior to instruction of that chapter curriculum.

Review the Recommended Method of Instruction Section for each chapter for that day to make sure you have all the supplies that may be needed during that instruction period. Interruptions during instruction to collect supplies can disrupt the learning process.

There are “Student Reviews” at the end of each chapter. Once chapter instruction is completed, the students should be told to turn to the Student Review for that chapter in the student manual. The students should be given 15 minutes to complete the Student Review. Each student should do this individually and it should not be treated as a group activity. This should also be a closed-book review. Once the class has completed the Student Review, the instructor should review the correct answers with the class. Encourage the students to use the entire student manual, including the Student Reviews, to study for the final exam.

Prior to conducting clinical demonstrations, it is important to make arrangements with the assisted living facility for resident volunteers. Participation of actual residents when demonstrating resident care can be a crucial learning tool and will have far more impact on the student than practicing on each other. This will provide an opportunity for students to interact with the population they will be serving and an opportunity for the instructor to coach and model appropriate technique and behavior.

For those instructors that are unable to make arrangements with an assisted living facility for clinical demonstrations, it is important to use a location suitable for proper learning and for student-based demonstrations. The instructor should make every effort to temporarily or permanently obtain items for clinical demonstration (i.e. wheelchair, walker).

Resident Volunteers: It is recommended that that the instructor and facility have a written agreement regarding resident volunteers that the resident and/or Responsible Party signs. It is the instructor’s responsibility to ensure the safety of the resident volunteers. It is recommended that the students practice on each other prior to a resident volunteer.



# **Assisted Living Facility Direct Care Staff Training**

## **Curriculum Outline**



# Assisted Living Facility Direct Care Staff Training

## Curriculum Outline

- 1 Introduction to the Uniform Assessment Instrument and the Individualized Service Plan [1.5 hours]
  - 1.1 Person-Centered Care
  - 1.2 Coordination of Services
  - 1.3 Uniform Assessment Instrument (UAI) and Individualized Service Plans (ISP)
  - 1.4 The Team Approach in Planning Care
  - 1.5 Staff Responsibilities
  
- 2 Infection Control [2.5 hours]
  - 2.1 Basic Definitions
  - 2.2 How Infection is Spread
  - 2.3 Standard Precautions
  - 2.4 Signs and Symptoms of Infection
  - 2.5 Risk Reduction Behavior in the Environment
  - 2.6 Staff Responsibilities
  
- 3 Aging 101 [3 hours]
  - 3.1 Aging Demographics: Facts, Myths, and Ageism
  - 3.2 Theories of Aging and Optimal Aging
  - 3.3 What are the Changes that Happen with Aging
  - 3.4 The Experience of Aging
  - 3.5 Staff Responsibilities
  
- 4 Resident Rights [2 hour]
  - 4.1 Resident Rights
  - 4.2 Mandated Reporting
  - 4.3 Adult Abuse, Neglect, and Exploitation
  - 4.4 Staff Responsibilities
  
- 5 Residents with Disabilities and Special Conditions [4 hours]
  - 5.1 General Overview of Disabilities and Special Conditions
  - 5.2 General Guide to Interacting/Communicating with Individuals with Disabilities
  - 5.3 Residents with Sensory and Physical Disabilities
  - 5.4 Residents with Developmental Disabilities
  - 5.5 Residents with Mental Illness
  - 5.6 Residents with a History of Substance Abuse

- 5.7 Residents with Aggressive Behavior
- 5.8 Staff Training Requirements
- 5.9 Staff Responsibilities
  
- 6 Residents with Special Health Care Needs [4 hours]
  - 6.1 Common Health Conditions in Assisted Living
  - 6.2 Hypertension
  - 6.3 Arthritis/Rheumatoid Arthritis
  - 6.4 Heart Disease
  - 6.5 Osteoporosis
  - 6.6 Diabetes
  - 6.7 Stroke
  - 6.8 Other Health Conditions
  - 6.9 Special Care
    - 6.9.1 Oxygen Therapy
    - 6.9.2 Skin Care
    - 6.9.3 Incontinence Care
  - 6.10 Staff Responsibilities
  
- 7 Dementia and Other Cognitive Impairments [2 hours]
  - 7.1 What is Dementia: Definition and Causes of Dementia
  - 7.2 Alzheimer's Disease: Definition, Diagnosis, Symptoms, and Treatment
  - 7.3 Alzheimer's Disease vs. "Normal" Aging
  - 7.4 Other Types of Cognitive Impairment
  - 7.5 Communication Challenges in People with Alzheimer's Disease or Other Dementias
  - 7.6 Behaviors of People with Dementia
  - 7.7 Staff Responsibilities
  - 7.8 Alzheimer's Association Dementia Care Practice Recommendations for Assisted Living
  
- 8 Intimacy and Aging [1 hour]
  - 8.1 Intimate Relationships and the Older Adult
  - 8.2 Aging and Intimacy
  - 8.3 Medical Conditions and Intimacy
  - 8.4 What does it Mean to be a GLTBI Older Adult?
  - 8.5 Intimacy and Dementia
  - 8.6 Staff Responsibilities

- 9 Meals and Nutrition [1 hour]
  - 9.1 Nutritional Needs for Older Adults
  - 9.2 Age-Related Changes and Nutrition
  - 9.3 Signs and Symptoms of Malnutrition and Dehydration
  - 9.4 Chronic Diseases and Nutrition
  - 9.5 Staff Responsibilities
  
- 10 Activities [1 hour]
  - 10.1 What is an Activity?
  - 10.2 The Staff Member's Role in Activities
  - 10.3 Physical Impairment: What Does that Mean?
  - 10.4 Cognitive Impairment
  - 10.5 Adapting Activities for the Individual
  
- 11 Provision of Personal Care [10 hours]
  - 11.1 What is Personal Care and Its Importance
    - 11.1.1 Dignity and Personal Care
    - 11.1.2 Observation of Changes in a Resident
  - 11.2 Personal Care
    - 11.2.1 Assisting Residents with Bathing
    - 11.2.2 Assisting Residents with Dressing
    - 11.2.3 Assisting Residents with Bathroom Needs
    - 11.2.4 Assisting Residents with Transferring
    - 11.2.5 Assisting Residents with Eating
    - 11.2.6 Mouth, Teeth, and Denture Care
    - 11.2.7 Skin and Nail Care
    - 11.2.8 Shaving
    - 11.2.9 Hair Care
    - 11.2.10 Eyeglasses and Hearing Aids
    - 11.2.11 Housekeeping
    - 11.2.12 Laundry
    - 11.2.13 Other Personal Care Functions and Tasks
  
- 12 Transfer and Ambulation [3 hours]
  - 12.1 The Basics of Body Mechanics
  - 12.2 Transferring a Resident
  - 12.3 Assisting the Resident to Ambulate
  - 12.4 The Hospice Resident
  - 12.5 Staff Responsibilities
  
- 13 Emergency Preparedness and Injury Prevention [1.5 hours]
  - 13.1 Common Injuries and Injury Prevention in Assisted Living
  - 13.2 Emergency Supplies and Medical Emergency Techniques
  - 13.3 Emergency Preparedness and Natural Disasters

13.4	Staff Responsibilities	
14	Restraint Use in the Assisted Living Facility	[2.5 hours]
14.1	The Definition of "Restraint" and Applicable Laws	
14.2	Non-Emergency Restraint Use	
14.3	Emergency Restraint Use	
14.4	Negative Outcomes from Restraint Use	
14.5	Preventing Negative Outcomes	
14.6	Restraint Avoidance and Reduction	
14.7	Staff Training Requirements	
14.8	Staff Responsibilities	
15	End of Life Care: Death, Dying, and Bereavement	[1 hour]
15.1	Death in the United States Today	
15.2	End of Life Decisions	
15.3	Elizabeth Kübler-Ross Stage Model	
15.4	Bereavement and Grief	
15.5	Staff Responsibilities	
16	Glossary	
17	Final Exam and Final Exam Key	

**Introduction to the  
Uniform Assessment Instrument  
and the  
Individualized Service Plan**

**Chapter One**

**Time Required: 1.5 hours**

## **Chapter One – Introduction to the Uniform Assessment Instrument and the Individualized Service Plan**

This chapter will provide the student with an introduction to the Uniform Assessment Instrument (UAI) and the Individualized Service Plan (ISP). This overview does not meet the regulatory training requirements for completing either the UAI or the ISP. Additional training is required to meet those requirements.

### **1.1 Person-Centered Care**

### **1.2 Coordination of Services**

### **1.3 Uniform Assessment Instrument (UAI) and Individualized Service Plans (ISP)**

### **1.4 The Team Approach to Planning Care**

### **1.5 Staff Responsibilities**

## Instructor Planning

### 1. Objectives and Expected Outcomes of Chapter

- a. To understand the concept of Person-Centered Care and why it is important
- b. To understand the purpose of the Uniform Assessment Instrument
- c. To understand the various aspects of the individual assessed using the UAI
- d. To understand the differences between the Private Pay UAI and the Public Pay UAI and have an understanding of how to complete them
- e. To recognize the Individualized Service Plan form and be knowledgeable of its contents
- f. To understand the basic protocol for developing, locating, and using the Individualized Service Plan
- g. To understand the direct care staff's role in developing, carrying out and coordinating the Individualized Service Plan

### 2. Recommended Method of Instruction

- Lecture and class discussion
- Review of Private Pay and Public Pay UAIs – **Handouts #1 and #2**
- Student Activity - Scenario (**Handout #3**)
- Review Individual Service Plan form – **Handout #4**
- Facility's Policy for Developing and Implementing the Individualized Service Plan (if available)
- Facility's Individualized Service Plan Form (if available)
- Student Review – Chapter One

## 1.1 Person-Centered Care

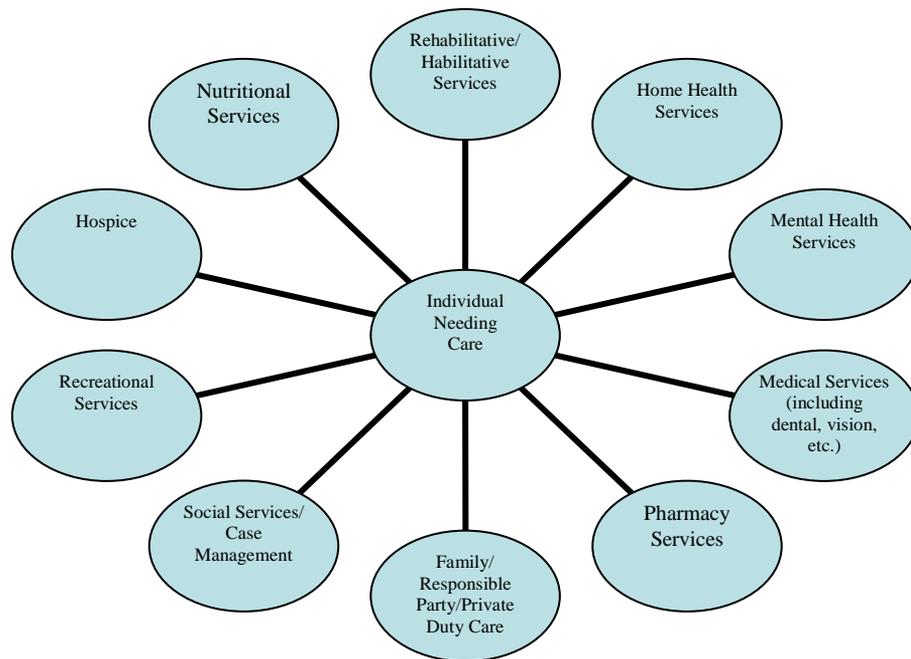
- § The ALF must provide a program that:
  - Meets the resident population's physical, mental, emotional and psychosocial needs
  - Provides protection, guidance, and supervision
  - Promotes a sense of security and self-worth
  - Meets the objectives of the Individualized Service Plan
- Definition of Person-Centered Care:
  - *"...Person Centered Care gives personal attention to the people who live in Long Term Care and empowers staff to be a resident advocate. We believe in honoring each person's dignity, rights, self-respect, and independence by giving them choices, respecting their wishes, meeting their needs, involving them in decision making process, giving them the control of their life and keeping them actively involved, happy and as healthy as possible."* - Eric Haider (leader in culture change)
- Why Person-Centered Care is important - According to NCAL (National Center for Assisted Living) the #1 guiding principles for quality in assisted living is person-centered care. They define it as follows:
  - "Person centered caring focuses on meeting the individual resident's needs. Decision-making is directed by the resident and staff assistance is not task-oriented. Person-centered caring is based on the concept that the staff and management knows each resident, their history, their needs, preferences, and expectations. The staff form meaningful relationships with the residents and their family members. Some ways to accomplish person-centered caring may include:
    - Encouraging the personal development of residents, on an individual basis;

- Maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;
- Supporting lifestyles that promote health and fitness;
- Promoting family and community involvement; and
- Developing positive relationships among residents, staff, families, and the community."

According to NCAL, "Research and experience has shown that person-centered care programs have also been successful in meeting some staff-based outcomes such as reduced staff turnover, reduction in staff accidents and incidents, and higher levels of both resident and employee satisfaction."

### 1.1 Coordination of Services

In order to meet the resident's needs, the ALF coordinates a wide variety of services for the resident. The ALF may not directly provide these services itself but helps the resident to connect with these services. The services may include:



- When the resident is in need of health care services, the resident shall be assisted in making appropriate arrangements for the needed help **(§)**. Healthcare services may include, but are not limited to:
  - Rehabilitative/habilitative services (Treatment for alcohol, drug, sex addiction; learning life skills, learning to live independently)
  - Home health [skilled nursing services (i.e. wound care), physical therapy, occupational therapy, speech therapy]
  - Mental health services (counseling, psychiatric care, substance abuse counseling, etc.)
  - Hospice care (for the resident with a terminal condition)
  - Medical care (physician services, dental/vision services, private duty nursing, etc.)
  - Pharmacy services (reviews all medications, drug-drug interactions, etc.)
  - Nutritional services (Reviews proper diet, weight appropriateness, food-drug interactions)

How do we know what services a resident needs? How do we know how to care for the residents? We get these answers from the Uniform Assessment Instrument (UAI) and Individualized Service Plan (ISP).

## **1.2 Uniform Assessment Instrument and Individual Service Plans**

### **Uniform Assessment Instrument (UAI)**

- The UAI was developed in 1994 through publicly funded human service agencies in Virginia including social services, area agencies on aging, Centers for Independent Living, state facility staff of the Department of Behavioral Health and Developmental Services, and nursing home pre-admission screening teams.
- It was last revised in January 2010

- A multidimensional questionnaire which assesses a resident's social, physical, and mental health and functional abilities
- Purpose of the UAI
  - To gather information for the determination of a resident's care needs and service eligibility
  - For planning and monitoring a resident's care across various agencies and long-term care services
- Provides a comprehensive look at a resident
- Assesses a resident's actual performance and functioning levels
- **§** Must be completed for all residents of the ALF within 90-days prior to admission, except in emergencies.
- **§** Must be completed at least annually; when a change in the resident's condition is expected to last more than 30 days or appears to warrant a change in the resident's level of care (residential living or assisted living); or change in service occurs (i.e. self-administering medications to staff administering)
- **§** Includes only those elements that are necessary for developing an Individualized Service Plan. These elements include:
  - **§** Activities of Daily Living (ADLs)
    - Bathing
    - Dressing
    - Toileting
    - Transferring
    - Bowel control
    - Bladder control
    - Eating/feeding
  - **§** Instrumental Activities of Daily Living (IADLs)
    - Meal preparation
    - Housekeeping

- Laundry
- Managing money
- **§** Ambulation
- **§** Hygiene and grooming
  - Shampooing, combing and brushing hair
  - Shaving
  - Trimming fingernails and toenails (if medically appropriate)
  - Skin care
- **§** Functions and tasks
  - Arrangement for transportation
  - Arrangement for shopping
  - Use of the telephone
  - Correspondence

#### Private Pay UAI

- The Private Pay UAI is less comprehensive and may be completed by qualified assessors of the ALF
  - **§** Qualified assessor means an individual who is authorized to perform an assessment, reassessment, or change in level of care for an applicant to or resident of an assisted living facility
  - **§** A qualified assessor is an employee of the assisted living facility trained in the completion of the UAI or an independent private physician or a qualified assessor for public pay individuals



#### Review Handout #1

#### Public Pay UAI

- Comprised of a short assessment and a full assessment and may be completed by a qualified assessor

- § A qualified assessor means an individual trained in the completion of the UAI.
- § A qualified assessor is an employee of a public human services agency.
- The short assessment [UAI – Part A]
  - Designed to be a screening document that allows for a brief overview of functional status, current service arrangements, and unmet needs
  - Designed to assess the severity of a resident's situation and decide whether a full assessment is warranted
- The full assessment
  - A multidimensional evaluation of resident functioning and physical environment
  - Designed to gather information about the resident, his/her needs, and his/her strengths in order to begin an individualized service plan
  - Completed during a face-to-face interview with the resident



## Review Handout #2

### **Individualized Service Plan (ISP)**

The ISP provides us with information we need to provide person-centered care. It provides us with individualized information on a resident's needs and preferences. The ISP comes initially from the UAI, in addition to other information gathered on the resident, as explained in Section 1.4. It is an explanation of the steps we need to take to carry out the needs listed on the UAI. The ISP may be updated if new needs are identified even if it does not warrant a change in the UAI (i.e. therapies, wound care, etc.) The ISP:

- Shall be designed to maximize the resident's level of functional ability
- § Shall support the principles of:

- Individuality
- Personal dignity
- Freedom of choice
- Home-like environment
- Support systems, formal and informal, that may participate in the delivery of services
- § Be easy to understand and easily accessible to the staff as follows:
  - Contain terminology that is easily understood
  - Be legible and easy to read
  - Be maintained in a location that is accessible to staff
- § The initial ISP shall be completed within 72 hours after admission and shall include the following that **reflect the resident's identified needs**:
  - Description of identified needs based on UAI, physical exam report (history and physical), interview with the resident, mental health progress report, resident personal/social data, and other sources
  - Written description of what services will be provided and who will provide them (ALF staff versus contracted services)
  - When and where services will be provided
  - Duration (time frame) of those services
  - Expected outcomes for the resident
  - Individuals participating in the development of the ISP
- § The comprehensive ISP shall be completed within 30 days of admission as an expansion of the initial ISP
- § Shall be reviewed and updated at least every 12 months and as needed as the condition of the resident changes (improvement or decline)
- § Must be updated each time the UAI is updated as follows:
  - Change in physical condition
  - Change in mental or cognitive state

- Change in functional ability
- Change in social supports (i.e. finances, family, additional needs of facility, etc.)
- The facility may choose a variety of formats in which to document the Individualized Service Plan, however, the plan should:
  - Identify the need or concern, including factors that are unique to the resident (i.e. cause of need, related conditions, or risk factors related to potential needs/concerns)
- Contain goals that are measurable
- Contain staff interventions (plan) to assist the resident in meeting the established goals.
  - Should be responsive
  - Should be related to the identified need and individualized goal

#### **1.4 The Team Approach to Planning Care**

- The Individualized Service Plan should be developed and implemented in conjunction with:
  - The resident
  - The resident's family (the legal responsible party and others authorized to participate)
  - Case worker, if applicable
  - Case manager, if applicable
  - Family and/or private duty caregivers
  - Healthcare providers
    - Direct care staff
    - Rehabilitative/habilitative services
    - Home Health
    - Mental Health (psychologist, psychiatrist, Licensed Clinical Social Worker, Community Services Board)
    - Hospice

- Social Services
- Recreational and social activities personnel
- Other persons as appropriate (Support groups such as Alcoholics Anonymous)



Review Handout #4 and Facility ISP (if available)

### 1.5 Staff Responsibilities

- Direct care staff of the ALF are expected to:
  - Be knowledgeable of resident strengths, limitations, risk factors for potential negative outcomes, contributing factors related to current conditions, etc.
  - Be knowledgeable of the location and content of resident's ISP
  - Assist in identifying individualized and realistic goals for the resident
  - Carry out the plan to the extent of their knowledge, skills, and abilities and within the scope of their position
  - Report all changes (improvement and decline) across all aspects of care so that a new ISP can be developed as necessary.



Review Facility Policy on ISPs (This section can be skipped if the Facility Policy is not available)



### Student Activity

- Scenario – **Handout #3**
- Use **VDSS (Handout #4) or Facility ISP Form**

**Instructor Notes:**

*The purpose of this activity is to show direct care staff of the importance of their participation in developing the plan of care for each resident. This activity should allow them the opportunity to “think outside the box” and to reinforce the understanding that residents are people and not room numbers with care needs. It is important that direct care staff understand that they are integral to the entire care process.*

*Activity procedures:*

- 1. Divide the class into groups of four.*
- 2. Have the participants recommend care options and services and document those options on the VDSS or facility’s ISP form.*
- 3. The students should use **Handout #1** Private Pay UAI as a tool as well*
- 4. Have each group discuss the care options they recommended. Have the following groups supplement the services already discussed.*

**The instructor should use the completed ISP Instructor Guide provided as your guide.**

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40-72-10	Definitions
22 VAC 40-72-40	Scope of program
22 VAC 40-72-430	Uniform assessment instrument
22 VAC 40-72-440	Individualized service plans
22 VAC 40-72-450	Personal care services and general supervision and care
22 VAC 40-72-460	Health care services
22 VAC 40-72-470	Restorative, habilitative and rehabilitative services

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

The Uniform Assessment Instrument

User's Manual, Virginia Uniform Assessment Instrument

VDSS or Facility's Individualized Service Plan Form

Facility's Policy for Developing and Implementing the Individualized Service Plan (if available)

National Center for Assisted Living (NCAL)

## Student Review – Chapter One

1. Why is the ISP important?

**It provides us with information on the resident's needs and preferences.**

2. Who might be involved in developing the ISP? (Student should be able to name at least four)

**Resident**

**The resident's family (the legal responsible party and others authorized to participate)**

**Case worker, if applicable**

**Case manager, if applicable**

**Family and/or private duty caregivers**

**Healthcare providers (direct care staff, rehabilitative/habilitative services, home health, mental health, hospice, social services, recreational and social activities personnel, and other persons such as support groups.**

3. Why is the input of those individuals important?

**It assists in meeting all of the resident's needs.**

4. What is the role and responsibility of direct care staff for development of the ISP?

**Direct care staff assists in identifying individualized and realistic goals for the resident.**

**It is the direct care staff members responsibility to be knowledgeable of the resident's strengths, limitations, and risk factors.**

5. How and when is the ISP revised or updated?

**The initial ISP shall be completed within 72 hours after admission. The comprehensive ISP shall be completed within 30 days of admission as an expansion of the initial ISP. It shall be reviewed and updated at least every 12 months and as needed as the condition of the resident changes.**

6. Where is the ISP located in the facility?

**In a location accessible to staff.**



## VIRGINIA UNIFORM ASSESSMENT INSTRUMENT For Private Pay Residents of Assisted Living Facilities

Dates: Assessment: 1/20/2009  
Reassessment: / /

### 1. IDENTIFICATION

**Name:** Mathers Marva B. **Social Security Number:** 123-45-5678  
(Last) (First) (Middle Initial)  
**Current Address:** 1515 Happy Health Drive City VA 89101 **Phone:** (804) 234-5678  
(Street) (City) (State) (Zip Code)  
**Birth date:** 1 /15/ 1926 **Sex:**  Male  Female  
(Month) (Day) (Year)  
**Marital Status:**  Married  Widowed  Separated  Divorced  Single  unknown

### 2. FUNCTIONAL STATUS (Check only one block for each level of functioning) D = Dependent or Totally Dependent (TD or DD)

	Needs Help?		Mechanical Help Only 10	Human Help Only 2		Mechanical & Human Help 3		Performed by Others 40			D/TD Is Not Performed 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3
Bathing		✓			✓						
Dressing		✓		✓							
Toileting		✓					✓				
Transferring		✓					✓				
Eating/Feeding	✓										
Continance	Needs Help?		Incontinent Less than weekly 1	Ext. Device/Indwelling/Ostomy Self Care 2	Incontinent Weekly or More 3	External Device Not Self Care 4		Indwelling Catheter Not Self Care 5		Ostomy Not Self Care 6	
	No 00	If Yes Check Type of Help									
Bowel		✓			✓						
Bladder		✓			✓						
AMBULATION	Needs Help?		Mechanical Help Only 10	Human Help Only 2		Mechanical & Human Help 3		Performed by Others 40			Is Not Performed 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3
Walking											✓
Wheeling		✓			✓						
Stairclimbing											✓
Mobility		✓					✓		Confined Moves About		Confined Does Not Move About

## 2. FUNCTIONAL STATUS (Continued)

D=Dependent

IADLS	Needs Help?	
	No <sub>0</sub>	Yes <sub>1</sub> <sup>D</sup>
Meal Prep		✓
Housekeeping		✓
Laundry		✓
Money Mgmt.		✓

Medication Administration
How can you take your medicine?
<input type="checkbox"/> Without assistance <sub>0</sub> <input checked="" type="checkbox"/> Administered/monitored by lay person <sub>1</sub> D <input type="checkbox"/> Administered/monitored by professional nursing staff <sub>2</sub> D
Describe help/Name of helper: Daughter

## 3. PSYCHO-SOCIAL STATUS

Behavior Pattern	Orientatio
<input checked="" type="checkbox"/> Appropriate <sub>0</sub> <input type="checkbox"/> Wandering/Passive - Less than weekly <sub>1</sub> <input type="checkbox"/> Wandering/Passive - Weekly or more <sub>2</sub> d <input type="checkbox"/> Abusive/Aggressive/Disruptive - Less than weekly <sub>3</sub> D <input type="checkbox"/> Abusive/Aggressive/Disruptive - Weekly or more <sub>4</sub> D <input type="checkbox"/> Comatose <sub>5</sub> D	<input type="checkbox"/> Oriented <sub>0</sub> <input type="checkbox"/> Disoriented - Some spheres, some of the time <sub>1</sub> d <input checked="" type="checkbox"/> Disoriented - Some spheres, all the time <sub>2</sub> d <input type="checkbox"/> Disoriented - All spheres, some of the time <sub>3</sub> D <input type="checkbox"/> Disoriented - All spheres, all of the time <sub>4</sub> D <input type="checkbox"/> Comatose <sub>5</sub> D
Type of inappropriate behavior:	Spheres affected:
	Time, Day
Current psychiatric or psychological evaluation needed? <input type="checkbox"/> No <sub>0</sub> <input checked="" type="checkbox"/> Yes <sub>1</sub>	

## 4. ASSESSMENT SUMMARY

Prohibited Conditions
Does applicant/resident have a prohibited condition? <input checked="" type="checkbox"/> No <sub>0</sub> <input type="checkbox"/> Yes <sub>1</sub>
Describe:

Level of Care Approved
1) Residential Living <input type="checkbox"/> 2) Assisted Living <input checked="" type="checkbox"/>

Assessment Completed by:			
Assessor	Assessor's Signature	Agency/Assisted Living Facility Name	Date
If the assessor is an assisted living facility employee, the administrator or designee must signify approval by signing below:			
_____ Administrator or Designee Signature	_____ Title	_____ Date	
_____ Administrator or Designee Signature	_____ Title	_____ Date	
Comments:			

Note: Form must be filed in private pay resident's record upon completion



Client Name:

Client SSN:

**Current Formal Services**

Do you currently use any of the following types of services?

No 0	Yes 1	(Check All Services That Apply)	Provider/Frequency:
_____	_____	Adult Day Care	_____
_____	_____	Adult Protective	_____
_____	_____	Case Management	_____
_____	_____	Chore/Companion/Homemaker	_____
_____	_____	Congregate Meals/Senior Center	_____
_____	_____	Financial Management/Counseling	_____
_____	_____	Friendly Visitor/Telephone Reassurance	_____
_____	_____	Habilitation/Supported Employee	_____
_____	_____	Home Delivered Meals	_____
_____	_____	Home Health/Rehabilitation	_____
_____	_____	Home Repairs/Weatherization	_____
_____	_____	Housing	_____
_____	_____	Legal	_____
_____	_____	Mental Health (Inpatient/Outpatient)	_____
_____	_____	Mental Retardation	_____
_____	_____	Personal Care	_____
_____	_____	Respite	_____
_____	_____	Substance Abuse	_____
_____	_____	Transportation	_____
_____	_____	Vocational Rehab/Job Counseling	_____
_____	_____	Other:	_____

**Financial Resources**

Where are you on the scale for annual (monthly) family income before taxes?

- \_\_\_\_\_ \$20,000 or More (\$1,667 or more) 0
- \_\_\_\_\_ \$15,000 - 19,999 (\$1,250 - \$1,666) 1
- \_\_\_\_\_ \$11,000 - 14,999 (\$ 917 - \$1,249) 2
- \_\_\_\_\_ \$ 9,500 - 10,999 (\$ 792 - \$ 916) 3
- \_\_\_\_\_ \$ 7,000 - 9,499 (\$ 583 - \$ 791) 4
- \_\_\_\_\_ \$ 5,500 - 6,999 (\$ 458 - \$ 582) 5
- \_\_\_\_\_ \$ 5,499 or Less (\$ 457 or Less) 6
- \_\_\_\_\_ Unknown 0

Number in Family unit: \_\_\_\_\_  
Optional: Total monthly family income: \_\_\_\_\_

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	Names
_____	_____	Legal Guardian _____
_____	_____	Power of Attorney _____
_____	_____	Representative Payee _____
_____	_____	Other _____

Do you receive any benefits or entitlements?

No 0	Yes 1	
_____	_____	Auxiliary Grant
_____	_____	Food Stamps
_____	_____	Fuel Assistance
_____	_____	General Relief
_____	_____	State and Local Hospitalization
_____	_____	Subsidized Housing
_____	_____	Tax Relief

Do you currently receive income from...?

No 0	Yes 1	Optional: Amount
_____	_____	Black Lung _____
_____	_____	Pension _____
_____	_____	Social Security _____
_____	_____	SSI/SSDI _____
_____	_____	VA Benefits _____
_____	_____	Wages/Salary _____
_____	_____	Other _____

What types of health insurance do you have?

No 0	Yes 1	
_____	_____	Medicare, # _____
_____	_____	Medicaid, # _____
_____	_____	Pending: _____ No 0 _____ Yes 1
_____	_____	QMB/SLMB: _____ No 0 _____ Yes 1
_____	_____	All Other Public/Private: _____

Client Name:

Client SSN:

**Physical Environment**

**Where do you usually live? Does anyone live with you?**

	Alone <sup>1</sup>	Spouse <sup>2</sup>	Other <sup>3</sup>	Names of Persons in Household	
<input type="checkbox"/> House: Own <sup>0</sup>					
<input type="checkbox"/> House: Rent <sup>1</sup>					
<input type="checkbox"/> House: Other <sup>2</sup>					
<input type="checkbox"/> Apartment <sup>3</sup>					
<input type="checkbox"/> Rented Room <sup>4</sup>					
	Name of Provider (Place)			Admission Date	Provider Number (If Applicable)
<input type="checkbox"/> Adult Care Residence <sup>50</sup>					
<input type="checkbox"/> Adult Foster <sup>60</sup>					
<input type="checkbox"/> Nursing Facility <sup>70</sup>					
<input type="checkbox"/> Mental Health/Retardation Facility <sup>80</sup>					
<input type="checkbox"/> Other <sup>90</sup>					

**Where you usually live are there any problems?**

No <sup>0</sup>	Yes <sup>1</sup>	(Check All Problems That Apply)	Describe Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Barriers to Access	
<input type="checkbox"/>	<input type="checkbox"/>	Electric Hazards	
<input type="checkbox"/>	<input type="checkbox"/>	Fire Hazards/No Smoke Alarm	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Heat/Air Conditioning	
<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Hot Water/Water	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Toilet Facilities (Inside/Outside)	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Stove, Refrigerator, Freezer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Defective Washer/Dryer	
<input type="checkbox"/>	<input type="checkbox"/>	Lack of/Poor Bathing Facilities	
<input type="checkbox"/>	<input type="checkbox"/>	Structural Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Telephone Not Accessible	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe Neighborhood	
<input type="checkbox"/>	<input type="checkbox"/>	Unsafe/Poor Lighting	
<input type="checkbox"/>	<input type="checkbox"/>	Unsanitary Conditions	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	

Client Name: \_\_\_\_\_

Client SSN: \_\_\_\_\_

**2** **FUNCTIONAL STATUS** (Check only one block for each level of functioning.)

ADLS	Needs Help?	
	No <sup>00</sup>	Yes
Bathing		
Dressing		
Toileting		
Transferring		
Eating/Feeding		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed by Others 40 D			Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2	Spoon Fed 1	Syringe/Tube Fed 2	Fed by IV 3	

Continence	Needs Help?	
	No <sup>00</sup>	Yes
Bowel		
Bladder		

Incontinent Less than Weekly 1	Ext. Device/ Indwelling/ Ostomy Self Care 2	Incontinent D Weekly or More 3	External Device Not Self Care 4	Indwelling D Catheter Not Self Care 5	Ostomy D Not Self Care 6

Ambulation	Needs Help?	
	No <sup>00</sup>	Yes
Walking		
Wheeling		
Stand/lying		
Mobility		

MH Only 10 Mechanical Help	HH Only 2 D Human Help		MH & HH 3 D		Performed D by Others 40	Is Not D Performed 50
	Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
					Confined Never About	Confined Does Not Move About

IADLS	Needs Help?	
	No <sup>0</sup>	Yes <sup>1</sup>
Meal Preparation		
Housekeeping		
Laundry		
Money Mgmt		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

**Outcome: Is this a short assessment?**

\_\_\_\_\_ No, Continue with Section 3 (0)      \_\_\_\_\_ Yes, Service Referrals (1)      \_\_\_\_\_ Yes, No Service Referrals (2)

Screener: \_\_\_\_\_ Agency: \_\_\_\_\_

Client Name:

Client SSN:

### PHYSICAL HEALTH ASSESSMENT

#### Professional Visits/Medical Admissions

Doctor's Name(s) (List all)	Phone	Date of Last Visit	Reason for Last Visit

#### Admission: In the past 12 months have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

#### Do you have any advance directives such as... (Who has it...Where is it...)?

No 0 Yes 1 Location

\_\_\_\_\_ Living Will, \_\_\_\_\_

\_\_\_\_\_ Durable Power of Attorney for Health Care, \_\_\_\_\_

\_\_\_\_\_ Other, \_\_\_\_\_

#### Diagnoses & Medication Profile

#### Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as ... (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset	Diagnoses
		Alcoholism/Substance Abuse (01)
		Blood-Related Problems (02)
		Cancer (03)
		Cardiovascular Problems
		Circulation (04)
		Heart Trouble (05)
		High Blood Pressure (06)
		Other Cardiovascular Problems (07)
		Dementia
		Alzheimer's (08)
		Non-Alzheimer's (09)
		Developmental Disabilities
		Mental Retardation (10)
		Related Conditions
		Anxiety (11)
		Carotid Pulse (12)
		Epilepsy (13)
		Fibrositis/Alexia (14)
		Multiple Sclerosis (15)
		Muscular Dystrophy (16)
		Spina Bifida (17)
		Digestive/Liver/Gall Bladder (18)
		Endocrine/Gland Problems
		Diabetes (19)
		Other Endocrine Problem (20)
		Eye Disorders (21)
		Immune System Disorders (22)
		Muscular/Skeletal
		Arthritis/Rheumatoid Arthritis (23)
		Osteoporosis (24)
		Other Muscular/Skeletal Problems (25)
		Neurological Problems
		Brain Trauma/Injury (26)
		Spinal Cord Injury (27)
		Stroke (28)
		Other Neurological Problems (29)
		Psychiatric Problems
		Anxiety Disorder (30)
		Bipolar (31)
		Major Depression (32)
		Personality Disorder (33)
		Schizophrenia (34)
		Other Psychiatric Problems (35)
		Respiratory Problems
		Black Lung (36)
		COPD (37)
		Pneumonia (38)
		Other Respiratory Problems (39)
		Urinary/Reproductive Problems
		Renal Failure (40)
		Other Urinary/Reproductive (41)
		All Other Problems (42)

Enter Codes for 3 Major, Active Diagnoses: \_\_\_\_\_ None 00 \_\_\_\_\_ DX1 \_\_\_\_\_ DX2 \_\_\_\_\_ DX3

Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Total No. of Medications: \_\_\_\_\_ (If 0, skip to Sensory Function) Total No. of Tranquilizer/Psychotropic Drugs: \_\_\_\_\_

Do you have any problems with medicine(s)...?	How do you take your medications?
No 0 Yes 1	Without assistance 0
_____ Adverse reactions/allergies	_____ Administered/monitored by lay person 1
_____ Cost of medication	_____ Administered/monitored by professional nursing staff 2
_____ Getting to the pharmacy	Describe help: _____
_____ Taking them as instructed/prescribed	Name of helper: _____
_____ Understanding directions/schedule	

Client Name:

Client SSN:

### Sensory Functions

**How is your vision, hearing, and speech?**

	No Impairment <sub>0</sub>	Impairment		Complete Loss <sub>3</sub>	Date of Last Exam
		Record Date of Onset/Type of Impairment			
		Compensation <sub>1</sub>	No Compensation <sub>2</sub>		
Vision					
Hearing					
Speech					

### Physical Status

**Joint Motion: How is your ability to move your arms, fingers, and legs?**

- \_\_\_\_\_ Within normal limits or instability corrected <sub>0</sub>  
 \_\_\_\_\_ Limited motion <sub>1</sub>  
 \_\_\_\_\_ Instability uncorrected or immobile <sub>2</sub>

**Have you ever broken or dislocated any bones ... Ever had an amputation or lost any limbs ... Lost voluntary movement of any part of your body?**

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
_____ None 000 _____ Hip Fracture 1 _____ Other Broken Bone(s) 2 _____ Dislocation(s) 3 _____ Combination 4 <b>Previous Rehab Program?</b> _____ No/Not Completed 1 _____ Yes 2 <b>Date of Fracture/Dislocation?</b> _____ 1 Year or Less 1 _____ More than 1 Year 2	_____ None 000 _____ Finger(s)/Toe(s) 1 _____ Arm(s) 2 _____ Leg(s) 3 _____ Combination 4 <b>Previous Rehab Program?</b> _____ No/Not Completed 1 _____ Yes 2 <b>Date of Amputation?</b> _____ 1 Year or Less 1 _____ More than 1 Year 2	_____ None 000 _____ Partial 1 _____ Total 2 Describe: _____ <b>Previous Rehab Program?</b> _____ No/Not Completed 1 _____ Yes 2 <b>Onset of Paralysis?</b> _____ 1 Year or Less 1 _____ More than 1 Year 2

### Nutrition

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent Weight Gain/Loss: \_\_\_\_\_ No <sub>0</sub> \_\_\_\_\_ Yes <sub>1</sub>  
 (Inches) (lbs.) Describe: \_\_\_\_\_

Are you on any special diet(s) for medical reasons?	Do you have any problems that make it hard to eat?
_____ None 0 _____ Low Fat/Cholesterol 1 _____ No/Low Salt 2 _____ No/Low Sugar 3 _____ Combination/Other 4	No <sub>0</sub> Yes <sub>1</sub> _____ _____ Food Allergies _____ _____ Inadequate Food/Fluid Intake _____ _____ Nausea/Vomiting/Diarrhea _____ _____ Problems Eating Certain Foods _____ _____ Problems Following Special Diets _____ _____ Problems Swallowing _____ _____ Taste Problems _____ _____ Tooth or Mouth Problems _____ Other: _____
Do you take dietary supplements?	
_____ None 0 _____ Occasionally 1 _____ Daily, Not Primary Source 2 _____ Daily, Primary Source 3 _____ Daily, Sole Source 4	

Client Name: \_\_\_\_\_ Client SSN: \_\_\_\_\_

**Current Medical Services**

**Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as...?**

No 0	Yes 1	Frequency
_____	_____	Occupational _____
_____	_____	Physical _____
_____	_____	Reality/Motivation _____
_____	_____	Respiratory _____
_____	_____	Speech _____
_____	_____	Other _____

**Special Medical Procedures: Do you receive any special nursing care, such as ...?**

No 0	Yes 1	Site, Type, Frequency
_____	_____	Bowel/Bladder Training _____
_____	_____	Dialysis _____
_____	_____	Dressing/Wound Care _____
_____	_____	Eye care _____
_____	_____	Glucose/Blood Sugar _____
_____	_____	Infections/IV Therapy _____
_____	_____	Oxygen _____
_____	_____	Radiation/Chemotherapy _____
_____	_____	Restraints (Physical/Chemical) _____
_____	_____	ROM Exercise _____
_____	_____	Trach Care/Suctioning _____
_____	_____	Ventilator _____
_____	_____	Other: _____

**Do you have pressure ulcers?**

None 0	Location/Size
_____	Stage I 1 _____
_____	Stage II 2 _____
_____	Stage III 3 _____
_____	Stage IV 4 _____

**Medical/Nursing Needs**

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? \_\_\_\_\_ No 0 \_\_\_\_\_ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

**Comments:**

Optional: Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Others: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature/Title)

Client Name:

Client SSN:

## 4 PSYCHO-SOCIAL ASSESSMENT

### Cognitive Function

**Orientation** (Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)

**Person:** Please tell me your full name (so that I can make sure our record is correct).

**Place:** Where are we now (*state, county, town, street/route number, street name/box number*)? Give the client 1 point for each correct response.

**Time:** Would you tell me the date today (*year, season, date, day, month*)?

Spheres affected: \_\_\_\_\_

- \_\_\_\_\_ Oriented 0
- \_\_\_\_\_ Disoriented – Some spheres, some of the time 1
- \_\_\_\_\_ Disoriented – Some spheres, all the time 2
- \_\_\_\_\_ Disoriented – All spheres, some of the time 3
- \_\_\_\_\_ Disoriented – All spheres, all of the time 4
- \_\_\_\_\_ Comatose 5

### Recall/Memory/Judgment

**Recall:** I am going to say three words. And I want you to repeat them after I am done ( House, Bus, Dog). \* Ask the client to repeat them. Give the client 1 point for each correct response on the first trial. \* Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

**Attention/ Concentration:** Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).

**Short-Term:** \* Ask the client to recall the 3 words he was to remember.

**Long-Term:** When were you born ( What is your date of birth)?

**Judgment:** If you needed help at night, what would you do?

No 0 Yes 1

- \_\_\_\_\_ Short-Term Memory Loss?
- \_\_\_\_\_ Long-Term Memory Loss?
- \_\_\_\_\_ Judgment Problems?

Optional: MMSE Score

(5)

(5)

(3)

(5)

Total:

Note: Score of 14 or below implies cognitive impairment.

### Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc...) or become agitated and abusive?

- \_\_\_\_\_ Appropriate 0
- \_\_\_\_\_ Wandering/Passive – Less than weekly 1
- \_\_\_\_\_ Wandering/Passive – Weekly or more 2
- \_\_\_\_\_ Abusive/Aggressive/Disruptive – Less than weekly 3
- \_\_\_\_\_ Abusive/Aggressive/Disruptive – Weekly or more 4
- \_\_\_\_\_ Comatose 5

Type of inappropriate behavior: \_\_\_\_\_ Source of Information: \_\_\_\_\_

### Life Stressors

Are there any stressful events that currently affect your life, such as ...?

- |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|
| No 0  | Yes 1 | No 0  | Yes 1 | No 0  | Yes 1 |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
- Change in work/employment      Financial problems      Victim of a crime  
 Death of someone close      Major illness- family/friend      Failing health  
 Family conflict      Recent move/relocation      Other: \_\_\_\_\_

Client Name:

Client SSN:

**Emotional Status**

In the past month, how often did you ...?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 4
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you don't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living ... or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite ... that is, eat too much or too little?					

Comments:

**Social Status**

Are there some things that you do that you especially enjoy?

No 0 Yes 1

Describe

\_\_\_\_\_ Solitary Activities, \_\_\_\_\_

\_\_\_\_\_ With Friends/Family, \_\_\_\_\_

\_\_\_\_\_ With Groups/Clubs, \_\_\_\_\_

\_\_\_\_\_ Religious Activities, \_\_\_\_\_

How often do you talk with your children family or friends either during a visit or over the phone?

Children

Other Family

Friends/ Neighbors

\_\_\_\_\_ No Children 0

\_\_\_\_\_ No Other Family 0

\_\_\_\_\_ No Friends/Neighbors 0

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Daily 1

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Weekly 2

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Monthly 3

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Less than Monthly 4

\_\_\_\_\_ Never 5

\_\_\_\_\_ Never 5

\_\_\_\_\_ Never 5

Are you satisfied with how often you see or hear from your children other family and/or friends?

\_\_\_\_\_ No 0

\_\_\_\_\_ Yes 1

Client Name:

Client SSN:

### Hospitalization/Alcohol – Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves emotional/mental health alcohol or substance abuse problems?

No 0 Yes 1

Name of Place	Admit Date	Length of stay/Reason

Do (did) you ever drink alcoholic beverages?

Never 0  
 At one time, but no longer 1  
 Currently 2  
 How much: \_\_\_\_\_  
 How often: \_\_\_\_\_

Do (did) you ever use non-prescription, mood altering substances?

Never 0  
 At one time, but no longer 1  
 Currently 2  
 How much: \_\_\_\_\_  
 How often: \_\_\_\_\_

If the client has never used alcohol or other non-prescription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?	Do (did) you ever use alcohol/other mood-altering substances with ...	Do (did) you ever use alcohol/other mood-altering substances to help you ...
No 0 Yes 1	No 0 Yes 1	No 0 Yes 1
Describe concerns:	<input type="checkbox"/> Prescription drugs? <input type="checkbox"/> OTC medicine? <input type="checkbox"/> Other substances? Describe what and how often:	<input type="checkbox"/> Sleep? <input type="checkbox"/> Relax? <input type="checkbox"/> Get more energy? <input type="checkbox"/> Relieve worries? <input type="checkbox"/> Relieve physical pain? Describe what and how often:

Do (did) you ever smoke or use tobacco products?

Never 0  
 At one time, but no longer 1  
 Currently 2  
 How much: \_\_\_\_\_  
 How often: \_\_\_\_\_

Is there anything we have not talked about that you would like to discuss?

Client Name:

Client SSN:

## Assessment Summary

*Indicators of Adult Abuse and Neglect: While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1-35.3, to report this to the Department of Social Services, Adult Protective Services.*

### Caregiver Assessment

Does the client have an informal caregiver?

No 0 (Skip to Section on Preferences)  Yes 1

Where does the caregiver live?

- With client 0
- Separate residence, close proximity 1
- Separate residence, over 1 hour away 2

Is the caregiver's help ...

- Adequate to meet the client's needs? 0
- Not adequate to meet the client's needs? 1

Has providing care to client become a burden for the caregiver?

- Not at all 0
- Somewhat 1
- Very much 2

Describe any problems with continued caregiving:

### Preferences

Client's preference for receiving needed care:

Family/Representative's preference for client's care:

Physician's comments (if applicable):

Client Name: \_\_\_\_\_ Client SSN: \_\_\_\_\_

**Client Case Summary**

**Unmet Needs**

No  Yes  *(Check All That Apply)*  
 \_\_\_\_\_  
 \_\_\_\_\_ Finances  
 \_\_\_\_\_ Home/Physical Environment  
 \_\_\_\_\_ ADLS  
 \_\_\_\_\_ IADLS

No  Yes  *(Check All That Apply)*  
 \_\_\_\_\_  
 \_\_\_\_\_ Assistive Devices/Medical Equipment  
 \_\_\_\_\_ Medical Care/Health  
 \_\_\_\_\_ Nutrition  
 \_\_\_\_\_ Cognitive/Emotional  
 \_\_\_\_\_ Caregiver Support

**Assessment Completed By:**

Assessor's Name	Signature	Agency/Provider Name	Provider #	Section(s) Completed

Optional: Case assigned to: \_\_\_\_\_ Code #: \_\_\_\_\_

## Chapter One Scenario

Marva B. Mathers is an 83 year old female that was admitted to Happy Health Assisted Living on January 29, 2009. Her daughter has been her primary caregiver for the past three (3) years and was present during the initial assessment. Mrs. Mathers was diagnosed with probable Alzheimer's disease two years ago. Her daughter is also a fulltime caregiver to her brother diagnosed with Mental Retardation, her two children, and one grandchild. The house they live in is owned by Mrs. Mathers.

Upon initial assessment of Mrs. Mathers, she was confined to a wheelchair and unable to self-ambulate to the bathroom. She was incontinent of bowel and bladder. Her daughter stated that Mrs. Jones could stand using grab bars and with only the daughter's assistance. Mrs. Mathers needs assistance with washing her back and low extremities but can wash the rest of her body with simple instructions provided by her daughter. Mrs. Mathers can also dress herself when provided instructions are given to her one at a time.

Mrs. Mathers had experienced a significant weight loss over the past six (6) months (greater than 10%). The daughter cooked all three meals a day and found it difficult to get her mother to eat anything. The daughter cooked her Mom's favorite meals including spaghetti and chicken. She stopped encouraging her mother to eat foods she disliked like green beans. Mrs. Mathers can use her utensils properly but generally just picks at her food. The only thing she would drink was Coca Cola and they used that for her pills. She had recently visited the doctor and was not suffering from a UTI or other illness that would make her not eat. She uses glasses and hearing aids in both ears. Mrs. Mathers communication is currently limited to "yes" and "no" statements. The daughter gives her Mom her medication because her Mom is not aware of the time of day and her daughter is unsure if she is aware of the day of the week. Some of Mrs. Mathers medications include Aricept for memory, Darvocet for pain, Zoloff for depression, Elavil for anxiety, and Lasix for fluid retention.

Mrs. Mathers daughter also pays all of the bills, washes all of the laundry, and does all of the housekeeping.



**INDIVIDUALIZED SERVICE PLAN**

Chapter 1, Handout #4, Instructor Guide

If applicable: Medicaid # \_\_\_\_\_  
 DMAS Provider ID# \_\_\_\_\_

Resident's Name: Marva B. Mothers Name of ALF: Happy Health Assisted Living

See reverse side for signatures and additional information.

*Description of needs is based upon the UAI, medical reports, and any additional assessments necessary to meet the care needs of the resident.*

**A. If the resident lives in a building housing 19 or fewer residents, does the resident need to have a staff member awake and on duty at night?  Yes  No**

<b>B. Description of Needs and Date Identified</b>	<b>Services to be Provided</b>	<b>Persons Who will Provide Services</b>	<b>When and Where Services will be Provided</b>	<b>Expected Outcomes/Goals (Include Time Frames)</b>
1/29/09 Resident needs physical and occupational therapy for poor ambulation.	Instruction on walking with assistive device (walker), self-ambulation in wheelchair, brushing teeth and hair, and bathing.	Physical and occupational therapist and/or PTA or COTA	Up to three times a week as tolerated in resident's room and ALF	Resident will increase mobility and fine motor skills within the next six weeks.
1/29/09 Resident takes two psychotropic medications for the diagnoses of depression and probable Alzheimer's Disease.	Behavioral observation for increased signs of confusion, self-isolation, non-participation in activities and meals.	All staff	Ongoing throughout ALF	Resident will show decreased signs of depression, require less redirection, show an increase in activities, and increased socialization with other residents of meals.
1/29/09 Resident needs individual therapy to promote verbal skills due to inability of resident to communicate more than one word responses.	1. Routine individual therapy 2. Staff to encourage resident to verbally communicate needs.	Psychologist or Licensed Clinical Social Worker All Staff	Weekly in resident's room Throughout the day in resident's room	Resident will improve verbal communication within the next eight weeks.
1/29/09 Resident needs increased socialization due to isolation while living at home. Resident had little contact with outside individuals while resident with her daughter.	Activity participation	Activity staff	Minimum of three times a week throughout ALF.	Resident will show decreased signs of depression and increased socialization (decreased self-isolation) within the next month and ongoing.

Resident's Name: Marva B. Mathers

Chapter 1, Handout #4, Instructor Guide

<b>B. Description of Needs and Date Identified</b>	<b>Services to be Provided</b>	<b>Persons Who will Provide Services</b>	<b>When and Where Services will be Provided</b>	<b>Expected Outcomes/Goals (Include Time Frames)</b>
<p>1/29/09 Resident needs assistance with bathing due to poor ambulation and inability to transfer independently to promote proper hygiene and prevent skin breakdown.</p>	<ol style="list-style-type: none"> <li>1. Staff will provide resident with a sink bath and appropriate bathing materials (wash cloth, soap, lotion, etc) to clean up.</li> <li>2. Staff will assist resident with a shower by washing resident's back and lower extremities</li> <li>3. Staff will encourage resident to participate in bathing independently and using washcloths for proper cleaning.</li> <li>4. Staff to encourage resident to use grab bars when transferring in and out of the shower.</li> </ol>	<p>Nursing staff</p> <p>Nursing staff</p>	<p>Each morning in resident's bathroom or sink area</p> <p>Twice a week and as needed in resident's bathroom or shower room</p>	<p>Resident will maintain and/or improve proper hygiene until the next review.</p> <p>To reduce skin risk and potential skin breakdown within the next month and ongoing.</p>
<p>1/29/09 Resident needs a balanced diet due to poor eating habits and only drinking coke.</p>	<ol style="list-style-type: none"> <li>1. Dietary staff to provide a balanced diet based on physician orders.</li> <li>2. Monitor weight monthly</li> <li>3. Monitor food intake</li> <li>4. Resident's food will be cut up for ease of eating. Resident likes spaghetti and chicken with a Coca Cola. Dislikes green beans.</li> </ol>	<p>Daily - Dietary and nursing staff - meal supervision, food intake, food cut up.</p> <p>Monthly - dietitian - proper diet, weight change</p>	<p>Each meal for food intake and proper diet in dining room</p> <p>Monthly weights in resident room</p> <p>Dietician oversight - monthly or nurses' station and discussing with resident in resident room</p>	<p>Resident will receive a well-balanced meal and show an increase in proper food intake and improved appropriate weight.</p> <p>Proper diet to occur immediately.</p> <p>Food intake to improve over the next month.</p>
<p>1/29/09 Resident needs medications administered daily due to confusion regarding types of medications, dosages and administration times.</p>	<ol style="list-style-type: none"> <li>1. Medications are to be administered as prescribed by the physician.</li> <li>Physician is to be contacted if adverse medication reactions are noted or difficulty taking medications are observed.</li> </ol>	<p>Licensed Nursing staff and Registered Medication Aides</p> <p>Licensed Nursing staff</p>	<p>Administered as prescribed in resident's room</p> <p>Administered in resident's room</p>	<p>Resident will show no signs of adverse medication reactions, swallowing difficulty, or refusing to take medications immediately and ongoing.</p>

Resident's Name: Marva B. Mathers

Chapter 1, Handout #4, Instructor Guide

<b>B. Description of Needs and Date Identified</b>	<b>Services to be Provided</b>	<b>Persons Who will Provide Services</b>	<b>When and Where Services will be Provided</b>	<b>Expected Outcomes/Goals (Include Time Frames)</b>
1/29/09 Resident needs pain management based on facial expressions upon transferring to and from wheelchair.	<ol style="list-style-type: none"> <li>Control pain prior to transferring resident to and from wheelchair.</li> <li>Staff is to ask resident if she is in pain and needs medication prior to am care and/or therapy services.</li> </ol>	Licensed Nursing staff and Registered Medication Aides	Daily in resident's room	Resident will show decreased signs of pain and will reduce the number of narcotic pain medications needed for services rendered.
1/29/09 Resident needs supervision with getting clothes ready due to difficulty with ambulation. Resident will dress/undress independently with verbal commands.	<ol style="list-style-type: none"> <li>Staff to provide resident a choice of clothes each morning and sleepwear each evening.</li> <li>Staff to place clothes in reach of resident and provide supervision with dressing and assistance with buttons and zippers if needed</li> <li>Staff will provide one-step instructions to the resident on dressing/undressing.</li> </ol>	Nursing staff	Each morning and each evening in resident's room	Resident will maintain independence with dressing/undressing until next review.
1/29/09 Resident needs assistance with toileting due to incontinence. Resident is at risk for skin breakdown.	<ol style="list-style-type: none"> <li>Staff will take resident to the restroom and thoroughly clean resident after toileting.</li> <li>Staff will take resident to the restroom at any time incontinence is noted. Resident will be thoroughly cleaned after toileting.</li> </ol>	Nursing staff	Every two hours in resident's room. As needed in resident's room.	Resident will reduce number of incontinent episodes within six months. Resident will show no signs of skin breakdown until the next ISP review.

**SIGNATURES:**

Staff Person Who Completed Plan	Date Plan Completed	Resident	Date
Licensed Health Care Professional (630.J) (For Assisted Living Care Residents)	Date	Other, if any, Involved in Development of Plan (Specify Title/Relationship)	Date

**PLAN REVIEW/MODIFICATIONS**

NOTE: Changes in plan should be initiated by staff person making change, resident, and for assisted living care residents, licensed health care professional (630.J).

Staff Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: \_\_\_\_\_

Dates Implementation Monitored and Initials: \_\_\_\_\_

**SIGNATURES:**

Staff Person Who Completed Plan Review	Date	Staff Person Who Completed Plan Review	Date
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# **ASSISTED LIVING FACILITY PRIVATE PAY ASSESSMENT MANUAL**

**Commonwealth of Virginia  
Department of Social Services  
Division of Family Services, Adult Services Program**

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## **I. 1. PURPOSE OF THIS MANUAL**

This manual provides guidance on the assessment of all private pay individuals residing in or planning to reside in an assisted living facility (ALF). It also describes use of the Private Pay Uniform Assessment Instrument (UAI). The Private Pay UAI is an alternate version of the full, 12-page UAI and contains only the information necessary to determine whether a private pay individual meets the level of care criteria for residential or assisted living. It uses the common definitions associated with the full assessment. A copy of the Private Pay UAI is found in Appendix A of this manual.

This manual should be used in conjunction with the User's Manual: Virginia Uniform Assessment Instrument (revised July 2005). The User's Manual: Virginia Uniform Assessment Instrument describes the process for using the UAI to assess individuals who reside in an ALF or are planning to reside in an ALF. The manual is located online at <http://www.dss.virginia.gov/family/as/manual.cgi>

An ALF provider uses the Private Pay UAI to determine an individual's care needs and ensure these needs match the level of care for which the ALF is licensed to provide. Virginia regulations [22 VAC 40-72](#), Standards for Licensed Assisted Living Facilities and [22 VAC 40 745](#), Assessment in Assisted Living Facilities, state that no individual is to be admitted to or remain in an ALF, if the ALF cannot provide or secure appropriate care for the individual. An ALF is prohibited from admitting or retaining an individual if the ALF cannot provide the level of service or is not licensed for a type of service or if the ALF does not have the staff appropriate in numbers and with the appropriate skill to provide such services. In addition to the completed UAI, the ALF must ensure that for admission, there is a physical examination report for the individual, mental health screening if indicated, and an interview between the administrator or a designee responsible for admission and retention decisions and the individual or his or her personal representative. The ALF must make any admission decision based on the completed UAI, the physical examination, mental health screening if indicated, the interview, or any other available physical, psychosocial and functional status assessments.

Assessors should become familiar with this manual and use it as a reference document. The assessor needs to obtain the most complete, accurate information on each individual being assessed. A chart outlining the assessment process is located in Appendix B.

## **II. 2. BACKGROUND**

Since July 1, 1994, publicly funded human service agencies in Virginia, including the local departments of social services, area agencies on aging, centers for independent living, state facility staff of the Department of Behavioral Health and Developmental Services (DBHDS) and Pre-Admission Screening (PAS) teams have been using the UAI to gather information to determine an individual's care needs, for service eligibility,

and for planning and monitoring of an individual's needs across agencies and services. There are several versions of the UAI, including the short form, the full 12-page document, and the Private Pay version. For individuals paying privately to reside in an ALF, the Private Pay UAI is used during the assessment process. However an ALF provider may use the short form or the full UAI during the assessment of an individual who is paying privately for an ALF.

### III. 3. LEGAL BASIS

Effective February 1, 1996, § [63.2-1804](#) of the Code of Virginia, and regulations, 22 VAC 40-745, have required that all individuals prior to admission to an ALF, and individuals residing in an ALF must be assessed, at least annually, using the UAI to determine the need for residential or assisted living care, regardless of payment source or length of stay. Throughout this manual, text that appears in capital letters denotes text taken from the Department of Social Services (DSS) regulations.

### IV. 4. DEFINITIONS

**4.1 "ACTIVITIES OF DAILY LIVING (ADLS)"** MEANS BATHING, DRESSING, TOILETING, TRANSFERRING, BOWEL CONTROL, BLADDER CONTROL, AND EATING/FEEDING. A PERSON'S DEGREE OF INDEPENDENCE IN PERFORMING THESE ACTIVITIES IS A PART OF DETERMINING APPROPRIATE LEVEL OF CARE AND SERVICES ([22 VAC 40-72-10](#))

**4.2 "ADMINISTRATOR"** MEANS THE LICENSEE OR A PERSON DESIGNATED BY THE LICENSEE WHO IS RESPONSIBLE FOR THE GENERAL ADMINISTRATION AND MANAGEMENT OF AN ASSISTED LIVING FACILITY AND WHO OVERSEES THE DAY-TO-DAY OPERATION OF THE FACILITY, INCLUDING COMPLIANCE WITH ALL REGULATIONS FOR LICENSED ASSISTED LIVING FACILITIES ([22 VAC 40-72-10](#)).

**4.3 "APPLICANT"** MEANS AN ADULT PLANNING TO RESIDE IN AN ASSISTED LIVING FACILITY ([22 VAC 40-745-10](#)).

**4.4 "ASSESSMENT"** MEANS A STANDARDIZED APPROACH USING COMMON DEFINITIONS TO GATHER SUFFICIENT INFORMATION ABOUT APPLICANTS TO AND RESIDENTS OF ASSISTED LIVING FACILITIES TO DETERMINE THE NEED FOR APPROPRIATE LEVEL OF CARE AND SERVICES ([22 VAC 40-745-10](#)).

**4.5 "ASSISTED LIVING CARE"** MEANS A LEVEL OF SERVICE PROVIDED BY AN ASSISTED LIVING FACILITY FOR ADULTS WHO MAY HAVE PHYSICAL OR MENTAL IMPAIRMENTS AND REQUIRE AT LEAST MODERATE ASSISTANCE WITH THE ACTIVITIES OF DAILY LIVING. MODERATE ASSISTANCE MEANS DEPENDENCY IN TWO OR MORE OF THE ACTIVITIES OF DAILY LIVING. INCLUDED IN THIS LEVEL OF SERVICE ARE INDIVIDUALS WHO ARE DEPENDENT IN BEHAVIOR PATTERN (I.E., ABUSIVE, AGGRESSIVE, DISRUPTIVE) AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT ([22 VAC 40-72-10](#)).

**4.6 "ASSISTED LIVING FACILITY (ALF)"** MEANS ANY PUBLIC OR PRIVATE ASSISTED LIVING FACILITY THAT IS REQUIRED TO BE LICENSED AS AN ASSISTED LIVING FACILITY BY THE DEPARTMENT OF SOCIAL SERVICES UNDER CHAPTER 17 (§ 63.2-1700 ET SEQ.) OF TITLE 63.2 OF THE CODE OF VIRGINIA, SPECIFICALLY, ANY CONGREGATE RESIDENTIAL SETTING THAT PROVIDES OR COORDINATES PERSONAL AND HEALTH CARE SERVICES, 24-HOUR SUPERVISION, AND ASSISTANCE (SCHEDULED AND UNSCHEDULED) FOR THE MAINTENANCE OR CARE OF FOUR OR MORE ADULTS WHO ARE AGED, INFIRM OR DISABLED AND WHO ARE CARED FOR IN A PRIMARILY RESIDENTIAL SETTING, EXCEPT (I) A FACILITY OR PORTION OF A FACILITY LICENSED BY THE STATE BOARD OF HEALTH OR THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, BUT INCLUDING ANY PORTION OF SUCH FACILITY NOT SO LICENSED; (II) THE HOME OR RESIDENCE OF AN INDIVIDUAL WHO CARES FOR OR MAINTAINS ONLY PERSONS RELATED TO HIM BY BLOOD OR MARRIAGE; (III) A FACILITY OR PORTION OF A FACILITY SERVING INFIRM OR DISABLED PERSONS BETWEEN THE AGES OF 18 AND 21, OR 22 IF ENROLLED IN AN EDUCATIONAL PROGRAM FOR THE HANDICAPPED PURSUANT TO § 22.1-214 OF THE CODE OF VIRGINIA, WHEN SUCH FACILITY IS LICENSED BY THE DEPARTMENT AS A CHILDREN'S RESIDENTIAL FACILITY UNDER CHAPTER 17 (§ 63.2-1700 ET SEQ.) OF TITLE 63.2 OF THE CODE OF VIRGINIA, BUT INCLUDING ANY PORTION OF THE FACILITY NOT SO LICENSED; AND (IV) ANY HOUSING PROJECT FOR PERSONS 62 YEARS OF AGE OR OLDER OR THE DISABLED THAT PROVIDES NO MORE THAN BASIC COORDINATION OF CARE SERVICES AND IS FUNDED BY THE U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, BY THE U.S. DEPARTMENT OF AGRICULTURE, OR BY THE VIRGINIA HOUSING DEVELOPMENT AUTHORITY. INCLUDED IN THIS DEFINITION ARE ANY TWO OR MORE PLACES, ESTABLISHMENTS OR INSTITUTIONS OWNED OR OPERATED BY A SINGLE ENTITY AND PROVIDING MAINTENANCE OR CARE TO A COMBINED TOTAL OF FOUR OR MORE AGED, INFIRM OR DISABLED ADULTS. MAINTENANCE OR CARE MEANS THE PROTECTION, GENERAL SUPERVISION AND OVERSIGHT OF THE PHYSICAL AND MENTAL WELL-BEING OF AN AGED, INFIRM OR DISABLED INDIVIDUAL (22 VAC 40-745-10).

**4.7 "AUXILIARY GRANTS PROGRAM"** MEANS A STATE AND LOCALLY FUNDED ASSISTANCE PROGRAM TO SUPPLEMENT INCOME OF A SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENT OR ADULT WHO WOULD BE ELIGIBLE FOR SSI EXCEPT FOR EXCESS INCOME, WHO RESIDES IN AN ASSISTED LIVING FACILITY WITH AN APPROVED RATE (22 VAC 40-745-10).

**4.8 "CASE MANAGEMENT"** MEANS MULTIPLE FUNCTIONS DESIGNED TO LINK INDIVIDUALS TO APPROPRIATE SERVICES. CASE MANAGEMENT MAY INCLUDE A VARIETY OF COMMON COMPONENTS SUCH AS INITIAL SCREENING OF NEED, COMPREHENSIVE ASSESSMENT OF NEEDS, DEVELOPMENT AND IMPLEMENTATION OF A PLAN OF CARE, SERVICE MONITORING, AND FOLLOW-UP (22 VAC 40-745-10).

**4.9 "CASE MANAGEMENT AGENCY"** MEANS A PUBLIC HUMAN SERVICE AGENCY WHICH EMPLOYS OR CONTRACTS FOR CASE MANAGEMENT (22 VAC-40-745-10)

**4.10 "CASE MANAGER"** MEANS AN EMPLOYEE OF A PUBLIC HUMAN SERVICES AGENCY WHO IS QUALIFIED AND DESIGNATED TO DEVELOP AND COORDINATE PLANS OF CARE (22 VAC 40-745-10).

**4.11 "CONSULTATION"** MEANS THE PROCESS OF SEEKING AND RECEIVING INFORMATION AND GUIDANCE FROM APPROPRIATE HUMAN SERVICES AGENCIES AND OTHER PROFESSIONALS WHEN ASSESSMENT DATA INDICATE CERTAIN SOCIAL, PHYSICAL AND MENTAL HEALTH CONDITIONS (22 VAC 40-745-10).

**4.12 "DEPARTMENT" OR "DSS"** MEANS THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES (22 VAC 40-745-10).

**4.13 "DEPENDENT"** MEANS, FOR ACTIVITIES OF DAILY LIVING (ADLs) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs), THE INDIVIDUAL NEEDS THE ASSISTANCE OF ANOTHER PERSON OR NEEDS THE ASSISTANCE OF ANOTHER PERSON AND EQUIPMENT OR DEVICE TO SAFELY COMPLETE THE ACTIVITY. FOR MEDICATION ADMINISTRATION, DEPENDENT MEANS THE INDIVIDUAL NEEDS TO HAVE MEDICATIONS ADMINISTERED OR MONITORED BY ANOTHER PERSON OR PROFESSIONAL STAFF. FOR BEHAVIOR PATTERN, DEPENDENT MEANS THE PERSON'S BEHAVIOR IS AGGRESSIVE, ABUSIVE, OR DISRUPTIVE (22 VAC 40-745-10).

**4.14 "DISCHARGE"** MEANS THE MOVEMENT OF A RESIDENT OUT OF THE ASSISTED LIVING FACILITY (22 VAC 40-745-10).

**4.15 "EMERGENCY PLACEMENT"** MEANS THE TEMPORARY STATUS OF AN INDIVIDUAL IN AN ASSISTED LIVING FACILITY WHEN THE PERSON'S HEALTH AND SAFETY WOULD BE JEOPARDIZED BY NOT PERMITTING ENTRY INTO THE FACILITY UNTIL REQUIREMENTS FOR ADMISSION HAVE BEEN MET (22 VAC-40-745-10).

**4.16 "FACILITY"** MEANS AN ASSISTED LIVING FACILITY (22 VAC 40-745-10).

**4.17 "INDEPENDENT PHYSICIAN"** MEANS A PHYSICIAN WHO IS CHOSEN BY THE RESIDENT OF THE ASSISTED LIVING FACILITY AND WHO HAS NO FINANCIAL INTEREST IN THE ASSISTED LIVING FACILITY, DIRECTLY OR INDIRECTLY, AS AN OWNER, OFFICER, OR EMPLOYEE OR AS AN INDEPENDENT CONTRACTOR WITH THE FACILITY (22 VAC 40-745-10).

**4.18 "INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)"** MEANS MEAL PREPARATION, HOUSEKEEPING, LAUNDRY, AND MONEY MANAGEMENT. A PERSON'S DEGREE OF INDEPENDENCE IN PERFORMING THESE ACTIVITIES IS A PART OF DETERMINING APPROPRIATE LEVEL OF CARE AND SERVICES (22 VAC 40-745-10).

**4.19 "MAXIMUM PHYSICAL ASSISTANCE"** MEANS THAT AN INDIVIDUAL HAS A RATING OF TOTAL DEPENDENCE IN FOUR OR MORE OF THE SEVEN ACTIVITIES OF DAILY LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT (22 VAC 40-745-10).

**4.20 "MEDICATION ADMINISTRATION"** MEANS THE DEGREE OF ASSISTANCE REQUIRED TO TAKE MEDICATIONS AND IS A PART OF DETERMINING THE NEED FOR APPROPRIATE LEVEL OF CARE AND SERVICES (22 VAC 40-745-10).

**4.21 "PRIVATE PAY"** MEANS THAT A RESIDENT OF AN ASSISTED LIVING FACILITY IS NOT ELIGIBLE FOR BENEFITS UNDER THE AUXILIARY GRANTS PROGRAM (22 VAC 40-745-10).

**4.22 "PUBLIC HUMAN SERVICES AGENCY"** MEANS AN AGENCY ESTABLISHED OR AUTHORIZED BY THE GENERAL ASSEMBLY UNDER CHAPTERS 2 AND 3 (§§ 63.2-203 ET SEQ. AND 63.2-300 ET SEQ.) OF TITLE 63.2, CHAPTER 7 (§ 2.2-700 ET SEQ.) OF TITLE 2.2, CHAPTERS 1 AND 10 (§§ 37.1-1 ET SEQ. AND 37.1-194 ET SEQ.) OF TITLE 37.1, ARTICLE 5 (§ 32.1-30 ET SEQ.) OF CHAPTER 1 OF TITLE 32.1, CHAPTER 1 (§ 51.5-1 ET SEQ.) OF TITLE 51.5, OR §§ 53.1-21 AND 53.1-60 OF THE CODE OF VIRGINIA, OR HOSPITALS OPERATED BY THE STATE UNDER CHAPTERS 6.1 AND 9 (§§ 23-50.4 ET SEQ. AND 23-62 ET SEQ.) OF TITLE 23 OF THE CODE OF VIRGINIA AND SUPPORTED WHOLLY OR PRINCIPALLY BY PUBLIC FUNDS, INCLUDING BUT NOT LIMITED TO FUNDS PROVIDED EXPRESSLY FOR THE PURPOSES OF CASE MANAGEMENT (22 VAC 40-745-10).

**4.23 "PUBLIC PAY"** MEANS THAT A RESIDENT OF AN ASSISTED LIVING FACILITY IS ELIGIBLE FOR BENEFITS UNDER THE AUXILIARY GRANTS PROGRAM (22 VAC 40-745-10).

**4.24 "QUALIFIED ASSESSOR"** MEANS AN INDIVIDUAL WHO IS AUTHORIZED TO PERFORM AN ASSESSMENT, REASSESSMENT, OR CHANGE IN LEVEL OF CARE FOR AN APPLICANT TO OR RESIDENT OF AN ASSISTED LIVING FACILITY. FOR PUBLIC PAY INDIVIDUALS, A QUALIFIED ASSESSOR IS AN EMPLOYEE OF A PUBLIC HUMAN SERVICES AGENCY TRAINED IN THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT. FOR PRIVATE PAY INDIVIDUALS, A QUALIFIED ASSESSOR IS STAFF OF THE ASSISTED LIVING FACILITY TRAINED IN THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT OR AN INDEPENDENT PRIVATE PHYSICIAN. (22 VAC 40-745-10)

**4.25 "REASSESSMENT"** MEANS AN UPDATE OF INFORMATION AT ANY TIME AFTER THE INITIAL ASSESSMENT. IN ADDITION TO A PERIODIC REASSESSMENT, A REASSESSMENT SHOULD BE COMPLETED WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION (22 VAC 40-745-10).

**4.26 "RESIDENT"** MEANS AN INDIVIDUAL WHO RESIDES IN AN ASSISTED LIVING FACILITY FOR THE PURPOSES OF RECEIVING MAINTENANCE OR CARE (22 VAC 40-72-10).

**4.27 "RESIDENTIAL LIVING CARE"** MEANS A LEVEL OF SERVICE PROVIDED BY AN ASSISTED LIVING FACILITY FOR ADULTS WHO MAY HAVE PHYSICAL OR MENTAL IMPAIRMENTS AND REQUIRE ONLY MINIMAL ASSISTANCE WITH THE ACTIVITIES OF DAILY LIVING. INCLUDED IN THIS LEVEL OF SERVICE ARE INDIVIDUALS WHO ARE DEPENDENT IN MEDICATION ADMINISTRATION AS DOCUMENTED ON THE UNIFORM ASSESSMENT

INSTRUMENT. THIS DEFINITION INCLUDES SERVICES PROVIDED BY THE FACILITY TO INDIVIDUALS WHO ARE ASSESSED AS CAPABLE OF MAINTAINING THEMSELVES IN AN INDEPENDENT LIVING STATUS (22 VAC 40-745-10).

**4.28 "SIGNIFICANT CHANGE"** MEANS A CHANGE IN A RESIDENT'S CONDITION THAT IS EXPECTED TO LAST LONGER THAN 30 DAYS. IT DOES NOT INCLUDE SHORT-TERM CHANGES THAT RESOLVE WITH OR WITHOUT INTERVENTION, A SHORT-TERM ACUTE ILLNESS OR EPISODIC EVENT, OR A WELL-ESTABLISHED, PREDICTIVE, CYCLIC PATTERN OF CLINICAL SIGNS AND SYMPTOMS ASSOCIATED WITH A PREVIOUSLY DIAGNOSED CONDITION WHERE AN APPROPRIATE COURSE OF TREATMENT IS IN PROGRESS (22 VAC 40-745-10).

**4.29 "TOTAL DEPENDENCE"** MEANS THE INDIVIDUAL IS ENTIRELY UNABLE TO PARTICIPATE IN THE PERFORMANCE OF AN ACTIVITY OF DAILY LIVING (22 VAC 40-745-10).

**4.30 "UNIFORM ASSESSMENT INSTRUMENT"** MEANS THE DEPARTMENT-DESIGNATED ASSESSMENT FORM. THERE IS AN ALTERNATE VERSION OF THE UNIFORM ASSESSMENT INSTRUMENT WHICH MAY BE USED FOR PRIVATE PAY RESIDENTS; SOCIAL AND FINANCIAL INFORMATION WHICH IS NOT RELEVANT BECAUSE OF THE RESIDENT'S PAYMENT STATUS IS NOT INCLUDED ON THIS VERSION (22 VAC 40-745-10).

**4.31 "USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT"** MEANS THE DEPARTMENT-DESIGNATED HANDBOOK CONTAINING COMMON DEFINITIONS AND PROCEDURES FOR COMPLETING THE DEPARTMENT-DESIGNATED ASSESSMENT FORM (22 VAC 40-745-10).

**4.32 "VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)"** MEANS THE SINGLE STATE AGENCY DESIGNATED TO ADMINISTER THE MEDICAL ASSISTANCE SERVICES PROGRAM IN VIRGINIA (22 VAC 40-745-10).

## **V. 5. INDIVIDUALS TO BE ASSESSED**

ALL RESIDENTS OF AND APPLICANTS TO ASSISTED LIVING FACILITIES SHALL BE ASSESSED FACE-TO-FACE USING THE UNIFORM ASSESSMENT INSTRUMENT PURSUANT TO THE REQUIREMENTS IN ASSESSMENT IN ASSISTED LIVING FACILITIES ([22 VAC 40-745-20](#)). ASSESSMENTS SHALL BE COMPLETED PRIOR TO ADMISSION, ANNUALLY, AND WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION ([22 VAC 40-72-430](#)).

Except in the event of a documented emergency, all individuals must be assessed to determine the necessity for ALF placement **prior to** the ALF placement. See Section 26.2 for additional information on emergency placement.

## VI. 6. ASSESSORS FOR PRIVATE PAY INDIVIDUALS

FOR PRIVATE PAY INDIVIDUALS, QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY OR AN INDEPENDENT PRIVATE PHYSICIAN MAY COMPLETE THE UNIFORM ASSESSMENT INSTRUMENT. QUALIFIED STAFF OF THE ASSISTED LIVING FACILITY ARE EMPLOYEES OF THE FACILITY WHO HAVE SUCCESSFULLY COMPLETED STATE-APPROVED TRAINING ON THE UNIFORM ASSESSMENT INSTRUMENT FOR EITHER PUBLIC OR PRIVATE PAY ASSESSMENTS ([22 VAC 40-745-20](#))

A person may assess private pay individuals if he or she meets one of the following criteria:

- Is a qualified staff of the ALF. The qualifications for an employee of an ALF to complete the assessment include documented training in the completion of the private pay UAI and appropriate application of level of care criteria. Documentation of training must be placed in the ALF employee's personnel record. ALF staff training in the private pay UAI may be documented in one of the following three ways:
  - Through a certificate from the Virginia Institute for Social Services Training Activities (VISSTA) demonstrating completion of the online course, **ADS 1102: Private Pay Uniform Assessment Instrument**;
  - Through a certificate from UAI training offered by a state agency (such as DSS) or;
  - Through a written document describing the content of the training, the name of the trainer and his or her qualifications to provide UAI training, the agency or facility from which the trainer came, the date of the training, and the length of the training. For example, if an ALF staff member has attended one of the UAI training sessions offered by a state agency, and has documentation of such training, he or she may train other staff members on completing the UAI. The documentation of the UAI training must be maintained in the employee's personnel record. Private Pay UAIs that are completed by qualified staff of the ALF must be approved and signed by the administrator or the administrator's designated representative.
- Is an independent private physician. The responsibilities of physicians may be implemented by nurse practitioners or physicians' assistants as assigned by the supervising physician and within the parameters of professional licensing.
- Is a public agency case manager or other qualified assessor. A specified fee may be charged for their services in the assessment of a private pay individual. However the fee may not exceed the charge for public pay assessments. Payment is the responsibility of the individual being assessed. Public human services agency assessors are not required to assess private pay individuals,

but may to do so when requested.

## **VII. 7. PRIVATE PAY UAI ONLINE TRAINING**

Individuals desiring to be qualified as assessors for private pay individuals may complete **ADS1102: Private Pay Uniform Assessment Instrument (UAI)**, a free, online course offered by the Virginia Institute for Social Services Activities (VISSTA) at Virginia Commonwealth University. A certificate is automatically generated upon successful completion of the on-line course. For more information, please go to <http://www.vcu.edu/vissta/>. The certificate of successful completion of the course must be placed in the assessor's personnel file.

## **VIII. 8. RESPONSIBILITIES OF ALF STAFF**

ALF staff are responsible for:

- Ensuring the assessment is completed prior to admission, except in a documented emergency admission
- Completing the reassessment every 12 months or when there is a significant change
- Knowing levels of care criteria
- Knowing prohibited conditions
- Keeping the UAI in the individual's ALF file
- Arranging for discharge when an individual's needs do not meet level of care
- Sending the UAI with an individual when the individual transfers to another ALF

## **IX. 9. REQUEST FOR ASSESSMENT**

THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED WITHIN 90 DAYS PRIOR TO THE DATE OF ADMISSION TO THE ASSISTED LIVING FACILITY. IF THERE HAS BEEN A SIGNIFICANT CHANGE IN THE INDIVIDUAL'S CONDITION SINCE THE COMPLETION OF THE UNIFORM ASSESSMENT INSTRUMENT WHICH WOULD AFFECT THE ADMISSION TO AN ASSISTED LIVING FACILITY, A NEW UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED ([22 VAC 40-745-30](#)).

An assessment to determine the need for ALF care must be completed for *any* individual applying for ALF admission. The assessment must be completed prior to the individual's admission to the ALF.

The individual who wishes to reside in an ALF, a family member, the physician, a community health services or social services professional, or any other concerned individual in the community can initiate a request for assessment.

## **X. 10. INDIVIDUALS WHO LIVE OUT-OF-STATE**

An ALF assessment may be completed by telephone by the Virginia-authorized assessor for individuals who live out-of-state. However, the Virginia assessor must

verify this assessment information by a face-to-face visit with the individual within seven days of the individual's admission to a Virginia ALF. All required paperwork must be completed.

## **XI. 11. COMPLETING THE UAI**

The UAI provides the framework for determining an individual's care needs. It contains measurable and common definitions for rating how individuals function in daily life and other activities.

THE ASSESSMENT SHALL BE CONDUCTED WITH THE DEPARTMENT-DESIGNATED UNIFORM ASSESSMENT INSTRUMENT WHICH SETS FORTH A RESIDENT'S CARE NEEDS. THE UNIFORM ASSESSMENT INSTRUMENT IS DESIGNED TO BE A COMPREHENSIVE, ACCURATE, STANDARDIZED, AND REPRODUCIBLE ASSESSMENT OF INDIVIDUALS SEEKING OR RECEIVING LONG-TERM CARE SERVICES ([22 VAC 40-745-30](#)).

The User's Manual: Virginia Uniform Assessment Instrument provides thorough instructions regarding completion of the assessment and must be utilized in the completion of the UAI. This manual may be found at: <http://www.dss.virginia.gov/family/as/manual.cgi>.

A copy of the Private Pay UAI is found in Appendix A of this manual. The Private Pay UAI is also available at: <http://www.dss.virginia.gov/family/as/forms.cgi>.

THE ASSESSOR SHALL CONSULT WITH OTHER APPROPRIATE HUMAN SERVICE PROFESSIONALS AS NEEDED TO COMPLETE THE ASSESSMENT ([22 VAC 40-745-30](#))

It is very important that an accurate assessment of the individual's functional status and other needs be recorded on the UAI, since this information forms the basis for a determination of whether the individual meets the assisted living facility level of care criteria. The assessor must note the individual's degree of independence or dependence in various areas of functioning. Guidelines for assessing an individual are in Appendix C.

The process used to assess dependency considers how the individual is currently functioning (i.e. is the individual actually receiving assistance to perform an activity of daily living) and whether the individual's functioning demonstrates a need for assistance to perform the activity (i.e. the individual does not receive assistance to bathe but is unable to adequately complete his or her bath, and, as a consequence, has recurrent body rashes). If the individual currently receives the assistance of another person to perform the activity, or if the individual demonstrates a need for the assistance of another person to complete the activity, the individual is deemed dependent in that activity. **The individual's need for prompting or supervision in order to complete an activity qualifies as a dependency in that activity.**

In determining whether an individual is dependent in medication administration (i.e., “administered by professional staff”), this choice should be made when a professional staff person is necessary to **assess** the individual and **evaluate** the efficacy of the medications and treatment. Individuals who receive medication from medication aides who have completed the medication management course would not be described as receiving medication “administered by professional staff” but rather as receiving medication “administered/monitored by lay person.”

A table describing behavior pattern and orientation is shown in Appendix E of this manual. There is an optional worksheet available in Appendix H that helps the assessor quickly determine the level of care an individual may need.

## **XII. 12. PROHIBITED CONDITIONS**

Assessors must also determine that individuals do not have any of the prohibited conditions listed below before authorizing placement in an ALF. If any of these conditions are present, the assessor must document that they are present on the UAI. If appropriate, contact a health care or mental health care professional for assistance in the assessment of these prohibited conditions.

Appendix D contains additional information on assessing skin breakdown (see Section 12.2). This information is taken from the DSS, Division of Licensing Programs guidance document entitled Technical Assistance for Standards for Licensed Assisted Living Facilities (Incident Report section, 22 VAC 40-72-100-A) which is located at [http://www.dss.virginia.gov/facility/alf\\_regulations.cgi](http://www.dss.virginia.gov/facility/alf_regulations.cgi).

State law prohibits admission or retention of individuals in an ALF when they have any of the following conditions or care needs (Bold text indicates language from [22 VAC 40-72-340](#)).

- 12.1 Ventilator dependency** describes the situation where a ventilator is used to expand and contract the lungs when an individual is unable to spontaneously breathe on his or her own. Some individuals require the ventilator for all of their respirations, while others require it in the event that they are unable to breathe on their own.
- 12.2 Dermal ulcers stage III and IV except those stage III ulcers which are determined by an independent physician to be healing** and care is provided by a licensed health care professional under a physician's treatment plan: Dermal ulcers include pressure ulcers (e.g., bed sores, decubitus ulcers, pressure sores) which may be caused by pressure resulting in damage of underlying tissues and stasis ulcers (also called venous ulcer or ulcer related to peripheral vascular disease) which are open lesions, usually in the lower extremities, caused by a decreased blood flow from chronic venous insufficiency. The prohibition is based on

the size, depth, and condition of the wound regardless of the cause. The following is a summary of dermal ulcer stages:

**12.2.1 Stage I:** A persistent area of skin redness, without a break in the skin that does not disappear when pressure is relieved.

**12.2.2 Stage II:** A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater.

**12.2.3 Stage III:** A full thickness of skin lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue. The wound extends through all layers of the skin and is a primary site for a serious infection to occur. The goals and treatments are to alleviate pressure and covering and protecting the wound as well as an emphasis on nutrition and hydration. Medical care is necessary to promote healing and to treat and prevent infection. This type of wound progresses very rapidly if left unattended.

**12.2.4 Stage IV:** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. This wound extends through the skin and involves underlying muscle, tendons, and bone. The diameter of the wound is not as important as the depth. This is very serious and can produce a life-threatening infection, especially if not aggressively treated. All of the goals of protecting, cleaning, and alleviation of pressure on the area still apply. Nutrition and hydration is now critical. Without adequate nutrition, this wound will not heal. This wound requires medical care by someone skilled in wound care. Surgical removal of the necrotic or decayed tissue is often used on wounds of larger diameter.

**12.3 Intravenous therapy or injection directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia.** Intravenous (IV) therapy means that a fluid or drug is administered directly into the vein. Examples may include the infusion of fluids for hydration, antibiotics, chemotherapy, narcotics for pain, and total parenteral nutrition (TPN).

Intermittent intravenous therapy may be provided for a limited period of time on a daily or periodic basis by a licensed health care professional under a physician's treatment plan. When a course of treatment is expected to be ongoing and extends beyond a two-week period, evaluation is required at two-week intervals by a licensed health care professional.

- 12.4 Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.**
- 12.5 Psychotropic medications without appropriate diagnosis and treatment plans.** Psychopharmacologic or psychotropic drugs include any drug prescribed or administered with the intent of controlling mood, mental status, or behavior. They include such drug classes as antipsychotic, antidepressants, and the anti-anxiety/hypnotic class. Examples include, but are not limited to, Abilify, Amytal, Atarax, Ativan, Benadryl, Celexa, Clozaril, Dalmane, Depakene, Depakote, Desyrel, Effexor, Elavil, Haldol, Lexapro, Librium, Lithium, Luvox, Klonopin, Mellaril, Navane, Norpramine, Pamelor, Paxil, Prozac, Remeron, Restoril, Risperdal, Seroquel, Serax, Serzone, Stelazine, Thorazine, Tofranil, Tranxene, Valium, Vistaril, Wellbutrin, Xanax, Zoloft, and Zyprexa. A treatment plan means a set of individually planned interventions, training, habilitation, or supports prescribed by a qualified health or mental health professional that helps an individual obtain or maintain an optimal level of functioning, reduce the effects of disability or discomfort, or improve symptoms, undesirable changes or conditions specific to physical, mental, behavioral, social, or cognitive functioning.
- 12.6 Nasogastric tubes.** A nasogastric (NG) tube is a feeding tube inserted into the stomach through the nose. It is used when the individual is unable to manage oral nutrition or feeding.
- 12.7 Gastric tubes except when the individual is capable of independently feeding himself or herself and caring for the tube.** Gastric tube feeding is the use of any tube that delivers food, nutritional substances, fluids and/or medications directly into the gastrointestinal system. Examples include, but are not limited to, gastrostomy tube (GT), jejunostomy tube (JT), and percutaneous endoscopic gastrostomy tube (PEG).
- 12.8 Individuals presenting an imminent physical threat or danger to self or others.** Imminent physical threat cannot be classified by a diagnosis; the determination is made based upon the behavior of the individual.
- 12.9 Individuals requiring continuous licensed nursing care** (seven days a week, twenty-four hours a day). Continuous licensed nursing care means around-the-clock observation, assessment, monitoring, supervision, or provision of medical treatment by a licensed nurse. Individuals requiring continuous licensed nursing care may include:

**12.9.1** Individuals who have a medical instability due to complexities created by multiple, interrelated medical conditions; or

**12.9.2** Individuals with a health care condition with a high potential for medical instability.

**12.10** Individuals whose physician certifies that placement is no longer appropriate.

**12.11** Unless the individual's independent physician determines otherwise, individuals who require maximum physical assistance as documented by the UAI and meet Medicaid nursing facility level of care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument. An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.

**12.12** Individuals whose physical or mental health care needs cannot be met in the specific assisted living facility as determined by the facility.

### **XIII. 13. PRIVATE PAY INDIVIDUALS ONLY-EXCEPTIONS TO PROHIBITED CONDITIONS**

At the request of the private pay individual, care for the conditions or care needs specified in 12.3 and 12.7 above may be provided to an individual in an ALF by a physician licensed in Virginia, a nurse licensed in Virginia under a physician's treatment plan, or by a home care organization licensed in Virginia when the individual's independent physician determines that such care is appropriate for the individual.

When care for an individual's special medical needs is provided by licensed staff of a home care agency, the ALF staff may receive training from the home care agency staff in appropriate treatment monitoring techniques regarding safety precautions and actions to take in case of emergency.

**These exceptions do not apply to individuals who receive Auxiliary Grant (AG).**

### **XIV. 14. HOSPICE CARE IN THE ALF**

Notwithstanding the prohibited conditions described in Section 12, at the request of the individual residing in the ALF, hospice care may be provided in an ALF if the hospice program determines that such a program is appropriate for the individual.

## **XV. 15. ASSISTED LIVING FACILITY CRITERIA**

THE APPROPRIATE LEVEL OF CARE MUST BE DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT, COMPLETED IN A MANNER CONSISTENT WITH THE DEFINITIONS OF ACTIVITIES OF DAILY LIVING AND DIRECTIONS PROVIDED IN THE USER'S MANUAL: VIRGINIA UNIFORM ASSESSMENT INSTRUMENT ( [22 VAC 40-745-50](#)).

### **A. 15.1 Criteria for Residential Living**

INDIVIDUALS MEET THE CRITERIA FOR RESIDENTIAL LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT WHEN AT LEAST ONE OF THE FOLLOWING DESCRIBES THEIR FUNCTIONAL CAPACITY:

1. RATED DEPENDENT IN ONLY ONE OF SEVEN ADLS (I.E., BATHING, DRESSING, TOILETING, TRANSFERRING, BOWEL FUNCTION, BLADDER FUNCTION, AND EATING/FEEDING).
2. RATED DEPENDENT IN ONE OR MORE OF FOUR SELECTED IADLS (I.E., MEAL PREPARATION, HOUSEKEEPING, LAUNDRY, AND MONEY MANAGEMENT).
3. RATED DEPENDENT IN MEDICATION ADMINISTRATION ([22 VAC 40-745-60](#)).

### **B. 15.2 Criteria for Assisted Living**

INDIVIDUALS MEET THE CRITERIA FOR ASSISTED LIVING AS DOCUMENTED ON THE UNIFORM ASSESSMENT INSTRUMENT WHEN AT LEAST ONE OF THE FOLLOWING DESCRIBES THEIR CAPACITY:

1. RATED DEPENDENT IN TWO OR MORE OF SEVEN ADLS.
2. RATED DEPENDENT IN BEHAVIOR PATTERN (I.E., ABUSIVE, AGGRESSIVE, AND DISRUPTIVE) ([22 VAC 40-745-70](#)).

## **XVI. 16. INDEPENDENT LIVING STATUS**

Individuals who are assessed as independent can be admitted into an ALF. A person does not have to meet the residential level of care criteria to live in an ALF licensed for residential care. Individuals who are assessed as independent are **NOT** eligible for AG payments unless they were receiving AG prior to February 1, 1996.

## **XVII. 17. OUTCOMES OF ALF ASSESSMENTS**

The possible outcomes of an ALF assessment may include:

1. A recommendation for ALF care;

2. Referral to a PAS team if the individual needs nursing facility care and would need public assistance (Medicaid) within 180 days of admission to the nursing facility;
3. Referrals to other community resources (non-Medicaid funded) such as health services, adult day care centers, home-delivered meals, etc.; or
4. A determination that services are not required.

#### **XVIII. 18. REFERRALS TO MEDICAID FUNDED HOME AND COMMUNITY-BASED SERVICES OR NURSING FACILITY**

Home and Community-based services or nursing facility services may be considered when the assessor completes an assessment and determines that an individual meets the criteria for nursing facility care and is at risk of nursing facility placement unless additional help is received. The individual would need to apply for Medicaid and meet the eligibility criteria for Long-Term Care services. Home and community-based services include waiver services such as the Elderly or Disabled with Consumer Direction (EDCD) waiver which offers services such as personal care, adult day health care, and respite care. For additional information about Medicaid Long-Term Care services visit the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov).

If the assessor believes the individual may be appropriate for Medicaid funded home and community-based services or nursing facility services, the assessor should contact the local PAS team and send the original UAI to the local department of health to initiate a preadmission screening.

#### **XIX. 19. TIME LIMITATION ON ASSESSMENTS**

An authorized assessor's approval decision and the completed UAI regarding an individual's appropriateness for ALF placement are valid for 12 months from the date of the assessment or until an individual's functional or medical status changes, and the change indicates the individual may no longer meet the authorized level of care criteria.

See section 26.3 concerning time limitations on assessments for individuals who are awaiting admission to an ALF.

When a current assessment has been completed within 12 months and no change in level of care has occurred, a new assessment is not needed for the following situations: 1) transfer from one ALF to another; 2) respite care; or 3) discharge back to the ALF from the hospital.

## **XX. 20. REQUEST FOR AN INDEPENDENT ASSESSMENT**

AT THE REQUEST OF THE ASSISTED LIVING FACILITY, THE RESIDENT, THE RESIDENT'S REPRESENTATIVE, THE RESIDENT'S PHYSICIAN, DSS, OR THE LOCAL DEPARTMENT OF SOCIAL SERVICES, AN INDEPENDENT ASSESSMENT USING THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED TO DETERMINE WHETHER THE RESIDENT'S CARE NEEDS ARE BEING MET IN THE CURRENT PLACEMENT. AN INDEPENDENT ASSESSMENT IS AN ASSESSMENT THAT IS COMPLETED BY AN ENTITY OTHER THAN THE ORIGINAL ASSESSOR. THE ASSISTED LIVING FACILITY SHALL ASSIST THE RESIDENT IN OBTAINING THE INDEPENDENT ASSESSMENT AS REQUESTED. IF THE REQUEST IS FOR A PRIVATE PAY RESIDENT, AND THE INDEPENDENT ASSESSMENT CONFIRMS THAT THE RESIDENT'S PLACEMENT IS APPROPRIATE, THEN THE ENTITY REQUESTING THE INDEPENDENT ASSESSMENT SHALL BE RESPONSIBLE FOR PAYMENT OF THE ASSESSMENT, IF APPLICABLE ([22 VAC 40-745-30](#)).

An independent assessment is an assessment that is completed by an entity other than the original assessor; this may be another assessor within the same agency. An independent assessment is requested when one of the above entities questions the outcome of an assessment and desires a second assessment to be completed.

## **XXI. 21. PSYCHOSOCIAL ASSESSMENTS**

An individual's psychological, behavioral, emotional or substance abuse issues can impact on an individual's ability to live in an ALF and the ability of the ALF staff to provide proper care.

Cognitive impairments can affect an individual's memory, judgment, conceptual thinking and orientation. In turn, these can limit the individual's ability to perform ADLs and IADLs. When assessing an individual for possible cognitive impairment, it is important to distinguish between normal, minor losses in intellectual functioning and the more severe intellectual impairments caused by cognitive disorders such as Alzheimer's Disease or Organic Brain Syndrome (OBS). Some intellectual impairments may be caused by a physical disorder or by side effects or interactions of medications.

When determining the appropriateness of ALF admission for individuals with mental illness, mental retardation/intellectual disability, or a history of substance abuse, a current psychiatric or psychological evaluation may be needed. The need for this evaluation may be indicated if the UAI demonstrates dependencies in the Psychosocial Status section of the UAI. A recommendation for further assessment may also be suggested by the individual's case manager, another assessor or by the admission staff at the time of the admission interview. The psychiatric or psychological evaluation must be completed by a person having no financial interest in the ALF, directly or indirectly as an owner, officer, employee, or as an independent contractor with the facility.

The assessor is not diagnosing the individual, but rather using his professional judgment to look for indicators of the possible need for a referral to a mental health professional for a more thorough mental health and/or substance abuse assessment and possible diagnosis.

## **XXII. 22. REFERRAL FOR MENTAL HEALTH (MH), MENTAL RETARDATION/INTELLECTUAL DISABILITY (MR/ID), OR SUBSTANCE ABUSE EVALUATION**

For an individual's admission to or continued stay in an ALF, DSS, Division of Licensing Programs requires:

A SCREENING OF PSYCHOLOGICAL, BEHAVIORAL, AND EMOTIONAL FUNCTIONING, CONDUCTED BY A QUALIFIED MENTAL HEALTH PROFESSIONAL, IF RECOMMENDED BY THE UAI ASSESSOR, A HEALTH CARE PROFESSIONAL, OR THE ADMINISTRATOR OR DESIGNEE RESPONSIBLE FOR THE ADMISSION AND RETENTION DECISION. THIS INCLUDES MEETING THE REQUIREMENTS OF 22 VAC 40-72-360 ([22 VAC 40-72-340](#)).

If the UAI or other screening tool reveals mental health indicators, an evaluation completed within six months of the proposed admission date will be needed for consideration for the individual's admission.

It is the responsibility of the individual seeking admission to an ALF, his legal representative and the ALF admission staff to ensure that the evaluation is completed.

If the ALF staff can provide adequate care, the individual may be admitted before the completion of his or her evaluation. In this situation, the decision to admit the individual without the completed evaluation must be documented in the individual's ALF record.

Referrals for MH, MR/ID, or substance abuse evaluations should be made using the following guidelines:

### **A. 22.1 Referral for MH Evaluation**

A referral for a MH evaluation is made for a diagnosis of schizophrenia, personality disorder, mood disorder, panic, somatoform disorder, other psychiatric disorders, paranoid disorder, or other serious anxiety disorders and when the individual exhibits distorted thought processes, mood disorders, or maladaptive behavior manifested by:

1. Acts detrimental to self or others;
2. Acts of abuse, aggression, or disruption; or

3. Emotional status which interferes with functioning ability (i.e., agitation, fearfulness, or depression).

**B. 22.2 Referral for MR/ID Evaluation**

A referral is made for an MR/ID evaluation if:

1. The individual has been assessed as having below average intellectual functioning on individually administered tests, (i.e. IQ 70 or below); age of onset was before 18 years; and there are concurrent limitations in two or more applicable adaptive skills areas such as communication, social skills, health and safety, work, self care, home living, community use, self-direction, functional academics, and leisure; or
2. Based on assessment, individual evidences functional limitations (i.e. cognitive limitations along with concurrent limitations in two or more applicable adaptive skills areas as listed above) that lead to a reasonable suspicion of a diagnosis of MR/ID.

**C. 22.3 Referral for Substance Abuse Evaluation**

A referral for evaluation should be considered for further exploration when the individual reports current drinking of more than two alcoholic drinks per day, has current use of non-prescription mood-altering substances such as marijuana, amphetamines, etc., and/or abuses prescribed mood-altering substances.

**XXIII. 23. LICENSING REQUIREMENTS FOR SCREENING OF PSYCHOSOCIAL, BEHAVIORAL AND EMOTIONAL FUNCTIONING PRIOR TO ADMISSION**

**A. 23.1 Mental Health Screening**

A MENTAL HEALTH SCREENING SHALL BE CONDUCTED PRIOR TO ADMISSION IF BEHAVIORS OR PATTERNS OF BEHAVIOR OCCURRED WITHIN THE PREVIOUS SIX MONTHS THAT WERE INDICATIVE OF MENTAL ILLNESS, MENTAL RETARDATION, SUBSTANCE ABUSE OR BEHAVIORAL DISORDERS AND THAT CAUSED, OR CONTINUE TO CAUSE, CONCERN FOR THE HEALTH, SAFETY, OR WELFARE EITHER OF THAT INDIVIDUAL OR OTHERS WHO COULD BE PLACED AT RISK OF HARM BY THAT INDIVIDUAL.

**Exception:** IF IT IS NOT POSSIBLE FOR THE SCREENING TO BE CONDUCTED PRIOR TO ADMISSION, THE INDIVIDUAL MAY BE ADMITTED IF ALL OTHER ADMISSION REQUIREMENTS ARE MET. THE REASON FOR THE DELAY SHALL BE DOCUMENTED AND THE SCREENING SHALL BE CONDUCTED AS SOON AS POSSIBLE ([22 VAC 40-72-360](#)).

## **B. 23.2 Psychosocial and Behavioral History**

WHEN DETERMINING APPROPRIATENESS OF ADMISSION FOR AN INDIVIDUAL WITH A MENTAL HEALTH DISABILITY, THE FOLLOWING INFORMATION SHALL BE OBTAINED BY THE FACILITY:

1. IF THE PROSPECTIVE RESIDENT IS REFERRED BY A STATE OR PRIVATE HOSPITAL, COMMUNITY SERVICES BOARD, BEHAVIORAL HEALTH AUTHORITY, OR LONG-TERM CARE FACILITY, DOCUMENTATION OF THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL FUNCTIONING SHALL BE ACQUIRED.

2. IF THE PROSPECTIVE RESIDENT IS COMING FROM A PRIVATE RESIDENCE, INFORMATION ABOUT THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL FUNCTIONING SHALL BE GATHERED FROM PRIMARY SOURCES, SUCH AS FAMILY MEMBERS OR FRIENDS. THERE IS NO REQUIREMENT FOR WRITTEN INFORMATION FROM PRIMARY SOURCES.

THE ADMINISTRATOR OR HIS DESIGNEE SHALL DOCUMENT THAT THE INDIVIDUAL'S PSYCHOSOCIAL AND BEHAVIORAL HISTORY WERE REVIEWED AND USED TO HELP DETERMINE THE APPROPRIATENESS OF THE ADMISSION, AND IF THE PERSON IS ADMITTED, TO DEVELOP AN INDIVIDUALIZED SERVICE PLAN ([22 VAC 40-72-365](#))

## **XXIV. 24. MENTAL HEALTH SCREENING DETERMINATION FORM**

The model Mental Health Screening Determination form in Appendix G can be used to document the completion of individual's mental health screening. A copy of the form is available at: [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi). The ALF may develop its own format but it must address the same information as on the model form.

The decision to admit an individual without a mental health evaluation must meet the following criteria and be documented in the individual's ALF record:

1. The facility's decision to admit the individual, without the pending assessment, is based on a careful consideration of any information regarding the individual's emotional or behavioral functioning that could signal high risk concerns for the health and safety of the individual and/or others;
2. The facility has developed a preliminary plan of care that appropriately addresses any identified concerns to a degree that the individual is not considered high risk for harm to self and/or others;
3. The facility has been informed by the qualified mental health professional (QMHP) as to the expected date of completion of the mental health evaluation and the facility has determined that the length of time to have the evaluation

completed and forwarded to the facility would cause hardship for the individual and/or family;

4. The facility follows up with the disposition of the mental health evaluation and, upon receiving it, re-evaluates its ability to meet the needs of the individual regarding the mental health care/supervision that might be needed;
5. The facility clearly documents all efforts made to get the mental health evaluation completed; and
6. The facility meets all other admission requirements (i.e. completed UAI, and physical examination, and the individual has no prohibited conditions as described in Section 12).

## **XXV. 25. ADMISSION OF INDIVIDUALS WITH SERIOUS COGNITIVE IMPAIRMENTS**

When determining the appropriateness of ALF admission, serious cognitive deficits should be noted on the UAI or other screening tool. The ALF must determine if it can meet the needs of the individual.

All facilities that care for individuals with serious cognitive impairments due to a primary psychiatric diagnosis of dementia who cannot recognize danger or protect their own safety and welfare are subject to additional licensing requirements. Individuals meeting this diagnosis may reside in a mixed population with enhanced safety precautions or in a safe, secure environment. A facility that cares for individuals with serious cognitive impairments due to any other diagnosis who cannot recognize danger or protect their own safety and welfare must meet the enhanced safety requirements for a mixed population.

### **A. 25.1 Mixed Population**

These requirements include:

1. Additional staffing and staff training;
2. A security monitoring systems such as door alarms, cameras, constant staff oversight, security bracelets that are part of an alarm system, or delayed egress mechanisms;
3. A secured outdoor area or close staff supervision; and
4. Special environmental precautions.

These additional requirements do not apply to ALFs with 10 or fewer individuals if no more than three of the individuals have serious cognitive impairments and cannot recognize danger or protect their own safety or welfare.

## B. 25.2 Safe, Secure Environment

Some ALFs may have one or more self-contained special care units in the facility or the whole facility may be a special care unit designed for individuals with serious cognitive impairments due to primary psychiatric diagnosis of dementia who cannot recognize danger or protect their own safety and welfare. These special care units must meet additional licensing requirements. These requirements include:

1. Additional assessment-Prior to admission to a special care unit, the individual shall have been assessed by an independent clinical psychologist licensed to practice in the Commonwealth or by an independent physician. See Appendix F for a copy of the Assessment of Serious Cognitive Impairment. This form can also be found at: [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi). The assessment must be in writing and address, but not be limited to, the following areas:
  - Cognitive functions, i.e., orientation, comprehension, problem-solving, attention/concentration, memory, intelligence, abstract reasoning, judgment, insight
  - Thought and perception, i.e., process, content
  - Mood/affect
  - Behavior/psychomotor
  - Speech/language
  - Appearance
  
2. Approval-Prior to an individual's admission to a special care unit, the ALF must obtain written approval from one of the following persons, in the following order of priority:
  - a. The individual, if capable of making an informed decision;
  - b. A guardian or other legal representative
  - c. A relative willing to act as the individual's representative in the following specific order:
    - i. Spouse,
    - ii. Adult child,
    - iii. Parent,
    - iv. Adult sibling,
    - v. Adult grandchild,
    - vi. Adult niece or nephew,
    - vii. Aunt or uncle.
  
  - d. An independent physician, if the individual is not capable of making an informed decision and there is no one else available.

3. Facility determination of appropriateness of admission and continued residence;
4. Additional activities;
5. Additional staffing and staff training;
6. A security monitoring system such as door alarms, cameras, constant staff oversight, security bracelets that are part of an alarm system, pressure pads at doorways, delayed egress mechanisms, locking devices, or perimeter fence gates.
7. A secure outdoor area or close staff supervision; and
8. Special environmental precautions.

**XXVI. 26. ADMISSION TO AN ALF**

**A. 26.1 Physical Examination**

DSS, Division of Licensing Programs regulations require that all individuals admitted to an ALF have a physical examination completed prior to the admission. Licensing Programs has prepared a model form, Report of the Physical Examination, which may be used for the physical examination. A copy of the form is available at [http://www.dss.virginia.gov/facility/alf\\_forms.cgi](http://www.dss.virginia.gov/facility/alf_forms.cgi).

The use of this form is not required; any physical examination form that addresses all of the requirements is acceptable (i.e. includes tuberculosis status, etc.). A physician must sign the physical examination report.

It is the responsibility of the ALF to ensure that the physical examination is completed.

If the same person completes both the UAI and the physical examination report, it is not necessary to repeat the same information on the physical examination that is also on the UAI. The assessor may make reference to the UAI (i.e. “see UAI”) only for that information needed on the physical examination report that is the same as the information provided on the UAI. All other parts of the physical examination report must be completed.

**B. 26.2 Emergency Placements in an ALF**

AN EMERGENCY PLACEMENT SHALL OCCUR ONLY WHEN THE EMERGENCY IS DOCUMENTED AND APPROVED BY A VIRGINIA ADULT PROTECTIVE SERVICES WORKER OR CASE MANAGER FOR PUBLIC PAY INDIVIDUALS OR AN INDEPENDENT PHYSICIAN OR A VIRGINIA ADULT PROTECTIVE SERVICES WORKER FOR PRIVATE PAY INDIVIDUALS ([22 VAC 40-72-370](#)).

An emergency is a situation in which an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to self or others. Typically, an emergency placement will involve an adult who lives outside of an institution and is not currently residing in an ALF.

Prior to the emergency placement, the APS worker or the physician must discuss with the ALF the individual's service/care needs based on the APS investigation and/or physician assessment to ensure that the ALF is capable of providing the needed services. The individual cannot be admitted to an ALF on an emergency basis if the individual has any of the prohibited conditions listed in Section 12.

This is the **only** instance in which an individual may be admitted to an ALF without first having been assessed to determine if he or she meets ALF level of care.

WHEN AN EMERGENCY PLACEMENT OCCURS, THE PERSON SHALL REMAIN IN THE ASSISTED LIVING FACILITY NO LONGER THAN SEVEN WORKING DAYS UNLESS ALL THE REQUIREMENTS FOR ADMISSION HAVE BEEN MET AND THE PERSON HAS BEEN ADMITTED ([22 VAC 40-72-370](#)).

After the emergency placement is made, the UAI must be completed within seven working days from the date of the placement. There must be documentation in the individual's ALF record that a Virginia APS worker or physician approved the emergency placement. A notation on the UAI signed by the APS worker will meet this requirement. The assessment must be completed by a qualified assessor.

In the case of an emergency placement, the assisted living authorization is considered effective as of the date of the emergency admission. Emergency placements are to be used only when a true emergency can be documented and justified.

### **C. 26.3 Awaiting ALF Admission**

At times, an individual who has been assessed as appropriate for ALF admission has to remain in the community while waiting the admission. When the admission can proceed, and if no more than 90 days have elapsed, a new assessment does not have to be completed unless there has been a significant change in the individual's condition. If more than 90 days have elapsed since the assessment was conducted, then a new assessment must be completed.

### **D. 26.4 Respite Services**

Individuals admitted to an ALF for respite services must be assessed prior to admission. Respite is a temporary stay in the facility, usually to relieve

caregivers from their duties for a brief period of time. The initial assessment is valid for 12 months if the level of care of the individual remains the same. A reassessment would be required annually provided that the respite services continue to be provided, even if it is provided intermittently.

## **XXVII. 27. ANNUAL REASSESSMENT**

THE UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED AT LEAST ANNUALLY ON ALL RESIDENTS OF ASSISTED LIVING FACILITIES. UNIFORM ASSESSMENT INSTRUMENTS SHALL BE COMPLETED AS NEEDED WHENEVER THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION. ALL UNIFORM ASSESSMENT INSTRUMENTS SHALL BE COMPLETED AS REQUIRED BY 22 VAC 40-745-20. ([22 VAC 40-745-30](#)).

The purpose of the annual reassessment is the reevaluation of service need and utilization review. The assessor shall review each individual's need for services annually, or more frequently as required, to ensure proper utilization of services. Each individual residing in an ALF must be reassessed at least annually.

The annual reassessment is based upon the date of the last completed assessment. The reassessment does not need to be performed in the same month as the initial assessment. A current assessment is one that is not older than 12 months. The ALF shall keep the individual's UAI and other relevant data in the individual's ALF record.

## **XXVIII. 28. WHO CAN CONDUCT THE ANNUAL REASSESSMENT?**

Designated ALF staff with documented training in the completion of the UAI may complete reassessments for private pay individuals. ALF staff are not permitted to complete assessments, reassessments, or changes in level of care of individuals residing in an ALF who are receiving an AG. See Appendix J for a listing of assessors for individuals who receive AG.

## **XXIX. 29. COMPLETING THE ANNUAL REASSESSMENT**

The three options for completing the reassessment are as follows:

- Mark only those items that have changed from the previous assessment. The assessor *clearly* updates the previous assessment and marks the reassessment information by crossing out old information and initialing and dating all changes. The assessor then signs and dates the UAI and marks the front of the instrument as a reassessment.
- For private pay individuals for whom there have been no changes in the items listed on the UAI since the immediately preceding assessment, it is sufficient to have the assessor indicate "no change" on the UAI. The statement "no change" may be written in the comment section of the Private Pay UAI or the summary section of the Public Pay UAI (if that

version is being used). It is not necessary to answer each item individually listed on the assessment for the reassessment. The assessor must sign and date the UAI to indicate when the reassessment occurred.

- Begin a new assessment on a new Private Pay UAI form.

### **XXX. 30. CHANGES IN LEVEL OF CARE**

DURING AN INSPECTION OR REVIEW, STAFF FROM EITHER THE DEPARTMENT, THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, OR THE LOCAL DEPARTMENT OF SOCIAL SERVICES MAY INITIATE A CHANGE IN LEVEL OF CARE FOR ANY ASSISTED LIVING FACILITY RESIDENT FOR WHOM IT IS DETERMINED THAT THE RESIDENT'S UAI IS NOT REFLECTIVE OF THE RESIDENT'S CURRENT STATUS ( [22 VAC 40-72-430](#)).

The UAI must be completed or updated as needed whenever there is a significant change in the individual's condition that is expected to last more than 30 days or appears to warrant a change in the individual's approved level of care. A change in level of care assessment should be conducted within two weeks when a significant change in level of care is indicated, including when the individual presents with one or more of the prohibited conditions as described in Section 12 or no longer meets level of care criteria for which he or she was most recently assessed.

#### **A. 30.1 Significant Changes in Condition**

"**SIGNIFICANT CHANGE**" MEANS A CHANGE IN A RESIDENT'S CONDITION THAT IS EXPECTED TO LAST LONGER THAN 30 DAYS. IT DOES NOT INCLUDE SHORT-TERM CHANGES THAT RESOLVE WITH OR WITHOUT INTERVENTION, A SHORT-TERM ACUTE ILLNESS OR EPISODIC EVENT, OR A WELL-ESTABLISHED, PREDICTIVE, CYCLIC PATTERN OF CLINICAL SIGNS AND SYMPTOMS ASSOCIATED WITH A PREVIOUSLY DIAGNOSED CONDITION WHERE AN APPROPRIATE COURSE OF TREATMENT IS IN PROGRESS ([22 VAC 40-745-10](#)).

#### **B. 30.2 Temporary Changes in Condition**

Temporary changes in an individual's condition are those that can be reasonably expected to last less than 30 days. Such changes do not require a new assessment or update. Examples of such changes are short-term changes that resolve with or without intervention, changes that arise from easily reversible causes such as a medication change, short-term acute illness or episodic event.

### **XXXI. 31. OUTCOMES OF ANNUAL REASSESSMENT OR CHANGE IN LEVEL OF CARE**

The possible outcomes from a reassessment may include:

- Continue at the current level of care;
- Change in the level of care;
- Transfer to another ALF at the appropriate level of care;
- Referral to a PAS team if the individual needs nursing facility care or Medicaid funded home and community based services and would need Medicaid within 180 days of admission to a nursing facility.

## **XXXII. 32. TRANSFER TO ANOTHER SETTING**

### **A. 32.1 ALF-to-ALF Transfer**

WHEN A RESIDENT MOVES TO AN ASSISTED LIVING FACILITY FROM ANOTHER ASSISTED LIVING FACILITY OR LONG-TERM CARE SETTING THAT USES THE UAI, IF THERE IS A COMPLETED UAI ON RECORD, ANOTHER UAI DOES NOT HAVE TO BE COMPLETED EXCEPT THAT A NEW UAI SHALL BE COMPLETED WHENEVER:

1. THERE IS A SIGNIFICANT CHANGE IN THE RESIDENT'S CONDITION; OR
2. THE PREVIOUS ASSESSMENT IS MORE THAN 12 MONTHS OLD ([22 VAC 40-72-430](#)).

The ALF from which the individual is moving must send a copy of all current assessment material to the facility to which the individual is moving. The requirements for discharge notifications must be followed. The receiving ALF is then responsible to initiate the appropriate documentation for admission purposes.

### **B. 32.2 ALF-to-Hospital Transfer**

Screening teams in hospitals do not complete an assessment for individuals who are admitted to a hospital from an ALF, when the individual is to be discharged back to either the same or a different ALF and the individual continues to meet the same ALF level of care or is expected to meet the same criteria for level of care within 30 days of discharge. In the event that the individual's bed has not been held at the ALF from which the individual left prior to being hospitalized, the individual would still not need to be evaluated by the hospital staff provided that he or she is admitted to another ALF at the same level of care. The hospital may, however, elect to perform the assessment, but is not required to do so.

If an individual is admitted to a hospital from an ALF and the individual's condition has not changed, but placement in a different ALF is sought, a new assessment is NOT required. The second ALF would be required to complete

necessary documentation for admission. The first ALF must provide the required discharge notifications.

If there has been a change in level of care since the individual's admission to the hospital, the hospital assessors could perform a change in level of care assessment, unless the change is anticipated to be temporary (i.e., expected to last less than 30 days).

If an individual is admitted to the hospital from an ALF and the individual needs to transfer to Medicaid funded home and community-based services or nursing facility, a preadmission screening must be completed.

### **XXXIII. 33. DISCHARGE FROM AN ALF**

When there is a determination made that an individual is no longer appropriate for ALF level of care and must be discharged, the ALF must follow certain discharge procedures.

WHEN ACTIONS, CIRCUMSTANCES, CONDITIONS, OR CARE NEEDS OCCUR THAT WILL RESULT IN THE DISCHARGE OF A RESIDENT, DISCHARGE PLANNING SHALL BEGIN IMMEDIATELY, AND THERE SHALL BE DOCUMENTATION OF SUCH, INCLUDING THE BEGINNING DATE OF DISCHARGE PLANNING. THE RESIDENT SHALL BE MOVED WITHIN 30 DAYS, EXCEPT THAT IF PERSISTENT EFFORTS HAVE BEEN MADE AND THE TIME FRAME IS NOT MET, THE FACILITY SHALL DOCUMENT THE REASON AND THE EFFORTS THAT HAVE BEEN MADE.

AS SOON AS DISCHARGE PLANNING BEGINS, THE ASSISTED LIVING FACILITY SHALL NOTIFY THE RESIDENT AND THE RESIDENT'S LEGAL REPRESENTATIVES AND DESIGNATED CONTACT PERSON IF ANY, OF THE PLANNED DISCHARGE, THE REASON FOR THE DISCHARGE, AND THAT THE RESIDENT WILL BE MOVED WITHIN 30 DAYS UNLESS THERE ARE EXTENUATING CIRCUMSTANCES AS REFERENCED IN SUBSECTION A OF THIS SECTION. WRITTEN NOTIFICATION OF THE ACTUAL DISCHARGE DATE SHALL BE GIVEN TO THE RESIDENT AND THE RESIDENT'S LEGAL REPRESENTATIVES AND CONTACT PERSON IF ANY, AT LEAST 14 CALENDAR DAYS PRIOR TO THE DATE THAT THE RESIDENT WILL BE DISCHARGED.

THE ASSISTED LIVING FACILITY SHALL ADOPT AND CONFORM TO A WRITTEN POLICY REGARDING THE NUMBER OF CALENDAR DAYS NOTICE THAT IS REQUIRED WHEN A RESIDENT WISHES TO MOVE FROM THE FACILITY. ANY REQUIRED NOTICE OF INTENT TO MOVE SHALL NOT EXCEED 30 DAYS.

THE FACILITY SHALL ASSIST THE RESIDENT AND HIS LEGAL REPRESENTATIVE, IF ANY, IN THE DISCHARGE OR TRANSFER PROCESS. THE FACILITY SHALL HELP THE RESIDENT PREPARE FOR RELOCATION, INCLUDING DISCUSSING THE RESIDENT'S DESTINATION. PRIMARY RESPONSIBILITY FOR TRANSPORTING THE RESIDENT AND HIS POSSESSIONS RESTS WITH THE RESIDENT OR HIS LEGAL REPRESENTATIVE ([22 VAC 40-72-420](#)).

An individual must be discharged from the ALF if a prohibited condition is revealed during the reassessment or a PAS team determines that the individual needs nursing facility level of care. The individual must also be discharged if the ALF is not licensed for the level of care needed.

**A. 33.1 Emergency Discharge**

WHEN A RESIDENT'S CONDITION PRESENTS AN IMMEDIATE AND SERIOUS RISK TO THE HEALTH, SAFETY OR WELFARE OF THE RESIDENT OR OTHERS AND EMERGENCY DISCHARGE IS NECESSARY, 14-DAY NOTIFICATION OF PLANNED DISCHARGE DOES NOT APPLY, ALTHOUGH THE REASON FOR THE RELOCATION SHALL BE DISCUSSED WITH THE RESIDENT AND, WHEN POSSIBLE, HIS LEGAL REPRESENTATIVE PRIOR TO THE MOVE.

UNDER EMERGENCY CONDITIONS, THE RESIDENT'S LEGAL REPRESENTATIVE, DESIGNATED CONTACT PERSON, THE FAMILY, CASEWORKER, SOCIAL WORKER OR OTHER AGENCY PERSONNEL, AS APPROPRIATE, SHALL BE INFORMED AS RAPIDLY AS POSSIBLE, BUT BY THE CLOSE OF THE BUSINESS DAY FOLLOWING DISCHARGE, OF THE REASONS FOR THE MOVE ([22 VAC 40-72-420](#)).

**B. 33.2 Discharge to a Nursing Facility**

The PAS team in the locality of the ALF is responsible for the assessment and authorization of individuals who are residing in an ALF but will need Medicaid funded nursing facility services within 180 days from the date of the admission to the nursing facility. The ALF must schedule with the PAS team to complete a screening of the individual. The PAS team handles this referral like any other referral coming from anywhere else in the community.

A private pay individual who is discharged to a nursing facility does not require a pre-admission screening unless the individual will be eligible for Medicaid within 180 days.

**C. 33.3 Discharge to Medicaid Funded Home and Community-Based Services**

The PAS team in the locality of the ALF is responsible for assessment and authorization for individuals who could leave the ALF and return to the community with the assistance of Medicaid funded home and community-based services. The individual must apply for Medicaid and meet the eligibility criteria for Long-Term Care services. The ALF will schedule with the PAS team to complete a screening of any individual who wishes to be discharged home with Medicaid funded home and community-based services. The PAS team handles this referral as it would a referral coming from anywhere else in the community.

**D. 33.4 Discharge to the Community without Medicaid Funded Home and Community-Based Services**

When an individual in an ALF moves back to the community without Medicaid funded home and community-based services, an updated copy of the UAI may be forwarded to a local service provider if requested by the individual or his representative. The ALF must follow all required discharge procedures.

**XXXIV. 34. CHANGES IN AN INDIVIDUAL'S FINANCIAL STATUS**

**A. 34.1 When a Private Pay Individual Needs to Apply for an Auxiliary Grant (AG)**

When a private pay individual needs to apply for an AG, an application for AG must be submitted to the local department of social services where the individual last lived prior to entering an institution. ALFs are considered institutions for purposes of determining AG eligibility. If an individual has had a Private Pay UAI completed, and he or she becomes eligible for AG, a public pay UAI must be completed in order for services to be authorized. Only qualified assessors, listed in Appendix J may complete a UAI for an individual who is receiving AG.

The public pay assessor must provide the LDSS eligibility worker with a copy of the Medicaid Funded Long-Term Care Services Authorization (DMAS-96) for verification of the assessment. If there is a full UAI on record (not the two-paged private pay version) that is less than twelve months old, the individual does not need to be reassessed unless there is indication that his level of care has changed.

For more information about the AG Program see Appendix J.

An ALF must complete a provider agreement before being approved to accept individuals with AG. The AG provider agreement is located at [http://www.dss.virginia.gov/family/as/auxgrant\\_forms.cgi](http://www.dss.virginia.gov/family/as/auxgrant_forms.cgi).

**B. 34.2 When an Individual with AG Becomes a Private Pay Individual**

If an individual becomes ineligible for AG based on income or countable resources, the LDSS eligibility worker will issue a notice of action to terminate the AG payment. The ALF and the individual must determine whether the individual will continue to reside in the ALF. If ongoing case management services are being provided, the case manager will participate in the discharge planning process, if appropriate, and then terminate case management services. If the individual plans to pay privately to reside in the ALF, the public

pay UAI remains valid for one year after the assessment date on the UAI unless there has been a significant change. Assessment requirements for private pay individuals must be followed after the expiration of the public pay UAI.

**XXXV.35. SUSPENSION OF LICENSE OR CLOSURE OF AN ASSISTED LIVING FACILITY**

UPON ISSUING A NOTICE OF SUMMARY ORDER OF SUSPENSION TO AN ASSISTED LIVING FACILITY, THE COMMISSIONER OF THE VIRGINIA DEPARTMENT OF SOCIAL SERVICES OR HIS DESIGNEE SHALL CONTACT THE APPROPRIATE LOCAL DEPARTMENT OF SOCIAL SERVICES TO DEVELOP A RELOCATION PLAN. THE RESIDENTS OF AN ASSISTED LIVING FACILITY WHOSE LICENSE HAS BEEN SUMMARILY SUSPENDED PURSUANT TO § 63.2-1709 OF THE CODE OF VIRGINIA SHALL BE RELOCATED AS SOON AS POSSIBLE TO REDUCE THE RISK OF JEOPARDIZING THE HEALTH, SAFETY, AND WELFARE OF RESIDENTS. AN ASSESSMENT OF THE RELOCATED RESIDENT IS NOT REQUIRED, PURSUANT TO 22 VAC 40-745-30 C 3. ([22 VAC 40-745-40](#))

The ALF Relocation Plan is available to local department of social services staff at the Department's website at <http://spark.dss.virginia.gov/divisions/dfs/as/documents.cgi>.

**XXXVI. 36. RECORD RETENTION**

All assessment forms must be retained for five years from the date of assessment. Assessments and related documentation must be legible and maintained in accordance with accepted professional standards and practices. All records, including the UAI as well as any computerized records and forms, must be signed with name and professional title of author and completely dated with month, day, and year.

XXXVII. Appendix A: PRIVATE PAY UAI

**VIRGINIA UNIFORM ASSESSMENT INSTRUMENT**  
**For Private Pay Residents of Assisted Living Facilities**

Dates: Assessment: / /  
 Reassessment: / /

**1. IDENTIFICATION**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Social Security Number: \_\_\_\_\_

Current Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone: (\_\_\_\_) \_\_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_  
(Month) (Day) (Year)

Sex:  Male <sub>0</sub>  Female <sub>1</sub>

Marital Status:  Married <sub>0</sub>  Widowed <sub>1</sub>  Separated <sub>2</sub>  Divorced <sub>3</sub>  Single <sub>4</sub>  
 Unknown <sub>9</sub>

**2. FUNCTIONAL STATUS** (Check only one block for each level of functioning) D = Dependent or Totally Dependent (TD or DD)

	Needs Help?		Mechanical Help Only <sup>d</sup> <sub>10</sub>	Human Help Only <sup>D</sup> <sub>2</sub>		Mechanical & Human Help <sup>D</sup> <sub>3</sub>		Performed by Others <sup>D/TD</sup> <sub>40</sub>			D/TD Is Not Performed <sub>50</sub>	
	No <sub>00</sub>	If Yes Check Type of Help		Supervision <sub>1</sub>	Physical Assistance <sub>2</sub>	Supervision <sub>1</sub>	Physical Assistance <sub>2</sub>		Spoon Fed <sub>1</sub>	Syringe/Tube Fed <sub>2</sub>	Fed by IV <sub>3</sub>	
Bathing												
Dressing												
Toileting												
Transferring												
Eating/Feeding												
Continenence	Needs Help?		Incontinent <sup>d</sup>	Ext. Device/ Indwelling/ Ostomy <sup>d</sup>	Incontinent <sup>D</sup>	External Device <sup>D/TD</sup>	Indwelling Catheter <sup>D/TD</sup>	Ostomy <sup>D/TD</sup>				
	No <sub>0</sub>	If Yes Check Type of Help	Less than weekly <sub>1</sub>	Self Care <sub>2</sub>	Weekly or More <sub>3</sub>	Not Self Care <sub>4</sub>	Not Self Care <sub>5</sub>	Not Self Care <sub>6</sub>				
Bowel												
Bladder												

AMBULATION	Needs Help?		Mechanical Help Only 10	Human Help Only 2		Mechanical & Human Help 3		Performed by Others 40	Is Not Performed 50
	No 00	If Yes Check Type of Help		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

## 2. FUNCTIONAL STATUS (Continued)

*D=Dependent*

IADLS	Needs Help?	
	No 0	Yes 1 <sup>D</sup>
Meal Prep		
Housekeeping		
Laundry		
Money Mgmt.		

Medication Administration
How can you take your medicine?
<input type="checkbox"/> Without assistance 0
<input type="checkbox"/> Administered/monitored by lay person 1 D
<input type="checkbox"/> Administered/monitored by professional nursing staff 2 D
Describe help/Name of helper:

## 3. PSYCHO-SOCIAL STATUS

Behavior Pattern	Orientation
<input type="checkbox"/> Appropriate 0 <input type="checkbox"/> Wandering/Passive - Less than weekly 1 <input type="checkbox"/> Wandering/Passive - Weekly or more 2 d <input type="checkbox"/> Abusive/Aggressive/Disruptive - Less than weekly 3 D <input type="checkbox"/> Abusive/Aggressive/Disruptive - Weekly or more 4 D <input type="checkbox"/> Comatose 5 D	<input type="checkbox"/> Oriented 0 <input type="checkbox"/> Disoriented - Some spheres, some of the time 1 d <input type="checkbox"/> Disoriented - Some spheres, all the time 2 d <input type="checkbox"/> Disoriented - All spheres, some of the time 3 D <input type="checkbox"/> Disoriented - All spheres, all of the time 4 D <input type="checkbox"/> Comatose 5 D
Type of inappropriate behavior:	Spheres affected:
Current psychiatric or psychological evaluation needed? <input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1	

## 4. ASSESSMENT SUMMARY

Prohibited Conditions
Does applicant/resident have a prohibited condition? <input type="checkbox"/> No 0 <input type="checkbox"/> Yes 1 Describe:

<b>Level of Care Approved</b>	
1) Residential Living <input type="checkbox"/>	2) Assisted Living <input type="checkbox"/>

<b>Assessment Completed by:</b>			
Assessor	Assessor's Signature	Agency/Assisted Living Facility Name	Date

If the assessor is an assisted living facility employee, the administrator or designee must signify approval by signing below:

_____ Administrator or Designee Signature	_____ Title	_____ Date
_____ Administrator or Designee Signature	_____ Title	_____ Date

Comments:
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*Note: Form must be filed in private pay resident's record upon completion.*

**XXXVIII.**

## Appendix B: ASSESSMENT PROCESS CHART

Step 1: Contact	Request for assessment is made. Assessor makes contact with the individual/requester. If possible, conduct a preliminary screening to determine if there are any prohibited conditions or other medical issues that may require more services than is available in an ALF. Refer to the Pre-admission screening (PAS) team, if appropriate.
Step 2: UAI	Conduct a face-to-face visit. Assessor completes the appropriate UAI. If UAI has been completed in last 90 days, and there are no changes, do not complete a new UAI. If individual meets NF criteria, stop assessment process. Refer to PAS team for authorization of nursing facility (NF) or home and community-based services if individual will be eligible for Medicaid.
Step 3: Prohibited Conditions	Assessor determines if individual has a prohibited condition. The individual is NOT eligible to reside in an ALF if he has a prohibited condition except for private pay exceptions. Stop assessment process and refer to the PAS team or to other services.
Step 4: Determine Level of Care	Determine individual's level of care using ALF criteria (i.e., residential or assisted living).
Step 5: ALF Availability/	Ensure that ALF has the appropriate license for the individual's level of care. Verify that ALF can provide requested services or if they are available in the community.
Step 6: Plan Reassessment	At least every 12 months, perform reassessment.

**XXXIX.**

**XL. Appendix C: GUIDELINES FOR ASSESSING AN INDIVIDUAL**

**INTERVIEW**

Prior to beginning the interview, the assessor should establish rapport with the individual being assessed. If the individual feels comfortable, he or she will speak more openly, allowing the assessor to gather valuable, necessary information. Developing rapport will also result in a better understanding of the individual, which will help to direct the conversation.

In some situations (such as assessing an individuals with a cognitive impairment), it may be necessary to use other sources of information such as family members, friends, facility staff, and/or individual records. It is important to note on the form when sources other than the individual are used to gather information and to obtain valid and reliable assessment information. When asking questions, the following suggestions will help to ensure accurate and useful responses:

- Always remain neutral.
- Do not make statements or offer nonverbal cues that might suggest a particular response is correct or incorrect, unusual or inappropriate, or similar to or different from others.

Many times individuals say they do not know the answer to a question when they are still thinking about it. At other times, they give answers that do not seem to fit the question or give general answers when a more specific response is required. On these occasions, use a neutral probe to help the individual answer. Neutral probes are questions or actions that are meant to encourage a more complete response without suggesting what the answer should be. The following ways of providing neutral probes may be useful:

- Repeat all questions that are misunderstood or that lead to "don't know" responses.
- If the question has specific response categories, read the categories and ask the individual which is more appropriate to him or her or which fits him or her best.
- Ask a neutral question, such as "Do you have more to say about that?" or "Is there anything else?" Probes that begin with "Don't you think. . ." or "Most people have said. . ." or "I assume what you're trying to get at is . . ." all serve to direct individuals toward particular answers, and individuals are less likely to express their true feelings.

## **COMPLETING THE UAI**

The Private Pay UAI contains an essential set of **minimum** data to be recorded in the spaces provided. These data are important because the completed UAI will be reviewed by DSS licensing staff to ensure that the individual meets the level of care the ALF has a license to provide. Assessors may wish to use the comment section to record additional information. Some specific points about completing the assessment are listed below.

- All of the questions are closed-ended with a fixed set of responses. Only "codable" responses are acceptable, and assessors may have to probe individuals for answers.
- All questions call for one answer; if two or more are given, probe for the response that comes closest in the individual's view.
- Use a check "✓" or an "X" to mark the appropriate response.
- Read the response choices to familiarize the respondent with the range of responses.
- Make sure every question has the appropriate number of responses recorded.

## **AUTHORIZATION OF SERVICES TO BE PROVIDED**

The assessor is responsible for authorizing the appropriate level of care for admission to and continued stay in an ALF. Assessor must also be knowledgeable of level of care criteria and is responsible for discharge of the individual whenever an individual does not meet the criteria for level of care in an ALF upon admission or at any later time. The appropriate level of care must be documented based on the completion of the Uniform Assessment Instrument (UAI) and definitions of activities of daily living and directions provided in the User's Manual: Virginia Uniform Assessment Instrument.

## **CRITERIA FOR RESIDENTIAL LIVING IN AN ALF**

Individuals meet the criteria for residential living as documented on the UAI when at least one of the following describes their functional capacity:

1. Rated dependent in only one of seven ADLs (i.e., bathing, dressing, toileting, transferring, bowel function, bladder function, and eating/feeding); OR
2. Rated dependent in one or more of four selected IADLs (i.e., meal preparation, housekeeping, laundry, and money management); OR

3. Rated dependent in medication administration.

## CRITERIA FOR ASSISTED LIVING IN AN ALF

Individuals meet the criteria for assisted living as documented on the UAI when at least one of the following describes their capacity:

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern (i.e., abusive, aggressive, and Disruptive).

## IDENTIFICATION INFORMATION

- **Date:** In the upper right-hand corner of the UAI is space to record the date of the assessment and date of the reassessment. The assessment date is when the initial assessment is done. The reassessment date is the date when the individual is reassessed. This date will always be later than the assessment date.
- **Name:** Record the full name of the individual (last, first, middle initial).
- **Social Security Number (SSN):** The purpose of requesting the individual's social security number (SSN), a nine-digit number, is so every person has a **unique** number to identify the individual's records. **For private pay individuals, a facility identification number will also be acceptable in lieu of the Social Security Number.** Most individuals should have a SSN, but the assessor will find that many females use their Medicare number as their SSN and/or their husband's SSN as their own. Medicare numbers are SSNs with an additional letter added. A Medicare number ending with the letters A, J, M, or T is equal to the female's own SSN. However, a Medicare number ending in B or D is the husband's SSN. B means the husband is still alive and D means the husband is deceased. Assessors can use the Medicare number ending in D as the wife's SSN since the husband is deceased.
- **Current Address:** The full current address (street, city, state, and zip) of the individual. If the individual assessed is a currently residing in the ALF, the name and location of the ALF is all that is required.
- **Telephone:** The telephone number recorded on the form should be the number where the individual can be reached. This may be the ALF's telephone number.
- **Birth Date:** Record the individual's date of birth (month, day and year).
- **Sex:** Record the individual's gender.
- **Marital Status:** Choose the answer that describes the individual's current status relative to the civil rite or legal status of marriage, as reported by the person.

- **Married** includes those who have been married only once and have never been widowed or divorced, as well as those currently married individuals who remarried after having been widowed or divorced.
- **Widowed** includes individuals whose most recent spouse has passed away.
- **Separated** includes legally separated, living apart, or deserted.
- **Divorced** means a marital dissolution by court decree of competent jurisdiction.
- **Single** includes never married, annulled marriage and individuals who claim a common law marriage, which is not recognized as a legal status in Virginia.

## FUNCTIONAL STATUS

### Components of Functional Status

Measurements of functional status are commonly used across the country as a basis for differentiating among levels of long-term caregiving. Functional status is the degree of independence with which an individual performs Activities of Daily Living (ADLs), Ambulation, and Instrumental Activities of Daily Living (IADLs).

- **ADLs** indicate an individual's ability to perform daily personal care tasks. They include: bathing, dressing, toileting, transferring, eating/feeding, and bowel and bladder control (continence).
- **Ambulation** is the individual's ability to get around indoors and outdoors, climb stairs, and use a wheelchair.
- **IADLs** indicate the individual's ability to perform certain social tasks that are not necessarily done every day, but which are critical to living independently. The IADLs used in determining ALF level of care criteria include Meal Preparation, Housekeeping, Laundry, and Money Management.

There are three important points to remember when assessing functional status:

- **First**, functional status is a measure of the individual's impairment level and need for personal assistance. In many cases, impairment level and need for personal assistance are described by the help received, but this could lead to an inaccurate assessment. For example, an individual with a disability **needs** help to perform an activity in a safe manner, but he or

she lives alone, has no formal supports and "receives no help." Coding the individual's performance as "independent" because no help is received is very misleading in terms of the actual impairment level. In order to avoid this type of distortion, interpret the ADLs in terms of what is usually needed to safely perform the entire activity.

- **Second**, an assessment of functional status is based on what the individual is **able** to do, not what he or she prefers to do. In other words, assess the individual's *ability* to do particular activities, even if he or she doesn't usually do the activity. Lack of capacity should be distinguished from lack of motivation, opportunity or choice. This is particularly relevant for the IADLs. For example, when asking someone if he or she can prepare light meals, the response may be "no," he or she does not prepare meals, even though he or she may be able to do so. This individual should be coded as not needing help. If someone refuses to perform an activity, thus putting self at risk, it is important to probe for the reason why the individual refuses in order to code the activity correctly. *The emphasis in this section is on assessing whether ability is impaired.* Physical health, mental health, cognitive, or functional disability problems may manifest themselves as the inability to perform ADL, Ambulation, and IADL activities. If an individual has no physical or cognitive impairment, there is no safety risk to the individual, and the individual chooses not to complete an activity due to personal preference or choice, indicate that the individual does not need help.
- **Third**, the emphasis of the measurement of each of the functional activities should be *how the individual usually performed the activity over the past two weeks*. For example, if an individual *usually* bathes self with no help, but on the date of the interview requires some assistance with bathing, code the individual as requiring no help unless the individual's ability to function on the date of the assessment accurately reflects ongoing need.

There are several components to each functional activity, and the coded response is based on the individual's ability to perform **all** of the components. For example, when assessing the ability to bathe, it is necessary to ask about the individual's ability to do all of the bathing activities such as getting in and out of the tub, preparing the bath, washing, and towel drying. Interviewers will need to probe in detail in order to establish actual functional level. The definitions of each ADL and other functional activities that follow should serve as a guide when probing for additional information.

Self-reporting on ADLs and other functional activities should be verified by observation or reports of others. This is especially critical when individuals report that they do activities by themselves, but performance level or safety of the individual is in question.

Some questions in this section are personal and the individual may feel somewhat embarrassed to answer (i.e. toileting, bladder and bowel control). Ask these questions in a straightforward manner and without hesitation. If the assessor asks the questions without embarrassment or hesitation, the person will more likely feel comfortable. If the individual is embarrassed, it is the assessor's responsibility to reassure him or her that it is O.K. and that the assessor understands how he or she could feel that way. Let the individual know that answers to these questions are important because they will help the assessor better understand his or her needs and provide a care plan that is right for the individual.

**Because each item in the functional status section is critical to determining level of care needs, every functional question in this section must have a valid answer. No "Unknown" responses are allowed.**

Dependence in functional status is used to differentiate among levels of long-term care. The total number of dependencies an individual has will determine the type of care appropriate to meet his or her needs. Dependence includes a continuum of assistance that ranges from minimal to total.

**Independent:** Independent means an individual usually completes an activity without assistance (i.e., mechanical or human) **(Independent=I)**.

**Semi-dependence:** Semi-dependence means an individual needs only mechanical help in a functional area **(semi-dependent=d)**. No human help or supervision is needed.

**Dependence:** Dependence means an individual needs at least the assistance of another person (human help only) OR needs at least the assistance of another person and equipment or a device (mechanical help and human help) to safely complete the activity. Human assistance includes supervision (verbal cues, prompting) or physical assistance (set-up, hands-on care). See scoring options below for the correct way to define supervision and physical assistance **(Dependence=D)**.

**Total Dependence:** An individual is considered **totally dependent (TD)** in each level of the seven ADLs when the individual is entirely unable to participate or assist in the activity performed. This scoring level may also be seen as "DD", another designation for totally dependent. For the purpose of an ALF assessment, "D," "TD," and "DD" all indicate dependence or "D." An individual who can participate in any way with the performance of the activity is not considered to be totally dependent.

## ADL SCORING OPTIONS

**Needs Help** means whether or not the individual needs help (equipment or human assistance) to perform the activity. If the individual does need help, score the specific type of help on the UAI in the boxes to the right.

**Mechanical Help Only** means the individual needs equipment or a device to complete the activity, but does not need assistance from another human (**d=semi-dependent**).

**Human Help Only** means the individual needs help from another person, but does not need to use equipment in order to perform the activity. A need for human help exists when the individual is unable to complete an activity due to cognitive impairment, functional disability, physical health problems or safety. An unsafe situation exists when there currently is a negative consequence from not having help (e.g., falls, skin rash or breakdown, weight loss, exacerbation of a diabetic condition as a result of an inadequate diet), or when there is the potential for a negative consequence to occur within the next 3 months without additional help. The decision that potential exists must be based on some present condition, such as a situation where the individual has never fallen when transferring, but shakes or has difficulty completing the activity. The assessor should not assume that any person over 60 and without help has the potential for negative consequences. Within the human help category, specify whether the assistance needed is supervision or physical assistance. If both supervision and physical assistance are required, the category that should be used is the one reflecting the greatest degree of need, physical assistance (**D=Dependent**).

- **Supervision (Verbal Cues, Prompting)**. The individual is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her **to safely perform the complete activity**. This code should only be used when the only way the activity gets completed is through this supervision. For example, if an individual is not likely to put on all the necessary clothes without prompting, this code should be used. Another example is when an individual requires supervision while bathing to ensure that the task is completed and that they remain safe. This code often pertains to individuals with cognitive impairment, but may include those who need supervision for other reasons.
- **Physical Assistance (Set-Up, Hands-On Care)**. Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

**Mechanical Help and Human Help** means the individual needs equipment or a device and the assistance of another person to complete the activity. For this category, specify whether human help is supervision or physical assistance as defined above (**D=Dependent**).

**Performed by Others** means another person completes the entire activity and the individual does not participate in the activity at all (**D=Dependent/Totally Dependent**).

**Is Not Performed** means that neither the individual nor another person performs the activity (**D=Dependent/Totally Dependent**).

## **RATING OF LEVELS OF CARE ON THE UAI**

The rating of functional dependencies on the preadmission screening assessment instrument must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. Please see the User's Manual: Virginia Uniform Assessment Instrument for more detailed definitions.

### **BATHING**

**Bathing:** Getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

**Does Not Need Help.** Individual gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink and does not require immersion bathing, without using equipment or the assistance of any other person.

**Mechanical Help Only** Individual usually needs equipment or a device such as a shower/tub chair/stool, grab bars, pedal/knee-controlled faucet, long-handled brush and/or a mechanical lift to complete the bathing process (**d=semi-dependent**).

#### **Human Help Only (D=Dependent)**

- **Supervision.** Individual needs prompting and/or verbal cues to safely complete washing the entire body. This includes individuals who need someone to teach them how to bathe.
- **Physical Assistance.** Someone fills the tub or brings water to the individual, washes part of the body, helps the individual get in and out of the tub or shower, and/or helps the individual towel dry. Individuals who only need human help to wash their backs or feet would not be included in this category. Such individuals would be coded as "Does Not Need Help".

**Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of others to bath (**D=Dependent**).

**Performed by Others.** Individual is completely bathed by other persons and does not take part in the activity at all (**D=Dependent/Totally Dependent**).

## **DRESSING**

**Dressing:** Getting clothes from closets and/or drawers, putting them on, fastening and taking them off. Clothing refers to clothes, braces, and artificial limbs worn daily.

**Does Not Need Help.** Individual usually completes the dressing process without help from others. If the individual only receives help tying shoes, do not count as needing assistance.

**Mechanical Help Only.** Individual usually needs equipment or a device such as a long-handled shoe horn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process (**d=semi-dependent**).

**Human Help Only (D=Dependent).**

- **Supervision.** Individual usually requires prompting and/or verbal cues to complete the dressing process. This category also includes individuals who are being taught to dress.
- **Physical Assistance.** Individual usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc.

**Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of another person(s) to dress (**D=Dependent**).

**Performed by Others.** Individual is completely dressed by another individual and does not take part in the activity at all (**D=Dependent/Totally Dependent**).

**Is Not Performed.** Refers only to bedfast individuals who are considered not dressed (**D=Dependent/Totally Dependent**).

## **TOILETING**

**Toileting:** Ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush.

**Does Not Need Help.** Individual uses the bathroom, cleans self, and arranges clothes, and flushes without help.

**Mechanical Help Only.** Individual needs grab bars, raised toilet seat or transfer board and manages these devices without the aid of others. Includes individuals who use handrails, walkers or canes for support to complete the toileting process (**d=semi-dependent**).

**Human Help Only (D=Dependent).**

- **Supervision.** Individual requires verbal cues and/or prompting to complete the toileting process.
- **Physical Assistance.** Individual usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, or cleansing after elimination. The individual participates in the activity.

**Mechanical and Human Help.** Individual usually needs equipment or a device *and* requires assistance of others to toilet (**D=Dependent**).

**Performed by Others.** Individual does use the bathroom, but is totally dependent on another's assistance. Individual does **not** participate in the activity at all (**D=Dependent/Totally Dependent**).

**Is Not Performed.** Individual does not use the bathroom (**D=Dependent/Totally Dependent**).

## **TRANSFERRING**

**Transferring:** Measures the level of assistance an individual needs to move between the bed, chair and/or wheelchair. If an individual needs help with some transfers but not all, code assistance at the highest level.

**Does Not Need Help.** Individual usually completes the transferring process without human assistance or use of equipment.

**Mechanical Help Only.** Individual usually needs equipment or a device, such as lifts, hospital beds, sliding board, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, and individual manages these devices without the aid of another person (**d=semi-dependent**).

**Human Help Only (D=Dependent).**

- **Supervision.** Individual usually needs verbal cues or guarding to safely transfer.

- **Physical Assistance.** Individual usually requires the assistance of another person who lifts some of the individual's body weight and provides physical support in order for the individual to safely transfer.

**Mechanical and Human Help.** Individual usually needs equipment or a device and requires the assistance of another to transfer (**D=Dependent**).

**Performed By Others.** Individual is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the individual does not bear weight on any body part in the transferring process he or she is not participating in the transfer. Individuals who are transferred with a mechanical or Hoyer lift are included in this category (**D=Dependent/Totally Dependent**).

## **EATING/FEEDING**

**Eating/Feeding:** The process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual.

**Does Not Need Help.** Individual is able to perform all of the activities without using equipment or the supervision or assistance of another.

**Mechanical Help Only.** Individual usually needs equipment or a device, such as adapted utensils, hand splint and/or nonskid plates, in order to complete the eating process. Individuals needing mechanically adjusted diets (pureed food) and/or food chopped are included in this category (**d= semi-dependent**).

**Human Help Only (D=Dependent).**

- **Supervision.** Individual feeds self, but needs verbal cues and/or prompting to complete the eating process.
- **Physical Assistance.** Individual needs assistance to bring food to the mouth, cut meat, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability (e.g., severe arthritis, Alzheimer's disease). This category must **not** be checked if the individual is able to feed self, but it is completed by the caregiver/staff instead.

**Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of others to eat (**D=Dependent**).

**Performed By Others.** Includes individuals who are spoon fed, fed by syringe or tube, or individuals who are fed intravenously (IV). *Spoon fed* means the individual does not bring any food to his mouth and is fed completely by others.

*Fed by syringe or tube* means the individual usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach). *Fed by I.V.* means the individual usually is fed a prescribed sterile solution intravenously (**D=Dependent/Totally Dependent**).

## **CONTINENCE**

**Contenance:** is the ability to control urination (bladder) and elimination (bowel). Incontinence may have one of several different causes, including specific disease processes and side-effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?"; and "Do you use pads or Depends?"

●**Bowel:** The physiological process of elimination of feces.

**Does Not Need Help.** The individual voluntarily controls the elimination of feces.

**Incontinent Less Than Weekly.** The individual has involuntary elimination of feces less than weekly (e.g., every other week) (**d=semi-dependent**).

**Ostomy - Self-Care.** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and he or she completely cares for the ostomy. Individuals who use pads or adult diapers and correctly dispose of them without assistance should be coded here (**d=semi-dependent**).

**Incontinent Weekly or More.** The individual has involuntary elimination of feces at least once a week. Individuals who use pads or adult diapers and do not correctly dispose of them should be coded here (**D=Dependent**).

**Ostomy - Not Self-Care.** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy: stoma and skin cleansing, dressing, application of appliance, irrigations, etc. (**D=Dependent/Totally Dependent**).

●**Bladder:** The physiological process of elimination of urine.

**Does Not Need Help.** The individual voluntarily empties his or her bladder without help.

**Incontinent Less Than Weekly.** The individual has involuntary emptying or loss of urine less than weekly (**d=semi-dependent**).

**External/Indwelling Device (e.g., Catheter or Ostomy) - Self-Care.** The individual has a urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder

(internal catheter) or a surgical procedure that establishes an external opening into the ureter(s) (ostomy). The individual completely cares for urinary devices (changing the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. Individuals who use pads or adult diapers and correctly dispose of them should be coded here **(d=semi-dependent)**.

**Incontinent Weekly or More.** The individual has involuntary emptying or loss of urine at least once a week. Individuals who use pads or adult diapers and do not dispose of them should be coded here **(D=Dependent)**.

**External Device - Not Self-Care.** Individual has a urosheath or condom with a receptacle attached to collect urine. Another person cares for the individual's external device. This code should never be used with individuals who only use pads or adult diapers **(D=Dependent/Totally Dependent)**.

**Indwelling Catheter - Not Self-Care.** Individual has a hollow cylinder passed through the urethra into the bladder. Another person cares for the individual's indwelling catheter **(D=Dependent/Totally Dependent)**.

**Ostomy - Not Self Care.** Individual has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the individual's ostomy **(D=Dependent/Totally Dependent)**.

## **AMBULATION**

Ambulation is the ability to get around indoors and outdoors, climb stairs, and wheel. Ambulation is not part of the ALF level of care criteria, but provides information on the individual's ability to exit the facility in event of an emergency. Specific information for each ambulation activity is reported below.

● **Walking:** The process of moving about indoors on foot or on artificial limbs.

**Does Not Need Help.** Individual usually walks steadily more than a few steps without the help of another person or the use of equipment.

**Mechanical Help Only.** Individual usually needs equipment or a device to walk. Equipment or device includes braces and/or splints, canes and/or crutches, special shoes, walkers, handrails and/or furniture.

### **Human Help Only**

- **Supervision.** Individual usually requires the assistance of another person who provides verbal cues or prompting.

- **Physical Assistance.** Individual usually requires assistance of another person who provides physical support, guarding, guiding or protection.

**Mechanical and Human Help.** Individual usually needs equipment or a device *and* requires assistance of others to walk.

**Is Not Performed.** The individual does not usually walk. Individuals who are bedfast would be coded here. Individual may be able to take a few steps from bed to chair with support, but this alone does not constitute walking and should be coded as **Is Not Performed**.

•**Wheeling:** The process of moving about by using a wheelchair.

**Does Not Need Help.** The individual usually walks, or the individual uses a wheelchair and independently propels the device unaided. Includes individuals who usually do not use a wheelchair to move about. Do not code individuals confined to a bed or chair here.

**Mechanical Help Only.** Individual usually needs a wheelchair equipped with adaptations, such as an electric chair, amputee chair, one-arm drive, and removable arm chair.

### **Human Help Only**

- **Supervision.** Individual usually needs a wheelchair and requires the assistance of another person who provides prompting or cues.
- **Physical Assistance.** Individual usually needs a wheelchair and requires assistance of another person to wheel.

**Mechanical and Human Help.** Individual usually needs an adapted wheelchair and requires assistance of others to wheel.

**Performed By Others.** Individual is transported in a wheelchair and does not propel or guide it. The individual may wheel a few feet within his or her own room or within an activity area, but this alone does not constitute wheeling.

**Is Not Performed.** The individual is confined to a chair or wheelchair that is not moved, or the individual is bedfast.

•**Stair Climbing:** The process of climbing up and down a flight of stairs from one floor to another. If the individual does not live in a dwelling unit with stairs, ask whether he or she can climb stairs if necessary.

**Does Not Need Help.** Individual usually climbs up and down a flight of stairs steadily on his or her own.

**Mechanical Help Only.** Individual usually needs equipment or a device to climb stairs. Equipment or device includes leg braces and/or splints, special shoes and/or canes, crutches and/or walkers, and special hand railings. Regular hand railings are considered equipment if the person is dependent upon them to go up or down the stairs.

### **Human Help Only**

- **Supervision.** Individual usually requires assistance such as guarding and guiding from another person.
- **Physical Assistance.** Individual usually requires assistance from another person who physically supports the individual climbing up or down the stairs.

**Mechanical and Human Help.** Individual usually needs equipment or a device and requires assistance of others to climb stairs.

**Is Not Performed.** The individual does not usually climb a flight of stairs due to mental or physical disabilities.

• **Mobility:** The extent of the individual's movement outside of his or her usual living quarters. Evaluate the individual's ability to walk steadily and level of endurance.

**Does Not Need Help.** Individual usually goes outside of his or her residence on a routine basis. If the only time the individual goes outside is for trips to medical appointments or treatments by ambulance, car, or van, do not code here because this is not considered going outside. These individuals would be coded either in the "confined - moves about" or "confined - does not move about" categories.

**Mechanical Help Only.** Individual usually needs equipment or a device to go outside. Equipment or device includes splints, leg braces, crutches, special shoes, canes, walkers, handrails, wheelchairs, chair lifts, and special ramps.

### **Human Help Only**

- **Supervision (verbal cues, prompting).** Individual usually requires the assistance of another person who provides supervision, cues or coaxing to go outside.
- **Physical Assistance (set-up, hands-on care).** Individual usually requires assistance of another person who physically supports or steadies the individual to go outside.

**Mechanical and Human Help** - Individual usually needs equipment or a device and requires assistance of other(s) to go outside.

**Confined - Moves About.** Individual does not customarily go outside of his or her residence, but does go outside of his or her room.

**Confined - Does Not Move About.** The individual usually stays in his or her room.

## **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)**

IADLs are more complex than activities related to personal self-care. Personal motivation plays an important role in an individual's ability to perform IADLs. For example, an individual who is depressed may easily neglect activities such as cooking and cleaning. IADLs also measure an individual's social situation and environment rather than ability level. For example, the inability to cook, for one who has never cooked, does not necessarily reflect impaired capacity. In both of these situations, the assessor should probe to get information about the type of help needed to do the activity.

### **Scoring Options**

**Does Not Need Help** means the individual does not require personal assistance from another to complete the entire activity in a safe manner. Individuals who need equipment but receive no personal assistance are included in this category.

**Does Need Help** means the individual needs personal assistance, including supervision, cueing, prompts, set-up and/or hands-on help to complete the entire activity in a safe manner (**D=Dependent**).

### **Activities**

**Meal Preparation:** The ability to plan, prepare, cook and serve food. If it is necessary for someone to bring meals to the individual which he or she reheats, this is considered needing help.

**Housekeeping:** The ability to do light housework such as dusting, washing the dishes, making the bed, vacuuming, cleaning floors, and cleaning the kitchen and bathroom.

**Laundry:** Washing and drying clothes. This includes putting clothes in and taking them out of the washer/dryer, and folding and putting clothes away. If the individual lives with others and does not do his or her own laundry, be sure to ask whether he or she *could* do laundry.

**Money Management:** This does not refer to handling complicated investments or taxes. It refers to the individual's ability to manage day-to-day financial matters such as paying bills, writing checks, handling cash transactions, and making change.

## **MEDICATION ADMINISTRATION**

Assess the capability of the individual to take his or her medicine. Focus on ability (what the individual **can** do) rather than biases imposed by the environment. For example, an individual who is able to take his or her medicine without any help, but who uses help because it is available, should be coded as *Without Assistance*. For those needing some type of assistance taking medicine, use the space provided to record the type of help and the name of the helper.

**Without Assistance** means the individual takes medication without any assistance from another person.

**Administered/Monitored by lay person(s)** means the individual needs assistance of a person without pharmacology training to either administer or monitor medications. This category includes medications administered or monitored by a medication aide. **(D=Dependent)**.

**Administered/Monitored by Professional Nursing Staff** means the individual needs licensed or professional health personnel to administer or monitor some or all of the medications **(D=Dependent)**.

## **BEHAVIOR PATTERN**

**This question is not designed to be asked directly of the individual. The answer is based on the assessor's judgment based on observation and information gathered about the individual.**

This question assesses the way the individual conducts self in his or her environment, and it taps three types of behavior: wandering, agitation, and aggressiveness. Other things to consider include whether the individual:

- ever engages in intrusive or dangerous wandering that results in trespassing, getting lost or going into traffic;
- gets easily agitated (overwhelmed and upset, unpleasantly excited) by environmental demands;
- becomes verbally or physically aggressive when frustrated; or
- becomes resistive or combative toward the caregiver when assisted with ADLs.

If several of the responses could describe the individual, code the most dependent. *Specify the type of inappropriate behavior and the source of the information in the space provided.*

- **Appropriate** means the individual's behavior pattern is suitable to the environment and adjusts to accommodate expectations in different environments and social circumstances.
- **Wandering/Passive - Less than Weekly** means the individual physically moves about aimlessly, is not focused mentally, or lacks awareness or interest in personal matters and/or in activities taking place in close proximity (e.g., the failure to take medications or eat, withdrawal from self-care or leisure activities). The individual's behavior does not present major management problems and occurs less than weekly.
- **Wandering/Passive - Weekly or More** means the individual wanders and is passive (as above), but the behavior does not present major management problems and occurs weekly or more (**d=semi-dependent**).
- **Abusive/Aggressive/Disruptive - Less than Weekly** means the individual's behavior exhibits acts detrimental to the life, comfort, safety and/or property of the individual and/or others. The behavior occurs less than weekly (**D=Dependent**).
- **Abusive/Aggressive/Disruptive - Weekly or More** means the abusive, aggressive or disruptive behavior occurs at least weekly (**D=Dependent**).
- **Comatose** refers to the semi-conscious or unconscious state (**D=Dependent/Totally Dependent**).

## **ORIENTATION**

Ask the questions related to person, place, and time in order to evaluate orientation, or the individual's awareness of his or her environment.

**Person:** "Please tell me your full name so that I can make sure our record is correct." Alternative questions to assess orientation to person are "Please tell me the name of your next door neighbor" or "Please tell me the name of the person who takes care of you."

**Place:** For orientation to place, ask "Where are we now?" or "What is the name of this place?" The complete mailing address, excluding zip code, is preferred. It may be necessary to probe for more details when individuals give vague answers such as "my house" or "my room". Ask for the state, county, town,

street name and number or box number. For individuals residing in an ALF, the facility name and floor is also considered correct.

**Time:** For orientation to time, the month, day and year are required. Ask “Would you tell me the date today?”

***Based on the individual's answers to the questions on Person, Place, and Time, code his or her level of orientation/disorientation. An individual is considered disoriented if he or she is unable to answer any of the questions. In order to code the specific type of disorientation, it may be necessary to consult a caregiver about the spheres affected and the frequency (i.e., some of the time or all of the time). Use the space provided to record the spheres in which the individual is disoriented.***

- **Oriented** means the individual has no apparent problems, is aware of who he or she is, where he or she is, the day of the week, the month, and people around him or her.
- **Disoriented, Person, Place, or Time, Some of the Time** means the individual sometimes has problems with one or two of the three cognitive spheres. *Some of the Time* means there are alternating periods of awareness-unawareness (**d=semi-dependent**).
- **Disoriented, Person, Place, or Time, All of the Time** means the individual is disoriented in one or two of the three cognitive spheres, and this is the individual's usual state (**d=semi-dependent**).
- **Disoriented, Person, Place, and Time, Some of the Time** means the individual is disoriented to person, place, and time some of the time (**D=Dependent**).
- **Disoriented, Person, Place, and Time, All of the Time** means the individual is disoriented to person, place, and time all of the time (**D=Dependent**).
- **Comatose** refers to the semi-conscious or unconscious state (**D=Dependent/Totally Dependent**).

## **XLI. Appendix D: DESCRIPTIONS OF SKIN BREAKDOWN**

Stage 1: These are areas where the skin is unbroken but is persistently pink or red and may look like a mild sunburn. The resident may complain that the area is tender, painful or itchy.

Stage 2: The skin is broken and the second layer of tissue is involved. The area is red and painful, and there may be some swelling and/or some drainage oozing from the wound. In the early development of these wounds, they may be very small. It is important to take action and report any broken skin that may be a developing pressure ulcer (not to be confused with skin tears or incontinence injury).

Stage 3: The skin has broken down and the wound extends through all three layers of the skin into soft tissue. The pressure ulcer is deeper and very difficult to heal. The site now has the risk for serious infection to occur. In order for the resident to remain in the assisted living facility, the wound must be healing and periodic observation and treatment must be provided as directed in the written treatment plan from a physician or other licensed prescriber. This care and treatment must be provided by a licensed health care professional employed by or under contract with the facility, the resident, the responsible party or a home care agency licensed in Virginia.

Stage 4: The wound extends into muscle and bone requiring extensive medical and/or surgical intervention and skilled observation and treatment due to the extreme risk of life-threatening infection. Because care of this level of pressure ulcer is prohibited by law in assisted living, the resident cannot be admitted to or retained in assisted living and must be transferred to a setting where appropriate services can be provided. In those rare occasions where the resident is an enrolled Hospice recipient and wishes to stay in the assisted living facility, the Hospice program is responsible for the skilled services, including the care of any Stage 4 ulcers.

Note: necrotic or dead tissue may obscure the base of the wound making it difficult to differentiate a stage III from a stage IV wound. Necrotic tissue in the wound also predisposes a resident to infection

**XLII. Appendix E: ORIENTATION/BEHAVIOR PATTERN DETERMINATION**

<b>Behavior</b>					
	Appropriate	Wandering/Passive Less Than Weekly	Wandering/ Passive More Than Weekly	Abusive/Aggressive /Disruptive Less Than Weekly	Abusive/Aggressive/ Disruptive More Than Weekly
Oriented	I	I	I	d	d
Disoriented --Some spheres --Some of the time	I	I	d	d	D
Disoriented --Some spheres --All of the time	I	I	d	d	D
Disoriented --All spheres --Some of the time	d	d	d	d	D
Disoriented --All spheres --All of the time	d	d	d	d	D

**I=Independent**

**d=Semi-dependent**

**D=Dependent**

Appendix F: ASSESSMENT OF SERIOUS COGNITIVE IMPAIRMENT

**Standards and Regulations for Licensed Assisted Living Facilities requires:**

Prior to his admission to a safe, secure environment, a resident shall have been assessed by a clinical psychologist licensed to practice in the Commonwealth or by an independent physician as having a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare. The physician making the assessment shall have an appropriate clinical background in the relevant area of serious cognitive impairments.

The regulation defines “serious cognitive impairment” as severe deficit in mental capability of a chronic, enduring or long term nature that affects areas such as thought processes, problem-solving, judgment, memory, and comprehension and that interferes with such things as reality orientation, ability to care for self, ability to recognize danger to self or others, and impulse control. Such cognitive impairment is not due to acute or episodic conditions, nor conditions arising from treatable metabolic or chemical imbalances or caused by reactions to medication or toxic substances.

**Name of Prospective Resident:** \_\_\_\_\_

**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_

(Street)

\_\_\_\_\_

(City)

\_\_\_\_\_

(State/Zip Code)

**Cognitive Functions (Orientation, Comprehension, Problem-solving, Attention/Concentration, Memory, Intelligence, Abstract Reasoning, Judgment, Insight, Etc.):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thought and Perception (Process, Content):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Mood/Affect:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name of Prospective Resident: \_\_\_\_\_

Behavior/Psychomotor: \_\_\_\_\_

\_\_\_\_\_

Speech/Language: \_\_\_\_\_

\_\_\_\_\_

Appearance: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

**DOES THE INDIVIDUAL NAMED ABOVE HAVE A SERIOUS COGNITIVE IMPAIRMENT DUE TO A PRIMARY PSYCHIATRIC DIAGNOSIS OF DEMENTIA WITH AN INABILITY TO RECOGNIZE DANGER OR PROTECT HIS/HER OWN SAFETY AND WELFARE?**

YES

NO

\_\_\_\_\_  
**Signature of Licensed Physician or Virginia-Licensed Clinical Psychologist**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
**(Please print or type physician's or psychologist's name here)**

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

(Street)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State/Zip Code)

**XLIII. Appendix G: MENTAL HEALTH SCREENING DETERMINATION FORM**

**Mental Health Screening Determination Form**  
**(See 22 VAC 40-72 340, 360 and 365)**

**Resident’s Name:**

**Referred for Admission by:**

**Date Resident Interviewed for Admission:**

**Date Resident Admitted to this Facility:**

**Part I. Mental Health Screening**

Date mental health screening was recommended for admission or retention, if applicable:  
\_\_\_\_\_

Date mental health screening was completed for admission or retention: \_\_\_\_\_

Date mental health screening was reviewed by facility: \_\_\_\_\_

- 1) Based on all sources of information gathered for determining the appropriateness of admission or retention, has a recommendation been made, if appropriate, to have the (prospective) resident referred to a qualified mental health professional (QMHP) to determine whether the person presents a risk of harm to self and/or others? [Circle one: Yes / No] If a recommendation for a screening was made but a referral was not done, explain:
- 2) If a mental health screening was recommended but there will be a delay in having it completed and the results made available to the facility, explain the reason for the delay and the expected length of the delay.
- 3) If a mental health screening was recommended and the results were made available to the facility, did the facility use the information to help determine whether the facility can meet or continue to meet the needs of the individual, such as equipping staff with specialized training, providing a higher level of supervision, offering psychosocial activities, or providing a type of physical environment that will enhance protection? [Circle one: Yes / No]
- 4) If there are special considerations for the facility to help support meeting the mental health needs of the (prospective) resident, what are they?
- 5) If a QMHP completed a mental health screening for a (prospective) resident and a recommendation for mental health services was made, have the resident, a mental health services provider, the authorized contact person, the physician of record, and, if applicable, the legal representative been notified? [Circle one: Yes / No] If not, explain:

**Part II. Psychosocial and Behavioral History**

1) If there are indications of mental health problems within the past six months, has the referring party provided a documented psychosocial and behavioral history that describes the prospective resident’s psychological, social, emotional, and behavioral functioning (if the party is a family member, a significant other, or friend, the information may be obtained by interview and documented by the

facility)? [Circle one: Yes / No]

2) Did the facility consider the information contained in the psychosocial and behavioral history in making a decision about whether the facility can meet the needs of the individual? [Circle one: Yes / No] Date History Reviewed:

3) Does the psychosocial and behavioral history indicate special considerations for the facility to help meet the mental health needs of the prospective resident [Circle one: Yes / No] If so, what are they?

4) If the person is admitted, was the psychosocial and behavioral history used in the development of the individualized service plan? [Circle one: Yes / No]

**Additional Comments Regarding Admission/Retention:**

**Signature of Facility Administrator  
(or Designee):** \_\_\_\_\_

**Date:** \_\_\_\_\_

**XLIV. Appendix H: WORKSHEET TO DETERMINE ALF LEVEL OF CARE**

(Use of this worksheet is optional)

**Resident's Name:**

\_\_\_\_\_

**STEP 1: Based on the completed UAI, complete sections below.**

<b>ADLs</b>	<b>Check if Dependent (D)</b>	<b>Selected IADLs</b>	<b>Check if Dependent (D)</b>
Bathing		Meal Preparation	
Dressing		Housekeeping	
Toileting		Laundry	
Transferring		Money Management	
Eating/Feeding			
Bowel			
Bladder			

Number of ADL Dependencies: \_\_\_\_\_

Number of IADL Dependencies: \_\_\_\_\_

Medication Administration: Check here if Dependent \_\_\_\_\_

Behavior Pattern: Check here if Dependent \_\_\_\_\_

Behavior Pattern and Orientation: Check here if Semi-Dependent or Dependent \_\_\_\_\_

The resident has no prohibited conditions per the Code of Virginia, § 63.2-1805. \_\_\_\_\_

**STEP 2: Apply the above responses to the criteria below to determine where the individual fits and circle the appropriate level of care.**

**RESIDENTIAL LIVING LEVEL OF CARE IN AN ALF:**

1. Rated dependent in only one of seven ADLs; OR
2. Rated dependent in one or more of four selected IADLs; OR
3. Rated dependent in medication administration.

**ASSISTED LIVING LEVEL OF CARE IN AN ALF:**

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern.

## **XLV. Appendix I: FORMS AND CONTACT INFORMATION**

The following forms may be needed during the assessment process of a private pay individual. These forms are available at <http://www.dss.virginia.gov/family/as/forms.cgi>.

- Consent to Exchange Information (including instructions)
- Interagency Consent to Release Confidential Information for Alcohol or Drug Patients

### **Agency Contact Information**

#### **DEPARTMENT OF SOCIAL SERVICES**

WyteStone Building  
801 East Main Street  
Richmond, VA 23219  
<http://www.dss.virginia.gov>

#### **Adult Services Program**

Gail Nardi, Manager, Adult Services Programs 804-726-7537  
Tishaun Harris-Ugworji, Adult Services Programs Consultant 804-726-7560  
Paige McCleary, Adult Services Programs Consultant 804-726-7536  
Venus Bryant, Administrative Assistant 804-726-7533  
FAX 804-726-7895

#### ***VDSS Regional Adult Services Consultants***

Central Region	vacant	(contact another consultant)
Eastern Region	Heather Crutchfield	757-491-3983
Northern Region	David Stasko	540-347-6313
Piedmont Region	Bill Parcell	540-204-9638
Western Region	Carol McCray	276-676-5636

Report suspected adult abuse, neglect or exploitation 24-hours a day, 7 days a week to the toll-free **APS Hotline at 1-888-832-3858**. For signs of adult abuse, neglect or exploitation visit <http://www.dss.virginia.gov/family/as/aps.cgi>.

**VDSS Division of Licensing Programs** 804-726-7165  
<http://www.dss.virginia.gov/division/license/district.html>

#### ***VDSS Division of Licensing Programs Field Offices***

Western (Abingdon)	276-676-5490
Fairfax	703-934-1505
Central (Henrico)	804-662-9743
Peninsula (Newport News)	757-247-8020
Piedmont (Roanoke)	540-857-7920

Valley (Fishersville)	540-332-2330
Eastern (Virginia Beach)	757-491-3990
Northern (Warrenton)	540-347-6345

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

<http://www.dmas.virginia.gov>.

**DEPARTMENT FOR THE AGING**

<http://www.vda.virginia.gov>

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES**

<http://www.dbhds.virginia.gov/>

**DEPARTMENT OF HEALTH**

<http://www.vdh.state.va.us/>

## Appendix J: AUXILIARY GRANT PROGRAM

The Auxiliary Grant (AG) Program is a state and locally funded assistance program to supplement the income of an individual who is receiving Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals residing in a licensed ALF. This assistance is available from local departments of social services to ensure that individuals are able to maintain a standard of living that meets a basic level of need. Before an individual can receive assistance from the AG program, the local department of social services, where the individual resides, must determine eligibility for the program. Residence for AG eligibility is determined by the city or county within the state where the individual last lived outside of an institution or adult foster care home. Any records/statements can be used to determine place of residence. If residency cannot be determined, residency is where the individual is living at the time of application. Entitlement to assistance begins the month all criteria are met.

All individuals applying for an AG must have an assessment completed before an AG payment can be issued. Verification of the initial assessment will be a completed DMAS-96, Medicaid Funded Long-Term Care Services Authorization, sent to the appropriate local department of social services eligibility worker by the assessor. At the time of an individual's annual reassessment, the assessor completes the ALF Eligibility Communication Document. This form tells the eligibility worker that the individual continues to meet the criteria for continued ALF placement.

To be eligible for an AG in Virginia, an individual must meet all of the following:

- Be 65 or over or be blind or be disabled.
- Reside in a licensed ALF or approved adult foster care home.
- Be a citizen of the United States or an alien who meets specified criteria.
- Have a non-exempted (countable) income less than the total of the AG rate approved for the ALF plus the personal needs allowance.
- Have non-exempted resources less than \$2,000 for one person or \$3,000 for a couple.
- Have been assessed and determined to be in need of care in an ALF or adult foster care home.

The AG provides for the following services:

### **Room and Board**

- Provision of a furnished room in a facility that meets applicable building and fire safety codes.
- Housekeeping services based on the needs of the resident.
- Meals and snacks, including extra portions and special diets.
- Clean bed linens and towels as needed and at least once a week.

### **Maintenance and Care**

- Medication administration, including insulin injections.
- Provision of generic personal toiletries including soap and toilet paper.
- Minimal assistance with personal hygiene including bathing, dressing, oral hygiene, hair grooming and shampooing, care of clothing, shaving, care of toenails and fingernails, arranging for haircuts as needed, care of needs associated with menstruation or occasional bladder or bowel incontinence.
- Minimal assistance with care of personal possessions; care of personal funds if requested by the recipient and residence policy allows it; use of telephone; arranging transportation; obtaining necessary personal items and clothing; making and keeping appointments; correspondence; securing health care and transportation when needed for medical treatment; providing social and recreational activities as required by licensing regulations; and general supervision for safety.

## **ASSESSORS FOR PUBLIC PAY INDIVIDUALS**

FOR PUBLIC PAY INDIVIDUALS, A UNIFORM ASSESSMENT INSTRUMENT SHALL BE COMPLETED BY A CASE MANAGER OR A QUALIFIED ASSESSOR TO DETERMINE THE NEED FOR RESIDENTIAL CARE OR ASSISTED LIVING CARE SERVICES. THE ASSESSOR IS QUALIFIED TO COMPLETE THE ASSESSMENT IF THE ASSESSOR HAS COMPLETED A STATE-APPROVED TRAINING COURSE ON THE STATE-DESIGNATED UNIFORM ASSESSMENT INSTRUMENT. PUBLIC HUMAN SERVICES AGENCY ASSESSORS WHO ROUTINELY COMPLETE, AS PART OF THEIR JOB DESCRIPTIONS, UNIFORM ASSESSMENT INSTRUMENTS FOR APPLICANTS TO OR RESIDENTS OF ASSISTED LIVING FACILITIES PRIOR TO JANUARY 1, 2004, MAY BE DEEMED TO BE QUALIFIED ASSESSORS WITHOUT THE COMPLETION OF THE TRAINING COURSE.

For public pay individuals, assessors include the following:

- **Local departments of social services**
- **Area agencies on aging**
- **Centers for independent living**
- **Community services board / Behavioral health authority**
- **Local departments of health**
- **An independent physician**
- **State facilities operated by the Department of Behavioral Health and Developmental Services**
- **Acute care hospitals**
- **Department of Corrections, Community Release Units or the Department's designee**

All of the above assessors may conduct initial assessments as well as annual reassessments with the exception of:

- State facilities operated by the Department of Behavioral Health and Developmental Services

- Acute care hospitals
- Department of Corrections Community Release Units or the Department's designee.

These three entities may complete the initial assessment **only**.

# **Infection Control**

## **Chapter Two**

**Time Required: 3 hours**

## **Chapter Two – Infection Control**

This chapter provides an overview of infection control protocols including how to protect residents, direct care staff, family members, and visitors from the spread of infection and communicable diseases. Infection Control will be thoroughly described as well as procedures to implement these protocols. Each facility should maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. Infection Control Programs should include all staff members and should include the entire physical plant and grounds. As health care providers, it is the responsibility of direct care staff to assist in the prevention of the spread of germs in order to control infections. It is also important for direct care staff to protect themselves from any illness and/or disease that could prevent the ability to work and potentially further spread infection to others.

### **2.1 Basic Definitions**

### **2.2 How Infection Is Spread**

### **2.3 OSHA**

### **2.4 Signs and Symptoms of Infection**

### **2.5 Staff Responsibilities**

## Instructor Planning

### 1. Objectives and Expected Outcomes of Chapter

- a. To understand basic terminology associated with Infection Control.
- b. To understand how infections are spread.
- c. Identifying signs and symptoms of infections.
- d. To understand the importance of OSHA Standards and techniques of applying standard precautions.
- e. To understand proper techniques in hand washing as well as putting on and taking off gloves and to demonstrate both techniques.
- f. To understand how to properly handle and dispose of contaminated material.
- g. To understand direct care staff's role in the recognition, prevention, and control of infections.
- h. To understand the procedures regarding infection control. Use facility policies if available.

### 2. Recommended Method of Instruction

- Lecture and class discussion – **Handouts #1 and #2**
- Review of Infection Control Program (Use facility program if available)
- Student Activity – Scenario (**Handout #3**) and Skills Checklists (**Handouts #4 and #5**)
- Student Review - Chapter Two

## 2.1 Basic Definitions

The purpose of this section is to provide you with a basic understanding of key terms used in the practice of infection control. Most of these terms will be discussed throughout this chapter.

### Definitions

*Microorganism* – a tiny living thing that is only visible by microscope.

*Pathogen* – disease causing microorganisms.

*Non-pathogen* – a microorganism that does not cause disease.

*Germs* – micro-organisms that are everywhere. Micro-organisms are inside and outside of the human body. Germs can be bacteria, viruses, a fungi, or parasites. Germs can be found in the air, on any surface, and on the bodies of humans and animals. Some germs are good while others may cause infections and illnesses. Germs can move through body fluids, air, animals and insects, and by eating or drinking infected food and drinks. These are considered pathogens.

*Bacteria* – single-celled organisms that can live in air, soil, water, organic matter, and skin.

*Viruses* – smaller than bacteria and is only able to multiply within living cells of a host.

*Parasites* – live on, in, or with another organism because it cannot live on its own.

*Fungi* – lives in moist, humid and dark environments.

*Infections* – conditions or diseases that happen when germs enter the body and grow.

*Infection Control* – any technique used to control and limit the spread of potential infection.

*Transmission* – the manner in which a germ, infection, or disease is transferred or passed from one person to another.

*Contaminated* – the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated materials are considered “soiled.”

*Uncontaminated* – no presence or anticipated presence of blood or other potentially infectious material on an item or surface. Uncontaminated materials are considered “clean.”

*Waste Materials* – any item that comes in contact with bodily fluids.

*Personal Protective Equipment (PPE)* – equipment worn by direct care staff for protection against germs and infections. This equipment also protects residents from germs and infections the direct care staff may be carrying. PPE protects the skin since the skin is the first barrier of defense against infection.

*Asepsis* – a condition in which no infection/disease is present.

*Sepsis* – a serious condition in which infection/disease is present.

*Health care Acquired Infection (HAI)* – an infection that an individual gets in a healthcare setting such as a hospital or nursing home.

Bloodborne pathogens – diseases that are carried in the blood.

## 2.2 How Infection is Spread

In order for direct care staff to protect themselves and others from infections, it is important to know how infections are spread. Identifying and controlling infections prevents the spread of infections. Infections are spread through what is called the Cycle of Infection.

- Cycle of Infection - includes the host, a way to move out of the host, as well as a way to move into a new host. Below is a diagram describing the Cycle of Infection Process.



- The Host may never exhibit signs of infection. The host is the individual, animal, item, or surface having the infection. The host is also referred to as the carrier.
- The Method of Transmission is the way the infection moves out of the Host to a new location. Infections can be spread through the air, water, and the environment.
  - Airborne transmission – Infection can be spread through the air through droplets. Droplets are microorganisms that fall through the air and are transmitted by laughing, coughing, sneezing, or talking. These droplets travel only a short distance but can be transferred when another individual breathes the droplets into their lungs.
  - Water – Infection can be spread through drinking contaminated water.
  - Environment – Infections can be spread through direct and indirect contact in the environment.
    - Direct contact – coming in contact with a pathogen by touching the infected body fluids while caring for a resident.
    - Indirect contact – coming in contact with a pathogen by touching something that has a resident's infected bodily fluids on it (i.e. used tissues).
- The New Host is the individual, animal, item, or surface receiving the infection. This host can then transfer the infection to other new hosts.

## 2.3 OSHA

As part of the Occupational Safety and Health Act of 1970, Congress created a Federal agency called Occupational Safety and Health Administration (OSHA). The purpose of this agency is to help ensure safe and healthy work conditions for all individuals. OSHA enforces workplace safety and health standards that must be met by employers. Part of the OSHA standards include OSHA's Bloodborne Pathogens Standard which was developed to help reduce the risk of occupational exposure to those workers that may have contact with blood or bodily fluids as part of their jobs. OSHA mandates that all employees that are covered by the Bloodborne Pathogen Standard be trained upon hire and annually. The Bloodborne Pathogens Standard will be described throughout the rest of the chapter in addition to various communicable diseases/infections and signs and symptoms of those infections.

- Bloodborne Pathogens Standard (BBP) – contains a number of components that must be met by employers. These components include exposure control, work place controls, standard precautions/PPE, housekeeping, Hepatitis B vaccine, and occupational exposure follow-up. Some of the components of BBP will be discussed more thoroughly than others in this chapter.
  - Exposure Control Plan
    - The Infection Control Plan for the assisted living. The plan should describe who is covered under BBP, different methodology to reduce the risk of exposure, and procedures that must be followed if there is an occupational exposure.
      - Any worker that could potentially come in contact with blood or bodily fluids is covered under BBP
      - Methodology to Reduce the Risk of Exposure
        - Infections that occur are generally transmitted by human sources. Infections do occur as the result of the environment as well. Transmissions

because of humans include healthcare providers, roommates, and visitors. Proper sanitation of the environment helps to reduce the spread of infection. All trash shall be kept in proper trash receptacles in the resident rooms and public areas. All trash on the grounds of the property should be kept in the dumpster with the dumpster area secured.

- Medical Supplies and Equipment
  - *Cleaning versus Disinfecting*
    - Cleaning removes soil, dirt, dust, organic matter, and certain germs such as bacteria, viruses, and fungi. Cleaning is done so that dirt can be lifted off surfaces and then rinsed off with water.
    - Disinfecting destroys germs and will prevent them from growing. Disinfecting agents (chemicals) do not have an effect on dirt, soil, or dust. Disinfecting agents are regulated by the EPA (Environmental Protection Agency). Disinfectants should be used after an area has been cleaned. The EPA website ([www.epa.gov](http://www.epa.gov)) has a list of registered disinfectant agents used to destroy germs associated with specific illnesses.

- *Supplies*

- Any supplies used to provide resident care should not come in contact with any bodily fluid or other contaminant. If any supplies are suspected of being contaminated, those supplies must be discarded according to the facility protocol.
  - All re-usable medical supplies/equipment should be properly disinfected before and after use with each resident.
  - Gloves should always be worn when handling medical supplies and equipment. The following equipment should be wiped down with an alcohol pad before and after each use with a resident:
    - Thermometer (even when using a thermometer cover).
    - Blood pressure cuffs.
    - Stethoscopes.
  - The supplies/equipment should also be properly stored to reduce direct and indirect contact with potential contaminants.

- *Equipment*
  - All equipment shall be thoroughly cleaned after coming in contact with a contaminant.
  - Any part of the equipment that came in contact with a potential contaminant should be wrapped in a plastic bag and taken to the appropriate location for proper sanitation.
  - Bleach solution or an EPA registered disinfectant may be used as the cleaning agent in most cases.
  - Manufacturer's guidelines should be followed for dilution, contact time, safety precautions, etc. Different concentrations of bleach or other disinfectants may be necessary depending on the type of outbreak or communicable disease/infection in the facility. Generally, a 1:100 bleach solution is used.

- To prepare a 1:100 bleach solution:
  - Bleach solutions should always be prepared in a well-ventilated area.
  - Individuals preparing bleach solutions should wear Personal Protective Equipment in the same manner as if resident care was being performed. It is especially important that protective eye wear is worn to prevent bleach from splashing in your eyes.
  - In order to prepare a 1:100 bleach solution, mix  $\frac{1}{4}$  cup of bleach with one gallon of water.
  - NOTE: Each container containing bleach solutions should be properly labeled with the name of the chemical, the bleach solution ratio (i.e. 1:100 Bleach Solution), as well as the date made.

- Bleach solution is only good for 24 hours. The bleach solution must be prepared fresh daily and the old bleach solution should be discarded.
  - The equipment shall be rinsed thoroughly prior to being returned to the building to prevent bleaching carpet, etc.
- Medical Waste
  - Medical waste should be stored in a medical waste container. These containers are constructed to prevent the leakage of fluids when handling, transporting, or storing medical waste. Medical waste containers are always labeled with a biohazard label and are placed in a locked area inaccessible to residents and visitors.
  - Proper disposal of medical and other waste materials also helps to prevent the spread of infection. Any item containing blood or that comes in contact with bodily fluid during routine (i.e. bathing, oral care, incontinence care, etc.) and/or emergency care is considered medical waste. Where medical waste is present during an emergency, the following items must be used:

- Gloves.
- Medical supplies needed.
- Hydrogen peroxide.
  - This may be needed for first aid
- Spill kit.
- C-fold towels.
  - These can be used to clean up bodily fluid or cover an area containing bodily fluid until it can be properly cleaned.
  
- Mop/mop bucket (if needed).
- Red bags.
- Any item that comes in contact with medical waste shall be placed in the red bag. This includes gloves used during the incident.
  - The red bags shall be tightly tied then transported to the biohazard area and placed in the medical waste bin or other area where the medical waste bin is stored.
  - Mop heads used to clean bodily fluid or blood should be placed in a red bag, tied, and placed in the contaminated materials bin in the biohazard area.

- The mop bucket used shall be cleaned according to the equipment protocol stated in this chapter.
  - Resident's personal clothing and/or linens containing medical waste shall be placed in a red bag, tied thoroughly, labeled with the resident's name and room number and placed in a location per facility protocol.
  - All medical waste shall remain in the biohazard area in the contaminated materials bin.
- Resident Room and Facility Cleanliness
  - Special utility gloves should be worn when cleaning resident rooms to protect the staff from cleaning chemicals. Any area that has come in direct or indirect contact with bodily fluids or contaminated material must be properly disinfected immediately.
  - *Soiled Laundry and Bedding*
    - Soiled linen may contain large amounts of microorganisms; however, the risk of acquiring a disease from soiled linen is minor. The following protocol should be used when cleaning, handling, and transporting soiled laundry (clothes) and bedding (linens):

- Gloves and other personal protective equipment should be used at all times while handling soiled linen.
- Soiled linen and laundry should not be set down on any surface (i.e. carpet). As soon as the soiled items come in contact with a new surface, that surface is now contaminated as well.
- Any soiled linens should be bagged in a laundry bag or large trash bag in location of the linen. A non-porous bag should be used. Non-porous bags prevent fluids and infected material from leaking out of the bag.
- The linen should be double-bagged if necessary to prevent leaking of the contaminated linen during transportation to laundry services. The bag should be tied prior to leaving the resident's room.
- No employee should attempt to "sanitize" the linen in the resident's room. This includes rinsing out the linen.

- Soiled linen should not be placed on surrounding furnishings including the floor, chairs, or counters.
- Soiled linen should be handled as little as possible.
- Soiled linen should be agitated as little as possible. This will prevent contamination of the surrounding air and contaminating the person holding the linen.
- Soiled linen should be rolled up away from the body. The soiled areas should be rolled so they are inside the clean areas of the linen.
- Label the linen with the resident's name and room number. This can be accomplished by writing this information on a piece of paper and inserting it into the bag prior to transporting it to the laundry room.
- Gloves used to handle the soiled linen should be removed prior to leaving the resident's room and placed in a second

plastic bag for removal. Clean gloves should be put on after properly sanitizing the employee's hands prior to transporting the soiled linen to laundry services.

- Soiled linen should not be washed with non-contaminated linens or clothing material.
- Soiled linens should be washed at temperatures of at least 160° F with bleach or appropriate detergent.
- Clean linen should be transported back to the resident's room in a manner that maintains cleanliness.

- Occupational Exposure and Follow-Up

- Managing Blood Spills

- The spill area should be covered with paper towels, towels, etc. until the DCS can return with proper cleaning supplies. These supplies could include:
      - Clear plastic and red bags
      - Leak proof containers.
      - Bleach solution.
      - Spill kit.
      - Disinfectant wipes.

- Put on PPE. This includes, gloves, mask, gown, booties, and goggles, if necessary.
  - Follow the directions on the spill kit and/or the facility policy on cleaning up spills.
  - Bleach solutions should not be used on carpet.
  - All items that do not contain blood borne pathogens may be placed in the clear bag.
  - All items containing blood borne pathogens must be placed in the red bag. This would include any PPE used. The red bag should be tied twice and immediately transported to the biohazard area.
- Occupational Exposure Follow-Up
    - Should direct care staff be exposed, the DCS should wash the area with soap and water immediately. If the area is the eyes or mucous membranes, flush with water immediately.
    - Report the incident to a supervisor so that immediate medical treatment may be sought, if necessary.
    - Follow facility protocol regarding documentation of injuries and Worker's Compensation claims.
- Engineering Controls
    - This refers to systems the facility has in place or mechanical devices that are used that are designed to reduce the risk of exposure.
      - Examples of this would include sharps (needle) disposal containers or retractable needles.

- These items will not be discussed in this curriculum since it is out of the scope of practice for Direct Care Staff.
- Work Place Controls
  - This refers to practices that the employees should follow to prevent spreading Blood borne pathogens to others.
  - Techniques used as part of work place control practices include:
    - Hand washing - direct care staff should wash his or her hands immediately upon entering the assisted living to start work, throughout the day, and prior to exiting the building.
    - Proper hand washing is the most effective approach to infection control. Hand washing serves as the primary method to prevent the transmission of infection from one individual to another. Proper hand washing protects the resident and direct care staff. Any part of the body that touches a potentially infectious item or individual should be scrubbed thoroughly with soap and water. Direct care staff should wash his or her hands prior to and after engaging in any of the following activities:
      - Eat, drink, or touch food.
      - Serve food.
      - Put on make-up or lip balm/chap stick.
      - Touch a resident, co-worker, or visitor.

- Handling any items given to or used by a resident or any resident's personal items (i.e. toothbrush, dentures, medications, lotions, creams, food/drinks, etc.).
- Touch contact lenses.
- Providing any resident care (bathing, dressing, toileting, changing incontinence pads/undergarments, re-positioning, oral hygiene, etc.).
- Using the restroom.
- Wearing gloves.
- Smoking.
- Touching any part of your own body including mouth, nose, eyes, hair, face, and ears.
- Since gloves are not worn during the entire work day, hand washing should occur after the following situations:
  - Touching a surface that could have germs on it.
  - Sneezing, coughing, blowing your nose, handling garbage or waste materials. If needed, the individual should sneeze or cough into the inner elbow and not use hands to cover the mouth.
  - When wearing gloves and the glove becomes punctured or tears.



## Review Handout #1

- Exhibiting proper hand washing techniques

- Personal hygiene practices should also be followed:
  - Personal food or beverages should never be placed in refrigerators, freezers, or countertops (i.e. nurses stations) that may store potentially infectious materials.
  - Consuming food and beverages and applying cosmetics in areas where a potential exposure to blood or body fluids may occur should be avoided.

- Standard Precautions/PPE

Preventing the transmission of bacteria and viruses through the population (including the staff members) can be controlled through the consistent exercise of implementing Standard Precautions when working with residents or potentially hazardous material. Preventing and controlling infections in assisted living is not only assuring the well-being of the residents, but requires less effort from direct care staff than treating those with infectious illnesses.

- Standard Precautions - "A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered."
- Standard Precautions means using infection control practices so there is no direct contact with a resident's bodily fluids (e.g urine, feces, blood, nasal drainage, etc.).

- Designed to reduce the risk of transmission of micro-organisms from known and unknown sources of infections.
- Should be used in the care of all individuals in assisted living, regardless of their diagnosis or presumed infection status.
- Applies to all body fluids, secretions, and excretions, regardless of whether or not they contain visible blood. This includes blood, urine, feces, vomit, sputum, vaginal discharge, semen, secretions, saliva, and potentially, sweat. Since it is not always known if a person is carrying a blood borne disease, all persons should be cared for as if the potential for blood borne disease is present.
- Applies to non-intact skin (e.g. skin tears, open wounds, etc.).
- Applies to mucous membrane secretions (e.g. nasal drainage).
- Personal Protective Equipment (PPE) is always worn when working with bodily fluids.
  - Personal Protective Equipment includes gloves, masks, gowns, eye protection, face shield, lab coats, resuscitation bags, and booties.
    - Gloves –
      - Should be worn if there is any potential to come in direct or indirect contact with bodily fluids.
      - Are for the protection of direct care staff and other residents.
      - Should never be worn twice.

- Should never be used on a resident after providing care for another resident.
- Should be removed after providing resident care and prior to leaving that resident's room.
- The gloves should be discarded in the resident's trashcan and the trash should be bagged and discarded immediately if the direct care staff came in contact with bodily fluids.
- Examples of when gloves should be worn:
  - Providing first aid.
  - Changing incontinence garments.
  - Changing linens, towels, or clothes.
  - Cleaning bodily fluids.
  - Cleaning resident bathrooms.
  - Providing toileting assistance including the use of bedpans, urinals, or catheters.
- If you are unsure of whether or not to wear gloves, put them on!
- Should be put on and removed properly.



## Review Handout #2

- Pest Control
  - The facility should have a pest control program to reduce potential contaminants and the introduction of infection to the property. Direct care staff should use standard precautions when coming in contact with a resident's pet and any animal brought into the facility.
- Additional Direct Care Staff Precautions
  - To prevent the spread of infection to residents or anyone else, the following additional guidelines should be followed:
    - Rings and bracelets should not be worn at work. Rings with crevasses (i.e. diamonds) can contain more bacteria as the bacterium gets “trapped.”
    - Fingernails should be kept clean and short.
    - Artificial nails should not be worn.
    - Bandages should be worn over any exposed skin that has a cut. No resident food preparation or service should be done by staff with wounds on their hands or forearms, even if covered, due to the potential for disease transmission.
    - Lotion should be put on hands to prevent hands from drying out. Try to avoid oil-based lotions as they can decrease the sturdiness of latex gloves resulting in glove breakdown. This could cause the gloves to tear.
    - Do not taste or blow on resident's food.
    - Do not come to work when sick. Some infections require a period of 24-hours of experiencing no symptoms before it is safe to return to work. Many of the more severe, widespread outbreaks are made worse when staff return to work before they should.

## 2.5 Signs and Symptoms of Infection

In order to properly prevent the spread of infection, direct care staff should know how to recognize the signs/symptoms of infection, isolate these infections, and prevent and control these infections. Older adults and adults with disabilities in long term care may be more prone to infection. This population is considered a Highly Susceptible Population (HSP). This section will discuss general signs and symptoms of infection as well as signs and symptoms of specific infections found in older adults in assisted living.

- Why Older Adults and Adults with Disabilities may be more susceptible to infection:
  - Compromised immune systems.
  - More frequent hospitalizations.
  - Improper nutrition and hydration.
  - Thinner skin.
  - Longer recovery period from illness.
  - Decreased mobility.
  - Environmental influences.
  - Multiple chronic disease states.
  - May be extremely fatigued.
  - May be experiencing significant stress.
  - May not be practicing good hand washing techniques.
- If it is determined that a resident has a potential infection that could be contagious, the resident needs to be removed from the presence of other residents until the physician is contacted and orders have been received.
- If it is determined that the resident has a contagious infection:
  - All areas in which the resident has been within the previous 24-hours must be properly sanitized.

- The resident's room shall be properly sanitized using bleach solution.
- Any soiled clothes or linens, supplies, or equipment shall be properly sanitized and transported to the proper location according to the protocols described in this chapter and the facility's procedures for sanitizing rooms and equipment.
- The facility's written infection control manual and policies and procedures regarding infection control should be readily available to staff.
- General Signs and Symptoms
  - Redness around the potentially infected area.
  - Swelling around the potentially infected area.
  - Fluid secreting out of the potentially infected area.
  - Skin warm to the touch in the potentially infected area.
  - Pain in the potentially infected area.
  - Fever (generally over 100.4°F).
  - Chills.
  - Nausea.
  - Vomiting.
  - Showing fatigue.
  - Urine (appearance, odor, frequency).
  - Mental status (confusion, decreased memory, disorientation).
  - Increased difficulty with ADLs.
  - Falls.

**INSTRUCTOR NOTE: It is important to emphasize that changes of mental status can be a crucial sign in discovering an infection. Confusion, decreased memory, disorientation, etc. should not be assumed to be a normal part of aging and should not be ignored. Residents that may be disoriented in his or her normal state and show increased signs of confusion should also be thoroughly evaluated. It is also important to emphasize that any change in condition should be immediately reported to a supervisor or person in charge.**

- Frequently Occurring Infections in Older Adults and Adults with Disabilities
  - *Urinary Tract Infections (UTI):*
    - Urinary Tract Infections are the most common type of infection in older adults and can be extremely debilitating. Urinary Tract Infections can occur in residents with or without a catheter. Signs and symptoms are:
      - Fever (over 100.4°F) and/or chills.
      - New or increased burning upon urination.
      - Frequent urination or increased urge to urinate.
      - Lower back (flank) or lower abdominal pain or tenderness.
      - Change in character of urine (color, odor).
      - Increased confusion, decreased memory performance.
      - Incontinence or an increase in frequency of incontinence.
      - Any behavioral change.
  - *Respiratory Infections:*
    - Respiratory Infections refer to an infection of the respiratory system (nose, sinuses, throat or lungs) that is caused by either viral or bacterial infections. These infections are often seasonal and can be controlled. General signs and symptoms are:
      - Influenza (flu)
        - Runny or stuffy nose.

- Muscle or body aches.
- Sore throat, hoarseness, or difficulty swallowing.
- Cough.
- Headaches.
- Fatigue.
- Fever or feverish/chills.
- Tuberculosis (TB)
  - Bacteria transmitted through the air by coughing, sneezing, talking, or singing. TB usually attacks the lungs but can attack the kidney, spine, or brain.
  - Signs and symptoms may include:
    - A bad cough that lasts three (3) weeks or longer.
    - Pain in the chest.
    - Coughing up blood or sputum.
    - Weakness or fatigue.
    - Weight loss.
    - No appetite.
    - Chills.
    - Fever.
    - Sweating at night.
    - Usually feel sick.
  - Individuals with TB can be carriers or can have active TB
  - § Results of a risk assessment documenting the absence of TB in a communicable form as evidenced by the completion of the

current screening form published by the Virginia Department of Health (VDH) or a form consistent with it should be obtained within 30 days prior to admission on each resident.

- **§** Annual risk assessments shall be completed on each resident and staff member utilizing the current screening form published by the Virginia Department of Health (VDH) or a form consistent with it.
- **§** Any resident or staff member who develops respiratory symptoms lasting three or more weeks in duration without a medical explanation shall be referred for evaluation for the presence of infectious TB.
- **§** All employees should provide on, or within seven days prior to, the first day of work the results of a risk assessment documenting the absence of TB. The risk assessment shall be no older than 30 days.
- **§** Any staff member that is suspected of having infectious TB shall not be allowed to return to work or have any contact with residents or personnel of the facility until a physician has determined that the individual is free of infectious TB.
- **§** Any staff person, household member, or resident that comes in contact with a known case of infectious TB shall be screened as

deemed appropriate in consultation with the local health department.

- § The facility shall report to the local health department any active cases of TB developed by a staff member or resident.

**INSTRUCTOR NOTE: Students should be informed that there are additional requirements in the Standards regarding tuberculosis that direct care staff should review. The items listed above are not the only regulatory requirements.**

- Pneumonia
  - Pneumonia is an infection found in either one or both lungs. Pneumonia is caused by germs including bacteria, viruses, and fungi. Older adults are more susceptible to pneumonia because many are also experiencing chronic disease states making it more difficult to fight germs.
  - Signs and Symptoms may include:
    - High fever.
    - Shaking chills.
    - Shortness of Breath.
    - Cough with phlegm.
    - Chest pain during breathing or coughing.
    - Feeling worse after a cold or flu.

- *Gastrointestinal Infections:*
  - Gastrointestinal infections refer to an inflammation in the stomach and intestines. These infections are often seasonal as well and can be controlled. However, they are highly contagious.
  - Direct Care Staff should report to a supervisor immediately any resident that has a change in GI

symptoms since outbreaks happen rapidly in assisted living facilities. These outbreaks can also effect staff and their families.

- Norovirus\*
  - Nausea.
  - Vomiting.
  - Diarrhea.
  - Possible stomach cramping.
  - Low-grade fever.
  - Chills.
  - Fatigue.
  - Body aches.
  - Headache.

\*Assisted living residents die every year from Norovirus. Norovirus is not killed by hand sanitizer.

- Shigella -
  - Diarrhea usually containing blood.
  - Stomach cramps.
  - Fever.

○ *Wound Infections:*

- Direct care staff should be aware of signs and symptoms of infections in existing and/or new wounds. Signs and symptoms are:
  - Increase in the size or drainage of the sore.
  - Increased redness and/or puffiness around the wound.
  - Odor begins to evolve from wound and/or wound turns greenish in color.

- Fever.
- Increased temperature at wound (warm/hot to touch).
- Any changes or the appearance of signs and/or symptoms of infection from any cause should be reported to a supervisor and documented in the resident's record per facility protocol.
- Other Potential Sources of Infection
  - Insect bites (West Nile Virus).
  - Scabies (mite infestation).
  - Bed Bugs.
  - Pets
    - Animal bites.
    - Disease
      - Residents are permitted to have a pet live in his or her room as facility policy permits. These pets must be free of disease and documentation must be provided accordingly by a licensed veterinarian. § Regular immunizations records must also be provided.
      - § Pets are not permitted in any central food preparation or serving areas. Pets would be permitted in a food service area only if the pet is providing service to the resident (i.e. seeing eye dog).
      - Any signs of disease exhibited by a pet must be reported to a supervisor immediately.

- Direct care staff must not come in direct contact with pet waste materials while providing personal care for a resident.
- Foodborne Illnesses
  - § Virginia Department of Health requires the reporting of any resident or staff member exhibiting gastrointestinal symptoms of the below “Big 5” that may have been contracted by food as well as any outbreak. Virginia Department of Health will then investigate the potential cases of illnesses to confirm these cases and assist the facility in treatment and infection control measures.
    - Norovirus (described above).
    - Shigella (described above).
    - Hepatitis A – contagious liver disease.
      - Illness can last from a few weeks to several months
      - Generally spread by ingesting fecal matter (even microscopic amounts).
      - Occurs from contact with material objects, food, or drinks that are contaminated by feces of a Hepatitis A infected person.
      - Usually ingested by mouth.
      - Does not always exhibit symptoms. Symptoms that do occur may be:
        - Fever.
        - Fatigue.
        - Loss of appetite.
        - Nausea.
        - Vomiting.
        - Abdominal pain.

- Dark urine.
  - Clay-colored bowel movements.
  - Joint pain.
  - Jaundice (a yellowing of the skin or eyes).
- Salmonella Typhi (*S. Typhi*) – bacteria that causes a life threatening illness that lives only in humans. This is also called typhoid fever.
  - Those infected with Salmonella Typhi carry the bacteria in the bloodstream and intestinal tract.
  - Individuals can be carriers after recovering from the illness. The bacteria are shed (eliminated) through their feces.
  - Contracted through eating food or drinking beverages that were handled by a person shedding the bacteria.
  - Can also be contracted through contaminated household drinking water or washing food contaminated with household water that became contaminated through sewage.
  - Symptoms include:
    - Fever as high as 103° to 104°.
    - Weakness.
    - Stomach pains.
    - Headache.
    - Loss of appetite.
    - Flat, rose-colored spots.

- E. coli – bacteria found in the intestines of infected humans and cows.
  - Most commonly occurs when an individual consumes undercooked ground beef and/or raw meat.
  - Spread by consuming food or water that has been contaminated by the feces of an infected human or animal.
  - Individuals no longer exhibiting symptoms of E. Coli can still be carriers and can continue to spread the bacteria for up to three weeks or more.
  - Does not always exhibit symptoms. Symptoms that do occur may be:
    - Bloody diarrhea resembling bloody water.
    - Vomiting.
    - Fever.
    - Chills.

NOTE: The Virginia Department of Health also requires assisted living facilities to report any health-related outbreak (i.e. norovirus). One resident is not considered an outbreak but five at one time may be. It is considered an outbreak if there is more than the expected level of disease activity within a facility over a certain period of time. It is important that Direct Care Staff always report any signs and/or symptoms a resident is experiencing to an immediate supervisor and to document those signs and symptoms in the resident's record.

- Multidrug-resistant organisms (MDROs)
  - Bacteria that may not be treatable with certain antibiotics and require treatment with medications that may be less effective but more toxic, and more expensive.
  - The microorganisms in MDROs can be carried in an individual's body without showing any symptoms and without tissue invasion or damage. This is referred to as colonization. The microorganisms that are actively invading tissues and causing damage are referred to as infections. The symptoms that may indicate an active infection may be dependent on the type of organism, the location of the infection, and that individual's risk factors. An individual can have MRSA, or other illness, that is colonized but not have the infection. It is important to know if the individual is colonized or infected as it directly relates to how they are treated, including isolation precautions.
  - One MDRO that is being seen more frequently in assisted living facilities is MRSA.
    - Methicillin-resistant Staphylococcus Aureus (MRSA)
      - Health care acquired infection (HAI).
      - Bacteria that is resistant to certain antibiotics.
      - Risk factors
        - Reduced functional status.
        - Conditions that may cause skin breakdown/infections.
        - Invasive devices (i.e. catheter).
        - History of colonization.
        - Wounds including pressure ulcers.
        - Frequent hospitalization.
        - Poor antibiotic therapy.

- Primary transmission occurs through the hands (primarily of the healthcare provider).
- Contact precautions should be implemented
  - PPE should be worn at all times when in contact with an individual with MRSA (gloves, gowns, and masks).
  - Hands should be thoroughly washed after removing gloves and prior to coming in contact with another resident.
- Isolation precautions may be necessary particularly if the individual has secreting wounds.
- Not all individuals with active MRSA need to be isolated.
  - If the active MRSA is contained (i.e. infection located in the urine and the resident uses a catheter), isolation precautions may not be necessary.
  - The determination for isolation precautions, or any type of precautions used, should be made by the resident's physician.
- Group activities are still vital to these individuals for socialization purposes and to decrease the risk of depression. Group meals and activities may be attended if the wounds secreting fluids are thoroughly covered and the resident's health care provider has determined that it is safe for the facility.
  - For residents who must be confined to their rooms, provision should be made for

activities and interaction to prevent social isolation.

- Equipment that came in contact with the individual should be thoroughly cleaned per facility policy.
  - Laundry should be transported according to the facility infection control policy.
- 
- C-diff
    - Clostridium difficile, known as C. diff, is a germ than causes diarrhea and is most frequently seen in individuals taking antibiotics.
    - Older adults and individuals with certain medical conditions are at highest risk of getting C. diff.
    - C. diff can be spread through person-to-person contact, contaminated medical equipment, bed linens, bed rails, bathroom fixtures, etc. or any equipment contaminated with fecal material.
    - Problematic in resident's with dementia.
    - Thorough hand washing and the cleaning and disinfecting of the areas where the person has been is the primary method of reducing transmission.
  - Hepatitis
    - Hepatitis A
      - Liver disease caused by ingesting fecal matter, even in microscopic amounts.
      - Transmission occurs when an uninfected individual comes in contact with objects, food, or drinks that are contaminated by an infected person's feces or stool.

- Hepatitis B
  - Most common serious liver infection.
  - Transmitted by blood and/or infected bodily fluids by blood-to-blood contact, unprotected intercourse, using unsterile needles, and to a newborn through delivery.
  - Prior to the introduction of the vaccine, this was the most common Bloodborne disease contracted by healthcare workers.
  - OSHA mandates that the Hepatitis B vaccine must be offered to all employees that may be exposed to blood or bodily fluids while working.
    - The vaccine consists of a series of three injections over a six month period.
    - Must be offered to employees free of charge.  
Employees are permitted to waive the vaccine but may request it at any time during their employment.
- Hepatitis C
  - Liver disease that occurs when blood from an infected individual enters the body of an uninfected individual.
  - Can be spread by blood transfusions and organ transplants as well as sharing needles during illegal drug use.
  - Can also lead to liver cancer.

## 2.6 Staff Responsibilities

- Direct Care Staff has the responsibility to apply the appropriate precautions to residents on a daily basis to prevent infection:
  - Make sure the resident is well-hydrated (fluid intake).
  - Make sure the resident has proper nutrition (well-balanced meals).
  - Make sure the resident is engaging in proper hygiene.
  - Make sure you and the resident are using good hand washing techniques.
  - Use standard precautions when emptying bedpans, bedside commodes, foley catheter drainage bags, and changing incontinence pads.
  - Encourage rest.
  - Make sure residents' personal items such as glasses, wheelchairs, walkers, scooters, etc. are clean and free of food particles, bodily fluids, and other contaminants.
- Direct Care Staff has the responsibility for their health and protection as well as those of residents:
  - Direct Care Staff that has a communicable infection should stay home until symptoms subside. Direct Care Staff should use good judgment along with facility protocol for employee illnesses.
  - Direct Care Staff should be thoroughly trained on resident-specific disease states/illnesses discussed in this Chapter. Direct Care Staff should also be trained on proper isolation precautions prior to caring for any resident needing isolation.
    - Direct Care Staff have the right to refuse a resident assignment if the staff member has not been trained on standard precautions, PPE, and proper isolation

precautions. Direct Care Staff do not have the right to refuse an assignment if he or she has been trained but the staff is concerned about working with a resident that is considered contagious.

- Cough or sneeze into your elbow.
- Report any respiratory symptoms you are experiencing lasting three or more weeks to a supervisor.
- Report any incidents of coming in contact with known cases of infection.
- Report any fever, gastrointestinal symptoms (e.g. norovirus), or any other potentially contagious condition to a supervisor.
- Wear simple jewelry.



## Student Activity

### **Instructor Notes:**

*The purpose of this activity is to allow direct care staff to identify potential infection control issues and discuss methods of risk reduction behavior.*

*Activity Procedures:*

- 1. Have the students read the scenario **Handout #3** and answer the corresponding questions.*
- 2. The instructor should ask the students to provide responses to each question and discuss the answers provided.*
- 3. The instructor should also discuss any answers missed. The discussion should not last longer than 15 minutes.*



## Student Activity

### Instructor Notes:

*The purpose of this activity is for each student to demonstrate proper hand washing technique and how to properly put on and remove gloves.*

*Activity Procedures:*

- 1. Have each student open the student handbook to **Handouts #4** and **Handouts #5** – Skills Checklists.*
- 2. The instructor should sign off on each line item after the student has demonstrated proper technique.*
- 3. The student should be provided the opportunity to repeat the skills checklist if the student does not properly demonstrate technique.*

## **Standards for Licensed Assisted Living Facilities**

### **Effective July 17, 2013\***

- 22 VAC 40-72-90 Infection control program
- 22 VAC 40-72-100 Incident reports
- 22 VAC 40-72-290 Staff records and health requirements
- 22 VAC 40-72-350 Physical examination and report
- 22 VAC 40-72-820 Pets living in the assisted living facility
- 22 VAC 40-72-830 Pets visiting the assisted living facility
- 22 VAC 40-72-850 Maintenance of buildings and grounds

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

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## Student Review – Chapter Two

1. Name and provide definitions for five (5) of the basic terminology described in this chapter.

### Definitions

***Microorganism*** – a tiny living thing that is only visible by microscope.

***Pathogen*** – disease causing microorganisms.

***Non-pathogen*** – a microorganism that does not cause disease.

***Germs*** – micro-organisms that are everywhere. Micro-organisms are inside and outside of the human body. Germs can be bacteria, viruses, a fungi, or parasites. Germs can be found in the air, on any surface, and on the bodies of humans and animals. Some germs are good while others may cause infections and illnesses. Germs can move through body fluids, air, animals and insects, and by eating or drinking infected food and drinks. These are considered pathogens.

***Bacteria*** – single-celled organisms that can live in air, soil, water, organic matter, and skin.

***Viruses*** – smaller than bacteria and is only able to multiply within living cells of a host.

***Parasites*** – live on, in, or with another organism because it cannot live on its own.

***Fungi*** – lives in moist, humid and dark environments

***Infections*** – conditions or diseases that happen when germs enter the body and grow.

***Infection Control*** – any technique used to control and limit the spread of potential infection.

***Transmission*** – the manner in which a germ, infection, or disease is transferred or passed from one person to another.

**Contaminated** – the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated materials are considered “soiled.”

**Uncontaminated** – no presence or anticipated presence of blood or other potentially infectious material on an item or surface.

Uncontaminated materials are considered “clean.”

**Waste Materials** – any item that comes in contact with bodily fluids.

**Personal Protective Equipment (PPE)** – equipment worn by direct care staff for protection against germs and infections. This equipment also protects residents from germs and infections the direct care staff may be carrying. PPE protects the skin since the skin is the first barrier of defense against infection.

**Asepsis** – a condition in which no infection/disease is present.

**Sepsis** – a serious condition in which infection/disease is present.

**Health Acquired Infection (HAI)** – an infection that an individual gets in a healthcare setting such as a hospital or nursing home.

**Bloodborne pathogens** – diseases that are carried in the blood.

2. Describe the Cycle of Infection



3. Name three (3) reasons why older adults may be more susceptible to infection compared to other populations.

**Compromised immune systems**

**More frequent hospitalizations**

**Improper nutrition and hydration**

**Thinner skin**

**Longer recovery period from illness**

**Decreased mobility**

**Environmental influences**

**Multiple chronic disease states**

**May be extremely fatigued**

**May be experiencing significant stress**

**May not be practicing good hand washing techniques**

4. Identify four (4) general signs and symptoms of infection

**Redness around the potentially infected area**

**Swelling around the potentially infected area**

**Fluid secreting out of the potentially infected area**

**Skin warm to the touch in the potentially infected area**

**Pain in the potentially infected area**

**Fever (generally over 100.4°F)**

**Chills**

**Nausea**

**Vomiting**

**Showing fatigue**

**Urine (appearance, odor, frequency)**

**Mental status (confusion, decreased memory, disorientation)**

5. Describe the direct care staff member's role in recognizing, preventing, and controlling infections. Describe why this role is important.

**Report any respiratory symptoms you are experiencing lasting three or more weeks to a supervisor. Report any incidents of coming in contact with known cases of infection. Report any fever, gastrointestinal symptoms (e.g. norovirus), or any other potentially contagious condition to a supervisor. Direct Care Staff has the responsibility to apply the appropriate precautions to residents on a daily basis to prevent infection. Direct Care Staff has the responsibility for their health and protection as well as that of residents.**



## **Proper Hand Washing**

Direct care staff should wash hands upon entering work, before and after resident care, and immediately prior to exiting the building upon completion of work. See previous section for a more thorough list of “when to wash.” Below is a description of proper hand washing techniques:

1. Remove watch, roll up sleeves and push sleeves above your elbow.
2. Stand away from the sink. Germs can live on faucets and inside the sink. These germs can get on your clothes and can contaminate you and spread to all those around you.
3. Get a clean paper towel and use it to cut on the hot and cold water. Discard paper towel.
4. Get your hands, wrists, and arms up to your elbow wet. Point fingertips down.
5. Put liquid soap on your hands and wrist. If using bar soap, rinse the bar soap and hold it throughout lathering.
6. Lather all areas, including between fingers, and under fingernails
7. Vigorously scrub your hands, wrists, and arms for 30 seconds. This is about the same amount of time it would take you to sing “Happy Birthday” two times. Clean nails by rubbing them into the palm of your other hand.
8. Rinse thoroughly starting at below your elbow so the water runs down to your fingertips.
9. Get a clean paper towel and dry your hands and arms beginning below your elbow and drying down.
10. Discard paper towel
11. Get a clean paper towel to cut off water and open door.
12. Discard paper towel in trashcan.
13. Use skin lotion if frequent washing irritates your skin. Chapped skin can lead to the potential for increased infection.

If at anytime you touch the faucet or sink with your bare hands, you must wash your hands again.

## **Properly Putting On and Removing Gloves**

### Putting On Gloves:

1. Wash your hands according to protocol previously described in this chapter.
2. Remove the gloves from the box and check for holes or tears. Discard glove(s) if any holes or tears are found, regardless of the size of the hole or tear.
3. Put the gloves on immediately prior to entering the resident's room or providing any type of resident care. Do not put on gloves prior to arriving at resident's room (i.e. putting gloves on at nurses station and walking down hallway)
4. Put one glove on.
5. Use your gloved hand to hold the other glove near the wrist portion of the glove. Do not touch bare skin with gloved hand.
6. Pull glove up as far up on wrist as it will go.

### Removing Gloves:

1. Use your gloved right hand to hold the left glove near the wrist. Do not touch bare skin.
2. Point hands down and peel left glove straight down from the wrist so the glove turns inside out as it is removed.
3. Place removed glove into your right gloved hand.
4. Put two fingers of your left hand inside the right glove. Do not touch the outside of the glove with your bare hand.
5. Point hands down and pull right glove straight down so that the glove is peeled off inside out and covers the glove you are holding. The right glove should be inside out over the left glove.
6. Discard gloves in the closest trashcan.
7. Wash your hands.

## **Chapter Two Scenario – Infection Control Facility Tour**

Once Mrs. Mathers initial paperwork was completed for move-in, a direct care staff member entered the Marketing Office to escort Mrs. Mathers to her room. The staff member noticed that the wheelchair needed to be cleaned as it had food and other particles on the seat, sides, brake levers, and other areas. The staff member did not have gloves in her pocket when she entered the office. She grabbed the handles of the wheelchair and proceeded down the hall to take Mrs. Mathers to her room. On the way down the hallway, a resident stopped to introduce herself to Mrs. Mathers. They chatted briefly and the direct care staff member gave the resident a hug. Prior to going to the room, the direct care staff member noticed a tissue on the floor. She picked it up and put it in her pocket. Once they reached Mrs. Mathers' room, the direct care staff member grabbed the door handle and opened the door to the room. Upon entering the room, the direct care staff member opened the blinds and turned on the television. The direct care staff member showed the resident how to use items around the room by turning them on an off and welcomed her to the facility. The direct care staff member took the tissue out of her pocket and threw it in the resident's trashcan that did not contain a plastic bag. She asked the resident if she needed anything else. When Mrs. Mathers said no, the direct care staff member rubbed her back and exited the room grabbing the door handle and closing the door as she left.

1. How many times did the direct care staff member potentially spread infection? Name the locations of the potential contamination sites.

### **Eight**

**Grabbing the handles on the wheelchair without gloves.**

**Hugging the resident in the hallway. *\*\*INSTRUCTOR: It is important to reinforce that hugging is not a violation of good infection control practices. In this case, the direct care worker could have been contaminated from the wheelchair and spread those germs to the individual she hugged.\*\****

**Picking the tissue up with her hand and putting it in her pocket.**

**Grabbing the resident's door handle to her room with her bare hand.**

**Opening the blinds with her bare hand.**

**Using her bare hand to show the resident how to turn items on and off in her room.**

**Taking the tissue out of her pocket and putting it in the trashcan without a plastic bag.**

**Using her bare hand to grab the door handle to open the door when exiting the room.**

2. Describe what the staff member should have done to avoid these potential contaminations.

**Washed hands prior to going to the Marketing Office.**

**Properly putting on gloves prior to escorting resident to her room.**

**Not hugging resident in hallway with gloves on.**

**Put a trash bag in the resident's trashcan.**

**Removing gloves prior to exiting resident's room and placing in bagged trashcan.**

**Wash hands at nearest staff hand washing sink.**

**Putting on clean gloves, picking up tissue and placing it in the closest bagged trashcan.**

**Properly removing gloves and placing them in the trashcan.**

**Wash hands at the nearest staff hand washing sink.**



## Proper Hand Washing Techniques Skills Checklist

	<b>Technique</b>	<b>Properly Demonstrated Yes/No</b>	<b>Instructor Initials</b>	<b>Comments</b>
1.	Take off watch, roll up sleeves above elbow			
2.	Stand away from the sink			
3.	Used a clean paper towel to turn on hot and cold water			
4.	Thoroughly wet hands, wrists, and arms up to elbow pointing fingertips downward			
5.	Put liquid hand soap on hands and wrists and lather			
6.	Scrub hands, wrists, and lower arms up to below elbow for 30 seconds			
7.	Clean nails by rubbing them into the palm of opposite hand			
8.	Rinse beginning below elbow allowing water to run down arms, hands and over fingertips			
9.	Use a clean paper towel to dry arms, wrists, and hands beginning below the elbow			
10.	Discard paper towel			
11.	Use clean paper towel to turn off water and open door			
12.	Discard paper towel in trashcan prior to exiting hand washing area.			



## Proper Putting On and Removing of Gloves Skills Checklist

	<b>Technique – Putting On Gloves</b>	<b>Properly Demonstrated Yes/No</b>	<b>Instructor Initials</b>	<b>Comments</b>
1.	Wash your hands according to protocol previously described in this chapter.			
2.	Remove the gloves from the box and check for holes or tears. Discard glove(s) if any holes or tears are found, regardless of the size.			
3.	Put one glove on.			
4.	Use gloved hand to hold the other glove near the wrist portion of the glove. Do not touch bare skin with gloved hand.			
5.	Pull glove up as far up on wrist as it will go.			
	<b>Technique – Removing Gloves</b>	<b>Properly Demonstrated Yes/No</b>	<b>Instructor Initials</b>	<b>Comments</b>
1.	Use your gloved right hand to hold the left glove near the wrist. Do not touch bare skin.			
2.	Point hands down and peel left glove straight down from the wrist so the glove turns inside out as it is removed.			
3.	Place removed glove into your right gloved hand.			
4.	Put two fingers of your left hand inside the right glove. Do not touch the outside of the glove with your bare hand.			
5.	Point hands down and pull right glove straight down so that the glove is peeled off inside out and covers the glove you are holding. The right glove should be inside out over the left glove.			
6.	Discard gloves in the closest trashcan.			
7.	Wash your hands.			

# **Aging 101**

## **Chapter Three**

**Time Required: 3 hours**

## **Chapter Three - Aging 101**

Although people of all ages live in assisted living, the majority of assisted living residents are older adults. This chapter seeks to provide an overview of aging to include demographics, myths, optimal aging and the changes that may occur in various body systems considered to be a normal part of the aging experience. Aging is a life experience that is shared by all of us. It is important for assisted living staff to see things from the perspective of older adults and this chapter should provide them with information to help them in this.

Understanding the changes associated with aging will assist staff in how they can help older adults, supporting them as they need and helping them to be as independent as possible.

It is important to remember that everything discussed in this curriculum is connected. It is important to understand that improving one factor of care, health status, etc. in a resident under your care can have significant positive impacts on the health and well-being of an older adult.

### **3.1 Aging Demographics: Facts, Myths, and Ageism**

### **3.2 Theories of Aging and Optimal Aging**

### **3.3 What are the Changes that Happen with Aging**

### **3.4 The Experience of Aging**

### **3.5 Staff responsibilities**

## Instructor Planning

### 1. Objectives and Expected Outcomes of Chapter

- a. Understand the demographics and facts of aging, and dispel myths about aging
- b. Review the concept of ageism
- c. Understand “optimal aging”
- d. Identify the physical, psychological, cognitive, and social changes associated with aging and how these impact care of older adults
- e. Experience aspects of aging to understand the perspective of older adults

### 2. Recommended Method of Instruction

- Lecture and class discussion (**Handout #3 and Handout #4**)
- Student Activity - Large and small group exercises (**Handout #1 and Handout #2**)
- Student Review - Chapter Three

### 3.1 Aging Demographics: Facts, Myths, and Ageism

- Aging Demographics: Facts
  - You may have heard of the phrase “the graying of society”. More of us are living longer than ever before. In 1900, the average life expectancy was 47.3. In 2004 the average life expectancy was 77.8.
  - In 2006 there were about 37 million people 65 and over in the United States. This means that one in 12 people in the US is 65 and over. Older adults are becoming a larger proportion of our society.
  - In Virginia, there are about 900,000 people 65 and over. One in 12 Virginians are 65 and over.
  - From 2000 to 2030 the number of older adults is expected to double!
- Who is an older adult?
  - There are many terms we use for older adults: senior citizens, seniors, elderly, older adults, elders, etc.
  - Generally speaking, when we talk about older adults, we are talking about people age 65 and older. This is because this is the standard age at which people are available for benefits such as Medicare and Social Security. There are other types of senior services that are available for people 60 and over and some services have no age restriction. However, most people seem to agree that “old” is relative.
  - Women tend to live longer than men (by about 8 years!). As a result, there are more older women than older men in our society.
  - People age 85 and older are actually the fastest growing older age group. In 1900, there were about 100,000 people 85 and

over in all of the United States. In 2006 there were 5.3 million people 85 and older.

- Before we learn more about aging and what it means to you in your work as direct care workers, let's take some time to see what **you** know about aging.



## Student Activity

- Group Exercise - Facts on Aging Bingo (**Handout #1**)

### Instructor Notes:

*The purpose of this activity is to combat some of the myths and stereotypes of aging and to assist in opening the students' awareness of their own bias towards older adults.*

*Activity procedures:*

- 1. Each student should turn to **Handout #1** in the student manual.*
- 2. Instruct the students to read through the statements and X all statements that are true.*
- 3. In order to get bingo, the student would need to X a 2X2 square. The student that finishes first calls "Aging Bingo!"*
- 4. Once everyone has finished, go through the statements using the instructor key and discuss which ones were false or true and why.*

- Aging and illness
  - With aging comes an increased risk for certain diseases and conditions. In assisted living, the older adults you see are generally sicker than the rest of the aging population. They may have chronic diseases or conditions such as dementia that cause them to need assistance in their daily lives.
  - In 2004, the leading cause of death among people age 65 and over was heart disease, followed by cancer, stroke, chronic

lower respiratory diseases, Alzheimer's disease, diabetes mellitus and influenza and pneumonia. The most common chronic conditions in both older men and women are hypertension and arthritis.

- Older adults may also have challenges with ADL's (activities of daily living) or IADL's (instrumental activities of daily living). This is more typically seen as older adults reach old-old age which is classified as 85 years of age and older. The challenges seen within the older adult population (considered 65 years and older) do not automatically begin to occur at age 65 but much later.
  - ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet.
  - IADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, housework, home maintenance, transportation, meal preparation, shopping, laundry or managing money.
- Although many people believe that old equals disabled, that is not true. Less than half of people 65 and over report some sort of functional limitation.
- Gerontology and Geriatrics
  - There are specializations in the study and care of older adults.
    - Gerontology is the study of aging processes and individuals. It is multidisciplinary, meaning it includes the study of physical, mental, and social changes in older people as they age.



- Another example of a stereotype would be the belief that all older people are disabled.
- When we stereotype people, we disregard their uniqueness and individuality. Person Centered Care encourages us to recognize, respect, and plan according to individual uniqueness.



## Student Activity

- Group Exercise – Ageist Terms (**Handout #2**)

### Instructor Notes:

*The purpose of this activity is to combat some of the myths and stereotypes of aging and to assist in opening the students' awareness of their own bias towards older adults through language. It is important that direct care staff understand that the terminology they use to describe older adults and adults with disabilities can carry significant negativity and project the image of ageism.*

### Activity procedures:

1. Each student should read aloud the ageist terms on **Handout #2** in the student manual.
  2. After they are done, ask the students why these terms would be offensive. Discuss the student responses.
  3. Ask the students if they think any of these terms aren't ageist and why?
- Elderspeak
    - Elderspeak is the name given to the way we might talk to older adults in a childlike way. When we use elderspeak, we may talk down to people. For example, one might say to an older resident after helping her eat her meal "Good girl!" Or maybe

a person might say to a resident, “Where do you think you are going, sweetie? That is not your room, silly girl!”

- Although we might say these things with good intentions and genuine warmth, it is important to think about the effect of this language on an older adult. Older adults may find this language condescending and disrespectful. It is important to realize that although some older adults become dependent on others for their care, they are not children.
- Not only might elderspeak be offensive to older adults, it might make them more agitated, particularly people with dementia. It might also hurt their self-esteem, cause them to be withdrawn, or make them feel incompetent.
- Elderspeak has been connected to poor health outcomes among older adults. Our job as care providers is to promote positive aging and health outcomes. This applies not only to the care that is delivered but also the way it is delivered. It is not just what is said but how it is said.



Review Handout #3

**Instructor Notes: Be sure to solicit responses from the students regarding rewording elderspeak in the examples.**

### **3.2 Theories of Aging and Optimal Aging**

- At the most basic level, aging is the process of growing older.
- We all age. Aging is a normal part of life.
- Sometimes we think of older adults as people that are different than us. But they are people like us, grown older. We will be old someday too!



## Student Activity

- **Group Exercise: What will you be like when you are 75?**

### Instructor Notes:

*The purpose of this activity is to open each student's awareness to their own aging and to assist each student in realizing that (hopefully) everyone will grow older.*

*Activity procedures:*

- 1. Divide the class into pairs.*
- 2. Have the students talk to each other about how they see themselves at age 75. Also have them think about family members that are 75. Ask them to be realistic about their health and how this will impact their aging. Give them 5 minutes.*
- 3. After they are done, ask them if it was hard to see themselves as older people. Remind them that the older adults they will be caring for were once their age!*
- 4. Discuss how every person is an individual with certain personality characteristics - these will likely not change as they get older. So, if someone is a crabby younger person, she or he will likely be a crabby older person!*

- Why do we age?
  - There are many theories about how and why we age. We do know that we are living longer than ever before.
    - There are two main sets of theories on the causes of aging.
      - One set of theory says that aging is the result of a lifetime of random events that have hurtful effects that accumulate over time. This could be

“breakdowns” in our bodies, or external (environmental) causes. Aging and death results from the cumulative effects of these damages.

- The other theory says that our lifespan is predictable and determined before we are even born. This can be thought of that we have “clocks” that are set at birth to run for a specific period of time and then stop.
- What is “optimal aging”?
  - There are different ways of looking at how we can age. One way we can look at aging is through the idea of “optimal aging”.
  - Optimal aging is: “The capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual – **to one’s satisfaction and in spite of one’s medical conditions.**” (Brummel-Smith, 2007)
    - A few important things about this definition are:
      - When we are talking about aging we are talking not just about physical changes but change and growth in all these areas:
        - Functional - “Functional” means the ability to take part in daily activities.
        - Cognitive - “Cognitive” refers to mental processes of perception, memory, judgment, and reasoning.
        - Emotional - “Emotional” refers to feelings or psychological states.
        - Social - “Social” refers to how one relates to the society around him or her.

- Spiritual - "Spiritual" refers to religious or sacred beliefs and practices.



### Group Question

**Ask the students the following question: What does this mean for the residents in your care?**

**Discussion:**

*This means that the residents in care may have functional needs but are very healthy psychologically, cognitively, spiritually, emotionally, and socially. For example, a resident may need physical assistance with bathing, dressing, transferring, etc but functions independently throughout the facility in all other areas (i.e the resident may be actively involved socially in and out of the facility as well as responsible for his or her own finances, etc.)*

- Another important thing to remember is that optimal aging is individualized. This means that everyone ages differently and finds meaning in different things. For one person, it might not matter as much that she cannot walk very well. It might mean more to that person as she ages to have family and friends around her. For another person, having a rich spiritual life as she ages is very important and she does not worry as much about her memory loss.
- Another thing about "optimal aging" is that it is possible even when you have medical conditions. This means that just because you are in a wheelchair, or use a walker, or have dementia, does not necessarily mean you cannot experience optimal aging. You can still live a good life.

You might say that in spite of illness or disability, it is important that we age the best we can.

- How do older adults deal with the challenges of aging so that they can still enjoy life?
  - As we age, we adapt to changing circumstances, like illness, loss of hearing, loss of mobility, etc. Older adults compensate for losses by finding different ways of doing things. Additionally, older adults rely on help to be as independent as possible and do the things they want to do. That is where you come in! You have a role in helping older adults age optimally. Here is an example.
  - Being social is a very important part of Mrs. Gerrity's life. She loves to have tea with other women who live at her assisted living community. It is difficult for her to get around to invite them to tea. It is hard for her to get dressed and ready for the day. You help fulfill this important need for her by asking her friends if they can meet for tea this afternoon. You help Mrs. Gerrity to get ready by helping her get dressed, doing her hair, etc. You and other staff can help her find a place to sit with her friends and make sure that tea is available for them.
    - Your help with Mrs. Gerrity is an important part of her being able to age optimally and to live the way she would like. What aspects of her optimal aging are you supporting (biological, psychological, social, cognitive, spiritual)?

**NOTE: The idea of “optimal aging” includes the idea that everyone ages in his or her own way, that there are different ways of aging well, and that every person has unique characteristics that influence how they age.**

### 3.3 What are the Changes that Happen with Aging

Aging brings a number of physical, functional, cognitive, emotional, social, and spiritual changes. There is a good amount of variability in the changes that individuals experience as they age. Changes vary with age group, sex, race, socioeconomic status, health history, etc. These changes are lifestyle dependent and most do not occur until old-old age. Because aging varies so much between people, every person has different needs. This is why it is so important to look at a resident's Individualized Service Plan to understand what she or he needs.

**NOTE: With all of these changes, it is essential to keep in mind how important it is to know the residents well. When you know the residents well, you will be better able to determine if the changes they are experiencing are “normal” for them or a new change. This means a new change to that person that may be reversible versus a “normal” part of the aging process.**

The physical changes that are going to be described below will not definitively happen as a result of the aging process. Although genetics may contribute to how an individual ages, it is important to remember that some changes occur as a result of lifestyle over the course of an individual's life. Contributing lifestyle components include deconditioning. This means that an individual may not have made appropriate efforts to maintain his or her body to achieve optimal aging. Lifestyle components such as not exercising, poor nutrition, smoking, etc. can contribute to physical decline. These components compound each other contributing to additional physical decline. Lack of access to proper healthcare and socioeconomic status will also be compounding factors. All of this can be explained by the law of small effects.

- Physical changes with aging
  - We will first look at the physical changes that happen with aging, looking at the body systems.
  - Each system in our bodies experiences changes due to aging.

- Circulatory system
  - What does it do?
    - The circulatory system continually pumps blood throughout the body.
    - It pumps blood with food and oxygen around the body.
    - It takes waste out of cells (cells create waste as a part of their normal processes in “running the body systems”).
    - It brings waste to the lungs and kidneys.
    - The circulatory system is made up of three parts that work together:
      - Pulmonary circulation: the movement of blood from the heart, to the lungs, and back to the heart again.
      - Coronary circulation: the movement of blood through the tissues of the heart.
      - Systemic circulation refers to the rest of the system. Blood vessels (arteries, veins, and capillaries) supply nourishment to all of the tissue located throughout your body.
  - How does it work?
    - Oxygen-rich blood enters the blood vessels through the heart's main artery called the aorta. Contractions of the heart forces the blood into the aorta and then to many small arteries throughout the body. The blood enters the capillaries throughout the body where it releases the oxygen and nutrients. Waste then goes through the veins, which flows back to the heart. Pulmonary circulation then allows the waste-rich blood carried by the veins to be pumped through the heart to the lungs. In the lungs,

carbon dioxide is released and oxygen picked up. Through the pulmonary veins, oxygen-rich blood enters the heart and is pumped through the heart to start the process all over again. During systemic circulation, the blood also passes through the kidneys, which filters waste from the blood, as well as through the small intestine and liver. The liver filters sugar for the blood and stores it for future usage.

- Changes in the circulatory system as we age:
  - In general, the flow of blood changes.
  - The heart gets weaker so it doesn't work as well.
  - The veins that carry blood to and from the heart get harder and narrower, which slows down the flow of blood.
- How do older adults experience these changes?
  - Feeling weak.
  - Heartbeat may be faster, slower, or uneven.
  - High or low blood pressure.
  - Feeling more cold, especially in the hands and feet.
  - Heartbeat may be faster when one gets upset.
  - Shortness of breath after doing things.
- Potential Staff Therapeutic Interventions
  - To help with blood flow, encourage them to not cross their legs.
  - Encourage them to move around.
  - Encourage them to put their feet up.
  - To help with shortness of breath, encourage them to take their time doing things and rest as they need it
  - Exercise to maintain good heart health.

- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Swelling in their legs.
  - Heartbeat that is faster, slower, or uneven.
  - Change in skin color, especially around the lips or under nails.
  - Shortness of breath.
- Digestive System
  - What does it do?
    - Breaks down food into tiny bits that the body can use.
    - Organs that make up the digestive tract are the mouth, esophagus, stomach, small intestine, large intestine (or colon), rectum, and anus. Other digestive organs are the liver, pancreas and gallbladder.
  - How does it work?
    - When we eat food or drink liquid, it is not in a form that can be used as nutrients for the body. It must be broken down to use its nutrients. Digestion begins as food enters the mouth and is chewed; it is then swallowed. When you first swallow, this is a voluntary movement (one you can control). It then becomes involuntary (automatic, not under your control) as food is pushed down the esophagus to the stomach. The stomach has three jobs: 1) to store food, 2) to mix food, liquids, and digestive juices, and 3) to empty its contents into the small intestine. Juices from the pancreas, liver, and intestine mix with the food and push it further through the intestines. Nutrients from the digested food pass through the walls of the intestine and into the blood, where it is carried throughout the body. Waste from

the digestive process goes into the colon, where it is expelled from the body by a bowel movement.

- Changes in the digestive system as we age:
  - Stomach cannot hold as much food.
  - Fewer taste buds.
  - Feel less thirsty.
  - Less saliva.
  - Food stays in the stomach longer.
  - Muscles of the large bowel do not work as well.
  - Less urge to empty bowel.
  - Liver less able to remove drugs and other substances.
  - Muscles involved in swallowing weaken.
- How do older adults experience these changes?
  - Eating less.
  - Difficulty swallowing.
  - Dry mouth.
  - Gas, bloating, or stomach pain.
  - Hard bowel movements.
  - The effects of drugs and other substances may last longer.
- Potential Staff Therapeutic Interventions
  - Ensure they are hydrated and are getting proper nutrition.
    - Offer them snacks or more frequent smaller meals, if they do not want a large meal (make sure this is what their Individualized Service Plan says).
  - Make their food look better and have more flavor.
  - Olfactory cueing
    - This refers to the sense of smell that can stimulate appetite. For example, food that smells good will be more appealing to the resident.

- Offer fluids often. If they do not want a lot to drink, offer small amounts more frequently.
      - Do not rush eating- encourage them to eat at their own pace.
      - Do not rush toileting- give them enough time to empty their bowels.
        - Create a bowel and bladder training schedule to assist in consistent elimination of the bladder.
  - Direct Care Staff should report any of the following observations and document according to facility protocol:
    - Eating less.
    - Drinking less.
    - Problems swallowing.
    - Feeling sick to their stomach or vomiting.
    - Stomach pain.
    - Blood or mucus in their stools.
    - Changes in bowel habits (for example, more frequent, less frequent, not being able to control bowel movements, etc.).
    - Hard or loose stools.
    - Excessive gas.
- Nervous system
  - What does it do?
    - The nervous system is a complex system that directs all of the body's activities. It is the control center for all the body systems. As part of the nervous system:
      - The brain controls the whole body.

- Messages from the rest of the body are transmitted to the brain.
- Controls the things you do with your body, like walking.
- Controls the things your body does on its own, like breathing.
- The nervous system has two parts:
  - Central nervous system – made up of the brain and spinal cord.
  - Peripheral nervous system – made up of all other neural elements (nerves and nerve fibers).
- In addition to these, other organs of the nervous system include:
  - eyes
  - ears
  - sensory organs of taste
  - sensory organs of smell
  - sensory receptors located in the skin, joints, muscles, and other parts of the body
- Changes in the nervous system as we age:
  - Nerve cells may reduce in functioning.
  - The senses may not work as well.
- How do older adults experience these changes?
  - Trouble falling asleep.
  - Trouble getting used to changes in light.
  - Trouble getting up and down stairs.
  - Trouble with balance.

- Potential Staff Therapeutic Interventions
  - If older residents have trouble getting to sleep:
    - Encourage them to move around during the day.
    - Encourage them to avoid coffee, tea, chocolate, and alcohol before bed.



#### Review Handout #4

- If older residents have trouble with their balance:
  - Encourage them to use handrails or other supports for balance.
  - Remind them to change position slowly.
  - Remind them to sit on the side of the bed before getting up so that they don't get dizzy.
  - Give them plenty of time to move around.
  - Encourage exercise for strength and balance.
  - Encourage the use of proper footwear.
  - Encourage the use of the call bell.
  - Remind them and assist with maintaining proper lighting and having clear pathways.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Major changes in behavior, such as aggression, yelling, etc.
  - Dizziness.
  - More difficulty talking or moving.
  - Increased confusion.
  - Unsteady gait or any fall.

- Respiratory System
  - What does it do?
    - It supplies the blood with oxygen so that oxygen can get to all parts of the body.
    - It gets rid of carbon dioxide.
    - We do this as we breathe. We breathe in oxygen and breathe out carbon dioxide.
    - The respiratory system includes: mouth, nose, trachea, bronchi, bronchial tubes, lungs, and diaphragm.
  - How does it work?
    - Oxygen enters the respiratory system through the nose and mouth. It then goes through the larynx and trachea into the chest cavity. In the chest cavity, the trachea splits into smaller tubes called bronchi and then even smaller tubes called bronchial tubes. The bronchial tubes lead into the lungs, where they separate into tiny tubes that have sacs called alveoli. From the alveoli, oxygen passes through the capillaries into the blood of the arteries. Waste in the blood of the veins then releases its carbon dioxide into the alveoli and it takes the same path out of the body when you exhale. The diaphragm helps to pull carbon dioxide out of the lungs and oxygen into the lungs.
  - Changes in the respiratory system as we age:
    - Older adults may not take in oxygen or breathe out carbon dioxide as well.
    - Their breathing airway may get more easily clogged with mucous.

- Increase in mucous production as well as a decrease in the activity and the number of cilia produced.
  - Lungs may become stiffer and the muscle strength and endurance of the lungs diminish.
- How do older people experience these changes?
  - Trouble breathing when moving around.
  - May cough more and may cough up more mucous since there are fewer cilia produced and increased mucous production.
  - May be less aware of respiratory symptoms. Increased risk for mortality based on an unrecognized respiratory cause.
- Potential Staff Therapeutic Interventions
  - Encourage exercise to maintain vital lung capacity.
  - Encourage them to take their time.
  - Encourage them to take rests as needed.
  - Make sure the resident is positioned properly while in a chair and/or eating.
  - Practice good infection control techniques like hand washing.
  - Help them get comfortable in bed so they can breathe easier.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Increased coughing or sneezing.
  - Coughing up fluids.
  - Coughing up blood.
  - Bluish skin, lips, or nail beds.
  - Trouble breathing.

- Feels very hot or very cold.
  - Makes whistling or wheezing sounds when they breathe.
- Skeletomuscular System
  - What does it do?
    - Holds up the body.
    - Protects the inside parts of the body.
    - Allows people to move.
  - There are five basic tissues in the skeletomuscular system:
    - Bones
    - Ligaments
    - Cartilage
    - Tendons
    - Skeletal muscles
  - Muscles are connected to bones by tendons. Bones are connected to each other by ligaments.
  - Changes in the skeletomuscular system as we age:
    - The spine may change- it may become shorter or more curved. The head may also bend forward.
    - Bones get weaker because of losses in calcium.
    - Muscles get weaker and stretch less.
    - Joints are stiffer, especially after sleep or rest.
  - How do older people experience these changes?
    - May break bones more easily.
    - May have more pain in their muscles and joints.
    - Get tired more easily.
    - May have less hand strength.
    - Need more time to do things.
  - Potential Staff Therapeutic Interventions

- If their Individualized Service Plan (ISP) indicates this, encourage exercise. This will help them move their joints and muscles if necessary.
- Encourage them to rest and take their time when moving around.
- Closely monitor for fall risks.
- Encourage them to use whatever supports they have to get around (e.g. cane, walker, etc).
- Try to ensure that things are within their reach.
- Prevent sitting for prolonged periods of time.
- Encourage position changes especially when wheelchair bound.

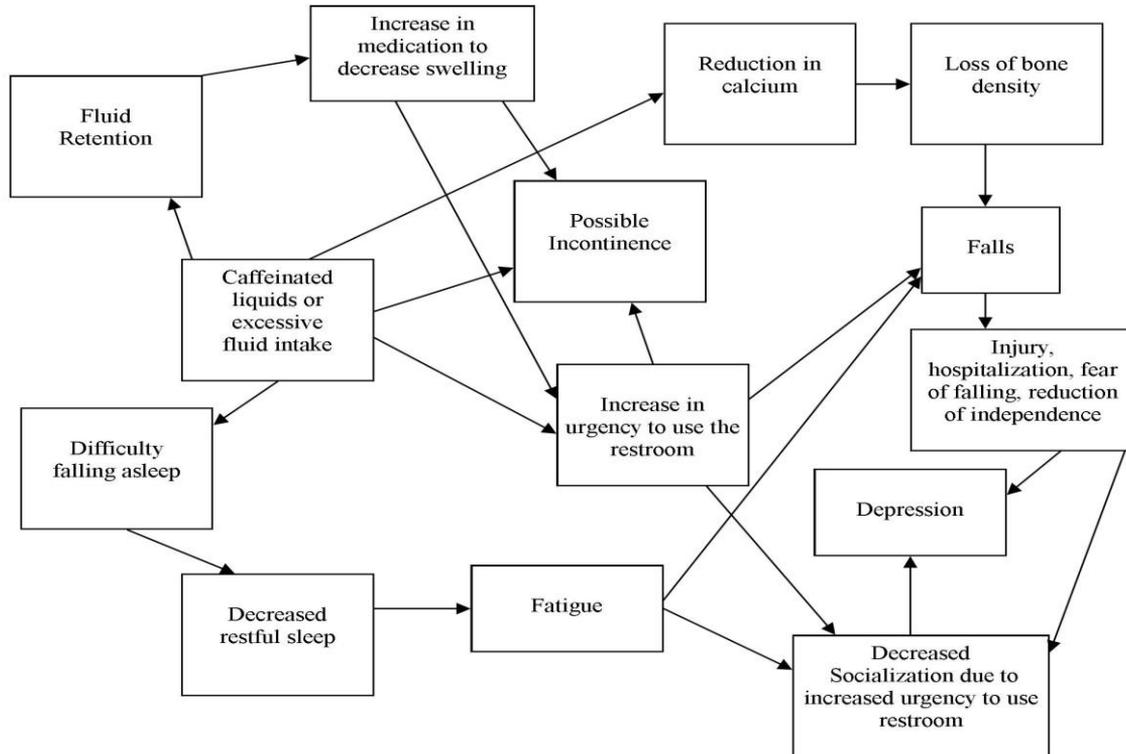
**NOTE: It is important to stress that individuals can gain muscle mass and bone density across the adult life span with exercise.**

- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - An older adult falls.
  - Trouble moving around more than usual.
  - More problems than usual with balance.
  - Not using devices like walkers or wheelchairs correctly.
  - Swollen joints.
  - Expresses pain in joints or muscles.
  - Note: people with dementia may not be able to express pain in typical ways. Some clues they may have pain:
    - They may pay more attention to a particular body part.
    - They may say a body part is on fire.
    - They may not attempt to move.

- Integumentary System: The skin, hair, and nails
  - What does it do?
    - Is the largest system of the body.
    - Protects the inside of the body from germs.
    - Keeps the body from getting too cold or too hot.
    - Holds in fluids.
    - Sends message to the brain about pain, temperature, pressure, and touch.
  - Changes in the skin, hair, and nails as we age:
    - Fat under the skin moves around so that there is less fat in some places and more in others. The layer of fat under the skin also thins.
    - Glands produce less oil.
    - Sweat glands produce less sweat.
    - Skin loses elasticity and strength.
    - The outer layer of skin thins.
    - Veins become more visible through skin.
    - Skin may appear thinner and paler because of less pigment.
    - Blood vessels in the skin layers become more fragile, making it easier to bruise.
    - Fingernails get ridges and may break more easily. Toenails get thicker and harder.
    - Age spots or other discoloration appear.
    - Hair turns gray and becomes coarser.
  - How do older adults experience these changes?
    - Wrinkles.
    - Fingernails may become more jagged or rough.
    - Skin may be dry, thin and more subject to tearing.

- Easily get cuts, sores, and bruises.
  - Skin takes longer to heal.
  - Skin may be more sensitive to sensations such as fabric type, water pressure, temperature, etc.
- Potential Staff Therapeutic Interventions
  - When bathing, use less soap, be gentle, and pat them dry.
  - If appropriate, use lotion to help with dryness.
  - Make sure the older adult is appropriately dressed since they may be more sensitive to cold temperatures.
  - If the person is incontinent and wears briefs, change them frequently to avoid skin breakdown.
    - Create a bowel and bladder program.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - New wounds or wound changes.
  - Rashes or other skin problems.
  - Dry skin.
  - Very hot or cold skin.
  - Redness, especially on and around bony prominences (ex. buttocks, heels, ears, etc.).
- Urinary System
  - What does it do?
    - Gets waste out of the blood.
    - Gets waste out of the body.
    - Helps keep the right amount of fluids and chemicals in the body.
  - Changes in the urinary system as we age:
    - Bladder muscles weaker and stretched.

- Bladder able to hold less urine.
- Man's prostate gland gets bigger.
- How do older adults experience these changes?
  - Difficulty controlling their bladder and may have accidents.
  - May have to urinate more frequently.
  - Note that incontinence is not a normal part of aging.
- Potential Staff Therapeutic Interventions
  - Help them get to the bathroom in time- this may mean bringing them more frequently. Create a bowel and bladder program for the resident.
  - Make sure their path to the bathroom is clear and the bathroom is well lit.
  - Making sure they get plenty of liquids to remain hydrated.
  - Encourage them to limit certain liquids before bed, such as tea, coffee, soda, or alcohol.
    - It is important to recommend the limitation of the above-named beverages as they are dehydrating and reduce the amount of calcium in the body and the compounding effects that these types of beverages may have. The diagram below helps explain these compounding effects.



- Encourage them to monitor their eating of salty foods at dinner, as this could make them thirstier and drink more before bed.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Blood in urine.
  - Urine with a strange smell or thickness.
  - Person has burning or painful sensation when urinating.
  - Person urinating frequently or not often.
  - Person has trouble controlling when they have to urinate.
  - Person has trouble starting urinating.
  - Confusion as this could be an indicator of a UTI.

- Reproductive System
  - What does it do?
    - Includes the organs necessary for reproduction.
  - Changes in the reproductive system as we age:
    - Decrease in female hormone levels.
    - Vaginal tissues become thinner and drier.
    - Male hormones decrease but more slowly than female hormones.
    - Erectile dysfunction may be more common as men age.
  - Potential Staff Therapeutic Interventions
    - Respect the privacy of older adults related to sexuality.
  - Direct Care Staff should report any of the following observations and document according to facility protocol:
    - Vaginal changes such as discharge.
    - Penile discharge.
    - Sores.
    - Changes in breasts and other reproductive areas that include lumps and hard areas.
    - Odor.
- Endocrine system
  - What does it do?
    - Helps control what the body does.
    - Makes hormones and releases them into the blood. Hormones are chemical messengers that travel throughout the body.
    - Glands are groups of cells that produce and secrete hormones. The major glands that make up the human endocrine system are the hypothalamus, pituitary, thyroid, parathyroid, adrenals, pineal body, and the

reproductive glands, which include the ovaries and testes. The pancreas is also part of the endocrine system, even though it is also associated with the digestive system because it also produces and secretes digestive enzymes.

- The hypothalamus is in the lower central part of the brain and is the main link between the endocrine and nervous systems.
- The pituitary gland is right below the hypothalamus in the brain and is called the “master gland” because it makes hormones that control other glands.
- The thyroid is in the front part of the lower neck and makes hormones called thyroxine and triiodothyronine, which control the rate at which cells burn fuels from food to produce energy.
- Parathyroids are attached to the thyroid and control the levels of calcium in the blood.
- There are two adrenal glands, which are on top of each kidney. One part of the adrenal glands produces hormones called corticosteroids that control salt and water balance in the body, the body's response to stress, metabolism, the immune system, and sexual development and function. Another part of the adrenal glands secrete adrenaline, which increases blood pressure and heart rate when a body is under stress.
- The pineal gland secretes melatonin, which regulates the sleep-wake cycle.

- The reproductive glands secrete sex hormones such as testosterone, estrogen, and progesterone.
  - The pancreas produces insulin and glucagon. They work together to maintain a steady level of glucose, or sugar, in the blood and to keep the body supplied with fuel to produce and maintain stores of energy.
- Changes in the endocrine system as we age:
    - The amount of hormones produced may change and the body may become less sensitive to the effect of hormones.
    - Insulin is a hormone secreted by the pancreas. As we get older, we may become more resistant to insulin, which keeps the body from turning glucose into energy. This may turn into diabetes.
    - Decreased muscle mass.
  - How do older adults experience these changes?
    - May feel very tired.
    - May gain (or lose?) weight.
    - Takes them longer to heal.
    - May hold onto fluid.
  - Potential Staff Therapeutic Interventions
    - Encourage proper nutrition.
    - Encourage fluid intake.
  - Direct Care Staff should report any of the following observations and document according to facility protocol:
    - Light-headedness.
    - Weight changes.
    - Signs of fluid retention.

- Sensory System
  - What does it do?
    - The sensory system is actually a part of the nervous system. It gives information to the body about what is happening inside and outside of the body.
  - There are five senses:
    - Vision
    - Hearing
    - Smell
    - Taste
    - Touch
- Vision and Hearing are most affected by aging, although there are changes in all five senses. Although vision and hearing are discussed below, a more thorough explanation, including discussions regarding disease states and more specific changes will be thoroughly discussed in Chapter Five: Residents with Disabilities and Special Conditions.
- Vision
  - Changes associated with vision as we age:
    - About 95% of older adults report that they need glasses.
    - There is a decrease in the ability to make tears.
    - A part of the eye called the cornea flattens, letting less light into the eye.
    - There are changes in the lens of the eye.
      - It becomes stiffer, making it harder to focus on things that are close.
      - It becomes less transparent and denser, causes changes in the way we see certain colors and makes it harder to see in dim light.

- Changes in the retina cause problems in seeing contrast and general depth perception.
  - The pupil does not react as well to light.
- How do older adults experience these changes?
  - May have trouble differentiating cool colors such as blues and greens. This may result in the inability to see stains on clothing.
  - Have trouble seeing in dim light.
  - May be more sensitive to light and glare.
  - May have trouble seeing certain colors.
  - May not see the contrasts between certain colors, like gray with a blue background.
  - Problems with depth perception may cause them to misjudge where items are. They may “misstep” in areas they cannot see well, especially stairs or inclines/declines.
  - Eyes may feel dry.
- Potential Staff Therapeutic Interventions
  - In rooms with a lot of windows, be aware of the light and glare and if it is bothersome to residents.
  - With printed materials, use high contrast amongst colors like a light yellow and black, large type font, etc. and large-print books.
  - Help them have their glasses clean and available.
  - Make sure their path is not obstructed and is free of clutter.
  - Keep the environment well lit, particularly at night.
  - Keep eye glasses and magnifiers clean. Encourage the resident to wear eye glasses and use magnifiers and to

see his or her optometrist annually and more often if needed.

- Establish a coding system for arranging clothing by color, season, and use.
  - Provide “talking books” and other audio material
  - Use contrasting colors to assist in recognition of objects and foods.
  - Tell residents when steps are in their way, identify changes in the level of surfaces [i.e. Moving from carpet to polished floor or gravel areas].
  - Talk in a normal conversational manner.
  - Use normal language to describe situations and the environment.
  - Use descriptive words to describe specific items and use comparative terms [“bright red about the size of a quarter”].
  - Do not move furniture or objects in the resident's room.
- Hearing
    - Changes in hearing are related to lifetime noise exposure as well as aging.
    - Hearing loss may contribute to people being socially isolated because they cannot participate in conversation.
    - Changes associated with hearing as we age:
      - Parts of the middle ear become less flexible, causing less sensitivity to sounds.
      - Changes in the middle ear also cause problems with balance.

- Changes in the ear make it harder to hear high pitched sounds.
  - Ear wax may accumulate more affecting hearing.
- How do older adults experience these changes?
  - Consonants become harder to hear and understand. They may think people are mumbling.
  - More trouble hearing conversations in places where there is a lot of background noise.
- Potential Staff Therapeutic Interventions
  - Speak slowly and clearly. Rather than yelling, announce words, especially the consonants. If you have a high-pitched voice, try talking at a lower pitch.
  - Face the person directly when speaking. Say the resident's name or otherwise get the resident's attention before speaking.
  - Get close to the person when you are talking to them.
  - Remind them to wear their hearing aid, if they have one.
  - Limit noise distractions when talking to them.
  - Be patient with the resident.
  - Be emotionally supportive of the resident.
  - Do not seat the resident in the back during activities. Make sure resident is close to the individual conducting the activity.
  - Check the resident's hearing aid batteries to make sure they are working.
  - Keep the hearing aids clean (i.e. make sure there is no wax in the hearing aid).
  - Avoid shouting, chewing gum, or covering mouth when speaking.

- Use paper and pencil for communication if necessary.
- Establish consistent gestures for certain tasks.
- Use a communication board.
- NEVER use q-tips to clean a resident's inner ear!!!



## Instructor Demonstration

- Instructor Demonstration – Proper Body Positioning

### Instructor Notes:

*The purpose of this demonstration is to show the students the proper positioning when communicating with a resident.*

*Demonstration procedures:*

1. *Set two chairs facing each other.*
2. *Ask one of the students to sit in one of the chairs and the instructor should sit in the other chair facing the student.*
3. *Demonstrate to the student how to face the person, make eye contact, and speak clearly.*
4. *Next, the instructor should turn his or her head away from the student and face the floor. Speak to the student in a muffled tone.*

*Discussion:*

*Ask the students if they noticed the difference in body positioning and sound of your voice, including sound quality. Discuss the feedback received from the students and again stress the importance of proper body positioning and clear communication.*

- Smell
  - The number of smell receptors decrease, making it harder to smell.
  - Smells need to be more intense to be identified.

- By age 80 a person's sense of smell is reduced by half.
- Lack of smell can cause a number of challenges:
  - May be less interested in eating.
  - May not be able to detect spoiled food.
  - May not be able to smell signs of danger like burning, smoking, or gas leaks.
  - May not smell body odor and may not see the need to clean or bathe.
- Taste
  - Taste buds decrease with age. This affects the taste for sweet and salt more than sour and bitter. Because they cannot taste sweet or salt very well, they may want foods that are sweeter and saltier.
  - Food may taste bland because of changes in taste.
  - Mouths may become drier as saliva production decreases. This may affect taste. This may be compounded by reduced fluid intake.
  - General dental and denture problems may make it harder to eat or less pleasurable. This may be compounded by reduced saliva.

**Instructor Note: Remind the students of previous discussions regarding the law of small effects and that these issues will not arise in every older adult. These issues are impacted by lifestyle choices, access to health care, etc.**

- Touch
  - The number of nerve endings in the skin decreases. Older adults become less sensitive to temperature, pain, and pressure. This can be dangerous because people may not feel pain as much or may not sense that things are hot.

- Emotional or Psychological Changes with Aging
  - In general, an individual's personality remains stable as they age. In other words, if you are generally an optimistic, happy-go-lucky person when you are young, you will likely continue to be that as you get older.
    - An exception might be people with dementia.
    - The risk for depression does increase with aging.
  - Aging can be fearful for people, as they think about time they have left in their lives. A great fear of aging is the loss of health, function, and independence.
    - If a person experiences bad health, loss of function or independence with aging, she or he may need to find ways of coping with his or her losses. These things may also create depression and anxiety.
  - As we get older, we may experience many losses, especially the death of spouses, family members and friends. The loss of loved ones causes grief, and may also cause depression and anxiety. Grieving older adults may isolate themselves more from others.
  - As people age they may think more about how their life went and may think about regrets they had. They may work hard to overcome these disappointments and come to peace with them. This process is called "life review".
  - Older adults may not have a positive outlook about living in assisted living or nursing homes. They may see it as another loss of independence. Some may even see it as a step closer to death. It is important to give older adults time to adjust to life in assisted living and recognize that this may take awhile. Some

people adjust easier than others. You can help them adjust by being supportive and getting to know them.

- It is also important to consider the psychological impact of the physical changes we described earlier. These changes may cause depression and anxiety, or perceived changes in personality. For example, an older adult who can no longer walk without help may be very frustrated and take this out on people trying to help him or her. Coping with the changes related to aging is an adjustment process and every person handles it differently. For example, a loss of mobility may be upsetting to one person, while vision loss may be frustrating to another. This will depend on lifestyle, hobbies and preferences. It is important to think about your own lifestyle and what physical abilities have the greatest meaning to you.
- Cognitive Changes with Aging
  - Many people fear changes in their minds as they age. The fear of dementia is probably greater than the fear of death. In the chapter on Alzheimer's and dementia we will go into this in more detail. However, it is important to know that dementia is NOT a normal part of aging.
  - What are some other changes in aging related to mental processes?
    - Changes in learning: We continue to be able to learn as we age, although we may learn in different ways. It may take longer to learn new things. In general, older adults have greatest ability to learn things they want to learn or are motivated to learn.
    - Reaction time/processing: Our reaction and processing time slows down with age, meaning it takes longer to

respond to situations and questions. Complex tasks may cause people to slow down. However, older people make fewer mistakes than younger people in their responses, and have a greater store of knowledge to rely on in decision making.

- Social changes with aging
  - Like with many of these changes, they are very individual. While one person may enjoy being surrounded by many people, another person may prefer being with someone one-on-one. Some people need more alone time than others. However, having meaningful social connections is very important as we age. It is important to understand that social connections are also different among each individual. It is the meaning of the social connection that is important.
  - Older people may find that their social networks become smaller as they age. Assisted living might be a great opportunity for older adults to make new friends and socialize with others.
  - There are many reasons why an older adult may not be interested in socializing. She or he could always have preferred to be alone or with smaller groups of people. Or, social isolation could be due to illness, pain, depression, anxiety, hearing impairments, visual impairments, or dementia. Encouraging older adults to have social contact is an important part of their care. This too should be part of the resident ISP.
- You have a role in supporting Optimal Aging!
  - We have focused in this section on diseases and declines that may be related to aging. It is important to remember that older adults experience positives along with the negatives.

Most people do not experience all of these negative changes. However it is important for you to be familiar with them all. For many people, aging is a time of great meaning. Many people find great pleasure in thinking about their accomplishments and life experiences. It is also a time when people may realize what is important in life. For many people, aging provides new growth and understanding of who they are as individuals. And there are still opportunities as an older adult to carry out unfulfilled dreams. Professional and family caregivers, as well as members of the community-at-large, all have a role in providing opportunities for meaningful aging to residents.

### 3.4 The Experience of Aging

In working with older adults, it is helpful to see things from the perspective of older adults. The changes that we have talked about in this chapter present challenges for older adults in their daily lives. Being sensitive to these challenges helps you understand how older adults are experiencing their lives.



#### Student Activity

- Group Exercise: Aging Sensitivity - What is it like to be an “older adult”?

#### Instructor Notes:

*The purpose of this activity is to provide an experiential learning exercise to help students understand what the day-to-day routine may be for an older adult or adult with disability.*

*Activity procedures:*

1. *Group the students into pairs*

2. *Each pair will participate in each of the three activities. Each activity should take no more than 15 minutes.*
3. *When everyone is finished, bring the group together and start a discussion on their experiences.*

*Materials needed:*

- *Sunglasses, with lens smeared with Vaseline*
- *2 pairs yard gloves (thick, heavy kind)*
- *3 pairs ear plugs or cotton balls*
- *Sugar packets and cups*
- *Toothpaste*
- *Newspaper*

*The amount of materials depends on the class size. These materials are for three pairs of students.*

*Activity 1: Have Student #1 put on sunglasses and ear plugs. Have Student #2 hand Student #1 the newspaper. Have Student #2 ask him or her to read the article on page 3. Have students switch roles.*

*Activity 2: Have Student #1 put on the yard gloves and ear plugs. Student #2 will give him or her a sugar packet and ask him or her to open it and put it in the cup. Have students switch roles.*

*Activity 3: Have Student #1 put on the yard gloves and ear plugs. Student #2 will give him or her a tube of toothpaste and ask him or her to open it. Have students switch roles.*

**Discussion:**

**The sunglasses simulate vision problems such as cataracts. The ear plugs simulate hearing impairments. The gloves simulate changes in touch and dexterity.**

1. *What did it feel like to be the older adult with a hearing, visual, or dexterity impairment? If your partner tried to help you, how did it feel?*

2. What did it feel like to watch the person with an impairment try to accomplish his or her task? Did you try to help him or her? How could you have helped them?

**Note: The simplest thing in these situations is to do the task for older adult.**

**But..... think about ways in which you could help the person without doing it for them. For example, if an older adult is having trouble opening sugar packets, instead of opening the sugar packets for them all the time, what about finding another way to dispense sugar that she could more easily use, like a sugar container on the table?**

### **3.5 Staff Responsibilities**

- Direct care staff of the ALF are expected to:
  - Be knowledgeable of the age-related changes that occur and the potential psychological and emotional consequences of those changes.
  - Be knowledgeable of resident strengths, limitations, and risk factors for potential negative outcomes as they pertain to age-related changes and contributing factors related to current conditions.
  - Implement potential staff therapeutic interventions to assist the resident in maintaining as much independence as possible.
  - Report all changes (improvement and decline) across all aspects of care so that any changes in a resident can be properly monitored and a new ISP can be developed as necessary.

## **Standards for Licensed Assisted Living Facilities**

**Effective July 17, 2013\***

None in this chapter

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

Paraprofessional Healthcare Institute. (). Providing Personal Care Services to Elders and People with Disabilities. Retrieved from <http://phinational.org/training/resources/entry-level-training-material/>.

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[http://www.ageworks.com/course\\_demo/513/module3/module3.htm](http://www.ageworks.com/course_demo/513/module3/module3.htm)

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[http://www.healthinaging.org/agingintheknow/chapters\\_ch\\_trial.asp?ch=3](http://www.healthinaging.org/agingintheknow/chapters_ch_trial.asp?ch=3)

<http://ambassadorscare.com/Family-Resources/Articles/The-Importance-of-Quality-Sleep-for-Seniors.aspx>



## Student Review - Chapter Three

1. Name three myths of aging and why they are myths.

*The following are myths, as identified in the Bingo exercise:*

- Losing one's memory is expected as you age
- **FALSE/MYTH: Losing one's memory is NOT expected as you age. Memory loss is not a predictable consequence of aging, and is generally the result of a medical issue.**
- Urinary incontinence is a natural part of aging.
- **FALSE/MYTH: Urinary incontinence is NOT a natural part of aging. It is a sign that there is an underlying problem. Urinary incontinence (leaking urine) affects only 10% of older adults, mostly women.**
- Most older adults live in nursing homes.
- **FALSE/MYTH: In fact, only about 5% of the population over the age of 65 lives in long-term care facilities. Close to 80% of today's older adults live in their own home, either alone or with their spouse.**
- Older adults are unable to learn anything new.
- **FALSE/MYTH: Older men and women can and do learn new things. What it takes to learn (amount of time, level of concentration) changes with age, and older people must learn to work at their own pace, practice new skills, and avoid competitive situations that favor youthful quickness. Older adults are quite skilled at integrating knowledge and skills acquired over the lifetime.**
- Older adults should have decisions made for them because they are incapable of making them alone.
- **FALSE/MYTH: The ability to learn and apply knowledge does not diminish because of age. Older adults with dementia may lose the ability to make certain decisions and this is determined by a doctor. When we make decisions for an older person this is called paternalism, which means we are treating them like children.**

- The average older adult is either uninterested in or physically unable to participate in sexual activity.
- **FALSE/MYTH: Sexual interest and attitudes are a continuation of lifelong patterns and do not change significantly just because of age. A decrease in sexual activity is frequently due to medication or the loss of a partner. Intimacy is a need of all human beings.**
- Most older adults will develop dementia.
- **FALSE/MYTH: Dementia is not a part of the normal aging process. However, the risk of getting dementia increases as a person gets older. Dementia affects 5-8% of people age 65-74, up to 20% of those 75-84 and up to 50% of those 85 and over.**
- Most older adults have incomes below the poverty level.
- **FALSE/MYTH: Less than 12% of those over the age of 65 live in poverty. However, some older people are more likely to be below the poverty level: women, people over the age of 75, black older adults, and older adults living alone.**
- In general, all older adults are alike.
- **Older people are just as diverse in their individuality as younger people. In fact, we become more different from each other as we age. This is because the older we get, the more diverse life experiences we have, which sets us apart from each other.**
- Most older adults lose all their teeth.
- **FALSE/MYTH: Older adults of today are much more likely to have their own teeth than older adults of years ago. This is because of improved dental care. This makes good oral healthcare very important in late life.**
- Older adults become grouchy as they age.
- **FALSE/MYTH: Being older does not necessarily make a person more grouchy. Chances are, a grouchy older person was a grouchy younger person. A person's grouchiness might be misinterpreted if they are sick, in pain, or depressed.**

- To be old is to be sick.
- **FALSE/MYTH: Illness and disability are not synonymous with aging. In fact, the majority of older people report they have good health. Although older people may be more likely to experience certain health conditions, not all older people are sick. And most of the people who have health conditions are fairly functional.**

2. What is ageism?

**Ageism means discriminating against people because of their age. It is a prejudice against older people.**

3. What is optimal aging?

**Optimal aging is: "The capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual – to one's satisfaction and in spite of one's medical conditions."**

**Optimal aging is individualized. Everyone ages differently and finds meaning in different things.**

4. For each of these systems, name one change related to aging and how this change might affect an older adult:

*a. Circulatory*

- **Changes in the circulatory system as we age:**
  - In general, the flow of blood changes.
  - The heart gets weaker so it doesn't work as well.
  - The tubes that carry blood to and from the heart get harder and narrower, which slows down the flow of blood.
- **How do older adults experience these changes?**
  - Feeling weak.
  - Heartbeat may be faster, slower, or uneven.
  - High or low blood pressure.
  - Feeling more cold, especially in the hands and feet.
  - Heartbeat may be faster when one gets upset.
  - Shortness of breath after doing things.

*b. Digestive*

- **Changes in the digestive system as we age:**
  - **Stomach cannot hold as much food.**
  - **Fewer taste buds.**
  - **Feel less thirsty.**
  - **Less saliva.**
  - **Food stays in the stomach longer.**
  - **Muscles of the large bowel do not work as well.**
  - **Less urge to empty bowel.**
  - **Liver less able to remove drugs and other substances.**
  - **Muscles involved in swallowing weaken.**
- **How do older adults experience these changes?**
  - **Eating less.**
  - **Difficulty swallowing.**
  - **Dry mouth.**
  - **Gas, bloating, or stomach pain.**
  - **Hard bowel movements.**
  - **The effects of drugs and other substances may last longer.**

*c. Nervous*

- **Changes in the nervous system as we age:**
  - **Nerve cells die.**
  - **The senses do not work as well.**
- **How do older adults experience these changes?**
  - **Difficulty coping with change.**
  - **Trouble falling asleep.**
  - **Trouble getting used to changes in light.**
  - **Trouble getting up and down stairs.**
  - **Trouble with their balance.**

- **Trouble with their senses- seeing, hearing, smelling, tasting, and feeling things.**

*d. Respiratory*

- **Changes in the respiratory system as we age:**
  - **Older adults do not take in oxygen or breathe out carbon dioxide as well.**
  - **Their breathing tubes may get more easily clogged with mucous.**
- **How do older people experience these changes?**
  - **Trouble breathing when moving around.**
  - **May cough more and may cough up mucous.**

*e. Skeletomuscular*

- **Changes in the skeletomuscular system as we age:**
  - **The spine may change- it may become shorter or more curved. The head may also bend forward.**
  - **Bones get weaker because of losses in calcium.**
  - **Muscles get weaker and stretch less.**
  - **Joints are stiffer, especially after sleep or rest.**
- **How do older people experience these changes?**
  - **May break bones more easily.**
  - **May have more pain in their muscles and joints.**
  - **Get tired more easily.**
  - **May have less hand strength.**
  - **Need more time to do things.**

*f. Endocrine*

- **Changes in the endocrine system as we age**
  - **The amount of hormones produced may change and the body may become less sensitive to the effect of hormones.**

- Insulin is a hormone secreted by the pancreas. As we get older, we may become more resistant to insulin, which keeps the body from turning glucose into energy. This may turn into diabetes.
- Decreased muscle mass.
- How do older adults experience these changes?
  - May feel very tired.
  - May gain (or lose?) weight.
  - Takes them longer to heal.
  - May hold onto fluid.

*g. Urinary*

- Changes in the urinary system as we age:
  - Bladder muscles weaker and stretched.
  - Bladder able to hold less urine.
  - Man's prostate gland gets bigger.
- How do older adults experience these changes?
  - Difficulty controlling their bladder and may have accidents.
  - May have to urinate more frequently.
  - Note that incontinence is not a normal part of aging.

*h. Integumentary*

- Changes in the skin, hair, and nails as we age:
  - Fat under the skin moves around so that there is less fat in some places and more in others. The layer of fat under the skin also thins.
  - Glands produce less oil.
  - Sweat glands produce less sweat.
  - Skin loses elasticity and strength.
  - The outer layer of skin thins.
  - Veins become more visible through skin.
  - Skin may appear thinner and paler because of less pigment.

- **Blood vessels in the skin layers become more fragile, making it easier to bruise.**
- **Fingernails get ridges and may break more easily. Toenails get thicker and harder.**
- **Age spots or other discoloration appear.**
- **Hair turns gray and becomes coarser.**
- **How do older adults experience these changes?**
  - **Wrinkles.**
  - **Break fingernails more often.**
  - **Skin may be dry.**
  - **Easily get cuts, sores, and bruises.**
  - **Skin takes longer to heal.**
  - **Skin may be more sensitive to sensations such as fabric type, water pressure, temperature, etc.**

5. What losses might an older adult experience that would affect his or her emotional health?

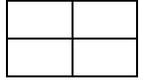
**A great fear of aging is the loss of health, function, and independence. As we get older we might experience many losses including the death of spouses, family members, and friends. These things may also create depression and anxiety. The older adult may need to find ways of coping with his or her losses. Physical and cognitive decline that results in loss of independence, including loss of a home also affect emotional health.**



**Aging Bingo: Fact or Myth?**

Look through these items and see which are true. If you think a square is true put an "x" through it.

To get bingo, you need to make a 2X2 square of items that are true about aging. Example:



<p><b>Losing one's memory is expected as you age.</b></p> <p>FALSE/MYTH: Losing one's memory is NOT expected as you age. Memory loss is not a predictable consequence of aging, and is generally the result of a medical issue.</p>	<p><b>Urinary incontinence is a natural part of aging.</b></p> <p>FALSE/MYTH: Urinary incontinence is NOT a natural part of aging. It is a sign that there is an underlying problem. Urinary incontinence (leaking urine) affects only 10% of older adults, mostly women.</p>	<p><b>Most older adults live in nursing homes.</b></p> <p>FALSE/MYTH: In fact, only about 5% of the population over the age of 65 lives in long-term care facilities. Close to 80% of today's older adults live in their own home, either alone or with their spouse.</p>	<p><b>Older adults are unable to learn anything new.</b></p> <p>FALSE/MYTH: Older men and women can and do learn new things. What it takes to learn (amount of time, level of concentration) changes with age, and older people must learn to work at their own pace, practice new skills, and avoid competitive situations that favor youthful quickness.</p>
<p><b>Older adults should have decisions made for them because they are incapable of making them alone.</b></p> <p>FALSE/MYTH: The ability to learn and apply knowledge does not diminish because of age. Older adults with dementia may lose the ability to make certain decisions and this is determined by a doctor. When we make (over) decisions for an older person this is called</p>	<p><b>The average older adult is either uninterested in or physically unable to participate in sexual activity.</b></p> <p>FALSE/MYTH: Sexual interest and attitudes are a continuation of life long patterns and do not change significantly just because of age. A decrease in sexual activity is frequently due to medication or the loss of a partner. Intimacy is a (over) need of all human beings.</p>	<p><b>Older adults sleep less.</b></p> <p>TRUE: Although older adults still need about 7-9 hours of sleep a night, they tend to sleep less deeply, take longer getting to sleep, and wake up more often throughout the night.</p>	<p><b>Older adults have changes in vision.</b></p> <p>TRUE: Aging brings changes that may weaken the eyes. This does not mean that all older people see poorly- they just have more eye problems than younger people.</p>

<p>paternalism, which means we are treating them like children.</p>			
<p><b>Most older adults will develop dementia.</b></p> <p>FALSE/MYTH: Dementia is not a part of the normal aging process. However, the risk of getting dementia increases as a person gets older. Dementia affects 5-8% of people age 65-74, up to 20% of those 75-84 and up to 50% of those 85 and over.</p>	<p><b>Most older adults have incomes below the poverty level.</b></p> <p>FALSE/MYTH: Less than 12% of those over the age of 65 live in poverty. However, some older people are more likely to be below the poverty level: women, people over the age of 75, black older adults, and older adults living alone.</p>	<p><b>Older adults lose muscle mass as they age.</b></p> <p>TRUE: Muscle mass declines with age. This generally starts in middle age but is more dramatic starting in the 60's.</p>	<p><b>The bones of older adults become more brittle with age.</b></p> <p>TRUE: Bone mass or density is lost as people age. The bones lose calcium and other minerals and they become more brittle. They may break more easily.</p>
<p><b>In general, all older adults are alike.</b></p> <p>FALSE/MYTH: Older people are just as diverse in their individuality as younger people. In fact, we become more different from each other as we age. This is because the older we get, the more diverse life experiences we have, which sets us apart from each other.</p>	<p><b>Most older adults lose all their teeth.</b></p> <p>FALSE/MYTH: Older adults of today are much more likely to have their own teeth than older adults of years ago. This is because of improved dental care.</p>	<p><b>Older adults become grouchy as they age.</b></p> <p>FALSE/MYTH: Being older does not necessarily make a person more grouchy. Chances are, a grouchy older person was a grouchy younger person. A person's grouchiness might be misinterpreted if they are sick, in pain, or depressed.</p>	<p><b>To be old is to be sick.</b></p> <p>FALSE/MYTH: Illness and disability are not synonymous with aging. In fact, the majority of older people report they have good health. Although older people may be more likely to experience certain health conditions, not all older people are sick. And most of the people who have health conditions are fairly functional.</p>

Source: NC Division of Health Services regulation, Geriatric Aide Curriculum

**Chapter Three - Ageist Terms**

- Ancient**
- Biddy**
- Codger**
- Coot**
- Crone**
- Crotchety old man**
- Dirty old man**
- Old Foggy**
- Fossil**
- Geezer**
- Gone senile**
- Hag**
- Little old lady**
- Sorry old man**
- Old fart**
- Old goat**
- One foot in the grave**
- Over the hill**
- Sweet old lady**

### **Chapter Three - Examples of Elderspeak and Alternative Ways of Communicating**

- Diminutives (inappropriately intimate terms of endearment, imply parent-child relationship)
  - Examples: honey, sweetie, dearie, grandma
  - Alternative strategy: refer to residents by their full name (i.e., Mrs. Robinson) or by their preferred name
- Inappropriate plural pronouns (substituting a collective pronoun, e.g., we, when referring to an independent older adult)
  - Example: "Are we ready for our medicine?"
  - Alternative strategy: "Are you ready for your medicine?"
- Tag questions (prompts the answer to the question and implies the older adult can't act alone)
  - Example: "You would rather wear the blue socks, wouldn't you?"
  - Alternative strategy: "Would you like to wear the blue socks?"
- Shortened sentences, slow speech rate, and simple vocabulary (sounds like baby talk)

These communication patterns do not improve comprehension of speech for most older adults and are perceived as patronizing or demeaning.

**\*\*Terms of endearment may be acceptable if you have a relationship with the older adult AND she or he is comfortable with you using that term of endearment.\*\***

From Williams, K., Kemper, S., & Hummert, M.L. (2004). Enhancing communication with older adults: Overcoming elderspeak. *Journal of Gerontological Nursing*, 30(10): 1-9.

### Chapter Three – Good Sleep Hygiene

The following items are recommendations for good sleep hygiene for older adults.

<b>General Sleep Recommendations</b>	<b>Reason</b>
Maintain a routine sleep schedule	Go to bed and get out of bed at the same time each day to maintain routine
Engage in activities	Social activities including active involvement with family/friends and even work keeps a higher activity level for the individual's body and helps to prepare the body for sleep
Napping	Napping close to bedtime may interfere with a good night sleep but short naps (15-30 minutes) earlier in the day may improve overall restfulness and assist in a more restful night sleep
Sunlight	Sunlight increases melatonin levels which assist in regulating the sleep-wake cycles. Two hours of sunlight a day is recommended.
Reduce snoring	Wear ear plugs if needed to block out snoring noises so sleep is not interrupted throughout the night
Make bedtime earlier	Matching the bedtime to when the body is saying it needs sleep
Quit smoking	Nicotine is a stimulant and will keep the body awake. If quitting is not an option, try not to smoke within three hours of going to bed.
Combine sex and sleep	Sex and physical intimacy (i.e. hugging and massage) can assist in a more relaxed sleep
Reduce caffeine	Avoid consuming food or beverages that contain caffeine such as coffee, tea, soft drinks and chocolate late in the day
Reduce alcohol intake	Alcohol makes individuals sleepy but actually disrupts sleep
Don't go to bed hungry	Eat a light snack such as crackers or cereal. Avoid large or spicy meals that may cause indigestion. Eat a smaller dinner at least three hours before bedtime.
Reduce fluid intake	Minimizing beverages within an hour and a half before bedtime reduces the need to use the restroom during the middle of the night
Minimize mental stress	Journal, complete items on the to-do list, listen to music, read a book, etc to reduce mental stress and aid in a more restful sleep



# **Resident Rights**

## **Chapter Four**

**Time Required: 2 hours**

## **Chapter Four – Resident Rights**

Every individual who lives in an assisted living facility has rights that are protected by law. These rights help to ensure that a person has a good quality of life and care in his or her assisted living facility, as well as protect that person from abuse, neglect, and exploitation. Resident rights ensure that residents can exercise self-determination over their lives. This chapter will provide an overview of residents' rights in assisted living, as well as elder abuse, neglect, and exploitation.

### **4.1 Resident Rights**

### **4.2 Mandated Reporting**

### **4.3 Abuse, Neglect and Exploitation**

### **4.4 Staff Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. Understand the Rights and Responsibilities of Residents of Assisted Living Facilities and how residents are made aware of these rights;
- b. Identify what to do if a resident thinks that his or her rights have been violated;
- c. Describe elder abuse, neglect, and exploitation;
- d. Understand mandated reporting and the role of all ALF staff in serving as mandated reporters; and
- e. Be aware of what steps need to be taken if it is determined that Rights and Responsibilities have been violated.

### **2. Recommended Method of Instruction**

- Lecture and class discussion – **Handouts #3, #4, #5, and #6**
- Student Activity - small group discussion (**Handout #1 and Handout #2**)
- Student Review – Chapter Four

### **3. Supplementary Materials if available**

- Facility Policy/Policies on Resident Rights
- Facility Policy on Reporting Resident Rights Violations
- Facility Policy on Mandated Reporting (if available)

## 4.1 Resident Rights

Every person who lives in an assisted living facility has rights which are protected by law. These rights were developed to protect assisted living residents from abuse, neglect, and exploitation. Resident rights are the rights, given by law, by which every resident of an assisted living facility is protected. These rights refer to treatment and care, privacy and confidentiality, personal choice, safety, and § disclosure of information related to services and fees charged for accommodations, services, and care. These rights are referred to as § Rights and Responsibilities of Residents of Assisted Living Facilities.



### Student Activity

- Group Discussion – Rights and Responsibilities of Residents of Assisted Living Facilities (**Handout #1**)

#### Instructor Notes:

*The purpose of this activity is to ensure that each student has knowledge and good understanding of the meaning of each of the Rights and Responsibilities of Residents of Assisted Living Facilities.*

#### Activity Procedures:

1. Each student should turn to **Handout #1** in the Student Manual.
2. Read aloud each Resident Right with the students.
3. After reading each Resident Right, ask the students to explain what he or she thinks that Right means.
4. Supplement the students' responses with the information they left out so they have a clear understanding of each Resident Right.

**NOTE: We are going to go over these rights with real life examples in a few minutes. First, it is important to understand how residents know about their rights.**

- How does a resident in your assisted living facility find out about these rights?
  - Discuss facility policies of how resident rights information is shared with residents, if available.
  - § They are given to residents upon admission (resident's sign that they receive them). If there are family members involved they may also be given information on resident rights.
  - § They must also be posted in a conspicuous place in the assisted living facility.
  - § They are reviewed with residents on an annual basis. If the facility thinks the resident is no longer capable of understanding their rights during the annual review, the facility shall get documentation stating this from the doctor.
  - Although resident rights may not be understood by some residents, particularly those with dementia, **all resident rights still apply to them. All residents have these rights.**
  - § If a resident is deemed by a physician to not be able to understand his or her rights, the assisted living facility must require a "responsible party" to be made aware of these rights and decisions that may affect these rights. This is usually determined by the physician before the resident moves in, but may happen once the resident has been living there for awhile. The Responsible Party must sign annually that he or she received a copy of the Rights.



## Student Activity

- Group Exercise – Examples of Resident Rights

### Instructor Note:

The purpose of this activity is to teach students how to recognize violations in Resident Rights.

Activity procedures:

1. The students should turn to **Handout #2** in student manual.
  2. Divide the class into four (4) small groups (adjust as needed as determined by class size).
  3. Assign each group a different group of scenarios (ex. Group 1 should use the Handout #2, Group 1 scenarios, Group 2 should use Group 2 scenarios, etc.).
  4. Instruct the students as follows:
    - a. Each group should read the scenarios together.
    - b. Discuss which Resident Rights are being violated for each scenario and write that in the column titled "Right(s) being violated.
    - c. Allow approximately 15 minutes to complete the exercise.
    - d. Have a representative from each group read the scenario and describe the Resident Rights violated. Solicit additional violations from the rest of the class.
- What if a resident thinks his or her rights have been violated?
    - § Assisted living communities must provide residents with information about what they can do if they believe their rights are being violated. There are a number of different organizations a resident could contact. They are:
      - Virginia Department of Social Services

- Virginia Department of Social Services licenses and regulates assisted living facilities.
- Adult Protective Services
  - Adult Protective Services (APS) is a division of the Virginia Department for Aging and Rehabilitative Services that investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age.
- The Virginia Long-Term Care Ombudsman
  - The Ombudsman serves as an advocate for older adults receiving long-term care. They receive complaints regarding care issues in long-term care and assist residents in exercising their rights.



#### Group Question

**Instructor Notes: Discuss with the group what they think their responsibility is if they think a resident's rights have been violated. Review the facility policy if it is available.**

**NOTE: It is encouraged that a staff person report suspected resident rights violations to a supervisor immediately. If abuse, neglect, or exploitation is suspected, the staff person has the obligation to report this to the appropriate agency.**



#### Review Handout #3

## 4.2 Mandated reporting: If you suspect abuse, neglect, or exploitation

- What is a Mandated Reporter?
  - As a direct care worker in assisted living, you are considered by Virginia law to be a “Mandated Reporter.” § Mandated reporters are required to report suspected abuse, neglect, or exploitation of elders or incapacitated adults.
- How do you report potential abuse, neglect, or exploitation?
  - Suspected abuse, neglect, or exploitation is reported to Adult Protective Services (APS).
- Keep in mind that these individuals could be anyone, including family members or friends of the resident, professionals involved in the care of the resident, or even strangers (for example, businesses that take advantage of the resident financially).
  - Examples:
    - An adult child visits her mom living at the assisted living facility. When her mom “misbehaves”, she spansks her.
    - A business calls a resident and asks for money in exchange for a service or product. The resident never receives the service or product.
    - The facility maintenance person sees that a resident has fallen off her chair in her room but doesn't tell anyone because it is “not his job.”
- If your facility has a specific procedure regarding reporting situations to APS, please discuss it now.
- You are encouraged to talk to your Administrator about the situation. **However**, your employer cannot prohibit you from reporting a situation to APS. Also, if your supervisor was involved in the suspected

abuse, neglect, or exploitation report the situation to another supervisor or person of authority. Or, call APS directly.

- It is important to stress that informing a supervisor of alleged abuse, neglect, or exploitation does not release the direct care staff member from the responsibility of notifying APS. The direct care staff needs to ensure that the notification has been made or make notification him or herself.
- Documentation of the conversation with a supervisor should be made in the resident's record as well as any conversations with APS.



#### Review Handout #4

- Mandated reporters are expected to:
  - Immediately report potential abuse, neglect, or exploitation when they become aware of the situation
  - Provide information about the individual(s) involved as well as any information you have regarding the potential abuse, neglect, or exploitation.
  - Make available to APS investigators information that documents the abuse (even things normally considered confidential). This would include nurses notes, financial records, resident's personal identification information, etc.



#### Review Handout #5

- What are the rights of the mandated reporter?
  - According to the law "A person who makes a report is immune from civil and criminal liability unless the reporter acted in bad faith or with a malicious purpose." This means that there are

certain protections for people who have witnessed potential abuse and report it. This protection is not intended for people who were involved in the abuse situation, or who reported it in bad faith. An example of a bad faith report would be an employee of an assisted living facility reporting another employee for abuse, neglect, or exploitation because he or she did not like the employee, not because any actual abuse, neglect, or exploitation had actually occurred.

- A person who reports has a right to have his/her identity kept confidential unless consent to reveal his/her identity is given or unless the court orders that the identity of the reporter be revealed.
- A person who reports has a right to hear from the investigating local department of social services confirming that the report was investigated.
- What is the penalty for not reporting an abuse situation?
  - Failure to make a report by mandated reporters is punishable by a civil money penalty of not more than \$500 for the first failure and not less than \$100 nor more than \$1,000 for subsequent failures. This means that if you witnessed an abuse, neglect, or exploitation situation, and did NOT report it, you can be fined.



### 4.3 What is Abuse, Neglect, and Exploitation

- Abuse is when someone does something or says something that hurts another person. There are different types of abuse:
  - Physical abuse:
    - Physical abuse is hurting someone on purpose, isolating them without a reason, or punishing them in a way that hurts or harms their body.
    - Examples of Physical Abuse:
      - Hitting, slapping, punching, beating, spanking.
      - Hitting with an object.
      - Shoving, tripping, pulling, twisting.
      - Scratching, biting, spitting.
      - Squeezing hard, pinching.
      - Burning.
      - Using water that's too hot (e.g., for bathing).
      - Using water that's too cold (e.g., for bathing).
    - Signs of Physical Abuse:
      - Bruises, swelling.
      - Skin tears, scratches, cuts.
      - Burns.
      - Arm or leg out of place or broken.
      - Change in walking.
      - Change in behavior.
      - Unexplained depression.
      - Unusual fear.
      - Withdrawal.
      - Denial of signs or excuses.

- Psychological abuse:
  - Psychological abuse (sometimes called emotional or mental abuse) is when someone threatens to hurt, isolate, or punish someone else. It includes threatening or humiliating with words, in a way that hurts or harms a person's emotional well-being, or makes them afraid.
  - Examples of Psychological Abuse:
    - Yelling or screaming.
    - Threatening to punish the person.
    - Saying mean things or making fun of someone.
    - Talking to someone as if they were a child.
    - Talking about someone as if they weren't there.
    - Leaving someone in bed or in a chair, without any way to get up or get out.
    - Not allowing someone to participate in activities.
    - Ignoring questions or comments.
    - Being silent.
    - Humiliating someone by leaving them naked or exposed with no privacy.
  - Signs of Psychological Abuse:
    - Sudden change in behavior.
    - Unusual fear or suspicions.
    - Refusal to talk.
    - Denial of signs.
    - Unexplained depression.
    - Withdrawal.
    - Lack of interest in anything.
    - Change in activity level.

- Sexual abuse
  - Sexual abuse is sexual touching or sexual activity that is not wanted by the other person.
  - Examples of Sexual Abuse:
    - Male consumer touching the sex organs of a confused female resident.
    - Direct-care worker touching the sex organs of a resident during bathing, more than what is necessary for cleaning.
    - Any sexual activity that happens when one person does not want it.
    - Resident or resident's family member demanding sexual contact with a direct-care worker.
    - Direct-care worker having intercourse with a resident who has a mental disability or who is unable to say no.
  - Signs of Sexual Abuse:
    - Scratches, tears, redness, or swelling around the genitals.
    - Discomfort in sitting or walking.
    - Abnormal discharge from the penis or vagina.
    - Withdrawal, depression.
    - Unexplained signs of fear or discomfort associated with specific people.

- Neglect is when someone does NOT do something they were supposed to do, and it hurts another person.
  - Active Neglect
    - When you don't do something for someone on purpose, and you know that what you are NOT doing is going to hurt the other person.
    - Examples of Active Neglect include:
      - Not giving food or water to a person, on purpose. This includes second helpings.
      - Not assisting with an ADL, when you know the person needs help.
      - Not taking a person to the toilet, when you know they need to go.
      - Not changing or cleaning a person who has had an accident.
      - Ignoring calls for assistance.
  - Passive Neglect
    - When you don't do something for someone, but you didn't mean to hurt the other person. Forgetting to do something for a resident happens to every worker once in a while. It becomes "neglect" when it happens over and over, resulting in harm to the resident.
    - Examples of Passive Neglect include repeatedly:
      - Telling a person you will be back in 5 minutes, and then forgetting to come back.
      - Leaving a person on the toilet and not coming back.
      - Forgetting to help someone with an ADL.
      - Not following all the safety rules.

- Forgetting to clean, or cleaning improperly.
  - Forgetting to feed a person.
- Signs of Neglect (Active and Passive):
  - Weight loss.
  - The resident smells bad, has matted hair, is wearing soiled or stained clothing.
  - Skin breakdown, particularly in the perineum.
  - Dirty or unsafe living conditions.
  - Withdrawal or unexplained depression.
  - Sudden changes in behavior.
  - Anger, demanding behavior from the resident.
- Financial Exploitation is when money or things belonging to one person are used to benefit another person, without the owner's permission.
  - Examples of Financial Exploitation:
    - Taking money inappropriately from a person when they offer.
    - Stealing.
    - Using a person's things without permission.
    - Not listening when a person complains of things being taken or missing.
    - Not returning proper change after shopping.
    - Eating the consumer's food/drink without permission.
    - Accepting "tips" or "gifts" against facility policy.
    - Asking for a loan or accepting if a loan is offered.
  - Signs of Financial Exploitation:
    - Missing clothes.
    - Missing valuables, including money.
    - Missing food/drink.

- Reports of theft by the resident.

*Paraprofessional Healthcare Institute. (2009). Providing Personal Care Services to Elders and People with Disabilities. New York: Paraprofessional Healthcare Institute.*

#### **4.4 Staff Responsibilities**

- Direct care staff of the ALF are expected to:
  - Know and respect the rights of residents living in assisted living facilities;
  - Report violations of resident rights to the appropriate entities as specified by their facility policies;
  - Be able to identify the various forms of abuse, neglect, and exploitation; and
  - Understand their obligations as mandated reporters to report suspected abuse, neglect or exploitation.

## **Standards for Licensed Assisted Living Facilities**

### **Effective July 17, 2013\***

22 VAC 40-72-60	Disclosure
22 VAC 40-70-180	Staff orientation
22 VAC 40-72-550	Resident rights

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

Paraprofessional Healthcare Institute. (2009). *Providing Personal Care Services to Elders and People with Disabilities*. New York: Paraprofessional Healthcare Institute.

Virginia Department of Social Services. (2009). *Mandated Reporters: What You Need to Know*. Richmond, VA: VDSS.



## **Student Review – Chapter Four**

1. What are some examples of resident rights – name five (5)?

**§ 63.2-1808. Rights and responsibilities of residents of assisted living facilities; certification of licensure.**

**A. Any resident of an assisted living facility has the rights and responsibilities enumerated in this section. The operator or administrator of an assisted living facility shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the assisted living facility:**

**1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;**

**2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the facility and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;**

**3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;**

**4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;**

- 5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;**
- 6. In the event a medical condition should arise while he is residing in the facility, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the facility and the right to refuse treatment;**
- 7. Is not required to perform services for the facility except as voluntarily contracted pursuant to a voluntary agreement for services that states the terms of consideration or remuneration and is documented in writing and retained in his record;**
- 8. Is free to select health care services from reasonably available resources;**
- 9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;**
- 10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;**
- 11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;**
- 12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;**
- 13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;**
- 14. Is encouraged to function at his highest mental, emotional, physical and social potential;**

**15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:**

**a. As necessary for the facility to respond to unmanageable behavior in an emergency situation, which threatens the immediate safety of the resident or others;**

**b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;**

**16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician, physician assistant, or nurse practitioner;**

**17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:**

**a. In the care of his personal needs except as assistance may be needed;**

**b. In any medical examination or health-related consultations the resident may have at the facility;**

**c. In communications, in writing or by telephone;**

**d. During visitations with other persons;**

**e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the Board;**

**f. In visits with his spouse; if both are residents of the facility they are permitted but not required to share a room unless otherwise provided in the residents' agreements;**

**18. Is permitted to meet with and participate in activities of social, religious, and community groups at his discretion unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record; and**

- Is fully informed, as evidenced by the written acknowledgment of the resident or his legal representative, prior to or at the time of admission and during his stay, that he should exercise whatever due diligence he deems necessary with respect to information on any sex offenders registered pursuant to Chapter 9 (§ [9.1-900](#) et. seq.) of Title 9.1, including how to obtain such information. Upon request, the assisted living facility shall assist the resident, prospective resident, or the legal representative of the resident or prospective resident in accessing this information and provide the resident, prospective resident, or the legal representative of the resident or prospective resident with printed copies of the requested information.

2. What can a resident do if she or he thinks her or his rights are being violated?

**There are a number of different places a resident could contact.**

- **Virginia Department of Social Services**
  - Virginia Department of Social Services licenses and regulates assisted living facilities.
- **Adult Protective Services**
  - Adult Protective Services (APS) is a division of the Department for Aging and Rehabilitative Services that investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age.
- **The Virginia Long-Term Care Ombudsman**
  - The Ombudsman serves as an advocate for older adults receiving long-term care. They receive complaints regarding care issues in long-term care and assist residents in exercising their rights.

3. **True** Direct care workers are mandated reporters.

4. What are the responsibilities of a mandated reporter?

**Mandated reporters are expected to:**

- **Immediately report potential abuse, neglect, or exploitation when they become aware of the situation**
- **Provide information about the individual(s) involved as well as any information you have regarding the potential abuse, neglect, or exploitation.**
- **Make available to APS investigators information that documents the abuse (even things normally considered confidential).**

5. What are the main types of abuse?

- **Physical abuse**
- **Psychological abuse**
- **Sexual abuse**

6. What does neglect and exploitation mean?

**Neglect is when someone does NOT do something they were supposed to do, and it hurts another person.**

**Financial exploitation is when money or things belonging to one person are used to benefit another person, without the owner's permission.**

7. What are some signs of potential abuse, neglect, or exploitation?

- **Signs of Physical Abuse:**
  - **Bruises, swelling**
  - **Skin tears, scratches, cuts**
  - **Burns**
  - **Arm or leg out of place or broken**
  - **Change in walking**
  - **Change in behavior**
  - **Unexplained depression**
  - **Unusual fear**
  - **Withdrawal**

- Denial of signs or excuses
- **Signs of Psychological Abuse:**
  - Sudden change in behavior
  - Unusual fear or suspicions
  - Refusal to talk
  - Denial of signs
  - Unexplained depression
  - Withdrawal
  - Lack of interest in anything
  - Change in activity level
- **Signs of Sexual Abuse:**
  - Scratches, tears, redness, or swelling around the genitals
  - Discomfort in sitting or walking
  - Abnormal discharge from the penis or vagina
  - Withdrawal, depression
  - Unexplained signs of fear or discomfort associated with specific people
- **Signs of Neglect (Active and Passive):**
  - Weight loss
  - The resident smells bad, has matted hair, is wearing soiled or stained clothing
  - Skin breakdown, particularly in the perineum
  - Dirty or unsafe living conditions
  - Withdrawal or unexplained depression
  - Sudden changes in behavior
  - Anger, demanding behavior from the resident
- **Signs of Financial Exploitation:**
  - Missing clothes
  - Missing valuables, including money

- **Missing food/drink**
  - **Reports of theft by the resident**
8. What do you do if you think someone is being abused, neglected, or exploited?
- **Suspected abuse, neglect, or exploitation is reported to Adult Protective Services (APS). You are encouraged to talk to your Executive Director about the situation. However, your employer cannot prohibit you from reporting a situation to APS. Also, if your supervisor was involved in the suspected abuse, neglect, or exploitation report the situation to another supervisor or person of authority. Or, call APS directly. Informing a supervisor of alleged abuse, neglect, or exploitation does not release the direct care staff member from the responsibility of notifying APS. The direct care staff needs to ensure that the notification has been made or make notification him or herself. Documentation of the conversation with a supervisor should be made in the resident's record as well as any conversations with APS.**



**RIGHTS AND RESPONSIBILITIES OF  
RESIDENTS OF ASSISTED LIVING FACILITIES**

**§ 63.2-1808. Rights and responsibilities of residents of assisted living facilities; certification of licensure.**

- A. Any resident of an assisted living facility has the rights and responsibilities enumerated in this section. The operator or administrator of an assisted living facility shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the assisted living facility:
1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;
  2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the facility and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;
  3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;
  4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;
  5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;
  6. In the event a medical condition should arise while he is residing in the facility, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the facility and the right to refuse treatment;

7. Is not required to perform services for the facility except as voluntarily contracted pursuant to a voluntary agreement for services that states the terms of consideration or remuneration and is documented in writing and retained in his record;
8. Is free to select health care services from reasonably available resources;
9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;
10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;
11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;
12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;
13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;
14. Is encouraged to function at his highest mental, emotional, physical and social potential;
15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:
  - a. As necessary for the facility to respond to unmanageable behavior in an emergency situation, which threatens the immediate safety of the resident or others;
  - b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;
16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician, physician assistant, or nurse practitioner;

17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:
    - a. In the care of his personal needs except as assistance may be needed;
    - b. In any medical examination or health-related consultations the resident may have at the facility;
    - c. In communications, in writing or by telephone;
    - d. During visitations with other persons;
    - e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the Board;
    - f. In visits with his spouse; if both are residents of the facility they are permitted but not required to share a room unless otherwise provided in the residents' agreements;
  18. Is permitted to meet with and participate in activities of social, religious, and community groups at his discretion unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record; and
  19. Is fully informed, as evidenced by the written acknowledgment of the resident or his legal representative, prior to or at the time of admission and during his stay, that he should exercise whatever due diligence he deems necessary with respect to information on any sex offenders registered pursuant to Chapter 9 (§ 9.1-900 et. seq.) of Title 9.1, including how to obtain such information. Upon request, the assisted living facility shall assist the resident, prospective resident, or the legal representative of the resident or prospective resident in accessing this information and provide the resident, prospective resident, or the legal representative of the resident or prospective resident with printed copies of the requested information.
- B. If the resident is unable to fully understand and exercise the rights and responsibilities contained in this section, the facility shall require that a responsible individual, of the resident's choice when possible, designated in writing in the resident's record, be made aware of each item in this section and the decisions that affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

- C. The rights and responsibilities of residents shall be printed in at least 12-point type and posted conspicuously in a public place in all assisted living facilities. The facility shall also post the name and telephone number of the regional licensing supervisor of the Department, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program, any sub-state ombudsman program serving the area, and the toll-free number of the Virginia Office for Protection and Advocacy.
- D. The facility shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.
- E. The provisions of this section shall not be construed to restrict or abridge any right that any resident has under law.
- F. Each facility shall provide appropriate staff training to implement each resident's rights included in this section.
- G. The Board shall adopt regulations as necessary to carry out the full intent of this section.
- H. It shall be the responsibility of the Commissioner to ensure that the provisions of this section are observed and implemented by assisted living facilities as a condition to the issuance, renewal, or continuation of the license required by this article.

(1984, c. 677, § 63.1-182.1; 1989, c. 271; 1990, c. 458; 1992, c. 356; 1993, cc. 957, 993; 1997, c. 801; 2000, c. 177; 2002, cc. 45, 572, 747; 2004, c. 855; 2006, 396; 2007, cc. 120, 163.)

**In Case of Questions or Concerns, You May Call:**

**Regional Licensing Administrator,  
Virginia Department of Social Services:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Toll-Free Telephone Number for Adult Protective Services: 1-888-832-3858  
(1-888-83ADULT)**

**Toll-Free Telephone Number for Virginia Long-Term Care Ombudsman Program:  
1-800-552-3402**

**Local/Sub-State Ombudsman Program:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Toll-Free Telephone Number for the Virginia Office for Protection and Advocacy:  
1-800-552-3962**

Group 1	
<p><b>As a group, take a look at these case studies. Looking at your list of resident rights, which right or rights do you think are being violated in these scenarios? Prepare to present your findings to the whole class.</b></p>	
Scenario	Right(s) Being Violated
<p>When Mrs. G moved into PeachTree Assisted Living, she carefully went over the admission paperwork with staff and said she understood everything. Last month, she got a bill and had some questions about some new charges. The staff told her they did not have time to go over the charges again and that they had already explained them to her.</p>	<p>2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the facility and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;</p> <p>11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;</p>
<p>Mrs. S has been living at PeachTree Assisted Living for 2 months. She has had no visitors and her family history shows no close family. She has no power of attorney. One day, a woman comes to visit Mrs. S. After her visit, she indicates she is Mrs. S's niece and her only living relative. She is very nice to everyone, seems to make Mrs. S happy. After her visit, she asks to talk to Mrs. S's aide and asks her questions about Mrs. S, like "What type of medications is she taking?" She also wants to know whether she has dementia, because "she seems a little foggy to me".</p>	<p>4. Is afforded <b>confidential</b> treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;</p>
<p>Mrs. W, a resident of PeachTree Assisted Living, is frequently visited by a male friend of hers. They will usually visit in her room. Mrs. W's aide insists that Mrs. W keep the door open when her friend visits so she "can keep an eye on her".</p>	<p>17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited to the following:</p> <p>a. In the care of his personal needs except as assistance may be needed;</p>

	<p>b. In any medical examination or health-related consultations the resident may have at the facility;</p> <p>c. In communications, in writing or by telephone;</p> <p>d. During visitations with other persons;</p> <p>e. In the resident's room or portion thereof; residents shall be permitted to have guests or other residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not enter a resident's room without making their presence known except in an emergency or in accordance with safety oversight requirements included in regulations of the Board;</p> <p>f. In visits with his spouse; if both are residents of the facility they are permitted but not required to share a room unless otherwise provided in the residents' agreements;</p> <p>11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;</p>
<p>Mrs. Q, a two-time cancer survivor, finds out that her cancer has returned and has spread.</p>	<p>6. In the event a medical condition should arise while</p>

<p>Her assisted living facility community arranges for a followup visit with her oncologist. They talk about treatment options and she decides to not have chemotherapy or radiation. A week later, the nurse at the assisted living facility tells her that if she does not have treatment for her cancer, she will not be able to live there. Without asking her, she has called her family and told them that they need to force her to have treatment.</p>	<p>he is residing in the facility, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the facility and the right to refuse treatment;</p> <p>11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;</p> <p>4. Is afforded <b>confidential</b> treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility;</p>
<p>PeachTree Assisted Living has a new resident! Unfortunately, Mrs. K notices that he can be sexually inappropriate, and when her granddaughter comes to visit, he asks her granddaughter to go to his room with him. She hears gossip that he was in jail at some time. Her daughter encourages her to ask the facility about him and his past, particularly if he had a history of sex crimes. The staff tell her she is just blowing this out of proportion- that he is just a "dirty old man" and there is no sense digging up information that is not going to help anybody. They tell her, "What are you trying to do- cause problems for everybody?"</p>	<p>19. Is fully informed, as evidenced by the written acknowledgment of the resident or his legal representative, prior to or at the time of admission and during his stay, that he should exercise whatever due diligence he deems necessary with respect to information on any sex offenders registered pursuant to Chapter 9 (§ <a href="#">9.1-900</a> et. seq.) of Title 9.1, including how to obtain such information. Upon request, the assisted living facility shall assist the resident, prospective resident, or the legal representative of the</p>

	<p>resident or prospective resident in accessing this information and provide the resident, prospective resident, or the legal representative of the resident or prospective resident with printed copies of the requested information.</p> <p>12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;</p>
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Group 2

**As a group, take a look at these case studies. Looking at your list of resident rights, which right or rights do you think are being violated in these scenarios? Prepare to present your findings to the whole class.**

When Mr. H moved into PeachTree Assisted Living, he had come from the rehab at the nursing home and was a little confused. Now, he is feeling better and seems to be clearheaded. He keeps asking the staff to see the paperwork from when he moved in. The family asked them not to let him see it, because they “did not want him to see how much this place is costing him”.

1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record;

2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services available in the facility and of any related charges; this shall be reflected by the resident's signature on a current resident's agreement retained in the resident's file;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements

	<p>reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;</p>
<p>Mrs. P, a resident at PeachTree Assisted Living, loves to give to her church. Every month, she writes a pretty large check to them. Staff disagree with her doing this and decide to hide her checkbook so she can't write any more checks.</p>	<p>3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;</p>
<p>PeachTree Assisted Living has some nursing students who are learning about caring for older adults. They are doing a research project to see whether residents of assisted living facilities prefer female or male nurses. Without asking permission from the residents, or telling the residents that they are students, the staff allows the student nurses to perform physicals on the residents for the research study.</p>	<p>9. Is free to refuse to participate in human subject experimentation or to be party to research in which his identity may be ascertained;</p>
<p>Mr. G has been living at PeachTree Assisted Living for a year. For the past few months he</p>	<p>12. Is encouraged, and informed of appropriate</p>

has had a new aide. He does not like her and finds her to be rough. He tells the Director that he would like another aide. The Director tells Mr. G that he is "being overly sensitive" and that if he makes a big deal about it, he is going to be asked to leave. He also tells Mr. G that he doesn't have a choice as to what aide he gets and that he is going to start getting a reputation as a "difficult patient".

means as necessary, throughout the period of stay to exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;



Group 3

**As a group, take a look at these case studies. Looking at your list of resident rights, which right or rights do you think are being violated in these scenarios? Prepare to present your findings to the whole class.**

Mrs. H has finished her first month at PeachTree Assisted Living. She receives a notice that she needs to leave PeachTree by the end of the week. She is not given any reason by the staff, and when she tries to talk to the Director, the staff tell her the Director already talked to her family about it.

5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record;

3. Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law;

Mr. V really enjoys living at PeachTree Assisted Living. The only thing he doesn't like is that when

8. Is free to select health care services from

<p>he needs to go to the doctor, the staff will only arrange appointments with the doctors who work at PeachTree Hospital up the street. He likes his own doctor, who he has been seeing for 25 years.</p>	<p>reasonably available resources;</p> <p>6. In the event a medical condition should arise while he is residing in the facility, is afforded the opportunity to participate in the planning of his program of care and medical treatment at the facility and the right to refuse treatment;</p>
<p>Mr. K can get quite annoying. Because of his dementia, he will say “help me” over and over again. Staff decide to keep him in his room most of the time so that they and others don't have to listen to him.</p>	<p>10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;</p> <p>11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;</p>
<p>Mrs. B moved into Room 132 yesterday. She brought all sorts of figurines that she keeps on her dresser. The staff tell her to put the figurines away because it is too difficult to clean them.</p>	<p>13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents;</p> <p>11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;</p>
<p>Mr. D is a veteran and has been actively involved in VFW for many years. He recently moved into PeachTree Assisted Living and is</p>	<p>18. Is permitted to meet with and participate in activities of social, religious, and</p>

looking forward to maintaining his connections with his "buddies" at the VFW. Mr. D needs help getting ready for his VFW meeting this afternoon. The staff tell him they do not have time to get him ready for his meeting and he is just going to have to miss it.

community groups at his discretion unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record;

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;



Group 4

**As a group, take a look at these case studies. Looking at your list of resident rights, which right or rights do you think are being violated in these scenarios? Prepare to present your findings to the whole class.**

Mrs. K is a resident at PeachTree Assisted Living. Since she moved in, she enjoys sitting by the front door and greeting everyone as they come in. The staff begin to rely on her as a receptionist and even let one of the receptionists go because Mrs. K is “up there anyway”. Mrs. K tells staff that she would like to participate in some other things at Peachtree but she is afraid to give up her “job”. They tell her that times are tough and they don’t know what they would do without her at the front desk.

7. Is not required to perform services for the facility except as voluntarily contracted pursuant to a voluntary agreement for services that states the terms of consideration or remuneration and is documented in writing and retained in his record;

Mrs. D is such a sweet lady. She has urinary incontinence but will sometimes not say anything about it because she is shy and “knows the staff are busy”. One day she has an accident in the living room. Although there are other residents there, the staff person says to her loudly, “Mrs. D, did you just have an accident? That is not very ladylike!”

11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;

Mr. V moved into Peachtree Assisted Living after a long rehabilitation after knee surgery. It takes him a long time to get around, but he can. His aide loses patience with him when she helps him down the hallway. Many days, she will tell him he needs to go to dinner in a wheelchair

14. Is encouraged to function at his highest mental, emotional, physical and social potential;

11. Is treated with courtesy,

<p>because he is taking too long to get there.</p>	<p>respect, and consideration as a person of worth, sensitivity, and dignity;</p>
<p>Mrs. E has dementia. She likes to pace and will sometimes try to leave PeachTree unattended. Staff decide that it is taking too much time to keep an eye on her. They notice that there is a chair in the living room that she cannot get up from. Every day they put her in the chair so she doesn't walk around. She will moan and ask to get up but they tell her she has to stay there.</p>	<p>15. Is free of physical or mechanical restraint except in the following situations and with appropriate safeguards:</p> <ul style="list-style-type: none"> <li>a. As necessary for the facility to respond to unmanageable behavior in an emergency situation, which threatens the immediate safety of the resident or others;</li> <li>b. As medically necessary, as authorized in writing by a physician, to provide physical support to a weakened resident;</li> </ul> <p>10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not neglected or ignored by personnel of the facility;</p>
<p>Mrs. F, a resident at PeachTree, has trouble sleeping. She wanders around the facility at night. The night staff person would like her to go to sleep. She has Tylenol PM in her purse and gives it to Mrs. F, telling her she needs to take it.</p>	<p>16. Is free of prescription drugs except where medically necessary, specifically prescribed, and supervised by the attending physician, physician assistant, or nurse practitioner;</p>

**If you suspect a resident's rights have been violated, call one of these numbers:**

**Adult Protective Services:**

**1-888-832-3858**

**(1-888-83ADULT)**

**Virginia Long-Term Care Ombudsman Program**

**1-800-552-3402**

**Virginia Department of Social Services, Division of Licensing Programs**

**(804) 726-7165**



Categories named in the Code of Virginia (§63.2-1606) as persons who are required to report suspected abuse, neglect, or exploitation of elders and incapacitated adults are called **MANDATED REPORTERS**. Any person may voluntarily report suspected abuse to Adult Protective Services (APS).

### Who is Mandated to Report?

The Code of Virginia identifies the following groups of persons as mandated reporters:

- Any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, except persons licensed by the Board of Veterinary Medicine:
  - *Board of Nursing*: Registered Nurses (RN); Licensed Nurse Practitioners (LNP); Licensed Practical Nurses (LPN); Clinical Nurse Specialists; Certified Massage Therapists; Certified Nurse Aides (CNA)
  - *Board of Medicine*: Doctors of Medicine, Surgery, Osteopathic Medicine, Podiatry, and Chiropractic; Interns and Residents; University Limited Licensees; Physician Assistants; Respiratory and Occupational Therapists; Radiological Technologists and Technologists Limited; Licensed Acupuncturists; Certified Athletic Trainers
  - *Board of Pharmacy*: Pharmacists, Pharmacy Interns, and Technicians; Permitted Physicians; Medical Equipment Suppliers; Restricted Manufacturers; Humane Societies; Physicians Selling Drugs; Wholesale Distributors; Warehousemen
  - *Board of Dentistry*: Dentists and Dental Hygienists
  - *Board of Funeral Directors and Embalmers*: Funeral Establishments, Services Providers, Directors, and Embalmers; Resident Trainees; Crematories; Surface Transportation and Removal Services; Courtesy Card Holders
  - *Board of Optometry*: Optometrists
  - *Board of Nursing Home Administrators*: Nursing Home Administrators
  - *Board of Counseling*: Licensed Professional Counselors; Certified Substance Abuse Counselors; Counseling Assistants; Certified
- *Rehabilitation Providers*; Marriage and Family Therapists; Licensed Substance Abuse Treatment Practitioners
- *Board of Psychology*: School, Clinical, and Applied Psychologist; Sex Offender Treatment Providers; School Psychologists – Limited
- *Board of Social Work*: Registered Social Workers; Associate Social Workers; Licensed Social Workers; Licensed Clinical Social Workers
- *Board of Audiology and Speech Pathology*: Audiologists; Speech-Language Pathologists; School Speech-Language Pathologists
- *Board of Physical Therapy*: Physical Therapist and Physical Therapist Assistant.
- Any mental health services provider as defined in § 54.1-2400.1;
- Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5
- Any guardian or conservator of an adult
- Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity
- Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker and personal care workers
- Any law-enforcement officer

### What Are Mandated Reporters Required to Report?

Mandated reporters are required to report suspected abuse, neglect, or exploitation of elders or incapacitated adults. The report is made so that persons responsible for investigating can make the determination as to whether the adult identified needs protective services.

### What Is the Timeframe for Making Reports?

The Code of Virginia says that reports should be made "immediately."

### Where Are Mandated Reporters to Report?

The Code of Virginia assigns responsibility for receiving and investigating reports of adult abuse, neglect, and exploitation to local departments of social services or the Virginia Department of Social Services APS hotline at 1 (888) 832-3858. Mandated reporters are required to report to local departments of social services or the APS hotline. When sexual abuse, death, serious bodily injury, or disease believed to be caused by abuse or neglect, and any criminal activity involving abuse or neglect that places the adult in imminent danger of death or serious bodily harm are suspected, mandated reporters are required to report to both local departments of social services and local law enforcement.

### What Other Responsibilities Are Given to Mandated Reporters?

Mandated reporters also are required to share any records and reports that document the basis for the report and without regard to the reporting person with the local department of social services.

# WHAT MANDATED REPORTERS NEED TO KNOW

## Some Common Signs of Adult Abuse, Neglect, and Exploitation

- Injury that has not been cared for properly
- Evidence of inadequate care
- Burns, welts, scratches, bruises, and fractures
- Signs of confinement (locked in room, tied down)
- The adult is not allowed to visit alone with others
- Malnourishment
- The adult is reluctant to speak openly
- Severe anxiety, fearfulness, and depression
- Personal belongings, such as art, silverware, or jewelry, are missing
- Property or savings are mismanaged
- The adult does not have adequate clothing or personal care items when there appears to be enough money to provide for them.

## What Rights Do Mandated Reporters Have?

- A person who makes a report is immune from civil and criminal liability unless the reporter acted in bad faith or with a malicious purpose.
- A person who reports has a right to have his/her identity kept confidential unless consent to reveal his/her identity is given or unless the court orders that the identity of the reporter be revealed.
- A person who reports has a right to hear from the investigating local department of social services confirming that the report was investigated.

## Is There a Penalty for Failure to Report?

Failure to make a report by mandated reporters is punishable by a civil money penalty of not more than \$500 for the first failure and not less than \$100 nor more than \$1,000 for subsequent failures. The Commissioner of the Department of Social Services shall determine and impose the fine for all mandated reporters except law enforcement.

APS also will refer matters as necessary to the appropriate licensing, regulatory or legal authority for administrative action or criminal investigation.

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*This brochure is provided to you by:*

Virginia Department of Social Services  
Adult Services Program  
7 North Eighth Street  
Richmond, Virginia 23219-1849

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## REPORT ADULT ABUSE 1 (888) 832-3858

**Questions an APS Worker may ask a Mandated Reporter**

**As a mandated reporter, you may not have all of this information, but it is still important to make the report.**

1. What is your name, address and phone number? (You can report anonymously.)
2. What is the name, address and approximate age of the adult?
3. Does an emergency exist?
4. How would you describe the circumstances of the abuse, neglect or exploitation? Why do you suspect the adult is at risk of abuse, neglect or exploitation?
5. What are the names and relationships of other members of the adult's household, if applicable?
6. Is the adult incapacitated?
7. Do you know the name and address of caregiver, if applicable?
8. Do you know the name and relationship of the alleged perpetrator?
9. Are there other people who might be concerned or have knowledge of the adult?
10. Do you know the name of the adult's physician(s) and pharmacies?
11. Do you know of any medications or treatments the adult is taking or undergoing?
12. Do you know the adult's income and other resources?

From "Mandated Reporters: Recognizing and Reporting Abuse, Neglect, and Exploitation of Older Adults", VCU VISSTA



Virginia Department of Social Services
Adult Protective Services Program
801 E. Main Street
Richmond, VA 23219
Telephone: 804-726-7533

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

(This form is an optional form for employers of mandated reporters to document that their employees have been notified of their mandated reporter status; other forms of documents are also acceptable. If used, this form should be retained by the employer.)

I, \_\_\_\_\_, understand that when I am employed as a
(Employee Name)

\_\_\_\_\_, I am a mandated reporter pursuant to
(Type of Employment)

§§ 63.2-1603 through 1610 of the Code of Virginia. This means that I am required to report or cause a report to be made to Virginia Adult Protective Services (APS) either by calling the APS Hotline (1-888-83-ADULT) or the appropriate local department of social services whenever I have reason to suspect that an adult age 60 or over or an incapacitated adult age 18 and over and who is known to me in my professional or official capacity may be abused, neglected, or exploited. I understand that I must follow the reporting protocol, if any, of my employer, but my employer may not prohibit me from reporting directly to APS.

I understand that if I suspect a death of an adult age 60 or over or an incapacitated adult age 18 and over occurred due to abuse or neglect, I must report the death to the medical examiner and the law enforcement agency in the locality in which the death occurred.

I understand that I am immune from civil or criminal liability on account of any reports, information, testimony and records I release if the report is made in good faith and without malicious intent. My identity will be held confidential unless I authorize the disclosure or disclosure is ordered by the court.

I understand that if I fail to make a required report of suspected adult abuse, neglect, or exploitation, immediately upon suspicion, I may be subject to a civil money penalty imposed by the Commissioner of the Virginia Department of Social Services. If I am a law-enforcement officer, I understand the money penalty does not apply to me but that I will be referred to the court system for non-reporting of suspected adult abuse, neglect, or exploitation. If I am licensed, certified, or regulated by a health regulatory board, I may also be subject to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation.

I understand that there is no charge when calling the Hotline number (1-888-83-ADULT or 1-888-832-3858) and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me pursuant to §§ 63.2-1603 through 1610 of the Code of Virginia.

\_\_\_\_\_  
Signature of Applicant/Employee

\_\_\_\_\_  
Date

# **Residents with Disabilities and Special Conditions**

## **Chapter Five**

**Time Required: 4 hours**

## **Chapter Five – Residents with Disabilities and Special Conditions**

This chapter will focus on residents with disabilities and special conditions. Individuals with disabilities and special conditions have the same needs and rights as people without disabilities. This chapter will provide a description of disabilities and special conditions and recommendations on how to maximize a resident's potential based on his or her physical, mental, or emotional condition.

### **5.1 General Overview of Disabilities and Special Conditions**

### **5.2 General Guide to Interacting/Communicating with Individuals with Disabilities**

### **5.3 Residents with Sensory and Physical Disabilities**

### **5.4 Residents with Developmental Disabilities**

### **5.5 Residents with Mental Illness**

### **5.6 Residents with a History of Substance Abuse**

### **5.7 Residents with Aggressive Behavior**

### **5.8 Staff Training Requirements**

### **5.9 Staff Responsibilities**

## Instructor Planning

### 3. Objectives and Expected Outcomes of Chapter

- a. To understand the care needs of residents with sensory impairments and physical disabilities.
- b. To be able to identify and implement therapeutic staff interventions to maximize the independence of residents with sensory impairments and physical disabilities.
- c. To be able to define and understand the care needs of residents with developmental disabilities.
- d. To be able to list the major categories of mental illness and understand the care needs of those residents with mental illness.
- e. To understand the care needs of residents with a history of substance abuse.
- f. To be knowledgeable of the major categories of drugs common to substance abuse.
- g. To be able to understand the variables in the determination of aggressive behavior.
- h. To understand the care needs of residents exhibiting aggressive behavior and identify therapeutic staff interventions.

### 4. Recommended Method of Instruction

- Lecture and class discussion - **Handouts #1, #2, #4, #5, #6 and #7**
- Student Activity – Instructor Demonstration – **Handout #3**
- Student Activity – Group Exercise
- Student Review – Chapter Five

## 5.1 Overview of Disabilities and Special Conditions

Residents that may have multiple chronic disease states and are experiencing difficulties with aspects of aging can make completing the most basic needs independently a challenge. The goal of health care providers is to assist the resident in satisfying as many of their needs as independently as possible. Any adult with a disability or special condition should be able to express themselves independently and have as much physical, psychological, and social independence as possible. This includes spiritual independence; the individual having the choice and opportunity to select a religious preference and worship accordingly. Disabilities may include physical limitations, sensory impairments, cognitive impairments, mental illness, etc. These residents may need personal and environmental accommodations to maximize potential ability.

- Personal accommodations may include:
  - Assistance with ADLs and IADLs.
  - Medication administration.
  - Assistance with exercise.
  - Assistance with therapeutic recreation and/or favorite activities.
  - Assistance with financial management and planning.
- Environmental accommodations may include:
  - Use of assistive devices such as walkers, canes, wheelchairs, eye glasses, etc.
  - Use of prosthetic devices such as glass eyes, breast inserts, artificial arms and/or legs.
  - Home or vehicle modifications (ramps, adaptive vans).
  - Providing a structured living or work environment.
  - Special educational and vocational needs.

## 5.2 General Guide to Interacting/Communicating with Individuals with Disabilities

The information below describes the Do's and Don'ts of interacting with an individual with a disability. It should be used as a guide of how to properly communicate with an individual with a disability in an effort to reduce the resident's anxiety and that of the direct care staff worker.

- **§** Individuals with disabilities are people and should be treated accordingly. This means that you should treat the person by focusing on the individual first and the disability second. This is a resident's right.
- Make sure that you properly listen to what the individual might be telling you and don't assume that you already know. Allow the person time to tell you what he or she needs.
- The person with the disability is not ill and you won't "catch" the disability.
- Treat the person according to their chronological age. For example, do not treat an older adult or an individual with a disability as a child if this person needs assistance.
- Talk directly to the person, as you would anyone else. Direct all questions to the resident first and make every effort not to question the responsible party or primary caregiver about the resident in front of the resident. If the individual has difficulty communicating, find out how the person communicated with others prior to moving into the assisted living facility.
- Do not rush the resident to bathe, dress, or use the restroom. This can cause anxiety in the resident and reduce the possibility of completing the goal. This can also potentially lead to aggressive behavior. Allow the individual the time he or she needs.
- Relax and be your professional self.

- Potential Staff Therapeutic Interventions
  - Encourage self-care.
  - Involve the resident in decision-making activities; empower the resident to make choices.
  - Encourage independence and socialization.
  - Monitor for safety.
  - Assist the resident in use of assistive devices that promote independence.
  - Explain new situations and changes in daily routines.
  - Be patient; offer encouragement and praise for efforts.
  - Monitor for changes in healthcare status and dietary intake:
    - Regular bowel elimination.
    - Onset of seizures.
    - Excessive thirst.
    - Potential for injury.
    - Potential for skin breakdown.
    - Dental changes.
    - Weight changes.
    - Changes in eating habits.
    - Changes in sleeping habits.
    - Injuries of unknown origin.
    - Any behavior that differs from the individual's typical behavior.

### **5.3 Residents with Sensory and Physical Disabilities**

Sensory impairments can have a significant impact on a resident's day-to-day life. The inability to see, hear, taste, etc. can make activities such as eating and watching television more difficult and less enjoyable. This section will provide a physical description of the eye and the ear, and their associated diseases

and/or impairments relevant to this population. This chapter will also provide a brief overview of physical disabilities and assistive devices that may be used to help the resident in maximizing his or her own potential.



### Review Handout #1

**Instructor Notes: Direct the students to turn to Handout #1 in the Student Manual.**

**Review this handout with the class prior to discussing diseases of the eye.**

**Describe each part and its location as it is important that the class understands the parts of the eye in order to properly understand diseases and impairments of the eye.**

### Vision

Lack of proper vision can be a significant source of stress. Individuals with limited vision may tend to self-isolate, are at higher risk for falls, may mis-administer medications, and often report a lower quality of life. Many visual impairments can be corrected through surgical interventions [i.e. removal of cataracts, retinal transplants, etc.]. Seeing-eye dogs may also be used by individuals and can provide an added element of safety and assistance for individuals that are completely blind. Visual losses that cannot be corrected through surgery may be improved through the use of assistive devices (i.e. eye glasses, magnifying glasses, etc.) or environmental accommodations (i.e. strategic placement of furniture, additional lighting, etc.) may be made so the individual continues to live as independently as possible.

Below are a few visual impairments and/or diseases that may be seen in older adults:

- Macular Degeneration
  - Definition and Changes that occur:
    - Occurs when new blood vessels form in the macula area (responsible for central vision) of the eye when they are

not supposed to grow. The result is that the macula is weakened.

- A disease that results in the inside of the picture you normally see disappearing. Only the outside of the picture can be seen.
- Most frequently seen in older adults.
- Blurred vision can occur as can distortions of lines on pages.
- Creates a “blind spot” in sight.



## Review Handout #2

**Instructor Notes: Review this handout with the class. It provides the perspective of the individual that has certain eye diseases. Discuss each photo after you have discussed that particular disease of the eye.**

- There are two types of macular degeneration: Wet and Dry
  - Wet
    - Results when the body attempts to create new blood vessels to get more nutrients and oxygen to the retina. This creates scarring behind the retina.
    - New blood vessels leak blood and fluid resulting in permanent damage to retinal cells.
    - Results in more serious vision loss.
  - Dry
    - More common than the wet macular degeneration.
    - Yellow spots form and accumulate around the macula.
    - Gradual vision loss occurs.

- Potential Staff Therapeutic Interventions
  - Move objects to one side or another so the resident can see using his or her peripheral (side) vision if this is the resident's preference. Let the resident guide you on how it is easier for him or her to see the object.
  - Encourage resident to wear sunglasses with UV protection when in the sun.
  - The physician may recommend vitamins C and E as it slows progression of the disease (primarily for dry).
- Glaucoma
  - Definition and Changes that occur:
    - Results when there is increased pressure in the eye because of excess fluid build-up in the eye.
    - A disease of the eye that results in the outside of the picture you normally see disappearing. Only the center of the picture can be seen.
    - Can result in decreased mobility due to lack of peripheral (side) vision.
    - If not caught and treated early, damage to the optic nerve occurs resulting in permanent loss of peripheral vision.
  - Potential Staff Therapeutic Interventions
    - Encourage residents that self-administer their medications to use their eye drops as prescribed. Non-compliance with these drops is one of the primary reasons for worsening of glaucoma.
    - Place items that a resident needs directly in front of the resident versus on the sides of the resident.

- Cataracts
  - Definition and Changes that occur:
    - A condition that results in everything viewed being blurred and looking out of focus. This condition can cause pain from the glare of light.
    - Clouding on the lens occurs.
    - The pupil changes color from black to a cloudy white.
    - As time goes on, the lens will continue to let in less light.
  - Potential Staff Therapeutic Interventions
    - Make sure you face the resident directly when speaking with them.
    - Speak to the resident prior to touching him or her so that the resident is not startled.
    - Use soft lighting to reduce the amount of glare around the resident.
- Diabetic Retinopathy
  - Definition and Changes that occur:
    - A condition that results when blood is no longer fed to the retina through the blood vessels in the eye.
    - Blood vessels often leak fluid into the retina. This results in blurring, blind spots, and difficulty with peripheral vision.
    - It is often associated with diabetes.
    - Blood sugar levels and blood pressure that is not in control can cause retinopathy.
  - Potential Staff Therapeutic Interventions
    - Make sure resident's blood pressure and blood sugar stay within normal limits to reduce the progression of the disease.

- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Direct care staff should ask the resident if he or she is experiencing any of the symptoms listed below.
    - Pain in the eyes.
    - Seeing halos (circles of light) around the eyes.
    - Seeing black dots “floating” across the eye.
    - Sudden loss or decrease in vision.
    - Redness in or around the eyes.
    - Walking into objects.
    - Inability to see an object at his or her side.



### Review Handout #3

**Instructor Notes: Review this handout with the class prior to discussing diseases/impairments of the ear. Describe each part and its location as it is important that the class understands the parts of the ear in order to properly understand impairments of the ear.**

- Hearing
  - Many conditions and diseases may cause deafness. More than 50% of people over 65 years of age have hearing loss in both ears. However, this figure is lifestyle dependent. The person with a slight hearing loss may be unaware that he or she has this loss. Many individuals that are deaf also have impaired speech. At no point should hearing or speech be equated with intelligence. Even the most basic infections (i.e. ear infections) can be problematic for an older adult as the inner ear is responsible for helping provide balance to the entire body. Ear infections can increase fall risks in older adults by disturbing the body's equilibrium.

- Definitions and Changes that occur:
  - Deafness – occurs when hearing does not return to normal with the use of hearing aids.
  - Conductive hearing loss
    - High pitch sounds are hard to hear, particularly for men.
    - Some letter sounds are difficult to distinguish (“s” versus “f”; “d” versus “b”).
    - Speech may become louder and slurred. This is because the resident is trying to hear him or herself speak.
- Potential Staff Therapeutic Interventions
  - Reference Chapter 3 that was previously discussed for a review of potential staff therapeutic interventions.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Direct care staff should ask the resident if he or she is experiencing any of the symptoms listed below.
    - Sudden loss of hearing.
    - Ear pain.
    - Dizziness.
    - Loss of balance.
- Physical Disabilities
  - Physical disabilities can result in powerful feelings of frustration and helplessness. Although it was once thought that physical disability was a normal part of aging, it is now known that it is not an inevitable occurrence. Improved medical care, behavioral changes, higher education levels, higher incomes, and the use

of assistive devices have all been shown to reduce disability and aging. Assistive devices can be used to allow independence on tasks where the resident may have been previously dependent. The ability to provide self-care boosts personal morale, self-confidence, and can improve quality of life and health outcomes.



#### Review Handout #4

**Instructor Notes: Handout #4 should be used in conjunction with the information below. Each assistive device should be described as well as why it is used. The proper way to use each assistive device should be demonstrated immediately after describing it. Examples of the improper use of each device should be displayed as well and the consequences of improper use.**

- Assistive Devices
  - Assistive devices are mechanical items that help a resident perform activities of daily living without another individual's physical assistance. Use of assistive devices promotes independence.
    - Types and Uses of Assistive Devices:
      - Mobility – assistive devices are used so that residents can ambulate from one point to another without assistance or with minimal assistance.
        - Cane.
        - Walker.
        - Wheelchair.

- Toileting – assistive devices are used so that residents can empty their bowel or bladder without assistance or with minimal assistance.
  - Bedside commode.
  - Raised toilet seats.
  - Grab bars beside commode.
  - Toilet tissue aid.
- Eating/Drinking – assistive devices are used so that a resident can eat without assistance and will not need to be fed by another individual.
  - Specialized knives, spoons, forks, made to fit the resident's hand.
  - Plates and bowls with suction cups to prevent dining wear from falling off the table and plates with curved edges to keep food on the plate.
  - Cups with straws for ease in drinking.
- Reaching – assistive devices are used so the residents can pick up items that are on the floor or on a shelf without assistance and to reduce fall risk.
  - Grabber/Reacher.
- Writing/Recreation/Exercise – assistive device that allows residents to write letters, sign checks, or for general communication.
  - Writing Bird.
- Dressing/Grooming – assistive devices are used so that residents can engage in fine motor skill activities like dressing and grooming without assistance.
  - Sock Donner.

- Zipper Pull/Button Threader.
  - Dressing stick.
  - Long-handled comb and brush.
  - Long-handled shoe horn.
  - Elastic shoe laces.
- Showering/Bathing – assistive devices are used so that the resident reduces the risk of falling and maintains dignity by being able to bathe without supervision.
  - Shower chair.
  - Shower bench.
  - Grab bars in shower.
  - Hand-held shower massager.
  - Long-handled bathing sponge.
  - Hair washing brush.
- Transferring – assistive devices used so that a resident can transfer from one place to another (i.e. bed to chair; chair to commode) with reduced assistance. This reduces the resident fall risk as well as risk for resident and staff injury.
  - Transfer board.
  - Hoyer lift.
- General Staff Therapeutic Interventions not listed above:
  - Be sensitive to the residents' feelings.
  - Respect the resident's mental and physical abilities.
  - Be familiar with the use of the assistive devices being used.
  - Make sure assistive devices are in good repair and readily accessible to the resident.

- Encourage resident to provide self-care and be positive regarding any progress.
- Be available to residents when they use assistive devices in case they need your help with the device. Some residents may need frequent coaching on how to use the assistive devices as they may forget how to use them, or become confused by them.
- Families may also need to be educated about assistive devices and how they are intended to keep residents as independent as possible.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Sudden complaints of pain or numbness in an arm or leg.
  - Sudden change in strength or coordination of movements.
  - Dizziness.



### **Student Activity**

- Group Exercise: Understanding Assistive Devices

#### **Instructor Notes:**

*Prior to beginning the activity, set up stations with an equal number of assistive devices at each station. You should have at least four different assistive device stations: walker, wheelchair, grabber/reacher, shower chair/shower bench, etc. The purpose of this activity is to have the students experience what it would be like to use an assistive device and to practice using the assistive device in the proper manner.*

*Activity procedures:*

1. *Separate the class into groups of two or three students.*

2. *Each student using the assistive device should be limited in some way. For example, the students could have one of their arms strapped to his or her body (you could use a belt, roll gauze, etc.) so that he or she has limited mobility when using the devices.*
3. *Have each student in each group use the assistive device for approximately five minutes each. Once each group has used the assistive device, move that group to another assistive device station. Require each group to maneuver around the room using the assistive device.*
4. *It is recommended that you create obstacles that may be difficult to easily move around with these devices. If using the grabber/reacher, make sure the item is out of reach! If using a shower chair/shower bench, have another student assist in transferring the individual to the shower chair.*
5. *Be sure to maintain a safe environment at all times.*

**After all of the students have used each assistive device, ask the students the following:**

1. What was difficult about using this assistive device?
2. How did it feel to require help from another individual? Did you feel embarrassed? Helpless?
3. What approach could you use when working with a resident to help reduce their anxiety when being assisted?

**Thoroughly discuss the responses with the class and discuss the importance of promoting independence with these devices as well as respecting the residents' right to dignity (§).**

## 5.4 Residents with Developmental Disabilities

Individuals with developmental disabilities are living longer. It is estimated that by 2030, there will be millions of older adults with developmental disabilities. It is no longer uncommon for an older adult and his or her adult child with a developmental disability to move in to an assisted living facility together. Most older adults with life-long disabilities appear to age at the same rate as the general older adult population and have the same risk factors for decreased health. Many of these individuals also have an additional diagnosis of dementia. In general, a developmentally disabled individual is cognitively impaired as measured by an IQ test and is impaired in adaptive functioning [ability to use learned behaviors] in such spheres as interpersonal relationships, daily living skills (grooming, hygiene, dressing, self care, safety and self-preservation), and managing vocational and/or recreational aspects of life. As with any condition that affects cognition (developmental disability, mental illness, substance abuse), it should be determined if the individual needs a psychological consult prior to admission. This should be documented on the UAI.

- There are many misconceptions about individuals with developmental disabilities that may adversely affect care:
  - It is sometimes believed that individuals with developmental disabilities cannot have a mental illness as well; in fact, they can suffer from a full range of mental illnesses.
  - Too often individuals with developmental disabilities are treated as if they do not have normal feelings and emotions. These individuals are capable of the full range of human emotions. They are vulnerable and sensitive just like any other human being.
  - It is sometimes thought that individuals with developmental disabilities are not affected by changes in their environment. In

fact, with a reduced capacity to understand what is happening to them, people with developmental disabilities may have heightened reactions to such events as staff turnover or other changes in their residential or vocational programs, new roommates, or illnesses in family members. These are all stressors that can precipitate behavioral deterioration.

- It may not be recognized that individuals with a developmental disability can also have substance abuse problems, particularly with alcohol.
- The inability to read (illiteracy) does not mean an individual has a developmental disability.
- The section below will discuss a number of developmental disabilities. These developmental disabilities will be seen more frequently in assisted living facilities and are not specific to older adults as individuals aged 18 and over may reside in an assisted living facility. This section provides a basic description of each developmental disability followed by a general overview of how to interact properly with an individual with a developmental disability.
  - Autism or Autism Spectrum Disorder (ASD) is a developmental disability that results from a range of neurodevelopmental disorders. An individual diagnosed with autism may show signs of social impairment, communication difficulties, and repetitive behaviors. Individuals diagnosed with autism can have a range of impairments from mild to severe. Many individuals with autism can work and live either independently or in a supervised environment.
  - Down's Syndrome is a developmental disability that occurs when an individual is born with three, rather than two, copies of the 21st chromosome. The additional copy of the 21st

chromosome changes the course of development from birth through adulthood. The life expectancy of an individual with Down's syndrome is approximately 60 years of age. It is more common for an individual with a diagnosis with Down's Syndrome to also develop Alzheimer's Disease compared to the general older adult population. An individual with Down's Syndrome is three to five times more likely to develop Alzheimer's Disease with symptoms starting much earlier, typically around 35 years of age.

- Intellectual Disabilities – An individual with an intellectual disability is described as an individual having significant limitations in intellectual functioning and adaptive skills area including conceptual, social, and practical adaptive skills. The intellectual disability usually originates prior to the age of 18.
  - Adaptive skill areas
    - Refers to the basic skills needed to function in everyday life.
      - Communication
        - This refers to the ability to understand what is being said to the individual and to be able to appropriately respond.
      - Self-care
        - This refers to everyday functioning such as getting dressed, going to the bathroom, and feeding oneself.
      - Home living
        - This refers to the ability to engage in everyday activities that occur in the

home such as setting the table,  
cleaning the house, or cooking dinner.

- Social skills
  - This refers to the ability to interact appropriately with peers, family members, and people outside the individual's normal social circle (knowing the rules of conversation).
- Leisure
  - This refers to how to engage in fun activities such as knowing the rules of a game.
- Health and safety
  - This refers to the ability to recognize dangerous situations and respond accordingly. This may include how to properly hold a knife or knowing what to do if smoke is in a house.
- Self-direction
  - This refers to the ability to engage in certain activities such as home living, work, or personal needs without being guided by another individual.
- Functional academics (reading, writing, basic math)
  - This refers to the ability to engage in basic academics such as reading a street sign, writing a name, or counting money.

- Work
  - This refers to the ability to maintain gainful employment on at least a part-time level.

## **5.5 Residents with Mental Illness**

Mental illness can range from slight impairment to severe impairment. Many individuals that have been diagnosed with a mental illness do not receive the right type of help. Many have experienced discrimination and are often not accepted by their own families. § An individual diagnosed with a mental illness must have a mental health screening conducted prior to moving into the assisted living facility. It is also required that all care needs directly related to the mental illness be placed on the resident's individual service plan. § This is also true for residents with substance abuse issues. § Information regarding the individual's behavior over the previous six (6) months should be well-documented prior to admission.

- Individuals with mental illness may have difficulty:
  - Developing emotionally, creatively, intellectually, and spiritually.
  - Initiating, developing, and sustaining mutually satisfying personal relationships.
  - Facing problems and applying appropriate problem-solving skills.
  - Being assertive, appearing aggressive when it is not the resident's intent, and exhibiting confidence.
  - Being alone.
  - Experiencing satisfaction through recreational activities.
  - Showing happiness.
- Adults may experience a number of types of mental illness including Neurotic Disorders, Psychotic Disorders, Anxiety Disorders and Mood Disorders.



## Group Discussion

**Instructor Notes: Ask the students the following questions:**

**Have any of you had experiences working with individuals with a mental illness?**

**Can you name any categories of mental illness that might be found in assisted living facilities?**



Review Handout #5

**Instructor Note: Direct the students to turn to Handout #5 in the Student Manual so that the students may follow along. Thoroughly describe the category and the description of the associated mental illnesses. Thoroughly review the symptoms associated with each. After each section, ask the group if they have any questions.**

- Potential Staff Therapeutic Interventions
  - Encourage the resident to engage in a safe activity that he or she enjoys.
  - Encourage resident to engage in a regular exercise program.
  - Encourage resident to reduce their intake of coffee, alcohol, nicotine, and other addictive substances.
  - Encourage resident to reminisce about positive past experiences and explore future positive experiences.
  - Encourage resident to express emotions in a positive and safe way.
  - Develop and sustain a relationship with the resident.
  - Listen to and respect the resident, particularly in times of distress.
  - Utilize validation therapy techniques to help reduce the risk of an episode occurring.
  - Engage the resident in activity-based therapies such as music, drama, art, dance, and problem-solving therapies.

- Engage the resident in formal psychotherapy.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Changes in mood or behavior
    - Excess crying.
    - Self-isolation.
    - Extreme mood swings.
    - Aggressive behavior.
  - Any injuries that could be self-inflicted.
  - Non-compliance with medications.
  - Making comments about committing suicide or wishing he or she was no longer alive.
  - Making comments about harming others.

## **5.6 Residents with a History of Substance Abuse**

Substance abuse is considered the excessive use, generally self-administered, of any legal or illegal drug without regard to the physical or mental consequences.

Substance abuse can be the result of:

- An individual self-administering treatment (also called self-medicating) to relieve the feelings of depression, anxiety, grief, etc.
- Social habits that become addictive.
- Using prescribed medications with other drugs, including alcohol, or self-administering these medications outside the recommended dosages.

### Types of Substance Abuse

- Alcohol Abuse
  - Alcoholism is an illness. No individual starts drinking with the intention of becoming an alcoholic. Alcoholism is defined as follows:

- Any degree of alcohol use that results in physical, emotional, social, or occupational deterioration.
- It is the leading cause of deaths resulting from traumatic accidents.
- It is the most abused drug and is responsible for broken homes, poverty, unemployment, crime, neglected children, deteriorating health, etc.
- Alcohol has significant effects on the body and can cause the following:
  - Brain damage.
  - Gastrointestinal damage.
  - Liver damage.
  - Heart damage.
  - Predisposition to Infectious Diseases (i.e. pulmonary infections).
  - Sexual performance (i.e. promiscuity and the decreased ability to perform).
- Alcoholism is a treatable disease although some symptoms or conditions from prolonged excessive use may not be reversible. One example of this is Wernicke-Korsakoff's Syndrome.
  - Wernicke-Korsakoff's Syndrome – this is a result of damage that occurs in the brain based on the lack of Vitamin B1 (thiamine). This is typically seen in individuals with a long history of alcohol abuse. The alcohol prevents the proper breakdown of the Vitamin B1 in the body resulting in the deficiency. Symptoms may include:
    - Loss of memory, sometimes severe.
    - Loss of muscle coordination and unsteady gait.
    - Having visual and auditory hallucinations.

- Drooping eyelids, double vision, and abnormal eye movements.
  - Making up stories that aren't true.
  - Difficulty forming and retaining new memories.
- Potential Staff Therapeutic Interventions:
    - Monitor resident for intake of alcohol or controlled substances.
    - Provide alcohol or controlled substances only as prescribed by the physician.
    - Reduce any stressors that may lead the resident to want to drink.
    - Develop and carryout individualized service plan in conjunction with mental health providers (psychiatrist, mental health worker/clinic, local Community Services Board, alcoholic support organizations – Alcoholics Anonymous) as per the mental health services agreement (§).
    - Educate family and visitors on facility alcohol policy.
    - Encourage resident participation in recreational activities.
    - Maintain a safe and comfortable environment.
    - Monitor resident for fall risk.
  - Direct Care Staff should report any of the following observations and document according to facility protocol:
    - Changes in level of alertness.
    - Tardive Dyskinesia.
    - Change in behavior.
    - Increased agitation.
    - Changes in personality.
    - Jaundice.

- Prescription Medication Abuse
  - Despite what the general population might think, older adults do abuse prescription medication. This can be intentional or unintentional. This can occur when an older adult may not think the medication is working properly and takes the medication more frequently or takes more than the prescribed amount at each administration time.
  - Classes of medications that are often seen in assisted living facilities that have the potential for abuse include barbiturates, tranquilizers, methaqualones, hallucinogens, and narcotics.



Review Handouts #6 and #7

**Instructor Notes: Direct the students to turn to Handout #6 in the Student Manual so that the students may follow along. Review each classification of medication as well as it's medical use, side effects, and hazards for abuse.**

**NOTE: The effects of alcohol are often enhanced when combined with the effects of aging and in combination with prescription and non-prescription medication.**

**Direct the students to turn to Handout #7 in the Student Manual. Review the American Geriatrics Society Updated Beers Criteria.**

## **5.7 Residents with Aggressive Behavior**

Aggressive behavior is behavior exhibited by an individual in a violent, hostile, and destructive manner. This can be potentially dangerous to the resident exhibiting the behavior, other residents in the facility, staff members, and visitors. Aggression can be verbal or physical. Aggressive behavior can occur as the result of a developmental disability, mental illness, substance abuse, Alzheimer's

Disease and other dementias, or other impairments. Aggressive behavior may also occur in response to medications [Medication-Related Problems (MRP)], situations such as being in restraints for safety purposes, isolation, pain, perceived threats, stress, grief, etc. Whether known or unknown, there is a cause for the behavior and it should never be considered “just acting out” or “attention-seeking.”

- Aggression is typically divided into two categories: verbal and physical.
  - Verbal aggression.
    - This is considered aggression if the individual receiving the verbalization, or anyone that overheard it, has a negative response and feels offended in any way.
    - It can be self-directed or directed at others. Self-directed aggression is often seen with individuals diagnosed with schizophrenia or severe mood disorders.
  - Physical aggression
    - This may pose real or potential physical harm to the resident being aggressive as well as other residents, staff, and visitors.
- Harm
  - Harm is defined as causing physical or psychological injury or damage. Although it is not unusual to encounter residents exhibiting physical and verbal aggression, it is also not uncommon to observe residents inflicting harm in other ways as well. Harm may include physical, psychological, emotional, and social aspects.
    - Physical harm – behavior of one individual that results in the physical injury of self or another individual. For example, a resident that becomes aggressive and throws

an object physically injuring another individual or causing the aggressive resident to fall and become physically injured.

- Social harm – behavior of one individual that prevents another from participating in a desired activity. For example, a resident won't go to bingo any more because another resident always publicly accuses him of cheating.
  - Psychological harm – withdrawal, fear, isolation, and agitation. For example, the same resident has stopped participating in other activities just so he won't have to see the resident that accused him of cheating at bingo.
  - Emotional harm – periods of anger, crying, and/or uncontrollable laughter. For example, the resident is walking to the dining room and bursts out laughing uncontrollably when his "bingo accuser" has fallen and is lying on the floor.
- § It is a requirement of all staff members to protect the residents from any form of harm, regardless of who is inflicting the harm.
  - If a staff member notices any behavior not considered normal for that individual, the staff member needs to determine if the behavior is aggressive in nature. The staff member needs to be observant of the signs of behavior that is escalating towards an aggressive or harmful nature. These signs may include:
    - Yelling or increased volume of voice and/or harsher tone towards other residents or staff.
    - Pacing.
    - Repetitive motions such as constant foot tapping.
    - Staring (glaring) at other residents or staff members for a longer than usual amount of time.

- Potential exit-seeking behavior.
  - Attempting to force another resident to do something he or she may not want to do.
- All staff should be aware of the signs of potential harm to self, others, or community. These include:
  - Physical aggression towards self (i.e. hitting, biting, scratching, throwing self on floor).
  - Physical or verbal aggression towards others (i.e. hitting, scratching, biting, inappropriate language, yelling, etc.).
  - Throwing and/or breaking items in the community.
  - Sexual aggression (i.e. inappropriate touching, verbal harassment, etc.).
- Signs of behavior that could be disruptive to other residents, staff, or visitors:
  - Crying, yelling or calling out, moaning, loud outburst, and inappropriate language.
  - Interfering with other resident's ability to carry out activities.
  - Generates fear or other negative emotions from other residents.
  - Verbal aggression, including making rude comments to other residents.
  - Note: Keep in mind that some of these behaviors may be the result of dementia and might be avoided or decreased through interacting with people with dementia in a different way (see Chapter 7 on Dementia).
- Signs that behavior may impact care:
  - Physical and/or verbal aggression towards staff while trying to provide care.

- Potential Staff Therapeutic Interventions that may assist with aggression (these interventions should be considered early interventions and do not apply to residents with dementia). These interventions are for the safety of the resident exhibiting potentially harmful behaviors, other residents, staff members, and visitors:
  - Establish “ground rules” for acceptable language and appropriate behavior. Inform the resident when he or she is using inappropriate language.
  - Establish incentives for positive behavior.
  - Offer praise for efforts made by the resident to display proper behavior.
  - Attempt to re-direct (distract) the resident and engage him or her in an activity that requires physical exertion.
  - Have another staff member attempt to interact with the resident and you exit the vicinity. Direct care staff develop closer relationships with certain residents. Those Direct Care staff that has the closest relationship with an escalating resident should assist with this resident.
- Below are some additional de-escalating strategies that can be also used as early interventions:
  - Approach the resident with caution making every effort not to startle the individual.
  - Avoid using any words that could be perceived as provoking the resident. Make sure that clear, calm, and respectful language is used.
  - Maintain awareness of your own facial expressions, body posture, and tone of voice.

- Avoid making any statements that could be perceived as you challenging the resident and don't make promises to the resident.
- Remove dangerous objects from your person (i.e. syringes, pens, etc).
- Make sure you are aware of the exits and that you have positioned yourself near the exit should you need to use it in a violent situation.
- Avoid body positions that make you vulnerable, such as turning your back on the resident that is becoming agitated.



### Group Discussion

**Instructor Notes: Ask the students the following question:**

**How can you help protect the resident (and yourself) from aggressive behavior?**

- Potential Staff Therapeutic Interventions and Preventative Measures:
  - Always position yourself in the room so that you are closest to the exit.
  - Never have the resident between you and the exit.
  - Never sit with your back to the exit.
  - Never approach the resident with your hands out in front of your body. Individuals with tendencies for aggressive behavior may perceive this action as an attack.
  - Never respond aggressively or in a stern tone when working with an aggressive resident.
- Direct Care Staff should report any of the following observations and document according to facility protocol:
  - Actions or verbalizations that are considered aggressive.

- Report/investigate any comments/complaints from other residents.
- Residents threatening to engage in aggressive behaviors.
- **§** The following should be reported to a supervisor and documented in the resident's record as assisted living facilities are prohibited from allowing residents to continue to reside in a facility if the resident is a danger to self or others:
  - Any verbal or physically aggressive action that is perceived as harmful to anyone in the community.
  - Any complaints of aggressive behavior by other residents.
  - **§** Any physically aggressive act that results in physical contact between two residents. This is extremely important as it is required by VDSS regulations to submit an incident report detailing related facts to the licensing office. **§** This is also particularly important to determine continued stay in the assisted living facility per the resident agreement.
  - Any change in care needs that may require a change on the UAI or ISP.

## **5.8 Staff Training Requirements**

- **§** Staff should receive training on any specific mental illness or developmental disability that a resident in assisted living may have prior to that resident moving into the community.
- **§** Staff should receive training on aggressive behavior any time there is a resident that may exhibit these behavioral signs.
- **§** Staff should receive refresher courses annually on aggressive behavior if potentially aggressive residents still reside in the facility.
- **§** Staff should be thoroughly trained in resident emergencies, which includes how to handle a mental health emergency.

## **5.9 Staff Responsibilities**

- Staff are responsible for the safety and general welfare of the residents.
- Staff are responsible for knowing facility policies for treatment of injuries, fire safety and evacuation, and proper reporting of incidents.
- Staff is responsible for reporting and documenting accidents when they occur.
- Staff is responsible for teaching residents how to avoid falling and other potential injuries so they can continue with normal activities.

## **Standards for Licensed Assisted Living Facilities**

**Effective July 17, 2013\***

22 VAC 40-72-100	Incident reports
22 VAC 40-72- 180	Staff orientation
22 VAC 40-72- 260	Direct care staff training
22 VAC 40-72- 310	Direct care staff training when aggressive or restrained residents are in care
22 VAC 40-72-360	Mental health screening
22 VAC 40-72-365	Psychosocial and behavioral history
22 VAC 40-72-390	Resident agreement with facility
22 VAC 40-72-430	Uniform assessment instrument
22 VAC 40-72-440	Individualized service plans
22 VAC 40-72-500	Mental health services coordination, support, and agreement
22 VAC 40-72-550	Resident rights
22 VAC 40-72-970	Plan for resident emergencies and practice exercise

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Chapter Review - Chapter Five

1. Name three (3) assistive devices for the following needs:
  - a. Mobility
    1. **Cane**
    2. **Walker**
    3. **Wheelchair**
  - b. Toileting
    1. **Bedside commode**
    2. **Raised toilet seats**
    3. **Grab bars beside commode**
    4. **Toilet tissue aid**
  - c. Eating/Drinking
    1. **Specialized knives, spoons, forks, made to fit the resident's hand**
    2. **Plates and bowls with suction cups to prevent dining wear from falling off the table and plates with curved edges to keep food on the plate**
    3. **Cups with straws for ease in drinking**
  - d. Showering/Bathing
    1. **Shower chair**
    2. **Shower bench**
    3. **Grab bars in shower**
    4. **Hand-held shower massager**
    5. **Long-handled bathing sponge**
    6. **Hair washing brush**
2. Name two (2) diseases of the eye and provide definitions for each disease:
  - a. **Macular Degeneration - occurs when new blood vessels form in the macula area (responsible for central vision) of the eye when they are not supposed to grow. The result is that macula is weakened.**



- b. Be emotionally supportive of the resident**
  - c. Do not seat the resident in the back during activities. Make sure resident is close to the individual conducting the activity.**
  - d. Reduce background noise**
  - e. Check the resident's hearing aid batteries to make sure they are working**
  - f. Keep the hearing aids clean (i.e. make sure there is no wax in the hearing aid)**
  - g. Speak slowly and clearly and in a lower toned voice**
  - h. Avoid shouting, chewing gum, or covering mouth when speaking**
  - i. Use paper and pencil for communication if necessary**
  - j. Establish consistent gestures for certain tasks**
  - k. Face the resident directly when communicating so he or she can read lips.**
  - l. Use a communication board**
  - m. NEVER use q-tips to clean a resident's ear**
5. Name two (2) misconceptions about persons with developmental disabilities:
- a. It is sometimes believed that individuals with developmental disabilities cannot have a mental illness as well; in fact, they can suffer from a full range of mental illnesses.**
  - b. Too often individuals with developmental disabilities are treated as if they do not have normal feelings and emotions. These individuals are capable of the full range of human emotions. They are vulnerable and sensitive just like any other human being.**
  - c. It is sometimes thought that individuals with developmental disabilities are not affected by changes in their environment. In fact, with a reduced capacity to understand what is happening to them, people with developmental disabilities may have heightened**

reactions to such events as staff turnover or other changes in their residential or vocational programs, new roommates, or illnesses in family members. These are all stressors that can precipitate behavioral deterioration.

- d. **It may not be recognized that individuals with a developmental disability can also have substance abuse problems, particularly with alcohol.**
  - e. **The inability to read does not mean an individual has a developmental disability.**
6. Name three (3) general rules in interacting with an individual with a disability:
- a. **Individuals with disabilities are people and should be treated accordingly. This means that you should treat the person by focusing on the individual first and the disability second. This is a resident's right.**
  - b. **Make sure that you properly listen to what the individual might be telling you and don't assume that you already know. Allow the person time to tell you what he or she needs.**
  - c. **The person with the disability is not ill and you won't "catch" the disability.**
  - d. **Treat the person according to their age.**
  - e. **Talk directly to the person, as you would anyone else. Direct all questions to the resident first and make every effort not to question the responsible party or primary caregiver about the resident in front of the resident. If the individual has difficulty communicating, find out how the person communicated with others prior to moving into the assisted living facility.**
  - f. **Do not rush the resident to bathe, dress, or use the restroom. This can cause anxiety in the resident and reduce the possibility of**

**completing the goal. This can also potentially lead to aggressive behavior. Allow the individual the time he or she needs.**

**g. Relax and be your professional self.**

7. Name five (5) changes in healthcare status and dietary intake that direct care staff should closely monitor when working with an individual with a developmental disability:

**a. Regular bowel elimination**

**b. Onset of seizures**

**c. Excessive thirst**

**d. Potential for injury**

**e. Potential for skin breakdown**

**f. Dental changes**

**g. Weight changes**

**h. Changes in eating habits**

**i. Changes in sleeping habits**

**j. Injuries of unknown origin**

**k. Any behavior that differs from the individual's typical behavior**

8. Name two (2) staff interventions that can be implemented to assist residents diagnosed with a mental illness:

**a. Encourage the resident to engage in a safe activity that he or she enjoys.**

**b. Encourage resident to engage in a regular exercise program.**

**c. Encourage resident to reduce their intake of coffee, alcohol, nicotine, and other addictive substances.**

**d. Encourage resident to reminisce about positive past experiences and explore future positive experiences.**

**e. Encourage resident to express emotions in a positive and safe way.**

**f. Develop and sustain a relationship with the resident.**

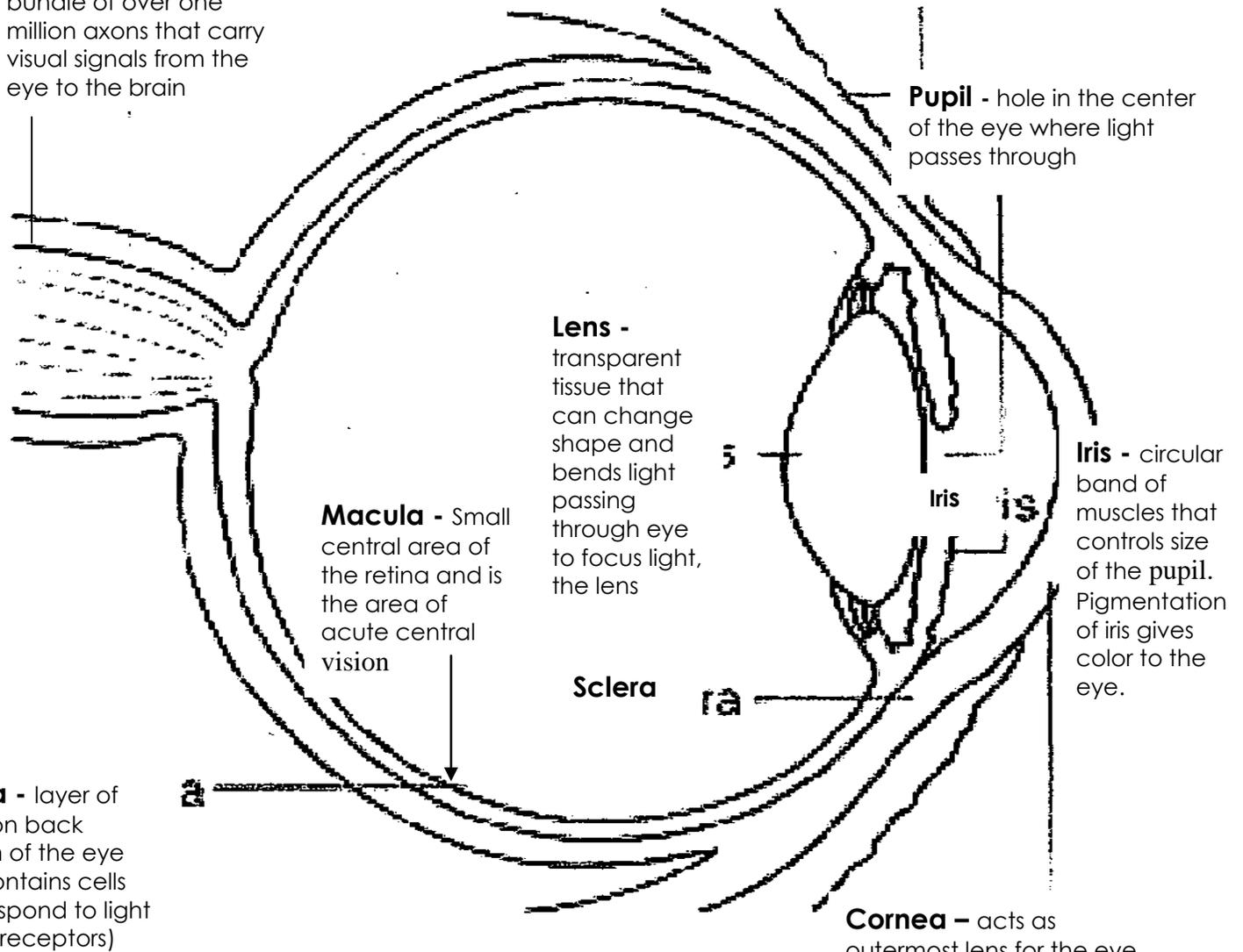
**g. Listen to and respect the resident, particularly in times of distress.**

9. Name three (3) classes of drugs and provide descriptions of each class:
- a. **Barbiturates** - Treat hypertension, seizure disorders, relaxation before and during surgery
  - b. **Cannabis** - *Experimental* use for treatment of glaucoma and control of side effects of chemotherapy
  - c. **Narcotics** - lowers perception of pain
  - d. **Hallucinogens** – no medical use. Illegal recreational use only.
  - e. **Methaqualone** - Treat anxiety and insomnia
  - f. **Tranquilizers** - Treat anxiety, relax muscles
  - g. **Amphetamines** – Control weight, treat mild depression
  - h. **Cocaine** – Rarely used for medical purposes

# The Eye

**Optic Nerve -**  
bundle of over one million axons that carry visual signals from the eye to the brain

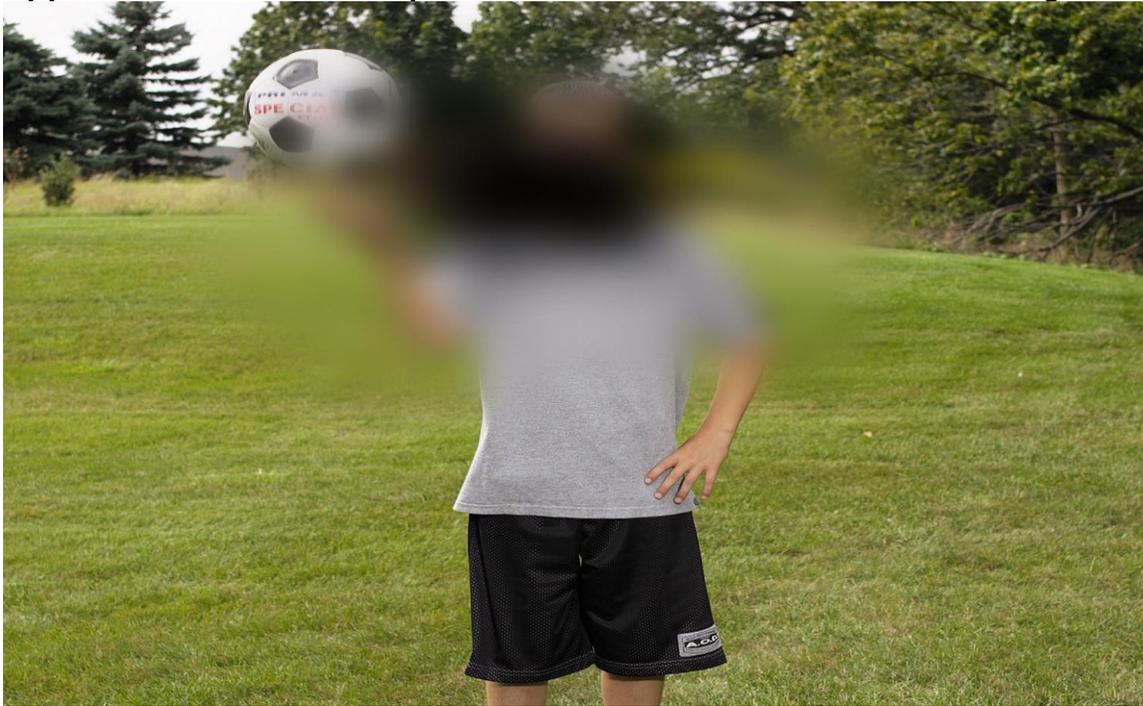
**Conjunctiva -** a mucous membrane that covers the exposed front portion of the sclera and lines the inside of the eyelids.



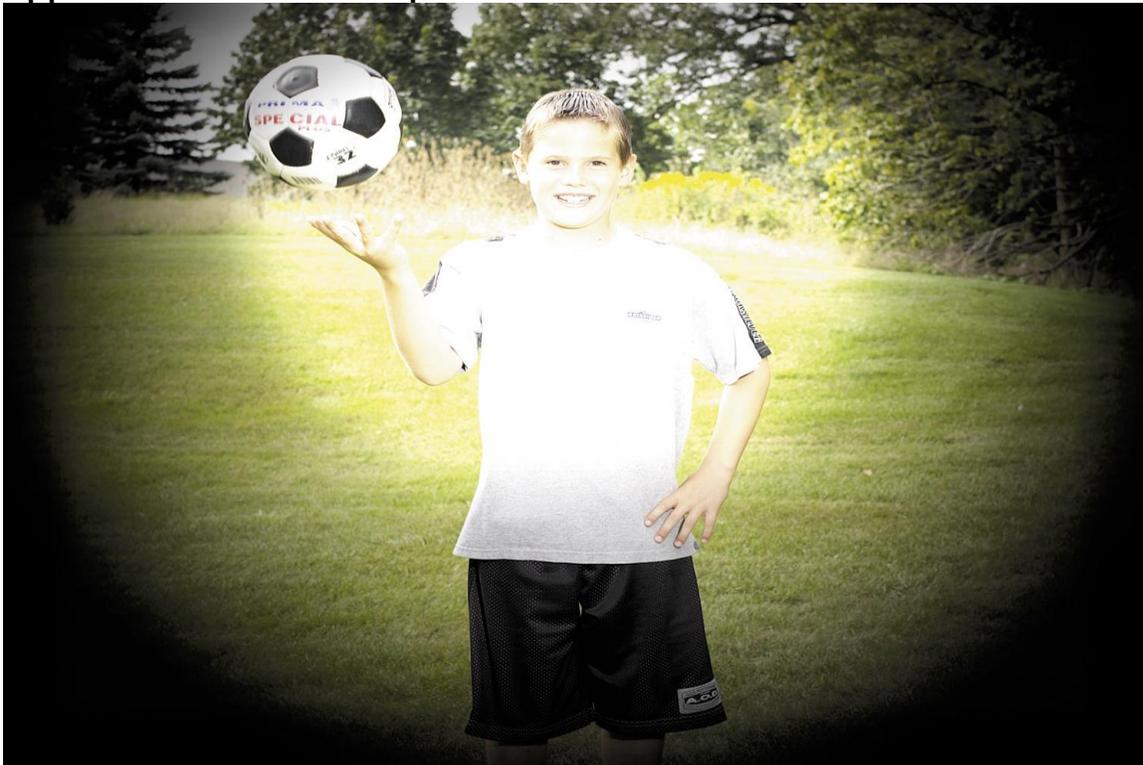
**Sclera -** tough, white outer covering of the eyeball that the extraocular muscles attach to in order to move the eye

**Diseases of the Eye**

**Appearance from the Perspective of the Individual with Macular Degeneration**



**Appearance from the Perspective of the Individual with Glaucoma**



**Appearance from the Perspective of the Individual with Cataracts**

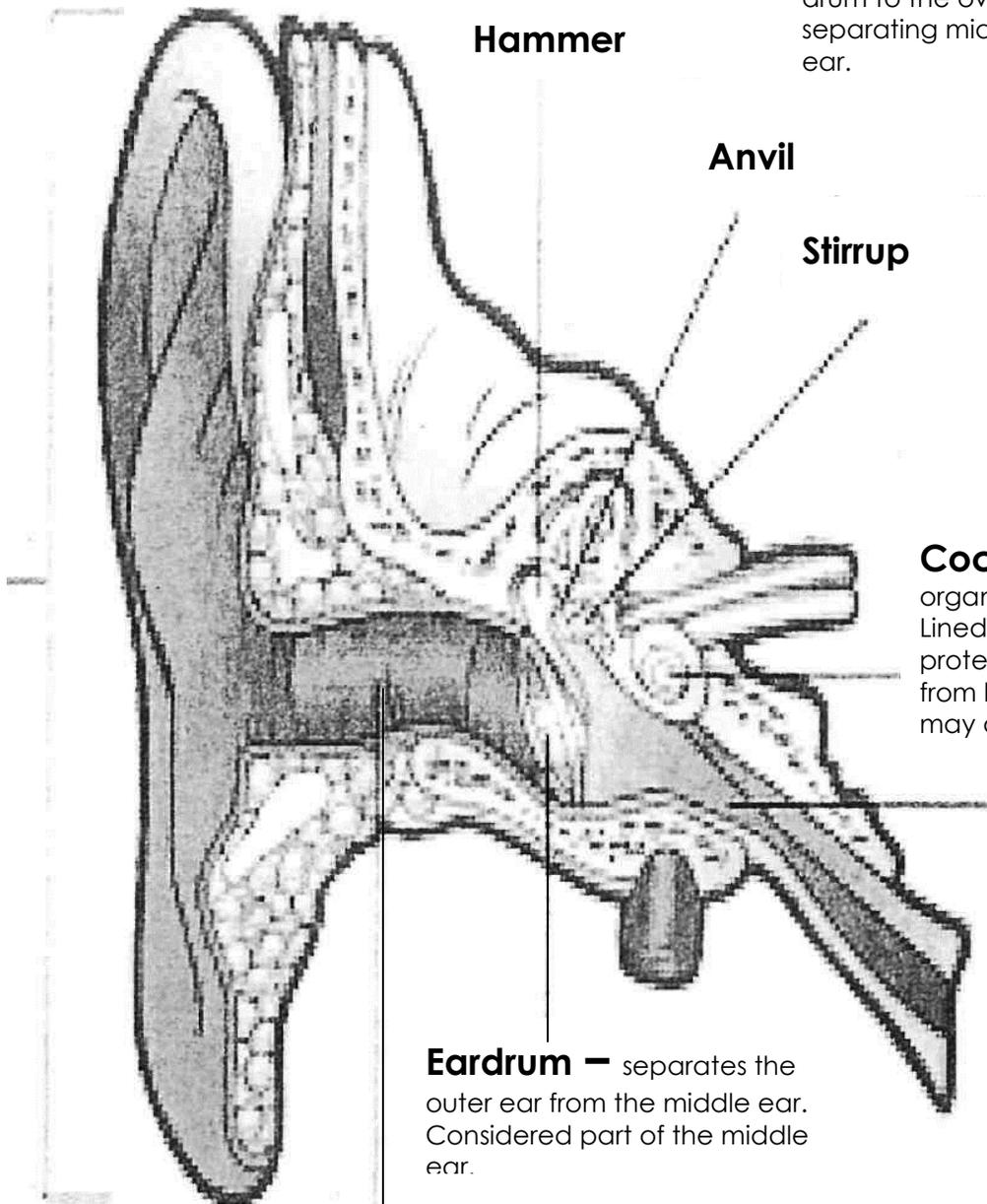


**Appearance from the Perspective of the Individual with Diabetic Retinopathy**



## The Ear

The **Hammer**, **Anvil**, and **Stirrup** are the three bones found in the ear. They are all connected and transmit sound from the ear drum to the oval window (area separating middle and inner ear).



**Auricle –** ear lobe. Considered part of the outer ear. Delivers sound to the middle ear.

**Cochlea –** actual organ of hearing. Lined with hairs that protect the inner ear from loud sounds that may damage hearing.

**Eustachian Tube –** connects the middle ear to the throat

**Eardrum –** separates the outer ear from the middle ear. Considered part of the middle ear.

**Outer Ear Canal –** sound waves pass through here to the ear drum

## Assistive Devices

**Instructor Note: Review all items shown to class. If possible, gather as many of these items as possible to show the staff how to use them. Pass the devices around and encourage staff to attempt to use them.**

### Mobility

The ability to move from one place to another without assistance significantly contributes to independence. There are many types of mobility devices used to assist with walking. For the resident that may be unsteady when walking or for the resident that is not able to walk at all, there are many types of walking assistive devices and accessories.



**Cane**



**Quad-cane**



**Walker**



**Front-wheel walker**



**Front and rear-wheel walker**



**Wheelchair**

## Toileting

Many residents may need assistance with transferring on and off the commode. There are a number of devices available so that the resident doesn't have to walk far or sit down as far to use the commode.



**Bedside commode**



**Raised toilet seats**



**Grab bars beside commode**



**Toilet Tissue aid**

## Eating/Drinking

Among the special utensils available are forks, spoons, and knives to assist the resident in picking up the food. There are also cups to prevent spilling hot liquids and to reduce having to lift the cup so high. Plates and bowls are also available to assist in keeping the food on the plate.



**Utensil with holding strap**



**Curved utensils and utensils with grips**



**Cup with handle and lid**



**Skid-free place mats**



**A**



**B**



**C**



**D**



**Plates with Curved Edges**

Reaching

Grabbing device used to grab items off the floor, a shelf or assist with putting on pants, etc.



**Grabber**

Writing/Recreation/Exercise

Writing devices assist the resident in communication, provides the ability for the resident to continue to pay bills independently and promote socialization.



**Writing Bird**

## Dressing/Grooming

There are many devices available to assist the resident in dressing independently. These devices help residents put on socks, fasten buttons, and close zippers. There are also assistive devices for personal grooming for brushing hair and teeth.



**Zipper pull**



**Sock Donner**



**Elastic shoe laces**



**Button threader**



**Collapsible dressing stick**



**Long-handled shoe horn**



**Long-handled comb and brush**

## Showering/Bathing

Assisted devices for the shower aid the residents who are unsteady by allowing these individuals the ability to bath independent while reducing the risk of falling.



**Shower Chair**



**Grab bars for tub**



**Shower Transfer Bench**



**Grab bars in shower**



**Long-handled bathing sponge**



**Hand-held shower massager**



**Hair washing brush**

### Transferring

Assistive devices for transfers allows for great mobility and independence. These devices assist the resident in getting out of bed or moving from the bed to the wheelchair independently or with minimal supervision.



**Bed Cane**



**Transfer board**



## Major Categories of Mental Illness

### Neurotic Disorders – Anxiety Disorders

Characteristics	Examples	Treatment
<p>A generalized feeling of apprehension, tension and uneasiness, usually associated with anticipation of a negative event. May be chronic or acute in nature.</p>	<ul style="list-style-type: none"> <li>• <b>Phobias</b> – excessive or unreasonable fear of a specific object or situation</li> <li>• <b>Panic Disorder</b> – sudden onset of intense apprehension, fear, or terror that is unrelated to a specific object or situation</li> <li>• <b>Generalized Anxiety Disorder</b> – persistent anxiety usually accompanied by symptoms; examples include, but are not limited to:               <ul style="list-style-type: none"> <li>○ Restlessness</li> <li>○ Pacing</li> <li>○ Biting nails</li> <li>○ Nausea/upset stomach- “butterflies”</li> <li>○ Sweaty palms</li> <li>○ Heart palpitations</li> <li>○ Wringing hands</li> <li>○ Twitches</li> </ul> </li> <li>• <b>Post-traumatic Stress Disorder</b> – development of characteristic symptoms following a psychologically traumatic event (abuse, observation of a situation resulting in severe injury or death, recovery from a severe accident, “near-death” experience, war). Symptoms include:               <ul style="list-style-type: none"> <li>○ Re-experiencing the event</li> <li>○ Reducing involvement in normal activities (work, play, etc.)</li> <li>○ Dysphoria-an emotional state characterized by depression, restlessness, and malaise, usually accompanied by poor self-esteem.</li> </ul> </li> <li>• <b>Compulsive Disorders</b> – a disorder in which anxiety is controlled by associating it with repetitive thoughts and acts; expressed as the persistent recurrence of a distressing thought, a persistent urge to perform negative acts, or a recurring thought accompanied by an urge to perform a repetitive act.</li> </ul>	<p>Medications</p> <p>Psychological counseling</p> <p>Psychiatric care</p> <p>Reduction of stress factors/supportive environment</p>

### Psychotic Disorders – Schizophrenic Disorders

Characteristics	Examples	Treatment
<p>Severe disruption of reality and cognitive disturbances (hallucinations and delusions)</p>	<ul style="list-style-type: none"> <li>• <b>Paranoid</b> – suffers primarily from delusions of persecution, delusions of grandeur, and delusions of body changes; the person with paranoid schizophrenia cannot identify himself as part of the real world seen by others, but only identifies himself as part of the world he sees.</li>   <li>• <b>Catatonic</b> – the chief symptom is the patient's assumption of "frozen", often bizarre and uncomfortable positions, held for considerable periods of time; the person may resist being moved and, if forced to move may go into a state of extreme physical excitement.</li> </ul>	<p>Medications</p> <p>Psychiatric care</p> <p>Reduction of stress factors/supportive environment</p>

### Mood Disorders – Affective Disorders

Characteristics	Examples	Treatment
<p>Mood disturbances predominate in the affective disorders; however, cognitive disturbances may also occur</p>	<ul style="list-style-type: none"> <li>• <b>Depression</b> – an illness which affects thoughts, feelings, and behaviors.               <ul style="list-style-type: none"> <li>○ Emotional symptoms                   <ul style="list-style-type: none"> <li>▪ Persistent sad or anxious state</li> <li>▪ No/reduced interest or pleasure in daily activities</li> <li>▪ Feelings of emptiness or isolation</li> <li>▪ Feelings of guilt, worthlessness, or shame</li> <li>▪ Thoughts of death or suicide</li> <li>▪ Low self-esteem</li> <li>▪ Self-destructive thinking/behavior</li> </ul> </li> <li>○ Thought-process change (cognitive impairments)                   <ul style="list-style-type: none"> <li>▪ Slowed thinking</li> <li>▪ difficulty concentrating, remembering or making decisions</li> </ul> </li> <li>○ Physical symptoms                   <ul style="list-style-type: none"> <li>▪ Low energy; fatigue</li> <li>▪ Disturbance in sleep pattern (insomnia, early awakening, sleeping late)</li> <li>▪ Weight change (loss or gain)</li> <li>▪ Headaches, digestive disorders, pain</li> <li>▪ Agitation, restlessness, nervous twitching, non-purposeful movements, tremulous hands</li> <li>▪ Delusions and/or hallucinations</li> <li>▪ Decreased interest in sexual activity; sexual dysfunction</li> <li>▪ Self-destructive behavior or suicide attempts</li> </ul> </li> </ul> </li> <li>• <b>Manic-Depressive (Bi-polar disorder)</b> – person fluctuates between periods of depression and periods of elation; mood swings may be very rapid, with the resident going from an elated mood to a depressive mood in a short period of time. Manic symptoms include:               <ul style="list-style-type: none"> <li>▪ Irritability</li> <li>▪ Distractibility; poor judgment</li> <li>▪ Loud, rapid speech; may be slurred</li> <li>▪ Decreased need for sleep</li> <li>▪ Inflated self-esteem</li> <li>▪ Increased involvement in goal-directed activity</li> <li>▪ Excessive involvement in activities that may be dangerous to self or others</li> <li>▪ Inability to recognize danger</li> <li>▪ May demonstrate hostility and paranoia</li> <li>▪ Increased physical or verbally abuse behavior</li> </ul> </li> </ul>	<p>Medications</p> <p>Psychological care</p> <p>Psychiatric care</p> <p>Reduction of stress factors/supportive environment</p>

Types of Drugs

Stimulants - "uppers"; speed up the nervous system

Classification	Medical Use	Effects	Hazards of Abuse
<p><b>Amphetamines</b>                      ["speed" "bennies"                      "pep pills" "whites"]</p> <p><b>Prescription Medications:</b>                      Adderall</p>	<ul style="list-style-type: none"> <li>• Control weight</li> <li>• Treat mild depression</li> </ul>	<ul style="list-style-type: none"> <li>• Increased heart rate; increased blood pressure</li> <li>• Loss of appetite</li> <li>• Feeling of alertness, increased self-esteem or self-confidence</li> </ul>	<ul style="list-style-type: none"> <li>• Extreme exhaustion due to increased activity</li> <li>• Tolerance and psychological dependence</li> <li>• Withdrawal of drug can result in suicidal depression</li> <li>• Continued high doses can cause physical dependence, heart problems, infections, malnutrition, death</li> </ul>
<p><b>Cocaine</b>                      ["coke" "snow"                      "flake"]</p>	<ul style="list-style-type: none"> <li>• Rarely used for medical purposes</li> </ul>	<ul style="list-style-type: none"> <li>• Quickened pulse and circulation</li> <li>• Sharpened or heightened reactions</li> <li>• Increased restlessness, anxiety, depression</li> <li>• Feelings of well-being, over-confidence, etc.</li> <li>• Confusion</li> <li>• Paranoia</li> <li>• Nervous exhaustion</li> <li>• Hallucinations</li> </ul>	<ul style="list-style-type: none"> <li>• Chronic use can destroy nasal membranes</li> <li>• Lesions in lungs</li> <li>• Tolerance and psychological dependence</li> <li>• Overdose can cause seizures, respiratory or cardiac failure, or death</li> </ul>

**Depressants - "Downers"; slows down the central nervous system**

<b>Classification</b>	<b>Medical Use</b>	<b>Effects</b>	<b>Hazards of Abuse</b>
<p><b>Barbiturates</b>                      ["Barbs"; "goof-balls"; "blues"]</p> <p><b>Prescription Medications:</b>                      Phenobarbital, Amytal</p>	<ul style="list-style-type: none"> <li>• Treat hypertension</li> <li>• Treat seizure disorders</li> <li>• Relaxation before and during surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Slowed heart rate and respiration</li> <li>• Lowered blood pressure or hypotension</li> <li>• Slowed reactions</li> <li>• Confusion</li> <li>• Weakened emotional control; lability</li> <li>• Distortion of reality</li> <li>• Reduced awareness</li> </ul>	<ul style="list-style-type: none"> <li>• Tolerance and psychological dependence</li> <li>• Impaired judgment can cause accidents due to slowed response time, confusion</li> <li>• Overdose can cause coma, seizures, respiratory or cardiac failure, or death; accidental overdose is possible due to unawareness of how much of the drug has been taken</li> <li>• Withdrawal can be dangerous and require medical interventions</li> </ul>
<p><b>Tranquilizers</b></p> <p><b>Prescription Medications:</b>                      Valium, Ativan, Xanax, Ambien</p>	<ul style="list-style-type: none"> <li>• Treat anxiety</li> <li>• Relax muscles</li> </ul>	<ul style="list-style-type: none"> <li>• Slowed heart rate and respiration</li> <li>• Lowered blood pressure or hypotension</li> <li>• Slowed reactions</li> <li>• Drowsiness; relaxation</li> <li>• Reduced awareness</li> <li>• Confusion</li> <li>• Loss of coordination</li> <li>• Changes in personality</li> </ul>	<ul style="list-style-type: none"> <li>• Same as for Barbiturates</li> </ul>
<p><b>Methaqualone</b>                      ["Soapers"; "quads"; "ludes"]</p>	<ul style="list-style-type: none"> <li>• Treat anxiety</li> <li>• Insomnia</li> </ul>	<ul style="list-style-type: none"> <li>• Slowed heart rate and respiration</li> <li>• Lowered blood pressure or hypotension</li> <li>• Slowed reactions</li> <li>• Sleepiness, drowsiness; relaxation</li> <li>• Reduced awareness</li> <li>• Confusion</li> <li>• Loss of coordination</li> <li>• Impaired perception</li> <li>• Dizziness</li> <li>• Feeling of well-being</li> </ul>	<ul style="list-style-type: none"> <li>• Same as for Barbiturates</li> </ul>

**Depressants – continued**

Classification	Medical Use	Effects	Hazards of Abuse
<p><b>Hallucinogens</b></p>	<ul style="list-style-type: none"> <li>• None</li> </ul>	<ul style="list-style-type: none"> <li>• Changes in perception and consciousness</li> <li>• Increased heart rate and blood pressure</li> <li>• Increased blood sugar</li> <li>• Irregular respiration</li> <li>• Euphoria</li> <li>• Loss of ability to separate fact and fantasy</li> <li>• Distortion of senses</li> <li>• Hallucinations</li> <li>• Paranoia, panic</li> <li>• Violence, irrational behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Tolerance develops quickly</li> <li>• Increased risk of birth defects in user's children</li> <li>• "Flashbacks", effects may recur intermittently without use of drug</li> <li>• Overdose can cause psychosis</li> <li>• Death, increased risk for accidents and suicide</li> </ul>
<p><b>Narcotics</b>  <b>Lowers perception of pain</b>  <b>Prescription Medications:</b>  <b>Morphine, Codeine, Fentanyl, Methadone, Oxycotin, Percodet, Percodan</b></p>	<ul style="list-style-type: none"> <li>• Heroin: None</li> <li>• Morphine: Relieves pain</li> <li>• Opium: Relieves pain; treat diarrhea; suppress cough</li> <li>• Codeine: Relieves pain, suppress cough</li> <li>• Demerol: Relieves pain</li> <li>• Methadone: treat Heroin addiction</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced respiratory rate</li> <li>• Reduced hunger, thirst</li> <li>• Drowsiness, lethargy</li> <li>• Reduced sex drive</li> <li>• Euphoria</li> <li>• Apathy</li> <li>• Heavy feeling in extremities</li> <li>• Impaired concentration</li> <li>• Loss of judgment and self-control</li> </ul>	<ul style="list-style-type: none"> <li>• Physical and psychological dependence</li> <li>• Withdrawal is very painful</li> <li>• Overdose can cause coma, seizures, respiratory or cardiac failure, death</li> <li>• Malnutrition</li> <li>• Infections at injection sites; poor self-care</li> <li>• Hepatitis</li> <li>• Renal failure</li> </ul>
<p><b>Cannabis</b>  <b>Alters mood, thinking and behavior</b>  <b>[Marijuana, Hashish]</b></p>	<ul style="list-style-type: none"> <li>• <b>Experimental</b> use for treatment of glaucoma and control of side effects of chemotherapy</li> </ul>	<ul style="list-style-type: none"> <li>• Increased heart rate</li> <li>• Lowered body temperature</li> <li>• Increased appetite</li> <li>• Loss of coordination</li> <li>• Feeling of well-being</li> <li>• Confusion</li> <li>• Distortion of reality</li> <li>• Depression, panic, anxiety</li> <li>• Hallucinations may occur with large dosages</li> </ul>	<ul style="list-style-type: none"> <li>• Psychological dependence</li> <li>• Overdose may cause paranoia, psychosis like state</li> <li>• Long-term use is associated with chronic lung disease</li> </ul>

# Identifying Medications that Older Adults Should Avoid or Use With Caution: the 2012 American Geriatrics Society Updated Beers Criteria

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## Summary of this Study

For more than 20 years, *the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* has been the leading source of information about the safety of prescribing drugs for older people. To help prevent medication side effects and other drug-related problems in older adults, the American Geriatrics Society (AGS) has updated and expanded this important resource. The expanded *AGS Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults* identifies medications with risks that may be greater than their benefits for people 65 and older.

## Why Experts Developed the Beers Criteria

As you get older, your body changes. These changes can increase the chances that you'll have side effects when you take medications. Older people usually have more health problems and take more medications than younger people. Because of this, they are also more likely to experience dangerous drug-drug interactions. Every year, one in three adults 65 or older has one or more adverse (harmful) reactions to a medication or medications. This is why it's important for researchers to identify and help reduce use of drugs that are associated with more risks than benefits in older people.

The *Beers Criteria* was last updated in 2003. The criteria need to be updated regularly because new drugs continue to be marketed and new studies continue to provide information on the safety of existing medications. In 2011, the criteria was updated by the American Geriatrics Society using a panel of healthcare and pharmacy experts. The AGS will continue to update the criteria on a regular basis.

The updated 2012 AGS Beers Criteria is published in the *Journal of the American Geriatrics Society*. It is available online at [www.americangeriatrics.org](http://www.americangeriatrics.org).

## What the Researchers Found

Using a time-tested method for developing care guidelines, and following the recommendations of the Institute of Medicine, members of the expert panel reviewed more than 2,000 high-quality research studies about medications prescribed for older adults.

Based on the review of this research, the experts identified:

- 34 medications and types of medications that are "potentially inappropriate" for older people. Healthcare providers should consider avoiding drugs on this list when

prescribing for adults 65 or older. These medications pose a higher risk of side effects, may not work as well in an older person, and may be replaced with safer or more effective medications or non-drug remedies.

- Medications used for 14 common health problems that are potentially inappropriate for older adults. Older adults often have other diseases or disorders in addition to these 14 health problems that the medications may make worse.
- 14 types of drugs that are potentially inappropriate and should be used only with caution in older adults. Drugs on this list may cause medication-related problems and may not be completely effective. However, they may be the best choice available for certain older patients. Healthcare providers need to carefully monitor how these drugs are working and keep an eye out for side effects. And older adults who take these medications, or their caregivers need to let their healthcare professionals know if these drugs don't seem to be working, or appear to be causing side effects.

## How Health Professionals Are to Use this List

Healthcare providers refer to the *AGS Beers Criteria* when deciding whether and what to prescribe for older adults, but *should not make these decisions based only on the criteria*. Among other reasons, they shouldn't do this because the criteria don't apply to all situations that older patients face. The criteria, for example, don't take into account all of the unique circumstances of older people getting palliative or hospice care.

Because the criteria shouldn't dictate what healthcare providers prescribe, healthcare providers should not be penalized for prescribing a medication for an older person simply because it is on one of the criteria lists. Different older adults respond differently to the same medication, and, again, for some patients, drugs listed in the criteria will be the best choices.

The criteria are also used in research, training, determining healthcare policy, developing insurance company policies regarding medication coverage, efforts to improve the quality of prescribing for older people, and the development of quality standards for drug therapy for older adults.

## What You Can Do

To lower the chance of drug-related problems:

- Keep a list of all of the medications you take—both non-prescription and prescription. This includes any supplements that you take, such as vitamins. You should also write down the doses, and bring it with you whenever you see a healthcare professional. This way, he or she will know what drugs and supplements you are taking and can check whether these might be causing side effects, or could cause side effects, if taken along with new medications.

- Ask if any of your medications are known to cause side effects. And if so, ask what they are—so you can watch for them. If you think you may be having a bad reaction to a drug, tell your healthcare professional. You should also speak with your healthcare provider if a drug you are taking appears in the *2012 AGS Beers Criteria* and you are concerned that it may be causing side effects or other problems. You should **not** simply stop taking a medication because you think it may not be working or causing side effects, or because it is included in one of the three lists mentioned above. **You should never stop taking medications without first checking with a healthcare professional.**
- Keep in mind that if a drug you take is on one of the lists in the *AGS Beers Criteria*, this does not necessarily mean that it poses greater risks than benefits *for you*. The way you respond to a medication or medications can differ from the way other people respond to it. This is why the experts who updated the criteria use the phrase “*potentially inappropriate*.” While the drugs on the lists *may* cause side effects in some older adults, they won’t necessarily cause these problems in *all* older people.

<b><i>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</i></b>		
<b>Drugs and Categories of Drugs</b>	<b>Why these drugs may be inappropriate for older adults</b>	<b>Recommendations</b>
<i>Anticholinergic drugs—these drugs can cause side effects such as confusion, hallucinations, sleepiness, blurred vision, difficulty urinating, dry mouth and constipation in older adults.</i>		
Antihistamines—drugs that are typically prescribed for allergies, hives and eczema: <ul style="list-style-type: none"> <li>• Brompheniramine</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine</li> <li>• Cyproheptadine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine</li> <li>• Diphenhydramine (oral)</li> <li>• Doxylamine</li> <li>• Hydroxyzine</li> <li>• Promethazine</li> <li>• Triprolidine</li> </ul>	These drugs cause many side effects in older adults, including confusion, drowsiness, blurred vision, difficulty urinating, dry mouth and constipation. Safer medications are available.	Avoid  Use of diphenhydramine in special situations—such as for treating severe allergic reactions—may be appropriate.

### AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

Drugs and Categories of Drugs	Why these drugs may be inappropriate for older adults	Recommendations
Antiparkinsonian drugs prescribed for Parkinson's disease and other health problems: <ul style="list-style-type: none"> <li>• Benzotropine (oral)</li> <li>• Trihexyphenidyl</li> </ul>	There are other medications that are usually more effective for Parkinson's disease and related disorders than these. The drugs should not be used for other conditions, like treating side effects of other medications (for example the movement side effects of antipsychotic medications).	Avoid
Antispasmodic medications prescribed to relieve cramps or spasms: <ul style="list-style-type: none"> <li>• Belladonna alkaloids</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Dicyclomine</li> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> </ul>	It's is not clear whether these drugs are effective, but they have side effects.	Avoid except if used in short-term "comfort care."
<i>Antithrombotics—these are medications to prevent or dissolve blood clots that can form inside blood vessels. These blood clots can be life-threatening.</i>		
The short-acting form of Dipyridamole that is taken by mouth	This form may make your blood pressure drop when you stand up. This can make you dizzy and may lead to dangerous falls. More effective alternatives are available. The form of dipyridamole that is injected, however, can be used during a heart "stress test."	Avoid
Ticlopidine	Safer, effective alternatives to this drug are available.	Avoid
<i>Anti-infective drugs—such as antibiotics and antiviral drugs</i>		
Nitrofurantoin, an antibacterial drug prescribed for urinary tract infections	This drug may cause side effects that affect the lungs. Safer medications are available.	Avoid long-term use and in patients with certain kidney problems.

**AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

Drugs and Categories of Drugs	Why these drugs may be inappropriate for older adults	Recommendations
<i>Cardiovascular drugs—for disorders that affect the heart and blood vessels.</i>		
Alpha <sub>1</sub> blockers—drugs for the prostate but also prescribed for high blood pressure. <ul style="list-style-type: none"> <li>• Doxazosin</li> <li>• Prazosin</li> <li>• Terazosin</li> </ul>	These drugs can cause a drop in blood pressure and dizziness when you stand up. This can lead to falls. Alternative treatments provide better results with lower risks.	Avoid using for high blood pressure.
Medications, called Alpha agonists, which are prescribed for high blood pressure. <ul style="list-style-type: none"> <li>• Clonidine</li> <li>• Guanabenz</li> <li>• Guanfacine</li> <li>• Methyldopa</li> <li>• Reserpine at doses greater than 0.1 milligrams daily</li> </ul>	These drugs may cause a slow heartbeat and dizziness. They are not recommended for routine treatment of high blood pressure.	Clonidine should not be a first-choice treatment for high blood pressure. The other drugs on the list should be avoided.
Antiarrhythmic drugs prescribed for atrial fibrillation (irregular heart beat). (Class Ia, Ic, III) <ul style="list-style-type: none"> <li>• Amiodarone</li> <li>• Dofetilide</li> <li>• Dronedarone</li> <li>• Flecainide</li> <li>• Ibutilide</li> <li>• Procainamide</li> <li>• Propafenone</li> <li>• Quinidine</li> <li>• Sotalol</li> </ul>	Other treatments may provide better results, or cause fewer side effects, or both.  Amiodarone may contribute to thyroid, lung and heart problems.	These drugs should not be the first choice for treating atrial fibrillation.
Disopyramide	Disopyramide may increase risks of heart failure in older adults and may cause confusion, blurred vision, difficulty urinating, dry mouth and constipation. Safer medications are available.	Avoid
Dronedarone	There are other drugs that provide better results in patients with atrial fibrillation (irregular heartbeat) or heart failure.	Avoid in some patients with atrial fibrillation or heart failure.

**AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

Drugs and Categories of Drugs	Why these drugs may be inappropriate for older adults	Recommendations
Digoxin at doses higher than 0.125 milligrams per day	In older patients with heart failure, higher doses appear to offer no additional benefit and may increase risks of dangerous side effects. Older patients with kidney problems are at particular risk of side effects.	Avoid
Nifedipine, immediate release	This drug may lower blood pressure and could cause other heart problems.	Avoid
Spironolactone at doses higher than 25 milligrams daily	In people with heart failure, higher doses may boost risks of high potassium.	Avoid higher doses in patients with heart failure or lower kidney function.
<i>Drugs affecting the brain and spinal cord</i>		
Tertiary Tricyclic Antidepressants, alone or in combination: <ul style="list-style-type: none"> <li>• Amitriptyline</li> <li>• Chlordiazepoxide-amitriptyline</li> <li>• Clomipramine</li> <li>• Doxepin at doses of more than 6 milligrams per day.</li> <li>• Imipramine</li> <li>• Perphenazine-amitriptyline</li> <li>• Trimipramine</li> </ul>	Potential side effects include: confusion, drowsiness, blurred vision, difficulty urinating, dry mouth and constipation in older adults. They can also cause a drop in blood pressure and dizziness when you stand up. Safer medications are available.	Avoid
All antipsychotic drugs	These drugs may increase risks of confusion, sleepiness, blurred vision, difficulty urinating, dry mouth, constipation, stroke, and death in people with dementia.	Avoid using these drugs to treat behavioral problems in older people with memory disorders unless non-drug options haven't worked and the patient is a threat to himself or herself or others.
Thioridazine Mesoridazine	These drugs may cause confusion, sleepiness, blurred vision, difficulty urinating, dry mouth and constipation. They may also increase risks of dangerous changes in heartbeat.	Avoid

**AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

Drugs and Categories of Drugs	Why these drugs may be inappropriate for older adults	Recommendations
Barbiturates <ul style="list-style-type: none"> <li>• Amobarbital</li> <li>• Butabarbital</li> <li>• Butalbital</li> <li>• Mephobarbital</li> <li>• Pentobarbital</li> <li>• Phenobarbital</li> <li>• Secobarbital</li> </ul>	These medications can be addictive. Over time, they get less effective in helping older adults sleep. They are more likely to cause overdoses at lower doses than alternative drugs.	Avoid
Benzodiazepines <i>Short- and intermediate-acting:</i> <ul style="list-style-type: none"> <li>• Alprazolam</li> <li>• Estazolam</li> <li>• Lorazepam</li> <li>• Oxazepam</li> <li>• Temazepam</li> <li>• Triazolam</li> </ul> <i>Long-acting:</i> <ul style="list-style-type: none"> <li>• Chlorzepate</li> <li>• Chlordiazepoxide</li> <li>• Chlordiazepoxide-amitriptyline</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Clonazepam</li> <li>• Diazepam</li> <li>• Flurazepam</li> <li>• Quazepam</li> </ul>	Older adults are especially sensitive to these medications. These drugs may increase risks of mental decline, delirium, falls, fractures, and car accidents in older adults.  Despite these risks, they may be appropriate, in certain cases, for treating seizures, certain sleep disorders, anxiety disorders, withdrawal from benzodiazepine drugs and alcohol, and end-of-life care.	Avoid benzodiazepines (all types) when treating insomnia, agitation, or delirium (serious confusion that may have lasting effects).
Chloral hydrate	Not effective long-term, with high risk of overdose.	Avoid
Meprobamate	This medication makes older adults sleepy and can be addictive.	Avoid
Nonbenzodiazepine hypnotics <ul style="list-style-type: none"> <li>• Eszopiclone</li> <li>• Zolpidem</li> <li>• Zaleplon</li> </ul>	These medications may not significantly improve sleep and can cause many serious side effects, including confusion, falls, and bone fractures.	Avoid ongoing use of these drugs (over 90 days).
Ergot mesylates Isoxsuprine	These medications are not very effective.	Avoid

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>		
<b>Drugs and Categories of Drugs</b>	<b>Why these drugs may be inappropriate for older adults</b>	<b>Recommendations</b>
<i>Drugs and treatments for conditions affecting the glands that produce and secrete hormones, such as androgens (“male hormones”) and estrogen and progestins (“female hormones”)</i>		
Androgens • Methyltestosterone • Testosterone	These drugs may worsen heart problems and cause other side effects. They shouldn’t be prescribed for men with prostate cancer.	Avoid using in men with prostate cancer. In other men, prescribe only for moderate to severe declines in natural testosterone production.
Desiccated thyroid	Desiccated thyroid may not be appropriate for patients with a history of heart problems. Safer medications are available.	Avoid
Estrogens with or without progestins	These hormones may increase risks of breast cancer and cancer of the lining of the uterus. They don’t appear to help protect women from heart disease or loss of cognitive (thinking) ability in later life.  Estrogen cream inserted into the vagina does help vaginal dryness and is safe in women with breast cancer, especially if low doses are used.	Avoid pills and skin patches. Vaginal creams can be used at low doses to relieve pain during sex, and help prevent urinary tract infections, and related vaginal problems.
Growth hormone	Growth hormone has many side effects, including joint pain, swelling, enlargement of breast tissue in men, and carpal tunnel syndrome. It may also increase the chance of getting diabetes.	Avoid, except in patients who have had their pituitary gland removed for medical reasons.
Insulin, sliding scale	This way of dosing insulin is not very effective and can increase the chance of low blood sugar.	Avoid
Megestrol	This drug, prescribed to increase appetite, is not very effective, and may increase the chance of blood clots and, possibly, death.	Avoid

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>		
<b>Drugs and Categories of Drugs</b>	<b>Why these drugs may be inappropriate for older adults</b>	<b>Recommendations</b>
Sulfonylureas, long-duration <ul style="list-style-type: none"> <li>• Chlorpropamide</li> <li>• Glyburide</li> </ul>	Both medications can cause dangerous low blood sugar and other side effects in older adults. Safer medications are available.	Avoid
<i>Medications for gastrointestinal problems</i>		
Metoclopramide	This medication may cause shakiness, sleepiness, and uncontrollable abnormal body movements. Frail older adults may be even more likely to get these effects.	Avoid, except for gastroparesis, a condition that reduces the ability of the stomach to empty its contents.
Mineral oil, taken by mouth	When swallowed, mineral oil may be accidentally inhaled and, as a result, can cause pneumonia. Safer medications are available.	Avoid
Trimethobenzamide	Not very effective for treating vomiting. This medication can cause side effects such as shakiness, sleepiness, and abnormal body movements.	Avoid
<i>Pain Medications</i>		
Meperidine	This is not a very effective pain reliever and may cause seizures. Safer medications are available.	Avoid

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>		
<b>Drugs and Categories of Drugs</b>	<b>Why these drugs may be inappropriate for older adults</b>	<b>Recommendations</b>
Non-COX-selective Non-Steroidal Anti-inflammatory Drugs (NSAIDs), oral <ul style="list-style-type: none"> <li>• Aspirin at doses higher than 325 milligrams per day</li> <li>• Diclofenac</li> <li>• Diflunisal</li> <li>• Etodolac</li> <li>• Fenoprofen</li> <li>• Ibuprofen</li> <li>• Ketoprofen</li> <li>• Meclofenamate</li> <li>• Mefenamic acid</li> <li>• Meloxicam</li> <li>• Nabumetone</li> <li>• Naproxen</li> <li>• Oxaprozin</li> <li>• Piroxicam</li> <li>• Sulindac</li> <li>• Tolmetin</li> </ul>	<p>These medications increase the chance of stomach and intestinal bleeding in adults 75 or older, and adults 65 and older taking certain other medications (like prednisone warfarin, and clopidogrel) and medicines to prevent stroke.</p> <p>Taking a powerful stomach medication like a proton-pump inhibitor (omeprazole) or misoprostol at the same time as these drugs lowers—but doesn't eliminate—these risks.</p>	Do not use these medications regularly unless there are no other effective alternatives and they are prescribed along with a proton-pump inhibitor or misoprostol.
Indomethacin Ketorolac	These drugs are NSAIDs that are even more likely to increase the chance of stomach and intestinal bleeding and ulcers or to cause other harmful effects.	Avoid
Pentazocine	This pain reliever can cause confusion, hallucinations and other side effects. Safer medications are available.	Avoid
Skeletal muscle relaxants <ul style="list-style-type: none"> <li>• Carisoprodol</li> <li>• Chlorzoxazone</li> <li>• Cyclobenzaprine</li> <li>• Metaxalone</li> <li>• Methocarbamol</li> <li>• Orphenadrine</li> </ul>	Most muscle relaxants have questionable effectiveness and can cause side effects such as sleepiness and increased risks of bone fractures in older people.	Avoid

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>			
<b>Disease or Syndrome</b>	<b>Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>
Heart failure	<ul style="list-style-type: none"> <li>• Nonsteroidal antiinflammatory drugs (NSAIDs) and COX-2 inhibitors (see above list for examples)</li> </ul> Pioglitazone, rosiglitazone Cilostazol Dronedarone  If the heart failure is systolic heart failure: <ul style="list-style-type: none"> <li>• Diltiazem</li> <li>• Verapamil</li> </ul>	These drugs may increase the chance of fluid retention, and contribute to heart failure.	Avoid
Syncope or fainting	Acetylcholinesterase inhibitors <ul style="list-style-type: none"> <li>• Donepezil</li> <li>• Galantamine</li> <li>• Rivastigmine</li> </ul> Peripheral alpha blockers <ul style="list-style-type: none"> <li>• Doxazosin</li> <li>• Prazosin</li> <li>• Terazosin</li> </ul> Tertiary Tricyclic Antidepressants (TCAs): Amitriptyline, chlordiazepoxide-amitriptyline, clomipramine, doxepin, imipramine, perphenazine-amitriptyline, trimipramine Chlorpromazine, thioridazine, and olanzapine	These drugs increase the chance of dizziness, fainting, and falling, and may cause a slowed heartbeat.	Avoid
Chronic seizures or epilepsy	Bupropion Chlorpromazine Clozapine Maprotiline Olanzapine Thioridazine Thiothixene Tramadol	These medications may increase the frequency of seizures in some older adults. But they may be acceptable in older patients with well-controlled seizures and for whom other drugs have not been effective.	Avoid unless seizures are well controlled and other drugs do not work.

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>			
<b>Disease or Syndrome</b>	<b>Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>
Delirium	All Tricyclic Antidepressants (TCAs) All Anticholinergic drugs Benzodiazepines Chlorpromazine Corticosteroids H <sub>2</sub> -receptor antagonist Meperidine Sedative hypnotics Thioridazine	These medications can cause or worsen delirium in older people. Avoid these drugs in older adults with or at high risk of delirium.	Avoid
Dementia and cognitive/mental impairment	Anticholinergic drugs Benzodiazepines H <sub>2</sub> -receptor antagonists Zolpidem Antipsychotics—used regularly or as needed	Avoid these drugs in adults with cognitive or “thinking” problems because these medications may make this worse.  Antipsychotic drugs should not be prescribed for behavioral problems related to dementia unless non-drug or safer drug options are not working and a patient is a threat to himself or others. Antipsychotic drugs may increase the chance of stroke and death in people with dementia.	Avoid
A history of falls or fractures	Anticonvulsants Antipsychotics Benzodiazepines Nonbenzodiazepine hypnotics <ul style="list-style-type: none"> <li>• Eszopiclone</li> <li>• Zaleplon</li> <li>• Zolpidem</li> </ul> Tricyclic Antidepressants (TCAs) and Selective Serotonin Uptake Inhibitors (SSRIs)	These drugs can cause fainting and falls, and make it hard to coordinate movements.	Avoid unless safer medications are not available. Avoid anticonvulsant drugs in someone with a history of falls/fractures unless it is for seizures.

**AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

Disease or Syndrome	Drug(s)	Rationale	Recommendation
Insomnia	Oral decongestants <ul style="list-style-type: none"> <li>• Pseudoephedrine</li> <li>• Phenylephrine</li> </ul> Stimulants <ul style="list-style-type: none"> <li>• Amphetamine</li> <li>• Methylphenidate</li> <li>• Pemoline</li> </ul> Other medications <ul style="list-style-type: none"> <li>• Theophylline</li> <li>• Caffeine</li> </ul>	These drugs make insomnia worse.	Avoid
Parkinson's disease	All antipsychotics except quetiapine and clozapine  Antiemetics <ul style="list-style-type: none"> <li>• Metoclopramide</li> <li>• Prochlorperazine</li> <li>• Promethazine</li> </ul>	These drugs may worsen symptoms of Parkinson's disease and/or cause Parkinson's-like symptoms  Quetiapine and clozapine appear to be less likely to worsen symptoms of Parkinson's disease than the other drugs listed here.	Avoid
Chronic constipation	Oral medications for urinary incontinence <ul style="list-style-type: none"> <li>• Darifenacin</li> <li>• Fesoterodine</li> <li>• Oxybutynin</li> <li>• Solifenacin</li> <li>• Tolterodine</li> <li>• Trospium</li> </ul> Antihistamines <ul style="list-style-type: none"> <li>• Brompheniramine (various)</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine (various kinds)</li> <li>• Cyproheptadine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine (various kinds)</li> <li>• Diphenhydramine</li> <li>• Doxylamine</li> <li>• Hydroxyzine</li> <li>• Promethazine</li> <li>• Triprolidine</li> </ul>	The medications can worsen constipation and safer medications are available.	Avoid unless no other alternatives are available.

<b>AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>			
<b>Disease or Syndrome</b>	<b>Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>
Chronic constipation (cont'd)	Heart/blood pressure medications <ul style="list-style-type: none"> <li>• Diltiazem</li> <li>• Verapamil</li> </ul> Other medications <ul style="list-style-type: none"> <li>• Antipsychotics</li> <li>• Belladonna alkaloids</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Dicyclomine</li> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> <li>• Tertiary Tricyclic Antidepressants (amitriptyline, clomipramine, doxepin, imipramine, and trimipramine)</li> </ul>	The medications can worsen constipation and safer medications are available.	Avoid unless no other alternatives are available.
Repeated stomach or intestinal ulcers	Aspirin at doses higher than 325 milligrams per day Non-COX-2 selective NSAIDs	These drugs may make ulcers worse and increase the chance of new ulcers.	Avoid these drugs unless other medications are not effective and the patient can take an accompanying medication that can help prevent ulcers—such as a proton-pump inhibitor or misoprostol.
Poor kidney function	Nonsteroidal anti-inflammatory drugs  Triamterene (alone or in combination with other medications)	These drugs may increase risks of potentially serious kidney damage.	Avoid
Urinary incontinence (accidental loss of urine) in women	Estrogen in pill or patch form (but not estrogen cream inserted into the vagina)	Estrogen in pill or patch form can make urinary incontinence worse in women.	Avoid in women.

**AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**

<b>Disease or Syndrome</b>	<b>Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>
Prostate enlargement or urinary problems in men	Ipratropium inhaler Tiotropium inhaler	These medications may cause aggravated prostate problems and make urination more difficult.	Avoid in men.
Stress or mixed urinary incontinence (loss of urine when sneezing/ coughing/ bending over/with exercise)	Alpha-blockers • Doxazosin • Prazosin • Terazosin	These may make bladder-control problems worse	Avoid in women.

<b>2012 AGS Beers Criteria for Potentially Inappropriate Medications to Be Used with Caution in Older Adults</b>		
<b>Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>
Aspirin to prevent heart attacks and other "cardiac events"	In adults 80-years-old and older, aspirin may do more harm than good	Use aspirin with caution in adults 80 and older.
Dabigatran	This medication, used to prevent the formation of blood clots in patients with atrial fibrillation, increases the chance of bleeding in adults 75 years and older more than another drug, warfarin, that is used for the same purpose. There isn't enough evidence that dabigatran is effective and safe in patients with kidney problems.	Use this drug with caution in adults 75 and in older adults with kidney problems.
Prasugrel	This drug can increase the chance of bleeding in older adults, but may be appropriate for some older adults at very high risk of future heart problems.	Use with caution in adults 75 years or older.
Antipsychotics Carbamazepine Carboplatin Cisplatin All antidepressants Vincristine	These drugs may lower your blood sodium level to dangerous levels. Healthcare providers should monitor patients taking these medications.	Use with caution.
Vasodilators	These drugs may increase risks of fainting in older adults with a history of fainting.	Use with caution.

This summary is from the full report titled, *AGS Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*. It is in the March 2012 issue of the *Journal of the American Geriatrics Society (JAGS)*. The report is authored by the American Geriatrics Society 2012 Beers Criteria Update Expert Panel.

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<b>Table 2. 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</b>					
<b>Organ System/ Therapeutic Category/Drug(s)</b>	<b>Rationale</b>	<b>Recommendation</b>	<b>Quality of Evidence</b>	<b>Strength of Recommendation</b>	<b>References</b>
<i>Anticholinergics (excludes TCAs)</i>					
First-generation antihistamines (as single agent or as part of combination products) <ul style="list-style-type: none"> <li>• Brompheniramine</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine</li> <li>• Cyproheptadine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine</li> <li>• Diphenhydramine (oral)</li> <li>• Doxylamine</li> <li>• Hydroxyzine</li> <li>• Promethazine</li> <li>• Triprolidine</li> </ul>	Highly anticholinergic; clearance reduced with advanced age, and tolerance develops when used as hypnotic; increased risk of confusion, dry mouth, constipation, and other anticholinergic effects/toxicity.  Use of diphenhydramine in special situations such as acute treatment of severe allergic reaction may be appropriate.	Avoid	Hydroxyzine and promethazine: high; All others: moderate	Strong	<a href="#">Agostini 2001</a> <a href="#">Boustani 2007</a> <a href="#">Guaiana 2010</a> <a href="#">Han 2001</a> <a href="#">Rudolph 2008</a>
Antiparkinson agents • Benztropine (oral) <ul style="list-style-type: none"> <li>• Trihexyphenidyl</li> </ul>	Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson disease.	Avoid	Moderate	Strong	<a href="#">Rudolph 2008</a>
Antispasmodics <ul style="list-style-type: none"> <li>• Belladonna alkaloids</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Dicyclomine</li> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> </ul>	Highly anticholinergic, uncertain effectiveness.	Avoid except in short-term palliative care to decrease oral secretions.	Moderate	Strong	<a href="#">LechevallierMichel 2005</a> <a href="#">Rudolph 2008</a>
<i>Antithrombotics</i>					
Dipyridamole, oral short-acting* (does not apply to the extended-release combination with aspirin)	May cause orthostatic hypotension; more effective alternatives available; IV form acceptable for use in cardiac stress testing.	Avoid	Moderate	Strong	<a href="#">De Schryver 2010</a> <a href="#">Dipyridamole Package Insert</a>
Ticlopidine*	Safer, effective alternatives available.	Avoid	Moderate	Strong	<a href="#">Ticlopidine Package Insert</a>

<i>Anti-infective</i>					
Nitrofurantoin	Potential for pulmonary toxicity; safer alternatives	Avoid for long-term suppression;	Moderate	Strong	<a href="#">Felts 1971</a> <a href="#">Hardak 2010</a> <a href="#">Holmberg</a>

	available; lack of efficacy in patients with CrCl <60 mL/min due to inadequate drug concentration in the urine.	avoid in patients with CrCl <60 mL/min.			<a href="#">1980</a>
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*Cardiovascular*

Alpha <sub>1</sub> blockers <ul style="list-style-type: none"> <li>• Doxazosin</li> <li>• Prazosin</li> <li>• Terazosin</li> </ul>	High risk of orthostatic hypotension; not recommended as routine treatment for hypertension; alternative agents have superior risk/benefit profile.	Avoid use as an antihypertensive.	Moderate	Strong	<a href="#">ALLHAT 2000</a> <a href="#">Aronow2011</a>
Alpha blockers, central <ul style="list-style-type: none"> <li>• Clonidine</li> <li>• Guanabenz*</li> <li>• Guanfacine*</li> <li>• Methyldopa*</li> <li>• Reserpine (&gt;0.1 mg/day)*</li> </ul>	High risk of adverse CNS effects; may cause bradycardia and orthostatic hypotension; not recommended as routine treatment for hypertension.	Avoid clonidine as a first-line antihypertensive.  Avoid others as listed.	Low	Strong	<a href="#">Aronow 2011</a> <a href="#">Methyldopa Package Insert</a> <a href="#">Reserpine Package Insert</a>
Antiarrhythmic drugs (Class Ia, Ic, III) <ul style="list-style-type: none"> <li>• Amiodarone</li> <li>• Dofetilide</li> <li>• Dronedarone</li> <li>• Flecainide</li> <li>• Ibutilide</li> <li>• Procainamide</li> <li>• Propafenone</li> <li>• Quinidine</li> <li>• Sotalol</li> </ul>	Data suggest that rate control yields better balance of benefits and harms than rhythm control for most older adults.  Amiodarone is associated with multiple toxicities, including thyroid disease, pulmonary disorders, and QT interval prolongation.	Avoid antiarrhythmic drugs as first-line treatment of atrial fibrillation.	High	Strong	<a href="#">Roy 2008</a> <a href="#">Doyle 2009</a> <a href="#">Fuster 2006</a> <a href="#">Van Gelder 2002</a> <a href="#">Wann 2011a</a> <a href="#">Wyse 2002</a>

Disopyramide*	Disopyramide is a potent negative inotrope and therefore may induce heart failure in older adults; strongly anticholinergic; other antiarrhythmic drugs preferred.	Avoid	Low	Strong	<a href="#">Fuster 2006</a> <a href="#">Disopyramide Package Insert</a>
Dronedarone	Worse outcomes have been reported in patients taking dronedarone who have permanent atrial fibrillation or heart	Avoid in patients with permanent atrial fibrillation	Moderate	Strong	<a href="#">Connolly 2011</a> <a href="#">FDA Drug Safety 2011</a> <a href="#">Hohnloser 2009</a> <a href="#">Korber 2008</a>

	failure. In general, rate control is preferred over rhythm control for atrial fibrillation.	or heart failure			<a href="#">Dronedarone Package Insert – revised Dec2011</a>
Digoxin >0.125 mg/day	In heart failure, higher dosages associated with no additional benefit and may increase risk of toxicity; decreased renal clearance may lead to increased risk of toxic effects.	Avoid	Moderate	Strong	<a href="#">Adams 2002</a> <a href="#">Ahmed 2007</a> <a href="#">Rathore 2003</a>
Nifedipine, immediate release*	Potential for hypotension; risk of precipitating myocardial ischemia.	Avoid	High	Strong	<a href="#">Furberg 1995</a> <a href="#">Nifedipine Package Insert</a> <a href="#">Pahor1995</a> <a href="#">Psaty1995a</a> <a href="#">Psaty1995b</a>
Spironolactone >25 mg/day	In heart failure, the risk of hyperkalemia is higher in older adults if taking >25 mg/day.	Avoid in patients with heart failure or with a CrCl <30 mL/min.	Moderate	Strong	<a href="#">Juurlink 2004</a>

*Central Nervous System*

<p>Tertiary TCAs, alone or in combination:</p> <ul style="list-style-type: none"> <li>• Amitriptyline</li> <li>• Chlordiazepoxideamitriptyline</li> <li>• Clomipramine</li> <li>• Doxepin &gt;6 mg/day</li> <li>• Imipramine</li> <li>• Perphenazine-amitriptyline</li> <li>• Trimipramine</li> </ul>	<p>Highly anticholinergic, sedating, and cause orthostatic hypotension; the safety profile of low-dose doxepin (<math>\leq 6</math> mg/day) is comparable to that of placebo.</p>	<p>Avoid</p>	<p>High</p>	<p>Strong</p>	<p><a href="#">Coupland 2011</a> <a href="#">Nelson 2011</a> <a href="#">Scharf 2008</a></p>
<p>Antipsychotics, first- (conventional) and second- (atypical) generation (see <b>Table 8</b> for full list)</p>	<p>Increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia.</p>	<p>Avoid use for behavioral problems of dementia unless nonpharmacologic options have failed and patient is threat to self or others.</p>	<p>Moderate</p>	<p>Strong</p>	<p><a href="#">Dore 2009</a> <a href="#">Maher 2011</a> <a href="#">Schneider 2005</a> <a href="#">Schneider 2006a</a> <a href="#">Schneider 2006b</a> <a href="#">Vigen 2011</a></p>
<p>Thioridazine Mesoridazine</p>	<p>Highly anticholinergic and greater risk of QT-</p>	<p>Avoid</p>	<p>Moderate</p>	<p>Strong</p>	<p><a href="#">Goldstein 1974</a> <a href="#">Ray 2001</a></p>

	<p>interval prolongation.</p>				<p><a href="#">Stollberger 2005</a></p>
<p>Barbiturates • Amobarbital*</p> <ul style="list-style-type: none"> <li>• Butobarbital*</li> <li>• Butalbital</li> <li>• Mephobarbital*</li> <li>• Pentobarbital*</li> <li>• Phenobarbital</li> <li>• Secobarbital*</li> </ul>	<p>High rate of physical dependence; tolerance to sleep benefits; greater risk of overdose at low dosages.</p>	<p>Avoid</p>	<p>High</p>	<p>Strong</p>	<p><a href="#">Cumbo 2010</a> <a href="#">McLean 2000</a> <a href="#">Messina 2005</a></p>

<p>Benzodiazepines <i>Short- and intermediate-acting:</i></p> <ul style="list-style-type: none"> <li>• Alprazolam</li> <li>• Estazolam</li> <li>• Lorazepam</li> <li>• Oxazepam</li> <li>• Temazepam</li> <li>• Triazolam</li> </ul> <p><i>Long-acting:</i></p> <ul style="list-style-type: none"> <li>• Chlorazepate</li> <li>• Chlordiazepoxide</li> <li>• Chlordiazepoxideamitriptyline</li> <li>• Clidinium-chlordiazepoxide</li> <li>• Clonazepam</li> <li>• Diazepam</li> <li>• Flurazepam</li> <li>• Quazepam</li> </ul>	<p>Older adults have increased sensitivity to benzodiazepines and decreased metabolism of long-acting agents. In general, all benzodiazepines increase risk of cognitive impairment, delirium, falls, fractures, and motor vehicle accidents in older adults.</p> <p>May be appropriate for seizure disorders, rapid eye movement sleep disorders, benzodiazepine withdrawal, ethanol withdrawal, severe generalized anxiety disorder, periprocedural anesthesia, end-of-life care.</p>	<p>Avoid benzodiazepines (any type) for treatment of insomnia, agitation, or delirium.</p>	<p>High</p>	<p>Strong</p>	<p><a href="#">Allain 2005</a> <a href="#">Cotroneo 2007</a> <a href="#">Finkle 2011</a> <a href="#">Paterniti 2002</a></p>
<p>Chloral hydrate*</p>	<p>Tolerance occurs within 10 days and risk outweighs the benefits in light of overdose with doses only 3 times the recommended dose.</p>	<p>Avoid</p>	<p>Low</p>	<p>Strong</p>	<p><a href="#">Bain 2006</a> <a href="#">Goldstein 1978</a> <a href="#">Miller 1979</a></p>
<p>Meprobamate</p>	<p>High rate of physical dependence; very sedating.</p>	<p>Avoid</p>	<p>Moderate</p>	<p>Strong</p>	<p><a href="#">Keston 1974</a> <a href="#">Rhalimi 2009</a></p>
<p>Nonbenzodiazepine hypnotics</p> <ul style="list-style-type: none"> <li>• Eszopiclone</li> <li>• Zolpidem</li> <li>• Zaleplon</li> </ul>	<p>Benzodiazepinereceptor agonists that have adverse events similar to those of benzodiazepines in older adults (e.g.,</p>	<p>Avoid chronic use (&gt;90 days)</p>	<p>Moderate</p>	<p>Strong</p>	<p><a href="#">Allain 2005</a> <a href="#">Cotroneo 2007</a> <a href="#">Finkle 2011</a> <a href="#">McCrae 2007</a> <a href="#">Orriols 2011</a> <a href="#">Rhalimi 2009</a></p>
	<p>delirium, falls, fractures); minimal improvement in sleep latency and duration.</p>				<p><a href="#">Wang 2001b</a> <a href="#">Yang 2011</a></p>
<p>Ergot mesylates* Isoxsuprine*</p>	<p>Lack of efficacy.</p>	<p>Avoid</p>	<p>High</p>	<p>Strong</p>	<p><a href="#">Isoxsuprine Package Insert</a></p>

<i>Endocrine</i>					
Androgens <ul style="list-style-type: none"> <li>• Methyltestosterone*</li> <li>• Testosterone</li> </ul>	Potential for cardiac problems and contraindicated in men with prostate cancer.	Avoid unless indicated for moderate to severe hypogonadism.	Moderate	Weak	<a href="#">Basaria 2010</a> <a href="#">Jones 2011</a>
Desiccated thyroid	Concerns about cardiac effects; safer alternatives available.	Avoid	Low	Strong	<a href="#">Baskin2002</a> <a href="#">ReesJones1977</a> <a href="#">ReesJones1980</a> <a href="#">Sawin1978</a> <a href="#">Sawin1989</a>
Estrogens with or without progestins	<p>Evidence of carcinogenic potential (breast and endometrium); lack of cardioprotective effect and cognitive protection in older women.</p> <p>Evidence that vaginal estrogens for treatment of vaginal dryness is safe and effective in women with breast cancer, especially at dosages of estradiol &lt;25 mcg twice weekly.</p>	<p>Avoid oral and topical patch.</p> <p>Topical vaginal cream: Acceptable to use lowdose intravaginal estrogen for the management of dyspareunia, lower urinary tract infections, and other vaginal symptoms.</p>	<p>Oral and patch: high</p> <p>Topical: moderate</p>	<p>Oral and patch: strong</p> <p>Topical: weak</p>	<a href="#">Bath 2005</a> <a href="#">Cho 2005</a> <a href="#">Epp 2010</a> <a href="#">Hendrix 2005</a> <a href="#">Perrotta 2008</a> <a href="#">Sare 2008</a>
Growth hormone	Impact on body composition is small and associated with edema, arthralgia, carpal tunnel syndrome, gynecomastia, impaired fasting glucose.	Avoid, except as hormone replacement following pituitary gland removal.	High	Strong	<a href="#">Liu 2007</a>

Insulin, sliding scale	Higher risk of hypoglycemia without improvement in hyperglycemia management regardless of care setting.	Avoid	Moderate	Strong	<a href="#">Queale 1997</a>
Megestrol	Minimal effect on weight; increases risk of thrombotic events and possibly death in older adults.	Avoid	Moderate	Strong	<a href="#">Bodenner 2007</a> <a href="#">Reuben 2005</a> <a href="#">Simmons 2005</a> <a href="#">Yeh 2000</a>
Sulfonylureas, long-duration <ul style="list-style-type: none"> <li>Chlorpropamide</li> <li>Glyburide</li> </ul>	Chlorpropamide: prolonged half-life in older adults; can cause prolonged hypoglycemia; causes SIADH Glyburide: higher risk of severe prolonged hypoglycemia in older adults.	Avoid	High	Strong	<a href="#">Clarke 1975</a> <a href="#">Gangji 2007</a> <a href="#">Shorr 1996</a>
<i>Gastrointestinal</i>					
Metoclopramide	Can cause extrapyramidal effects including tardive dyskinesia; risk may be further increased in frail older adults.	Avoid, unless for gastroparesis.	Moderate	Strong	<a href="#">Bateman 1985</a> <a href="#">Ganzini 1993</a> <a href="#">Miller 1989</a>
Mineral oil, given orally	Potential for aspiration and adverse effects; safer alternatives available.	Avoid	Moderate	Strong	<a href="#">Marchiori 2010a</a> <a href="#">Marchiori 2010b</a> <a href="#">Meltzer 2006</a> <a href="#">Simmons 2007</a>
Trimethobenzamide	One of the least effective antiemetic drugs; can cause extrapyramidal adverse effects.	Avoid	Moderate	Strong	<a href="#">Bardfeld 1966</a> <a href="#">Moertel 1963</a>
<i>Pain Medications</i>					
Meperidine	Not an effective oral analgesic in dosages commonly used; may cause neurotoxicity; safer alternatives available.	Avoid	High	Strong	<a href="#">Kaiko 1982</a> <a href="#">Szeto 1977</a> <a href="#">Meperidine Package Insert</a>

<p>Non-COX-selective NSAIDs, oral</p> <ul style="list-style-type: none"> <li>• Aspirin &gt;325 mg/day</li> <li>• Diclofenac</li> <li>• Diflunisal</li> <li>• Etodolac</li> <li>• Fenoprofen</li> <li>• Ibuprofen</li> <li>• Ketoprofen</li> <li>• Meclofenamate</li> <li>• Mefenamic acid</li> <li>• Meloxicam</li> <li>• Nabumetone</li> <li>• Naproxen</li> <li>• Oxaprozin</li> <li>• Piroxicam</li> <li>• Sulindac</li> <li>• Tolmetin</li> </ul>	<p>Increases risk of GI bleeding/peptic ulcer disease in high-risk groups, including those &gt;75 years old or taking oral or parenteral corticosteroids, anticoagulants, or antiplatelet agents. Use of proton pump inhibitor or misoprostol reduces but does not eliminate risk. Upper GI ulcers, gross bleeding, or perforation caused by NSAIDs occur in approximately 1% of patients treated for 3–6 months, and in about 2%–4% of patients treated for 1 year. These trends continue with longer duration of use.</p>	<p>Avoid chronic use unless other alternatives are not effective and patient can take gastroprotective agent (protonpump inhibitor or misoprostol)</p>	<p>All others: moderate</p>	<p>Strong</p>	<p><a href="#">AGS Pain Guideline 2009</a>  <a href="#">Langman 1994</a>  <a href="#">Lanas 2006</a>  <a href="#">Llorente</a>  <a href="#">Melero 2002</a>  <a href="#">Pilotto 2003</a>  <a href="#">Piper 1991</a></p>
<p>Indomethacin Ketorolac, includes parenteral</p>	<p>Increases risk of GI bleeding/peptic ulcer disease in high-risk groups (See above Non-COX selective NSAIDs) Of all the NSAIDs, indomethacin has most adverse effects.</p>	<p>Avoid</p>	<p>Indomethacin: moderate  Ketorolac: high;</p>	<p>Strong</p>	<p><a href="#">Onder2004</a></p>
<p>Pentazocine*</p>	<p>Opioid analgesic that causes CNS adverse effects, including confusion and hallucinations, more commonly than other narcotic drugs; is also a mixed agonist and antagonist; safer alternatives available.</p>	<p>Avoid</p>	<p>Low</p>	<p>Strong</p>	<p><a href="#">AGS Pain Guideline 2009</a>  <a href="#">Pentazocine Package Insert</a></p>

Skeletal muscle relaxants <ul style="list-style-type: none"> <li>• Carisoprodol</li> <li>• Chlorzoxazone</li> <li>• Cyclobenzaprine</li> <li>• Metaxalone</li> <li>• Methocarbamol</li> <li>• Orphenadrine</li> </ul>	Most muscle relaxants poorly tolerated by older adults, because of anticholinergic adverse effects, sedation, increased risk of fractures; effectiveness at	Avoid	Moderate	Strong	<a href="#">Billups2011</a> <a href="#">Rudolph 2008</a>
	dosages tolerated by older adults is questionable.				

**\*Infrequently used drugs**

*Abbreviations:* ACEI, angiotensin converting-enzyme inhibitors; ARB, angiotensin receptor blockers; CNS, central nervous system; COX, cyclooxygenase; CrCl, creatinine clearance; GI, gastrointestinal; NSAIDs, nonsteroidal anti-inflammatory drugs; SIADH, syndrome of inappropriate antidiuretic hormone secretion; TCAs, tricyclic antidepressants

*The primary target audience is the practicing clinician. The intentions of the criteria include: 1) improving the selection of prescription drugs by clinicians and patients; 2) evaluating patterns of drug use within populations; 3) educating clinicians and patients on proper drug usage; and 4) evaluating health-outcome, quality of care, cost, and utilization data.*

**Table 3. 2012 AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults Due to Drug-Disease or Drug-Syndrome Interactions That May Exacerbate the Disease or Syndrome**

Disease or Syndrome	Drug(s)	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation	References
<i>Cardiovascular</i>						
Heart failure	NSAIDs and COX-2 inhibitors  Nondihydropyridine CCBs (avoid only for systolic heart failure) <ul style="list-style-type: none"> <li>• Diltiazem</li> <li>• Verapamil</li> </ul> Pioglitazone, rosiglitazone  Cilostazol Dronedarone	Potential to promote fluid retention and/or exacerbate heart failure.	Avoid	NSAIDs: moderate; CCBs: moderate; Thiazolidinediones (glitazones): high; Cilostazol: low; Dronedarone: moderate	Strong	<a href="#">Cilostazol Package Insert</a> <a href="#">Connolly 2011</a> <a href="#">Dronedarone Package Insert – revised Dec2011</a> <a href="#">Heerdink 1998</a> <a href="#">Goldstein 1991</a> <a href="#">Jessup 2009</a> <a href="#">Korber 2009</a> <a href="#">Loke 2011</a> <a href="#">Pioglitazone Package Insert</a> <a href="#">Rosiglitazone Package Insert</a>

Syncope	Acetylcholinesterase inhibitors (AChEIs) Peripheral alpha blockers <ul style="list-style-type: none"> <li>• Doxazosin</li> <li>• Prazosin</li> <li>• Terazosin</li> </ul> Tertiary TCAs  Chlorpromazine, thioridazine, and olanzapine	Increases risk of orthostatic hypotension or bradycardia.	Avoid	AChEIs and alpha blockers: high  TCAs and antipsychotics: Moderate	AChEIs and TCAs: strong  Alpha blockers and antipsychotics: weak	<a href="#">Bordier 2005</a> <a href="#">Davidson1989</a> <a href="#">French 2006</a> <a href="#">Gaggioli1997</a> <a href="#">Gill 2009</a> <a href="#">Kim 2011</a> <a href="#">Litvinenko 2008</a> <a href="#">Nickel 2008</a> <a href="#">Schneider 2006a</a> <a href="#">Schneider 2006b</a> <a href="#">Wild 2010</a>
<i>Central Nervous System</i>						
Chronic seizures or epilepsy	Bupropion Chlorpromazine Clozapine	Lowers seizure threshold; may be acceptable in	Avoid	Moderate	Strong	<a href="#">Pisani 2002</a>

	Maprotiline Olanzapine Thioridazine Thiothixene Tramadol	patients with well-controlled seizures in whom alternative agents have not been effective.				
Delirium	All TCAs Anticholinergics (see <b>Table 9</b> for full list) Benzodiazepines Chlorpromazine Corticosteroids H <sub>2</sub> -receptor antagonist Meperidine Sedative hypnotics Thioridazine	Avoid in older adults with or at high risk of delirium because of inducing or worsening delirium in older adults; if discontinuing drugs used chronically, taper to avoid withdrawal symptoms.	Avoid	Moderate	Strong	<a href="#">Clegg 2011</a> <a href="#">Gaudreau 2005</a> <a href="#">Laurila 2008</a> <a href="#">Marcantonio 1994</a> <a href="#">Moore 1999</a> <a href="#">Morrison 2003</a> <a href="#">Ozbolt 2008</a> <a href="#">Panharipande 2006</a> <a href="#">Rudolph 2008</a> <a href="#">Stockl 2010</a>

Dementia and cognitive impairment	Anticholinergics (see <b>Table 9</b> for full list) Benzodiazepines H <sub>2</sub> -receptor antagonists Zolpidem Antipsychotics, chronic and as-needed use	Avoid due to adverse CNS effects.  Avoid antipsychotics for behavioral problems of dementia unless nonpharmacologic options have failed and patient is a threat to themselves or others. Antipsychotics are associated increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia.	Avoid	High	Strong	<a href="#">Boustani 2007</a> <a href="#">Hanlon2004</a> <a href="#">Finkle 2011</a> <a href="#">Frey 2011</a> <a href="#">Paterniti 2002</a> <a href="#">Rasmussen 1999</a> <a href="#">Rudolph 2008</a> <a href="#">Schneider 2005</a> <a href="#">Schneider 2006a</a> <a href="#">Schneider 2006b</a> <a href="#">Seitz 2011</a> <a href="#">Vigen 2011</a> <a href="#">Wright 2009</a>
History of falls or fractures	Anticonvulsants Antipsychotics Benzodiazepines Nonbenzodiazepine hypnotics <ul style="list-style-type: none"> <li>• Eszopiclone</li> <li>• Zaleplon</li> <li>• Zolpidem</li> </ul>	Ability to produce ataxia, impaired psychomotor function, syncope, and additional falls; shorter-acting benzodiazepines	Avoid unless safer alternatives are not available; avoid anticonvulsants except	High	Strong	<a href="#">Allain 2005</a> <a href="#">Berdot 2009</a> <a href="#">Deandrea 2010</a> <a href="#">Ensrud 2003</a> <a href="#">Hartikainen 2007</a> <a href="#">Jalbert 2010</a> <a href="#">Liperoti 2007</a>
	TCAs/SSRIs	are not safer than long-acting ones.	for seizure			<a href="#">Mets 2010</a> <a href="#">Sterke 2008</a> <a href="#">Turner 2011</a> <a href="#">van der Hoof 2008</a> <a href="#">Vestergaard 2008</a> <a href="#">Wagner 2004</a> <a href="#">Wang 2001a</a> <a href="#">Wang 2001b</a> <a href="#">Zint 2010</a>

Insomnia	<p>Oral decongestants</p> <ul style="list-style-type: none"> <li>• Pseudoephedrine</li> <li>• Phenylephrine</li> </ul> <p>Stimulants</p> <ul style="list-style-type: none"> <li>• Amphetamine</li> <li>• Methylphenidate</li> <li>• Pemoline</li> </ul> <p>Theobromines</p> <ul style="list-style-type: none"> <li>• Theophylline</li> <li>• Caffeine</li> </ul>	CNS stimulant effects	Avoid	Moderate	Strong	<a href="#">Foral 2011</a>
Parkinson disease	<p>All antipsychotics (see <b>Table 8</b> for full list, except for quetiapine and clozapine)</p> <p>Antiemetics</p> <ul style="list-style-type: none"> <li>• Metoclopramide</li> <li>• Prochlorperazine</li> <li>• Promethazine</li> </ul>	<p>Dopamine receptor antagonists with potential to worsen parkinsonian symptoms.</p> <p>Quetiapine and clozapine appear to be less likely to precipitate worsening of Parkinson disease.</p>	Avoid	Moderate	Strong	<a href="#">Bateman 1985</a> <a href="#">Dore 2009</a> <a href="#">Ganzini 1993</a> <a href="#">Morgan 2005</a> <a href="#">Thanvi 2009</a>
<i>Gastrointestinal</i>						
Chronic constipation	<p>Oral antimuscarinics for urinary incontinence</p> <ul style="list-style-type: none"> <li>• Darifenacin</li> <li>• Fesoterodine</li> <li>• Oxybutynin (oral)</li> <li>• Solifenacin</li> <li>• Tolterodine</li> <li>• Trospium</li> </ul> <p>Nondihydropyridine CCB</p> <ul style="list-style-type: none"> <li>• Diltiazem</li> <li>• Verapamil</li> </ul> <p>First-generation</p>	<p>Ability to worsen constipation; agents for urinary incontinence: antimuscarinics overall differ in incidence of constipation; response variable; consider alternative agent if constipation develops.</p>	Avoid unless no other alternatives	<p>For urinary incontinence: high</p> <p>All others: Moderate/low</p>	Weak	<a href="#">Glass 2008</a> <a href="#">Meek 2011</a>

	<p>antihistamines as single agent or part of combination products</p> <ul style="list-style-type: none"> <li>• Brompheniramine (various)</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine (various)</li> <li>• Cyproheptadine</li> <li>• Dexbrompheniramine</li> <li>• Dexchlorpheniramine (various)</li> <li>• Diphenhydramine</li> <li>• Doxylamine</li> <li>• Hydroxyzine</li> <li>• Promethazine</li> <li>• Triprolidine</li> </ul> <p>Anticholinergics/antispasmodics (see <b>Table 9</b> for full list of drugs with strong anticholinergic properties)</p> <ul style="list-style-type: none"> <li>• Antipsychotics</li> <li>• Belladonna alkaloids</li> <li>• Clidiniumchloridiazepoxide</li> <li>• Dicyclomine</li> <li>• Hyoscyamine</li> <li>• Propantheline</li> <li>• Scopolamine</li> <li>• Tertiary TCAs (amitriptyline, clomipramine, doxepin, imipramine, and trimipramine)</li> </ul>					
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History of gastric or duodenal ulcers	Aspirin (>325 mg/day) Non-COX-2 selective NSAIDs	May exacerbate existing ulcers or cause new/additional ulcers.	Avoid unless other alternatives are not effective and patient can take gastroprotective agent (protonpump inhibitor or misoprostol)	Moderate	Strong	<a href="#">Gabriel 1991</a> <a href="#">Laine 2010</a>
<i>Kidney/Urinary Tract</i>						
Chronic kidney disease stages IV and V	NSAIDs  Triamterene (alone or in combination)	May increase risk of kidney injury.  May increase risk of acute kidney injury.	Avoid  Avoid	NSAIDs: moderate  Triamterene: low	NSAIDs: strong  Triamterene: weak	<a href="#">Farge 1986</a> <a href="#">Favre 1982</a> <a href="#">Gooch 2007</a> <a href="#">Griffin 2000</a> <a href="#">Lafrance 2009</a> <a href="#">Murray 1995</a> <a href="#">Perazella 1999</a> <a href="#">Schneider 2006</a> <a href="#">Sica 1989</a> <a href="#">Winkelmayer 2008</a>
Urinary incontinence (all types) in women	Estrogen oral and transdermal (excludes intravaginal estrogen)	Aggravation of incontinence.	Avoid in women	High	Strong	<a href="#">Dew 2003</a> <a href="#">Epp 2010</a> <a href="#">Grodstein 2004</a> <a href="#">Hartmann 2009</a> <a href="#">Hendrix 2005</a> <a href="#">Perrotta 2008</a> <a href="#">Ruby 2010</a>
Lower urinary tract symptoms, benign prostatic hyperplasia	Inhaled anticholinergic agents  Strongly anticholinergic drugs, except antimuscarinics for urinary incontinence (see Table 9 for complete list).	May decrease urinary flow and cause urinary retention.	Avoid in men	Moderate	Inhaled agents: strong All others: weak	<a href="#">Afonso 2011</a> <a href="#">Athanasopoulos 2003</a> <a href="#">Barkin 2004</a> <a href="#">Blake-James 2006</a> <a href="#">Chapple 2005</a> <a href="#">Griebing 2009</a> <a href="#">Kaplan 2006</a> <a href="#">Kraus 2010</a> <a href="#">Malone-Lee 2001</a> <a href="#">Martin Merino 2009</a> <a href="#">Spigset 1999</a> <a href="#">Uher 2009</a> <a href="#">Verhamme 2008</a>

						<a href="#">Wuerstle 2011</a>
Stress or mixed urinary incontinence	Alpha-blockers • Doxazosin • Prazosin • Terazosin	Aggravation of incontinence.	Avoid in women	Moderate	Strong	<a href="#">Marshall 1996</a> <a href="#">Ruby 2010</a>
<p><i>Abbreviations:</i> CCBs, calcium channel blockers; AChEIs, acetylcholinesterase inhibitors; CNS, central nervous system; COX, cyclooxygenase; NSAIDs, nonsteroidal anti-inflammatory drugs; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants</p> <p><i>The primary target audience is the practicing clinician. The intentions of the criteria include: 1) improving the selection of prescription drugs by clinicians and patients; 2) evaluating patterns of drug use within populations; 3) educating clinicians and patients on proper drug usage; and 4) evaluating health-outcome, quality of care, cost, and utilization data.</i></p>						

Drug(s)	Rationale	Recommendation	Quality of Evidence	Strength of Recommendation	References
Aspirin for primary prevention of cardiac events	Lack of evidence of benefit versus risk in individuals ≥80 years old.	Use with caution in adults ≥80 years old.	Low	Weak	<a href="#">McQuaid 2006</a> <a href="#">Wolff 2009</a>
Dabigatran	Increased risk of bleeding compared with warfarin in adults ≥75 years old; lack of evidence for efficacy and safety in patients with CrCl <30 mL/min	Use with caution in adults ≥75 years old or if CrCl <30 mL/min.	Moderate	Weak	<a href="#">Connolly 2009</a> <a href="#">Diener 2010</a> <a href="#">Eikelboom 2011</a> <a href="#">Legrand 2011</a> <a href="#">Wann 2011b</a> <a href="#">Dabigatran Package Insert</a>

Prasugrel	Increased risk of bleeding in older adults; risk may be offset by benefit in highest-risk older patients (eg, those with prior myocardial infarction or diabetes).	Use with caution in adults ≥75 years old.	Moderate	Weak	<a href="#">Hochholzer 2011</a> <a href="#">Wiviott 2007</a> <a href="#">Prasugrel Package Insert</a>
Antipsychotics Carbamazepine Carboplatin Cisplatin Mirtazapine SNRIs SSRIs TCAs Vincristine	May exacerbate or cause SIADH or hyponatremia; need to monitor sodium level closely when starting or changing dosages in older adults due to increased risk.	Use with caution.	Moderate	Strong	<a href="#">Bouman 1998</a> <a href="#">Coupland 2011</a> <a href="#">Liamis 2008</a> <a href="#">Liu 1996</a>
Vasodilators	May exacerbate episodes of syncope in individuals with history of syncope.	Use with caution.	Moderate	Weak	<a href="#">Davidson1989</a> <a href="#">Gaggioli1997</a>

*Abbreviations:* CrCl, creatinine clearance; SIADH, syndrome of inappropriate antidiuretic hormone secretion; SSRIs, selective serotonin reuptake inhibitors; SNRIs, serotonin–norepinephrine reuptake inhibitors; TCAs, tricyclic antidepressants

*The primary target audience is the practicing clinician. The intentions of the criteria include: 1) improving the selection of prescription drugs by clinicians and patients; 2) evaluating patterns of drug use within populations; 3) educating clinicians and patients on proper drug usage; and 4) evaluating health-outcome, quality of care, cost, and utilization data.*

<b>Table 8. First- and Second-Generation Antipsychotics</b>	
<b>First-Generation (Conventional) Agents</b>	<b>Second-Generation (Atypical) Agents</b>
Chlorpromazine	Aripiprazole
Fluphenazine	Asenapine
Haloperidol	Clozapine
Loxapine	Iloperidone
Molindone	Lurasidone
Perphenazine	Olanzapine
Pimozide	Paliperidone
Promazine	Quetiapine
Thioridazine	Risperidone
Thiothixene	Ziprasidone
Trifluoperazine	
Triflupromazine	

**Table 9. Drugs with Strong Anticholinergic Properties**

<p>Antihistamines</p> <ul style="list-style-type: none"> <li>• Brompheniramine</li> <li>• Carbinoxamine</li> <li>• Chlorpheniramine</li> <li>• Clemastine</li> <li>• Cyproheptadine</li> <li>• Dimenhydrinate</li> <li>• Diphenhydramine</li> <li>• Hydroxyzine</li> <li>• Loratadine</li> <li>• Meclizine</li> </ul>	<p>Antiparkinson agents •</p> <ul style="list-style-type: none"> <li>• Benztropine</li> <li>• Trihexyphenidyl</li> </ul>	<p>Skeletal Muscle Relaxants •</p> <ul style="list-style-type: none"> <li>• Carisoprodol</li> <li>• Cyclobenzaprine</li> <li>• Orphenadrine</li> <li>• Tizanidine</li> </ul>
<p>Antidepressants</p> <ul style="list-style-type: none"> <li>• Amitriptyline</li> <li>• Amoxapine</li> <li>• Clomipramine</li> <li>• Desipramine</li> <li>• Doxepin</li> <li>• Imipramine</li> <li>• Nortriptyline</li> <li>• Paroxetine</li> <li>• Protriptyline</li> <li>• Trimipramine</li> </ul>	<p>Antipsychotics</p> <ul style="list-style-type: none"> <li>• Chlorpromazine</li> <li>• Clozapine</li> <li>• Fluphenazine</li> <li>• Loxapine</li> <li>• Olanzapine</li> <li>• Perphenazine</li> <li>• Pimozide</li> <li>• Prochlorperazine</li> <li>• Promethazine</li> <li>• Thioridazine</li> <li>• Thiothixene</li> <li>• Trifluoperazine</li> </ul>	
<p>Antimuscarinics (urinary incontinence)</p> <ul style="list-style-type: none"> <li>• Darifenacin</li> <li>• Fesoterodine</li> <li>• Flavoxate</li> <li>• Oxybutynin</li> <li>• Solifenacin</li> <li>• Tolterodine</li> <li>• Trospium</li> </ul>	<p>Antispasmodics</p> <ul style="list-style-type: none"> <li>• Atropine products</li> <li>• Belladonna alkaloids</li> <li>• Dicyclomine</li> <li>• Homatropine</li> <li>• Hyoscyamine products</li> <li>• Loperamide</li> <li>• Propantheline</li> <li>• Scopolamine</li> </ul>	



# **Residents with Special Health Care Needs**

## **Chapter Six**

**Time Required: 5 hours**

## **Chapter 6 - Residents with Special Health Care Needs**

This chapter will provide an overview of common health conditions of assisted living residents and how direct care staff can help residents in managing their conditions so that they can live optimally.

### **6.1 Common Health Conditions in Assisted Living**

#### **6.2 Hypertension**

#### **6.3 Arthritis/Rheumatoid Arthritis**

#### **6.4 Heart Disease (Cardiovascular Disease)**

#### **6.5 Osteoporosis**

#### **6.6 Diabetes**

#### **6.7 Stroke**

#### **6.8 Other Health Conditions**

#### **6.9 Special Care**

##### **6.9.1 Oxygen therapy**

##### **6.9.2 Skin Care**

##### **6.9.3 Incontinence Care**

#### **6.10 Staff Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. To understand common health conditions of assisted living residents
- b. To identify how you can help people with these health conditions
- c. To realize the psychosocial impact of these conditions
- d. To be aware of other special care needs of assisted living residents

### **2. Recommended Method of Instruction**

- Lecture and class discussion
- Student Activity – Group Exercise (**Handout #1**)
- Student Review – Chapter Six

## 6.1 Common Health Conditions in Assisted Living

Many individuals that move into assisted living require no assistance at all. It is a self-choice made for socialization purposes or to prepare for when the resident thinks he or she may need help. However, people generally move to assisted living because they need assistance with their ADL's or IADL's (Refer to Chapter One for the list of ADLs and IADLs). However, many residents in assisted living also have health conditions that may not only cause them to need help with their ADL's and IADL's but cause them to need special care. Details on how these health conditions impact a resident's care are found in a resident's ISP. However, some background information on these conditions will help direct care staff in their jobs and support them in providing the best quality care. According to the 2009 Overview of Assisted Living, there is a high incidence of the following health conditions in assisted living residents:

- **Hypertension (66% of residents or 2 out of 3 residents)**
- **Arthritis/Rheumatoid Arthritis (42% of residents, or a little less than half)**
- **Depression (30% or a little less than one in three)**
- **Heart Disease (33% of residents, or one out of three residents)**
- **Osteoporosis (27% of residents, or about one out of four residents)**
- **Macular Degeneration/Glaucoma (19% or a little less than one in five)**
- **Diabetes (17% of residents)**
- **Stroke (14% of residents)**

This chapter will provide an overview of some of these more common health conditions experienced by assisted living residents. Depression, macular degeneration and glaucoma are covered in Chapter Five.



### Group Discussion:

**Instructor Notes:** Asks the students, “How do you think dealing with a health condition every day might affect a person?” In responding to this question, think about what chronic conditions (if you have any) that affect you daily.

- **Discussion**
  - It may cause someone to be in a bad mood
  - It may cause someone to constantly be in discomfort or pain
  - It may cause someone to lose their appetite
  - It may cause someone to become depressed

## 6.2 Hypertension

- Hypertension
  - Definition and Changes that occur:
    - Hypertension is otherwise known as high blood pressure.
    - Hypertension is diagnosed by measuring someone's blood pressure. An example of this measurement is expressed with the following two numbers:

**140**  
**80**
    - The top number is the systolic pressure (the pressure created when the heart muscle contracts). The bottom number is the diastolic pressure (when the heart relaxes between beats). We will learn more about taking blood pressure in Chapter 11.
    - *Hypertension is defined as systolic blood pressure greater than 140 or diastolic blood pressure greater than 90.*
      - Prehypertension is a systolic pressure ranging from 120 to 139 mm Hg or a diastolic pressure ranging from 80 to 89 mm Hg. People with pre-hypertension are at serious risk for developing hypertension.

- For most people with hypertension, there is no identifiable cause.
- Symptoms of Hypertension
  - Unless someone has very high blood pressure, there are no major symptoms of hypertension so many people do not know they have it.
  - Symptoms of people with very high blood pressure are: dizziness, headaches, and more nosebleeds than normal.
- Treatment for Hypertension
  - There is no real cure for hypertension but it can be treated. Here are some ways it can be treated:
    - Medication
      - Medications that are effective in controlling hypertension include:
        - Diuretics stimulate urination and reduce salt and water retention. Diuretics may be effective alone or they may be prescribed along with another antihypertensive medication.
        - Beta blockers lower blood pressure and lower the heart rate, which reduces the amount of work the heart must do. These drugs are good for patients who have had a prior heart attack, angina (chest pain), and/or irregular heartbeats.
        - Angiotensin-Converting Enzyme Inhibitors (ACE inhibitors) lower blood

pressure, and help prevent or delay heart and kidney disease. These may cause cough and a rash in some people.

- Angiotensin Receptor Blockers (ARBs) have similar action to ACE inhibitors but do not cause cough.
- Alpha-Andrenergic Blockers relax the smooth muscle of blood vessel walls. These are helpful for men with diabetes, hypertension, and an enlarged prostate due to a benign prostatic hyperplasia (BPH).
- Calcium Channel Blockers relax blood vessels

- Changes in diet
- Exercise
- Weight loss
- Limiting alcohol
- Not smoking
- Reducing stress
- Other health conditions may exacerbate hypertension in older adults.
- Other medications, including many over-the-counter medications, may also cause hypertension.

○ Hypertension that is not treated can result in many other health problems, including:

- Stroke

- Heart attack
- Heart failure
- Kidney failure
- Hypertension is twice as common in people with diabetes and can cause additional serious problems. People with both diabetes and hypertension have a much greater risk of developing cardiovascular problems.
- Potential Staff Therapeutic Interventions
  - Diuretics can cause someone to urinate more frequently. Anticipate that residents on diuretics will need to use the bathroom more frequently.
  - Direct care staff should report any worsening of the symptoms and document according to facility protocol.

### **6.3 Arthritis/Rheumatoid Arthritis**

Arthritis means "inflammation of joints." Some people think arthritis is an unavoidable part of aging - this is not true. However, you are more likely to develop arthritis as you age. Many older people have some form of arthritis. There are different types of arthritis. Some of the most common are osteoarthritis, rheumatoid arthritis, and gout. Most arthritis is chronic, meaning it goes on for awhile. The most common type of arthritis in older adults is osteoarthritis, sometimes called degenerative arthritis. Some people believe that arthritis pain is just a "part of aging" and should just be tolerated. There are different treatment options and they should be explored so that a person can "live optimally". Living with pain can be very difficult and affects people psychologically and socially as well as physically.

- Osteoarthritis
  - Definition and Changes that occur:

- Osteoarthritis is a chronic disorder of cartilage (the connective tissue that cushions and protects the surface of bones where they meet to form joints), bones, and some of the tissues that surround joints. The cartilage begins to wear away and bones rub against each other.
  - Osteoarthritis most often happens in your hands, neck, lower back, or the large “weight-bearing” joints of your body, such as knees and hips. It does not necessarily affect the same joints on both sides of the body (for example, both knees).
  - It can cause pain, stiffness, deformity, and loss of function.
  - People have different levels of arthritis. For some people it is just aches and pains and for others it can be very disabling.
  - Arthritis is mostly caused by wear and tear on the joints. As you get older, your joints and the cartilage surrounding them are less able to recover from stress and damage. There are some things that may place people at greater risk for arthritis, like being overweight or previous injuries.
  - Arthritis can also be caused by abnormalities in the way joints are formed.
- Signs and Symptoms of Arthritis
    - Symptoms of arthritis usually develop gradually. Arthritis may start developing in only one or a few joints at first. With arthritis, people’s joints get stiff when they are not used. When a person with arthritis starts moving, it might be painful. Once they are moving, the pain usually gets less.

- Over time, the joints become more painful and it might be difficult to move. The joint might be unsteady and the person might have less range of movement.
  - Creaking sound(s) might be heard when a person moves.
  - Joints can become enlarged and deformed (like when you see “knotty”, gnarled hands).
  - Fluid buildup in large joints may also cause swelling.
  - Bony outgrowths may also form and press on nerves and blood vessels causing pain and decreased blood flow.
- Treatment for Arthritis
    - Medications may help relieve pain
      - acetaminophen (such as Tylenol)
      - **nonsteroidal anti-inflammatory drugs** (NSAIDS - such as ibuprofen)
    - Strengthening, endurance, and range-of-motion exercises may help reduce pain and restore function.
    - Providing a warm bath or warm clothing. Be cautious of using heating pads to provide warmth as this could be a burn risk.
    - Arthritis pain can be relieved in some people if they lose weight.
    - In some cases, surgery is performed to replace joints that are causing pain.
    - The right shoes and assistive devices (walkers, canes, etc.) may help someone with arthritis to get around.
    - Other assistive devices such as grabbers, gadgets to help open jars, etc. can help someone to be independent when arthritis may make it difficult to do every day things.

- Rheumatoid Arthritis (RA)
  - Definition and Changes that occur:
    - **It is the second most common type of arthritis.**
    - **It** is an *autoimmune* disease, a type of illness that makes your body attack itself.
    - It usually first appears in younger ages (between 25 and 50).
    - **It** can happen in many different joints at the same time. It can also happen in the same joint on both sides of your body.
    - **It** can also cause problems with your heart, muscles, blood vessels, nervous system, and eyes.
    - **It** causes pain, swelling, and stiffness that lasts for hours.
    - **It is an autoimmune disease. The body attacks its own connective tissue and damages the joints. The cause is unknown.**
  - **Signs and Symptoms of Rheumatoid Arthritis**
    - **It** is usually felt as pain, swelling, redness, warmth and tenderness in various joints.
    - While a person with rheumatoid arthritis might have morning stiffness, they might also have discomfort and fatigue that lasts throughout the day.
    - Some people have phases in which their symptoms are mild, with more extreme flare-ups that happen occasionally.
    - It may happen suddenly but most of the time it happens gradually.
    - People with **RA** often feel tired or run a fever.
    - Cysts might develop behind affected knees

- **RA** is more common in women than men.
- **Treatment for Rheumatoid Arthritis**
  - Medications may help alleviate pain and swelling. Some medications used are:
    - Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen
    - Anti-rheumatic drugs called DMARDs (**d**isease-**m**odifying **a**ntirheumatic **d**rugs)
    - Corticosteroids (such as prednisone)
    - Anti-cytokines
  - Exercise helps people with arthritis maintain motion in their joints.
  - Physical and occupational therapy
  - Knee or hip replacement in severe cases
  - Diet
  - For some people, certain types of food might cause flare-ups.
  - Rest
    - Periods of rest are important to help relieve pain, especially during flare-ups.
- Potential Staff Therapeutic Interventions
  - Residents with arthritis may require more time performing daily tasks. They may also need more help at different times, particularly when their joints are stiff.
  - Help residents to be as independent as possible
  - Help residents socialize with others
  - Help residents rest when necessary

- Watch for changes and report them - Notify a supervisor when a person has more pain or trouble moving.
- Psychosocial Impact of Arthritis
  - Arthritis may impact a resident psychosocially in addition to physically. This means that it may affect them psychologically (how they relate to themselves) and socially (how they relate to others).
  - Arthritis may result in a resident becoming depressed because she or he is in pain and may have trouble moving around.
  - Arthritis may cause residents to reduce their socializing because they are in pain, it takes longer for them to get moving, and they need more rest.

#### **6.4 Heart Disease (Cardiovascular Disease)**

Heart disease, or cardiovascular disease, is a general term given to a number of diseases and conditions related to the heart not working properly. The four most common types of heart disease are coronary heart disease, stroke, high blood pressure, and heart failure.

- Coronary Heart Disease
  - Definition and Changes that occur
    - Coronary heart disease, or coronary artery disease, is the most common form of heart disease.
    - Coronary heart disease is usually caused by atherosclerosis. To understand coronary heart disease, it is important to first understand atherosclerosis.
      - Atherosclerosis
        - Atherosclerosis is a blood vessel disorder.
        - Atherosclerosis is a slow, progressive condition that often starts in early adulthood or even

earlier. But by age 65 it affects one out of every two adults.

- In atherosclerosis, there is a build-up of fatty deposits called plaque on the inside walls of arteries. Over time, calcium accumulates in the plaques, making them stiff and causing them to enlarge. As the plaques enlarge, they reduce blood flow and sometimes block it.
  - In atherosclerosis, the artery may also become less elastic. When blood is pumped into them, the arteries cannot expand and the person may develop high blood pressure.
  - Blood clots may also form on plaques, which can also block blood flow through the artery.
  - Sometimes blood clots and plaques break off, travel through the bloodstream, and create blockages in an artery in another part of the body.
- Coronary heart disease occurs when plaques build up in the coronary arteries. These arteries supply your heart muscle with oxygen-rich blood.
  - If a coronary artery is completely blocked, some heart tissue may die. The death of heart tissue is called a myocardial infarction or heart attack.
  - If a lot of heart tissue dies, the heart's ability to pump blood to the rest of the body is impaired and heart failure may result.

- Risk factors for coronary heart disease and atherosclerosis
  - There are a number of risk factors that increase your chance of atherosclerosis and coronary heart disease.

They include:

- Smoking
  - Being physically inactive
  - Being overweight
  - Family history
  - Being older
  - High blood pressure
  - Abnormal cholesterol levels
  - Having diabetes
- Signs and symptoms of coronary heart disease
    - When the heart does not get enough oxygen, it causes a condition called myocardial ischemia. Its major symptom is **angina**. Angina is discomfort in the center of the chest behind the breastbone. It is usually described as tightness, squeezing, or pressure on the chest.
      - Angina may or may not be painful.
      - Angina usually develops gradually and goes away gradually. It may happen several times a day.
      - Angina is relieved by rest or taking a medication called nitroglycerin.
      - Individuals often mistake this for indigestion.
      - Direct Care Staff should report any of the symptoms to a supervisor immediately and document in the resident's record.

- With angina, people may also experience shortness of breath, nausea, dizziness, or fatigue. These symptoms might be triggered by physical activity.
- Other symptoms may occur when a heart attack occurs.
- Symptoms of a heart attack are similar to those of myocardial ischemia but they might last longer and be more severe.
  - Pain due to a heart attack may be felt in the chest, neck, throat, jaw, teeth, or arms.
  - However, in older people, a heart attack may cause very little chest pain or discomfort. Instead, a heart attack may cause shortness of breath, a smothering feeling, nausea, vomiting, sweating, dizziness, indigestion, palpitations, overwhelming fatigue, fainting, a feeling of impending doom, or any combination of these symptoms.
  - About one fourth of heart attacks occur without symptoms, as silent heart attacks.
- Treatment for coronary heart disease
  - Treatment depends on how bad the symptoms are and the extent of the blockage of the arteries.
  - People who have stable angina can be treated with drugs. People with unstable angina or heart attacks need to be hospitalized and treated immediately.
  - People with coronary heart disease take several different drugs. They may include:
    - Aspirin (or a similar drug)

- Antiplatelet drugs make blood clots less likely to form by preventing platelets from sticking together.
- Beta-blockers
  - Beta-blockers slow the heart rate and reduce the heart's need for oxygen. They also lower blood pressure.
- Nitrates
  - Nitrates, such as nitroglycerin, expand (dilate) blood vessels, improving blood flow to the heart.
- Calcium channel blockers
  - Calcium channel blockers dilate blood vessels, improve blood flow to the heart, and lower blood pressure.
- Angiotensin-converting enzyme (ACE) inhibitors
  - ACE inhibitors lower blood pressure and reduce the amount of work the heart has to do.
- Statins
  - Statins are used primarily to control abnormal cholesterol levels.
- Surgical procedures may be necessary in some cases. The common surgical procedures for coronary heart disease are:
  - Angioplasty

- Angioplasty is used to physically open a blocked coronary artery. It is less invasive than bypass surgery.
  - Bypass surgery
    - In bypass surgery, a vein or an artery from another part of the body is used to bypass the blocked coronary artery.
- Treatment may also include reducing risk factors for heart disease. For example:
  - Controlling cholesterol levels
  - Controlling blood pressure
  - Maintaining a healthy diet low in saturated and trans fats, eating more fruits, vegetables, and whole grains.
  - Not smoking
  - Losing weight
  - Exercising
- Heart Failure
  - Definition and changes that occur
    - Heart failure develops when the heart cannot pump as much blood as the body needs. It cannot keep up with the body.
    - The most common cause of heart failure is coronary heart disease. In particular, it is caused by heart attacks that cause the heart tissue to die. High blood pressure is also a major contributing factor.
    - When the heart cannot pump blood that the body needs, there are many consequences:

- The tissues of the body do not get enough oxygen and nutrients. Muscles may be more tired and organs may not function normally.
  - Fluid may accumulate in the abdomen, legs, feet, and lungs.
  - Blood clots may form, possibly leading to stroke.
- Symptoms of Heart Failure
    - Symptoms of heart failure may develop over a long period of time. Or, they may happen suddenly, such as if someone has a heart attack.
    - The main symptoms of heart failure are shortness of breath, fatigue, and swelling in the feet or ankles. The legs, liver, and abdomen may also swell because of fluid accumulation.
    - If heart failure becomes severe any physical activity may become difficult. Breathing becomes more and more difficult.
    - Some people may gasp or make gurgling sounds when they breathe. This happens when there is a lot of fluid accumulation in the lungs.
    - People in heart failure may appear pale or even blue. They may break out in a cold sweat. Blood pressure may be very high or very low.
    - Lack of blood flow to the brain can cause people to act confused.
    - When heart failure is very severe, a person may go into shock because their blood pressure is too low to keep blood flowing to their organs.

- Treatment for heart failure
  - The conditions that cause heart failure can be treated to help prevent heart failure.
  - However, for most people, heart failure is a chronic condition. Lifestyle changes may help heart failure from worsening and help people have a higher quality of life. These include diet, exercise, stopping smoking, losing weight, and limiting alcohol consumption.
- Potential Staff Therapeutic Interventions
  - Fatigue and shortness of breath may cause residents to take more time to do things and tire easily. Give them enough time in their daily activities.
  - Direct care staff should report any new symptoms or symptoms that get worse and document according to facility protocol.
- Psychosocial impact of Heart Disease
  - Heart disease not only affects the body but may affect residents psychosocially. This means that it may affect them psychologically (how they relate to themselves) and socially (how they relate to others).
  - Some ways that heart disease may affect a resident psychosocially:
    - They may have anxiety that they are going to have a heart attack. They may restrict their activities or isolate themselves.
    - They may be depressed about having a chronic health condition.
    - They may be less interested in eating because they cannot eat all the foods they would like.

- They may be concerned about incontinence, which can be a side effect of medications such as diuretics.
- They may feel isolated if they need frequent or constant oxygen.

## 6.5 Osteoporosis

- Osteoporosis
  - Definition and changes that occur
    - Osteoporosis belongs to a group of diseases called “musculoskeletal diseases”.
    - Osteoporosis is a disease in which bones become very fragile and are more likely to break. With osteoporosis, your bones become porous and less dense.
      - Bones become less dense over a long period of time, starting in middle adulthood.
      - Bones are constantly breaking down and being reformed. However, as you get older, more bone is broken down than it is reformed, resulting in an overall bone loss and causing it to weaken.
      - Fractures of the spine, hip, and wrist are most common.
    - Osteoporosis, and the fractures it can cause, can lead to loss of independence, disability, and decreased quality of life.
    - According to the American Geriatrics Society, approximately one in five older persons die within one year of a hip fracture, and approximately half of women with hip fractures do not fully recover previous function.

- There is likely a genetic component to osteoporosis.
- Types of Osteoporosis
  - There are two types of osteoporosis, primary and secondary.
  - Primary osteoporosis is the more common type and has no specific cause. It usually occurs in people over 50 and is more likely in people who:
    - Are middle-aged or older
    - Are female
    - Are White, Asian, or Hispanic
    - Are thin
    - Have a family history of osteoporosis
    - Do not consume enough calcium or vitamin D
    - Do not spend enough time in sunlight
    - Are physically inactive
    - Are having hormonal changes
    - Smoke cigarettes
    - Drink large amounts of alcohol
  - Secondary osteoporosis is caused by a specific disorder or drug. Disorders include inflammatory bowel disease, liver disorders, chronic kidney failure, rheumatoid arthritis, lupus, and hormonal disorders. Drugs that can cause osteoporosis include corticosteroids, thyroid hormone, certain anticonvulsants, and cyclosporine (an immunosuppressant, taken to prevent rejection of transplanted organs).
- Symptoms of Osteoporosis
  - Osteoporosis does not have symptoms at first.
  - As the disease progresses, symptoms may include:

- Back pain
  - Bone fracture (sometimes without falling or injury)
  - Bone pain or tenderness
  - Dentures that no longer fit
  - Loss of height
  - Dowager's hump
  - Neck pain
  - Difficulty sleeping due to pain and lack of activity
- Treatment of Osteoporosis
    - Medication
      - Drugs may prevent further decreases in density.
      - Bisphosphonates decrease the amount of bone being broken down.
      - Treatment with estrogen is sometimes suggested, although it is no longer routinely offered because of its risks.
      - Raloxifene belongs to a group of drugs called selective estrogen receptor modifiers (SERMs) and may also prevent further decreases in bone density.
    - Exercise
      - Weight bearing exercise is particularly important. Examples are walking, stair climbing, dancing, and weight training.
    - Consuming enough calcium and vitamin D helps maintain bone density.

- Potential Staff Therapeutic Interventions
  - Pain may cause residents with osteoporosis to do less or do things more slowly. Give them time to perform their daily activities.
  - Bone tenderness may make every day activities such as bathing painful. Consider how you can provide a gentler way of helping them with these activities.
- Psychosocial impact of osteoporosis
  - Depression due to chronic pain
  - Isolation due to difficulty in getting around
  - Embarrassment due to spine curvature that may result in a person hunching forward

## **6.6 Diabetes**

- Diabetes
  - Definition and changes that occur
    - Diabetes is a chronic disease associated with abnormally high levels of sugar (glucose) in the blood.
    - Normally, insulin controls blood sugar levels and keeps it controlled. In people with diabetes, they cannot make insulin or make low levels of insulin. As a result, blood sugar levels are uncontrolled and can get too high (called hyperglycemia).
    - There are two types of diabetes, Type 1 and Type 2.
      - Type 2 diabetes is the main form of diabetes amongst older people. In Type 2 diabetes, the body does not respond normally to the insulin that is produced. It is also called adult-onset diabetes or noninsulin-dependent diabetes.

- In Type 1 diabetes, insulin is not produced. This is also called insulin dependent diabetes.
  - When sugar from food is absorbed into the bloodstream, the pancreas responds by producing insulin. Insulin moves the sugar from the bloodstream to the cells, where it is converted into energy. If the body does not produce insulin or does not respond to insulin, sugar does not go to the cells. Instead, it stays in the bloodstream and the cells have to look for other sources for energy.
- Symptoms of Diabetes
  - Early symptoms of diabetes, when not treated, include:
    - Increased urination
      - High sugar levels may spill out of the blood into the urine. The kidneys respond by excreting additional water to dilute the sugar. As a result, a person has to urinate more frequently.
    - Increased thirst and drinking of water
      - The kidneys excreting more water also causes increased thirst.
    - Excessive hunger and weight loss
      - Because the body cannot use sugar for energy, a person may be very hungry, eat more, and lose weight.
    - Dehydration
      - When sugar levels become very high
    - Fatigue
    - Nausea
    - Vomiting

- Greater risk of infection in the bladder, skin, and vaginal areas.
  - Blurred vision
  - Sluggishness
- Treatment for Diabetes
- There is no cure for diabetes, but there are treatments.
  - The goal of treatment is to maintain blood sugar levels to prevent or reduce symptoms. Monitoring of blood sugar levels is key to effective treatment. Taking notice of blood sugar levels at different times of the day (generally 30 minutes before a meal) helps a person make necessary adjustments to their diet, exercise, and medication.
  - Maintaining a healthy diet may be an effective treatment. Starchy foods (such as bread, pasta, and rice) and sweets (such as fruits and foods with added sugar) are most likely to increase blood sugar levels and should be limited. Saturated fats should also be limited because they can contribute to cardiovascular risk factors.
  - Engaging in regular exercise can also help treat diabetes.
  - Medications may be used when diabetes cannot be controlled through other means.
    - Many people with Type 2 diabetes do not need medications. They can control their diabetes through diet and exercise. If this does not maintain their blood sugar levels, medications may be necessary.
    - Oral antihyperglycemic drugs
    - Everyone with Type 1 diabetes needs insulin.

- For people with Type 2 diabetes, insulin is usually given if oral antihyperglycemic drugs alone cannot control blood sugar levels.
- Treatment also includes monitoring for other risk factors, such as high blood pressure and high cholesterol
- Diabetes can cause complications in other body systems.
  - Poor circulation caused by blockages in arteries
  - Damage to blood vessels in eyes
  - Poor blood flow resulting in kidney failure
  - Nerve damage due to high blood sugar
  - Foot infections and ulcers when not enough blood reaches the feet
- People with diabetes can develop different types of foot problems. Proper foot care is important to prevent infection.
  - People with diabetes may experience a loss of feeling in their feet due to nerve damage. As a result, they may injure their feet and not realize it.
  - The skin on a diabetic's foot can become very dry so proper moisturizing is important.
- Potential Staff Therapeutic Interventions
  - Monitor their symptoms to help control blood sugar levels.
  - People with diabetes may need to urinate more frequently.
  - Direct care staff should report any observations of a diabetic resident's feet for signs of wounds, infection, severe calluses, etc. and document according to facility protocol.

- Psychosocial impact of diabetes
  - Resident may have anxiety about blood sugar levels getting too high or low.
  - Anxiety/depression over getting insulin injections.
  - Diet restrictions may result in a decreased interest in eating. It may also discourage people with diabetes from participating in social events in which there will be food they cannot have (e.g. birthday parties with birthday cake) or having to be served “different or diabetic” cake.
  - Depression over chronic illness.

## **6.7 Stroke**

- Stroke
  - Definition and changes that occur
    - A stroke, or a cerebrovascular accident (CVA), happens when there is a loss of blood supply to the brain. This is usually because the arteries supplying the brain with blood are blocked.
    - A stroke is considered to be a cardiovascular disease and a neurological disorder.
      - The loss of blood to the brain causes brain cells to die. The body parts that these cells control become damaged as a result. This may include paralysis, speech problems, memory and reasoning deficits, coma, and possibly death.
    - A stroke causes permanent brain damage. However, people who have had strokes may be able to regain function through rehabilitation.
    - There are two types of strokes: ischemic and hemorrhagic.

- In ischemic stroke, blood is prevented from reaching the brain. The most common cause is blockage of an artery. About 85% of strokes are ischemic strokes.
- In a hemorrhagic stroke, a blood vessel bursts and blood escapes into or around brain tissue. This blood accumulates in the brain and can irritate brain tissue. The accumulating blood causes swelling, putting pressure on and damaging brain tissue. It also interferes with the blood supply to brain tissue.
- Risk Factors for Stroke
  - Abnormal cholesterol levels
  - Atherosclerosis
  - Some heart disorders (such as abnormal heart rhythms, heart valve disorders, and heart attacks)
  - High blood pressure
  - Diabetes
  - Smoking cigarettes
  - Being physically inactive
  - Being overweight
  - Drinking large amounts of alcohol
- Symptoms of stroke
  - Symptoms of a stroke happen suddenly. They may get worse over a period of hours or days.
  - These are the common early symptoms of stroke, either ischemic or hemorrhagic:
    - Sudden difficulty moving or sudden abnormal sensations on one side of the body. The affected part may feel weak or be unable to move

(paralyzed). Or it may tingle, feel prickly, or be numb. One arm or leg, half of the face, or all of one side of the body may be affected.

- Sudden difficulty speaking or understanding speech. Speech may be slurred, or a person may suddenly become confused.
- Sudden changes in vision, particularly in one eye. Vision may be dim, blurred, double, or lost.
- Sudden loss of balance and coordination or sudden dizziness. Dizziness may involve unsteadiness or a sensation of spinning (vertigo). Falls may result.
- Sudden, severe headache with no apparent cause.
- People who have had strokes may also have difficulty swallowing, difficulty walking, partial loss of hearing, incontinence of bowel or bladder, cognitive issues such as problems with memory, understanding, orientation, attention, and concentration. They may also have problems with speech and language and problems controlling their emotions.
- In general, symptoms may depend on how much of the brain was affected as well as what part of the brain was affected.
- If a person continues to have a series of strokes, they may develop symptoms of dementia as a result of continuous brain damage.
- If these symptoms are observed, direct care staff must report it to the supervisor immediately and/or call 911 depending on the symptom. The

symptom(s) exhibited should be documented in the resident record along with what actions were taken at that time.

o Treatment for Stroke

- Controlling for risk factors can help prevent strokes from occurring or re-occurring.
- Lifestyle changes to reduce risk factors include:
  - Stopping smoking
  - Eating a healthy diet
  - Exercising
  - Losing weight
  - Having regular medical checkups
  - Controlling other disorders that might increase your risk of stroke, such as high blood pressure, diabetes, high cholesterol, and heart disease.
- There are some medications that are used to prevent or reduce the risk of stroke:
  - For people who are at risk of stroke, or have had a stroke, doctors may recommend they take an antiplatelet drug such as aspirin to help prevent strokes.
  - Warfarin (an anticoagulant) can help some people who have a heart disorder that can lead to a stroke.
  - Anticoagulants (commonly called blood thinners) make blood less likely to clot.
- When a person has a stroke, treatment depends on the type of stroke.
  - With ischemic strokes a drug called tissue plasminogen activator (TPA), which breaks up clots,

is sometimes used. However, it needs to be administered as early as possible after the onset of the stroke symptoms to be effective.

- Heparin may also be used to reduce the risk of blood clots.
- With hemorrhagic stroke, drugs such as mannitol may be given to decrease swelling in the brain and thus decrease pressure there. Occasionally, a drainage tube is placed in the brain to decrease pressure.
- After a person has had a stroke and leaves the hospital, a program of rehabilitation may begin to help the person regain some of their lost abilities. This may include physical therapy, occupational therapy, and speech therapy. Individuals may also have depression.
  - People recover most quickly in the 30 days after a stroke and then continue to recover at a slower pace over a period of months.
- People who have had strokes may use assistive devices to help them get around and perform daily activities.
- People who have had a stroke are at risk of having more strokes, so they must be monitored.
- Potential Staff Therapeutic Interventions
  - Help residents with their daily activities but also ask them when they would like to try to do things on their own. Helping them to be as independent as possible may help their recovery.
  - Be aware of visual problems that have been caused by the stroke. This impacts them being able to see you and

see what they are doing (e.g. brushing teeth, bathing, toileting, and eating).

## 6.8 Other Health Conditions

- Chronic Obstructive Pulmonary Disease (COPD)
  - Definition and changes that occur
    - COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time.
    - COPD can cause [coughing](#) that produces large amounts of mucus (a slimy substance), wheezing, shortness of breath, chest tightness, and other symptoms.
    - Cigarette smoking is the leading cause of COPD. Most people who have COPD smoke or used to smoke. Long-term exposure to other lung irritants, such as air pollution, chemical fumes, or dust, also may contribute to COPD.
    - The term "COPD" includes two main conditions— emphysema and chronic bronchitis. Both diseases decrease air movement in the lungs because of blockage in the airways.
      - In emphysema, the walls between many of the air sacs in the lungs are damaged, causing them to lose their shape and become floppy. This damage also can destroy the walls of the air sacs, leading to fewer and larger air sacs instead of many tiny ones. If this happens, the amount of gas exchange in the lungs is reduced. The destruction of the air sacs

causes obstructions in the lungs, making it harder to breathe.

- In chronic bronchitis, the lining of the airways is constantly irritated and inflamed. This causes the lining to thicken. Lots of thick mucus forms in the airways, making it hard to breathe.
- The air that you breathe goes down your windpipe into tubes in your lungs called bronchial tubes or airways. At the end of the airways are tiny air sacs called alveoli. In COPD, less air flows in and out of the airways because of one or more of the following:
  - The airways and air sacs lose their elastic quality.
  - The walls between many of the air sacs are destroyed.
  - The walls of the airways become thick and inflamed.
  - The airways make more mucus than usual, which tends to clog them.
- Symptoms of COPD
  - The damage done to the lungs cannot be reversed.
  - COPD develops slowly. A mild cough that produces clear sputum is frequently an early symptom of COPD. The person usually has this cough when first getting out of bed in the morning.
  - Over time, shortness of breath develops as obstruction in the lungs slows airflow and increases the effort of breathing. At first, the shortness of breath may be noted only with physical exertion. Or, the shortness of breath may be noted only with a chest cold (acute bronchitis).

- As the disease progresses, shortness of breath with exertion becomes more of a problem. The person may hear himself wheeze. Severe shortness of breath may even occur at rest.
- Severe COPD may prevent you from doing even basic activities like walking, cooking, or taking care of yourself.
- When COPD becomes more severe, some people lose weight because, among other reasons, shortness of breath makes it difficult to eat, and the overworked breathing muscles consume more energy. Also, the legs may swell, which may be due to heart failure. People with more severe COPD may sometimes cough up blood.
- As COPD progresses, some people develop altered breathing patterns. For example, they may breathe out through pursed lips. They may find it more comfortable to stand over a table with their arms outstretched and their weight on their palms. This position may help them breathe more easily. Some people may develop a barrel-shaped chest as their lungs expand because of trapped air. The skin, fingernails, or lips may turn bluish if the level of oxygen in the blood is very low.
- Occasionally, sudden pain develops on one side of the chest and shortness of breath worsens if an overexpanded area of the lung tears the lung's surface. The tear allows air to leak from the lung into the space between the lung and the rib cage (pleural space). This condition is called a pneumothorax. A pneumothorax can make breathing very difficult and usually requires emergency care.

- Treatment for COPD
  - The most important treatment for COPD is to stop all forms of smoking, including cigarettes, cigars, and pipes.
  - Many people with COPD benefit from staying in air-conditioned spaces.
  - Treatment aims to relieve symptoms of wheezing and shortness of breath by reducing airflow obstruction.
  - Many drugs used to treat COPD are taken through an inhaler, which is a device that allows the user to spray very tiny droplets of a drug into the lungs via the mouth and throat.
    - A nebulizer might also be used to deliver a mist of drugs
  - Other medications such as Theophylline and corticosteroids may be helpful.
  - Oxygen therapy may prolong life and help people with COPD have a better quality of life.
- Psychosocial impact of COPD
  - The person with COPD may not be able to participate in activities they have always enjoyed because of difficulty breathing.
  - The person with COPD may be embarrassed by his or her wheezing.
  - The person with COPD may be embarrassed by his or her oxygen tank.
  - The person may become depressed.
- Potential Staff Therapeutic Interventions
  - Follow infection control guidelines to help prevent the resident from getting sick.

- Help the resident rest.
- Direct care staff should report any observations and changes in symptoms and document according to facility protocol.

## **6.9 Special Care**

Assisted living residents with various health care conditions may require special care related to oxygen therapy, incontinence, and skin care. This section will provide an overview of that special care.

### **6.9.1 Oxygen Therapy**

- Oxygen therapy is a treatment that provides you with extra oxygen, a gas that your body needs to work properly.
- Normally, your lungs absorb oxygen from the air. However, some diseases and conditions can prevent you from getting the oxygen you need. Oxygen therapy can help you get enough oxygen, which may help you function better and be more active.
- Oxygen is supplied in a metal cylinder or other container. It flows through a tube and is delivered to your lungs in one of two ways:
  - Through a nasal cannula, which has two small plastic tubes that are placed in both nostrils
  - Through a face mask (also called reservoir nasal cannula) that goes over your nose and mouth
- § Oxygen is considered a medicine and must be prescribed by a physician. The source of the oxygen (i.e. compressed gas or concentrators) and the delivery service (i.e. nasal cannula, reservoir nasal cannulas or masks) must be written on the prescription along with the flow rate.

- A respiratory therapist may also help a person understand how to use their oxygen.
- Oxygen therapy helps by:
  - Decreasing shortness of breath
  - Decreasing fatigue
  - Improving sleep
- Oxygen can pose a fire hazard. It is not explosive but it can make a fire worse. The cylinder that oxygen comes in can explode when exposed to heat. It is important that you follow the instructions from the oxygen provider on safe handling of oxygen. For example, never store compressed oxygen gas cylinders and liquid oxygen containers in small, enclosed places, such as in closets, behind curtains, or under clothes.
- **§** Direct care staff responsible for the care of a resident using oxygen must have training or instruction in the use and maintenance, including routine cleaning, of resident-specific equipment and oxygen.
- Some safety tips for people using oxygen are:
  - Don't smoke or be around people who are smoking
  - Never use paint thinners, cleaning fluids, gasoline, aerosol sprays, and other flammable materials
  - Stay at least 5 feet away from gas stoves, candles, and other heat sources
  - **§** A sign stating "Oxygen in Use" must be present in all locations where oxygen is used including resident room doors and common dining and activity areas. This is done to enforce the smoking prohibition in any area of the building in which oxygen is in use.
  - **§** Only oxygen in a portable source may be used by residents in assisted living when outside their rooms. Long plastic tether lines

to the oxygen is prohibited. This creates a fall risk for those around the tether lines.

### 6.9.2 Skin Care

The normal aging process causes skin to thin and lose elasticity. Lifestyle factors like poor nutrition may exacerbate skin changes. As a result, it becomes easier to injure. Skin is a disease warning system. Changes in color, surface texture, temperature and moistness can be possible signs of a problem and should be monitored.

- Decubitus ulcers
  - Definition and changes that occur
    - Otherwise known as pressure ulcers, pressure sores, or bedsores; are injuries that result from unrelieved pressure on the skin.
    - Pressure ulcers are **100% preventable**.
      - With pressure ulcers, skin and tissue die as a result of poor circulation and pressure.
      - Pressure ulcers form where bone causes the greatest force on the skin and tissue and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair.
      - The greatest risk for pressure ulcers is for:
        - People confined to a bed or chair
        - People who are immobile or cannot change positions freely
        - People who are incontinent of bowel and/or bladder
        - People with poor nutrition

- People with decreased mental awareness
  - Pressure ulcers can range from mild (reddening of skin) to severe (deep wounds down to muscle and bone)
- Potential Staff Therapeutic Interventions and Regulatory Issues
  - Keep skin clean and dry (particularly with residents who are confined to wheelchairs, beds, or have difficulty moving, as well as residents who are incontinent)
    - Skin should be cleaned as soon as it is soiled
  - Encourage residents to change positions as frequently as, but no less than, every two hours.
  - If a resident is in bed for long periods of time, elevate heels off the bed linen with the use of pillows and utilize frequent position changes-no less than every two hours.
  - Monitor dryness of skin and moisturize as needed
  - Reduce friction or rubbing on skin
    - Use caution when transferring a person at risk of pressure ulcers
  - Water is essential to healthy skin. Help ensure residents are drinking enough fluids.
  - Direct care staff should report any of the following observations and document according to facility protocol:
    - Observe skin for:
      - Color
        - Have there been changes in the color of the skin?
        - Do any areas appear bruised, pink, red, purple, or have patches of different colors?

- Are there any open areas, sores, or scrapes?
  - Moisture/dryness
    - Does the skin appear dry?
    - Is it scaly?
    - Does it appear chapped?
    - Are there cracks in the skin?
    - Is the resident complaining of itching or burning skin? Does the resident appear to have been scratching his or her skin?
  - Tenderness
    - Is the skin tender to the touch?
    - Is the resident complaining of sensitivity to fabrics, lotions, water, etc.?
  - Wounds
    - Observe the general shape, size, color, whether there is drainage or odor
- **§** No resident that has decubitus ulcers in stages III or IV should be admitted to, or retained in, an assisted living facility, except:
  - **§** Those residents that have stage III ulcers may only stay if it has been determined by an independent physician that the ulcer is healing and that there is a treatment plan in place
  - **§** Wound care and treatment of a stage III ulcer may only be performed by a licensed health care professional using the prescriber's treatment plan
  - **§** The facility must report to the licensing inspector any resident that develops a decubitus ulcer while in an

assisted living facility or returns from a skilled nursing facility with a decubitus ulcer

- § The wound care provided to the resident must be implemented through the Individualized Service Plan (ISP)

### **6.9.3 Incontinence Care**

- Incontinence
  - Definition and changes that occur
    - There are two types of incontinence, fecal and urinary. Fecal incontinence refers to involuntary bowel movements. Urinary incontinence is defined as the uncontrollable loss of urine.
    - Incontinence is not a normal consequence of aging.
    - The average person takes in and puts out about 2.5 liters of water daily.
      - Once enough urine is collected in the bladder, the body automatically urges itself to eliminate it.
      - Approximately one (1) liter is output as urine.
      - Kidneys filter the blood for unwanted material and make urine.
      - This system is important as the urinary system helps control the body's fluid balance and also helps control blood pressure.
    - The kidneys become less efficient at producing urine as an individual ages which requires a greater daily intake of water.
    - Some people may be incontinent every time they have to urinate. Others may be incontinent every once in a while. Some people are incontinent during periods of illness or

recovery from surgery, but can regain their ability to control their bladder or bowel.

- If a resident suddenly becomes incontinent, report this to your supervisor. This could signal an underlying medical condition.

- Causes of Urinary Incontinence

- Impaired cognitive or ambulatory ability.
- Side effects of medication.
- Increased fluid intake.
- Disease process.
- Functional incontinence from such issues as stroke or spinal cord injury.

- Potential Staff Therapeutic Interventions

- Incontinence can increase the risk of skin rashes and pressure sores.
  - Protect the resident from skin breakdown and poor hygiene. Help keep the resident's skin clean and dry. When a resident who has had an "accident" requires your assistance, wear disposable gloves. Use soap and warm water, rinse and pat the skin dry.
  - Specially designed pads and undergarments can help keep people dry.
- Incontinence can also increase the risk of falls if residents are trying to get to the bathroom quickly.
  - Try to anticipate when a resident needs to go to the bathroom. Ensure the bathroom is accessible to them, the path to the bathroom is clear and well-lit, and assist them to get there if they need it.

- Handrails or grips should be present or in good repair.
- Establish a bowel and bladder program for residents with incontinence.
  - Every two hours is a common schedule but check with your resident's ISP.
  - Having a toileting schedule gives a resident the opportunity to empty the bowel or bladder and try to prevent accidents.
  - Having a toileting schedule gives residents a peace of mind knowing they can anticipate that someone will be available to assist them on a regular basis.
- Support the residents' dignity when they have "accidents". Do not attract attention to them, especially if they are with others. Maybe say "Let me help you freshen up". Also, use the term "adult briefs" or "briefs" rather than "diapers".
- Identify what might be contributing to a resident's incontinence.
  - Can the resident get to the bathroom on his or her own?
  - Is the resident only incontinent at certain times of day or overnight?
  - Does the resident forget how to call for assistance or is not able to call for assistance?
    - For example, Mrs. P. likes to hang out in the screened porch in the morning at her assisted living facility. However, she finds that sometimes she has to urinate and there is no

one around to help her and no way to call someone. A few times, she has had an accident because she waited too long, hoping to find someone to help her get out of her chair and to the bathroom.

- Use of Urinary Devices
  - Indwelling Catheter
    - Definition
      - An indwelling urinary catheter, also referred to as a Foley catheter, is a tube inserted into the bladder that drains urine out. The catheter is inserted through the urethra and held in place inside the bladder by the inflation of a small balloon at its tip.
      - Indwelling urinary catheters may only be inserted by a licensed healthcare professional trained in inserting catheters.
  - External Catheter
    - Definition
      - An external catheter, also called a condom catheter or Texas Catheter, is used for incontinent male residents. It fits over the tip of the penis and may be secured with an adhesive or soft Velcro band provided with the device.
      - It is often used with a small drainage bag that can be secured to the leg, also referred to as a leg bag, and allows the resident to get out of bed.

- Must be applied properly and replaced at least daily to prevent irritation/injury to the penis.
- Suprapubic catheters
  - Definition
    - A catheter that is inserted by a physician through the abdominal wall into the bladder. It remains in place to drain urine.
    - Caution must be used not to dislodge the catheter. The area around the insertion site must be kept clean and dry.
- Intermittent Urethral Catheterization
  - Definition
    - A catheter is inserted in order to drain the urine. It is removed immediately after the urine has been drained.

**Instructor Notes:** *It is strongly recommended that this section on catheter care be physically demonstrated using a doll and an actual catheter bag, tubing, collection container, etc.*

- Catheter Care
  - Proper daily care of the resident, the catheter and the collection tubing/bag is extremely important in reducing the risk of infection and/or other complications. Urine grows bacteria easily and there is a strong risk of infection if the catheter and drainage bag are not handled properly.

- Urine collected in a drainage bag must be kept below the level of the resident's bladder at all times.
- If a resident has side rails on his or her bed for safety, never hang the bag from the side rails.
- If a resident is in a wheelchair, secure the bag to a non-moving part.
  - It is important to make sure that the collection bag is covered when transporting the resident into public areas of the building for the comfort and dignity of the resident and other residents living in the assisted living facility.
- The catheter and the resident must be kept clean.
- Never pull on the catheter or tubing.
- Never let the catheter or drainage bag touch the floor.
- The catheter and tubing should be kept from kinking at all times.
- Do not rest bag on the floor.
- Hands should be thoroughly washed as instructed in Chapter Two prior to working with the catheter. This includes moving the bag, emptying the bag, collecting urine samples, cleaning the bag, etc.

- Perineal or Peri-care
  - Perineal or peri-care is providing care for a resident with a urinary catheter.
  - Perineal or peri-care includes cleaning around the catheter area itself along with the resident's genital area, including the anus.
  - Cleaning of the Catheter
    - It is important to assess the environment prior to performing any type of catheter care. The environment needs to be safe for the resident and the direct care staff.
      - Close the curtains in the resident's room and the resident's door to increase privacy.
      - Place an absorbent pad underneath the resident to protect the bed linens from becoming soiled.
      - If working with a resident that may be confused or have aggressive tendencies, it will be important to have a second direct care staff member in the room while perineal care is provided.
      - The second direct care staff member should be on the opposite side of the direct care

staff member performing perineal care. The second staff member should talk, interact, and comfort the resident during perineal care to help prevent aggressive behavior or the resident becoming fearful. It is also beneficial for a resident that may be confused in case the direct care staff member is accused of inappropriate actions with the resident.

- The resident should be positioned so that the direct care staff member has access to the catheter area and genitalia but also so the direct care staff can keep the resident comfortable during this process.
- The following materials will be needed when providing perineal care:
  - Basin with warm water.
  - Wash cloths.
  - Perineal wash solution or soap.  
*NOTE: Povidone-iodine, alcohol, or other strong agents should NOT be used in the genital area.*
  - Gloves.
  - All of the items above should be at the resident's bedside prior to

starting perineal care so that the resident does not have to be left during this process.

- Explain what you will be doing to the resident prior to starting care.
- Perineal Care for Female Residents
  - Direct care staff should thoroughly wash his or her hands as instructed in Chapter Two prior to beginning perineal care.
  - Put on gloves.
  - Retract the labia and wash the resident from the symphysis pubis towards the anus with the washcloth and warm water.
  - A clean side of the washcloth should be used for each wipe. Do not use wash cloths if they become soiled with feces.
    - Washing the female resident from front to back will help to reduce the risk of infections based on fecal material contamination.
  - Wash the first few inches of the outside of the catheter closest to the resident genitalia.

- Rinse thoroughly with a clean wash cloth and carefully dry skin and genital area.
- Replace the resident's clothing.
- Properly clean all items used during this procedure.
- Perineal Care for Male Residents
  - Direct care staff should thoroughly wash his or her hands as instructed in Chapter Two prior to beginning perineal care.
  - Put on gloves.
  - Wash the upper thighs of both legs.
  - Wash the insertion site of the catheter.
  - Use a clean side of the washcloth for each wipe.
  - Circumcised males:
    - Wash around the meatus and glans.
    - Wash down the shaft of the penis towards the scrotum.
    - Use a clean side of the washcloth for each wipe.
    - Wash down the shaft of the penis towards the scrotum.
    - Wash the scrotum to the anus. REMEMBER TO

ALWAYS USE A CLEAN SIDE  
OF THE WASHCLOTH WITH  
EVERY WIPE.

- Wash the first four (4) inches of the outside of the catheter closest to the resident.
- Rinse thoroughly with a clean wash cloth and carefully dry skin and genital area.
- Replace the resident's clothing.
- Properly clean all items used during this process.
- Uncircumcised males:
  - Retract the foreskin and wash the head of the penis.
  - Replace the foreskin. It is very important that this is done to prevent painful swelling and difficulty returning the foreskin to its original position.
  - Wash down the shaft of the penis towards the scrotum.
  - Wash the scrotum to the anus. REMEMBER TO ALWAYS USE A CLEAN SIDE

OF THE WASHCLOTH WITH EVERY WIPE.

- Wash the first four (4) inches of the outside of the catheter closest to the resident.
  - Rinse thoroughly with a clean wash cloth and carefully dry skin and genital area.
  - Replace the resident's clothing.
  - Properly wash all items used in this process.
- Emptying Standard and Leg Collection Bags
    - Standard collection bags and leg bags have a port with a drainage valve that is located near the bottom of the collection bag that is used to empty the bag.
    - Hands should be washed and gloves donned both before and after emptying a catheter drainage bag.
    - Never let any portion of the drainage tubing touch any surface including the inside of the collection container.
    - Never place your gloved hand any closer to the tip than the valve. If this happens, notify your administrator.

- The drainage valve should be held over some sort of collection container including a urinal, basin, or a container used for measuring urine. It is always good practice to document the amount of urine excreted each time the bag is emptied.
- Notify both the registered medication aide and the administrator if there is no urine output at the end of your shift and make sure to document as well.
- It is extremely important that the standard bag or leg bag is not lifted above the resident's bladder during emptying so the urine does not back up into the bladder.
- The drainage valve should be released and held until the collection bag is empty.
- The drainage valve should be locked and put back in place so that the urine doesn't leak once it begins to fill again.
- The collection container should be poured down the commode and flushed.
- The collection container should be rinsed out with hot water and a cleaning solution per the facility's protocol.



## Student Activity

- Group Exercise – Signs and Symptoms of Diseases (**Handout #1**)

### Instructor Notes:

The point of this activity is for the students to gain a clear understanding of the signs and symptoms of the disease states discussed in this chapter. This will assist these individuals to recognize changes in resident status.

### Activity Procedures:

1. Have the students form small groups – they can form pairs if the class is small.
2. Have the students turn to Chapter Six, **Handout #1**
3. Hold up one “disease” page at a time.
4. The first group, or pair, to properly call out a correct symptom for that disease gets a point.
5. Go through each “disease” page. The group that has the most points at the end of the “disease” pages wins. If possible, have candy or something available as a prize.
6. Use the chart below as your instructor key:

Condition	Symptoms or Description (what you want to hear called out)
Hypertension	<ul style="list-style-type: none"><li>• Systolic blood pressure greater than 140</li><li>• Dizziness</li></ul>
Osteoarthritis	<ul style="list-style-type: none"><li>• Stiff joints when not in use</li><li>• Stiffening lessens with use</li></ul>
Rheumatoid arthritis	<ul style="list-style-type: none"><li>• Autoimmune disease that affects the joints</li></ul>
Heart Disease	<ul style="list-style-type: none"><li>• Causes discomfort in the chest or angina</li><li>• Dizziness</li><li>• Shortness of breath</li></ul>

Osteoporosis	<ul style="list-style-type: none"> <li>• Bone fracture</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>• Abnormally high levels of sugar</li> <li>• Increased thirst</li> </ul>
Stroke	<ul style="list-style-type: none"> <li>• Sudden weakness on one side of body</li> <li>• Sudden slurring of speech</li> </ul>
Chronic Obstructive Pulmonary Disease	<ul style="list-style-type: none"> <li>• Wheezing</li> <li>• Shortness of breath</li> </ul>
Pressure Ulcer	<ul style="list-style-type: none"> <li>• Unrelieved pressure on the skin</li> </ul>
Incontinence	<ul style="list-style-type: none"> <li>• Uncontrollable loss of urine</li> </ul>

### 6.10 Staff Responsibilities

- **§** It is the responsibility of assisted living facility staff to make sure that the residents' health care services are provided.
- Direct care staff of the ALF are expected to:
  - Understand resident's health conditions and their role in helping residents manage their health conditions;
  - Follow residents' individualized service plans; and
  - Report changes in residents' health conditions to their supervisors.

## **Standards for Licensed Assisted Living Facilities**

### **Effective July 17, 2013\***

22 VAC 40-72-100	Incident reports
22 VAC 40-72-340	Admission and retention of residents
22 VAC 40-72-440	Individualized service plans
22 VAC 40-72-460	Health care services
22 VAC 40-72-690	Oxygen therapy

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Student Review - Chapter Six

1. What are three of the most common health conditions in assisted living residents?

- **Hypertension**
- **Arthritis/Rheumatoid Arthritis**
- **Depression**
- **Heart Disease**
- **Osteoporosis**
- **Macular Degeneration/Glaucoma**
- **Diabetes**
- **Stroke**

2. What is hypertension and how is it diagnosed?

**Hypertension is high blood pressure. It is measured by taking someone's blood pressure. Hypertension is defined as systolic blood pressure greater than 140 or diastolic blood pressure greater than 90.**

3. What are the symptoms of a heart attack?

- **Pain due to a heart attack may be felt in the chest, neck, throat, jaw, teeth, or arms.**
- **However, in older people, a heart attack may cause very little chest pain or discomfort. Instead, a heart attack may cause shortness of breath, a smothering feeling, nausea, vomiting, sweating, dizziness, indigestion, palpitations, overwhelming fatigue, fainting, a feeling of impending doom, or any combination of these symptoms.**
- **About one fourth of heart attacks occur without symptoms, as silent heart attacks.**

4. **True** People with diabetes might have to urinate more frequently.

5. What are the kinds of foot problems a person with diabetes might have?

- **People with diabetes may experience a loss of feeling in their feet due to nerve damage. As a result, they may injure their feet and not realize it.**

- **The skin on a diabetic's foot can become very dry so proper moisturizing is important.**

6. What are the symptoms of a stroke?

- **Symptoms of a stroke happen suddenly. They may get worse over a period of hours or days.**
- **These are the common early symptoms of stroke, either ischemic or hemorrhagic:**
  - **Sudden difficulty moving or sudden abnormal sensations on one side of the body. The affected part may feel weak or be unable to move (paralyzed). Or it may tingle, feel prickly, or be numb. One arm or leg, half of the face, or all of one side of the body may be affected.**
  - **Sudden difficulty speaking or understanding speech. Speech may be slurred, or a person may suddenly become confused.**
  - **Sudden changes in vision, particularly in one eye. Vision may be dim, blurred, double, or lost.**
  - **Sudden loss of balance and coordination or sudden dizziness. Dizziness may involve unsteadiness or a sensation of spinning (vertigo). Falls may result.**
  - **Sudden, severe headache with no apparent cause.**
  - **People who have had strokes may also have difficulty swallowing, difficulty walking, partial loss of hearing, incontinence of bowel or bladder, cognitive issues such as problems with memory, understanding, orientation, attention, and concentration. They may also have problems with speech and language and problems controlling their emotions.**
  - **In general, symptoms may depend on how much of the brain was affected as well as what part of the brain was affected.**

- **If a person continues to have a series of strokes, they may develop symptoms of dementia as a result of continuous brain damage.**

7. Who is at greatest risk for getting pressure ulcers?

**The greatest risk for pressure ulcers is for:**

- **People confined to a bed or chair**
- **People who are immobile or cannot change positions freely**
- **People who are incontinent of bowel and/or bladder**
- **People with poor nutrition**
- **People with decreased mental awareness**



# HYPERTENSION

# OSTEOARTHRITIS

# RHEUMATOID ARTHRITIS

# HEART DISEASE

# OSTEOPOROSIS

# DIABETES

# STROKE

# CHRONIC OBSTRUCTIVE PULMONARY DISEASE

# URINARY INCONTINENCE

# PRESSURE ULCER

# OXYGEN THERAPY



# **Alzheimer's Disease and Other Dementias**

## **Chapter Seven**

**Time Required: 2 hours**

## **Chapter 7 - Alzheimer's Disease and Other Dementias**

This chapter provides an overview of dementia and the most common cause of dementia, Alzheimer's disease. It is estimated that at least fifty percent of residents of assisted living facilities have some type of dementia. In assisted living, people with dementia may or may not live in specialized memory care neighborhoods, so it is likely that direct care staff will interact with them regardless of where they work in an assisted living facility. People with dementia present unique challenges in their care, as a result of the brain changes they have experienced that impact their communication and behavior. It is important for direct care staff to have an understanding of dementia, as well as knowledge of how to interact with people with dementia. This chapter will provide an overview of dementia, including communication challenges and behaviors in people with dementia.

### **7.1 What is Dementia: Definition and Causes of Dementia**

### **7.2 Alzheimer's Disease: Definition, Diagnosis, Symptoms, Treatment**

### **7.3 Alzheimer's Disease vs. "Normal" Aging**

### **7.4 Other Types of Cognitive Impairment**

### **7.5 Communication Challenges in People with Alzheimer's Disease or Other Dementias**

### **7.6 Behaviors of People with Dementia**

### **7.7 Staff Responsibilities**

### **7.8 Alzheimer's Association Dementia Care Practice Recommendations for Assisted Living**

## Instructor Planning

### **1. Objectives and Expected Outcomes of Chapter**

- a. Understand what dementia is, as well as possible causes of dementia.
- b. Be able to identify symptoms of Alzheimer's disease.
- c. Understand the differences between reversible and irreversible dementias.
- d. Recognize the difference between dementia and normal aging.
- e. Know about other types of cognitive impairment.
- f. Be aware of communication challenges experienced by people with dementia and learn techniques to communicate effectively with them.
- g. Understand behaviors of people with dementia and learn ways to interact with them.
- h. Have knowledge of the Alzheimer's Association Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes.

### **2. Recommended Method of Instruction**

- Lecture and class discussion
- Student Activity - Scenarios (**Handout #1**)
- Student Review - Chapter Seven

## 7.1 What is Dementia? Definition and Causes of Dementia



### Group Discussion

**Instructor Notes:** Ask the students the following question:

**What comes into your mind when you think of the term ‘dementia’?**

Potential Answers may include: Alzheimer’s, senile, crazy, memory loss, etc.

- **Discussion**
  - Discuss how confusing it is that all these terms are used. In this session we will try to clear things up.
  - The term dementia is used to mean a lot of things. However, these terms may not mean the same thing and some may be inappropriate. For example, “senility” or “senile dementia” is a term that is no longer used but was often used in the past to describe the symptoms of what we now know as dementia. It is usually thought of as a “negative” term.
- **Dementia**
  - Dementia refers to a group of symptoms, not a disease in itself.
  - Dementia is a general term for the loss of memory and other intellectual (or cognitive) abilities that are serious enough to interfere with daily life.
    - The symptoms of dementia are caused by disorders that change the brain.
  - People with dementia have problems with their thinking and may have challenges in doing everyday activities like getting dressed or eating.
  - Memory loss is probably the most common symptom of dementia. However, just having memory loss does not mean you

have dementia. People with dementia must have serious problems with at least two of their brain functions.

- Dementia has many causes, some are reversible and some are irreversible.
- Alzheimer's disease is the most commonly diagnosed and is currently accepted as the most common type of dementia.
- Some other irreversible causes of dementia are:
  - Vascular dementia
    - The second most common type of dementia.
    - Caused by vascular conditions that reduce blood flow to the brain. Vascular refers to the blood vessels.
  - Mixed dementia
    - When a person has both Alzheimer's disease and vascular dementia.
  - Parkinson's disease
    - Parkinson's disease causes challenges in movement, which results in tremors, stiffness, and impaired speech.
    - Individuals with Parkinson's disease may also develop symptoms of dementia.
  - Dementia with Lewy Bodies
    - With this illness, people may experience visual hallucinations as well as symptoms of dementia. They may also have tremors and muscle stiffness like people with Parkinson's disease.
  - Brain injury
    - People with brain injury may show signs of dementia.
  - Frontotemporal dementia or Pick's disease

- With Pick's disease personality change and disorientation usually happen before memory loss.
- Some reversible causes of dementia or things that may "look like" dementia:
  - Depression
    - Older adults with depression may show signs of memory loss or confusion.
  - Medications
    - Medications may have side effects that cause people to have memory loss, confusion, and personality or behavioral changes. Once they stop taking the medication, these symptoms go away.
  - Normal pressure hydrocephalus
    - Caused by a buildup of fluid in the brain, it can sometimes be treated by draining excess brain fluid.
  - Infections (for example, urinary tract infections)
    - Urinary tract infections can cause significant changes in behavior and personality in older adults. When the urinary tract infection is treated, these symptoms usually go away.
  - Hearing loss
    - People with hearing impairments have difficulties with communication and processing information because they cannot always hear everything being said.
- Dementia is not a normal part of aging. However, it is more common in older people.

## 7.2 Alzheimer's Disease: Definition, Diagnosis, Symptoms, Treatment

- Alzheimer's Disease
  - Because Alzheimer's disease is the most commonly diagnosed type of dementia, we will go into more detail about Alzheimer's disease, starting with its definition.
  - Definition and changes that occur
    - Alzheimer's disease is a progressive, degenerative brain disease that results in problems with memory, thinking, and behavior.
      - What we mean by progressive is that the disease, its symptoms, and a person's functioning get worse over time.
      - What we mean by degenerative is that the brain deteriorates over time.
    - Alzheimer's disease can happen in younger and older people. It is more common in older people and the risk for being diagnosed with Alzheimer's increases with age.
      - We use the term "younger-onset" to refer to people who have Alzheimer's disease and are under the age of 65. People in their 30's, 40's, and 50's have been known to have Alzheimer's disease.
    - Plaques and tangles form in the brain.
      - Plaques and tangles are abnormal structures found in the brains of people with Alzheimer's. Plaques build up between nerve cells and cause damage. Tangles form inside dying cells and damage them from within.
    - Brain cells die.
    - Brain function is affected.

- Diagnosis of Alzheimer's Disease
  - There is no single test that proves a person has Alzheimer's disease while that individual is still alive. When a person dies, an autopsy of the brain would show whether a person definitely had Alzheimer's disease.
  - Doctors rely on a number of tests to diagnose Alzheimer's disease: they include a full physical exam including blood work, a neurological exam, brain scans, and neuropsychological assessments. Even so, a diagnosis of Alzheimer's disease is a doctor's best guess because there is no way of knowing 100% whether a person has Alzheimer's disease.
  - Doctors are usually able to determine that a person has dementia, but may not be able to identify the cause for dementia (like Alzheimer's disease). This is why you see the diagnosis of "dementia" or "probable Alzheimer's" with some people- this usually means that the doctor knows the person has dementia but is not sure what is causing it.
- Signs and Symptoms of Alzheimer's Disease
  - Ten (10) Warning Signs of Alzheimer's disease (from the Alzheimer's Association)
    1. Memory Loss.
      - Forgetting recently learned information.
      - Short-term memory is more affected than long-term memory. This explains why a person with Alzheimer's may be able to remember his or her childhood but may not remember that she or he had breakfast.

2. Difficulty performing familiar tasks.
  - People with Alzheimer's find it very hard to do the things they have always done. This includes Activities of Daily Living (ADL's) such as bathing, dressing, grooming, eating, toileting, etc. It can also be things like turning the television on and off, operating lamps, making a phone call, reading, writing, or cooking. Activities that have multiple steps are especially hard for them because they lose track of the steps and get confused.



### **Group Discussion**

**Instructor Notes: State the following to the students:**

**Think about how many steps are involved in everyday activities like brushing your teeth or getting dressed.**

- **Discussion**
  - Facilitate conversation about how most tasks require many steps. What does this mean for direct care staff in assisted living? It means that they have to break down steps for people with Alzheimer's to help them complete tasks – brushing teeth and washing face are good task/activities. Have props on hand for demonstration.
  - Signs and Symptoms of Alzheimer's Disease (continued)

### 3. Problems with language

- Communication challenges are a significant issue for people with Alzheimer's. We will talk more in depth about this in another section of

this chapter, but this generally means they may forget words and what they want to say.

4. Disorientation to time and place

- The confusion that comes with Alzheimer's disease makes it difficult for people to know where they are and what time it is. They often get lost, even in familiar environments. This explains why people with Alzheimer's may think it is time to have breakfast when it is time for dinner. It may also explain why people with Alzheimer's frequently say they "want to go home", even when they are living in an assisted living facility. It may also explain why they wander and are frequently acting like they are looking for something.

5. Poor or decreased judgment

- People with Alzheimer's disease may act inappropriately, dress in inappropriate clothes, or have poor judgment on matters like money. The deterioration that is happening in their brain is affecting their thinking and judgment skills. This explains why a person with Alzheimer's may wear four layers of clothing on a hot summer day, or why they may give large amounts of money to solicitors (e.g. telemarketers, charities, etc).

6. Problems with abstract thinking

- Abstract thinking refers to complex mental tasks. Abstract thinking might be things like

working with numbers, but it can also mean problem-solving, following conversations, and interpreting what is being said.

7. Misplacing things

- People with Alzheimer's frequently forget where they put things. They may also put things in strange places, like putting a shoe in the toilet, because they are confused about what objects are and where they belong.

8. Changes in mood and behavior

- People with Alzheimer's may have rather abrupt changes in mood and behavior. It is likely the frustrations of confusion, memory loss, and these other symptoms cause some of these mood changes. Changes in the brain may also affect their ability to control their emotions- they may not have a "filter." For example, an older adult that would have typically not stated his or her opinion may be more prone to do so now and may blurt out remarks that are inappropriate or that may not have normally been stated by this individual.

9. Changes in personality

- It is not uncommon for a family member to say that their loved one with Alzheimer's disease is a "different person". This is due to the overall changes caused by the disease, but people may also experience personality changes.

Otherwise calm people may become agitated and upset easily. Some people with Alzheimer's develop suspiciousness of others. There may also be a decrease in conscientiousness and an increase in neuroticism.

#### 10. Loss of initiative

- People with Alzheimer's disease often lose motivation to do daily tasks. Someone who was once fairly active may instead sit in front of the TV for hours. This may be due to a number of reasons. Confusion, disorientation, and memory loss may cause a person to not know what they should be doing. She or he may also forget how to do things, so she or he may just not do anything at all.

#### o Stages of Alzheimer's disease

- There are a number of stage models for Alzheimer's disease. They are useful for understanding that the disease is progressive. But it is important to understand that every person will not experience the same symptoms or progress at the same rate. Also, some symptoms don't appear in certain stages as expected. As the saying goes: When you meet one person with Alzheimer's disease, you meet one person with Alzheimer's disease.
- There are three general stages of Alzheimer's disease:
  - Early-stage
  - Mid-stage
  - Late-stage

- In the earlier stages, you generally see milder forms of the above symptoms. People in the early-stage may be aware of their diagnosis. Sometimes it is hard to believe they have Alzheimer's disease because they seem very functional and can compensate pretty well for their losses.
- As the disease progresses through mid-stage to late-stage, people generally experience more losses and are able to do less and less for themselves. They may forget their family members. In the later stages they may lose the ability to walk, feed themselves, or speak.
- Treatment of Alzheimer's Disease
  - There is no cure for Alzheimer's disease, but there are medications that can help people with their symptoms. They are Aricept, Razadyne, Exelon, and Namenda. People with Alzheimer's disease may take other medications that address behavioral or psychiatric symptoms they may be having in addition to the typical symptoms of Alzheimer's disease. These medications do not stop the progression of the disease.
    - Another treatment for Alzheimer's disease is the care we provide for them. This includes providing a patient, supportive environment in which people with Alzheimer's feel secure, are encouraged to be as independent as possible, and are assisted with the things they can no longer do.

- A popular approach to working with residents with Alzheimer's Disease and other dementias is Validation Therapy.
- Validation Therapy is a method of communicating with older adults with dementia that focuses on the caregiver using an empathic attitude and a holistic approach to the resident. This method will be more thoroughly explained in Section 7.5 Communication Challenges in People with Alzheimer's Disease and Other Dementias.

### **7.3 Alzheimer's Disease versus Normal Aging**

- **Alzheimer's disease is not a normal part of aging.**
  - Most people do not have significant memory loss as they age.
  - People may, however, experience some memory changes or slowness in thinking as they age. This might mean occasionally forgetting where they put something or taking longer to remember someone's name. There is no clear line between what is "normal" and a disease, so people are encouraged to get themselves evaluated if they are concerned about their memory. If symptoms are present that are interfering with daily functioning, then that may be a sign of pathology and an individual should be evaluated by a physician.
  - This is important because we cannot assume that just because people are older they have Alzheimer's disease or another type of dementia. On the other hand, we cannot assume that an older person who has memory problems is "just getting old".

- What are the differences between symptoms of Alzheimer's disease and memory changes that are considered a normal part of aging?

<b>Symptoms of Alzheimer's disease</b>	<b>Memory changes related to normal aging</b>
Forget whole experience (i.e. resident may not remember child's graduation from high school)	Forget part of experience (i.e. resident will remember child's graduation from high school but may not remember where it was held)
Rarely able to remember later (i.e. a staff member may need to repeat the location of the dining room to the resident numerous times)	Often able to remember later (i.e. a staff member may only need to repeat the location of the dining room once or twice)
Gradually unable to follow written/spoken directions (i.e. resident may not be able to follow multiple step instructions)	Usually able to follow written/spoken directions (i.e. resident should be able to follow multiple step instructions)
Become unable to use notes as reminders (i.e. resident will not remember to brush teeth even with a note on the bathroom mirror)	Able to use notes as reminders (i.e. resident will be able to brush teeth with a reminder note on the bathroom mirror)
Become unable to care for oneself (i.e. resident will not remember how to care for self or will think he or she has already done it)	Usually able to care for oneself (i.e. resident will usually still be able to provide self care with cues and reminders)
From "Basics of Alzheimer's Disease: What it is and what you must do", Alzheimer's Association, 2008.	

## **7.4 Other Types of Cognitive Impairment**

- Cognitive impairment is a general term that refers to problems in mental functions, including intelligence, judgment, learning, memory, speech, and thinking.
- Cognitive impairment and dementia may be used interchangeably, but they are not necessarily the same. There are some instances in which a person has cognitive impairment but not dementia.
- While dementia is a common type of cognitive impairment, there are other causes of cognitive impairment. They may be:
  - Developmental disabilities such as mental retardation, cerebral palsy, and autism.
  - Mental illness.
  - Other brain conditions.
- Although the majority of individuals in assisted living are older adults, you may also care for younger individuals with cognitive impairment due to the above causes. These conditions were discussed in Chapter Five.
- What is important to remember is that people with any type of cognitive impairment may need additional assistance and special types of care. Many of the strategies provided in this chapter can be used with people with different types of cognitive impairment.

## **7.5 Communication Challenges in People with Alzheimer's disease or Related Disorders**

- People with Alzheimer's disease experience changes in communication as a result of the brain changes caused by the disease.

- Although these communication tips are geared toward people with Alzheimer's disease, they can also be used with people with other types of dementia.
- People with Alzheimer's disease and other dementias typically have aphasia. Aphasia is the medical term that refers to the inability to communicate effectively. Expressive aphasia refers to the inability to speak and write. Receptive aphasia refers to the inability to understand written or spoken words.
- Agnosia is another medical term that refers to the inability to recognize objects or people or to interpret sensory signals like pain, hunger, and thirst. Agnosia is also experienced by people with Alzheimer's. As we go through some communication challenges, you will see how aphasia and agnosia are the reason behind some of these challenges.
  - Common communication challenges:
    - Difficulty finding the right words.
    - Using familiar words over and over again.
    - Inventing new words for familiar things.
    - Losing train of thought.
    - Difficulty organizing words logically.
    - Reverting to one's native language.
    - Using curse words.
    - Speaking less often.
    - Using gestures instead of speaking.
  - Potential Staff Therapeutic Techniques
    1. Patience!
      - Being patient and supportive gives the person the opportunity to try to express herself or himself. It is important to let them know you are listening to them

and will give them a chance to try to say what is on their mind.

2. Show your interest

- Although you will be very busy with your work, it is important to let the person with Alzheimer's know that you are interested in what they are trying to say. Try to make eye contact with them. If a person is in a wheelchair, try not to stand over them. Get to their eye level when talking with them.

3. Offer comfort and reassurance

- A person with Alzheimer's may get very frustrated that they cannot say what they would like. Let them know that it is ok and encourage them to try to communicate.

4. Give the person time

- A person with Alzheimer's will need more time to communicate. Even though you are busy, give them some extra time to communicate. Try not to interrupt them.

5. Avoid criticizing or correcting

- This is extremely important. Criticizing or correcting someone will only result in them getting frustrated, angry, or agitated. Rather than try to correct what they are saying, try to look beyond the words to see what they could mean. For example, if a person says, "Today is my birthday", it is not important to correct them and tell them it is not. Try to figure out what she or he might be trying to tell you. Is she or he reminiscing about good times she or he had at

birthday celebrations in the past? Did something remind her of a birthday celebration? Instead, you might ask her questions about her birthday celebrations. It is important to understand that working with people with Alzheimer's means trying to see things from their perspective. You need to enter their "world", whether it is real or not. It is real to them.

6. Avoid arguing

- Also very important. Never argue with someone with Alzheimer's disease. You will never win the argument!
- It is best to just let things be rather than argue. If you are trying to help someone with something and she will not let you, give her a few moments to cool down and come back in a few minutes. If you argue with the person it will only escalate the situation and the person will become more upset. And you will not be able to do what you need to do!

7. Offer a guess

- Sometimes you can offer a guess to someone who is trying to communicate. You might ask them, "Are you hungry?" or "Are you looking for the word 'purse'?"
- Relationship with the person with Alzheimer's is extremely important in this case. If the person knows and trusts you, she will be more likely to accept your guess without getting upset.

8. Encourage unspoken communication
  - Ask the person to use gestures to say what they are trying to say. Ask her to point to what she would like or point to where she is having pain.
9. Limit distractions
  - In a noisy room with lots going on, it is particularly hard for a person with Alzheimer's to concentrate. A person will communicate better when there are less distractions.
10. Focus on the feelings, not the facts.



### **Group Discussion**

**Instructor Notes: Ask the students the following question:**

**Have you ever heard of a person with Alzheimer's saying all the time "I want to go home?" What do you think they mean?**

- **Discussion**
  - Answer: When a person says "I want to go home" she might not be thinking of a physical place or her actual home. She might be trying to express that she is homesick or misses her family or is feeling alone.



### **Group Discussion**

**Instructor Notes: Ask the students the following question:**

**How could you respond to someone if she is saying this?**

- **Discussion**
  - Answer: You might simply let her know that you are here for her. Make her comfortable and spend a few extra minutes with her.

o Potential Staff Therapeutic Interventions (continued)

11. Identify yourself

- You might have to identify yourself every time you interact with a person, since she may forget who you are. If she does not know who you are, she may become frightened and may even be combative when you try to help her. You may also have to explain what your role is. For example, “Hi, my name is Sonya and I am here to help you.”

12. Call the person by name.

13. Use short, simple words and sentences.

14. Talk slowly and clearly.

15. Give one-step directions.

- As we mentioned earlier, most tasks we do every day have a number of steps. You can help someone complete a task by breaking the task down into simple steps and giving one-step directions.

16. Ask one question at a time.

- Asking too many questions will confuse the person with Alzheimer's because it is too much information to process.

17. Patiently wait for a response.

18. Repeat information or questions.

19. Turn questions into answers.

- If you ask a person with Alzheimer's a question, you have to be prepared for the answer to be “no”. If there is something you need to do for a person, such as serve them lunch, it may be best to not phrase

this as a question. Rather than say “Would you like lunch?” you might say “Let’s have lunch”.

20. Avoid confusing expressions.

- People with Alzheimer’s may not be able to interpret expressions or slang, unless it was something they are very familiar with. You might not want to say “Let’s jump in the shower” because the person may take you literally.

21. Avoid vague words or pronouns.

- Instead of saying “Did she come today?” you might ask “Did your daughter come today?”
- Instead of saying “Did you find it?” you might ask “Did you find your purse?”

22. Emphasize key words.

- When helping with care, you may need to emphasize key words over and over again. For example, “Here is your CUP. Take your CUP and have a sip.”

23. Turn negatives into positives.

- People with Alzheimer’s are adults and generally do not like to be told what to do. Instead of saying something like “Don’t go over there” try saying something like “Let’s go over here”.

24. Give visual cues.

- Visual cues may help a person with Alzheimer’s understand the situation when they don’t understand the words. Laying out a person’s clothes, brush, etc and pointing to it may help a person understand she is going to get dressed.

- Although people with Alzheimer's have communication challenges, it is still important that we provide them choice in their daily lives and help them maintain independence and dignity. For example, giving two choices for things like clothes or food may help residents make decisions without getting overwhelmed (e.g. "Would you like to wear your white blouse or blue blouse?").

25. Avoid quizzing.

- Although it is important to help people reminisce, be careful to not ask someone too many questions or questions that are too detailed. This is because she or he may not know the answers to the questions and may become frustrated. Even something like asking how many children a person has could be frustrating because she may have forgotten. Another way of asking about a person's children would be "Tell me about your children".

26. Give simple explanations.

27. Write things down.

28. Treat the person with dignity and respect.

29. Be aware of the tone of your voice and body language

- Do not underestimate the impact of the tone of your voice and your body language. They can really impact how the message you are giving is being received.



## Group Discussion

**Instructor Notes: State the phrase “I have news for you” in three different ways, using the tone of your voice and your body language to change the message. For the first time, say with an excited voice, “I have news for you” as if the news is a good. For the second time, wag your finger at someone and, in an accusing way, say “I have news for you.” For the third time, act sad and say “I have news for you” as if you are telling someone really bad news.**

- **Discussion**

- Ask the group about the differences between the meanings of those statements even though the words are the same.

- 
- Communication Challenges in People with Alzheimer’s disease or Related Disorders (continued)
    - Potential Staff Therapeutic Interventions (continued)
      - Validation Therapy
        - Validation Therapy is a method used to communicate with older adults that are disoriented and is typically used with those individuals that have a diagnosis of dementia.
        - Validation theorizes that older people are still struggling to resolve unfinished life issues before death.
        - Validation includes physical, psychological, and social characteristics and is designed to stimulate energy, social interaction, and social roles.
        - There are ten principles of validation:
          - All older people are unique and worthwhile.

- Older people that are disoriented or have dementia should be accepted as they are and nobody should try to change them.
- Listening with empathy builds trust, helps reduce anxiety and helps restore dignity.
- Those painful emotions that are being expressed, acknowledged, and validated by the empathetic listener will be reduced. The same painful feelings that are not acknowledged will become worse.
- There is some reason behind every behavior.
- The reasons that cause the behavior can be connected back to a basic human need.
- When verbal ability and memory is diminished, early learned behavior will return.
- Things that older adults may use to express themselves (i.e. carrying around a clock) generally represent people, things, or concepts from some point in the individual's life that has a strong emotional connection.
- Older adults that are disoriented tend to have several levels or awareness that also occur at one time
- When the senses are not as effective, inner senses may be triggered (i.e. hearing sounds from the past).
- The benefits of validation include:
  - Residents tend to sit more erect.
  - Residents tend to keep their eyes open more.

- Residents display more social controls.
  - There is a decrease in crying, pacing, and pounding.
  - There is a decrease in aggression.
  - There is a decrease in need to medicate based on behaviors.
  - There is an increase in verbal and non-verbal communication.
  - There is improved gait.
  - There is a decrease in anxiety.
  - There is less withdrawal.
  - There appears to be improved self-worth.
  - There is an increase in assuming social roles in groups.
  - There is an improvement in awareness of reality.
  - There is an increased sense of humor.
  - There is a decrease in deterioration.
  - Direct Care Staff morale seems to increase and there appears to be a reduction in staff burnout.
  - Direct Care Staff turn-over appears to decrease.
  - In some cases there is an increase in family visitation.
- When using validation therapy, it is important to ask the resident “who”, “what”, “where”, “when”, and “how” questions to allow the resident to thoroughly

express him or herself. Ask follow-up questions using the same methodology to the responses.

- Examples of Validation Therapy:
  - Example One: A Direct Care Staff member is working with a resident on the secured unit. Every time the staff member comes to work the resident follows her around and calls her by the resident's sister's name, Hilda. The staff member knows from the family history that these sisters were very close. The resident's behavior causes the staff member stress because she can't provide care to any other residents without this one resident following her. The staff member is frustrated, irritated, and judgmental with the resident because she is starting to think the resident is doing it on purpose. The staff member should do the following:
    - Express her emotion, matching the resident's emotion. Rephrase. For example, "You need Hilda. You miss Hilda. You were close to Hilda."
    - Ask questions, "What do you miss the most about Hilda?" "What would you and Hilda be doing right now?"
    - Validate the resident's emotions. "You want to be with Hilda right now."
    - Reminisce: "What was your and Hilda's favorite game as kids?"

- Example Two: The resident hides her pictures, jewelry, etc and accuses the direct care staff member of taking it or throwing it away.
  - It is important that the direct care staff member acknowledges and validates the resident's anger over her belongings being missing. Rephrase. For example, "Your jewelry is missing and you said I have stolen it?"
  - Use visual senses, "The necklace you are missing was a beautiful gold necklace with a gold heart on it that your husband gave you."
  - Reminisce. "How old were you when your husband gave you that beautiful necklace?" "Where were you when your husband gave the necklace to you?"
  - Validate. "You are very angry that your beautiful necklace is missing." "I will help you look for it."

**Instructor Note: It is important to emphasize that people know when someone is lying to them, even individuals with dementia. It is extremely important to assist the resident in expressing him or herself and not try to deceive the resident as this will cause agitation, possibly aggression, and definitely mistrust.**

## **7.6 Behaviors in People with Alzheimer's Disease or Other Dementia**

Brain changes and changes in the way people with dementia perceive their surroundings and the people in them may result in them having some different, unpredictable, and challenging behaviors. While we may consider these "inappropriate" or "problem" behaviors, they may simply be the way a person with Alzheimer's is reacting to situations that frustrate them or they do not

understand. Other behaviors may simply be a result of the brain deterioration that is happening. Communication and behavior is closely related because some of the challenges in communication we just talked about may result in some of these behaviors.

- Some behaviors are:
  - Repetition
    - Saying or doing the same thing over and over again. This could be asking a question over and over again, or banging on a table over and over again.
      - Potential Therapeutic Staff Interventions:
        - Try to understand what the person is trying to communicate, including the possible emotions behind it. Does she need to go to the bathroom? Is she hungry? Is the person anxious?
        - Try to turn the behavior into an activity. If a person is continually rubbing a table or handrail, give her a cloth and ask if she will help dust.
        - Distraction. Ask a related question or repeat to them what you think they are trying to say. If the person is yelling “help” over and over again, ask them how you can help. Or, see if you can interest the person in another activity or conversation.
  - Wandering
    - This is the term we use for people who continually pace or walk around. There are many reasons why a person with Alzheimer's disease may wander.

- They are trying to find a way out.
  - It is natural for a person to want to leave a building or a room. However, it is not usually safe for a person to do this unattended. To limit this behavior, you may try taking the person for a walk, or distracting them from leaving by offering activities.
- They have a need that they would like met.
  - Although they may not be able to communicate their needs verbally, they may express them through wandering. For example, someone who needs to use the toilet may wander around a building looking for a bathroom. That person may also forget that she is looking for a bathroom but will continue wandering.
- They are anxious.
  - Many of us pace when we are angry or upset. People with Alzheimer's may have anxiety and release it through wandering.
- Trouble sleeping
  - People with Alzheimer's may have problems sleeping, or may even get their days and nights mixed up.
    - Potential Staff Therapeutic Interventions
      - Make sure they are comfortable when they are sleeping at night. Is it dark enough in the room, or too dark? Is the temperature comfortable? Do they have sufficient pillows, blankets?

- Help them keep a schedule during the day that includes regular meals, activities, etc. This may help them be more tired at night.
- Suspicion
  - People with Alzheimer's may become suspicious of others, probably because they are confused about where they are and who the people around them are. They may accuse others of theft or improper behavior.
    - Potential Staff Therapeutic Interventions
      - Do not take offense. Realize that this is the person's reality and is caused by the disease.
      - Rather than trying to convince the person she or he is wrong, listen and acknowledge what is being said.
      - If you have an answer that might explain the situation, make it simple. For example, if a person accuses you of stealing her clothes. You might say, "That must feel terrible to have your clothes go missing. But I believe they are being washed right now. I will bring them to you when they are done."
- Agitation and Aggression
  - In many cases, agitation and aggression are reactions to situations that the person is experiencing and is upsetting him or her. A person with Alzheimer's may be anxious or frustrated and this may escalate to agitation or aggression. Although we may not always realize it, it may be our behavior as staff that encourages a state of agitation or aggression. Arguing with people with

Alzheimer's, ignoring them, or pushing them to do things they do not want to do might all result in agitation and aggression. At other times, agitation and aggression may seem to come out of the blue. This may be the result of a person's interpretation of a situation that is based on their confusion. People with Alzheimer's may lack some control over their emotions as a result of their disease.

- Potential Staff Therapeutic Interventions
  - Try to understand what happened to make the person upset. What happened before the agitation and aggression? What happened earlier in the day?
  - When a person is becoming agitated, it is usually best to let them be and come back later. Make sure the resident is visible at all times and that direct care staff, other residents, visitors, and the agitated resident are not in danger.
  - Be reassuring and supportive but not too pushy.
  - If the environment is upsetting the person, or another resident, change what is upsetting them or move them to another location.
  - Report extreme changes in personality or behavior to a doctor. Document!
- If a person regularly or frequently gets agitated, attempt to engage them in activities to distract them. Know a person's "hot buttons" and think of ways to avoid or diffuse a situation before it elevates to agitation or aggression.



## Student Activity

- Group Exercise (Scenarios) – **Handout #1**

### Instructor Notes:

*The purpose of this activity is to teach the students some guidelines in responding to residents with dementia. There are many other ways of responding so these are not the only answers. Encourage students to talk about why their approaches may or may not work. Remind them that there is rarely one way to respond and it takes getting to know a resident to know the best ways to respond to him or her.*

### Activity Procedures:

1. *Have the class get into groups. If the class is small, this can be an individual activity.*
2. *Have the students turn to **Handout #1** in the student manual.*
3. *Assign one or two scenarios to each group or to an individual if the class is small.*
4. *Give each group/individual 5-10 minutes to read the scenario and develop different responses.*
5. *Use your Instructor Guide at the end of the chapter to stimulate ideas about possible responses and why some responses may not be effective.*

## 7.7 Staff Responsibilities

- Direct care staff of the ALF are expected to:
  - Understand the symptoms of dementia and how these symptoms might impact residents' daily activities.
  - Use appropriate techniques to communicate with residents with dementia.
  - Respond to behaviors as a form of communication in people with dementia.

## 7.8 Alzheimer's Association Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes

**Instructor Note:** This is a supplemental section to this chapter. While this is an important topic, you might find that your time limits covering this in detail. The Alzheimer's Association has developed recommendations for the care of individuals with dementia who live in assisted living facilities and nursing homes. These recommendations are based on the principles of person-centered care, or the idea that care should be individualized to the PERSON with dementia and include core values of dignity, choice, and respect. The recommendations can be found in more detail at [www.alz.org](http://www.alz.org) but here is summary of them that you can apply to your work.

The Alzheimer's Association has developed "fundamentals for effective dementia care". They are:

- People with dementia are able to experience joy, comfort, meaning, and growth in their lives.
- For people with dementia in assisted living facilities and nursing homes, quality of life depends on the quality of the relationships they have with the direct care staff.
- Optimal care occurs within a social environment that supports the development of healthy relationships between staff, family, and residents.
- Good dementia care involves assessment of a resident's abilities; care planning and provision; strategies for addressing behavioral and communication changes; appropriate staffing patterns; and an assisted living or nursing home environment that fosters community.
- Each person with dementia is unique, having a different constellation of abilities and need for support, which change over time as the disease progresses.

- Staff can determine how best to serve each resident by knowing as much as possible about each resident's life story, preferences and abilities.
- Good dementia care involves using information about a resident to develop "person-centered" strategies, which are designed to ensure that services are tailored to each individual's circumstances.

The goals for effective dementia care are:

- To ensure that staff provides person-centered dementia care based on thorough knowledge of residents and their abilities and needs.
- To help staff and available family act as "care partners" with residents, working with residents to achieve optimal resident functioning and a high quality of life.
- To have staff use a flexible, problem-solving approach to care designed to prevent problems before they occur by shifting care strategies to meet the changing conditions of people with dementia.

The Alzheimer's Association has focused on six dementia care practice areas.

More information can be found at [www.alz.org](http://www.alz.org). These six areas are:

- food and fluid consumption.
  - pain management.
  - social engagement.
  - wandering.
  - falls.
- physical restraints.

## **Standards for Licensed Assisted Living Facilities**

**Effective July 17, 2013\***

None for this Chapter

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

Alzheimer's Association. (2008). Basics of Alzheimer's disease: What it is and what you can do. Chicago, IL: Alzheimer's Association.

Alzheimer's Association. (2006). Dementia care practice recommendations for assisted living residences and nursing homes. Chicago, IL: Alzheimer's Association.

Alzheimer's Association. (2005). Communication: Best ways to interact with the person with dementia. Chicago, IL: Alzheimer's Association.

[www.vfvalidation.org](http://www.vfvalidation.org)

## Student Review - Chapter Seven

1. What is the definition of dementia? What is the most common cause of dementia?

**Dementia is a general term for the loss of memory and other intellectual (or cognitive) abilities that are serious enough to interfere with daily life.**

**Alzheimer's Disease is the most common cause of dementia.**

2. What are four of the ten "warning signs" of Alzheimer's disease?

**memory loss.**

**difficulty performing familiar tasks.**

**problems with language.**

**disorientation to time and place.**

**poor or decreased judgment.**

**problems with abstract thinking.**

**misplacing things.**

**changes in mood and behavior.**

**changes in personality.**

**loss of initiative.**

3. Describe two examples of how Alzheimer's disease is different from "normal aging"?

<b>Symptoms of Alzheimer's disease</b>	<b>Memory changes related to normal aging</b>
<b>Forget whole experience</b>	<b>Forget part of experience</b>
<b>Rarely able to remember later</b>	<b>Often able to remember later</b>
<b>Gradually unable to follow written/spoken directions</b>	<b>Usually able to follow written/spoken directions</b>
<b>Become unable to use notes as reminders</b>	<b>Able to use notes as reminders</b>
<b>Become unable to care for oneself</b>	<b>Usually able to care for oneself</b>
<b>From "Basics of Alzheimer's Disease: What it is and what you must do", Alzheimer's Association, 2008.</b>	

4. What are five common communication challenges in people with Alzheimer's disease?

**difficulty finding the right words.**

**using familiar words over and over again.**

**inventing new words for familiar things.**

**losing train of thought.**

**difficulty organizing words logically.**

**reverting to one's native language.**

**using curse words.**

**speaking less often.**

**using gestures instead of speaking.**

5. What are some ways in which you can help people with Alzheimer's communicate?

**Patience!**

**Show your interest**

**Offer comfort and reassurance.**

**Give the person time.**

**Avoid criticizing or correcting.**

**Avoid arguing.**

**Offer a guess.**

**Encourage unspoken communication.**

**Limit distractions.**

**Focus on the feelings, not the facts.**

6. Name two common behaviors in people with Alzheimer's and examples of how you might respond to them.

**repetition – offer a distraction; turn the behavior into an activity; try to understand what the person is trying to communicate.**

**wandering – take the person for a walk or distract the individual with an activity.**

**trouble sleeping – make sure resident is comfortable, keep the same schedule each day.**

**suspicion – listen and acknowledge what is being said and not try to convince the person otherwise.**

**agitation and aggression – try to determine what is causing the behavior; be reassuring and supportive; remove the individual or item that is causing the behavior; attempt to engage in an activity.**



## Chapter Seven – Student Activity

### Scenario 1

Joe is a 78 year old man with dementia. He was a CEO of a major company for many years and now lives in Great Assisted Living. Every day, like clockwork, Joe tells the staff that he has to go to work because he has a “big deal going on”. The staff tell him that he does not work anymore, that he is retired and lives here at assisted living. This makes him extremely angry, he gets terribly upset, and he starts trying to find ways to leave. Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** It is usually not effective to correct someone with dementia. Joe has his own reality, which you cannot change. Some ways in which this could have been handled:

- The staff could ask him questions about his work, what he did, etc., trying to distract him from leaving.
- The staff could let him know that breakfast is about to be served and then they can make plans for the day.
- The staff could distract him entirely by asking him to do something, like help in the dining room, or do an activity.
- Sometimes, you may think it is appropriate to “go along with what he is saying”. You might say something like “What time is your meeting?” or “They just called and canceled your meeting”. This may be effective at times. If this helps Joe to relieve his anxiety, then it may be helpful. But be careful of how many white lies you make- it could become disrespectful or Joe might become more agitated if he thinks you are “playing with him”.

### Scenario 2

Mary is a sweet lady who lives at Great Assisted Living. She has dementia and loves to chat with the staff but will often lose her train of thought and just keep talking “in circles”. While the staff love to talk with her, they sometimes feel pressured to end the conversation so they can attend to other responsibilities. However, they want to make sure that they are understanding what Mary is trying to say and if she needs anything. Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** It is hard to balance spending time with residents and completing all the work you have to get done. It is important to give people with dementia time to express what is on their minds. But, if you need to end the conversation, there are a few ways you can handle that:

- Ask Mary if she would help you with something to distract her.

- Apologize for interrupting her, and remind Mary that there is an activity going on that she wanted to attend.
- To make you understand what she may be communicating to you, ask Mary if there is anything she needs, or ask her a direct question about something she talked about. For example, if Mary comes to you and starts telling you about how she used to play the piano and loves music, ask her if she would like to listen to music or play a piano, if there is one.

### Scenario 3

Greta is a resident at Great Assisted Living and has dementia. While she lived in the US for many years and speaks English fluently, she has recently reverted to her native German language. No one on staff speaks German and they are not sure how to communicate with her. When they ask her to speak in English, she looks at them blankly, says something in German, and seems to get frustrated. Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** The best way to handle this may be to ask her simple questions in English. She may switch back to English when she hears you talking. It is usually not effective to correct her or tell her she is speaking German, because she may not be aware of that. You can ask her to point to what she needs or ask to follow her to see what she needs. Sometimes, it is important to just listen even though you may not understand her.

### Scenario 4

Lorene is a 95 year old resident at Great Assisted Living and has dementia. One morning a staff person comes into the room and starts undressing her and tells her she is going to take a bath now. She becomes very upset and starts yelling “No” and tries to push the staff person away. Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** If you look at this from the perspective of Lorene, a total stranger came into her room and started undressing her. Any of us would be frightened by that. The aide could have introduced herself and explained she was there to get her bath ready. When Lorene became upset, it would have been best for the aide to back off and leave her alone for a little while. Also, if the aide has a relationship with Lorene, and knows her, she might know when Lorene likes her bath and how she likes to be helped. The aide would know how to approach her.

### Scenario 5

William is an 85 year old resident at Great Assisted Living who has dementia. Occasionally, he will walk into the living room and start to take off his pants while he is walking around the room and trying different doors. What could he be trying to communicate? How would you respond?

**Discussion:** Ask yourself why William might be exhibiting this behavior. He could need to go to the bathroom and because he cannot tell you this with words, he is going through the motions. Rather than scold him for his behavior, gently bring him to the bathroom (if you think he needs to use it) or another room.

#### Scenario 6

Margaret, a resident at Great Assisted Living who has dementia, approaches a staff person looking very anxious. She asks them, "Have you seen my..thing....uh...oh dear. It has everything in it!! I have it everywhere with me when I go. Have you seen it?" Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** To relieve her anxiety, you might tell her that you are sorry she has lost something. Maybe offer some guesses as to what she is looking for: "Are you looking for your purse?"

#### Scenario 7

Joline is an aide at Great Assisted Living. She is helping a resident, Marge, who has dementia, to brush her teeth. Joline hands her the toothbrush and Marge starts brushing her hair with it. Using what you learned about communication and behaviors, how could you respond to this situation? How could Joline better communicate to Marge how to brush her teeth?

**Discussion:** Rather than criticize what she is doing, gently guide her in what she should be doing. Give her basic one step directions: "Here is your toothbrush. Let's rinse it. Ok, let's put some toothpaste on it....."

#### Scenario 8

Natasha is an aide at Great Assisted Living. She is working with Joanne, who has dementia. Joanne likes to wander and will sometimes try to leave the building. One day, Natasha watches her try to leave through a back door. Natasha, trying to stop her, yells, "Joanne, you are not allowed to leave!" Joanne gets upset when Natasha approaches her to turn her away from the door and starts yelling "Help!" Using what you learned about communication and behaviors, how could you respond to this situation?

**Discussion:** Joanne is likely confused about why someone is trying to prevent her from leaving. When Natasha tells her not to leave, that probably makes her angry. When Natasha approaches her, she may feel threatened. One way in which you could handle this is to say to Joanne, when you see her trying to leave, "Joanne, I am so glad I found you. Please come with me- I need you!"



# **Intimacy and Aging**

## **Chapter Eight**

**Time Required: 1 Hour**

## **Chapter Eight- Intimacy and Aging**

This chapter will provide the student with general information on the importance of intimacy in an older adult's life. A goal of the chapter is to dispel myths and stereotypes about older adults and sexuality. The students will examine the experience of heterosexual and GLBTI older adults. The chapter will also review normal changes in aging that affect sexual activity as well as illnesses that can affect intimacy. One section will focus specifically on the topic of dementia and intimacy because of the sensitivity and complexity of the issue. Additionally, this chapter will describe the staff member's role in promoting anti-ageist thoughts and actions as they relate to intimacy and aging.

- 8.1 Intimate Relationships and the Older Adult**
- 8.2 Aging and Intimacy**
- 8.3 Medical Conditions and Intimacy**
- 8.4 What Does it Mean to be a GLBTI Older Adult?**
- 8.5 Intimacy and Dementia**
- 8.6 Staff Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. Understand the role and right of intimacy in the older adult population and be knowledgeable of all elements involved in the intimate relationships of older adults
- b. Recognize normal aging versus illness and be able to change the misperceptions surrounding both topics and intimacy
- c. Be able to define GLBTI, recognize their rights as individuals, and be aware of the diversity of the older adult population and how that relates to their intimacy and rights as individuals
- d. Be able to recognize the intimate rights of people with dementia

### **2. Recommended Method of Instruction**

- Lecture and class discussion
- Classroom Sensitivity Contract **(Handout #1)**
- Student Activity - Scenario and Group Exercise **(Handout #2 and Handout #3)**
- Student Review - Chapter Eight



## **Student Activity**

- Classroom Sensitivity Contract – **Handout #1**

### **Instructor's Notes:**

*This chapter contains sensitive information about issues that are not always openly discussed. It is important that ALL participants in this class remain respectful and open-minded about the information, older adult population, and opinions of all other classmates. It is the goal of this chapter to provide information on topics to help the direct care staff better care for the residents of their community. It is a perfect time to reinforce the fact that it is not a time where judgment and preconceptions should cloud the need for respect and kindness. You, as the instructor, set the standard for the class. The Classroom Sensitivity Contract presents the idea of “ground rules” for the classroom to encourage respectful and open-minded participation.*

### *Activity Procedures:*

- 1. Have the students turn to the Classroom Sensitivity Contract **Handout #1** in their student manual.*
- 2. The instructor will read each point on the contract and request that each student sign on the signature line.*
- 3. If any student breaks the contract during the discussion of material, refer that student back to the contract and remind the student of the obligation made by signing it.*

## **8.1 An Introduction to Intimacy and Aging**

- What is intimacy?
  - Intimacy refers to the personal relationship felt between two individuals. Intimacy and sex are not the same. Adults of all ages can have sex and never feel a personal connection (intimacy) with the person.

- Intimacy can come from a sexual relationship or from the connection that a person feels with a friend over a cup of coffee and conversation.
- Adults of all ages value intimacy in their sexual relationships because it provides for an emotional and thoughtful element between the two individuals.
- Where do you find intimacy?
  - A person can experience intimacy through a variety of different ways.
    - A spouse who brings breakfast and conversation in bed every morning.
    - A partner who spends an hour everyday reading to her wife who has Alzheimer's disease or other dementias.
    - A friend who listens to your worries about moving your husband into an assisted living community.
    - A reassuring word to your child who expresses concerns over being a mother for the first time.
    - A pet who greets you every day after a long day at work.
    - Between two residents in an assisted living facility who enjoy each other's company and spend a lot of time together.
  - As you can see, intimacy brings life satisfaction and quality of life to anyone experiencing it.
- Sexual Relationships
  - The desire for sex doesn't end when a person becomes an older adult. Sex does not turn on or off based on your age but matures and changes with time.
  - Adults vary in their interest in sexual activity; however, age alone does not mean a person becomes less interested. Their level of interest or activity may be the result of lifelong habits.

- “He’s just a dirty old man” is just a stereotype
  - Stereotypes of older adults being over-sexualized through the “dirty old man” portrayal and asexual through the “old maid” picture have been placed on older adults by a society who denies them the right to have a sexual identity.
  - Greeting cards, movies, and commercials have further emphasized the fact that older adults are no longer “young and beautiful” therefore cannot be sexually desirable.
  - Fortunately, these stereotypes are changing and adapting to the increasing awareness of new aging lifestyles.

## **8.2 Aging and Intimacy**

- Physical and emotional changes in the resident are normal in the aging process. This can cause changes to occur in the resident's attitude toward sexual relationships and their engagement in sexual activity.
- Losing the desire for sex is not a normal part of the aging process
- Aging changes between females and males are outlined below
- Aging changes in transgendered and intersexed individuals could closely resemble the female, male, or both. It is important for both transgendered and intersexed individuals to participate in preventative care for prostate screenings, breast cancer screenings, and PAP screenings for cervical cancer.
  - Ex. It is common for a post-operative male to female (male who has had his penis removed and vagina constructed) transgendered person to still have his or her prostate (if taken out this could affect continence and sexual function), therefore these individuals must be screened for prostate cancer AND changes in the vagina that may turn into cancer.

- Aging changes in an older adult male
  - An older adult male's testosterone (a chemical produced in the testes that encourages the development of sexual characteristics) level is at its peak at age 15 or 16 and gradually declines throughout the lifespan. Males will always have testosterone but it may be in significantly smaller amounts as an older adult.
  - A 60-65 year old male may experience changes in his sexual response. It may take longer for his penis to become erect, and his erection may not be as firm.
  - It may take an older adult male longer to reach an orgasm (the peak of his sexual experience), leading to a longer sexual experience than when he was younger.
  - Every person ages differently. The person may experience an increase in sexual desire as they get older or a decrease. This will vary according to the person.
  - The older adult may change their perception of intimacy and desire more intimate touching instead of sex.
- Aging changes in an older adult female
  - An adult female will go through many physical and emotional changes during menopause (the time in a woman's life when she no longer has her period).
  - Females have a level of testosterone in their bodies that takes part in their sex drive that will gradually decline as she becomes older which can affect her sex drive.
  - The vaginal walls may become thinner, dryer, and less elastic making it more sensitive and easily irritated during sex. Foreplay can stimulate lubrication and make sex more enjoyable.
  - Foreplay may become a more important part of the sexual experience because it takes longer for a woman to become

sexually excited and achieve an orgasm (the peak of a woman's sexual experience).

- Psychological changes
  - The mind plays a large role in maintaining your sexual drive as you age.
  - If the person feels anxiety about their sexual ability then this will affect the way they respond to sex.
  - The stress and worry over sexual performance can cause impotence (inability to achieve an erection) for men and inability to experience sexual arousal for women.
  - The media portrays aging as "unattractive" and could affect the way the person looks at their body as they age. Their self-image can change as they age which could affect how well the person accepts intimate feelings from another.
  - The loss of a spouse or partner can cause a temporary loss in intimate desire.
  - An older adult's family, particularly adult children, may also not acknowledge that their aging parent has sexual desires and may actively discourage it, causing guilt and anxiety in an older adult.

### **8.3 Medical Conditions and Intimacy**

- Certain medical conditions can have a negative effect on the psychological and physical aspects of sex and intimacy.
- Surgery can cause a temporary or long-lasting affect on a person's sexual desire. In some cases such as hip or back surgery it may be difficult to engage in vaginal intercourse. For these reasons different ways of sexual intercourse could be options.

- Medications
  - Certain medications for hypertension (high blood pressure) can have a side effect that could reduce the desire for sex and make it harder for a male to have an erection and a female to produce lubrication.
  - Antihistamines (controls allergies), antidepressants (controls mood), and acid-blocking drugs (controls heart burn) can cause changes in sexual function as well.
  - Pain medications can cause fatigue and make it difficult to be active.
- Male Erectile Dysfunction
  - In today's media this has become a hot topic with commercials for drugs such as Viagra, Cialis, and Levitra showing men and women in intimate situations.
  - Erectile dysfunction is the inability to achieve or maintain a firm erection long enough to engage in sex.
  - It is seen the most in the older adult population but can occur throughout the lifespan.
  - Many different reasons can cause erectile dysfunction
    - Heart disease
    - Clogged blood vessels
    - Diabetes
    - Obesity
    - Parkinson's Disease
    - Multiple Sclerosis
    - Tobacco, alcohol, or drug use
    - Certain prescription drugs
    - Surgeries or injuries
    - Stress

- Fatigue
  - Depression
- Erectile Dysfunction can effect current or future relationships with partners and lead to depression.
- A doctor will try to treat the underlying medical condition that may be causing the problem.
- Drugs such as Viagra, Cialis, and Levitra can help maintain an erection.
- Sexual dysfunction in women
  - Older adult women, like men, can have problems with sexual desire, arousal, orgasms (reaching the peak of pleasure), and pain disorders.
  - The most common disorder in women relates to vaginal pain during intercourse known as vaginismus.
  - Vaginismus is caused by a decrease in lubrication and loss of elasticity in the vagina.
  - Unfortunately, there are not as many medications available to treat disorders found in women's sexual dysfunction disorders.

## **8.4 What Does it Mean to be a GLBTI Older Adult?**

- GLBTI
  - Gay, lesbian, bisexual, transgender, and intersex (GLBTI) designate a group of individuals that share a common bond through their minority status. It is difficult to place all individuals in the same group (GLBTI) because of the diversity of each group.
  - The older adult GLBTI community is a group of people who have seen significant changes in society over the decades.
  - The Stonewell riots of the 1960's, AIDs epidemic of the 1980's, and the marriage equality movement of the 2000's have all been

contributing factors to the individuals that make up the GLBTI community.

- What does GLBTI Mean?
  - The term "Gay" refers to men who have physical and emotional relationships with other men
    - Variations of the term “gay” can be present in men who have sexual relations with other men but who do not identify as gay or bisexual.
  - The term "Lesbian" refers to women who have physical and emotional relationships with other women
    - Variations of the term “lesbian” can be present in women who have sexual relations with other women but who do not identify as a lesbian or bisexual.
  - The term "Bisexual" is an individual who can have physical and emotional relationships with both men and women
  - The term "transgendered" is an umbrella term that includes individuals whose personal identity does not conform to society's view of "male" or "female". Some people who identify as transgendered will go through a process psychologically and/or operatively to "transition" into a male or female body.
    - Variations of this term can be seen in post-operative individuals who are attracted to same-sex individuals or other post-operative transgendered individuals.
    - Some members of the transgendered population prefer to not be classified as “transgendered” after they have transitioned into their male or female body.
  - The "I" refers to the intersexed population who may have been born with a combination of external and internal male or female genitalia.

- Types of intersex conditions
    - Androgen Insensitivity syndrome: female-looking genitals on a genetic male
    - Congenital adrenal hyperplasia: male-looking genitals on a genetic female
    - Sex chromosome syndromes
  - There is controversy over the treatment of intersexism discovered at birth. Some doctors prefer to remove parts of the genitals. Many intersexed older adults have been affected by the negative consequences of this surgery.
- In today's society, the concept of sexuality is an evolving concept with many different meanings. There are many different forms of GLBTI relationships that could be seen as an intertwining of many different forms of sexuality.
- Coming Out
  - “Coming out” refers to the act of disclosing one’s sexual identity to others. This is a lifelong process for most people. Each person that the resident will encounter is another time when their sexuality may be exposed.
  - Many older adults in communities today have lived in fear of telling others about their GLBTI status. Older adults have lived through discrimination and there are few laws to defend those individuals' rights against hate crimes.
  - Until 1973 gay, lesbian, and bisexual individuals were considered mentally ill in the Diagnostic and Statistical Manual of Mental Disorders used by psychological professionals.
  - Currently, transgendered individuals are still listed in the Diagnostic and Statistical Manual of Mental Disorders

- Going back into the closet
  - The fear of being discriminated against may lead an open GLBTI resident to revert back to hiding their sexuality (also known as going back into the closet).
  - There is little known about whether this decision has positive or negative impacts on the resident. It is known that hiding one's sexuality can cause feelings of sadness, guilt, and depression.
- Every person living in an assisted living facility has a life story. Each individual could have experienced discrimination, hate, and prejudice because of their race, religion, gender, sexual orientation, or disability status. It is our job to accept and respect each person regardless of their background.

### **8.5 Intimacy and Dementia**

- There are a number of things to consider with intimacy and dementia and they are outlined here to give you an overview of some of the issues involved. Each situation is different and open communication with supervisors, other staff, family members, and people with dementia, as appropriate, is important. We all have a right to intimacy, even people with dementia.
- Dementia changes many aspects of an intimate relationship between two people. It requires many changes for mothers and daughters, fathers and sons, and especially a person and his or her partner.
  - An individual with dementia may forget that the person is related to them so that the close connection through communication or touch could be strained.
- A man and wife, a GLBTI partner, or a life-long companion will need to adapt to the many changes that could affect an intimate relationship.

- A person with dementia may not remember the marriage or companionship which could put a strain on all aspects of their intimate relationship.
- The signs and symptoms of dementia can appear in the way a person may perceive intimacy.
  - An older adult with dementia may have:
    - an increased desire for sex
    - decreased interest in sex or not want to have sex at all
    - a difficulty in engaging in sex
    - a discomfort with intimate touching such as hugging, kissing, or hand holding
    - a change in displays of sexual behavior. A person may find it appropriate to undress themselves in public.
    - Confusion about with whom they have intimate relationships. This is seen in situations in which a person with dementia may develop an intimate relationship with someone who is not his or her spouse or partner. This is particularly difficult for adult children of people with dementia. Seeing their moms and dads suddenly develop relationships with people who are not their spouses or partners may be very upsetting for them and they may have strong reactions to this, such as “Don’t let them be together”. This is a very difficult situation that requires open communication with families and staff.
    - A resident will often display sexual behaviors at inappropriate times like during an activity or at the dinner table. What may appear to be a sexual behavior could be the resident's expression of a need. This need could be to use the bathroom, change clothes, or a sign of discomfort. The direct care staff member should not automatically assume that the

behavior is related to a sexual need and investigate further to determine if it is for another reason. Another consideration is that “inappropriate” sexual behavior in people with dementia may actually be a cry out for intimacy. In other words, they are seeking that closeness that comes with intimacy and it is not truly sexual. Another consideration is that people with dementia may have difficulty controlling their behaviors at times. In these situations, their dignity should be protected in a calm and gentle manner.

- Aides and residents are often in highly personal “intimate” situations in which an aide may be assisting a resident with activities such as bathing, toileting, and dressing. A person with dementia may see these situations as sexual and respond inappropriately. For example, a female aide is helping a male resident with bathing. She is assisting him in washing his private areas. Suddenly, the male resident says, “That’s nice, dear” and grabs her breast. The appropriate reaction to this situation would be to redirect the resident to the task at hand such as bathing or toileting and educate the resident on appropriate behaviors.
  - Along with this, it is not okay for direct care staff to joke with residents that they are their girlfriends, boyfriends, sweeties, etc. This could be very confusing, particularly with someone with dementia.
- Consent
    - Consent is the act of agreeing or giving permission to do something
    - With dementia and diseases that affect the brain, the ability to give consent to have sex or other intimate relations could be impaired.

- It is a difficult case when only one partner has dementia and the other person does not. It is also difficult when both partners have varying degrees of dementia, so one person's ability to consent is different from the other person's understanding of the situation.
- The resident may need a thorough assessment by a mental health professional, such as a psychologist, to determine if the person is able to consent. This is a very sensitive subject where both partners' emotions should be considered.
- If staff witnesses a situation where they think the rights of a person are being violated this should be reported to a supervisor and documented according to facility protocol.
- At what point is it not ok to have sex?
  - It is difficult to decide and it varies from person to person.
  - Know your resident. If the resident appears to be agitated, upset, or frightened then action must be taken to protect the resident from their partner.
  - Make sure that the resident is completely aware of the entire situation and is comfortable with the decision.
  - Decision-making involves being comfortable with the consequences after the decision has been made. For some people with dementia this can be difficult because of the effects of dementia on long-term memory.



### **Group Activity**

- Scenarios (**Handouts #2 and #3**)

#### **Instructor Notes:**

*The purpose of this activity is to promote discussion of a potential occurrence in an assisted living community. It is important that the instructor takes a moment to walk around to each group to listen to their discussions. If there is evidence of*

*any inappropriate conversations or behavior, laughs, or disrespect for the resident or group members then this observation needs to be brought up during the class discussion. The goal of this chapter is to prevent ageism, homophobia, and other prejudices from affecting the care received by the residents in the community.*

*Two scenarios are used to increase the size of the groups and enforce a team approach to situations encountered. Many people contribute to decisions made by staff in a community but it only takes one person to start a change.*

*Activity Procedures:*

- 1. Divide class into two groups.*
- 2. Have one group turn to **Handout #2** in the student manual and have the second group turn to **Handout #3** in the student manual.*
- 3. Tell the group to discuss each scenario and answer the questions.*
- 4. Designate a person from each group to record the answers to the questions and someone to share the answers to the questions with the class.*
- 5. After 15 minutes of group discussion, have a student in each group read the scenario and answers.*
- 6. Discuss the responses with the class.*

## **8.6 Staff Responsibilities**

- Be an advocate for residents!
  - Advocacy means to give "active verbal support to a cause or a position". This means that you make it your responsibility to be the voice for residents that may not be able to defend their rights and take action to make sure they are receiving the care they deserve.
  - Be supportive of all residents. Consider what is important to them as individuals.
  - Change starts with one person with a vision for doing things in a better way.

- If you see a resident being mistreated because of anything discussed in this chapter, make it your responsibility to change the situation.
- Lead by example! Promote anti-ageist attitudes and actions.
  - At any given moment everyone is experiencing the aging process
  - This chapter has given you more knowledge to change ageist attitudes and actions
  - Being a leader empowers others to look to you for answers to difficult questions or situations
- You are an important part of a resident's life
  - A direct care staff member is a key player in a resident's every day routine
  - Forming an intimate bond with the resident will promote healthy aging and well-being
  - Respecting the intimate bonds that the resident has with others can lead to a good relationship between you and the resident

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40-72-550 Residents rights

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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National Sexuality Resource Center

<http://nsrc.sfsu.edu/>

## Student Review - Chapter Eight

1. **True** Sex is only a part of the intimate experience and can evolve as a person ages.

2. What does each letter in GLBTI mean?

**Gay, Lesbian, Bisexual, Transgender, Intersex**

3. Name two **normal** age-related changes in a man that would affect sex.

**Decreased testosterone**

**Increased amount of time to achieve an erection**

4. Name two **normal** age-related changes in a woman that would affect sex.

**Decreased lubrication and elasticity**

**Decreased testosterone**

5. **False** A resident who undresses at the dinner table is only trying to have sex with the female resident sitting next to him at the table.

## Classroom Sensitivity Contract

The issues that are going to be discussed in this chapter are sensitive. The goal is to create an open environment to discuss the issues and present the chapter with unbiased, factual information regarding the topics.

1. I understand that stereotypes exist that falsely represent different groups in the population.
2. I recognize that my neighbor in this class is a unique individual that does not deserve to be placed in a category for any reason.
3. I understand that the media may represent age, race, religion, gender, or sexual orientation in a manner that could enhance stereotypes about these groups.
4. I understand that it is my responsibility as a direct care staff member to ensure that the resident's dignity, privacy, and independence is held at the highest priority and this class will help me to become more aware of the diversity that makes up the population in our community.
5. I understand that this chapter is not intended to be taken as humorous, so laughing and joking about the topics presented will only reinforce the idea that these negative thoughts about different groups still exist.
6. I understand that every person has the right to their opinion and should be allowed to express their opinion in a respectful manner without judgment.
7. I understand that my personal belief system should not interfere or influence the treatment and care I provide to the individuals or my colleagues.

*I acknowledge that I have read and understand the goals of this chapter:*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Scenario Exercise # 1

Mrs. McKay has been married to her husband for forty-five years. Mr. McKay is a regular visitor to Great Assisted Living and he has been a large part of her successful transition into the facility. Mrs. McKay moved into Great Assisted Living to receive care after she was diagnosed with Parkinson's disease. The direct care staff and her husband have noticed that Mrs. McKay has started to forget certain things about her day that she would usually remember. She has been asking the staff about when she may be going home and referring to her husband as their son Michael. Mrs. McKay has an appointment with her doctor on Friday.

On Tuesday, you interrupt Mr. and Mrs. McKay's visit in Mrs. McKay's room by walking into the room without knocking. Mr. and Mrs. McKay are seen in bed having sexual intercourse. You apologize and quickly shut the door.

**1. What was your gut reaction after leaving Mrs. McKay's room? How did you feel after leaving Mrs. McKay's room and having some time to think about the situation?**

There are a variety of answers to this question. A person could feel surprised, embarrassed, disgusted etc. The important part is that the direct care staff member is not having feelings that may stem from ageism.

**2. Do you think it is appropriate for Mr. and Mrs. McKay to be engaging in sexual activity? What is the reason behind your answer?**

If both Mr. and Mrs. McKay are consenting adults then it is appropriate for both to engage in sexual relations. Mrs. McKay is experiencing some memory loss due to an unknown cause. If Mrs. McKay appeared to be upset or agitated after having sex with her husband than it could be cause for concern. If Mrs. McKay has a roommate that could potentially walk into the room and witness the sexual act, then it may be appropriate to encourage the roommate to engage in an activity outside of the room to protect Mr. and Mrs. McKay's privacy, as well as, the privacy and rights of the roommate.

**3. What should you do after witnessing this event?**

It is important that the student knows that it is inappropriate for her or him to violate the resident's privacy and discuss what happened with other coworkers. If the student feels that Mrs. McKay is being harmed in any way then that student should report the incident to a supervisor or follow policy and procedures for reporting.

**4. You overhear two direct care staff members talking about the incident. They are laughing and talking about how they are surprised that Mr. and Mrs. McKay still engage in sexual activity. What is your reaction to this situation? What is your reaction to your colleagues?**

There are a variety of answers to this question. The goal is promote leadership in this situation. When a direct care staff member exhibits leadership that person does not stand back and agree with the behavior that is being displayed among her coworkers. This would be a chance for the direct care staff member to demonstrate the knowledge that she or he has learned in this chapter.

## Scenario Exercise #2

Mrs. Jessup is a seventy-two year old transgendered female. She was born a biological male and decided at sixty-five years old that she would spend part of her retirement money on surgery. Mrs. Jessup had plastic surgery that gave her two breast implants and a vagina. She no longer has a penis. She has been living as a woman for several years but is not open to everyone about her past because of the fear of discrimination. Her and her partner Susan have just moved into Great Assisted Living. Unfortunately, word has spread about Mrs. Jessup's background. While eating lunch, a group of your coworkers have begun to express concern about being able to properly provide care for Mrs. Jessup and her partner. They do not agree with her decisions and laugh about her surgery. Most of the direct care staff has refused to assist Mrs. Jessup with her shower. You have decided to assist Mrs. Jessup with her shower. Mrs. Jessup knows that the other staff is having a difficult time understanding her lifestyle. Mrs. Jessup confides in you and tells you that she was born a man and never felt like she was in the correct body. She decided to have the surgery because she had worked all of her life for other people and deserved to be happy.

### 1. Describe in words how you would respond to Mrs. Jessup's life story?

This question opens the floor for various thoughts and feelings to be expressed. It is important for a direct care staff member to be introduced to these feelings and learn how to develop the skills needed to continue to provide kind and respectful care to a resident like Mrs. Jessup and her partner Susan. In the student's response there should also be descriptions of actions taken such as continuing to provide personal care, using encouraging words to help ease Mrs. Jessup's fears about moving into Great Assisted Living, and being an active listener.

### 2. How would your response affect the care you would give Mrs. Jessup?

There could be two different types of responses to this question. One response would be the student would refuse care for Mrs. Jessup and the other response would be to continue assisting Mrs. Jessup with her shower. The first response would require an instructor to remind the student that this is Mrs. Jessup's home. She and her partner should feel safe in their home environment. A direct care staff member is aware of all rights given to the individual upon admission and refusing to provide personal care would be in violation of her rights.

### 3. How would you make Mrs. Jessup and her partner feel more comfortable living at Great Assisted Living?

- be an active listener and do not judge or criticize
- everyone comes from a unique background that may or may not be similar to your personal background or belief system
- encourage social activity
- lead by example by not listening to the possible criticizing remarks of your coworkers
- be the voice of assurance when the resident appears frightened or nervous in a new environment



# **Meals and Nutrition**

## **Chapter Nine**

**Time Required: 1 hour**

## **Chapter Nine - Meals and Nutrition**

This chapter will focus on the nutritional needs of older adults. Proper nutrition is crucial throughout the lifespan and a significant part of quality of life in older adulthood. The effects of certain physical and cognitive disabilities on nutritional intake of older adults will also be discussed. The student will be provided with information about the benefits of proper nutrition and fluid intake which are contributing factors for aging well.

### **9.1 Nutritional Needs for Older Adults**

### **9.2 Age-Related Changes and Nutrition**

### **9.3 Signs and Symptoms of Malnutrition and Dehydration**

### **9.4 Chronic Diseases and Nutrition**

### **9.5 Staff Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. To understand the effect of age-related changes in the body and nutritional status in older adults.
- b. To understand the effects of chronic diseases on nutritional needs and the implications of drugs with certain foods.
- c. To understand the basic nutritional needs of older adults.
- d. To be knowledgeable of the signs and symptoms of malnutrition and dehydration in older adults and to utilize this knowledge to identify and treat this condition.
- e. To understand the staff's role in providing proper nutrition on a daily basis.

### **2. Recommended Method of Instruction**

- Lecture and class discussion – **Handout #1** and **Handout #2**
- Facility's Policies and Procedures (if available)
- Student Review – Chapter Nine

## 9.1 Age-Related Changes and Nutrition

Our bodies change over time due to many factors such as life events, illnesses and genetics. There are a number of changes as we age that may affect nutrition.

- Oral Changes
  - Changes in the oral cavity can create issues for proper nutrition intake for the older adult.
  - These changes include:
    - Brittle teeth
      - Brittle teeth can be caused by gum disease and poor brushing habits. This can lead to pain and lack of interest in eating.
    - Tooth decay.
    - Loss of taste buds.
      - The average adult has 9,000 taste buds which detect salty, sweet, sour, and bitter foods. After the age of 60 adults start to lose taste buds. Usually the taste buds that detect salty and sweet foods are lost first followed by taste buds that detect sour and bitter foods. This may explain why older adults prefer sweeter and saltier foods.
    - Poor fitting dentures.
    - Decreased saliva production.
      - Saliva is important for swallowing and preventing the buildup of bacteria on teeth.
    - Age-related slowing of the swallowing response is known as Presbyphagia.

- Sensory Changes
  - Smell
    - The nerve endings in the nose may lose some of their smell detecting function as we age. If the older adult is unable to take in the pleasant aroma of food, it may mean a loss of desire to eat the meal.
  - Vision
    - The decline in sight could affect the desire for food consumption. If the person is unable to accurately see the food they are eating, then the person is less likely to partake of the meal.
    - A decline in vision could also cause a fear of cooking and meal preparation which could lead to poor nutritional status.
- Body Changes
  - The loss of lean body mass is often the most significant physical change in older adulthood. As discussed in previous chapters, this may be lifestyle dependent. Lean body mass holds 72 percent of the bodies' water supply. A loss in lean body mass can mean a greater risk of dehydration.
  - The most significant effect of loss of lean body mass is the decline in the metabolism of the older adult.
    - **Metabolism** is the rate that your body burns calories. As a person ages and loses lean body mass, their metabolism slows. If there is not a proper balance between how many calories a person consumes and physical activity in a day,

then the body will store calories as fat instead of burning calories. It is the balance of healthy living.

- Digestive tract
  - The rate at which food is propelled through the digestive track slows with age.
  - Important Tip:
    - Drinking water throughout the day helps the flow of food through the digestive tract and decreases the risk of constipation, a common problem in the older adult population.
  - Potential Staff Therapeutic Interventions
    - Encourage the resident to drink plenty of water
      - The amount of water needed is individualized. It depends on the individual's weight, amount of exercise completed each day, and a number of other factors. A general rule of thumb is to take the individual's weight and divide it in half. This will provide the number of ounces of water that should be consumed each day.
      - Approximately 20% of the daily water intake is consumed through the foods consumed for the day.
      - It is important to refer to the diagram in Chapter Three, Section Three, Urinary System for a refresher on why residents may not want to drink water and additional potential staff therapeutic interventions. Also reference the

diagram in that same section for compounding effects.

- Recommend low-sodium seasonings on vegetables and meats to increase the flavor.
- Recommend a variety of bright-colored vegetables which will provide nutrient dense foods plus help increase the pleasant sight of food.
- Direct Care Staff should assist the resident in good oral hygiene if assistance is required. This would include:
  - Making sure dentures are in properly.
  - Proper denture care.
  - Assisting the resident in acquiring professional dental services as needed.
  - Observing the resident during meals to make sure that dentures fit properly.
  - Assisting the resident with proper cleaning of teeth if assistance is required.

**INSTRUCTOR NOTE: Make sure students are aware that assistance with good oral hygiene will be thoroughly addressed in Chapter Eleven: Personal Care.**

## **9.2 Chronic Diseases and Nutrition**

Chronic disease plays a major part in the nutritional status of older adults. According to the Center for Disease Control (CDC), heart disease (29 percent) and cancer (22 percent) were the top two causes for death in adults 65 and over. Older adults affected by heart disease, cancer, and other chronic diseases need special considerations when it comes to their diet.

- **Cancer**
  - Impact on their nutritional status
    - Progressive weight loss and under-nutrition.

- Anorexia (refusing to eat).
- Sensory changes (taste, smell) that alter food intake.
- Tumors that may induce alterations in metabolism.
- Fluid imbalances.
- Nausea and vomiting putting the person at risk for malnutrition and dehydration.
- Stomatitis (redness or ulcers in the mouth area).
- Potential Staff Therapeutic Interventions
  - Important: this is resident specific- refer to resident's Individualized Service Plan to note any special nutritional needs.
  - Plan for extra meals and snacks (small meals may be better tolerated).
  - Avoid extreme temperatures of food.
  - Avoid empty calories.
  - Add extra protein and calories as needed.
  - Present food uncovered to avoid overwhelming odors and discouraging intake.
  - Soft and non-irritating foods.
  - Ask resident or family member food preferences and/or dislikes.
- **Coronary Heart Disease (CHD)**
  - Impact on nutritional status
    - Obese in many cases.
    - Usual diet is high in fat.
  - Potential Staff Therapeutic Interventions
    - Reduce saturated fat and cholesterol intake.
    - Aid resident in maintaining reasonable weight.
    - Encourage resident to exercise.

- Encourage consumption of fruits and vegetables.
- Reduce sodium intake.
- **Congestive Heart Failure (CHF)**
  - Impact on nutritional status
    - Anorexia, nausea, and vomiting.
    - Fluctuations in weight due to fluid changes in the body.
    - Decrease in appetite and food intake due to uncomfortable symptoms.
  - Potential Staff Therapeutic Interventions
    - Provide reduced salt items-look for the words brine, broth, pickled, corned or processed to be red flags for high sodium foods.
    - Encourage that salt is an acquired taste and it may take six (6) months to be satisfied with a reduced salt diet.
    - Suggest using Mrs. Dash or other herbal seasonings as an alternative to salt.
- **Chronic Obstructive Pulmonary Disease (COPD)**
  - Impact on nutritional status
    - Early satiety (feeling full early).
    - Bloating.
    - Anorexia.
    - Dyspnea (labored or difficult breathing).
    - Fatigue.
    - Constipation.
  - Potential Staff Therapeutic Interventions
    - Provide high calorie foods first.
    - Limit liquids at meals to avoid feeling full too early.
    - Treat shortness of breath before meals.
    - Do not rush resident during mealtime.

- Avoid carbonated and caffeinated beverages.
  - Limit sodium intake.
  - Provide frequent small meals and snacks.
  - Provide 4-8 cups of water per day and increase fiber in diet if constipation becomes a problem.
  - Choose lean meats, low dairy foods, cereals, breads, vegetables, and fruits.
- **HIV/AIDS**
    - AIDS is a chronic, life-threatening virus that attacks the body's immune system (part of the body that fights off other viruses and bacteria) causing your body to lose its defense to illness.
    - Impact on nutritional status
      - Anorexia.
      - Sores in mouth and esophagus (passageway to the stomach).
      - Increased metabolism may promote weight loss even with good food intake.
      - Alteration in taste.
      - Nausea and vomiting.
      - Diarrhea.
    - Potential Staff Therapeutic Interventions
      - Determine food preferences and review on a regular basis because of taste alterations.
      - Adjust diet to reflect foods best accepted.
      - Suggest cold items to aid in food acceptance when sores in mouth and esophagus are present.
      - Providing high calorie, nutrient dense food is often best for the end-stage resident.
      - Avoid greasy foods to decrease vomiting and diarrhea.

- Try dry crackers and ice chips for nausea and vomiting.
- **Diabetes mellitus**
  - Impact on nutrition status
    - Obesity.
    - Involuntary weight loss.
    - Fatigue.
    - Less interest in food.
    - Anorexia.
  - Potential Staff Therapeutic Interventions
    - Promote weight loss if resident is overweight.
    - Have meal plan reviewed by a Registered dietitian.
    - Encourage a diet low in fat, cholesterol, sugar, sodium, and high in fiber.
      - Offer sugar-free alternatives
- **Osteoporosis**
  - Impact on nutritional status
    - 1000-1100 mg of Calcium per day can help reduce the risk of fractures.
  - Potential Staff Therapeutic Interventions
    - Encourage consumption of calcium rich foods and beverages.
    - Vitamin D in milk and milk products should be provided daily.
    - Sunlight exposure for 10-30 minutes per day to increase Vitamin D levels.
    - Encourage physical activity when appropriate.
- **Dementia/Alzheimer's disease**
  - Impact on nutritional status

- Individuals may not be able to recognize their thirst or hunger.
  - Food and drink may need to be offered more frequently.
- May cause decreased food intake.
- May also cause individuals to eat frequently because they forget they have eaten.
- May create taste preference for sweet or spicy foods.
- May consume inedible items.
- Progressive weight loss.
- Pacing may cause individuals with dementia to need more food and liquids because they are very active.
  - Individuals who are pacing may not have the attention span to sit for whole meals so they may need “finger foods” that they can eat on the go.
- Brain changes may cause individuals confusion so that they:
  - Do not “see” food on their plates.
  - Have difficulty using utensils.
  - Generally have difficulty eating, swallowing, etc.
- Potential Staff Therapeutic Interventions
  - Provide adequate calories and protein.
  - Use creative techniques if resident needs assistance with eating
    - Examples: contrasting plates/placemats so residents can see plate more clearly, modified utensils so residents can independently eat, etc.
  - Allow adequate time for eating.

- Limit distractions when eating so residents with dementia can best focus on the mealtime and not other things going on.
      - Assess the best tolerated food texture for the resident.
- **Drug Effects on Nutritional Status**
  - Poor nutrition can interfere with drug efficacy (how well the drug does its job) or lead to a higher risk of drug toxicity.
  - The intestine is the site of most drug absorption and also metabolizes (breaks down) some drugs. Drug absorption and metabolism depends on a healthy gut.
  - Cancer chemotherapy can alter taste or appetite, thus decreasing food intake.
  - Some drugs can cause dry mouth, resulting in loss of appetite and ill-fitting dentures (e.g. Benadryl).
  - Some drugs can cause constipation, resulting in loss of appetite and nausea (e.g. Calcium supplements for osteoporosis).
  - Some drugs can cause incontinence or diarrhea, causing residents to not want to eat or drink and have “accidents.”
- **Drug – Food Interactions**
  - Foods high in Vitamin K can interfere with blood thinners (e.g. warfarin).
  - High fiber meals can decrease the absorption of some drugs (e.g. digoxin, lovastatin, penicillin).
  - High protein meals can also decrease the absorption of some drugs.
  - High protein meals may accelerate the metabolism of some drugs (e.g. drugs used to treat COPD).
  - Food high in tyramines can inhibit the absorption of anti-depressants (MAOIs).

- Grapefruit juice impairs the absorption of certain drugs (anti-depressants, anti-hypertensives, and anti-seizure medications) so should not be used to take pills.
- Medications are best taken with water.
- Acidic fruit juices, vegetable juices, and carbonated beverages can inhibit the absorption of some drugs.
- Not taking fluids with medications can also delay drug absorption.

### **9.3 Nutritional Needs for Older Adults**

- Overall, older adults' nutritional needs are similar to the general population.
- How much should an older adult eat?
  - A calorie is a way to count how much energy is found in food. You use the energy found in food to accomplish the things you need to do from day to day.
  - An older adult may not need as much caloric energy but may need more nutrients in their diet. Nutrients are obtained from eating proteins, vitamins, and minerals.
  - According to the National Institute on Aging:
    - A woman who:
      - Is not physically active needs about 1,600 calories daily.
      - Is somewhat active needs about 1,800 calories daily.
      - Has an active lifestyle needs between 2,400 and 2,800 calories daily.
    - A man who is:
      - Not physically active needs about 2,000 calories daily.

- Somewhat active needs about 2,200-2,400 calories daily.
- Has an active lifestyle needs between 2,400 and 2,800 calories daily.
  - If physically able to complete, both men and women need at least 30 minutes per day of physical activity.
- The United States Department of Agriculture (USDA) suggests that adults 70 and over eat healthy foods every day using the modified MyPyramid for Older Adults.



### Review Handout #1

**Instructor Notes: Direct the students to turn to Handout #5 in the Student Manual. Discuss each food group with the students. The Modified MyPyramid for Older Adults was created by Tufts University to represent the need for an individualized nutritional plan for older adults over 70 years old.**

- Protein
  - Protein helps the body maintain body tissue, muscle, and the immune system.
  - Older adults should consume 5-7 ounces of meat or other protein source daily.
  - Other sources of protein include beans, nuts, seeds, and tofu.
- Vegetables
  - The recommended amount of vegetables for a healthy diet is 2-3.5 cups per day.
  - It is important to eat many different colors and types of vegetables to provide for many different nutrients in the diet.
- Fruits

- The recommended amount of fruit is 1.5-2.5 cups per day. This is equal to one medium-sized piece of whole fruit or dried fruit.
- Grains
  - The recommended amount of grain intake each day is 6 or more servings which can be found in a small roll, muffin, or slice of bread.
  - Half of the grains each day should be whole.
- Milk
  - The recommended amount of milk each day is 3 cups of fat free or low fat milk, yogurt, or ice cream.
  - Milk is important for strong bones and teeth.
- Drink plenty of liquids
  - Age-related changes could affect the sense of thirst. For example, the brain may not register that the body needs water so the older adult may lose the sense of thirst.
  - Water is the most important nutrient for our body and the one that we need the most of each day to function properly.
  - It is very important to drink 6-8 glasses of water each day (about 1500-2000cc of fluid).
  - Chronic incontinence can lead to dehydration (lack of sufficient fluid in the body to maintain bodily functions) if fluid is not replenished.
  - Urine should be a pale yellow. If urine appears to be a bright or dark yellow then the older adult is at risk of, or experiencing, dehydration.
  - Water can be found in popsicles, sherbet, ice cream, and fruits.

- Fiber
  - Constipation is a common problem in the older adult population due to lack of activity and fiber in the diet.
  - Eating more fiber can also lower cholesterol and blood sugar levels.
  - Fiber is found in foods from plants including whole grains, fruits, nuts, seeds, beans, and vegetables.
  - It is better to receive fiber from food than from dietary supplements.
  - It is important to drink fluids while eating fiber to help push fiber through the intestines and control unwanted gas.
  
- General nutrition tips
  - Eat “empty calories” such as those found in chips, cookies, sodas, and alcohol in moderation. These foods and beverages contain a large amount of calories but lack nutrients essential to a healthy lifestyle.
  - Eat only small amounts of food with fats, oils, and foods high in sugars. Saturated fat is usually found in products from animals and should be eaten in limited amounts. Trans fats are found in margarines, cookies, and crackers and should be eaten in limited amounts as well.
  
- Importance of food
  - Food is important to all of us, not just for nutrition but as a social activity and something we find great pleasure in.
    - In all of our lives, many of our celebrations involve sharing of food (birthdays, holidays, etc.).

- The dining room is a chance for social connections to begin for residents who may be new members of the community.
- We all have “comfort foods” and foods that are important to us culturally.
- Mealtime is not just about the food we are eating but the presentation of the food, the environment in which we are eating, etc.
- Food is healing not just for its nutritional qualities but for its comfort.
  - Think of chicken soup, a nice cup of tea, etc.
- It is important to take time to get to know residents and their mealtime traditions, as well as their food and drink preferences.

#### **9.4 Signs and Symptoms of Malnutrition and Dehydration**

Physical, environmental, and social changes contribute to the risk of malnutrition and dehydration in older adults.

- Malnutrition
  - Defined as a lack of necessary or proper food substances in the body or improper absorption and distribution of them.
- Contributing risk factors can include
  - Incontinence.
  - Low income.
  - Cognitive and physical impairments.
  - Polypharmacy (using multiple drugs at the same time).
  - Oral health.
  - Depression.
  - Social isolation.

- Inadequate food intake.
- Signs and symptoms of malnutrition
  - Dull, dry or de-pigmentation of hair.
  - Redness, swelling of mouth.
  - Tongue swollen, scarlet, raw.
  - Skin with lack of fat, scaliness, dryness (sandpaper feel) or pallor (paleness of the skin).
  - Muscle wasting, weakness, muscle pain.
  - Nails beds curved and brittle.
  - Listlessness and memory impairment.
  - Change in body weight.
  
- Dehydration
  - Occurs when a person loses more fluid than is taken in, and the body does not have enough water and other fluids to carry out its normal functions.
- Risk Factors include
  - Older adults may lose the ability to know when they are thirsty (this may happen with dementia).
  - Lack of access to fluids.
  - Difficulty swallowing.
  - Fears of incontinence.
  - Diarrhea.
  - Vomiting.
  - Fever.
- Signs and symptoms of dehydration

- Dry mucous membrane (dry mouth).
  - Poor skin elasticity.
  - Change in mental status.
  - Increased weakness.
  - Constipation.
  - Dark, strong-smelling urine.
  - Dry, cracked lips.
  - Sunken eyes.
  - Increased body temperature.
  - Decreased blood pressure.
- **Preventative care is the key!**
  - Direct care staff is the frontline defense to preventing malnutrition and dehydration.



**Group Question: Ask the student the following question:**

**What are some ways that you, as a direct caregiver, can make sure residents are getting enough liquids?**

- Be aware of resident's eating and drinking habits at the dinner table.



**Instructor Notes: Discuss Facility's policy and procedure on monitoring food and liquid intake at meal times if available.**

## **9.5 Staff Responsibilities**

- Direct care staff may not be planning the meals but most likely will be serving the food to the residents. Be aware of the resident's intake and reaction to the food, and look for signs of poor nutritional habits.
- Be aware of possible difficulties with swallowing, handling silverware or glassware while eating. This can cause poor nutritional intake.

- Follow facility policy and procedures on recording food intake at meal times.
- Do not wait until dehydration and malnutrition occurs. Make snacks and liquids readily available to residents.
- § Direct care staff shall make drinking water readily available to all residents. Direct care staff shall know which residents need help getting water or other fluids and drinking from a cup or glass. Direct care staff shall encourage and assist residents who do not have medical conditions with physician or other prescriber ordered fluid restrictions to drink water or other beverages frequently.
- § Direct care staff should provide plenty of time (at least 30 minutes) to complete a meal.

## **Standards for Licensed Assisted Living Facilities Effective July 17, 2013\***

22 VAC 40-72-580	Food service and nutrition
22 VAC 40-72-620	Menus for meals and snacks

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

## **Bibliographies and Resources**

Nutritional Needs of Older Adults in LTC Facilities

[www.nutrition.gov](http://www.nutrition.gov)

[www.ext.colostate.edu/pubs/foodnut/09322.pdf](http://www.ext.colostate.edu/pubs/foodnut/09322.pdf)

[www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/aging.htm)

<http://www.nal.usda.gov/fnic/pubs/olderadults.pdf>

<http://www.nia.nih.gov/HealthInformation/Publications/healthyeating.htm>

[http://www.nia.nih.gov/NR/rdonlyres/4B267E65-7F01-472B-8FCE-](http://www.nia.nih.gov/NR/rdonlyres/4B267E65-7F01-472B-8FCE-24E3DB72FF28/14109/HealthyEatingAP_FEB262.pdf)

[24E3DB72FF28/14109/HealthyEatingAP\\_FEB262.pdf](http://www.nia.nih.gov/NR/rdonlyres/4B267E65-7F01-472B-8FCE-24E3DB72FF28/14109/HealthyEatingAP_FEB262.pdf)

<http://nutrition.tufts.edu/1197972031385/Nutrition-Page->

[nl2w\\_1198058402614.html](http://nutrition.tufts.edu/1197972031385/Nutrition-Page-nl2w_1198058402614.html)

<http://nutrition.about.com/od/hydrationwater/a/waterarticle.htm?p=1>

<http://www.cnpp.usda.gov/Publications/DiartyGuidelines/2010/DGAC/Report/>

[D-6-SodiumPottasiumWater.pdf](http://www.cnpp.usda.gov/Publications/DiartyGuidelines/2010/DGAC/Report/D-6-SodiumPottasiumWater.pdf)

## Student Review - Chapter Nine

1. **Fill in the blank**

A woman who is not physically active needs about **1,600** calories per day.

2. **Fill in the blank**

A man who has an active lifestyle needs between **2,400** and **2,800** calories per day.

3. **True** An inactive lifestyle can cause constipation, a common problem in the older adult population.

4. Describe three (3) oral changes that can create problems with proper intake of nutrition.

**Decrease in saliva production, brittle teeth, loss of taste buds**

5. **True** 72 percent of the bodies' fluid supply rests in the body's lean mass.

6. **Describe** the signs and symptoms of malnutrition.

**Dull, dry or de-pigmentation of hair**

**Tongue swollen, scarlet, and raw with redness and swelling of mouth**

**Change in body weight**

7. Describe the signs and symptoms of dehydration.

**Dry mouth**

**Poor skin elasticity**

**Change in mental status**

**Increased weakness**

**Constipation**

8. **False** The recommended amount of protein per day is between 15-20 ounces.

9. Describe two (2) benefits of adding more fiber into an older adult's diet.

**Reduces constipation risk and lowers blood sugar levels**

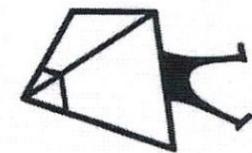
10. Describe two (2) impacts of HIV/AIDS on nutritional status of an older adult.

**Anorexia and nausea and vomiting**





## Food Guide Pyramid for Older Adults

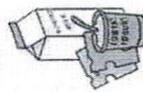


The Tufts University Food Guide Pyramid for Older Adults is geared to help people 50 years or older—and especially those 70 and older—eat a healthful diet. As you age, you need less food to maintain your weight. However, your need for vitamins and minerals may stay the same or even increase. That's why it is important to choose a variety of nutrient-rich foods everyday. And remember to include physical activity such as walking, climbing stairs or yard work as part of your daily routine.

### Make the Pyramid Work for You!

#### FOOD GROUP

##### Low- and Nonfat Dairy Products

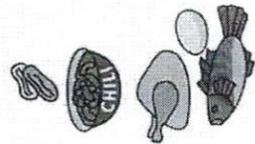


**RECOMMENDATIONS**  
 Eat or drink 3 or more servings of low- or nonfat dairy products. If you have trouble digesting milk products, try lactose-free dairy products, or add lactase to milk.

#### EXAMPLES OF SERVING SIZES

1 cup low- or nonfat milk or yogurt  
 1 1/2 oz lowfat cheese

##### Dry Beans and Nuts, Fish, Poultry, Lean Meat, and Eggs



Eat 2 or more servings of these protein-rich foods.  
 Beans are a good source of fiber, protein and other nutrients.  
 Choose fish, skinless poultry, lean meat or eggs.

1–1 1/2 cup cooked lentils or dry beans  
 1 1/2 cup chili  
 4 Tbsp peanut butter  
 2–3 oz. fish, skinless poultry or lean meat—baked, broiled or grilled  
 1/2 cup canned tuna  
 1 egg or 1/4 cup egg substitute



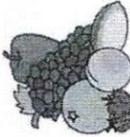
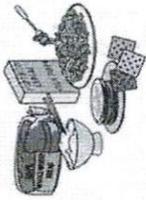
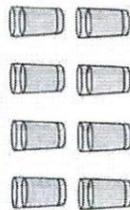
#### UNIQUE NUTRIENT NEEDS

The flag at the top of the pyramid signals special consideration for calcium, vitamin D and vitamin B12. You need higher levels of calcium and vitamin D to keep bones strong. Nonfat or lowfat milk provide an excellent source of calcium and vitamin D. Nonfat dairy products offer the best sources of calcium. Because many older adults cannot efficiently use the vitamin B12 that is found in animal foods, vitamin B12-fortified foods such as breakfast cereals or supplements are better absorbed. Check with your physician or health care provider to find out if you need supplements. Also, contact your health care provider when your food choices are limited over a period of time due to illness, chewing problems, lack of appetite or inability to shop or prepare food.

Here is a list of how much calcium, vitamin D and vitamin B12 is needed each day for adults over 50:

- **Calcium**—1,200 milligrams (mg)
- **Vitamin D**—400 International Units (IU) for adults 51–70 and 600 IU for those over 70. Do not exceed these recommendations.
- **Vitamin B12**—2.4 micrograms (mcg)

## Make the Pyramid Work for You, cont.

FOOD GROUP	RECOMMENDATIONS	EXAMPLES OF SERVING SIZES
<b>Bright-Colored Vegetables</b> 	Eat 3 or more servings of bright-colored fresh, frozen, or canned vegetables. Look for dark green, red, orange and/or yellow vegetables for best nutrients.	1 cup romaine lettuce 1/2 cup winter squash or sweet potato 3/4 cup 100% vegetable juice 1/2 cup carrots 1/2 cup cooked spinach
<b>Deep-Colored Fruit</b> 	Eat 2 or more servings of fresh, frozen, dried, or canned fruit packed in juice. Those with deep colors typically have more nutrients. Choose 100% fruit juice. Juices fortified with calcium provide a non-dairy calcium source.	1 medium peach or banana 1/2 cup berries or sliced melon 1/4 cup dried apricots or raisins 3/4 cup 100% orange juice
<b>Whole, Enriched and Fortified Grains and Cereals</b> 	Eat 6 or more servings of high-fiber, fortified, or whole grains such as brown rice, whole-wheat pasta, and bran cereal.	1/2 cup raisin bran or oatmeal 1 slice whole-wheat bread 1/2 cup cooked enriched pasta or rice
<b>Water/Liquids</b> 	Consume eight, 8-ounce glasses of water or beverages such as fruit or vegetable juice, milk, reduced sodium soup, tea or coffee each day.	8 oz. water 8 oz. tea or coffee 8 oz. reduced sodium soup 8 oz. nonfat milk

## TIPS FOR HEALTHFUL EATING

**USE SPARINGLY** items that appear at the top of the pyramid.

**SUGAR** adds calories, but not nutrients to the diet. Limit foods and beverages with added sugar.

**SATURATED AND TRANS FATS** raise levels of low-density lipoprotein (LDL), the so called bad cholesterol. Meat and full fat dairy products contain saturated fat. *Trans* fats are found in traditional stick margarines, shortenings and hydrogenated vegetable oils and foods made with these fats. Choose vegetable oils such as canola, soybean, corn and olive oil. Use tub margarine instead of butter.

**SALT** raises blood pressure in some people. Prepare foods with less salt/sodium and choose reduced sodium soups and frozen entrees.

**HIGH-FIBER** foods help to promote regularity. Dry beans, fruits, vegetables, whole grains and cereals, and nuts offer high-fiber choices. Be sure to drink more water if you increase your fiber intake.

**WATER/LIQUIDS** are needed everyday. As you get older you have a decreased sense of thirst and are more likely to become dehydrated. Some medications may contribute to this problem by increasing your need for water. Alcoholic beverages should not count toward your water/liquids intake.



# **Activities**

## **Chapter Ten**

**Time Required: 1 hour**

## **Chapter Ten – Activities**

Activities are linked to all aspects of a person's well-being. Activities give the resident the ability to preserve their individuality and promote their independence while living in an assisted living facility. Activities can have many purposes but all stem from the need to enhance quality of life. This chapter will provide the student with general information on the role of activities in an assisted living facility, as well as the role of the staff member in facilitating activities. It is the goal of this chapter to provide the student with the tools, knowledge, and desire to organize activities in their facility.

### **10.1 What is an Activity?**

### **10.2 The Staff Member's Role in Activities**

### **10.3 Physical Impairment: What Does That Mean?**

### **10.4 Cognitive Impairment**

### **10.5 Adapting Activities for the Individual**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter:**

- a. Be knowledgeable about what is involved in activities in the assisted living facility
- b. To understand the importance of the direct care staff member's role in creating an active environment for the resident
- c. Be aware of the stigma placed on individuals with physical impairments
- d. Be aware of the stigma placed on individuals with cognitive impairments
- d. To understand ways to apply the information learned to adapt every activity to meet all individual needs

### **2. Recommended Method of Instruction**

- Lecture and class discussion
- Review of facility policies (if available) and VDSS regulations on the coordination and implementation of activities
- Student Activity - Immersion Scenario
- Student Activity - Scenario and Group Exercise (**Handout #1**)
- Student Review - Chapter Ten

## 10.1 What is an activity?

- Alzheimer's Association defines an activity as
  - "Activity is the interaction between an individual and the environment"
- The National Association of Activity Professionals (NAAP) defines activities as
  - "Activity practice is based on assessment, development, implementation, documentation, and evaluation of the programs provided and the unique needs and interests of each individual served."
  - NAAP states that activity services and programs should "enable each individual to maximize their potential in activity participation."
- Ways in which we interact with the environment
  - Doing
  - Talking
  - Creating
  - Playing
  - Working
  - Worshipping
  - Arguing
- Our environment includes:
  - Physical
  - Social
  - Cultural
  - Spiritual
- Physical environment components
  - Noise level
  - Facility layout
  - Light

- Temperature
  - Comfort
- Social environment components
  - Communication among other residents
  - Personal space
  - Familiarity
- Cultural environment components
  - Shared values and beliefs
  - Shared history
  - Foods, rituals, and celebrations
  - Families
  - Ethnic groups
  - Geographic areas
- § Activities shall include (but not be limited to)
  - Physical
  - Social
  - Cognitive/intellectual/creative
  - Productive
  - Sensory
  - Reflective/Contemplative
  - Outdoor
  - Nature/Natural World
- § Activities shall:
  - Meaningfully support the physical, social, mental and emotional abilities and skills of residents
  - Promote or maintain the resident's highest level of independence and functioning

- Purpose of an Activity
  - Expression of who we are as an individual
  - Provides a purpose to our life
  - Provides for a sense of accomplishment
  - Contributes to life satisfaction
  - Emotional wellness
  - Physical wellness
  - Increases quality of life
- Quality of life
  - Difficult to define or to measure
  - Different for EVERYONE
  - Quality of life involves
    - The ability to engage in activities that represent you as an individual
    - The person's concept of well-being (either physical, social, emotional, spiritual)
    - Satisfaction with how you are seen by others and yourself
    - The sense of "belonging"

## 10.2 The staff member's role in activities



### **Student Activity**

- Open activity for students

#### **Instructor Notes:**

*The purpose of this activity is to demonstrate the importance of engaging residents in the facility. The scenario should make the students aware of the effect an inactive day could have on a resident.*

*Activity procedures:*

1. The instructor should instruct the students to sit completely still for 3 – 5 minutes. It is important that the students have no interaction with the environment, people, or objects around them.
2. The instructor should discuss with the students how he or she felt about sitting completely still and asking each student how he or she thinks their overall well-being would be if this type of inactivity was done all day.

### **Discussion**

- As you can see by our activity, sitting without interaction or activity for hours a day can have a negative impact on your quality of life.
- § Residents living in a facility licensed for residential care living only should have at least 11 hours of scheduled activity available to the residents each week for no less than 1 hour per day.
- § Residents living in residential and assisted living facilities should have at least 14 hours of scheduled activity per week and no less than 1 hour per day.
- § Residents living in a special care unit should have at least 16 hours of a variety of scheduled activities available to the residents.
- Who is involved in activities at an assisted living?
  - Housekeeping staff
    - A housekeeper could engage the resident in folding clothes or making the bed. This activity could give a resident more independence.
  - Family members
    - Family members are the largest source of information about a resident's past. They are usually the people in the resident's life that make situations more comfortable. A family member could be very helpful in encouraging a new resident to become involved in social activities or provide one on one time to ease the resident's anxiety about transitioning into the assisted living facility.

- Volunteers from outside the facility
  - Volunteers can provide a fulfilling link to the surrounding community. Volunteers can bring in church services, garden clubs, reading groups and other activities so that the resident will never be excluded from the community. Community outreach has been an important part of everyday life for many residents.
- Dietary Staff
  - In the home, the resident has relied on themselves to do all the cooking. After moving into the ALF, the resident now relies on a dietary staff to prepare all of the meals for the day. This fact can mean losing another part of their independence. The dietary staff can encourage residents to participate in recipe of the month activities, cooking activities, or setting the table for meals.
- Maintenance Staff
  - Some residents have come from a household where they had the responsibility of fixing broken objects in the home. The maintenance staff could give the resident one on one conversation when he or she is fixing something in the resident's room. Involvement in the process if possible brings another piece of home to the facility for the resident.
- Activity Staff
  - The activity staff is in charge of scheduling activities throughout the day. This process is a large undertaking and in many cases the activity staff consists of one or two individuals for many residents. This job can be difficult if activities are not seen as a team effort from all staff.

- Administration
  - Administration's role is coordinating the teamwork of the staff to make sure that the residents are satisfied with the level of activity in their lives. Participating in activities allows the administration to get to know residents and continue the person-center care approach.
- Residents
  - Residents can provide companionship to other residents. It is important that informal options for activity (newspapers, board games, puzzles etc) are available to residents.
- YOU
  - This is your chance to show your creativity, passion, and strengths. Bring an activity from home that you enjoy doing and share it with one individual or a group.
- Creating an active environment in an assisted living facility is a large undertaking. It takes many ideas, creative minds, and people to accomplish the daily activities in an ALF.
- In some facilities the direct care staff is involved in every aspect of care for the resident. The direct care staff is expected to cook, clean, and conduct activities on a daily basis. In all facilities direct care staff are expected to promote the active well-being of the individual.



**Review facility policy on the responsibilities of the direct care staff and activities in the facility, if available.**

- Active environments do not always mean loud noise or chaos. Activities are not meant to just take up time and fill a gap in downtime in the facility.
- Activities do not have to be scheduled throughout the day by activity staff. Activities can occur spontaneously and engage the resident as well as a group activity.

- Direct care staff is actively involved in the residents' day-to-day activities 24 hours a day. This interaction makes you a very knowledgeable member of the activities team.
- Knowing your residents is key to understanding what would be a desirable and beneficial activity for an individual resident.
- The direct care staff person should:
  - Encourage but not force the resident to participate or observe an activity. Not all residents enjoy participating in group activities. Some residents prefer one on one activities or individual activities such as reading and crossword puzzles.
  - Be aware of the attention spans and functional levels of the residents in the activity
  - Know methods in which to adapt the activity to meet the needs and abilities of the resident
  - Know various methods of engaging and motivating individuals to participate
  - Know the importance of providing appropriate instruction, education, and guidance throughout the activity
  - Recognize the importance of communication among staff members of all departments to ensure that the resident is prepared and available for activities. An example of this communication would be assisting the resident in dressing in the appropriate clothes for the activity and communicating with the dietary staff that the resident may need lunch early in order to participate in the activity.

### **10.3 Physical Impairment: What Does That Mean?**

- According to the Americans with Disabilities Act (ADA) a “physical impairment” is defined as:
  - Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine
- A physical impairment does NOT mean that a person has the inability to be engaged in activities.
- A person with a physical impairment should NOT be automatically assumed to not be able to adapt to an activity.
- It is important that the direct care staff knows how to adapt an activity for a resident with a physical impairment.
- Types of impairments seen in an ALF include but are not limited to:
  - Loss of hearing
  - Loss of sight
  - Inability to walk without device assistance (cane, walker, wheelchair)
  - Loss of limbs or limb function (paralysis)

### **10.4 Cognitive Impairment**

- Cognitive impairment may involve a difficulty in:
  - Learning and understanding
  - Capacity for learning
  - Paying attention and concentration
  - Problem-solving
  - Using language
  - Remembering

- Using Judgment
- Performing actions
- Sensing and perceiving
- Possible causes:
  - Dementia, for example Alzheimer's Disease
  - Intellectual Disabilities
  - Brain Trauma
  - Mental Illness
- Possible commonalities
  - Decreased attention span
  - Impulsivity
  - Unpredictable emotions
  - Memory problems
- **IMPORTANT TO REMEMBER**
  - **It is INCORRECT to assume that everyone with the same diagnosis will behave in the same manner**
  - **Look beyond the diagnosis**
  - **Person-centered care focuses on the individual NOT the disease**

### **10.5 Adapting Activities for the Individual**

- There are five components to an activity:
  - Materials Used
  - Process
  - Level
  - Task
  - Experience
- In order to adapt an activity you must understand these five parts.
- Materials Used
  - The materials are the objects with which the activity is performed

- The materials used in an activity can range from a soccer ball to a ribbon used for a craft
- The Process
  - The process is the actual steps in the activity that accomplish the goal
  - The process is what shapes the experience. The outcome may not be as important as the process. The act of making a craft may not be as important as what the craft looks like at completion.
  - Ex.
    - Playing dominos
      - Each resident takes 5 dominos
      - Upon each turn, the resident will match the dots of their domino to the dots of the domino in the middle
      - The goal is to get rid of all of your dominos
- The level
  - The level is the amount of difficulty of an activity for a resident
- The task
  - The task is the actual goal of the activity
  - In the dominos example the task was getting rid of all of your dominos
- The Experience
  - This describes how the resident feels about every part of the activity from materials used to accomplishing the overall task
  - Know what makes an activity enjoyable for the resident
- Adapting Activities
  - Each component can be adapted to meet the needs of each resident
  - The materials
    - bigger, louder, softer, harder

- The process
  - less steps, assistance with each step, cueing
- The level
  - changing any of the components can make the activity easier for the resident
- The task
  - each resident could work to a different goal based on the changes made
- The experience
  - changing components changes the experience
- All components should take into account that you are creating an activity for an adult, not a child. Consider the individual residents before offering activities that could be viewed as inappropriate such as coloring books, Thanksgiving “hand turkeys,” and puzzles. There is a difference between imposing a child’s activity on a resident and a resident asking to use a coloring book to relive memories with their grandchildren. This could lead to a community coloring event with local children becoming involved. There is also a difference between giving an adult a child’s baby doll to occupy their time and a resident with dementia independently picking up a baby doll. This baby doll could bring a resident a sense of purpose or bring back memories of their children at that age.
- **Be creative**
- **It is likely that the resident may have multiple care needs at the same time (both cognitive and physical).**
- **Know your residents**
- **Every person will participate in an activity differently**
- **The goal of every activity is to improve the quality of life for the resident**



## **Student Activity**

- Scenario - **Handout #1**

### **Instructor Notes:**

*The purpose of this activity is to provide the opportunity for the students to break down what the components of an activity are and why it is important for direct care staff to know how to conduct an activity.*

*Activity procedures:*

- 1. Divide class into groups of four*
- 2. Provide class 15 minutes to identify the 5 components of the activity and determine the best way to adapt the activity for the resident in the scenario*
- 3. Have each group discuss their options*

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40-72-520 Activity/recreational requirements

22 VAC 40-72-1100 Activities

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

### **Bibliography and Resources**

“Activities for the Cognitively Impaired: Part 1” Judy Hennessey, MEd, RN

Alzheimer’s Association

[http://www.alz.org/living\\_with\\_alzheimers\\_activities.asp](http://www.alz.org/living_with_alzheimers_activities.asp)

The Americans with Disabilities Act

<http://www.adata.org/whatsada-definition.aspx>

The facility policy on Activities

<http://www.thenaap.com/id19.html>

## Student Review – Chapter Ten

1. Why are activities important?

**Expression of who we are as an individual**

**Provides purpose to our life**

**Provides for a sense of accomplishment**

**Contributes to life satisfaction, emotional wellness and increases quality of life**

2. Who is involved in activities at an Assisted Living Facility?

**All staff including yourself**

3. **False** All people with Alzheimer's Disease will behave the same way in a game of Bingo.

4. What are some possible causes of cognitive impairments?

**Alzheimer's Disease and other dementias**

**Intellectual Disabilities**

**Brain Trauma**

**Mental Illness**

**There are many causes of cognitive impairments. Dementia is not the only cause.**

5. What are the 5 components of an activity?

**1. Materials Used**

**2. Process**

**3. Level**

**4. Task**

**5. Experience**

6. Name the 5 parts of our environment.

**1. Noise Level**

**2. Facility Layout**

**3. Light**

**4. Temperature**

**5. Comfort**

7. Describe the "process" of an activity.

**The process is the actual steps in the activity that accomplish the goal. It is what shapes the experience for the resident.**

8. Describe the "task" of an activity.

**The task is the actual goal of the activity. The outcome of the activity may not be as important as the experience for the resident.**

9. **True** A person with a physical impairment should not be automatically assumed to not be able to adapt to an activity.

10. Describe quality of life and what it means to you.

**Quality of life is difficult to define or measure. Quality of life can include the ability to engage in activities that represent you as an individual and the resident's concept of well-being. The resident can feel a sense of "belonging" in their community. This satisfaction with how they are seen by others can reflect by how active they are in their community. This question also gives a chance for a more open discussion on how the direct care staff view their concept of quality of care.**

### **Chapter Ten Scenario - Activities**

Mrs. Marva B. Mathers is an 83-year old resident at Great Assisted Living. The Activities Director at Great Assisted Living interviewed Mrs. Mathers' daughter, the primary caregiver, to find out Mrs. Mathers' interests prior to admission to the ALF. Her daughter explained that Mrs. Mathers' one love in life was bowling. She was a champion bowler and had many trophies from her wins at home. Mrs. Mathers has been wheelchair dependent for the past 10 years. She has not bowled in 10 years. She uses glasses and hearing aids. She has been diagnosed with probable Alzheimer's Disease. She can follow instructions, provided they are given to her step by step. Her speech is limited to "yes" and "no" statements.

Mrs. Mathers is having a hard time adjusting to moving out of her home and into Great Assisted Living. The Activities Director has just had 5 new residents move into Great Assisted Living and is having a hard time handling all of the activities alone. The bowling equipment provided by the facility includes 10 pins, a cardboard cutout for the floor to hold the pins in place, and a soft bowling ball with 3 holes cut out for fingers.

1. What are the components to this activity?
  - **Material Used: 10 pins, a cardboard cutout for the floor and a soft bowling ball with 3 holes.**
  - **Process: Mrs. Mathers must roll the bowling ball across the floor and knock down the pins.**
  - **Level: At this point, the level would be defined as challenging for Mrs. Mathers. This does not mean that Mrs. Mathers will not be able to participate in this activity. The key here is to know what steps to take to adapt the level to meet Mrs. Mathers needs.**
  - **Task: The actual goal of the game is to knock down the bowling pins. Looking beyond the goal of the game, Mrs. Mathers may want to gain more strength in her arm so that she can self-ambulate in her wheelchair. She may also want to experience enjoyment from an activity she participated in from her past.**
  - **Experience: This is your chance to connect with Mrs. Mathers through her enjoyment of the activity.**

2. As a direct care staff member, how would you adapt a game of bowling for Mrs. Mathers?

- **Materials Used:** The direct care staff member could use less pins, a lighter ball, a ball with larger holes, larger pins, darker colored pins to contrast with a light colored floor so Mrs. Mathers can see the pins easier.
- **Process:** The direct care staff could encourage Mrs. Mathers to use both hands on the ball for more strength and control. Mrs. Mathers could use multiple attempts to knock down the pins instead of just two attempts. Mrs. Mathers could avoid using the holes in the ball.
- **Level:** The direct care staff could adapt any of the components to decrease the level.
- **Task:** The direct care staff member could start by using three pins and work your way up to the full count of ten pins.
- **Experience:** The direct care staff member could take this time to connect with the resident by reminiscing about past bowling experiences and other activities that the resident may enjoy in the future.

# **Personal Care**

## **Chapter 11**

**Time Required: 10 hours**

## **Chapter Eleven: Personal Care**

This chapter provides the student with a basic overview of supporting an assisted living resident with personal care. This chapter not only should teach the learner how to provide actual hands-on care, but it should stress the importance of the psychosocial aspects; recognition of functional strengths and abilities in maximizing independence; and maintenance of dignity, privacy and resident rights. Throughout section 11.2 in this chapter, some sub-sections will have the skills checklist symbol (📋) beside them. These are the sections that you will be required to demonstrate the skill at the completion of the chapter.

### **11.1 What is Personal Care and Its Importance**

#### **11.1.1. Dignity and Personal Care**

#### **11.1.2 Observation of Changes in a Resident**

### **11.2 Personal Care**

#### **11.2.1 Assisting Residents with Bathing**

#### **11.2.2 Assisting Residents with Dressing**

#### **11.2.3 Assisting Residents with Bathroom Needs**

#### **11.2.4 Assisting Residents with Transferring**

#### **11.2.5 Assisting residents with Eating**

#### **11.2.6 Mouth, Teeth, and Denture Care**

#### **11.2.7 Skin and Nail Care**

#### **11.2.8 Shaving**

#### **11.2.9 Hair Care**

#### **11.2.10 Eyeglasses and Hearing Aids**

#### **11.2.11 Housekeeping**

#### **11.2.12 Laundry**

#### **11.2.13 Other Personal Care Functions and Tasks**

## **Instructor Planning**

### 1. Objectives of the Chapter

- a. To understand the importance of personal care in supporting a resident to live meaningfully and with dignity.
- b. To recognize how personal care can be a positive way of maintaining a high level of independence and functional ability for a resident.
- c. To learn about and practice assisting someone with personal care.

### 2. Recommended Method of Instruction

- Lecture and Class Discussion – **Handout #1**
- Student Activity – Instructor Demonstrations, return demonstrations, and simulations.
- Student Activity - Observation of care being given to an actual resident.
- Student Activity – Performance Skills Checklist - **Handout #2**
- Student Review - Chapter Eleven

### 3. Supplementary Materials if available

- Facility policies/procedures related to personal care assistance
- Forms/documentation for personal care assistance

## 11.1 What is Personal Care and Its Importance

In each of our daily lives, there are things we all do to maintain our health, hygiene, and to function socially. In assisted living, we refer to these things as personal care.

- Personal care services include a broad array of daily activities for which assisted living residents might need assistance. This includes ADLs, IADLs, ambulation, hygiene and grooming, and functions and tasks as described in Chapter One.
- **§** Personal care should be resident-centered, meaning:
  - Resident care is personalized. Each individual resident will need different degrees and types of assistance as specified by his or her ISP. **§** Resident care is tailored to the resident's needs and preferences. These tailored needs and preferences should be listed in the ISP.
  - **§** Residents should participate in all decisions about their care, including how personal care is given. Residents should be involved as much as possible in their personal care.
- **§** Assistance with personal care should focus on maximizing independence and helping residents achieve their highest potential. This is otherwise known as restorative care, promoting independence, and supportive independence.
- Helping residents maintain good hygiene and grooming is not just for well-being; it helps residents live with dignity.
- Supporting residents by assisting with personal care is important to them being able to live their lives meaningfully. For example, helping a resident to shower, do her hair, and dress as she likes might make it possible for her to be comfortable socializing with others.

- Ensuring residents receive personal care services according to their individualized service plan also prevents unnecessary medical or health conditions such as pressure ulcers, dehydration, contracture, loss of continence, and malnutrition.
  - Definitions (additional information on health conditions is in Chapter Six and additional information on nutrition in Chapter Nine).
  - **Pressure ulcers**, also known as decubitus ulcers, pressure sores, or bedsores are injuries that result from unrelieved pressure on the skin. Pressure ulcers form where bone causes the greatest force on the skin and tissue and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. Pressure ulcers can range from mild ones (reddening of skin) to severe (deep wounds down to muscle and bone).
  - **Dehydration** is the loss of water and salts necessary for living.
  - **Contracture** refers to the shortening and hardening of muscles, tendons, or other tissues. It results in the loss of motion for that body part.
  - Loss of continence or **incontinence** refers to the loss of bowel or bladder control.
  - **Malnutrition** is a condition that is the result of the body not getting enough vitamins, minerals, or other nutrients.



### Student Activity

- Group Exercise – Daily Routines (**Handout #1**)

### Instructor Notes:

*The purpose of this activity is to have students identify their own daily routines to underscore the point that we all have different daily routines and different daily activities that are important to us. Assisted living residents are no different.*

*Activity Procedures:*

- 5. Each student should be directed to turn to **Handout#1** in the Student Manual.*
- 6. Ask the students to complete the handout. Inform the students that they are moving into an assisted living facility and that this “form” is required as part of the move-in paperwork.*
- 7. After they are done, ask students to share some of the things they have written. The instructor might start by sharing her own personal example (e.g. “The first thing I like to do when I get out of bed is take a shower.”)*
- 8. Ask the students, “What do you notice when we share our responses with each other?” Answer: They are all different! Point out that this is no different for assisted living residents- each individual has his or her own preferences and daily routine.*
- 9. Read the Chapter 11 Handout #1 Instructor Guide to the class prior to proceeding to the discussion below.*

*Discussion:*

- a. How would it feel if someone else controlled our daily routine and we didn't have any say in it?*
- b. In our jobs as caregivers, how can we help residents to have the daily routines that are important to them?*

### **11.1.1. Dignity and Personal Care**

- According to § 63.2-1808. Rights and Responsibilities of Residents of Assisted Living Residents, “each assisted living resident has the right to*

be “treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity”.

- When assisting someone with personal care, consider the ways in which you can help residents to maintain their dignity and maximize independence. Honor the individuality and choices of residents.
- Here are a few things to consider:
  - Knowing the resident, including their strengths and weaknesses, allows you to know how much help the resident needs from you.
  - Knowing your residents' likes and dislikes is the first step to understanding how to help them maintain dignity. Communicate frequently with the resident about what you are helping them with and ask them how they would like to be assisted. For example, you might say, “Mrs. Jones, I am here to help you with your shower. Is this still a good time for you?”
  - Put the person before the task. Instead of thinking of a resident as a “shower to be done” think of your important role in caring for that whole person, knowing him or her as an individual, and what matters to him or her.
  - Respect the resident's right to choose in all aspects of their care, including when they would like to bathe and how they would like personal care assistance.
  - Residents have the right to make decisions regarding appearance, attire, attendance at facility functions, etc. If a resident has difficulty making decisions due to any type of cognitive impairment, try to give the resident as much choice as possible.
    - For example, a resident with a cognitive impairment might be overstimulated and may become more confused if she was asked “What would you like to wear today?” but you

- can offer choice by saying “Would you like to wear your red sweater or yellow sweater?”
- Encourage the resident to participate in care as much as possible and do as much as he or she can on his or her own. Ask how you can assist him or her in accomplishing that task.
    - Residents should be encouraged and supported to do as much as they can on their own and at their own pace. Direct care staff should provide supervision, guidance, and assistance as needed.
      - Provide cues to help the resident be successful in completing the task. For example, a resident might be able to hold the toothbrush in her mouth but needs verbal reminders to move the toothbrush up and down on her teeth.
  - Respect the resident's privacy
    - Residents will most likely be embarrassed about needing help with personal care. They might also be modest about you seeing them naked or helping them with intimate tasks such as bathing or toileting.
    - To help protect the resident's privacy:
      - Close the door when personal care is being given.
      - Limit exposure of the resident while providing care. Try to cover up the resident as much as you can.
      - Make sure the shower curtain is closed as much as possible while the resident is in the shower.
      - If you need to bring a resident to another room for bathing, either only undress the resident when you get to that room, or make sure the resident is covered while going to the room. Cover the resident

according to his or her comfort level. For example, some women might not want their bare legs to be uncovered.

- If the resident is in a public place and needs assistance, be discreet about helping him or her. For example, if a resident is at dinner and needs help with using the bathroom, quietly ask her to come with you.

### **11.1.2 Observation of Changes in a Resident**

As direct care staff you will spend a lot of time with your residents and get to know them well. You will know what is “normal” for them and will notice changes in their conditions. As direct care staff, you should be aware of changes in each resident’s condition as you help him or her with personal care. Report all changes to your supervisor and document in the resident’s record according to facility policy. In various sections of this chapter we will discuss changes in a resident that you may observe. § Direct care staff should regularly observe each resident for changes in physical, mental, emotional and social functioning in the residents. Below are examples of general changes in condition that will be important that you look for, report, and document:

- Physical changes in a resident
  - Skin
    - Bruising.
    - Swelling.
    - Pressure areas (such as reddening of skin in a particular area).
    - Dryness.
    - Sores or burns on heels and elbows.
    - Skin tears.

- When reporting these changes, be sure to describe location, size, and appearance.
- Weight change (gain or loss)
  - § Residents should not have more than a 5% in one (1) month; 7.5% change in three (3) months, or 10% in six (6) months.
- Level of physical functioning. Some examples might be:
  - Level of personal care needed. For example, resident is having difficulty bathing thoroughly independently.
  - A resident not being able to do her hair or a resident not being able to shave his face.
  - Changes in range of motion or ability to move arms and legs, reach or stretch.
    - Range of Motion (ROM) refers to the normal range of movement for a joint (how far it can be stretched or bent).

**INSTRUCTOR NOTE: Demonstrate Range of Motion**

- There are changes in the level of overall mobility ( i.e. it is harder for the resident to get in and out of the shower).
- Emotional or cognitive changes in a resident
  - Changes in a resident's mood or behavior. Does the resident not seem quite like him or herself?
  - Other important observations that should be addressed
    - Changes in personal habits
    - Resident suddenly does not want to get dressed
    - Failure to change clothes
    - Failure to shave or comb hair
    - Resistance to assistance with personal care

- Report all changes to your supervisor and document in the resident's record according to facility protocol. These changes could be an indicator of an underlying medical or psychological condition.

## 11.2 Personal Care

**Instructor Notes:** Refer to facility policy and procedure manual for facility-specific protocols. After classroom teaching of this chapter, personal care should be demonstrated to the students. Students can then practice and perform return demonstrations of all aspects of personal care.

### 11.2.1 Assisting Residents with Bathing

- In addition to keeping the resident clean, preventing germs and reducing body odor, bathing serves several very important medical needs:
  - Stimulating circulation.
  - Observing the skin for injury or breakdown.
  - Preventing pressure sores.
  - Overall well-being.
- **Refer to the resident's individualized service plan to find out what type of bathing is in the individualized service plan.** Each individual has lifelong bathing preferences that should be honored to the greatest extent possible. Ask the resident how he or she likes to take a bath/shower and what type of help the resident needs.



**Group Discussion:** Ask the students the following question:

**How do you think residents feel about having someone else bathe them?**

- Discussion:
  - In the discussion, note that helping someone bathe is a very personal task and residents might feel embarrassed to have

someone see them naked and touch private areas of their body.

- Bathing requires special sensitivity to a resident's privacy and personal dignity. Most individuals are not used to being bathed by someone. Residents might be uncomfortable having someone assist them with this intimate task, especially if they do not know you well. Being naked and bathed by someone else might also make someone feel vulnerable or unsafe. Building trust with the resident is an important step prior to assisting the resident with bathing. During the bathing process, talking with and listening to the resident may make him or her feel more comfortable.
- In preparing for a bath or shower, consider how to preserve the residents' dignity:
  - Does the resident have privacy?
  - Is the resident covered up as much as she would like to be?
  - If the resident does not want to be uncovered, bathe them under a towel or sheet.
  - If the resident needs to go to another room to bathe, wait until you are in that room before the resident undresses.
- Make the environment as comfortable as possible
  - Is the room temperature comfortable?
  - Is the water temperature comfortable?
  - Would playing music help the resident to be more comfortable?
- Consider the ways to make residents comfortable when you are bathing them:
  - Make conversation – get to know the resident.
    - It is particularly important to know your resident so that you know what is appropriate “shower talk” for that individual.

Bathing can be an intimate experience for a resident. If a resident starts a conversation regarding his or her spouse during the bathing process, that may be an indicator that the resident is remembering and missing intimate moments with the spouse. This may be an opportunity to ask questions about the spouse and reminisce, which can be a positive intimate experience for the resident. The opposite is also true. The resident may have past traumatic experiences with bathing so questions may be harmful versus beneficial. Know your resident!!

- Communicate with the resident what you are going to do before you do it.
- Speak to the person with dementia in soothing tones, in a supportive manner, and reassure him or her that everything is okay.

**Instructor Note:** It is important to stress that in some instances, with residents with dementia, the student may find that it does not help to explain each step because it creates anxiety for that person. In those situations, the students might consider trying to distract the person from the task by making conversation throughout the bath.



### **Student Activity**

- Role Play – Soothing Tones

### **Instructor Notes:**

*The purpose of this activity is to open student awareness of how they may interact with others and the importance of self-awareness of communication style.*

*Activity Procedures:*

1. *Place two chairs facing each other in the front of the class.*

2. *The instructor needs to set the scene that he or she will be assisting a resident with getting dressed.*
3. *The instructor needs to ask for a volunteer from the class to sit in one of the chairs.*
4. *The instructor should conduct the role play by talking through the steps of getting someone dressed. A low, monotone, uninterested tone of voice should be used. For example, "Okay Mrs Jones, it is time to get dressed." "Here is your shirt." "Here are your pants." "Do you need help with your shoes?"*
5. *The instructor should ask the students, "Did you perceive my actions with the resident as soothing or comforting?"*

*Discussion:*

*Allow the students an opportunity to respond and ask them to describe how he or she would feel if they were dependent on you for care? Would he or she feel vulnerable or that the direct care staff truly cared about them?*

6. *Conduct the same role play, having the same conversation using a soothing and comforting tone of voice.*
7. *The instructor should ask the students, "Think of the difference in the two role plays."*

*Discussion:*

*Ask the students to discuss the specific differences between the two role plays and ask again if the students had the same vulnerable or uncaring feeling as in the first role play. Why or Why Not?*

### **11.2.1 Assisting Residents with Bathing (continued)**

- Encourage the resident to be as independent as possible and provide assistance only when needed. Residents with dementia might need

- simple step-by-step reminders about what to do next to help the resident complete the shower or bath.
- Overall bathing tips:
    - Start with the cleaner areas and move to the dirtier areas.
      - This is done so a soiled cloth is not used to wash other parts of the body
    - Wash hair last if it needs to be washed
      - This is done to prevent the resident from getting a chill
    - Gently pat dry skin instead of rubbing, as older skin can be quite sensitive to tearing
  -  Assisting a resident with a tub bath
    - Prepare the room and gather supplies. Supplies might include:
      - Gloves.
      - Soap.
      - Washcloths and towels.
      - Clean clothing.
      - Other personal care articles such as lotion, deodorant, etc.
    - Greet the resident by name and talk to him or her about taking a bath. Ask the resident how much help is needed and specifically what the resident would like you to do to help. Continue to make conversation with the resident throughout bathing and let the resident know what you are doing.
    - Ensure that the resident has privacy - close the door or use a privacy curtain.
    - Fill the tub, ensuring the water is the proper comfortable temperature (§ range of 105 degrees to 120 degrees)
    - Put on your gloves.
    - Assist the resident in removing his or her clothes, if necessary.

- Assist the resident to get into the tub encouraging them to use grab bars and hand rails as needed.
- If the resident can wash on his or her own, stay nearby in case you are needed for assistance.
- If the resident needs assistance with washing, help the resident to wash his or her face, upper body, legs and feet, and between the legs.
- Drain the water from the tub and assist the resident in getting out of the tub.
- Drape a towel over the resident and assist them in patting themselves dry.
- Assist the resident in applying lotion, if needed.
- Assist the resident in dressing.
- Assist the resident in combing his or her hair.
- Assist the resident to his or her room.
- Clean the tub and wash your hands.
- Some residents, especially those with dementia, might be fearful of taking a bath in a tub. They might be afraid of the noises, not understanding what the tub is, etc. If you observe that a resident is fearful of a tub bath, report this to your supervisor and discuss bathing alternatives with the resident and/or Responsible Party. This bathing alternative should be addressed on the ISP.
-  Assisting a resident to shower
  - Prepare the room and gather supplies. Supplies might include:
    - Gloves.
    - Soap.
    - Washcloths and towels.
    - Clean clothes.

- Other personal care items such as shampoo, lotion, deodorant, etc.
- Greet the resident by name and talk to him or her about taking a shower. Ask him or her how he or she would like to do it. Keep talking to them throughout the shower. Explain what you are doing before and as you do it.
- Ensure that a resident has privacy- close the door and/or use the privacy curtain to give privacy.
- The resident may use a shower bench, shower chair, or a rolling shower chair depending on the resident needs.
  - A shower bench is a long bench that is placed in the tub and extends to the outside of the tub. This allows the resident to transfer to the shower bench and then slide into the shower lifting his or her legs over the side of the tub. This is a stationary device.
  - A shower chair is placed inside the tub or shower and does not extend outside the tub. The resident would have to transfer into the tub or shower prior to being able to sit on the shower chair. This is a stationary device.
  - A rolling shower bench is used in showers that a resident could walk-in without having to lift his or her feet over the edge. It is similar to a wheelchair in appearance except it has small holes in the seat portion, allowing water to drain through it.
- Turn on the water to the desired temperature, making sure it is not too hot (§ range of 105 degrees to 120 degrees).
- Put on gloves.
- Help the resident to undress and cover him or her with a towel, robe, or sheet.

- If the resident can climb into the shower, help them to do so. If the resident has a shower chair or shower bench, place the chair in place and assist the resident to sit on the chair following the transfer methods you will learn in Chapter Twelve. If the resident is in a rolling shower chair, roll the resident into the shower and lock the wheels.
- If the resident needs help with washing, help them to:
  - Wash the face.
  - Wash hair.
  - Wash the upper body.
  - Wash the legs and feet.
  - Wash between the legs.
- Turn off the water.
- If the resident can climb out of the shower, assist him or her in getting out of the shower.
- Drape the resident with a towel and help to pat dry.
- If the resident is in a rolling shower chair, roll the chair out of the shower.
  - If the shower chair is stationary, follow the transfer methods discussed in Chapter Twelve.
- Assist the resident in applying lotion, if the resident requires assistance.
- Assist the resident in dressing.
  - Remember to allow the resident to select clothing prior to getting into the shower and have the clothes ready so that the resident is unclothed for as little time as possible.
- Assist the resident in brushing or combing hair.
- Assist the resident in getting back into his or her room.
- Clean the shower area.

- Wash your hands.
- A bed bath is a bathing alternative for residents who must stay in bed or who do not wish to have a shower or bath.
-  How to give a bed bath
  - Greet the resident and tell him/her your name. Let the resident know that you are going to give him or her a bed bath; explain what you are doing during the whole process.
  - Get all the supplies you need (gloves, soap, washcloths, towels, clean clothing, brush/comb, other personal items such as lotion and deodorant).
  - Put on your gloves.
  - Raise the bed to a good height for you. If there are side rails, keep them raised if possible.
  - Bring a basin of warm water to the bed.
  - Lower the side rail and help the resident to lie on his or her back.
  - Remove or fold back the blanket and top sheet.
  - Help the resident to remove his or her clothing, covering him or her with a towel or sheet.
  - Help the resident to wash his or her face, if he or she cannot wash it by himself or herself. Use plain water with no soap. When washing around the eyes, wash from the inside corner to the outside corner. Pat dry.
  - Moving from shoulders to feet, wash with soap, rinse, and dry one body part at a time. Place a towel under each body part as it is being washed. Keep as much of the body covered as possible.
  - Place the basin on a towel by the resident's feet and place one foot in it. Wash, rinse, and dry that foot. Do the other foot.
  - Change the water in the basin and get a clean washcloth.

- Help the resident to turn on his or her side, away from you
- Clean the resident's back, buttocks, and thighs. Wash, rinse, and dry one part at a time, placing a towel under the body part being washed. Keep the rest of the body covered.
- Ask the resident if she or he can wash between his or her legs. If not, help them with this:
  - Washing the area between a resident's legs (penis, vagina, and buttocks) is called pericare.
  - Wash your hands prior to providing this care to the resident.
  - Continue to describe what you are doing throughout the task.
  - Make sure you have your bathing supplies available and ready to use:
    - Gloves.
    - Wash basin with warm water.
    - Soap.
    - Washcloths, bath towels, bath sheets.
    - Waterproof protector pad (if available).
    - Plastic bag.
    - Toilet tissue.
  - Make sure that the bed is at a good height for you and lower the side rail closest to you.
  - Put on your gloves.
  - Fold down or remove top bedding (so it doesn't get wet).
  - Cover the resident with a bath blanket, sheet or large towel. Arrange the sheet like a large diamond, with one point extending down between the legs.

- Help the resident to bend his/her knees and spread his/her legs. Fold back the point of the sheet toward the resident's belly. Keep the legs covered for warmth and privacy.
- Place a clean towel or bed protector under the resident's buttocks. If the bottom sheet is soiled, remove it and place it in a laundry bag.
-  Keeping the resident covered as much as possible, follow these steps:
  - For a woman:
    - Apply a small amount of soap to a washcloth.
    - Wash the outer lips of the vagina first. Wipe from front to back. Wipe once down each side and once down the center, using a clean part of the washcloth for each wiping.
    - Rinse the washcloth in warm water and wipe again from front to back. If at any point the washcloth becomes soiled with feces, replace it with a clean one.
    - Flip the washcloth and soap it lightly again. Spreading the outer lips, wash the inner lips with three wipes in the same way (down each side and the center).
    - Rinse and flip the washcloth, rinsing the inner lips with three wipes.
    - Pat the area dry.

**Instructor Note: It is extremely important to stress the important of proper cleaning. Women are at risk for vaginal infections, including yeast infections, UTIs, etc. that can lead to additional infections and illnesses.**

- For a man:
  - Place a small amount of soap on a clean washcloth.
  - Wash the tip of the penis, pushing back the foreskin if he has one.
  - Rinse and flip the washcloth, wiping the tip of the penis. Pat dry and place foreskin back in place if he has one.
  - Flip the washcloth. Wash the shaft of the penis, moving away from the tip.
  - Rinse and flip the washcloth, rinsing the penis shaft.
  - Flip and soap the washcloth. Wash both sides of the groin and the scrotum.
  - Rinse and flip the washcloth. Rinse the groin and scrotum.
  - Pat the scrotum and penis dry.
- Cleaning a resident's bottom/buttocks:
  - Put on gloves if you are not already wearing them.
  - Help the resident to turn on his or her side away from you.
  - Spread the buttocks and wipe the area with toilet paper if soiled.
  - Soap a clean washcloth.
  - Clean the area between the buttocks with three strokes, wiping from front to back. Use a different part of the washcloth for each stroke.

- Rinse and flip the washcloth (if the washcloth has been soiled, use a new one). Wipe and pat dry the buttocks and the area between the buttocks.
- Take off the towel or bed protector that was placed under the resident.
  - Help the resident to put on clean clothes.
  - Brush or comb the resident's hair.
  - Throw away your gloves using the glove disposal technique described in Chapter Two and wash your hands.
  - Place all soiled towels, wash cloths, etc. in the plastic bag and tie the bag. Place the bag in the resident's dirty laundry hamper or set aside in the room to take to the laundry room. This procedure will depend on the facility policy and the resident's laundry request.

**NOTE:** It is important to check the temperature of the water basin frequently to make sure that the water temperature has not become too cool. If the water has cooled down, pour out the cold water, rinse the water basin and refill with new soap and water.

- Bathing is a good time to make close observations of changes in a resident's physical condition. Report to your supervisor any of the following observations and document according to facility protocol:
  - Any redness, rash, or bruising of the skin.
  - Any skin tear, wounds, or ulcers.
  - Any foul smelling discharges or drainage.
  - Any difficulty moving or acting as if in pain.

Information in this section was taken from "Module 11: Supporting Consumers' Dignity While Providing Care" of the following curriculum:

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

## 11.2.2 Assisting Residents with Dressing

- Residents should be given the opportunity to be dressed in the clothing of his or her choice.
- Ask residents what he or she would like you to do to assist.
- Ask the resident to choose what to wear. Lay clothes out in the order they will be put on.
- Ensure that the resident has privacy.
- Maintain eye contact so the resident does not feel self-conscious about being naked.
- Talk to the resident during the whole process, letting him or her know what you are doing to assist.
- Offer a blanket, towel, or robe to cover exposed parts of the body.
- Undress and dress one part of the body at a time.
- Allow plenty of time as the resident might need to rest periodically and might need to move slowly.
-  Here are some specific tips on how to help a resident with dressing:
  - Wash your hands.
  - Greet the resident by name and let the resident know you are there to help him or her get dressed, if he or she needs it.
  - Ask him or her what type of help he or she needs.
  - If in the morning, assist the resident in taking off their night clothes.
    - Assist the resident in taking off his or her top. Cover the resident for warmth if needed or desired.
    - Assist the resident in putting on a clean top by:
      - If appropriate, helping the resident to put on bra or undershirt.
      - Starting by putting the weaker arm in one sleeve.

- Then help pull the shirt over the head or around the back.
    - Assist the resident in getting the stronger arm through the other sleeve.
  - Assist the resident in taking off his or her bottoms. Cover the resident for warmth if needed or desired. Assist the resident in taking off underwear.
  - Assist the resident in putting on a clean bottom by:
    - Assist the resident in putting on underwear.
    - Start with the weaker leg first and help guide the leg into the pants.
  - From the sitting position, help the resident put on socks and shoes.
    - When taking clothes off, remove clothes from the stronger side first.
- If residents have dementia, clothing choices might be over-stimulating. However, it is still important to offer choice to residents with dementia. One way to offer choice is to ask a resident to choose between two items. For example, you might ask “Mrs. C, would you like to wear your red sweater or your blue sweater?” while showing her both choices.
- Support residents in being as independent as possible in dressing themselves. Assist with buttons, zippers, or other difficult tasks only if needed.
- Residents with dementia might need verbal reminders while dressing. For example, people with dementia often have challenges in knowing the correct order in which clothes are worn so you might need to remind them that the socks go on before shoes, or underwear goes on first.

- Dressing is a good time to make close observations of changes in a resident's physical condition. Report to your supervisor any of the following observations:
  - Any redness, rash, or bruising of the skin.
  - Any skin tear, wounds, or ulcers.
  - Any foul smelling discharges or drainage.
  - Any difficulty moving or acting as if in pain.
  - Any disinterest or refusal in dressing or undressing.
  - Range of Motion.

Information in this section was taken from "Module 12: ADL: Bathing and Personal Care" of the following curriculum:

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

### **11.2.3 Assisting Residents with Bathroom Needs**

Assisting residents with bathroom needs, i.e. toileting or bowel and bladder care, is arguably the most personal task of personal care. Each resident has specific and unique needs regarding how much assistance is required. Refer to a resident's individualized service plan for information on what assistance the resident needs. Residents should be encouraged to be as independent as possible in attending to their bowel and bladder needs. The proper tone of voice when encouraging the resident is important here so it is not perceived by the resident and/or family as the direct care staff member pushing the resident to do for him or herself. Bowel and bladder care refers to passing urine and passing bowel movements while incontinence refers to loss of bowel and bladder control.

- Assisting a resident to follow a healthy bathroom schedule
  - Assisting a resident to use the bathroom on a regular schedule can help avoid bowel and bladder “accidents” and help prevent or minimize incontinence.
    - Helping a resident to maintain a bathroom schedule helps to protect dignity and supports independence.
    - Helping a resident to maintain a bathroom schedule can also help with feelings of safety and security.
    - Bathroom schedules are also referred to as “bowel and bladder programs.”
    - An example of a bathroom schedule is taking a resident to the bathroom every two hours throughout the day. Note that schedules should be individualized to meet the unique needs of each resident.
  - Talk to the resident about his or her typical bathroom schedule. For example, how many times a day does s/he typically go to the bathroom, does she need to go during the night?
    - Observe the resident to see how often s/he needs to use the bathroom to understand his or her natural schedule.
    - Let the resident know that you will create a schedule together. Knowing someone will be bringing him or her to the bathroom at certain times will help alleviate anxiety about possible bowel or bladder accidents.
  - Some residents might wear adult disposable briefs, i.e. Depends.
    - Ensure that briefs are checked and changed on a regular schedule to provide comfort and protect the skin. DO NOT CALL THESE DIAPERS!
  - For residents that need assistance with a bathroom schedule, it is important to document the number of times that resident voided

and/or had a bowel movement. Any changes in the resident's regular routine should be documented in the resident's chart and reported to the supervisor immediately as this could be a sign of constipation or illness.

-  Assisting a resident in using the bathroom:
  - Have available these supplies in case you need to wash someone between the legs:
    - Towel and washcloths.
    - 2 pairs of gloves.
    - Plastic trash bag.
  - Greet resident and let him or her know you are there to help them use the toilet. Talk to the resident throughout the process and let him or her know what you are doing. Ask the resident how much help s/he needs.
  - Assist the resident to get to the bathroom.
  - Assist the resident in lowering or removing his or her clothes.
  - Assist the resident to sit on the toilet, if necessary.
  - If you leave the resident alone, make sure s/he is safe. Remain close by in case the resident needs your help. Check in with them every five (5) minutes to assist with maintaining resident safety.
  - When the resident is finished and has called you in, come back into the bathroom.
  - If you need to help the resident wipe himself or herself, wash your hands and then put on gloves.
    - For women, wipe from front to back.
    - Remove and throw away gloves.
    - Wash your hands again.

- Assist the resident to get off the toilet and fix his or her clothes.
  - Assist the resident in washing his or her hands.
  - Assist the resident in getting back to his or her room, or wherever s/he would like to go.
-  Assisting residents with adult disposable briefs
    - To maintain a resident's dignity, do not refer to these as diapers. For adults, the person-centered term is adult briefs or undergarments.
    - Adult disposable briefs can help residents maintain their dignity by providing protection when they lose control of their bowel or bladder. This protection enables residents to more actively participate in their daily activities, particularly socializing.
    - Per the resident's individualized care plan and facility policy, you might need to track the “output” of a resident. This report might include: when a resident passes urine or stool, how much was passed, and what it looked like.
    - Changing a brief while the resident is laying down:
      - Have supplies available:
        - Gloves.
        - New brief (if needed).
        - Wipes/toilet paper.
        - Trash bag for disposing soiled brief.
        - Bathing supplies, if necessary.
      - Wash hands prior to assisting resident with care.
      - Greet resident and let them know you are there to help him or her.
      - Talk to him/her throughout the process and let him/her know what you are going to do.

- Ensure that the resident has privacy.
- Lower the resident's head if they are resting in an inclined position.
- Raise the bed level to make it easier for you to care for the resident.
- Put on gloves.
- Unfasten the tapes on the brief on both sides. Refasten the tapes to the brief itself to prevent the tapes from sticking to the resident's skin. (For example, if the tapes are coming from the bottom of the brief, refasten the tapes to the bottom.).
- Gently roll the front of the brief away from the resident, taking care not to wipe the resident with the dirty brief.
- Wipe from front to back. Place the soiled wipe in the soiled brief.
- Do not pull the brief out from under the person – this might injure the resident's skin. Instead, ask or gently roll the resident away from you.
- When the resident is on his or her side, wipe his or her buttocks.
- Roll the rest of the brief in on itself so it does not soil the bed.
- Tuck the closed soiled brief close to the resident so that it can be removed when the resident rolls to the other side.
- If your gloves are soiled, replace them with clean gloves.
- Place the new brief under the resident, ensuring that it is properly positioned so that the tape will easily fasten. At this point, do not undo the tape. Keep the tape fastened to the new brief.

- With the brief on the bed, ask or gently roll the resident on his or her other side, so that she or he is on the new brief.
- Remove the old brief and dispose.
- Gently roll the resident on his or her back.
- Fasten the tapes on the clean brief on both sides. Make sure it is snug but not so tight that it would cause the skin to break down.
- Remove gloves.
- Rearrange the resident's clothes back to its original place.
- Put the bed back to its original height and ask the resident how to make him or her comfortable in the bed.
- Wash hands when you are done assisting the resident.
- Changing a brief while a resident is standing up:
  - Have supplies available:
    - Gloves.
    - New brief (if needed).
    - Wipes/toilet paper.
    - Trash bag for disposing soiled brief.
    - Bathing supplies, if necessary.
  - Wash hands prior to assisting the resident with care.
  - Greet resident and let them know you are there to help him or her.
  - Talk to him/her throughout the process and let him/her know what you are going to do.
  - Ensure that the resident has privacy.
  - Ensure that the resident can stand safely and securely with proper balance.
  - Remove or rearrange clothes as necessary to access the brief.

- Unfasten the brief and remove it from front to back, folding it as you remove it to prevent it from soiling the resident's clothes.
  - Dispose of the soiled brief.
  - Wipe the resident between the legs from front to back (pericare). Dispose of the wipes.
  - Open the clean brief and place the brief behind the person with the back of the brief towards the back. Pull the front of the brief through the person's legs.
  - Arrange the brief so that it is properly positioned and fasten it. Ensure that it is snug but not too tight.
  - Rearrange the resident's clothing as needed.
  - Wash hands when you are done assisting the resident.
- Helping residents with bathroom needs provides an opportunity to make close observations of changes in a resident's physical condition. Report to your supervisor any of the following observations and document in the resident record according to facility protocol:
  - Any redness, rash, or bruising of the skin.
  - Any skin tear, wounds, or ulcers.
  - Any foul smelling discharges or drainage.
  - Any difficulty moving or acting as if in pain.
  - Range of Motion.
  - Changes in ability to control bowel or bladder.
  - Pain or difficulty when emptying bladder or bowel.
  - Urine that is dark in color, has a bad odor, or has blood in it.
  - Diarrhea or stools that appear abnormal for that person, including blood in stool or on toilet paper.
  - Constipation.

Information in this section was taken from “Module 16: ADL: Dressing and Toileting” of the following curriculum:

Paraprofessional Healthcare Institute. (2009). *Providing Personal Care Services to Elders and People with Disabilities*. Retrieved from <http://phinational.org/>.

### **11.2.4 Assisting Residents with Transferring/Ambulation**

Chapter 12 covers transferring and ambulation in depth. Proper transferring is an important part of personal care. Use good body mechanics to protect yourself and residents from injury.

### **11.2.5 Assisting Residents with Eating**

Refer to Chapter Nine on Meals and Nutrition for more information and details.

- First, never call meal assistance “feeding” and never call these residents “feeders.”
- Food is an important part of our daily lives, not just for the nutrition we need, but for the pleasure food gives us. Dining is also a social opportunity to connect with others. Here are some general things to keep in mind:
  - Provide residents with as much choice as possible in what and when they eat.
  - Recognize that, from the resident’s perspective, being fed by someone else can feel undignified. Consider how you can help a resident maintain his or her dignity by giving as much choice and independence as possible. It is also important to be sensitive to how a resident feels about receiving assistance with eating around other residents, friends, and family.
  - Support residents to be as independent as possible in feeding themselves. To maximize independence, set up a resident’s

dining area (table, placemat, plates, utensils, etc.) so that they have easy access to food and utensils.

- Ask the resident how you can prepare the food so that he or she can easily eat it. For example, would it help to have the food cut into smaller pieces? To help a resident maintain dignity, you might consider not cutting the food at the table, but in the kitchen or wherever you prepare it before it goes to the resident.
- If food or drinks are packaged, have wrapping, have caps, or need to be opened, ask the resident if he or she would like you to perform these tasks. Keep in mind that residents with physical and cognitive challenges might have difficulty opening a carton of milk or removing a straw wrapper.
- Help the resident to find the best position for eating, whether in a chair, wheelchair, or bed. For example, make sure they can reach the food, they can see the food, and they can move the food on the utensil to their mouths.
- Recognize that a resident might need more time to eat, particularly if that resident has physical or cognitive challenges. Give residents ample time to enjoy and finish their meals.
- Allow time for personal care prior to eating, if resident prefers.
- Eating in dining room vs. resident's room:
  - If possible, have a conversation with resident about whether he or she prefers to eat in the dining room or in his or her own room. Family members should be included when appropriate to determine resident preferences.
  - Talk through reasons a resident might not want to eat in the dining room and address them with the rest of the team, if

appropriate. For example, a resident states she would rather eat in her room because the dining room is too loud for her, ask her if she would consider sitting in a part of the dining room that is less noisy, or possibly at a time where there are fewer people in the room.

-  Helping a resident with eating:
  - Prepare the space for dining.
  - Sit down next to resident.
    - Dining is an opportunity to get to know a resident- make conversation with the resident. It is not appropriate to make conversation with other people at the table and not include the resident with whom you are assisting to eat.
    - Direct care staff should not be conversing about weekend plans while assisting a resident with his or her meal.
  - Ask the resident if he or she would like the food cut, lids removed, and seasoning or condiments on the food.
  - Serve each food item one bite at a time using a moderate amount of food each time. Do not put too much food in the resident's mouth as this is a major choking hazard.
  - Allow time to chew and swallow.
  - Offer a drink to the resident between bites.
  - Wipe resident's mouth as needed. If the resident is capable of wiping his or her own mouth, hand the resident the napkin and direct him or her to wipe his or her mouth clean.
  - When resident is finished eating, remove food.
  - Residents have varying degrees of need for help with eating. A resident's individualized service plan will provide information on how much help is needed.

- While residents with higher needs might need you to place food in their mouths for them, others might just need verbal cueing (reminding) to remind the resident of the different steps involved in eating (particularly people with dementia). **Support the resident in doing as much as he or she can independently.**
  - Record types and amount of fluids taken and percentage of food eaten per facility policy.
- Report to your supervisor and document in the resident record according to facility policy any of the following observations:
  - Any changes in the amount of food a resident is eating (whether it is more or less).
  - Changes in overall eating habits (not wanting to eat in the dining room, not wanting to eat around others).
  - Changes in how much help a resident needs with eating.
  - Weight loss or gain.
  - Signs or symptoms of difficulty chewing or swallowing certain types of foods or beverages.

### **11.2.6 Mouth, Teeth, and Denture Care**

- Cavities, gum disease, infections, bad breath, and difficulty with eating are among the many problems that result from poor oral hygiene. To prevent this, assist the resident to brush their teeth and take care of dentures.
- Problems associated with poor dental hygiene
  - Physical
    - Pain and discomfort associated with poor hygiene.
    - Bad breath, gum disease, and tooth decay.

- Poor fitting dentures can cause physical problems such as pain and mouth injuries, as well as challenges with eating.
    - Difficulty or pain with eating might result in less interest in eating. This could result in weight loss, malnutrition, etc.
  - Psychosocial
    - Low self-esteem, embarrassment, anxiety, depression
    - Residents with poor oral hygiene might avoid others or social situations.
- Assisting residents with oral hygiene and denture care
  -  Brushing Teeth
    - Oral hygiene, including brushing teeth and flossing, is a part of daily routine.
    - Should be done in am and pm (resident may wish to brush teeth and floss after meals as well).
    - Provide privacy.
    - Encourage resident to be as independent as possible.
    - Greet resident and let him or her know how you are going to help him or her. Talk to the resident throughout the routine.
    - Use gloves when assisting with mouth care.
    - What are the general steps involved in toothbrushing?
      - Place a towel on the resident's chest to keep him or her dry.
      - Put toothpaste on brush and wet brush.
      - Gently brush the inside and outside of the teeth with a horizontal back-and-forth motion.
      - Give the resident water to rinse and spit out. If resident is not by a sink, hold a small basin under the resident's chin so that they can spit out the water.

- Wipe the resident's mouth.
- What are the general steps in flossing?
  - Pull about six to eight inches of floss out of the container.
  - Wrap a small amount around your index fingers on each hand.
  - Gently glide the dental floss in between the resident's teeth and move up and down and left and right.
  - Remove the floss and move to the next tooth.
  - Discard dental floss when done.

Note that every resident is different in how much assistance he or she needs. Refer to the resident's individualized service plan for details about how much assistance is needed.

- Some residents might only need verbal cueing (reminding). For example, "take the cap off the toothpaste, squeeze some on the toothbrush....." Remember that people with dementia need simple, step by step directions.
- For residents who require a little more assistance, you might need to put toothpaste on the toothbrush, hand it to the resident, and guide it to her mouth, helping her move it up and down with your hand.
- For residents who need a lot of assistance, you might need to brush their teeth for them.

o  Dentures

- Encourage resident to be as independent as possible.
- Have resident take out and replace own dentures, if able.

- How to care for dentures:
  - Using a gloved hand and gauze pad, grasp the front of the upper denture with your thumb and index finger and loosen the seal by gently moving up and down.
  - Carefully pull the upper denture down from the gums and out of the mouth.
  - Grasp the lower denture and gently loosen, lifting up and out.
  - Rinse the dentures under warm water and put in the denture cup.
  - Line the sink with a face towel to ensure dentures do not slide into the drain while cleaning.
  - Applying the denture cleaner to the toothbrush, hold the dentures over the sink and brush them back and forth on the outside and inside.
  - Rinse under warm water, place them in the denture cup with cool water.
  - If the resident has any natural teeth, brush them as directed above.
  - Then insert the upper dentures while gently lifting the upper lip.
  - Insert the lower dentures while gently lowering the lower lip.
- Residents frequently lose dentures. Sometimes, they are wrapped in tissues and left on tables, beds, in pockets, and in purses. They might be mistakenly discarded as trash. Help keep track of a resident's dentures by

observing when a resident removes them and where s/he leaves them.

- Report to your supervisor and document in the resident record according to facility protocol any of the following observations:
  - Any sores, wounds, or bleeding in mouth and gums.
  - Any complaints of pain in the mouth.
  - Any bad odor, especially if it is not helped by mouth care.
  - Resident resisting or denying the need for oral care.

### **11.2.7 Skin and Nail Care**

- Skin care
  - Bathing is a primary means of caring for the skin. Some other ways of caring for skin are:
    - For residents who have limited mobility, help them change positions frequently so that they do not develop pressure sores. A resident's individualized service plan will specify this information.
    - Encourage residents to move so that blood flows and pressure on skin is relieved.
    - Encourage residents to drink plenty of water and eat a nutritious diet.
    - Offer extra padding for residents to sit or lie down on- the extra padding will help protect their skin from pressure.
  - Skin care is an opportunity to observe changes in a resident's skin. Look out for and report the following changes:
    - Odor

- Bruises
  - Red spots and changes in color
  - Cuts and sores
  - Dry skin
  - Fluid coming out of a cut
  - Swollen areas
  - Rashes
  - Skin that is hot or cold
- Back rub and skin care
  - A back rub can have many positive benefits for residents:
    - Overall relaxation and de-stressing.
    - Stimulation of blood flow to the skin.
    - Relaxation of muscles.
    - An opportunity for staff to observe skin condition.
- Nail Care
  - A resident's individualized service plan will specify the type of nail care needed. See your facility policy for who can cut a resident's nails.
  - Maintain cleanliness of nails for hygiene as well as self-esteem.
  -  How to help with nail care:
    - Talk to the resident about how you can assist with nail care.
    - Tell the resident what you are doing throughout the process.
    - Wash your hands.
    - Fill a basin with warm water and place the resident's hands in the basin to wash them.
    - Pat the resident's hands dry with a towel.

- If facility policy and the individualized service plan allow, cut the resident's nails straight across with a nail clipper. Do not clip nails shorter than the tips of the fingers.
  - Use a nail file to shape and smooth nails.
  - Use lotion to moisturize the resident's hands.
  - Empty the basin and clean the nail care area.
  - Wash your hands.
- With toenail care, follow the facility policy about who can cut residents' toenails.
- Do not cut nails of a diabetic resident without approval from a physician. Residents with a diagnosis of diabetes may:
  - Be more susceptible to infection – a small cut in a resident's foot can lead to a severe infection.
  - Have decreased circulation in the feet – infections may not heal due to decreased blood flow.
  - Have decreased sensitivity (i.e. feeling) in their feet – the resident may not be able to feel skin being cut as quickly to inform the direct care staff the nail is being cut too short.
- If facility policy and the individualized service plan allow, cut the resident's toenails following the procedures above.

Information in this section was taken from "Module 12: ADL: Bathing and Personal Care" of the following curriculum:

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

## 11.2.8 Shaving

- Encourage resident to do as much as he or she can to maintain self-esteem and independence.
- Both men and women have shaving needs.
- Talk to a resident about his or her shaving preferences (how, with what, when, etc.).
- Allow a resident a choice of razor type , as long as safety measures are met.
- Safety
  - Determine resident's ability to use non-electric razor.
  - Do not use electric razor when resident is receiving oxygen.
-  How to shave a person's face (general procedures):
  - Greet the resident and let him know what you are doing. Ask him how he likes to be shaved and how much he would like to do himself.
  - Have the resident sit comfortably.
  - Place a towel over the resident's chest and lower neck.
  - Put on gloves.
  - Wash the face and neck.
  - Rub shaving cream over the area.
  - Start in front of one ear. Hold the skin taught with one hand and bring razor down over his cheek and toward the chin. Do the other side and the rest of his face.
  - Use downward strokes, following the direction of hair growth.
  - Rinse the razor often.
  - In shaving his neck, make sure there is enough shaving cream on his neck. Shave upwards towards his chin, repeating until the neck is smooth.

- Rinse and dry the resident's face.

### **11.2.9 Hair care**

- Grooming of hair is done daily
  - Ask the resident if he or she is able to perform daily hair care.
  - Ask resident what his or her hairstyle normally is so when assisting the resident, his or her is styled like the resident likes it.
  - Good hair care maintains good self-esteem and dignity.
- Shampooing and styling
  - Ask resident how he or she prefers hair to be maintained and styled.
  - Check individualized service plan to see how and how often hair is washed.
    - Might be done by licensed hair stylist
      - If done by a stylist, make sure the resident's hair does not get wet while showering unless requested by the resident.
    - Might be done while showering or while in tub.
  - Hair should be thoroughly cleansed and rinsed using resident's choice of shampoo- not body soap.
  - Assist residents with blow drying and styling as needed.
- While washing and styling a resident's hair, report changes to your supervisor and document in the resident's record according to facility protocol. These changes might include:
  - Hair falling out
  - Sores on scalp
  - Scalp flaking

## 11.2.10 Eyeglasses and Hearing Aids

Eyeglasses and hearing aids are necessary for residents' well-being. They enable residents to be as independent as possible and maximize involvement in everyday activities. Helping residents take care of eyeglasses and hearing aids is a part of personal care.

-  Care of eyeglasses
  - Hold eyeglasses by their frames when handling them.
  - Wash eyeglasses every day with water and mild soap, drying them with a tissue or soft cloth.
  - For individuals with dementia, they might need reminders to put their glasses on.
  - Report problems with eyeglasses to your supervisor (for example, if they are not fitting properly, broken, lost).
-  Care of hearing aids
  - Clean the hearing aid as needed - clean the earpiece with soap and water and wipe wax from the tubing.
  - Make sure batteries are working and replace as needed.
-  Assisting residents to put in hearing aids:
  - Before putting in the hearing aid, test it by turning the sound up as loud as it can go. If you don't hear a whistle you need to replace the batteries.
  - When putting the hearing aid in, turn the sound to low.
  - If the hearing aid goes in the ear, gently put the earpiece in the ear canal and ask if it feels okay.
  - If it goes over the ear, loop the tubing over the resident's ear.
  - Assist the resident in making the sound lower or higher according to their preference.
-  Assisting residents in taking out hearing aids:

- Turn the sound to low or turn it off.
- Gently lift the earpiece up and out of the ear.
- Use tissues to clean it off.
- Take out the battery or open the battery door- this allows it to air out when not in use.
- Store the hearing aid in a safe place.
- Help residents keep track of their hearing aids. Sometimes residents leave hearing aids wrapped in tissue by their bed or somewhere in their room. This might result in it inadvertently being thrown out.
- Report changes to your supervisor and document in the resident's record according to facility protocol. The changes might include:
  - Resident not wearing glasses or hearing aid.
  - Glasses or hearing aid broken or needing repair.
  - Glasses or hearing aid not fitting properly or causing discomfort.

Information in this section was taken from "Module 9: Supporting Consumers at Home" of the following curriculum:

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

### **11.2.11 Housekeeping**

§ Housekeeping is considered a part of personal care services. Each assisted living community handles housekeeping differently, in terms of who provides it, when, and how much assistance residents need with housekeeping. If appropriate (if the students are receiving training by the assisted living facility in which they will be working), review the facility policies on how housekeeping is provided if they are available. Describe which staff persons are responsible for

housekeeping and what they are expected to do. One part of housekeeping for which you might be responsible is bed making.

- Bed making
  - A neat, clean and well-made bed provides comfort. Wrinkled or soiled sheets can cause skin irritations or even pressure sores. It is important to remove wet or soiled sheets as soon as possible to prevent skin irritation and pressure sores. Soiled sheets also can carry germs from body fluids. Most importantly, clean sheets make residents happy.
  - While individuals might have specific preferences as to how his or her bed is made, here are some general guidelines for making a bed:
    - Change sheets according to facility policy or as needed.
    - Wear gloves when handling soiled sheets.
    - Fold dirty linens- do not shake them.
    - Place dirty linens in bag, hamper, or other receptacle according to facility policy.
    - Keep all linens off the floor (both clean and dirty).
    - Wash hands before and after handling clean linens.
    - Linens should be smooth and tight. Smooth out wrinkles so they don't irritate skin.
    - Leave bed open or closed as the resident prefers.
      - Open beds have the top linen fan-folded back to about 24 inches from the foot; closed beds have the linens pulled up over the bed with a cuff of the sheet over the blanket/bedspread.
  - Making an empty bed:
    - Wash hands before handling clean sheets.

- Get the clean linens you will need.
  - Place clean linens in a clean place near the bed.
  - If the bed adjusts, raise the bed to a good height to make it easier for you to change the sheets.
  - Remove linens that you will reuse.
  - Put on gloves to handle soiled sheets.
  - Remove dirty bedding, folding it over and putting it in a laundry bag or other receptacle.
  - Remove and discard gloves.
  - Smooth out the wrinkles in the mattress pad (if there is one).
  - Remove and replace mattress pad if soiled.
  - Place the clean bottom sheet on the bed, tucking it under the bed if needed.
  - Place the clean top sheet – the sheet should go on with the “wrong side” face up and the wide hem at the top.
  - Place the blanket (if there is one) on the bed.
  - Place the bedspread or comforter on the bed (if there is one).
  - Place the clean pillowcases on the pillows.
  - Place the pillows on the bed and pull the bedspread over the pillows.
  - Lower the bed back to the original height.
  - Wash your hands.
- In some cases, you might need to make a bed while a resident is in the bed. Here are some guidelines for doing this:
    - Wash your hands.
    - Get the clean linens you will need.

- Greet the resident by name and let them know you are going to make the bed. Make conversation with him or her while you make the bed.
- Give the resident privacy while making the bed- keep her or him covered as much as possible.
- Place the clean linens in a clean space in the room.
- If the bed is adjustable, raise the height so that you can work around the bed easily. Also, lower the head of the bed and if needed, lower the side rail on the side you will start.
- Remove any linens that you will reuse and place them in a clean space.
- Put on gloves if you are handling soiled linens.
- Loosen the dirty top sheet and blanket at the bottom of the bed.
- Help the resident to turn on his or her side, away from you. Loosen the dirty bottom sheet on the side near you and move it to the middle of the bed.
- Put on a clean bottom sheet on the side near you and tuck it under if needed.
- Help the resident to turn on his or her other side, onto the clean bottom sheet.
- If the bed has side rails, raise the rails on the side that the resident is now facing.
- Go to the other side of the bed and lower the side rail (if there is one).
- Take off the dirty bottom sheet, fold it, and place it in a laundry bag or receptacle.
- Tuck in the clean bottom sheet.

- Smooth out wrinkles.
- Take off the dirty top sheet, folding it, and placing it in a laundry bag or other receptacle.
- Cover the resident with a clean sheet as soon as possible, tucking it in as needed.
- Cover the resident with a clean blanket, tucking it in as needed.
- Place the bedspread over the resident.
- Gently remove the pillow from beneath the resident's head, take off the dirty pillowcase, and place it in the laundry bag or receptacle.
- Put on a clean pillowcase and gently place the pillow back under the resident's head.
- Help the resident to get comfortable.
- Raise the side rail on the side you were working. If you elevated the bed, bring it back to the original height.
- If the resident has a call bell, make sure she can reach it in the bed.
- Throw away your gloves and wash your hands.

Information in this section was taken from "Module 10: ADL: Ambulating; Making a Bed" of the following curriculum:

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

## 11.2.12 Laundry

§ Laundry is also considered a part of personal care services. Each assisted living community handles laundry differently, in terms of who provides it and how often. Some residents do laundry themselves, some family members do laundry for residents, and some assisted living facilities provide it as a service for residents. If appropriate (if the students are receiving training by the assisted living facility in which they will be working), review the facility policies on how laundry is provided. Describe which staff persons are responsible for laundry and what they are expected to do.

## 11.2.13 Other Personal Care Functions and Tasks

Personal care services includes providing support services for residents that include assistance with arrangements for transportation, arrangements for shopping, use of the telephone and correspondence. Each assisted living facility is different in how it handles how staff assist residents with these services. If training staff to work at a particular assisted living facility, review the facility policy on how and by whom these services are provided.



### Personal Skills Checklist – Handout #2

**Instructor Notes:** The instructor should demonstrate to the class how to perform each skill. The instructor should then allow the direct care staff to demonstrate on each other how to perform each activity on Handout #2. Once all the students have completed the practice sessions, the instructor should observe each student demonstrate each skill independently. The instructor should sign-off on Handout #2 in each student's manual that the direct care staff member has successfully demonstrated the skill.

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40-72-450	Personal care services and general supervision and care
22 VAC 40-72-460	Health care services
22 VAC 40-72-720	Personal possessions
22 VAC 40-72-760	Laundry and linens

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

## **Bibliographies and Resources**

Paraprofessional Healthcare Institute. (2009). ***Providing Personal Care Services to Elders and People with Disabilities***. Retrieved from <http://phinational.org/>.

## Student Review - Chapter 11

1. What does it mean for personal care to be resident-centered?

- a. **Resident care is personalized. Each individual resident will need different degrees and types of assistance as specified by his or her individualized service plan. Resident care is tailored to the resident's needs and preferences.**
- b. **Residents have the right to participate in all decisions about their care, including how personal care is given. Residents should be involved as much as possible in their personal care.**

2. What types of changes in a resident should you know to observe?

Report all changes to your supervisor. Here are some specific changes to be aware of:

**a. Physical changes in a resident**

**i. In terms of their skin, what changes do you see? Do you notice:**

1. **Bruising**
2. **Swelling**
3. **Pressure areas (such as reddening of skin in a particular area)**
4. **Dryness**
5. **Sores or burns on heels and elbows**
6. **When reporting these changes, be sure to describe location, size, and appearance**

**ii. Do you see weight loss or gain?**

**iii. Are there changes in a resident's level of physical function?**

**Some examples might be:**

1. **You notice that a resident is no longer able to perform personal care for himself or herself.**

2. You notice that a resident can no longer do her hair or shave his face.
3. There are changes in range of motion of upper and lower extremities.
  - a. Range of motion refers to the normal range of movement for a joint (how far it can be stretched or bent).
  4. There are changes in the level of overall mobility, i.e. it is harder for the resident to get in and out of the shower.
- b. Emotional or cognitive changes in a resident
  - i. When helping with personal care, do you notice changes in a resident's mood or behavior? Report all changes to your supervisor- they could be an indication that something is wrong.
  - ii. Some things to look for:
    1. Changes in personal habits
    2. Resident suddenly does not want to get dressed
    3. Failure to change clothes
    4. Failure to shave or comb hair
    5. Resistance to assistance with personal care
3. **True** People with dementia need simple, one step directions when performing personal care.
4. What are some things to think about when maintaining privacy and preserving dignity while bathing?
  - a. Is the door or curtain closed
  - b. Is the person covered up as much as possible before, during, and after bathing
  - c. Would the person like to be covered by a towel or blanket
  - d. Are you addressing the resident by name

- e. **Have you introduced yourself to the resident**
5. What is a “bathroom schedule” and why is it important?
- a. **It is also known as a bowel and bladder program.**
  - b. **Assisting a resident to use the bathroom on a regular schedule can help avoid bowel and bladder “accidents” and help prevent or minimize incontinence.**
  - c. **Helping a resident to maintain a bathroom schedule helps to protect dignity and supports independence.**
  - d. **An example of a bathroom schedule is taking a resident to the bathroom every two hours throughout the day. Note that schedules should be individualized to meet the unique needs of each resident.**
6. **False** All residents like their food to be cut up for them.  
**Each resident has individual preferences and needs. Maximize independence by supporting residents in doing as much as they can on their own.**
7. **True** Do not cut nails of a diabetic resident without approval from a physician.



**Chapter Eleven – Daily Routines**

<b>ROUTINE</b>	<b>TIME (AM/PM)</b>
Time getting up each day	
Time eating breakfast each day	
Time doing the breakfast dishes each day	
Time eating lunch each day	
Time watching television each day	
Time leaving the house each day	
Time spent outside each day	
Time eating dinner each day	
Time bathing each day	
Time going to bed each day	

<b>FAVORITE ACTIVITY</b>	
Favorite breakfast meal	
Favorite lunch meal	
Favorite dinner meal	
Favorite outside activity	
Favorite activity when leaving the house (i.e. bridge club)	
Favorite television show	

*The Instructor should read the following narrative to the class. Prior to reading the narrative, ask the students to review their responses one more time and follow along as you read. The instructor should complete the table as well and discuss his or her answers with the class during the discussion.*

*Instructor narrative:*

Congratulations!! You have now moved into Great Assisted Living. Let me give you an idea about the daily routines in your new home. You will be woken up by a direct care staff member anywhere from 5:30am – 7:15am depending on your care needs. You will be taken to the dining room as soon as you are dressed to wait for breakfast. If you come to the dining room on your own, breakfast is served from 8:00am – 9:00am. If you are late, the staff may complain because they have already served everyone else their plates. Breakfast will be eggs, bacon, and grits with juice unless you have a special diet, then you get the alternate. Your physician has written a prescription to limit your caffeine so you will not be able to get a cup of coffee at breakfast. The dining room closes at 9:00am so make sure you are finished eating by then because the kitchen has to do the dishes. Lunch is served from 11:00am – 12:00pm. Again, get there as close to 11:00am as possible. Lunch will be breaded liver and onions with a potato and corn. If you need assistance to the dining room,

you may be brought to the dining room as early as 10:15am to sit and wait. The activity calendar states that the Price is Right will be on at 10:00am and that the outside activity of gardening is at 2:00pm. Dinner is served from 5:00pm – 6:00pm. Again, get there as close to 5:00pm as possible. Dinner will be minestrone soup and a sandwich. Your shower days will be Tuesdays and Fridays. Staff will come in some time during the 3pm-11pm shift to put you in the shower. The staff will put you in bed after your shower, even if it is 8:00pm. You asked the staff to change the time because they always interrupt Jeopardy but they have other residents to take care of and it will interrupt their schedule.

*Instructor:*

*Return to the curriculum for discussion points.*



**Personal Care Skills Checklist**

<b>Personal Care Skill</b>	<b>Demonstration</b>	<b>Return Demonstration</b>	<b>Independent</b>
Assisting Residents with Bathing- tub bath			
Assisting Residents with Bathing- shower			
Assisting Residents with Bathing- bed bath			
Assisting Residents with Bathing- peri-care			
Assisting Residents with Dressing			
Assisting Residents with Bathroom Needs- using the toilet			
Assisting Residents with Bathroom Needs-adult disposable briefs lying down			
Assisting Residents with Bathroom Needs- adult disposable briefs standing up			
Assisting Residents with Transferring			
Assisting Residents with Eating			
Assisting Residents with Mouth Care- Tooth brushing			
Assisting Residents with Mouth Care- Dentures			
Assisting Residents with Skin and Nail Care			
Assisting Residents with Shaving			
Assisting Residents with Hair Care			
Care of Eyeglasses and Hearing Aids			



# **Transfer and Ambulation**

## **Chapter Twelve**

**3 hours**

## **Chapter 12 – Transfer and Ambulation**

This chapter provides the student with information on the basic skills needed to safely and correctly transfer (move) a resident. The direct care staff member will learn about proper body mechanics, including how to lift properly, avoid unnecessary physical stress, the proper way to perform resident transfers and how to properly assist the resident with ambulation. These areas will be described in order to instruct the direct care staff member how to prevent injury to him or herself and the resident. This chapter will also describe methods the direct care staff member can use to help encourage and help the resident learn to transfer independently or with minimal assistance.

### **12.1 The Basics of Body Mechanics**

### **12.2 Transferring a Resident**

### **12.3 Assisting the Resident to Ambulate**

### **12.4 The Hospice Resident**

### **12.5 Staff Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes**

- a. To describe the importance of using good body mechanics
- b. To describe the causes of most back injuries and how to prevent those injuries
- c. To define safety issues for both staff and residents
- d. To describe and be able to demonstrate the basic transfer techniques utilized in assisted living (i.e. moving the resident in bed, transfers from bed to chair, etc. and techniques to assist the resident with ambulation)

### **2. Recommended Method of Instruction**

- Discussion and Lecture
- Student Activity – Instructor Demonstration of Lifting, Bending, Transferring
- Student Review – Chapter Twelve

## 12.1 The Basics of Body Mechanics

This section will provide a description of the basic techniques of good body mechanics. Good body mechanics allow the staff member to transfer the resident with less difficulty and helps to prevent direct care staff and resident injury. Good body mechanics aids in performing tasks more efficiently as well as increasing a resident's confidence in the staff's abilities. This section will also discuss causes of staff injuries. The basics of good body mechanics are applicable to one-, two-, and three-person transfers.

- What are body mechanics?
  - Body mechanics refer to individuals using muscles properly in order to move and to lift objects without injury.
  - Proper body mechanics is using an individual's strongest groups of muscles all at the same time. By doing this, the individual maximizes his or her strength and reduces the potential for strain.
- Causes of staff back injuries
  - Poor posture and body mechanics.
  - Stress.
  - Loss of flexibility.
  - Decreased physical fitness.
- Common mistakes in body mechanics
  - Poor posture
  - Improper lifting techniques.
  - Bending and twisting at the waist.
  - Fast jerking motions.
  - Carrying the resident.
  - Poor planning of transfers.
  - Failure to communicate with the resident regarding the lift or transfer steps being done.
  - Failure to get help with lifting.

- Wearing shoes that are not non-skid soles.
- Failure to use assistive devices or failure to use assistive devices properly.
- The basics of good body mechanics
  - Stay close to the individual being lifted or moved – do not reach or stretch.
  - Keep your back in good alignment (straight) while lifting and transferring.
  - Bend your knees and keep your back straight.
  - Use legs to support the weight being lifted. Do not use your back!
  - Bring resident close to your body before lifting (like dancing).
  - Don't twist - utilize a pivot or side step instead of twisting at the waist. Turn your entire body.
  - Keep stomach muscles tight while lifting.
  - Keep feet apart. Feet should be shoulder-width apart. This provides a wide base of support.
  - Keep head upright while lifting or transferring.
  - Keep neck straight and chest high.
  - Keep shoulders back.
  - Use body weight and momentum to move the resident.
  - Plan ahead before moving the resident.
  - Have proper equipment available for transfer and make sure it is properly positioned and locked. Examples of proper equipment include:
    - Gait (transfer) belt.
    - Chair, commode, wheelchair, walker, bedside rails.
  - Ask the resident to help - explain what you are going to do and give the resident specific step-by-step instructions on what you need the resident to do. Make sure the resident is ready before you begin.

- Get assistance from another person when needed.



### **Instructor Demonstration – Proper Body Mechanics**

**Instructor Notes: Demonstrate the improper way (i.e. twisting) of body mechanics that may cause injury. Demonstrate what is meant by proper body mechanics. Have each student also demonstrate these moves. Observe each student and correct any body mechanics done incorrectly. Thoroughly explain what moves were done incorrectly and how to correctly do it. If a gait belt is available, demonstrate the proper method of putting it on. If a gait belt is not available, thoroughly describe the proper method for putting it on.**

## **12.2 Transferring a Resident**

This section will describe the techniques to use when transferring a resident from location to location. It is extremely important that the resident is an active participant during the transfer process to the maximum extent able. The resident can be a participant even if he or she is not physically able. Regardless of the resident's physical condition and cognitive ability, the direct care staff member should explain what he or she is doing each time the resident is transferred. If the resident is able to participate, the staff member should also thoroughly explain what he or she needs the resident to do in order for the resident to provide assistance.

- Transferring from bed to regular chair/wheelchair and back (one-person transfer):
  - If the resident is being transferred into a wheelchair, make sure both breaks are locked on the wheelchair and that the leg rests have been unlocked and moved to each side of the wheelchair. Failure to do so can result in falls and skin tears causing potential injury to the resident and staff member.
  - The direct care staff member should explain to the

resident that it is time to transfer to a new location. Be specific about the location the resident is currently in and the location where the resident is being transferred. For example, "Mrs. Jones, I am going to move you from the bed to the wheelchair."

- The direct care staff member should explain to the resident what is going to be done and provide specific instructions on what the direct care staff member will need the resident to do to provide assistance. For example, "Mrs. Jones, once you are standing, I'm going to need you to help me turn your body to the left. Once I have started to lift you, reach your left hand behind you and place it on the left arm of the wheelchair for support." You may have to give these instructions one at a time, repeat them, and demonstrate them to the resident. This will become more automatic as you learn more about each resident.
- Have the resident sit on the edge of the bed:
  - Ask the resident if he or she is experiencing any dizziness. If the resident is experiencing dizziness, he or she is probably experiencing orthostatic hypotension (drop in blood pressure as a result of sitting up too quickly).
  - Allow the resident to sit up on the bed for a minimum of five (5) minutes until dizziness subsides. It is important that the resident is not moved while experiencing dizziness as this increases the resident's fall risk and reduces the ability of the resident to assist in the transfer. It can result in a swift drop in blood pressure. It also can contribute

- to the resident's fear of falling from feeling dizzy.
- Do NOT leave the resident alone and stay within arm's reach of the resident while resident is sitting up on the side of bed.
  - Position the wheelchair along the side of the bed on the resident's strongest side. Again, make sure the wheelchair legs have been moved and that the wheelchair is locked.
  - Place the gait belt around the resident's waist - hold onto the belt and not to the resident.
  - Have resident reach across chair to farthest arm rest and pivot into the chair.
  - The method above should be used for residents that only need one direct care staff member to assist with transfers.
  - If the resident can bear full weight:
    - Stand directly in front of the resident with feet positioned on either side of the resident's feet.
    - Do not allow the resident to hold on to you.
    - Keeping your back straight and bending your knees, reach around the resident, grasp the transfer belt on each side of resident's waist.
    - Have the resident lean slightly forward and push up with his or her feet.
    - Lean back and assist the resident to stand.
      - Pivot the resident and lower into wheelchair.
      - Reverse the procedure for returning the resident to bed (If the resident is in a wheelchair, make sure the wheelchair is

locked prior to transfer).

- If the resident cannot bear full weight:
  - Once the resident is sitting up on the side of the bed, as previously described, slide the resident forward until his or her feet are flat on the floor. Do not let go if the resident is not capable of sitting in an upright position without assistance.
  - Place the resident's hands in his or her lap.
  - The direct care staff member should place his or her arms around the resident's waist.
  - The direct care staff member should have his or her feet on the outside of each of the resident's feet and the resident's knees should be on the inside of the direct care staff member's knees.
  - If the resident is able, have the resident place his or her arms on your shoulders and ask the resident with the arm closest to the wheelchair to reach for the farthest wheelchair arm.
  - The direct care staff member should get a secure hold on the back of the resident's gait belt. If a gait belt is not available, the back of the resident's pants may be grabbed if necessary.
  - Pull towards you on the belt to lift the person up. DO NOT FORGET TO TALK THE RESIDENT THROUGH THIS PROCESS.
  - Begin to pivot towards the wheelchair and gently lower the resident into the wheelchair by bending your hips.
  - Lock the footrests in proper position.

**NOTE: If a resident has a catheter, the catheter must be moved and fastened to the wheelchair prior to transfer. Make sure the catheter tubing is not obstructing the transfer and that it will not get pulled during the transfer process.**

- Completing a Two-Person Transfer
  - Make sure the wheelchair is locked and that the leg rests have been moved prior to starting the transfer.
  - Prior to the transfer, the direct care staff member should instruct the resident to place his or her elbows as close to the side of the body as possible. If the resident is not physically capable of doing this, the direct care staff member shall move the resident's arms and elbows into the proper position.
  - The direct care staff member that is taller should stand at the back of the resident; the other direct care staff member should stand on the side of the resident opposite of the transfer location.
  - The direct care staff member standing at the back of the resident should put his or her arms under the resident's armpits and fold his or her arms over the resident's chest. This direct care staff member should make sure his or her feet are spread far enough apart to maintain proper balance and support.
  - The other direct care staff member should be standing on the side of the resident and place both arms under the resident's thighs clasp one hand over the opposite wrist. This will support the buttocks and lower legs.
  - Both direct care staff members should have their knees and hips slightly bent.

- On the count of three, both direct care staff members should slowly straighten their hips and their knees so they are lifting the resident at the same time. The direct care staff members should slowly walk toward the new location for the resident and gently place the resident there.
- The resident should be made comfortable and asked by one of the direct care staff members if he or she needs anything. The direct care staff members should get the resident what is needed prior to exiting the room. Always make sure that the call bell is in hand's reach of the resident.
- Transferring to and from a shower or tub
  - Utilize the same procedure for transferring resident from bed to chair.
  - Wheel or walk with the resident to the bathroom or shower room. If pushing a resident in a wheelchair, do not pull resident backwards - push the wheelchair forwards. The resident has the right to see where he or she is going.
  - Use a tub seat, shower seat or shower chair if possible.
  - Use a gait belt.
  - Only a resident with sufficient strength should be lowered into a tub.
  - Have resident sit on edge of tub.
  - Assist the resident to place one foot into the tub at a time.
  - Lower the resident into the tub, utilizing the belt.
  - Remove the resident by reversing the procedure.
- Transferring to and from a commode
  - Utilize the same procedure for transferring resident from bed to chair.

- If transferring from a wheelchair to a bedside commode, make sure the wheels on the wheelchair are locked!!
- Transferring to and from motor vehicles
  - Utilize the same procedure for transferring a resident from bed to chair.
  - Have resident sit on seat first - may use a transfer board if needed.
  - Assist resident to place one foot at a time into the car.
  - Upon exiting a car, reverse the above.

### **12.3 Assisting the Resident to Ambulate**

Many residents may need assistance in getting up out of a chair or out of bed, but do not need physical assistance with ambulation. This section will discuss general rules on how to utilize a gait belt when walking with a resident that may be unsteady, how to assist a resident to a standing position and how to lower a resident to a seated position.

- Utilization of a gait belt to assist with ambulation
  - Place gait belt snugly around resident's waist.
  - Stand slightly behind and to the resident's weakest side and hold tightly to the belt.
  - Do not hold on to the resident or let the resident hold on to you.
  - If resident starts to fall, sidestep with the resident - don't keep feet planted; bend one knee and allow the resident to slide down your leg slowly to the floor. Get help.
- Assisting a resident to a standing position
  - If the resident is seated in a wheelchair, make sure the wheelchair is locked and that the footrests have been unlocked and moved to the sides of the wheelchair.
  - If the resident will be using a walker, cane, or other assistive device to ambulate, place the assistive device in front of the

- resident as close to the currently seated location as possible.
- The direct care staff member should direct the resident to do the following:
    - Remind the resident not to grab the walker or other assistive device until he or she is in a standing position and completely steady.
    - Place both hands on the armrests of the chair.
    - Place feet flat on the floor keeping them approximately 12" apart to create a good support.
    - Lean forward with the shoulders directly above the knees.
    - Push with arms and legs to a standing position.
  - Once the resident is in a standing position, he or she should be told to grab the walker, cane, or other assistive device. If using a walker, the resident needs to be told to grab the walker using one hand at a time.
  - If the resident does not have the strength to push up out of the chair independently, the direct care staff member should stand on the weakest side of the resident, place his or her elbow under the resident's arm, and assist the resident on the count of three. Remind the resident to begin pushing up as the direct care staff member is lifting.
  - The direct care staff worker should make sure the resident is steady prior to the resident ambulating.
  - Utilization of walker, cane and crutches to ambulate
    - Have a physician, nurse, therapist or qualified durable medical equipment provider determine the extent of the resident's need of and the proper use of assistive devices.
  - Walker
    - Have resident keep both hands on the walker at all times with feet about 6 inches apart for balance.

- Have resident first place the walker about 6 inches ahead, then walk "into" the walker, stepping forward about 6 inches with one foot and then the other. This reduces the possibility of the resident falling backwards.
- Have resident then move the walker again.
- Use a walker with front wheels if the resident has back problems or extreme weakness.
- Canes – for straight or quad canes
  - The cane should be at the proper height. The top of the cane should reach to the crease in the resident's wrist when the resident stands up straight. The elbow should bend a bit when resident holds the cane.
  - Have resident hold the cane on the strong side [opposite from the side that needs the most support] about six inches to the side and 12 inches in front of the strong foot.
  - Have resident move weakest leg forward and even with the cane.
  - Then have resident step through with the stronger leg.
  - Finally have resident move the cane 12 inches forward and continue stepping.
- Crutches
  - Make sure crutches are properly sized – this should be done by a licensed physical therapist.
  - Crutches should not be tucked under the resident's arms.
  - The resident's shoulders should be level with the arms bent.
  - The resident should bear weight on the unaffected leg. The resident should place both crutches forward and step with strongest leg first then swing affected leg through.
- Assisting a resident to a seated position
  - The resident should be instructed to approach the wheelchair/chair from the side and make sure that both wheels

- of the wheelchair are locked.
- The resident should turn his or her back towards the chair. The resident should turn in the direction of his or her strongest side.
  - The resident should take small steps backwards toward the chair until the back of the resident's knees come in contact with the front of the chair.
  - The resident should reach back using his or her strongest side and firmly grab the armrest.
  - The resident should lean forward while bending at the knees and hips and slowly lower him or herself into the chair.
  - If the resident is unsteady, the direct care staff member should stand on the weakest side of the resident place his or her elbow under the resident's arm and assist in lowering the resident to the chair.



### **Demonstration of Good Body Mechanics**

#### **Instructor Notes:**

*The purpose of this activity is to demonstrate good body mechanics and to have the students demonstrate the proper techniques of lifting, bending and transferring.*

*Activity procedures:*

1. *Demonstrate the proper techniques of the following transfers below:*
  - a. *One-person transfer*
  - b. *Two-person transfer*
  - c. *Assisting a resident to a standing position and seated position*
  - d. *Assisting a resident with ambulation*
2. *Once you have demonstrated the above techniques, observe each student demonstrating the same techniques.*

## 12.4 Bed Bound Residents

This section will describe how to properly position a resident that is bed bound. Properly positioning a resident increases the resident's ability to rest more comfortably.

- Properly positioning a resident
  - Resident's that are bed bound should be turned every two (2) hours, at a minimum and perhaps more often. Turning a resident every two hours decreases the risk of skin breakdown that can cause discomfort and lead to decubitus ulcers (bed sores).
- Raising/lowering a resident's head and shoulders
  - Wash your hands prior to entering the resident's room.
  - Make sure you have clean gloves.
  - Greet the resident by name when you enter the room.
  - Explain to the resident why you are in the room and what you are about to do. Explain to the resident what you will need him or her to do to assist you. This should be done regardless of whether the resident is actually physically able to participate. § The resident has the right to be part of the entire care process.
  - If the resident is in a hospital bed, make sure the wheels of the hospital bed are locked. If the resident has side rails, lower the side rails immediately prior to lifting the resident.
  - Stand facing the bed keeping your feet about 12 inches apart.
  - Bend your arm that is closest to the resident with your fingers pointing towards the head of the bed. Place your arm between the resident's arm and body. Reach under the resident with your hand and hold the resident's shoulder.

- If the resident is able, ask the resident to reach up and hold on to your shoulder.
- Place your other arm under the resident's neck and shoulders placing your hand on the resident's shoulder that is farthest from you.
- Tell the resident that you are going to move him or her on the count of three (3). For example, "Mrs. Jones, I am going to lift your head and shoulders now. I am going to do this on the count of three (3). Are you ready?"
- Count loud enough for the resident to hear you. On the count of three (3), take the weight off the foot that is closer to the head of the bed and place it on the foot that is closer to the foot of the bed. Slowly lift the resident supporting his or her head to help the resident sit up a little. Use a rocking motion as necessary.
- Remove the arm that is behind the resident's neck and use it to add pillows to help the resident's head become elevated. The same procedure would be used if you were removing pillows to lower the resident's head.
- Make sure the resident is comfortable. For example, "Mrs. Jones, I have finished raising/lowering your head now, are you comfortable?" If the resident states no, readjust the pillows and continue to ask the resident until the resident is comfortable.
- Ask the resident if he or she needs anything else prior to exiting the room.
- If the resident is in a hospital bed with side rails that you previously lowered, make sure to raise the side rails prior to leaving the resident's bedside.
- Wash your hands after exiting the room.

- Transferring a resident that cannot assist
  - Prepare for the transfer in the same manner you would prepare for a one-person transfer described earlier in the chapter. If the resident is more than one-fourth your body weight, make every effort not to lift/transfer this resident without assistance.
  - Slide the resident to the side of the bed while the resident is still in a lying position.
  - Cross the resident's arms across his or her chest.
  - Make sure your feet are spread far enough apart to provide proper support.
  - Slightly bend at the knees placing one arm under the resident's neck and the other arm under the resident's knees.
  - Pull the resident close to your body, using your leg strength, while lifting up. Make sure to keep your back straight!
  - Keep your knees bent and take small steps toward the wheelchair. Gently lower the resident into the wheelchair.
  - Make sure the resident is properly seated in the wheelchair and is comfortable.
  - If the resident has a wheelchair belt, fasten the belt to prevent the resident from falling out of the wheelchair.

NOTE: The transfer method described above is not the ideal way to transfer a resident that cannot assist. When transferring a resident with limited ability to pivot or assist with transferring, it is always better for the safety of the resident and the staff member to use the two-person assist transfer method. If a one-person transfer is the only option, extreme care and caution should be taken when transferring the resident.

**Instructor Notes: The method above should be used when transferring an immobile resident to and from other locations as well (i.e. wheelchair to commode; wheelchair to shower bench).**

- Turning a resident properly in the bed
  - Wash your hands prior to entering the resident's room.
  - Make sure you have clean gloves.
  - Greet the resident by name when you enter the room.
  - Explain to the resident why you are in the room and what you are about to do. Explain to the resident what you will need him or her to do to assist you. This should be done regardless of whether the resident is actually physically able to participate. § The resident has the right to be part of the entire care process.
  - To turn a resident away from you:
    - Move the resident's body towards the side of the bed where you are standing. Use the same procedures that would be used if you were moving a resident to the side of the bed.
    - Place the residents hands and arms on his or her chest crossing them
    - Place one of your hands under the resident's shoulder and the other hand on the resident's hip. Gently roll the resident away from you on his or her side so his or her back is facing you.
  - To turn a resident toward you:
    - Make sure there is enough space on the bed for you to turn the resident toward you. If not, go to the opposite side of the bed and use the same procedures that would be used if you were moving a resident to the side of the bed then return to the

- opposite side of the bed.
- Cross the resident's leg that is farther from you over their other leg.
- Hold the resident behind his or her shoulder with one hand and behind the hip with the other hand.
- Gently roll the resident toward you.
- Whether you have turned a resident away from you or toward you:
  - Make sure the resident's head is on the pillow.
  - Make sure the resident is not lying on his or her arm.
  - Make sure that the arm on top is being properly held up by his or her body.
  - Make sure that the resident's back is being properly supported with either a wedge, pillow, or blanket that has been rolled up.
  - Make sure that the resident's top knee is bent and that both knees are not resting on top of one another. The top leg should be supported by a pillow or wedge.
  - Make sure the resident's hip is in the correct body alignment.
  - Make sure the resident is comfortable. For example, "Mrs. Jones, I have finished turning you now, are you comfortable?" If the resident states no, readjust the pillows and continue to ask the resident until the resident is comfortable.
  - Ask the resident if he or she needs anything else prior to exiting the room.
  - If the resident is in a hospital bed with side rails that you previously lowered, make sure to raise the side

rails prior to leaving the resident's bedside.

- Wash your hands after exiting the room.

## **12.5 Staff Responsibilities**

- Staff are responsible for the safety and general welfare of the resident while performing transfers and assisting the resident in ambulating or changing position.
- Staff is responsible for respecting all Rights and Responsibilities of Residents of Assisted Living Facilities.
- Staff is responsible for knowing facility policies for proper resident care and injury prevention.
- Staff is responsible for teaching residents how to avoid falling and prevention of other potential injuries.

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40 72-470 Restorative, habilitative and rehabilitative services

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Student Review - Chapter Twelve

1. List three [3] causes of most back injuries:

**Poor posture**

**Poor body mechanics**

**Stress**

**Loss of flexibility**

**Decreased physical fitness**

2. List six [6] of the basic components of good body mechanics:

**Keep your back in good alignment while lifting and transferring**

**Use legs to support the load - not your back!**

**Bend your knees and keep your back straight**

**Bring resident close to your body before lifting**

**Don't twist - utilize a pivot or side step instead of twisting at the waist**

**Keep stomach muscles tight while lifting**

**Keep feet apart - utilize a wide base of support**

**Get assistance from another person when needed**

**Keep head upright while lifting or transferring**

**Use body weight and momentum to move the resident**

**Plan ahead before moving the resident**

**Have proper equipment available for transfer and make sure it is properly positioned and locked:**

**Transfer belt**

**Chair, commode or wheelchair, walker**

**Ask the resident to help - explain what you are going to do**

3. Before moving a resident, the first thing you should do is **explain** what you are about to do.

4. All equipment on wheels should be **locked**.

5. **False** When transferring a resident, you should always have the resident hold on to you for security.

6. **True** When ambulating a resident, stand on the resident's weaker side.

7. **False** While ambulating a resident, if the resident begins to fall, you should make every attempt to catch the resident to prevent the fall.
8. The resident using a walker should move the walker ahead **six** inches at a time.
9. A resident should hold a cane on his **strong** side. Crutches are sized by a **physical** therapist.

# **Emergency Preparedness and Injury Prevention**

## **Chapter Thirteen**

**Time Required: 1.5 hours**

## **Chapter Thirteen – Emergency Preparedness and Injury Prevention**

This chapter will focus on emergency preparedness and injury prevention. Emergency preparedness describes a wide span of potential incidents from basic first aid to natural disasters. Emergency preparedness is a combination of all staffs participation to reduce the risk that an emergency may occur. This can include basic direct care measures to safeguarding the environment. This chapter also describes the important role that the direct care staff plays during emergencies and the importance of understanding preventative measures, and immediate action when an emergency occurs. The specific protocols regarding emergency preparedness and injury prevention largely depend on specific facility policies, procedures, and protocols. Facility protocols should be used in conjunction with this chapter and this chapter should supplement the material already present in the facility policies and procedures.

- 13.1 Common Injuries and Injury Prevention in Assisted Living**
- 13.2 Emergency Supplies and Medical Emergency Techniques**
- 13.3 Emergency Preparedness and Natural Disasters**
- 13.4 Staff Responsibilities**

## Instructor Planning

### 1. Objectives and Expected Outcomes of Chapter

- a. To understand the most common injuries that occur in assisted living.
- b. To understand the basic concepts behind injury prevention.
- c. To understand basic first aid techniques.
- d. To be knowledgeable of emergency preparedness as it pertains to natural disasters.
- e. To be knowledgeable of emergency supplies (the contents of first aid kits), how to use those items, and where those first aid kits are located throughout the building.
- f. To understand direct care staff responsibilities as it pertains to all aspects of emergency preparedness.
- g. To be knowledgeable and understand how to apply basic first aid techniques.

### 2. Recommended Method of Instruction

- Lecture and class discussion
- Student Activity – **Handout #1**
- Student Activity - Demonstration of items in first aid kit and grab bag game
- Facility's Emergency Supplies (First Aid) protocol
- Facility's Emergency Preparedness protocol
- Student Review - Chapter Thirteen

## 13.1 Common Injuries and Injury Prevention in Assisted Living

Unintentional Injuries are the ninth leading cause of death in the older adult population. Most injuries experienced by older adults are preventable. This section will describe the most common injuries that occur in assisted living facilities, environmental influences that contribute to injuries, and preventative strategies that can be implemented to reduce the number of injuries.

- Falls
  - Falls are any incident that occurs where a resident lands on the floor or lands on an inanimate object. Older adults often do not call these falls, but slip, trip, stumble, or sat down. This would include slipping off the edge of the bed or wheelchair and tripping and landing on a dresser. Falls are the number one cause of non-fatal emergency room visits for the older population and are one of the most difficult problems in an assisted living facility. Falls can have serious consequences as they can decrease the resident's ability to function at his or her highest level and can increase the resident's risk of co-morbidity and even death. Falls can temporarily, if not permanently, alter the resident's life. If a resident does not become physically injured during a fall, the resident may have serious psychological impacts as he or she can develop a fear of falling. This fear of falling can lead a resident to limit activities because he or she is scared a fall might occur. This decreased activity can result in reduced mobility, reduced physical fitness, and can actually increase the risk for falls.
  - Resident Risk Factors in Falling
    - Gait and balance problems.
    - Decreased mobility.
    - Medication changes (MRPs).
    - Decreased range of motion.

- Incontinence – sense of urgency to get to the restroom.
- Seizures or strokes.
- Nutritional deficiencies.
- Poor vision.
- Pain.
- Depression.
- History of falls.
- Use of psychotropic medication.
- Environmental Risk Factors in Falling
  - Wet, waxed, or slippery floors.
  - Stairs or steps without anti-slip strips.
  - Inappropriate bed height.
  - Poor placement of furniture or equipment.
  - Trip hazards such as oxygen tubing or clutter.
  - Poor lighting or color scheme on floors.
  - Inappropriate shoes.



### Group Question

**Instructor Notes: Ask the students the following question:**

**Name three strategies to prevent falls in each of the categories below (General Rules, Environment – Resident Room and Public Areas). Supplement their responses with the information below and discuss how each item can reduce falls.**

- General Rules in the Reduction of Falls
  - Medical treatment, rehabilitation, and environmental changes should occur together in order for fall prevention strategies to be effective. Falls can be a symptom of an underlying medical condition not yet diagnosed. The following are fall prevention strategies that should be implemented with all residents living in assisted living:

- All staff, regardless of department, should be trained on fall risk factors, recognizing residents at risk and corresponding prevention strategies.
- All residents should be assessed for fall risk prior to move-in and at least annually to determine a change in fall risk status.
- Residents should also be re-assessed if the resident starts falling or has a change in status that would increase his or her level of care.
- Develop a bowel and bladder toileting schedule to reduce the sense of urgency to get to the restroom.
- Report changes in resident's health (i.e. dizziness or unsteady gait; medication changes) immediately to supervisor and document in resident record.
  - Any change in resident condition could change fall risk status.
- Report any broken or malfunctioning equipment.
- Respond promptly to resident needs (i.e. request to go to the bathroom, etc.):
  - Look for signs that may indicate the resident may need to use the restroom.
  - Escort residents needing toileting assistance to the bathroom every two (2) hours. This will reduce the urgency to go to the restroom which can lead to falls.
- Encourage residents to sit on the edge of the bed for a few minutes to avoid getting dizzy when standing up when they first wake up and at any time the resident is getting ready to transfer.

- Caution should be taken when approaching a resident from behind so that the resident isn't startled and doesn't lose their balance. Never do this! This is particularly important when working with residents with dementia as this can also put you at risk of causing aggressive behavior in the resident.
  - Use brakes/locks on wheelchairs when attempting to stand.
  - Encourage residents to use the grab bars when entering or exiting the shower or tub.
  - Encourage resident to wear glasses and hearing aids when walking around, particularly at night (i.e. when going to the restroom):
    - Make sure eyeglasses are clean and hearing aids are functioning properly. Make sure both are worn properly.
    - Make sure resident visits an eye doctor at least once a year to insure the prescription is correct on the glasses.
  - Make sure resident is wearing proper shoes
    - Shoes should have low and even heels.
    - Soles of shoes and slippers should have tread.
    - Gripper socks are recommended to be worn when the resident cannot, or chooses not, to wear shoes.
- Environment in the reduction of falls
  - Residents Room
    - Clean up spills immediately.

- Reduce clutter. Make sure there is a clear pathway for the resident to walk. The resident should never have to walk around furniture to move around his or her room.
- Residents should be encouraged to remove all throw rugs and bathmats. Double-sided tape or a non-stick backing can be used; however, throw rugs and bathmats can still contribute to falls if a resident catches his or her walker or cane on it.
- Keep personal items within reach.
- Encourage resident to use assistive device (i.e. cane, walker, wheelchair, etc.) instead of furniture for stability while walking around room.
  - Make sure assistive devices have the rubber-covered tips to prevent snagging of the assistive device which can lead to falls.
  - Make sure residents are seated properly in the wheelchair. Sitting too close to the end of the wheelchair or scooting forward while rolling the wheelchair could result in the resident slipping out of the chair onto the floor.
- Keep oxygen tubing at a relatively short link and place concentrator in a location that would not allow the tubing to go all the way across the floor.
- Keep telephone cords short so they cannot stretch across the room.
- Discourage the use of placing items on high shelves or using a step stool in the resident's room.
- Keep area well lit. Keep a light by the bed so the resident can cut it on before the resident attempts to go to the

restroom. Keep a night light on in the hallway and in the bathroom at night.

- Use non-slip rubber mats or self-stick strips in the bathtub.

○ Public Areas

- Keep all equipment and furniture in good repair.
- Furniture should not be lightweight or unstable.
- All chairs should have arms on them to reduce the risk of falling when standing up and sitting down.
- Keep handrails free, unobstructed and secured to the wall, shower, etc.
- Keep hallways, dining room, and activity areas clean with nothing obstructing the walking areas.
- Cut all loose threads in carpet.
- Lights in the hallways of the assisted living need to be kept on at all times, especially at night.

○ Other recommendations

- Provide resident with a responder necklace or bracelet so he or she may call for help if falls occur out of range of a call bell cord or telephone.
- Encourage a regular exercise program
  - Exercise can maintain a resident's strength, range of motion, and balance.
  - Yoga, Tai Chi, and Qi Gong have been shown to reduce falls in older adults by increasing strength and improving balance.
- Have a pharmacist conduct a medication review of prescription and non-prescription medications. Eliminating non-essential medications or reducing dosages can reduce side effects and drug interactions.

- Residents that do fall frequently can wear hip pads to help prevent a hip fracture.



### **Student Activity**

- Scenario - **Handout #1**

#### **Instructor Notes:**

*The purpose of this scenario is to show direct care staff the importance of their active participation in injury prevention and emergency procedures. This activity should allow them the opportunity to “think outside the box” through determining what may have caused this incident and strategies to implement to prevent a future occurrence. It is important that direct care staff understand that they are integral to the entire care process.*

*Activity procedures:*

- 1. Have the students turn to **Handout #1** in the student manual and read the scenario individually.*
- 2. Read the scenario aloud to the class prior to discussing the events in the scenario.*
- 3. Have the students complete the questions at the end of the scenario.*
- 4. Ask students to discuss their responses and encourage others in the class to supplement the initial responses.*

- Skin Tears (Wounds)
  - Skin tears occur when the epidermis and dermis become separated. In older adults, the majority of skin tears occur on the arms and hands. Age-related factors, such as reduced skin collagen and elasticity, make the skin less able to withstand normal wear and tear. Unintentional cuts, which include skin tears, are the fifth leading cause of non-fatal emergency room visits in the older population. Skin tears can have serious potential for infection, particularly if there is tissue loss when the

injury occurs. In older adults, even minor skin tears can be very painful because the nerve endings so close to the skin tear could be damaged.

- Risk Factors for Skin Tears
  - History of skin tears in last 90 days.
  - Limited mobility.
  - Dependence with assistance in activities of daily living.
  - Use of a wheelchair or bed confinement.
  - Co-morbidities that can influence balance.
  - Cognitive impairment.
  - Decreased vision.
  - Bruises.
  - Agitation.
  - Decreased tactile stimulation.
  - Pitting edema in legs.
  - Pressure on one area for a long period.
  - Using the wrong type of adhesive tape on the skin.
  - Having a diagnosis of diabetes or anemia.
  - Dry skin.
- Preventative Strategies to Reduce Skin Tears
  - All staff, regardless of department, should be trained on skin risk factors, recognizing residents at risk and corresponding prevention strategies.
  - All residents should be assessed for skin risk prior to move-in and at least annually to determine a change in skin risk status.
  - Residents should also be re-assessed if the resident starts falling or has a change in status that would increase his or her level of care. Residents that have an increase in falls will have an increased risk of injury, particularly skin tears.

Residents are likely to get skin tears by hitting furniture and other objects during the fall.

- Report changes in resident's health (i.e. dizziness or unsteady gait) immediately to supervisor and document in resident record.
    - Any change in resident condition could change fall risk status.
  - Report any broken or malfunctioning equipment.
  - Encourage resident to wear glasses when walking around, particularly at night (i.e. when going to the restroom).
    - Make sure eyeglasses are clean and they are worn properly.
  - Prevent dry cracked skin by promoting good skin health
    - Use lotion after bathing since bathing can actually de-hydrate the skin.
    - Do not bathe daily unless for purposes of incontinence care.
  - Wear appropriate skid-free shoes.
  - Keep environment well-lit.
  - Avoid using soaps, detergents, and perfumes that may dry out skin. A soap substitute or emollient should be used.
  - Pad side rails for residents who are confined to the bed.
  - Offer fluids between meals.
  - Suggest wearing long sleeves and long pants.
  - Use proper transfer techniques to minimize skin friction.
  - Maintain proper nutrition.
- Burns
    - Older adults and adults with disabilities generally experience burns as a result of hot water (i.e. shower or bath), hot beverages (usually coffee or tea), hot food or steam, and

coming in contact with hot cookware. Kitchen appliances often found in resident rooms, such as microwave ovens were also identified as a risk factor for scald burns for residents. Specific items that residents burn themselves on are water, coffee, food, steam, and tea. Older adults generally receive burns on upper extremities such as the arm and hands and lower extremities such as the leg and foot. Because of co-morbid medical conditions, older adults have a worse prognosis as a result of a burn and generally require more intensive medical treatment to resolve the burn.

- Risk Factors for Burns
  - Thin skin.
  - Reduced mobility.
  - Decreased reaction time.
  - Decreased ability for the skin to feel heat.
  - Sensory impairment.
  - Cognitive impairment.
- Bathing
  - **§** Make sure water temperature is at the proper temperature (105° - 120°F).
  - Hot water should be run for two minutes to determine actual temperature. Water temperature should be tested prior to resident entering the shower/tub.
  - If the direct care staff member thinks the water may be too hot, he or she can test the water temperature with a cooking thermometer.
- Food and Beverages
  - Remind residents to make sure the hot beverage is cooled enough before drinking. This should particularly be done if steam is coming out the cup.

- Observe the resident for tremors or any form of shaking that could cause the resident to spill a hot beverage or soup.
- During mealtimes, if the plate is too hot for the direct care staff member to touch or carry, it is too hot to be placed in front of the resident.
- Direct care staff should report any misuse of the microwave oven to a supervisor and document according to facility protocol immediately. For example, if you see an item that is not normally cooked in a microwave (Kool-Aid), the process should be stopped immediately and the supervisor notified. Temporarily unplug the microwave until the issue is resolved.
- Smoking
  - Residents that smoke should be monitored regularly for safe smoking practices.
  - Make sure residents smoke in the proper area and do not smoke near a resident using oxygen.
  - Supervise resident smoking if resident exhibits signs of unsafe smoking practices such as: trembling hands, inability to properly extinguish cigarettes, chain smoking, lighting cigarettes inside prior to exiting the building, etc.
  - Have resident wear smoking apron while smoking.
- Other Potential Burns
  - Follow facility policy in terms of use of heating pads, heat lamps, and hot packs.

NOTE: The same burn for an older adult is worse than for a younger adult because the thinner skin of an older adult provides less protection.

## 13.2 Emergency Supplies (First Aid Kit) and Medical Emergency Techniques

The purpose of the emergency supplies (first aid kit) is to ensure that essential supplies are available for staff use after an injury. The purpose of this section is to describe the items in the first aid kit and provide information on how to use these supplies. This section will also discuss how to apply basic first aid. For those administering first aid, first aid training is required.

- Training Requirements
  - § There must be at least one staff person in the facility at all times that has a current certification in first aid and CPR from the approved organizations.
  - § Direct care staff must receive certification in CPR within 60 days of employment.
  - § If more than 100 residents live in the assisted living facility, one additional person must be certified in CPR (for every additional 100 residents).
  - § A staff person with a current certification in first aid and CPR shall be present for the entire activity for any facility-sponsored activities that are off the facility premises.
  - § The facility is required to keep a list readily available to all staff of all staff members currently certified in first aid and CPR.
  
- § Emergency Supplies (First Aid Kits)
  - A complete first aid kit must be kept at the facility at all times.
  - The first aid kit should be located in a designated place that is accessible to staff but not to residents.
  - All staff must be aware of the location of the kit.
  - A complete first aid kit should always go on the facility van during activity outings. It must not be accessible to residents.

- Required Contents of First Aid Kit (**Instructor Note:** Each item should be shown to the direct care staff as it is being discussed so they are familiar with the appearance of each item).
  - Activated Charcoal
    - This should be used if a resident has ingested a poisonous substance. This should only be used if instructed by a physician or Poison Control Center.
  - Adhesive tape
    - This should be used to secure gauze pads or roller gauze. Adhesive gauze should NEVER be applied directly to the skin. Caution should be used when selecting the type of adhesive tape used in case it does come in contact with the skin. Paper tape, a type of adhesive tape, is the least likely to tear a resident's skin. Using other types of adhesive tapes can actually tear the skin when it is removed.
  - Antiseptic ointment [**Instructor Note: The name of the various types of antiseptic ointment (i.e. triple antibiotic ointment, zinc oxide) should be discussed as should the appearance of the various types of packaging (i.e. tube vs individual foil pack)**].
    - This should be used on minor abrasions under the instructions of a licensed healthcare profession until the physician is contacted.
    - It should only be used on an emergency basis until the physician writes the order for the resident's own supply.
  - Band-aids -assorted sizes (**Instructor Note: Provide examples for each size/shape band-aid and the types of injuries that they may be used for**)

- This should be used to cover minor abrasions or skin tears.
- Blanket
  - This should be used to increase the body temperature of a resident and provide warmth and protection.
- Disposable single use breathing barriers/shields
  - This should be used with rescue breathing or CPR (CPR mask or other type).
  - The purpose of this supply is for staff protection-to prevent the staff from obtaining an illness or disease from the person being resuscitated.
- Cold pack
  - This should be used to reduce swelling on a designated area on the resident.
- Disposable single-use waterproof gloves (reference Chapter Two – Infection control regarding glove usage as necessary)
  - This should be used when handling any resident emergency.
  - Gloves should be put on prior to engaging in first aid and removed prior to leaving the area in which first aid was given.
- Gauze pads and roller gauze (assorted sizes)
  - This should be used on abrasions and lacerations that are too large for the assorted size band-aids to properly cover.
  - The purpose of this supply is to protect the wound from germs and other contaminants.

- Hand cleaner/sanitizer
  - This should be used after washing hands and prior to putting on gloves. It should also be used immediately after the removal of the soiled gloves until a hand sink can be used to thoroughly clean hands.
- Plastic bags
  - The purpose of this supply is to have a readily available trash receptacle to dispose of soiled supplies used prior to leaving the area in which the resident is being treated.
  - This would be used for items not contaminated with any type of bodily fluid (gowns, booties, masks, gloves, etc. that did not come in contact with body fluids).
- Scissors
  - These should be used to cut other supplies to fit the resident's injury such as gauze pads, roll gauze and adhesive tape.
- Small flashlight with extra batteries
  - This should be available in case of a power outage. The employee should put the flashlight in his or her pocket in case of need whenever the power is out.
- Thermometer
  - This should be used to measure a resident's internal body temperature any time there is a fall, suspected illness, or any other abnormal behavior.

- Triangular bandage (sling)
  - This should be used as a temporary restriction device of a resident's limb until medical treatment can be obtained.
- Tweezers
  - These are for external use and should only be used to remove foreign objects from a resident's skin such as splinters, etc.

NOTE: It is extremely important that the re-usable supplies are placed back in the kit after each use so they are available for future injuries. Re-usable supplies, such as tweezers and scissors should be thoroughly wiped with alcohol pads prior to being placed back in the first aid kit for infection control. Items used from the first aid kit that are not re-usable should be replenished immediately.



### **Student Activity**

- **Group Exercise - First Aid Grab Bag Game**

#### **Instructor Notes:**

*The purpose of this activity is to reinforce to the direct care staff the importance of thoroughly knowing the emergency supplies in the first aid kit and the proper use of each item.*

*Activity procedures:*

1. *Place all the items found in a first aid kit in a large paper bag.*
2. *Have one participant at a time reach his or her hand in the bag (without looking in it) and name one item that they grab.*
3. *Once the item has been named, the participant should pull the item out of the bag to determine if he or she is correct.*
  - a. *If correct, the participant should describe the use for that particular item and provide one example of when that item might be used. The instructor should encourage the class to supplement*

*the definition if all aspects of the use of the item were not adequately described. Set the item aside and do not place it back in the bag.*

*b. If not correct, the participant should put the item back in the bag and select another item.*

*4. The instructor should go around the room allowing each participant to name, describe, and provide examples of two items.*

*5. If all of the items have not been pulled by the time all participants have participated, the instructor should start again with the first participant.*

*Encourage group discussion of how each item should be properly used.*

- Medical Emergency Techniques
  - In any injury, once the resident's emergency care has been provided, it is very important that a thorough investigation of how the injury occurred be completed. In doing this, more preventative strategies can be implemented to reduce future injury. Direct care staff should ask the resident exactly how the injury occurred and assess the environment to determine what factors in the resident's surroundings could have influenced the injury. If not clearly obvious, ask the resident what happened, when did the injury happen, where did it happen, and how did it happen. Only staff that is certified in first aid should perform first aid techniques.



### **Review Facility Policy on First Aid Protocol**

**Instructor Note: Below are basic descriptions of first aid techniques. The preferred method of instruction would be to use the facility's first aid protocol. Use the information below as a supplement to facility protocols. If facility protocols are not available, use solely the information below.**

Direct care staff should always call a qualified staff member when any injury occurs. A qualified staff member is defined as an individual that has appropriate training and experience commensurate with the assigned responsibilities.

- Falls
  - DO NOT MOVE THE RESIDENT!
  - Reassure the resident.
  - Call for a qualified staff member to complete a thorough assessment.
  - If a qualified staff member is not available, assess the resident for any signs of broken bones, areas of severe pain, unconsciousness, etc.
    - If the resident is not complaining of any pain and has complete range of motion [(ROM)- ability of individual to have full range of moving extremities up, down, left, and right], assist the resident up, take vital signs, document the resident's condition according to facility policy and protocol, and contact the Responsible Party.
    - If the resident is complaining of pain, call 911 and the emergency crew will assess the resident. Again, DO NOT MOVE THE RESIDENT.
    - Prior to the arrival of emergency personnel:
      - Take resident's vital signs.
      - Prepare resident information and paperwork for emergency crew.
  - Do not dismiss any complaints the resident may have as insignificant. Even the smallest complaint could be a sign of serious injury.
  - Report injury to supervisor and document in resident record and 24-hour log according to facility protocol.

- Burns
  - The primary purpose of first aid on burns is to stop the burning sensation, cool the temperature of the burn, and provide pain relief.
    - Remove the individual burned from the source of the heat.
    - Call for a qualified staff member to complete a thorough assessment.
    - If a qualified staff member is not available, assess the resident's burn area for any signs of redness, blisters, discolorations, and swelling.
    - If the resident is complaining of moderate or above pain, call 911 and the emergency crew will assess the resident. The following should be done while waiting for emergency medical services to arrive:
      - Remove any clothing that also was burned as clothing retains heat and can continue to burn the resident. If the clothing is stuck to a burn, cut around the clothing to remove it instead of pulling the clothing off the burn.
      - Remove any jewelry that is near the burnt area as the jewelry can restrict blood flow if swelling occurs. This may result in the jewelry having to be cut off.
      - Cool the burnt area with cool water. The water should be tepid and not too cold. The area should be cooled with water for a minimum of 20 minutes using a sponge, spray, or by submerging the area in a bowl of cool water. Wet towels are not recommended as they become warm as they rest against the skin. Ice should not be used to cool the

burn because it can cause additional damage to the skin.

- If the burnt area is an arm or a leg, those extremities should be elevated as it helps to prevent swelling.
  - Cover with a clean, dry bandage. Do not wrap tightly as swelling of the area could restrict blood flow.
  - Never apply creams or ointments without speaking to a physician first. Never apply butter to a burn!! It increases the intensity of the burning sensation.
  - Report the injury to a supervisor and document in the resident record and 24-hour log according to facility protocol.
- Skin tears (Wounds)
    - Call for a qualified staff member to complete a thorough assessment.
    - If a qualified staff member is not available, assess the resident's pain level first and observe for tissue loss and depth of injury.
    - Clean the skin tear with normal saline.
    - The skin tear should air dry or pat dry. This needs to be done gently and very carefully.
    - Determine if 911 needs to be called and follow facility protocol for either calling 911 or dressing the skin tear.
  - Bleeding
    - Minor cuts
      - Clean the wound thoroughly with soap and water or saline, apply antiseptic ointment, and apply a band-aid or small gauze with adhesive tape.

- Profuse bleeding
  - Apply direct pressure to the bleeding wound using a clean cloth or bandage. Use hand if absolutely necessary (if there is nothing else sanitary available).
  - Call for a qualified staff member to complete a thorough assessment and to administer first aid.
  - Continue to add new dressings on top of previous dressings to apply more pressure.

### **13.3 Emergency Preparedness and Natural Disasters**

It is imperative that residents, staff, volunteers, and visitors be protected in case of emergency and that the wellness, personal care programs, and property are protected. Continuing and meaningful efforts to prevent incidents that lead to emergency situations should always be a primary focus. Different situations require different responses. The emergency procedures in this section are intended as guidelines for all of those staff having the responsibility for the health and safety of the residents, staff, volunteers, and visitors. Each staff member should be prepared for all types of emergencies at all times. Fire and emergency evacuation drills should be conducted each month on a different shift so that all shifts have conducted a drill each quarter. § Additionally, resident emergency drills should be conducted at least every six months.

**Instructor Note: Use the facility protocols in this section if available. The information below is a guide and should be used as supplemental material. If facility protocols are not available, use the information below. The students should be informed that they must learn the facility protocol where he or she intends to work and that the information below is intended to provide a general idea of what should be done in each type of emergency.**

- Fires
  - NEVER shout the word “fire.”
  - Act quickly, be calm and reassure residents.

- Teamwork is a must. Know the fire procedures and staff assignments.
- Do not move residents past or through fire unless there is no alternative exit.
- Evacuate all residents according to the facility fire plan. Those residents should be evacuated outside and away from the building. A staff member should account for each resident inside and outside of the building. § A method for accounting for each resident should be in place. The lists will be used by the firemen and staff to assure that all residents have been counted.
- If stairwells exist, do not leave stairwell doors open if smoke conditions exist. Only open the door enough to get in or out.
- The fire department will direct other evacuations as necessary. Only the fire department should cut off the sprinkler system.
- Close ALL windows and doors immediately when an alarm is sounded. Feel any door for heat before opening it. If you feel heat, DO NOT OPEN THE DOOR.
- Staff is to use the exits opposite the fire area.
- All nursing staff shall have keys on his or her person at all times so that secure areas and/or locked doors can be unlocked as appropriate.
- § Floor plans showing primary areas should be centrally located on each floor used by residents in the facility. The floor plan should indicate the primary and secondary evacuation routes, areas of refuge, assembly areas, telephones, fire alarm boxes and fire extinguishers.
- § Floor plans indicating where the shut off valves for utilities are located should be readily available.

- Mental Health Emergency
  - The designated staff person in charge shall conduct an assessment of the resident's condition immediately.
  - The designated staff person in charge should determine if the resident is in distress or if residents in the area or staff are in any physical danger.
  - If the resident in distress is showing any violent tendencies or is threatening violence, the designated staff person in charge shall designate another nursing staff member or other employee to call 911 immediately.
  - All other residents, family members, and visitors should be removed away from the resident in distress.
  - All residents, family members and guests should be asked to go to the resident's rooms they are visiting immediately and shut the door.
  - The doors to the kitchen should be closed and the fire doors (if the facility has them) as appropriate to prevent access to kitchen knives and protect the residents.
  - All items that could be potentially used as a weapon should also be removed from the immediate area of the resident in distress.
  - The designated staff person in charge should talk softly and quietly to the resident in distress in an attempt to calm the resident down.
  - The designated staff person in charge should not be in arms reach of the resident in distress and should make sure that he or she (employee) is closest to the exit door. MAKE SURE YOU ARE NEVER IN A SITUATION WHERE YOU CAN NOT EXIT THE AREA IMMEDIATELY. DO NOT EVER BLOCK YOURSELF IN.
  - If it is deemed that the resident cannot be calmed down and is continuing to exhibit behavior indicating that he/she is an

immediate threat to self or others, the Supervisor or designated staff person in charge should contact the emergency number for the local Community Services Board (CSB) as soon as possible if it is determined that a Temporary Detention Order (TDO) may be needed.

- If the resident is an immediate threat to him or herself or others, including staff, 911 should be called immediately.
- Once contact is made with the CSB, inform them that a Temporary Detention Order (TDO) may be needed. Provide all necessary information and request that the CSB assess the resident.
- If the police department responds, thoroughly explain the situation and provide any information requested by the police officer.
- If the resident has settled down and does not appear to be a threat to self or others any longer, a nursing staff member shall:
  - Take vital signs (pulse, respiration, temperature, blood pressure).
  - Call an ambulance if necessary. If the ambulance is called:
    - Clear the hallways of all equipment to ensure fire fighters/rescue squad have unrestricted access. If the building has multiple floors and the resident is on the second floor or above, have the elevator on the first floor ready for use.
    - One staff member should meet the rescue squad at the front door with the appropriate paperwork directing them to the resident. Make sure that another staff person stays with the resident.

- Medical personnel should be provided with as much of the following information as possible:
  - List of medications from Medication Administration Record.
  - Vital signs.
  - Brief summary of what has occurred.
  - Copy of Medicare card, Health Insurance card, and Social Security card.
  - Emergency contact information so the hospital can contact the responsible party.
  - Any advance directives (living will, DNR order, etc.)
- Contact the responsible party. Provide them with a brief summary of what has occurred and the hospital where the resident was taken as a result of the situation.
  - After the emergency has been resolved, the direct care staff should document in the resident's record as per facility protocol.
- Death of a Resident
  - Upon discovering a resident who appears to be unconscious, check the resident's vital signs. If you cannot locate a pulse and do not see or hear respirations, the following procedures should be followed:
    - Call 911.
    - Call a qualified staff member to complete a thorough assessment.
    - Go to the resident's chart to determine if the resident has a Do Not Resuscitate (DNR) order. This will be determined by the DNR sticker. The specific location of the DNR sticker on or in the chart is determined by facility policy.

- If the resident has a DNR order, **DO NOT ADMINISTER CPR.**
- If the resident does not have a DNR order, begin CPR and continue until emergency medical services personnel arrive. CPR should only be provided by a trained staff person.
- Bomb Threat
  - If the facility receives a call or information from another individual that a bomb has potentially been placed in or near the building, all staff must take this information seriously until informed by the proper officials that there is no valid threat. It is recommended that the following actions be taken:
    - Note the time of the call or the time the information was received.
    - If you receive this call, attempt to discuss with the caller the following information:
      - Location of the bomb.
      - The type of device.
      - Time the device may detonate.
      - Advise the caller that the facility is an assisted living and many people could be harmed.
    - Listen for the following information while on the phone:
      - Background noise (i.e. music, voices, etc.).
      - Voice quality (accents, speech impediments, etc.).
      - Male or female.
    - While on the phone with the caller, have another staff member do the following:
      - Call 911.
      - Call the Administrator.
    - The residents should be taken to their rooms until further instruction from the authorities. It is important to note that

if the caller provided information on the location of the bomb that staff should remove all residents from that area.

- Do not inform the residents of the bomb threat. It is recommended that you inform the residents that there is a facility emergency but do not discuss specifics.
  - When the police arrive, report any strangers seen in or on the grounds of the facility.
  - Do not touch or remove any suspicious objects.
  - Don't panic.
- Inclement Weather
    - § A battery-operated radio and flashlights should be readily available for use if there is a utility failure during inclement weather. A second form of communication (i.e. two-way radio, cell phone, etc) should be available as an alternate to the facility's landline telephone.
    - The exterior doors should be shut.
    - Any moveable objects on the exterior of the building should be secured prior to the inclement weather to help prevent the object from flying through a window and causing injury.
    - Blinds should be closed in resident rooms.
    - In severe winds (i.e. hurricanes or tornados) or potential earthquake, the residents should be moved away from windows.
  - Nuclear Emergency/Terrorism
    - § A battery-operated radio and flashlights should be readily available for use in case of a nuclear emergency/terrorism. The radio should be tuned to the local emergency broadcast station. A second form of communication (i.e. two-way radio, cell phone, etc) should be available as an alternate to the facility's landline telephone.

- All residents, staff, and visitors should be alerted that there is a facility emergency but do not discuss specifics.
- Close all doors, windows, blinds, drapes, etc.
- Move all residents into one area, away from windows, and behind fire doors (if the facility has them).
- Work Place Violence/Intruder
  - Contact 911 immediately.
  - Move all residents to their rooms or to a secure area until the situation is under control.
  - The doors to the kitchen should be closed to prevent access to weapons.
  - Remove any objects in the vicinity of the dispute that could be potentially used as a weapon.
  - Contact the Administrator.
  - Staff is to stay away from the disputing employees/intruder until the police arrive.
  - If evacuation of the facility is necessary, follow the proper evacuation procedures.
  - Once the dispute is under control, the direct care staff should notify residents and visitors and reassure them of their safety.
- Utilities Failure
  - **§** A battery-operated radio and flashlights should be readily available for use if there is a utility failure. A second form of communication (i.e. two-way radio, cell phone, etc) should be available as an alternate to the facility's landline telephone.
  - If there is an interruption in any utility that effects the facility (i.e. water, electricity, gas, heat) contact the Administrator or maintenance personnel.

- The direct care staff, if directed by a supervisor, should contact the utility company to determine the expected length of the outage.
- Direct care staff should check on each resident to make sure there are no injuries.
- Missing Residents
  - Notify the staff person in charge that a resident cannot be located.
  - Direct care staff should search the entire interior and exterior of the facility to attempt to locate the resident.
  - If the resident cannot be located the direct care staff needs to call 911 immediately.
  - Contact the Administrator.
  - When the police arrive, a full written description of the resident should be provided. § A written resident description should be in the resident's file.
  - A picture should be readily available to police to use.
  - Notify the Responsible Party or Power-of-Attorney for the resident.
  - Once the resident is located, the Responsible Party or Power-of-Attorney should be contacted.
  - The resident should be assessed for any injuries/trauma by a qualified individual and sent to a local hospital for evaluation if necessary.
  - Document all details in the resident's chart according to facility protocol.
- Medical Emergency
  - If there is a resident experiencing a medical emergency, the direct care staff should notify the staff person in charge.

- The staff person in charge should immediately conduct a thorough assessment of the resident's condition and examine the resident for injuries.
- Call 911 if necessary.
- Take the resident's vital signs (pulse, respiration, temperature, blood pressure).
- Provide the appropriate first aid until the rescue squad/medical personnel arrives.
- Medical Personnel should be provided the following information:
  - List of current medications.
  - Vital signs.
  - Brief summary of what happened.
  - Any advanced directives (living will, DNR order, etc.).
  - Any other information stated in facility policy.
- Contact the Responsible Party and inform him or her of the incident and if the resident is being transported to the hospital.
- Document the incident in the resident's record according to facility protocol.

### **13.4 Staff Responsibilities**

- Staff are responsible for the safety and general welfare of the residents.
- Staff are responsible for knowing facility policies for treatment of injuries, fire safety and evacuation, and proper reporting of incidents.
- Staff is responsible for reporting and documenting accidents when they occur.
- Staff is responsible for teaching residents how to avoid falling and other potential injuries so they can continue with normal activities.

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

11 VAC 40-72- 300	First aid and CPR certification
11 VAC 40-72- 930	Emergency preparedness and response plan
11 VAC 40-72- 940	Fire and emergency evacuation plan
11 VAC 40-72- 950	Fire and emergency evacuation drills
11 VAC 40-72- 960	Emergency equipment and supplies
11 VAC 40-72- 970	Plan for resident emergencies and practice exercise

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Student Review – Chapter Thirteen

10. Name ten (10) items found in a first aid kit and describe how to use each.

- a. **activated charcoal** – used if a resident ingests a toxic substance
- b. **adhesive tape** – used to secure gauze pads or roller gauze
- c. **antiseptic ointment** – used on minor abrasions
- d. **band-aids** – used to cover minor abrasions or skin tears
- e. **blanket** – increase the body temperature and provide warmth and protection
- f. **disposable single-use breathing barriers/shields** – used with rescue breathing or CPR mask
- g. **cold pack** – used to reduce swelling on a designated area
- h. **disposable single-use waterproof gloves** – used when handling any resident emergency
- i. **gauze pads and roller gauze** – used on abrasions and lacerations that are too large for the assorted size band-aids to properly cover
- j. **hand cleaner/sanitizer** – used after washing hands and prior to putting on gloves. Should be used immediately after removal of soiled gloves until hand sink can be used to clean hands.
- k. **plastic bags** – trash receptacle to dispose soiled supplies prior to leaving the area in which the resident was treated
- l. **scissors** – should be used to cut other supplies to fit the resident's injury
- m. **small flashlight with extra batteries** – used in case of a power outage
- n. **thermometer** – measure a resident's internal body temperature
- o. **triangular bandage** – temporary restriction device of a resident's limb until medical treatment can be obtained
- p. **tweezers** – to remove foreign objects from a resident's skin such as splinters.

11. Name the top three injuries found in assisted living.

- a. **falls**
- b. **skin tears**

**c. burns**

3. Name two risk factors for skin tears

**a. history of skin tears in the last 90 days**

**b. limited mobility**

**c. dependence with ADLs**

**d. use of a wheelchair**

**e. co-morbidities**

**f. cognitive impairment**

**g. decreased vision**

**h. bruises**

**i. agitation**

**j. decreased tactile stimulation**

**k. pitting edema in legs**

**l. pressure on one area for a long time**

**m. using the wrong type of adhesive tape on skin**

**n. having a diagnosis of diabetes or anemia**

**o. dry skin**

4. Name two environmental preventative measures for falls

**a. clean up spills immediately**

**b. reduce clutter**

**c. resident should be encouraged to remove throw rugs and bath mats**

**d. keep personal items within reach**

**e. encourage resident to use assistive devices**

**f. keep oxygen tubing at a relatively short length and place concentrator in a location that would not allow the tubing to go all the way across the floor**

**g. keep telephone cords short**

**h. discourage placing items on high shelves or using a step stool**

**i. keep area well lit**

**j. use non-slip rubber mats**

5. Name two risk factors for burns.

- a. **thin skin**
- b. **reduced mobility**
- c. **decreased reaction time**
- d. **decreased ability for the skin to feel heat**
- e. **sensory impairment**
- f. **cognitive impairment**



# **Chapter Fourteen**

## **Restraint Use In the Assisted Living Facility**

**2 Hours**

## **Chapter 14 – Restraint Use in the Assisted Living Facility**

This chapter provides the direct care staff member a thorough understanding of restraints in assisted living facilities. This chapter will describe the definition of restraints, the limited application of restraints, and resident's rights and restraint use. This chapter will also discuss using least restrictive methods when working with residents with the goal of having not only no physical restraints, but no chemical restraints as well. Students should obtain a good understanding of the negative outcomes that a resident may experience resulting from restraint use, as well as how to minimize those consequences.

- 14.1 The Definition of "Restraint" and Applicable Laws**
- 14.2 Non-Emergency Restraint Use**
- 14.3 Emergency Restraint Use**
- 14.4 Negative Outcomes from Restraint Use**
- 14.5 Preventing Negative Outcomes**
- 14.6 Restraint Avoidance and Reduction**
- 14.7 Staff Training Requirements**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. Be able to identify devices and practices that are considered restraints
- b. Be able to discuss regulatory compliance as it pertains to using restraints
- c. Be able to describe potential negative outcomes of restraint use and the care practices necessary to minimize those negative outcomes
- d. Be able to discuss proper monitoring techniques for physical and chemical restraints
- e. Be able to describe techniques that can be used as an alternative to restraint use
- f. To understand the adverse consequences and hazards related to restraint usage
- g. Be able to identify the roles of the resident, family, physician and caregiver, in making the decision to use restraints

### **2. Recommended Methods of Instruction**

- Lecture and class discussion
- Student Activity
- Facility Policy on Restraint Use/Reduction if available
- Student Activity – Instructor Demonstration and application of proper restraint application
- Student Review – Chapter Fourteen

## 14.1 The Definition of a Restraint and Applicable Laws

Restraints can be physical or chemical. Despite common belief, physical restraints do not prevent falls. Physical and chemical restraints actually increase a resident's risk of falling. This section will describe the definition of physical and chemical restraints as well as laws as they apply to restraint use. § Restraints may not be used for the purpose of discipline or convenience. § Restraints may only be used to treat a resident's medical symptoms or symptoms from mental illness or mental retardation. Restraint use should be minimized as much as possible, with the goal of being "restraint free."

- Physical Restraints
  - Definition:
    - § A physical restraint is defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement or access to his body."
  - Types of Physical Restraints
    - Posey vest
      - A vest that is placed on the resident that is then attached to a bed or a chair.
      - Typically used in high fall risk residents.
    - Waist restraint
      - Similar in appearance to a gait belt that is attached to a wheelchair or bed.
      - Typically used in high fall risk residents.
    - Wrist restraint
      - Cloth straps wrapped around each wrist that are then connected to a bed or wheelchair.
      - Typically used on residents that are a danger to

himself or herself.

- Pelvic restraint
  - Generally nylon material that wraps beneath the resident's legs and around the waist. It is then attached to the wheelchair.
  - Typically used on residents that slide down in their wheelchair.
- Side rails
  - Metal bars that go on either side of the resident's bed. These can be half rails or full rails.
  - Typically used to keep a resident in bed or to prevent a resident from rolling out of bed.
- Reclining chair
  - A regular reclining chair.
  - Typically used to prevent residents from getting up that are considered a high fall risk.
- Merry Walker
  - Similar to a wheelchair with the addition of a grab bar in the front. Residents generally need assistance getting in this device.
  - Typically used to increase independence in mobility for those residents that can't ambulate by foot. Often considered a restraint based on the need for assistance to get in and out of the device.
- Bean bag chairs
  - A regular bean bag chair.
  - Typically used for residents that are fall risk because of proximity to floor. Considered a restraint if the resident cannot get out of the bean bag chair

independently.

- Lap pillows (lap buddies)
  - Firm cushion placed on the resident's lap that connects to the wheelchair.
  - Typically used for resident's that lean too far forward in the wheelchair and become a fall risk.
- Locked doors and half doors
  - Doors that are locked from the opposite side preventing the resident from exiting. These can be full doors or half doors.
  - Typically used for residents that may be at risk for elopement.
- Wheelchair seat belts
  - Similar to a car seat belt.
  - Typically used for residents that may lean too far forward and fall out of the wheelchair. Considered a restraint if the resident cannot disengage the latch on the seatbelt independently.
- Mittens/Socks over hands
  - Mittens that cover all of the resident's fingers and are strapped around the wrist so the resident cannot remove them.
  - Typically used for residents that may self-harm either intentionally or unintentionally. Considered a restraint when it reduces the ability for the resident to do daily tasks independently such as opening a door or using the bathroom.
  - Socks over hands have the same effect.

- Geri-chair
  - Reclining chair with a built in table on the front.
  - Typically used for non-ambulatory residents that may be a fall risk.

**Instructor Notes:** It is important to note that a key point in determining whether something is a restraint is whether it restricts movement. For example, a side rail is not a restraint for residents who use the rail to help them sit up in bed and who can exit the bed by going around the rail or by going out the other side of the bed. On the other hand, the side rail is a restraint if it confines a resident to the bed.

Also, things that may not be thought of as restraints can act as restraints in some situations. For example, chair alarms could be used as a restraint if it prevents a resident from moving freely. Or, deliberately placing a resident in a chair or bed from which they cannot get up, with the intention of not allowing them to get up, could be considered a restraint.

Restraints should be evaluated in terms of each individual. A device that may act as a restraint for one individual may not be a restraint for another. If an individual can free themselves from the device without assistance, it is not a restraint. If an individual needs assistance freeing themselves from a device and that device restricts their movement and mobility, it is considered a restraint.

For example, Mrs. H has dementia. She is quite a busy lady and the staff describes her as always “getting into things” and trying to leave the assisted living facility. One day the staff realizes that when she is put in a chair at the dining room table and the table is brought close to her, she cannot get up. Although she tries to move the table and chair so she can get up, she cannot do it. The staff realize that when she is in this chair, she is much “easier to handle” so they leave her in the chair while they get other work done. Could this be considered a restraint?



### **Student Activity**

- Instructor Demonstration - Restraints

**Instructor Notes:** If any of the above restraints are available, demonstrate the proper method to apply the restraints. Supervise the students applying restraints to each other.



## Student Activity

- Group Exercise – Understanding Restraints from a Resident Perspective

**Instructor Notes: This exercise is to allow the students to experience what it may be like for a resident to be restrained. Prior to continuing, use gauze and secure each student securely around the waist so they have minimal maneuverability. If actual restraints are available, use those restraints instead of gauze. Also, secure the students non-dominant hand to the arm of the chair. Remove all student drinks and snacks out of arms reach. Keep the students in this position until the Group Discussion in Section 14.4 (page 671) is reached in this chapter.**

- Regulations Pertaining to Use of Physical Restraints
  - § May only be used when a resident's medical, mental illness, or mental retardation symptoms warrant the use to ensure the physical safety of the resident or other residents. For example, a physical restraint may only be used if the resident is in danger of causing harm to him or herself or to other residents. Restraints may not be used for the purposes of discipline or convenience. Additionally, restraints may only be used when all other restrictive means have not been effective.
  - § Physical restraints may only be applied if the assisted living facility has a signed physician's order that states the resident's condition warranting the physical restraint use and the circumstances and duration that the restraint will be used. Physical restraints may only be applied without a signed physician's order under extreme emergencies and if the signed physician's order can be readily obtained.
  - § Physical restraints should only be used to the minimum extent necessary to protect the resident or others
  - § Physical restraints can only be applied by those direct care staff members that have received training according to VDSS regulations. Additional restraint-specific training is also

required prior to the use of restraints and is described in Section 14.8.

- § The resident's condition must be monitored **at least** every 30 minutes
  - § The resident must be assisted with hydration, safety, comfort, range of motion, exercise, toileting, and any other needs at least 10 minutes every hour. NOTE: The resident should be released from the physical restraint as quickly as possible.
  - § All monitoring should be properly documented. Proper documentation includes the restraint used (i.e. posey vest, geri-chair), the outcome (i.e. resident less combative, resident asleep), the monitoring checks, hourly assistance needed and/or provided, notes regarding any unusual occurrences or problems (i.e. resident had chafing on skin from attempting to remove posey vest).
  - § The resident shall be released immediately upon the determination that he or she is no longer a threat to him or herself or other residents.
- Chemical Restraints
    - Definition:
      - § A chemical restraint is defined by VDSS as “a psychopharmacological drug that is used for discipline or convenience and not required to treat the resident's medical symptoms or symptoms from mental illness or mental retardation, that prohibits an individual from reaching his highest level of functioning.”
    - Pharmacological Names of Some Potential Chemical Restraints
      - Ativan.
      - Respirdal.

- Ziprexa.
- Seroquel.
- Xanax.
- Haldol.
- Ambien.

**Instructor Note: Students should be reminded here to refer to the Beer's list as medications older adults should not be on.**

- Regulations Pertaining to the Use of Chemical Restraints
  - § Chemical restraints are strictly prohibited.
- Although chemical restraints are strictly prohibited, they are frequently administered under the care of a physician. These medications are used for anxiety, aggression, inability to sleep, agitation (i.e. assistance with showering), wandering, etc. Although these medications may not be being prescribed for the purposes of being a chemical restraint, the resident's reaction to the medication results in it being a restraint.
  - Although a physician's order may be present, these medications are still considered restraints as they are frequently used for facility convenience prior to determining causes of negative behavior and implementing appropriate interventions.
    - For example, a facility may administer Seroquel to a resident at 8pm because the resident does not sleep well and is walking the halls in the middle of the night.
    - As an alternative to Seroquel, the facility could implement a number of potential interventions. Potential Staff Therapeutic Interventions will be discussed during the Group Discussion below.



## Group Discussion

**Instructor Note: Ask the students the following question:**

**Can you name five (5) alternatives that could be used instead of chemically restraining residents?**

- Potential Staff Therapeutic Interventions:
  - Reduce caffeine intake throughout the day.
  - Keep resident actively engaged during normal waking hours so that the resident may be more tired during normal sleeping hours.
  - Determine the resident's sleep/wake schedule when the resident was at home (if the resident used to work night shift then the resident's walking at night is not unusual).
  - Allow the resident to walk during the night monitoring him or her for fall risk, engage in an activity with the resident, etc.

## 14.2 Non-Emergency Restraint Use

Restraints may be used on residents in non-emergency situations for medical purposes and/or safety.

- Definition:
  - § A nonemergency as it applies to restraints as defined by VDSS is "circumstances that may require the use of a restraint for the purpose of providing support to a physically weakened resident."
- Regulations Pertaining to the Use of Non-Emergency Restraints
  - § May only be applied if there is a physician's order.
  - § **Nonemergency** restraints should only be used as a last resort and only after the facility has completed, implemented, and evaluated the resident's comprehensive assessment and ISP. The facility must have

also determined and documented that less restrictive methods have failed.

- **§** The restraints may only be used in accordance with the resident's ISP.
  - **§** The ISP must state why the restraint is needed and include a plan of rehabilitation that would result in the progressive removal of the restraint to either less restrictive restraints or restraint-free.
- **§** The restraints should only be applied so that the resident does not harm him or herself or others and must cause the resident the least discomfort.
- **§** Restraints may not be applied without explaining why the restraints are being used and the potential dangers when using restraints to the resident. If the resident is not cognitively able to understand, the responsible party must be contacted. The explanation must include the resident's right to refuse restraints. Written consent from the resident and/or responsible party must be obtained and placed in the resident's chart.
- **§** If the direct care staff member notifies the resident and/or responsible party, the direct care staff member should document in the resident's record the date, time, and person notified. The direct care staff member should also identify him or herself in the resident's record as the individual that made contact.
- The direct care staff member must document on the restraint log each time the resident is monitored and any observations made during monitoring.

### 14.3 Emergency Restraint Use

- Definition:
  - § An emergency, as it applies to restraints as defined by VDSS is “a situation that may require the use of a restraint where the resident's behavior is unmanageable to the degree an immediate and serious danger is presented to the health and safety of the resident or others.”
- Regulations Pertaining to the Use of Emergency Restraint Use
  - § Restraints should not be used unless they are necessary to alleviate an unanticipated immediate and serious danger to the resident or other individuals in the facility.
  - § The facility must obtain an oral or written order from the physician within one hour of the restraint being applied to the resident. It must be documented in the resident's record that the physician's order was obtained.
  - § Residents that are placed in restraints for emergency purposes must be in sight and sound of a direct care staff worker at all times.
  - § If the facility deems that the emergency restraint is required for more than a two (2) hour period, the resident must be transferred to a medical or psychiatric inpatient facility or monitored in the facility by a mental health crisis team until the his or her condition has stabilized to the point that the attending physician documents that restraints are not necessary.
  - § The facility must also contact the resident's responsible party no longer than 12 hours after the emergency restraint was applied. This notification must be documented in the resident's record including the date, time, person notified, and the staff member that provided the notification.

## 14.4 Negative Outcomes from Restraint Use

Any form of restraints can impact a resident's life. Restraint use can result in physical, psychological, social, and emotional impact on the resident. This section will discuss each of these categories and the potential negative outcomes from restraint use.

- Physical
  - Incontinence.
  - Falls.
  - Constipation.
  - Decreased bone and muscle strength.
  - Skin breakdown, pressure sores, skin tears, bruising.
  - Infection.
  - Reduced circulation and decreased range of motion.
  - Loss of appetite.
  - Pneumonia.
  - Pain.
  - Risk of serious injury (i.e. strangulation/asphyxiation).
  - Nerve injury.
  - Strains, fractures, contractures.
  - Death.
- Psychologically
  - Feelings of entrapment.
  - Feelings of depersonalization and helplessness.
  - Feelings of isolation.
  - Feeling of loneliness.
  - Loss of self-esteem.
  - Reduction of autonomy.
  - Depression.
  - Increased agitation and/or confusion.

- Anger.
- Socially
  - Isolation/Withdrawal.
  - Dependency.
- Emotionally
  - Panic and fear.
  - Anger.
  - Apathy.



### Group Discussion

**Instructor Notes: Remove the restraints from each student. Allow the students an opportunity to stretch, use the restroom, and eat and drink. Ask the students how they felt to not have maneuverability and discuss with the students how they think an older adult may feel.**

## 14.5 Preventing Negative Outcomes

Negative outcomes refer to any of the physical, psychological, social, and emotional impacts described in the previous section. This section will discuss how to prevent negative outcomes when applying restraints.

- Using restraints properly
  - Apply restraints properly.
  - Make sure the restraints do not restrict circulation and are not uncomfortably tight.
  - Tie knots that can be untied quickly in an emergency, such as a quick release knot.
  - Provide padding for bony areas that can be irritated by restraints or lack of movement to prevent skin breakdown.
- Monitor the resident frequently (previously discussed).
- § Check the resident every 30-minutes and more frequently if

necessary

- Check the resident's pulse and skin condition where the restraint is applied.
- Reposition the resident if the resident's skin is red or the resident appears to be uncomfortable.
- Ask the resident if his or her arms or legs are feeling numb.
- Ask the resident if he or she needs anything.
- Provide fluids and snacks hourly and more often if needed.
- Assist the resident to the bathroom hourly and more often if needed.
- Assist the resident with stretching his or her arms and legs and walk the resident hourly and more often if needed.
- Make sure the resident can reach the call bell.
- Discuss with the resident why he or she is restrained and what steps need to be taken in order to remove the restraints.

## 14.6 Restraint Avoidance and Reduction



### **Review facility policy on restraint use and reduction, if available.**

- Assess the Environment
  - Physical environment – the same procedures should be used here as were described in Chapter 13, Section 13.1, Common Injuries and Injury Prevention in Assisted Living. Every effort should be made to reduce fall risk status in the environment. Noise levels, other agitated residents, etc. also need to be assessed. Make every effort to minimize any anxiety or negative behavior triggers that may influence the resident.
  - Activities – the resident should be consistently engaged in activities that interest the resident. This should be particularly done prior to the time frame in which the resident is typically agitated. Engaging the

resident may reduce the possibility of negative behavior and reduce wandering which could lead to falls.

- Assessment of the Resident by Licensed Health Care Professionals
  - Medication Review – all medications should be evaluated for possible drug-drug interactions and over-medication.
  - Psychological assessment – mental health consult may reduce anxiety from psychological issues, thus reducing agitation and negative behavior.
  - Care needs assessment – the facility should determine if there are specific times of the day in which the resident is more restless, agitated, or combative. Every effort should be made to divert the resident to reduce this potential negative behavior. The resident should be assessed for assistive device needs.
  - Pain management assessment – the resident should be assessed for pain. A resident in pain can lead to agitation and physical weakness.
  - Mobility assessment – a residents gait, transfer techniques, and posture should be assessed to determine fall risk. Reducing fall risk can reduce the potential for restraints. Obtaining a consult from physical and occupational therapy could result in mobility improvement.
  - Elopement assessment – the resident should be assessed to determine if he or she is at risk for attempting to leave the facility. This is particularly important for cognitively impaired residents, residents with mental health needs, or residents with developmental disabilities that would be at risk for serious injury if unsupervised.
  - Orthostatic hypotension (rapid decrease in blood pressure when sitting or standing too quickly resulting in dizziness and/light-headedness) – it should be determined if the resident has orthostatic hypotension as this can significantly impact fall risk status.

- The Licensed Healthcare Professional responsible for healthcare oversight for the facility should be used as a resource for restraint assessments and alternatives to restraints.
- Direct care staff are vital for a restraint-free facility by thoroughly knowing the resident, behavior patterns, and functional abilities to assist in restraint reduction or avoidance.
- Adapt to the Resident
  - Increase frequency of rounds
    - If there are times during the day in which the resident is more restless, that resident should be check on more frequently. If facility protocol mandates every two hour rounds, the resident may need to be checked on every thirty minutes.
      - Frequent attempts to engage the resident in a meaningful activity should be done each time rounds are made.
  - Move the resident to a location where direct care staff can see the resident more frequently but also where the resident is still engaged in an activity that is meaningful to him or her.
  - Know the Resident Needs
    - Place a nightlight in the resident's room so the resident can see while attempting to go to the restroom at night. This will assist in fall reduction practices, may help prevent the use of side rails, and will help maintain resident independence.
    - Make sure the call bell is within reach of the resident.
    - Lower the bed closer to the floor.
    - Use a bed alarm so direct care staff can hear the resident attempting to get out of bed. Bed alarms should be used with caution as it can result in a fall when a resident hears an alarm and attempts to get up quickly to leave.

- Be aware of the four (4) P's. These can contribute falls. If direct care staff assists in ensure the four (4) P's below are met, falls and restraint use may decrease.
  - Pain – residents in pain may attempt to get up to obtain medication. Call bells should be within resident reach so he or she can call for assistance.
  - Position – residents may be in an uncomfortable position. Attempts to re-position may cause an unsteady balance.
  - Potty – residents needing to use the restroom that are fall risks should be placed on a bowel and bladder program so that the resident does not attempt to ambulate to the restroom independently.
  - Personal – residents may not be able to reach personal items that he or she may need such as eye glasses, glass of water, hearing aids, television remote, light, etc. Direct care staff should make sure these items and any frequently used item is within arm's reach.
- Re-direct the resident as frequently as needed.
  - If a resident is given a chemical restraint because of agitation but direct care staff observe that this resident is only agitated when in the presence of a particular other resident, every effort should be made to keep those residents apart.
- Allow the resident to go where the resident is comfortable.
  - If there is a particular area in the dining room that the resident becomes more agitated, allow the resident to sit in a location within the dining room that does not trigger that agitation.

- Review the ISP
  - Change goals for adapting environment and resident needs.
  - Should include methods to reduce/eliminate restraint use.
  - Should emphasize autonomy and the resident's right to be restraint-free.
  - Should be resident focused, not staff convenience focused.
  - Ensure interdisciplinary input (see Chapter One).
  - Upon implementation of the new ISP, the direct care staff member should document what efforts to reduce or eliminate restraints have worked (i.e. engaging a resident in a particular activity at the time of the day when the resident is typically trying to leave the facility unsupervised).
  - All falls should also be documented to note any patterns of falls. Determining a pattern of falls can provide the direct care staff worker with information for interventions.
- Make sure all staff members are familiar with restraint reduction/elimination methods specific to the resident.
- Be familiar with facility restraint protocols.
- Familiarize residents and family members with the plan for restraint reduction and removal.
- Be familiar with the resident's likes/dislikes and his or her personality. It is vital that the Direct Care Staff be thoroughly knowledgeable of the resident's needs and wants in order to properly contribute to the ISP and avoid restraint use. Being familiar with a resident can assist in preventing confusion and agitation. Refer to Chapter One for refresher on Direct Care Staff role and the ISP if necessary.

## 14.8 Staff Training Requirements

The following section will describe what training is required by VDSS prior to a direct care staff worker participating in the care of a resident with aggressive behavior and prior to participating in restraint use in any way. No direct care staff worker should engage in the provision of care with the residents described in this section if he or she has not received appropriate training.

- Direct Care Staff Training When Aggressive or Restrained Residents are in Care
  - Aggressive Residents
    - § Must be trained in methods of dealing with residents who have a history of aggressive behavior or of dangerously agitated states **prior** to being involved in the care of those residents. This includes methods in self-protection and how to de-escalate an aggressive resident.
  - Restrained Residents
    - § Must be trained in the care of residents in restraints and the healthcare needs associated with restrained residents. This includes:
      - § Proper techniques for applying and monitoring restraints.
      - § Skin breakdown prevention.
      - § Assisting in range of motion.
      - § Assessing blood circulation.
      - § Turning and positioning.
      - § Maintaining proper body temperature.
      - § Any additional attention pertaining to physical, mental, emotional, and social needs.
      - § Possible risks associated with restraint use and how

to reduce or eliminate those risks.

- § A refresher training should be completed annually if residents with a history of aggressive behavior or residents that are restrained are present.

## **Standards for Licensed Assisted Living Facilities**

**Effective July 17, 2013\***

§63.2-1808 Code of VA	Rights and responsibilities of residents of assisted living facilities
22 VAC 40-72-310	Direct care staff training when aggressive or restrained residents are in care
22 VAC 40-72-550	Resident rights
22 VAC 40-72-700	Restraints

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Student Review - Chapter Fourteen

1. Define physical restraint:

**A physical restraint is defined as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the resident cannot remove easily, which restricts freedom of movement or access to his body.”**

2. List three (3) physical restraints:

- a. Posey vest
- b. Waist restraint
- c. Wrist restraint
- d. Pelvic restraint
- e. Side rails
- f. Reclining chair
- g. Merry Walker
- h. Bean bag chairs
- i. Lap pillows (lap buddies)
- j. Locked doors and half doors
- k. Socks placed over hands
- l. Wheelchair seat belts
- m. Mittens
- n. Geri-chair
- o. Posey bars

3. Define chemical restraint:

**A chemical restraint is defined by VDSS as “a psychopharmacological drug that is used for discipline or convenience and not required to treat the resident’s medical symptoms or symptoms from mental illness or mental retardation, that prohibits an individual from reaching his highest level of functioning.”**

4. List three (3) medications that can be used as a chemical restraint:

- a. Ativan

- b. Seroquel
  - c. Xanax
  - d. Haldol
  - e. Ambien
5. List four (4) potential negative outcomes to physical restraints:
- a. Incontinence
  - b. Falls
  - c. Constipation
  - d. Decreased bone and muscle strength
  - e. Skin breakdown, pressure sores, skin tears, bruising
  - f. Infection
  - g. Reduced circulation and decreased range of motion
  - h. Loss of appetite
  - i. Pneumonia
  - j. Constipation
  - k. Risk of serious injury (i.e. strangulation/asphyxiation)
  - l. Nerve injury
  - m. Strains, fractures, contractures
  - n. Death
6. List five (5) potential psychological impacts of restraints:
- a. Feelings of entrapment
  - b. Feelings of depersonalization and helplessness
  - c. Feelings of isolation
  - d. Feeling of loneliness
  - e. Loss of self-esteem
  - f. Reduction of autonomy
  - g. Depression
  - h. Increased agitation and/or confusion

7. List three (3) regulations pertaining to the use of restraints:
- a. **May only be used when a resident's medical, mental illness, or mental retardation symptoms warrant the use to ensure the physical safety of the resident or other residents. For example, a physical restraint may only be used if the resident is in danger of causing harm to him or herself or to other residents.**
  - b. **Physical restraints may only be applied if the assisted living facility has a signed physician's order that states the resident's condition warranting the physical restraint use and the circumstances and duration that the restraint will be used. Physical restraints may only be applied without a signed physician's order under extreme emergencies and if the signed physician's order can be readily obtained.**
  - c. **Physical restraints should only be used to the minimum extent necessary to protect the resident or others**
  - d. **Physical restraints can only be applied by those direct care staff members that have received training according to VDSS regulations**
  - e. **The resident's condition must be monitored every 30 minutes**
  - f. **The resident must be assisted with hydration, safety, comfort, range of motion, exercise, toileting, and any other needs at least 10 minutes every hour. NOTE: The resident should be released from the physical restraint during this time if possible.**
  - g. **All monitoring should be properly documented. Proper documentation includes the restraint used (i.e. posey vest, geri-chair), the outcome (i.e. resident less combative, resident asleep), the monitoring checks, hourly assistance needed and/or provided, notes regarding any unusual occurrences or problems (i.e. resident had chafing on skin from attempting to remove posey vest).**
  - h. **The resident shall be released immediately upon the determination that he or she is no longer a threat to him or herself or other residents.**

- i. Chemical restraints are strictly prohibited.
- j. Physical restraints may only be applied if there is a physician's order.
- k. Nonemergency restraints should only be used as a last resort and only after the facility has completed, implemented, and evaluated the resident's comprehensive assessment and ISP. The facility must have also determined and documented that less restrictive methods have failed.
- l. The restraints may only be used in accordance with the resident's ISP.
- m. The ISP must state why the restraint is needed and include a plan of rehabilitation that would result in the progressive removal of the restraint to either less restrictive restraints or restraint-free.
- n. The restraints should only be applied so that the resident does not harm him or herself or others and must cause the resident the least discomfort.
- o. Restraints may not be applied without explaining why the restraints are being used and the potential dangers when using restraints to the resident. If the resident is not cognitively able to understand, the responsible party must be contacted. The explanation must include the resident's right to refuse restraints. Written consent from the resident and/or responsible party must be obtained and placed in the resident's chart.
- p. If the direct care staff member notifies the resident and/or responsible party, the direct care staff member should document in the resident's record the date, time, and person notified. The direct care staff member should also identify him or herself in the resident's record as the individual that made contact.
- q. The direct care staff member must document on the restraint log each time the resident is monitored and any observations made during monitoring.
- r. Restraints should not be used unless they are necessary to alleviate an unanticipated immediate and serious danger to the resident or other individuals in the facility.
- s. The facility must obtain an oral or written order from the physician within one hour of the restraint being applied to the resident. It must be documented in the

resident's record that the physician's order was obtained.

- t. Residents that are placed in restraints for emergency purposes must be in sight and sound of a direct care staff worker at all times.
- u. If the facility deems that the emergency restraint is required for more than a two (2) hour period, the resident must be transferred to a medical or psychiatric inpatient facility or monitored in the facility by a mental health crisis team until his or her condition has stabilized to the point that the attending physician documents that restraints are not necessary.
- v. The facility must also contact the resident's responsible party no longer than 12 hours after the emergency restraint was applied. This notification must be documented in the resident's record including the date, time, person notified, and the staff member that provided the notification.

- 8. **False** Restraints prevent falls.
- 9. **False** The direct care staff member should always tie knots tightly and securely in order to prevent the resident from escaping.
- 10. **False** The resident should be left alone and not interrupted until he or she calms down enough so the restraints can be removed.
- 11. **False** It is okay to give a resident a medication so he or she falls asleep instead of wandering at night.
- 12. **False** It is not necessary to notify the resident's responsible party when restraints are used.



# **End of Life Care: Death, Dying, and Bereavement**

## **Chapter Fifteen**

**Time Required: 1 hour**

## **Chapter Fifteen-End of Life Care - Death, Dying, and Bereavement**

This chapter will focus on the taboo, unspoken, and individual specific subject of death, dying, and the grief process. Each death encountered is different and unique to that person. This chapter will explain the broad concept of the dying and grief processes. The chapter will assist direct care staff in understanding difficult end of life decisions experienced by residents and family members. The chapter will provide information to assist direct care staff workers in supporting the family, resident, and direct care staff during the dying process.

### **15.1 Death in the United States Today**

### **15.2 End of Life Decisions**

### **15.3 Elizabeth Kübler-Ross Stage Model**

### **15.4 Bereavement and Grief**

### **15.5 Staff Roles and Responsibilities**

## **Instructor Planning**

### **1. Objectives and Expected Outcomes of Chapter**

- a. To understand the past and present statistics of death in the United States
- b. To understand end of life decisions such as Do Not Resuscitate orders, hospice care, etc. for family members and residents at the end of life
- c. To be able to recognize the stages and awareness of death and dying to support the resident and family members during the process
- d. To understand the individualized process of bereavement, grief, and loss of a loved one
- e. To be able to recognize the importance of person-centered care and support during the death, dying, and bereavement process

### **2. Recommended Method of Instruction**

- Lecture and class discussion
- Student Review – Chapter Fifteen



## Group Discussion

**Instructor Notes:** Ask the students the following question:

**What is a good death? Close your eyes and imagine you are at the point of your death. Take a moment to notice where you are, what you are doing, who is with you, how do you feel, what are the smells, sounds, and other specifics around you. What are you experiencing?**

**Instruct the class to share only what they are comfortable sharing about this topic. The idea of dying may not have been a thought that a direct care staff member has thought about happening to them. It may be hard for a direct care staff member to connect with a person at the end of life. This exercise will give the direct care staff the opportunity to envision what it is like to be the person at the end of life and what it would mean to have the support and respect from the people surrounding them before death.**

## 15.1 Death in the United States Today

The question above focuses on the personal aspect of the final stage of life: death. When this question was asked during a study by Hallenbeck and associates some of the common themes of a “good death” involved:

- Home.
- Comfort.
- Sense of Completion.
- Saying goodbye.
- Life-review.
- Love.
- The three most common ways that people would like to die are:
  - Sudden death while asleep.
  - Death at home.
  - Dying while being involved in a meaningful activity.

- 2.4 million Americans die each year. Factors such as how, when and where death occurs for these individuals has change dramatically for older adults living today.
- Life expectancy
  - This is the average number of years of life that can be expected for individuals of a certain age to live.
  - Older adults born in 1900 could have expected to live until the age of 47.
  - Older adults born in the year 2000 could expect to live until the age of 77.
- Mortality Rates for Older Adults 65 and older
  - This rate describes the number of people per 1000 people that die in a year.
  - 1900 the mortality rate: 17 out of 1000 people died.
  - 2000 the mortality rate: 8.7 out of 1000 people died.
- Primary causes of death have changed because of the invention of vaccines, technology, and cleaner conditions due to infection control measures.
- According to the US Census Bureau primary causes of death in 1900
  - Flu/Pneumonia            11.8%.
  - TB                            11.3%.
  - Gastritis                    8.3%.
  - Heart disease            8.0%.
  - Stroke                        6.2%.
- According to the US Census Bureau primary causes of death in 2000
  - Heat disease            25.7%.
  - Cancer                      20.0%.
  - Stroke                        6.0%.
  - COPD                        4.5%.

- Accidents 3.4%.
- In 2003 over half (57%) of people who died were hospitalized, 17 percent were living in a nursing home, and 20 percent were living at home.
- Despite the statistics, 80 percent of people would prefer to die in their own home.

## **15.2 End of Life Decisions**

- Dying with dignity
  - Advances in technology have made it possible for people to stay alive with the use of machines.
  - Each person has the right to decide what measures will be taken (machine, artificial nutrition/hydration, CPR etc.).
  - Several documents are used to determine what the person wishes to be done at the time of their death if they are no longer able to communicate these wishes.
- Advance directives
  - Living will
    - This document indicates the type of care that he/she would or would not want to receive if he/she was unable to communicate their wishes.
    - It is important for the resident to have an open conversation with their relatives or power of attorney so that wishes stated in the living will are carried out.
  - Durable Power-of-Attorney
    - This document will designate a person either to make medical or financial decisions on behalf of the resident if he/she is no longer able to make decisions on their own behalf. The goal is for the power of attorney to make

decisions based on what the person would have originally wanted if he/she could communicate these wishes.

- Do Not Resuscitate Order (DNR)
  - This medical document is signed by a physician and individual stating that if the heart stops then the individual does not want to receive Cardiopulmonary Resuscitation (CPR) or any other heroic measures to restart the heart.
  - CPR is the physical act of applying pressure to the chest and breathing into the lungs of a person whose heart has stopped beating and who is not breathing.
  - A DNR order is NOT the same as a living will. If a resident does not have a DNR order then CPR MUST be performed.
    - Risks of CPR
      - Broken ribs.
      - Punctured lung or spleen.
      - Brain damage from lack of oxygen reaching the brain.
  - CPR
    - Persons with the most chance of survival after CPR:
      - Individuals who were in good health before cardiac arrest (heart stops beating).
      - Individuals with irregular heartbeat.
      - Individuals who have stopped breathing but the heart is still beating.
    - Person with the least chance of survival after CPR:
      - Individuals with two or more medical conditions.
      - Individuals who need assistance from others for their care.
      - Individuals with more than one chronic illness.

- Hospice Care
  - More and more people are deciding on using hospice services to provide the person with comfort, free from pain and symptoms, and support from multiple professionals during the dying process.
  - Hospice care will provide comfort through palliative (relieving pain) care instead of curative (curing the disease or illness) care.
  - The focus of palliative care is the relief of pain, suffering, and stress of an illness to maintain quality of life. Palliative care can be combined with hospice care or it can be used to lessen the symptoms of a disease or illness.
  - The hospice team will consist of many different professionals working together to honor a person's right to die with dignity. This team can include:
    - Physicians.
    - Nurses.
    - Therapists.
    - Volunteers.
    - Certified Nurse Assistants.
    - Social Workers.
    - Counselors.
    - Spiritual Counselors.
  - The hospice team recognizes that having a terminal illness can affect a person on many different levels, whether it is physically, emotionally, or spiritually.
  - In order to qualify for hospice an individual must:
    - Receive physician approval.
    - Be diagnosed with a life-limiting illness in which survival after 6 months is unlikely.

- Desires to have pain management and remain comfortable instead of receiving treatment to cure the disease.
- Common hospice diagnoses
  - Dementia.
  - Cancer.
  - End-stage heart disease.
  - End-stage AIDS.
  - Stroke.
- The goal of hospice care is to provide care for the person whether through physical, emotional, or spiritual means to ensure comfort and dignity is preserved for as long as he or she has left to live.
- As a direct care staff, you will continue to be a part of the resident's care team, even if she or he decides to receive hospice services.

### **15.3 Elizabeth Kübler-Ross Stage Model**

Direct care staff work with older adults who are in a wide variety of situations. Some older adults could be experiencing chronic illnesses or receiving hospice services. There are many different responses when the individual learns that death is near. After spending most of her life researching the death experience, Dr. Elizabeth Kübler-Ross developed a five stage psychological response to help explain some of the emotions experienced at the end of life.

- Five Stages of Death and Dying
  - Denial
    - Denial is the first stage of coping when an individual or his or her loved one is dying.
    - Denial is used as a coping mechanism to deal with the shock that death is near.

- This is usually a temporary emotion that provides an individual time to adjust to the situation.
- Anger
  - In this stage the person may become angry and hostile to those around them.
  - The person may become jealous that they were “chosen” to die and another person was given the chance to live.
  - This anger could be directed at themselves, family members, or direct care staff and could be a very difficult time for those that care for the individual.
- Bargaining
  - In this stage the person may accept more of the reality that death is near but want it to come on their terms.
  - The person may bargain silently with his/her God or higher power to try to regain control of the situation.
  - The person may say something like, “I just want to see my daughter get married and then I will accept my death.”
- Depression
  - This stage signals the coming acceptance of the fate of the person.
  - There may be depression over the loss of relationships, loved ones, time etc. with this coming of acceptance.
- Acceptance
  - In this stage, the individual accepts that he or she will die sooner than planned.
  - A calm may come over the person as he or she lives out each day that is left with this acceptance.
- There is no one path to acceptance of death for a person. Each person may respond by going through the stages backward, skipping

steps, or never reaching the acceptance of their death. The job of a direct care staff worker is to meet the person at their point on their journey and support that individual.

- What to expect at the time of death
  - It is literally impossible to predict with 100 percent certainty the time and date of a person's death.
  - When death is approaching there are sensory changes that occur to signal the "active dying phase."
- Hunger Loss
  - The older adult may experience a decrease of hunger.
  - The older adult may also experience an increase of hunger because of the stress and fear of starvation and death.
  - What direct care staff can do to help:
    - Offer small bites of favorite foods but do not force the person to eat.
    - Liquid and soft items such as puddings and popsicles are sometimes better tolerated.
    - Comfort families and let them know that in order to support a good death we must follow the dying individual's lead.
- Thirst
  - Dry mouth does not always mean the person is thirsty
  - What direct care staff can do to help:
    - Small sips, ice chips, or swabs of liquid may help with dry mouth.
- Speech Loss
  - The person may become quiet and lack the desire to communicate.
  - The person also may lack the physical capability of speaking.

- This may cause the family to become distressed because of the realization that their loved one is dying.
- What direct care staff can do to help:
  - Encourage family members to continue to talk and reassure the person of their support.
  - Explain to the family that the person may not be able to speak but could likely hear their words.
- Vision loss
  - The person may appear to stare off into space or “look through” people.
  - Vision may become impaired.
  - What direct care staff can do to help:
    - Keep room at appropriate brightness based on the person’s wishes.
    - Reassure family that seeing/sensing deceased relatives is a normal part of the process for some.
- Loss of hearing and touch
  - Hearing and touch are the last senses to become impaired, allowing family the chance to be with the person through the process.
  - What direct care staff can do to help:
    - Speak clearly to the person but do not yell.
    - Do not be afraid to talk to the person or gently touch their hand if the resident is comfortable with this gesture.
    - Encourage the family to continue to speak to, be close to, touch and comfort the resident.
- Breathing changes
  - Breathing can be irregular and may stop for up to 20-30 seconds (called sleep apnea).

- The person may appear to be working harder and harder for each breath.
- A moaning sound is normal.
- What direct care staff can do to help:
  - Raise the head of the person to help them find an easier position to breathe.
- Confusion
  - Person may become more confused due to the lack of oxygen to the brain.
  - **Do not correct the resident so that the resident does not become more confused or agitated. For example, a resident that thinks a grandson is actually the son. The grandson should respond in a supporting manner so that the resident does not become upset.**
  - What direct care staff can do to help:
    - Stay with the person as much as possible, assuring them of your support.
    - Encourage family members to remain at the person's side for reassurance, if this is the dying person's wish.
- Secretions in the mouth
  - Secretions from the body may collect in the back of the throat causing a rattling or gurgling noise.
  - The person may try to cough up the mucus and the mouth may become dry.
  - What direct care staff can do to help:
    - A vaporizer in the room may add moisture to the lips and mouth to prevent dryness.
    - Clean the mouth with swabs dipped in cool water.
    - If possible, reposition the person to a more comfortable position to help with drainage.

- Restlessness
  - Restlessness may occur because of the lack of oxygen to the brain.
  - Hallucinations are common.
  - What direct care staff can do to help:
    - Using a calm voice may provide reassurance that the staff is there and he/she is not alone.
    - Soft music or a back rub may provide comfort, if this was the dying person's wish.
    - Oxygen may be ordered to alleviate this discomfort.
- Temperature changes
  - The person may feel hot one minute and cold the next due to the body losing its ability to control its internal temperature.
  - Arms and legs may appear blue or cold to the touch because of loss of circulation.
  - What direct care staff can do to help:
    - Add or remove blankets as needed for comfort.
    - A cool or warm washcloth as needed for comfort.
    - Change bed linens and clothing if soaked with perspiration.

**Important: Each direct care staff member will have a different experience with the dying process. It is always ok to reach out to other staff members for support in handling the death or dying process of a resident.**

## **15.4 Bereavement and Grief**

- Bereavement
  - The state of having lost something or someone important.
  - This is a normal event in everyone's life.

- The loss causes the survivor to adapt to life without this person or item.
- Grief
  - The actual emotion and reaction caused by bereavement.
  - There are four categories of grief that a person may feel in the time of bereavement:
    - Feelings.
    - Physical Sensations.
    - Cognitions.
    - Behaviors.
  - Feelings
    - Can include:
      - Loneliness.
      - Fear.
      - Guilt.
      - Anger.
      - Helplessness.
      - Depression.
      - Relief.
    - Some people may be able to identify and voice these feelings and some may not.
    - No two people will experience any part of grief the same way even if they both have experienced the same loss.
  - Physical sensations
    - Can include:
      - Appetite changes
      - Weakness
      - Sleep changes
      - Intestinal problems

- Shortness of breath
    - Stomach aches
  - Now is the time to encourage the loved one to take care of themselves by eating, drinking, and listening to their bodies' needs.
  - Every person's body reacts to stressful situations in different ways. In the grieving process the body may react by causing headaches, stomach aches, and intestinal problems.
- Cognitions
  - A person experiencing the loss may be in a state of disbelief or confusion.
  - The focus may be on the loss. The person may have a strong need to focus on the past and being with the deceased person.
  - The person may experience feeling or sensing the deceased is still present.
- Behaviors
  - Can include:
    - Sleep/appetite disturbances.
    - Crying.
    - Sighing.
    - Dreaming of the deceased.
    - Clinging to objects of the deceased.
  - Like any step in the grieving process, each person is different and this list does not include all behaviors that can be experienced by a person grieving over the loss of a loved one.
- Stages of Grief

- A person who has experienced the death of a loved one can go through grief stages:
  - Denial
    - Denial is a defense mechanism that shields the person from the effects of the loss.
  - Numbness
    - After the death of a person, the bereaved is often noted by others as “doing so well”. This fact can be an illusion based on the numbness felt from accomplishing the routine of preparing for the death arrangements. Once the arrangements have been planned and executed the bereaved may ultimately feel grief.
  - Searching
    - In this stage the bereaved looks back on the relationship with the deceased and may experience intense feelings of anger, guilt, and resentment.
    - It is important in this stage to support the person in expressing these feelings because not expressing them can lead to a long recovery period.
  - Disorientation
    - A bereaved person may change from wanting to stay attached to the deceased to wanting to move on with their life, accepting that the memory of the person will always be a part of their life.
    - It is important to be supportive in this time. The person may second guess decisions made because the deceased was the primary decision maker.

- Resolution
    - At this point the bereaved recognizes that he or she is able to have a future and that it is ok to let go of the deceased, cherishing their memory.
    - The person will never forget the individual, but the pain of the loss will not be such an overwhelming part of their life.
- What can direct care staff do to help?
  - Death and grief is a very uncomfortable topic to approach in today's society.
  - Some helpful words for the grieving person can be:
    - "I am sorry."
    - "I care about you."
    - "I can't imagine what you are going through, but I want you to know that I care."
  - Although well-intended, some words can make a bereaved person feel that their feelings have been dismissed. Examples include:
    - "It was God's will."
    - "Try not to cry."
    - "You need to get on with your life."
    - "Your loss is heaven's gain."
    - "I know just how you feel."
    - "He's in better hands now."
    - "God needed him more than we did."
- It is important to note that direct care staff is sometimes forgotten when it comes to the death of a resident. In most cases, the direct care staff spend more time in the lives of their residents than they do with relationships outside of their workplace. It is important to

recognize your own grief and be aware of your own needs during the process.

- Direct Care Staff need to acknowledge their own emotions regarding the loss of a resident.
- Direct Care staff may go through the same grieving process as a family member would.
- Direct Care Staff should speak with a Supervisor if additional support is needed in working through this process.

### **15.5 Staff Responsibilities**

- Don't treat others as you would like to be treated, but learn how they would like to be treated.
- It is important to keep in mind that you may or may not agree with your residents' (or his or her families') wishes regarding their advance directives and how they choose to die. Although it is important to recognize your feelings, it is important that you respect the residents' decisions and provide support to them.
- Emphasize courtesy and respect instead of criticism and confrontation.
- Take care of yourself after the death of a resident because it is normal to grieve.
- Recovery from the death of a loved one is different for everyone. It is important to accept and respect the fact that not all family members and loved ones will grieve in the same way as others.
- Most people do not picture their death in a longterm care community, so it is important to ensure comfort, support, and care for the resident.
- Talk with your supervisors and coworkers about how you can honor people who die. For example, having a community (the whole facility- residents, staff, and families) meeting in which everyone can share stories of the person who died.

- Each ALF will approach the death of its residents in a different way. Regardless of how your ALF handles death, it is important that you recognize your connection to the person who died and how you will cope with the loss.

## **Standards for Licensed Assisted Living Facilities** **Effective July 17, 2013\***

22 VAC 40-72-550      Resident rights

**\*Standard numbers are subject to change when the Standards for Licensed Assisted Living Facilities are updated. Please be sure to reference the current Standards for Licensed Assisted Living Facilities when teaching this curriculum.**

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## Student Review – Chapter Fifteen

1. Name three possible members of the hospice team.
  - a. **Physician**
  - b. **Nurse**
  - c. **Social Worker**
2. Name the five stages of grief.
  - a. **Denial**
  - b. **Numbness**
  - c. **Searching**
  - d. **Disorientation**
  - e. **Resolution**
3. What are the five phases of Dr. Kubler-Ross' model?
  - a. **Denial**
  - b. **Anger**
  - c. **Bargaining**
  - d. **Depression**
  - e. **Acceptance**
4. **False** The goal of hospice care is to provide a cure for the individual's chronic illness?
5. **False** If an individual has a living will then the staff does not have to perform CPR.
6. Which is the last sense a person loses before death?
  - a. **Sight**
  - b. **Smell**
  - c. **Hearing**
7. Name one common theme of a good death  
**Death at home**
8. **False** Cancer was the leading cause of death in 1900.
9. Describe one way that direct care staff can help when a person loses the ability to speak before death.

**Staff should still continue to communicate verbally and through touch to the individual because hearing is the last sense that a person loses before death.**

10. What can be expected when a person is in the “Bargaining” stage of the Elizabeth Kübler-Ross Stage Model?

**The person may ask their God or higher power to give them more time so that he or she will be able to see a significant event (i.e. birth of a grandchild) before death.**

# GLOSSARY

## Glossary

### Chapter One – Introduction to the Uniform Assessment Instrument and the Individualized Service Plan

- **Individualized Service Plan (ISP)** - Description of identified needs based on UAI, physical exam report (history and physical), interview with the resident, mental health progress report, resident personal/social data, and other sources
- **Person-Centered Care** – “...*Person Centered Care gives personal attention to the people who live in Long Term Care and empowers staff to be a resident advocate. We believe in honoring each person's dignity, rights, self-respect, and independence by giving them choices, respecting their wishes, meeting their needs, involving them in decision making process, giving them the control of their life and keeping them actively involved, happy and as healthy as possible.*” - Eric Haider (leader in culture change)
- **Uniform Assessment Instrument (UAI)** - A multidimensional questionnaire which assesses a resident's social, physical, and mental health and functional abilities

### Chapter Two – Infection Control

- **Asepsis** – a condition in which no infection/disease is present.
- **Contaminated** – the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface. Contaminated materials are considered “soiled.”
- **Cycle of Infection** - includes the host, a way to move out of the host, as well as a way to move into a new host.
- **Direct contact** – coming in contact with a pathogen by touching the infected body fluids while caring for a resident
- **E. coli** – bacteria found in the intestines of infected humans and cows.
- **Germ**s – micro-organisms that are everywhere. Micro-organisms are inside and outside of the human body. Germs can be bacteria, viruses, a fungi, or

parasites. Germs can be found in the air, on any surface, and on the bodies of humans and animals. Some germs are good while others may cause infections and illnesses. Germs can move through body fluids, air, animals and insects, and by eating or drinking infected food and drinks. These are considered pathogens.

- **Health care acquired infection (HAI)** – an infection that an individual gets in the hospital or nursing home.
- **Indirect contact** – coming in contact with a pathogen by touching something that has a resident's infected bodily fluids on it (i.e. used tissues)
- **Infection Control** – any technique used to control and limit the spread of potential infection.
- **Infections** – conditions or diseases that happen when germs enter the body and grow
- **Methicillin-resistant Staphylococcus Aureus (MRSA)** - bacteria that is resistant to certain antibiotics
- **Microorganism** – a tiny living thing that is only visible by microscope.
- **Non-pathogen** – a microorganism that does not cause disease.
- **Pathogen** – disease causing microorganisms.
- **Personal Protective Equipment (PPE)** – equipment worn by direct care staff for protection against germs and infections. This equipment also protects residents from germs and infections the direct care staff may be carrying. PPE protects the skin since the skin is the first barrier of defense against infection.
- **Salmonella Typhi (S. Typhi)** – bacteria that causes a life threatening illness that lives only in humans. This is also called typhoid fever.
- **Sepsis** – a serious condition in which infection/disease is present.
- **Standard Precautions** - “A group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.”

- **The Method of Transmission** - the way the infection moves out of the Host to a new location. Infections can be spread through the air, water, and the environment.
- **Transmission** – the manner in which a germ, infection, or disease is transferred or passed from one person to another.
- **Tuberculosis (TB)** - bacteria transmitted through the air by coughing, sneezing, talking, or singing. TB usually attacks the lungs but can attack the kidney, spine, or brain.
- **Uncontaminated** – no presence or anticipated presence of blood or other potentially infectious material on an item or surface. Uncontaminated materials are considered “clean.”
- **Waste Materials** – any item that comes in contact with bodily fluids.

### Chapter Three – Aging 101

- **ADL limitations** - difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet.
- **Ageism** - discriminating against people because of their age. It is a prejudice against older people.
- **Cognitive** - mental processes of perception, memory, judgment, and reasoning.
- **Elderspeak** - the name given to the way we might talk to older adults in a childlike way.
- **Emotional** - feelings or psychological states.
- **Functional** - the ability to take part in daily activities.
- **Geriatrician** - a medical doctor who specializes in the care of older adults.
- **Gerontologist** - a professional who has an advanced degree in the field of Gerontology. Gerontologists specialize in the unique life stage of late life, special needs and issues that relate to older adults and to aging populations

in general. Geriatrics is a branch of medicine that looks at health and disease in later life.

- **Gerontology** - the study of aging processes and individuals. It is multidisciplinary, meaning it includes the study of physical, mental, and social changes in older people as they age.
- **IADL limitations** - difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, housework, home maintenance, transportation, meal preparation, shopping, laundry or managing money.
- **Optimal aging** - "The capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual – **to one's satisfaction and in spite of one's medical conditions.**" (Brummel-Smith, 2007)
- **Social** - how one relates to the society around him or her.
- **Spiritual** - religious or sacred beliefs and practices.

#### **Chapter Four – Resident Rights**

- **Active Neglect** - when you don't do something for someone on purpose, and you know that what you are NOT doing is going to hurt the other person.
- **Adult Protective Services (APS)** - a division of the Department for Aging and Rehabilitative Services that investigates reports of abuse, neglect, and exploitation of adults aged 60 and over and incapacitated adults over 18 years of age.
- **Financial Exploitation**- when money or things belonging to one person are used to benefit another person, without the owner's permission.
- **Mandated Reporter** – anyone working in healthcare. Mandated reporters are required to report suspected abuse, neglect, or exploitation of elders or incapacitated adults.
- **Neglect** - when someone does NOT do something they were supposed to do, and it hurts another person.

- **Resident rights** - the rights, given by law, which every resident of an assisted living facility has to follow. These rights refer to treatment and care, privacy and confidentiality, personal choice, safety, and disclosure of information related to services and fees charged for accommodations, services, and care.
- **Passive Neglect** - when you don't do something for someone, but you didn't mean to hurt the other person. Forgetting to do something for a resident happens to every worker once in a while. It becomes "neglect" when it happens over and over, resulting in harm to the resident.
- **Physical abuse** - hurting someone on purpose, trapping them without a reason, or punishing them in a way that hurts or harms their body.
- **Psychological abuse (sometimes called emotional or mental abuse)** - when someone threatens to hurt, trap, or punish someone else. It includes threatening or humiliating with words, in a way that hurts or harms a person's emotional well-being, or makes them afraid.
- **Sexual abuse** - sexual touching or sexual activity that is not wanted by the other person.
- **Virginia Department of Social Services** - licenses and regulates assisted living facilities.
- **Virginia Long-Term Care Ombudsman** - serves as an advocate for older adults receiving long-term care. They receive complaints regarding care issues in long-term care and assist residents in exercising their rights.

### **Chapter Five – Residents with Disabilities and Special Conditions**

- **Aggressive behavior** - behavior exhibited by an individual in a violent, hostile, and destructive manner.

- **Assistive Devices** - mechanical items that help a resident perform activities of daily living without another individual's physical assistance. Use of assistance devices promotes independence.
- **Autism or Autism Spectrum Disorder (ASD)** - a developmental disability that results from a range of neurodevelopmental disorders. An individual diagnosed with autism may show signs of social impairment, communication difficulties, and repetitive behaviors. Individuals diagnosed with autism can have a range of impairments from mild to severe. Many individuals with autism can work and live either independently or in a supervised environment.
- **Cataracts** - a condition that results in everything viewed being blurred and looking out of focus. This condition can cause pain from the glare of light. Clouding on the lens occurs and the pupil changes color from black to a cloudy white.
- **Diabetic Retinopathy** – a condition that results when blood is no longer fed to the retina through the blood vessels in the eye. Blood vessels often leak fluid into the retina. This results in blurring, blind spots, and difficulty with peripheral vision.
- **Down's Syndrome** - a developmental disability that occurs when an individual is born with three, rather than two, copies of the 21st chromosome. The additional copy of the 21st chromosome changes the course of development from birth through adulthood.
- **Emotional harm** – periods of anger, crying, and/or uncontrollable laughter.
- **Glaucoma** – occurs when there is increased pressure in the eye because of excess fluid build-up in the eye. A disease of the eye that results in the outside of the picture you normally see disappearing. Only the center of the picture can be seen.
- **Harm** - causing physical or psychological injury or damage.

- **Intellectual Disabilities** – an individual with an intellectual disability is described as an individual having significant limitations in intellectual functioning and adaptive skills area including conceptual, social, and practical adaptive skills. The intellectual disability usually originates prior to the age of 18.
- **Macular Degeneration** - occurs when new blood vessels form in the macula area (responsible for central vision) of the eye when they are not supposed to grow. The result is that macula is weakened.
- **Physical harm** – behavior of one individual that results in the physical injury of self or another individual.
- **Psychological harm** – withdrawal, fear, isolation, and agitation. For example, the same resident has stopped participating in other activities just so he won't have to see the resident that accused him of cheating at bingo.
- **Social harm** – behavior of one individual that prevents another from participating in a desired activity
- **Substance abuse** - excessive use, generally self-administered, of any legal or illegal drug without regard to the physical or mental consequences.
- **Tardive Dyskinesia** - a neurological disorder that presents as involuntary and uncontrollable movements particularly around the mouth, tongue, trunk and limbs. This disorder is typically a result of prolonged used of antipsychotic medications.
- **Wernicke-Korsekoff's Syndrome** – a result of damage that occurs in the brain based on the lack of Vitamin B1 (thiamine). This is typically seen in individuals with a long history of alcohol abuse. The alcohol prevents the proper breakdown of the Vitamin B1 in the body resulting in the deficiency.

## **Chapter 6 - Residents with Special Health Care Needs**

- **Angioplasty** - used to physically open a blocked coronary artery. It is less invasive than bypass surgery.

- **Angiotensin-converting enzyme (ACE) inhibitors** - lower blood pressure and reduce the amount of work the heart has to do.
- **Arthritis** - inflammation of joints
- **Atherosclerosis** - is a blood vessel disorder. There is a build-up of fatty deposits called plaque on the inside walls of arteries. Over time, calcium accumulates in the plaques, making them stiff and causing them to enlarge. As the plaques enlarge, they reduce blood flow and sometimes block it.
- **Bypass surgery** - a vein or an artery from another part of the body is used to bypass the blocked coronary artery.
- **Calcium channel blockers** - dilate blood vessels, improve blood flow to the heart, and lower blood pressure.
- **Chronic Obstructive Pulmonary (PULL-mun-ary) Disease (COPD)**, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time.
- **Diabetes** - a chronic disease associated with abnormally high levels of sugar (glucose) in the blood. There are two types of diabetes, In Type 2 diabetes, the body does not respond normally to the insulin that is produced. It is also called adult-onset diabetes or noninsulin-dependent diabetes. In Type 1 diabetes, insulin is not produced. This is also called insulin dependent diabetes.
- **Fecal incontinence** - refers to involuntary bowel movements.
- **Heart failure** - develops when the heart cannot pump as much blood as the body needs. It cannot keep up with the body.
- **Hemorrhagic stroke** - a blood vessel bursts and blood escapes into or around brain tissue. This blood accumulates in the brain and can irritate brain tissue. The accumulating blood causes swelling, putting pressure on and damaging brain tissue. It also interferes with the blood supply to brain tissue.
- **Hypertension** - systolic blood pressure greater than 140 or diastolic blood pressure greater than 90.
- **Ischemic stroke** - blood is prevented from reaching the brain. The most common cause is blockage of an artery.

- **Nitrates** - expand (dilate) blood vessels, improving blood flow to the heart.
- **Osteoarthritis** - a chronic disorder of cartilage (the connective tissue that cushions and protects the surface of bones where they meet to form joints), bones, and some of the tissues that surround joints. The cartilage begins to wear away and bones rub against each other.
- **Osteoporosis** - a disease in which bones become very fragile and are more likely to break. With osteoporosis, your bones become porous and less dense.
- **Oxygen** is considered a medicine and must be prescribed by a physician. The source of the oxygen (i.e. compressed gas or concentrators) and the delivery service (i.e. nasal cannula, reservoir nasal cannulas or masks) must be written on the prescription along with the flow rate.
- **Rheumatoid Arthritis** - an autoimmune disease, a type of illness that makes your body attack itself.
- **Statins** - primarily to control abnormal cholesterol levels.
- **Stroke, or a cerebrovascular accident (CVA)** - a loss of blood supply to the brain. This is usually because the arteries supplying the brain with blood are blocked.
- **Urinary incontinence** - is defined as the uncontrollable loss of urine.

## Chapter 7 - Alzheimer's Disease and Other Dementias

- **Agnosia** - medical term that refers to the inability to recognize objects or people or to interpret sensory signals like pain, hunger, and thirst.
- **Alzheimer's Disease** - progressive, degenerative brain disease that results in problems with memory, thinking, and behavior.
- **Cognitive impairment** - a general term that refers to problems in mental functions, including intelligence, judgment, learning, memory, speech, and thinking.
- **Dementia** - a general term for the loss of memory and other intellectual (or cognitive) abilities that are serious enough to interfere with daily life.

- **Validation Therapy** is a method used to communicate with older adults that are disoriented and is typically used with those individuals that have a diagnosis of dementia.

### **Chapter Eight- Intimacy and Aging**

- **Advocacy** - to give "active verbal support to a cause or a position". This means that you make it your responsibility to be the voice for residents that may not be able to defend their rights and take action to make sure they are receiving the care they deserve.
- **Bisexual** - an individual who can have physical and emotional relationships with both men and women
- **Consent** - the act of agreeing or giving permission to do something
- **Gay** - refers to men who have physical and emotional relationships with other men
- **GLBTI** - Gay, lesbian, bisexual, transgender, and intersex - a group of individuals that share a common bond through their minority status. It is difficult to place all individuals in the same group (GLBTI) because of the diversity of each group.
- **Intersexed** - people who may have been born with a combination of external and internal male or female genitalia.
- **Intimacy** refers to the personal relationship felt between two individuals. Intimacy and sex are not the same. Adults of all ages can have sex and never feel a personal connection (intimacy) with the person.
- **Lesbian** - refers to women who have physical and emotional relationships with other women
- **Transgendered** - is an umbrella term that includes individuals whose personal identity does not conform to society's view of "male" or "female".

## Chapter Nine - Meals and Nutrition

- **AIDS** - a chronic, life-threatening virus that attacks the body immune system (part of the body that fights off other viruses and bacteria) causing your body to lose its defense to illness.
- **Metabolism** is the rate that your body burns calories.

## Chapter Ten - Activities

- **Activities** - "Activity practice is based on assessment, development, implementation, documentation, and evaluation of the programs provided and the unique needs and interests of each individual (as defined by The National Association of Activity Professionals)"
- **Physical Impairment** - Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine

## Chapter Eleven - Personal Care

- **Contracture** refers to the shortening and hardening of muscles, tendons, or other tissues. It results in the loss of motion for that body part.
- **Dehydration** is the loss of water and salts necessary for living.
- **Incontinence** refers to the loss of bowel or bladder control.
- **Malnutrition** is a condition that is the result of the body not getting enough vitamins, minerals, or other nutrients.
- **Pressure ulcers** - also known as decubitus ulcers, pressure sores, or bedsores are injuries that result from unrelieved pressure on the skin. Pressure ulcers form where bone causes the greatest force on the skin and tissue and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. Pressure ulcers can range from mild ones (reddening of skin) to severe (deep wounds down to muscle and bone)

- **Resident-Centered Care** - Each individual resident will need different degrees and types of assistance as specified by his or her ISP. Resident care is tailored to the resident's needs and preferences. These tailored needs and preferences should be listed in the ISP.

#### **Chapter 14 – Restraint Use in the Assisted Living Facility**

- **Chemical Restraint** - A chemical restraint is defined by VDSS as “a psychopharmacological drug that is used for discipline or convenience and not required to treat the resident’s medical symptoms or symptoms from mental illness or mental retardation, that prohibits an individual from reaching his highest level of functioning.”
- **Emergency Restraint Use** - An emergency, as it applies to restraints as defined by VDSS is “a situation that may require the use of a restraint where the resident’s behavior is unmanageable to the degree an immediate and serious danger is presented to the health and safety of the resident or others.”
- **Non-emergency restraint** - A nonemergency as it applies to restraints as defined by VDSS is “circumstances that may require the use of a restraint for the purpose of providing support to a physically weakened resident.”
- **Physical Restraints** - A physical restraint is defined as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the resident cannot remove easily, which restricts freedom of movement or access to his body.”

#### **Chapter Fifteen-End of Life Care - Death, Dying, and Bereavement**

- **Cardiopulmonary Resuscitation (CPR)** - the physical act of applying pressure to the chest and breathing into the lungs of a person whose heart has stop beating and is not breathing
- **Do Not Resuscitate Order (DNR)** - This medical document is signed by a physician and individual stating that if the heart stops then the individual does not want to receive Cardiopulmonary Resuscitation (CPR) or any other heroic measures to restart the heart

- **Durable Power-of-Attorney** - This document will designate a person either to make medical or financial decisions on behalf of the resident if he/she is no longer able to make decisions on their own behalf. The goal is for the power of attorney to make decisions based on what the person would have originally wanted if he/she could communicate these wishes.
- **Living will** - This document indicates the type of care that he/she would or would not want to receive if he/she was unable to communicate their wishes

**FINAL EXAM**  
**FINAL EXAM KEY**



## Direct Care Staff Curriculum Final Exam

This is a multiple choice and true/false exam. Read each question carefully.

1. Why is the ISP important?
  - a. It provides us with information on the resident's needs and preferences.
  - b. It does not provide us with the information we need to provide care.
  - c. It assesses the resident.
  - d. It provides us with the least amount of work.
2. Who might be involved in developing the ISP?
  - a. Resident
  - b. The resident's cousin that has no legal authority over the resident
  - c. The receptionist at the physician's office
  - d. The dental hygienist
3. Why is the input of those individuals important when developing the ISP?
  - a. Helps to reduce staff labor costs
  - b. Assists in meeting all of the resident's needs
  - c. It's not important
  - d. Both a and b
4. What is the role and responsibility of direct care staff for development of the ISP?
  - a. Direct care staff assists in identifying individualized and realistic goals for the resident.

- b. It is the direct care staff members responsibility to be knowledgeable of the resident's strengths, limitations and risk factors.
  - c. Direct care staff have no responsibility for this. It is up to the RNs and LPNs.
  - d. Both a and b.
5. How and when is the ISP revised or updated?
- a. It is initially developed by the information on the UAI and other assessment tools used and information gathered.
  - b. An ISP should be completed within 72 hours of the resident moving in.
  - c. A comprehensive assessment should be completed within 30-days of the resident moving in.
  - d. The ISP should be updated or revised any time there is a change in status lasting longer than 30 days and at a minimum of every 12 months.
  - e. All of the above.
6. Where should the ISP be located in the facility?
- a. Locked in the Director of Nursing's office.
  - b. In the reception area accessible to anybody.
  - c. In a location accessible to staff.
  - d. In the medication room
7. Which of the following is not a term used in basic terminology of infection control?
- a. *Macroorganism*
  - b. *Pathogen*
  - c. *Germs*
  - d. *Infections*
  - e. *Transmission*

8. T/F \_\_\_ The three (3) components in the Cycle of Infection are Host, Method of Transmission, and New Host.
9. Which reasons below would explain why older adults may be more susceptible to infection compared to other populations?
- Compromised immune systems
  - More frequent hospitalizations
  - Improper nutrition and hydration
  - Thinner skin
  - All of the above
10. Which of the following is not a general sign and symptom of infection.
- Redness around the potentially non-infected area
  - Swelling around potentially infected area
  - Fluid secreting out of the potentially infected area
  - Skin warm to the touch in potentially infected area
11. T/F \_\_\_ Direct Care Staff has the responsibility to apply the appropriate precautions to residents on a daily basis to prevent infection. Direct Care Staff has the responsibility for their health and protection as well as those of residents.
12. What is the most common infection in older adults?
- Respiratory Infections
  - Urinary Tract Infections
  - Gastrointestinal Infections
  - Wound Infections
13. PPE stands for:
- Private Protective Equipment
  - Personal Protective Equipment
  - Private-duty Protective Equipment
  - Personnel Protection Equipment

14. T/F \_\_\_ Losing one's memory is expected as you age.
15. T/F \_\_\_ Ageism means discriminating against people because of their age. It is a prejudice against older people.
16. T/F \_\_\_ Optimal aging is: "The capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual – to one's satisfaction and in spite of one's medical conditions."
17. Which of the following is not true in regards to changes in the circulatory system as we age:
- In general, the flow of blood changes.
  - The heart gets weaker so it doesn't work as well.
  - The tubes that carry blood to and from the heart get softer and thicker, which slows down the flow of blood.
18. T/F \_\_\_ If a person experiences bad health, loss of function or independence with aging, she or he may need to find ways of coping with his or her losses. These things may also create depression and anxiety.
19. What one is not an example of resident rights?
- Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record.
  - Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial

transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law.

- Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility.
- Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record.
- *None of the above*

20. T/F \_\_\_ A resident can contact VDSS, APS, or a Virginia Long-Term Care Ombudsman if he or she thinks his or her rights are being violated.

21. T/F \_\_\_ Direct care workers are mandated reporters.

22. What are the responsibilities of a mandated reporter?

- Immediately report potential abuse, neglect, or exploitation when they become aware of the situation.
- Provide information about the individual(s) involved as well as any information you have regarding the potential abuse, neglect, or exploitation.
- Make available to APS investigators information that documents the abuse (even things normally considered confidential).

- All of the above.
23. T/F \_\_\_ The main types of abuse are physical, psychological, and sexual.
24. T/F \_\_\_ Neglect is when someone does NOT do something they were supposed to do, and it hurts another person.
25. Which of the following are some signs of potential abuse, neglect, or exploitation?
- Skin tears, scratches, cuts
  - Sudden change in behavior
  - Discomfort in sitting or walking
  - Weight loss
  - All of the above
26. T/F \_\_\_ An employee should call Adult Protective Services (APS) if he or she thinks someone is being abused, neglected, or exploited.
27. Three (3) assistive devices for grooming include:
- a. Walker, cane, wheelchair
  - b. Raised toilet seat, grab bars beside commode, toilet tissue aid
  - c. Sock Donner, long-handed comb and brush, button threader
  - d. Skid-free placemats, utensil with holding strap, curved utensils
28. T/F \_\_\_ Glaucoma and Diabetic Retinopathy are diseases of the eye.
29. Which of the following is not a staff intervention that direct care staff can implement to assist a resident with visual impairment?
- Provide large-print books and reading materials
  - Keep the environment dimly lit, particularly at night
  - Use contrasting colors to assist in recognizing objects and food
  - Keep walkways clear of clutter

30. Which of the following is not a staff intervention that direct care staff can implement to assist a resident with hearing impairment?
- Keep hearing aids clean
  - Reduce background noise
  - Check hearing aid batteries to make sure they are working
  - Speak quickly and clearly in a lower toned voice
31. T/F \_\_\_ A person with development disabilities cannot have a mental illness as well as a developmental disability.
32. Direct care staff should closely monitor which changes in healthcare status and dietary intake when working with a resident with a developmental disability?
- Regular bowel elimination, onset of seizures, excessive thirst
  - Potential for injury, potential for skin breakdown
  - Dental changes, weight changes
  - Changes in eating habits, changes in sleeping habits
  - All of the above
33. T/F \_\_\_ Three (3) symptoms of depression are emotional symptoms, thought-process changes and physical symptoms
34. Which of the following is not a staff intervention that can be implemented to assist residents diagnosed with a mental illness?
- Encourage resident to engage in a safe activity that he or she enjoys
  - Encourage resident to engage in a regular exercise program
  - Encourage resident to reduce intake of coffee, alcohol, and nicotine
  - Encourage resident not to reminisce about positive past experiences

35. T/F \_\_\_ Tranquilizers treat anxiety and relaxes muscles.
36. T/F \_\_\_ People with diabetes might have to urinate more frequently.
37. T/F \_\_\_ People with diabetes may experience a loss of feeling in their feet due to nerve damage. As a result, they may injure their feet and not realize it.
38. T/F \_\_\_ Symptoms of a stroke happen slowly. They may get better over a period of hours or days.
39. Who is at greatest risk for getting pressure ulcers?
- People confined to a bed or chair
  - People who are mobile or can change positions freely
  - People who are continent of bowel and/or bladder
  - People with good nutrition
40. What is the most prevalent type of dementia?
- Alzheimer's Disease
  - Parkinson's Dementia
  - Vascular Dementia
  - Korsekoff's Syndrome
41. Which of the following is not a "warning sign" of Alzheimer's disease?
- a. problems with language
  - b. poor or decreased judgment
  - c. problems with abstract thinking
  - d. stable personality
42. T/F \_\_\_ Alzheimer's disease is different from "normal aging" in that a person with Alzheimer's disease may forget the whole experience while a person experiencing normal aging may forget part of the experience.

43. What are five common communication challenges in people with Alzheimer's disease?
- a. difficulty finding the right words, losing train of thought, using gestures instead of speaking
  - b. using unfamiliar words over and over again, never using curse words, speaking less often
  - c. inventing new words for familiar things, reverting to one's native language
  - d. easily organizing words logically
  - e. a and c
  - f. b and d
44. What are some ways in which you can help people with Alzheimer's communicate?
- a. Patience and give the person time
  - b. Show your interest
  - c. Avoid criticizing or correcting
  - d. Encourage unspoken communication
  - e. All of the above
45. T/F \_\_\_ GLBTI means Gay, Lesbian, Bisexual, Transgender, Intersex
46. T/F \_\_\_ A **normal** age-related changes in a man that would affect sex includes an increase in testosterone.
47. Name two **normal** age-related changes in a woman that would affect sex.
- a. decrease in testosterone (decrease in sex drive)
  - b. vaginal walls become thinner, dryer, and less elastic
  - c. increase in testosterone
  - d. vaginal walls become thinner
  - e. a and b

48. T/F \_\_\_ A resident who undresses at the dinner table is only trying to have sex with the female resident sitting next to him at the table.
49. T/F \_\_\_ An inactive lifestyle can cause constipation, a common problem in the older adult population.
50. T/F \_\_\_ 72 percent of the bodies' fluid supply rests in the body's lean mass.
51. T/F \_\_\_ The recommended amount of protein per day is between 15-20 ounces.
52. T/F \_\_\_ Decrease in saliva production, brittle teeth, and loss of taste buds are three oral changes that can create problems with proper intake of nutrition.
53. Describe the signs and symptoms of dehydration.
- Dry mouth and poor skin elasticity
  - Moist mouth and good skin elasticity
  - Change in mental status
  - No change in mental status
  - a and c
54. T/F \_\_\_ Two benefits of adding more fiber into an older adult's diet include increasing constipation risk and lowering blood sugar levels.
55. T/F \_\_\_ Two (2) impacts of HIV/AIDS on nutritional status of an older adult include anorexia and nausea/vomiting.
56. Why are activities important?
- Expression of who we are as an individual
  - Provides for a sense of accomplishment
  - Contributes to life satisfaction, emotional wellness and increases quality of life
  - All of the above

57. T/F \_\_\_ All staff including yourself should be involved in activities at an Assisted Living Facility.
58. T/F \_\_\_ All people with Alzheimer's Disease will behave the same way in a game of Bingo.
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99. T/F \_\_\_ Death at home is one common theme of a good death.
100. T/F \_\_\_ Cancer was the leading cause of death in 1900.



## Direct Care Staff Curriculum Final Exam Key

This is a multiple choice and true/false exam. Read each question carefully.

1. Why is the ISP important?
  - a. It provides us with information on the resident's needs and preferences.
  - b. It does not provide us with the information we need to provide care.
  - c. It assesses the resident.
  - d. It provides us with the least amount of work.
2. Who might be involved in developing the ISP?
  - a. Resident
  - b. The resident's cousin that has no legal authority over the resident
  - c. The receptionist at the physician's office
  - d. The dental hygienist
3. Why is the input of those individuals important when developing the ISP?
  - a. Helps to reduce staff labor costs
  - b. Assists in meeting all of the resident's needs
  - c. It's not important
  - d. Both a and b
4. What is the role and responsibility of direct care staff for development of the ISP?
  - a. Direct care staff assists in identifying individualized and realistic goals for the resident.

- b. It is the direct care staff members responsibility to be knowledgeable of the resident's strengths, limitations and risk factors.
  - c. Direct care staff have no responsibility for this. It is up to the RNs and LPNs.
  - d. Both a and b.
5. How and when is the ISP revised or updated?
- a. It is initially developed by the information on the UAI and other assessment tools used and information gathered.
  - b. An ISP should be completed within 72 hours of the resident moving in.
  - c. A comprehensive assessment should be completed within 30-days of the resident moving in.
  - d. The ISP should be updated or revised any time there is a change in status lasting longer than 30 days and at a minimum of every 12 months.
  - e. All of the above.
6. Where should the ISP be located in the facility?
- a. Locked in the Director of Nursing's office.
  - b. In the reception area accessible to anybody.
  - c. In a location accessible to staff.
  - d. In the medication room
7. Which of the following is not a term used in basic terminology of infection control?
- a. Macroorganism
  - b. Pathogen
  - c. Germs
  - d. Infections
  - e. Transmission

8. T/F **True** The three (3) components in the Cycle of Infection are Host, Method of Transmission, and New Host.
9. Which reasons below would explain why older adults may be more susceptible to infection compared to other populations?
- a. Compromised immune systems
  - b. More frequent hospitalizations
  - c. Improper nutrition and hydration
  - d. Thinner skin
  - e. All of the above**
10. Which of the following is not a general sign and symptom of infection.
- a. Redness around the potentially non-infected area**
  - b. Swelling around potentially infected area
  - c. Fluid secreting out of the potentially infected area
  - d. Skin warm to the touch in potentially infected area
11. T/F **True** Direct Care Staff has the responsibility to apply the appropriate precautions to residents on a daily basis to prevent infection. Direct Care Staff has the responsibility for their health and protection as well as those of residents.
12. What is the most common infection in older adults?
- a. Respiratory Infections
  - b. Urinary Tract Infections**
  - c. Gastrointestinal Infections
  - d. Wound Infections
13. PPE stands for:
- a. Private Protective Equipment
  - b. Personal Protective Equipment**
  - c. Private-duty Protective Equipment
  - d. Personnel Protection Equipment

14. T/F **False** Losing one's memory is expected as you age.
15. T/F **True** Ageism means discriminating against people because of their age. It is a prejudice against older people.
16. T/F **True** Optimal aging is: "The capacity to function across many domains—physical, functional, cognitive, emotional, social, and spiritual – to one's satisfaction and in spite of one's medical conditions."
17. Which of the following is not true in regards to changes in the circulatory system as we age:
- In general, the flow of blood changes.
  - The heart gets weaker so it doesn't work as well.
  - The tubes that carry blood to and from the heart get softer and thicker, which slows down the flow of blood.**
18. T/F **True** If a person experiences bad health, loss of function or independence with aging, she or he may need to find ways of coping with his or her losses. These things may also create depression and anxiety.
19. What one is not an example of resident rights?
- Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the admission agreement; evidence of this shall be the resident's written acknowledgment of having been so informed, which shall be filed in his record.
  - Unless a committee or conservator has been appointed, is free to manage his personal finances and funds regardless of source; is entitled to access to personal account statements reflecting financial transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial

transactions made on his behalf when a written delegation of responsibility to manage his financial affairs is made to the facility for any period of time in conformance with state law.

- Is afforded confidential treatment of his personal affairs and records and may approve or refuse their release to any individual outside the facility except as otherwise provided in law and except in case of his transfer to another care-giving facility.
- Is transferred or discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly transfer or discharge; such actions shall be documented in his record.

- *None of the above*

20. T/F **True** A resident can contact VDSS, APS, or a Virginia Long-Term Care Ombudsman if he or she thinks his or her rights are being violated.
21. T/F **True** Direct care workers are mandated reporters.
22. What are the responsibilities of a mandated reporter?
- Immediately report potential abuse, neglect, or exploitation when they become aware of the situation.
  - Provide information about the individual(s) involved as well as any information you have regarding the potential abuse, neglect, or exploitation.
  - Make available to APS investigators information that documents the abuse (even things normally considered confidential).

- All of the above.
23. T/F **True** The main types of abuse are physical, psychological, and sexual.
24. T/F **True** Neglect is when someone does NOT do something they were supposed to do, and it hurts another person.
25. Which of the following are some signs of potential abuse, neglect, or exploitation?
- Skin tears, scratches, cuts
  - Sudden change in behavior
  - Discomfort in sitting or walking
  - Weight loss
  - All of the above
26. T/F **True** An employee should call Adult Protective Services (APS) if he or she thinks someone is being abused, neglected, or exploited.
27. Three (3) assistive devices for grooming include:
- a. Walker, cane, wheelchair
  - b. Raised toilet seat, grab bars beside commode, toilet tissue aid
  - c. Sock Donner, long-handed comb and brush, button threader
  - d. Skid-free placemats, utensil with holding strap, curved utensils
28. T/F **True** Glaucoma and Diabetic Retinopathy are diseases of the eye.
29. Which of the following is not a staff intervention that direct care staff can implement to assist a resident with visual impairment?
- Provide large-print books and reading materials
  - Keep the environment dimly lit, particularly at night
  - Use contrasting colors to assist in recognizing objects and food
  - Keep walkways clear of clutter

30. Which of the following is not a staff intervention that direct care staff can implement to assist a resident with hearing impairment?
- a. Keep hearing aids clean
  - b. Reduce background noise
  - c. Check hearing aid batteries to make sure they are working
  - d. Speak quickly and clearly in a lower toned voice
31. T/F **False** A person with development disabilities cannot have a mental illness as well as a developmental disability.
32. Direct care staff should closely monitor which changes in healthcare status and dietary intake when working with a resident with a developmental disability?
- a. Regular bowel elimination, onset of seizures, excessive thirst
  - b. Potential for injury, potential for skin breakdown
  - c. Dental changes, weight changes
  - d. Changes in eating habits, changes in sleeping habits
  - e. All of the above
33. T/F **True** Three (3) symptoms of depression are emotional symptoms, thought-process changes and physical symptoms
34. Which of the following is not a staff intervention that can be implemented to assist residents diagnosed with a mental illness?
- a. Encourage resident to engage in a safe activity that he or she enjoys
  - b. Encourage resident to engage in a regular exercise program
  - c. Encourage resident to reduce intake of coffee, alcohol, and nicotine
  - d. Encourage resident not to reminisce about positive past experiences

35. T/F **True** Tranquilizers treat anxiety and relaxes muscles.
36. T/F **True** People with diabetes might have to urinate more frequently.
37. T/F **True** People with diabetes may experience a loss of feeling in their feet due to nerve damage. As a result, they may injure their feet and not realize it.
38. T/F **False** Symptoms of a stroke happen slowly. They may get better over a period of hours or days.
39. Who is at greatest risk for getting pressure ulcers?
- **People confined to a bed or chair**
  - People who are mobile or can change positions freely
  - People who are continent of bowel and/or bladder
  - People with good nutrition
40. What is the most prevalent type of dementia?
- **Alzheimer's Disease**
  - Parkinson's Dementia
  - Vascular Dementia
  - Korsekoff's Syndrome
41. Which of the following is not a "warning sign" of Alzheimer's disease?
- a. problems with language
  - b. poor or decreased judgment
  - c. problems with abstract thinking
  - d. stable personality**
42. T/F **True** Alzheimer's disease is different from "normal aging" in that a person with Alzheimer's disease may forget the whole experience while a person experiencing normal aging may forget part of the experience.
43. What are five common communication challenges in people with

Alzheimer's disease?

- a. difficulty finding the right words, losing train of thought, using gestures instead of speaking
- b. using unfamiliar words over and over again, never using curse words, speaking less often
- c. inventing new words for familiar things, reverting to one's native language
- d. easily organizing words logically

e. a and c

f. b and d

44. What are some ways in which you can help people with Alzheimer's communicate?

- a. Patience and give the person time
- b. Show your interest
- c. Avoid criticizing or correcting
- d. Encourage unspoken communication

e. All of the above

45. T/F **True** GLBTI means Gay, Lesbian, Bisexual, Transgender, Intersex

46. T/F **False** A **normal** age-related changes in a man that would affect sex includes an increase in testosterone.

47. Name two **normal** age-related changes in a woman that would affect sex.

- a. decrease in testosterone (decrease in sex drive)
- b. vaginal walls become thinner, dryer, and less elastic
- c. increase in testosterone
- d. vaginal walls become thinner

e. a and b

48. T/F **False** A resident who undresses at the dinner table is only trying

- to have sex with the female resident sitting next to him at the table.
49. T/F **True** An inactive lifestyle can cause constipation, a common problem in the older adult population.
50. T/F **True** 72 percent of the bodies' fluid supply rests in the body's lean mass.
51. T/F **False** The recommended amount of protein per day is between 15-20 ounces.
52. T/F **True** Decrease in saliva production, brittle teeth, and loss of taste buds are three oral changes that can create problems with proper intake of nutrition.
53. Describe the signs and symptoms of dehydration.
- a. Dry mouth and poor skin elasticity
  - b. Moist mouth and good skin elasticity
  - c. Change in mental status
  - d. No change in mental status
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54. T/F **False** Two benefits of adding more fiber into an older adult's diet include increasing constipation risk and lowering blood sugar levels.
55. T/F **True** Two (2) impacts of HIV/AIDS on nutritional status of an older adult include anorexia and nausea/vomiting.
56. Why are activities important?
- a. Expression of who we are as an individual
  - b. Provides for a sense of accomplishment
  - c. Contributes to life satisfaction, emotional wellness and increases quality of life
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