

## **Lesson # 11**

### **Title: Activities of Daily Living (Oral Care, Grooming, Nail Care)**

#### **Lesson Objectives:**

- I. The student will be able to explain the importance of and demonstrate competence in the provision of oral care/denture care.
- II. The student will be able to explain the importance of and demonstrate competence in the provision of grooming, including hair and facial hair.
- III. The student will be able to explain the importance of and demonstrate competence in the provision of fingernail and foot care.

#### **Key Terms:**

**Foot Care** – care of the feet, including inspection for areas of concern to be reported to the nurse

**NPO** – nothing by mouth

**Oral Care** – care of mouth, teeth and gums. Cleaning the teeth, gums, tongue, inside of mouth and dentures, if used

#### **Content:**

##### I. Grooming/Personal Hygiene

###### A. Points to Remember:

1. Always allow the resident to do as much as possible for themselves
2. Allow the resident to make choices and respect those choices
3. Be sensitive to established routines of the resident, incorporating those routines into daily care, as possible
4. Oral care includes cleaning the teeth, gums, inside of mouth and dentures and must be performed at least daily according to state rule, but recommended to occur more often
5. Oral care reduces the number of pathogens in the mouth, improves the resident's sense of well-being and appearance and improves sense of taste, enhancing appetite

6. Oral care eliminates particles from beneath the gums, preventing injury and improving ability to chew and consume meals
  7. Dentures should be handled carefully and stored in cool water in a labeled denture cup when not in use
  8. The caregiver should observe for ill-fitting dentures and report concerns to the nurse. Ill-fitting dentures could affect speech and chewing ability, thus, ultimately affecting meal consumption and contributing to potential weight loss
  9. More frequent oral care is needed for residents who are unconscious, breathe through their mouth, are being given oxygen, are in the process of dying and/or are NPO
  10. Observe and report to nurse: irritation, raised areas, coated or swollen tongue, sores, complaint of mouth pain, white spots, loose/chipped or decayed teeth
- A. Oral Care (**see RCP**)
  - B. Oral Care for Unconscious (**see RCP**)
  - C. Denture Care (**see RCP**)
    1. Always follow manufacturer's instructions for cleaning dentures
  - D. Shaving/Electric Razor (**see RCP**)
    1. Points to Remember:
      - a. Be certain that the resident wants you to shave him or assist him to shave before you begin
      - b. Wear gloves when shaving a resident
  - E. Safety Razor (**see RCP**)
  - F. Combing/Brushing Hair (**see RCP**)
    1. Always use hair care products that the resident prefers for his/her type of hair
  - G. Fingernail Care (**see RCP**)
    1. Nail care is provided when assigned or if nails appear dirty or have jagged edges

2. Check fingers and nails for color, swelling, cuts or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure

#### H. Foot Care (see RCP)

1. Support the foot and ankle throughout the procedure
2. Poor circulation occurs in the resident with diabetes. Even a small sore on the foot can become a large wound
3. Careful foot care, including regular daily inspection is important
4. During foot care, the feet should be checked for irritation or sores and reported to the nurse, if observed
5. **A nurse aide should never trim or clip any resident's toenails, but especially not the diabetic's toenails. Only a nurse or physician should do so**

#### Visual Aides:

- Toothbrush
- Lemon Glycerin Swabs
- Denture Cup
- Dentures (if available)
- Emesis Basin
- Nail Clippers
- Safety Razor
- Electric Razor (if available)
- Bath Basin

#### RCPS:

- Oral Care
- Oral Care for Unconscious
- Denture Care
- Electric Razor
- Safety Razor

- Comb/Brush Hair
- Fingernail Care
- Foot Care

**Review Questions**

1. Explain observations made during oral care that should be reported to the nurse.
2. Explain why a nurse aide should not clip the toenails of a diabetic resident.

## Lesson # 12

### **Title: Activities of Daily Living (Dressing, Toileting)**

#### **Lesson Objectives:**

- I. The student will be able to demonstrate competence in assisting the independent resident or dressing the dependent resident.
- II. The student will be able to demonstrate competence in assisting the resident with toileting needs.

#### **Key Terms:**

**Catheter** – tube used to drain urine from the bladder.

**Condom Catheter** – external catheter that has an attachment on the end that fits over the penis; also called a Texas catheter.

**Elimination** – process of expelling solid waste not absorbed into the cells.

**Enema** – specific amount of water flowed into the colon to eliminate stool.

**Fecal Impaction** – hard stool in the rectum that cannot be expelled.

**Fracture Pan** – bedpan used for a resident who cannot assist with raising hips on the regular bedpan.

**Hemiparesis** – weakness on one side of the body.

**Hemiplegia** – paralysis on one side of the body, weakness, or loss of movement.

**Incontinence** – inability to control the bladder or bowels.

**Indwelling Catheter** – catheter that remains in the bladder for a period of time.

**Paraplegia** – loss of function of lower body and legs.

**Portable Commode (Bedside)** – chair with a toilet seat and a removable container underneath.

**Prosthesis** – artificial body part.

**Quadriplegia** – loss of function of legs, trunk and arms.

**Suppository** – medication given rectally to cause a bowel movement.

**Void** - urination

#### **Content:**

- I. Dressing

- A. Residents have their own style and preferences
- B. Residents should be encouraged to dress in their own clothing of choice each day
- C. Each piece of the resident's clothing should be inventoried according to facility policy, adding new items and deleting discarded items as necessary
- D. Resident clothing should be labeled/identified in an inconspicuous place
- E. Affected limbs should be dressed first and undressed last
- F. Avoid pullover garments if the resident has an affected side or difficulty with the neck or shoulders, unless requested by the resident
- G. Change Gown (**see RCP**)
- H. Dressing a Dependent Resident (**see RCP**)

## II. Toileting

- A. Assist to Bathroom (**see RCP**)
- B. Bedside Commode (**see RCP**)

**NOTE \*Ensure bedside commode is in good repair and has intact rubber stops to prevent commode from moving with resident weight, potentially causing a fall.**

- C. Bedpan/Fracture Pan (**see RCP**)

1. A fracture pan is a bedpan that is flatter than a normal bedpan. It is used for residents who cannot assist to raise their hips onto a regular bedpan. When using a fracture pan, position with the handle toward the foot of the bed. If the resident cannot help, roll the resident onto the far side, slip the fracture pan under the hips and roll the resident back toward you onto the bedpan.
2. A standard bedpan is positioned with the wider part of the pan aligned with the resident's buttocks

- D. Urinal (**see RCP**)

- E. Bowel and Bladder Training

1. Incontinent residents may be identified as candidates for bowel and bladder training. If so, the following guidelines will apply:

- a. A record of the resident's bowel and bladder habits will be maintained and then observed for a pattern of elimination. A pattern will predict the frequency in which the resident will need to be assisted to use the bedpan or to toilet
- b. Explain the training schedule to the resident and attempt to follow the schedule closely
- c. Offer a trip to the commode or bathroom prior to beginning long procedures, as well as before and after meals
- d. Encourage residents to drink sufficient fluids. About 30 minutes after fluids are consumed, offer a trip to the bathroom or use of the urinal or bedpan
- e. Answer the resident's call light promptly, as residents cannot wait long when the urge to void is felt
- f. Provide privacy for elimination
- g. Praise successes and attempts to control bowel and bladder

F. Emptying urinary drainage bag/leg bag (**see RCP**)

G. Catheter Care (**see RCP**)

1. If a resident has a catheter, care is normally provided on each shift

H. Urine Specimen Collection (**see RCP**)

1. If a clean-catch (midstream) urine specimen is ordered, using the towelettes supplied, the caregiver will assist the resident to clean the area around the meatus. For females, separate the labia. Wipe from front to back along one side. Discard the towelette. With a new towelette, wipe from front to back along the other side. Using a new towelette wipe down the middle. For males, clean the head of the penis. Use circular motions with the towelettes. Clean thoroughly, changing the towelette after each circular motion. Discard after use. If the male is uncircumcised, pull back the foreskin of the penis before cleaning. Hold it back during urination. Make sure it is pulled back down after collecting the specimen. Ask the resident to begin urination, but to stop before urination is complete. Place the container under the urine stream and ask the resident to begin urinating

again. Fill the container at least half full. Remove the container and allow the resident to finish urinating in bedpan, urinal or toilet.

I. Stool Specimen Collection (**see RCP**)

1. Ask the resident to inform you when he or she can have a bowel movement.
2. Be ready to collect the specimen

J. Application of Incontinent Brief

1. Ensure brief is appropriate size for resident
2. Ensure appropriate application in a manner not to cause abrasion due to being too tight or having tape applied to skin
3. Monitor frequently for needed perineal care and change of brief

**Visual Aides:**

- Gown
- Clothing (shirt, slacks, etc.)
- Bedside Commode (if available)
- Bedpan/Fracture Pan
- Urinal
- Catheter/Drainage Bag/Leg Bag
- Urine Graduated container/Cylinder
- Urine Hat
- Urine Specimen Cup
- Stool Specimen Cup
- Incontinent Brief
- Incontinent Pad

**RCPS:**

- Change Gown
- Dressing a Dependent Resident
- Assist to Bathroom

- Bedside Commode
- Bedpan/Fracture Pan
- Urinal
- Empty Urinary Drainage Bag
- Urine Specimen Collection
- Stool Specimen Collection
- Application of Incontinent Brief

### **Review Questions**

1. Explain the difference between a routine urine specimen and a clean-catch (mid-stream) urine specimen.
2. Affected limbs should be dressed first and undressed last. True or False?

## Lesson # 13

### **Title: Resident Environment**

#### **Lesson Objectives:**

- I. The student will be able to explain the importance of individualization of the resident's environment.
- II. The student will be able to demonstrate competence in making an unoccupied bed.
- III. The student will be able to demonstrate competence in making an occupied bed.
- IV. The student will be able to explain environmental concerns of each resident and any revisions necessary to accommodate the visually impaired resident or the resident at risk of falls.

#### **Key Terms:**

**Call Light** – means to call for assistance, when needed.

**Closed Bed** – a bed completely made with the bedspread and blankets in place.

**Draw sheet** – turning sheet that is placed under residents who are unable to assist with turning, lifting or moving up in bed.

**Hoarding** – excessive collecting and maintaining of items in the resident's environment.

**Occupied Bed** – bed made while a resident is in the bed.

**Open Bed** – folding the linen down to the foot of bed.

**Reality Orientation** – using calendars, clocks, signs and lists to assist/cue residents with cognitive impairment.

**Unoccupied Bed** – a bed made while no resident is in the bed.

#### **Content:**

- I. Points to Remember:
  - A. When a resident enters a nursing facility, he/she experiences the loss of home and belongings. Familiar things create a positive and home-like environment. The staff should encourage the resident to bring items from home, as space permits
  - B. The room should be arranged according to resident preference, as possible
  - C. The resident's personal belongings should be safeguarded, as possible

- D. Types of beds may vary in each facility. Most beds have controls to raise, lower and adjust positions. A low bed may be used for a resident at risk for falls
- E. Temperature of the resident's room/environment should be considered. The resident's condition and preferences should determine the appropriate temperature
- F. Lighting should be sufficient for the resident's needs/preferences. Indirect lighting is preferable, in that glare causes fatigue
- G. The resident's environment should be cleaned of spills immediately, as spills are safety hazards contributing to falls
- H. Excessive noise levels in the environment can provoke irritation and problematic behaviors. Facilities should maintain equipment in good repair and refrain from overhead paging
- I. Fresh ice water should be maintained and within reach in the resident's environment, unless the resident's fluids are restricted by the physician, in an effort to encourage hydration
- J. The resident's call light should be placed within the resident's reach upon completion of care/staff assistance
- K. Defective or unsafe equipment should be taken out of service and reported to the nurse immediately

## II. Unoccupied Bed (see RCP)

## III. Occupied Bed (see RCP)

## IV. Resident Room/Environment/Fall Prevention

- A. Each room may have slightly different equipment. Standard room contents include: bed, bedside stand, over bed table, chair, call light and privacy curtain
- B. Always ensure the call light is within the resident's reach and answered immediately
- C. Clean the over bed table after use and place within resident's reach if commonly used items are stored on the table

- D. Remove anything that might cause odors or become safety hazards, such as trash, clutter, spilled fluids, etc.
- E. Clean up spills promptly
- F. Report signs of insects or pests when observed
- G. Fall prevention: To reduce risk of falls:
  - 1. Clear all walkways of clutter and cords
  - 2. Use non-skid mats when needed
  - 3. Assist residents to wear non-skid socks or shoes. Make certain shoelaces are tied
  - 4. Monitor to ensure residents wear clothing that is of proper length (e.g., not too tight, not too loose, or not too long)
  - 5. Keep frequently used items within reach of resident
  - 6. If ordered, ensure any devices or alarms are in place and functional as per plan of care
  - 7. Lock wheelchairs before assisting residents to transfer
  - 8. Offer to toilet resident frequently/according to toileting schedule to prevent unassisted attempts to toilet
  - 9. Visual cues or devices may be used for reality orientation such as a large face clock, calendar, etc. Familiar pictures, symbols or personal items may be displayed or hung to assist the resident with cognitive impairment to recognize his/her room, restroom, closet, etc.

**Visual Aides:**

- Resident Bed
- Linens

**RCPS:**

- Unoccupied Bed
- Occupied Bed

## **Review Questions**

1. List items that could be used to promote reality orientation.
2. The call light should always be placed within the resident's reach. True or False?

## Lesson # 14

### Title: Activities of Daily Living (Nutrition/Hydration)

#### Lesson Objectives:

- I. The student will be able to explain the importance of proper nutrition/hydration.
- II. The student will be able to demonstrate competence in proper feeding techniques and provision of assistance for the resident with special needs.
- III. The student will be able to explain the importance of following care guidelines for a resident receiving tube feedings and observations of resident condition that must be reported, if observed.

#### Key Terms:

**Aspiration** – inhalation of food or drink into lungs which has the potential to cause pneumonia or death.

**Calories** – the fuel or energy value of food.

**Carbohydrates** – the main source of energy for all body functions.

**Dehydration** – excessive loss of fluid from the body.

**Fats** – help the body store energy and use certain vitamins.

**Fluid Overload** – condition in which the body is unable to handle the amount of fluids consumed.

**Fluid Restriction** – a restriction of the amount of fluids a resident may have per day; usually divided between nursing and dietary (i.e., fluids with meals).

**Gastrostomy Tube (G-Tube)** – tube placed through the abdomen directly into the stomach and used to provide nourishment.

**Hydration** – fluids consumed.

**Jejunostomy (J-Tube)** – tube placed into the second part of the small intestines and used to provide nourishment.

**Minerals** – compounds found in the diet or dietary supplements; builds body tissue, regulates body fluids, promotes bone & tooth formation, affects nerve and muscle function.

**Nasogastric Tube** – tube placed through the nose to the stomach and used to provide nourishment.

**NPO** – nothing by mouth.

**Nutrients** – substances found in food which provide nourishment.

**Nutrition** – nourishment; the process by which the body takes in food to maintain health.

**PEG** (percutaneous endoscopic gastrostomy) – tube placed endoscopically, directly into the stomach and used to provide nourishment. Often called a “G-tube”.

**Proteins** – complex compounds found in all living matter; promote growth and repair of tissue.

**Vitamins** – organic compounds obtained from one’s diet or dietary supplements; helps the body function.

**Water** – H<sub>2</sub>O (one molecule of oxygen and two molecules of hydrogen); most essential nutrient for life.

Content:

I. Promoting Proper Nutrition and Hydration

A. Proper nutrition

1. Promotes physical health
2. Helps maintain muscle
3. Helps maintain skin & tissues
4. Helps prevent pressure sores
5. Increases energy level
6. Aids in resisting illness
7. Aids in the healing process

B. Six basic nutrients

1. Carbohydrates

- a. Provide energy for the body
- b. Provide fiber for bowel elimination

2. Fats

- a. Aid in absorption of vitamins
- b. Provide insulation and protect organs

3. Minerals

- a. Build body tissue and cell formation
- b. Regulate body fluids
- c. Promote bone and tooth formation
- d. Affect nerve and muscle function

4. Proteins

- a. Promote growth and tissue repair
- b. Found in body cells
- c. Provide an alternate supply of energy

5. Vitamins

- a. Two types: water soluble and fat soluble
- b. Body cannot produce
- c. Help the body function

6. Water

- a. Most essential nutrient for life

C. Diet specifics

1. Diet cards

- a. Specific to a resident

2. Basic or “general” diet

3. Therapeutic/special/modified diets

- a. Soft
- b. Bland
- c. High/low fiber
- d. Low fat
- e. High/low protein
- f. Low sodium
- g. Modified calorie/calorie count
- h. Liquid
  - i. High potassium
  - j. Diabetic (ADA)
  - k. NPO

4. Mechanically altered diets

- a. Mechanical soft
- b. Pureed

5. Thickened liquids (**see RCP**)

- a. Nectar thick

- b. Honey thick
- c. Pudding thick

D. Monitoring meal consumption/recording food consumed

- 1. Observation
- 2. Facility policy for recording

E. Proper hydration

- 1. Promotes physical health
  - a. Aids digestion and elimination
  - b. Maintains normal body temperature
  - c. Helps prevent dehydration
- 2. Force fluids/encourage fluids
- 3. Fluid restriction
  - a. Implemented by physician order due to concerns with fluid overload
  - b. Daily amount is limited and divided between dietary (for meal service) and nursing
- 4. Recording Intake and Output (I&O's)
  - a. Approximately 2000-2500cc daily
  - b. Determine resident's total fluid intake
    - 1. Use metric measurement (cubic centimeters = cc)
  - c. Measure output (urine and emesis)
    - 1. Graduated measuring container
    - 2. Use metric measurement (cubic centimeters =cc)
- 5. Passing Fresh Ice Water (**see RCP**)

F. Role of the Nurse Aide

- 1. Encourage resident to eat as much of their meal as possible
- 2. Note foods resident avoids or dislikes and report to the nurse
- 3. Review diet card before serving meal to resident to confirm correct diet
- 4. Be aware of food brought in to the resident from an outside source and potential conflict with ordered diet
- 5. Record food intake according to facility policy
- 6. Remind resident to drink often or offer ice/popsicles, when not on restriction

7. Have fresh ice water available and within the resident's reach at all times unless fluid restriction
8. Observe for and report to the nurse signs of dehydration:
  - a. mild symptoms (include but are not limited to): thirst, loss of appetite, dry skin, flushed skin, dark colored urine, dry mouth, fatigue or weakness, chills
  - b. advancing dehydration symptoms (include but are not limited to): increased heart rate, increased respirations, decreased sweating, decreased urination, increased body temperature, extreme fatigue, muscle cramps, headaches, nausea
  - c. severe dehydration symptoms (include but are not limited to)- muscle spasms, vomiting, racing pulse, shriveled skin, dim vision, painful urination, confusion, difficulty breathing, seizures
9. Observe for and report to the nurse signs of fluid overload which may include:
  - a. stretched and shiny-looking skin over a swollen area, increased abdomen size (ascites), shortness of breath or difficulty breathing (pulmonary edema), tightness of jewelry, clothing or accessories, low output of urine, even when the resident is drinking as much fluid as normal, a dimple in the skin covering the swollen area that remains for a few seconds after the pressing finger has been released
  - b. Symptoms of more serious fluid overload include difficulty breathing, shortness of breath when lying down, coughing, cold hands or feet
10. Measure Intake & Output accurately

II. Promoting the Use of Proper Feeding Technique/Assisting a Resident with Special Needs

**NOTE\* The caregiver should provide any necessary care and offer to assist the resident to toilet prior to meal service in an effort to promote a positive experience**

- A. Feeding (see RCP)
- B. Assist to eat (see RCP)
- C. Assistive Devices

1. Plate guards
2. Utensils with enlarged (built-up) handles
3. Drinking cups (nosey cups)
4. Divided plates
5. Non-skid plate/place mat

D. Visually impaired

1. Speak in a normal tone while facing the resident
2. Read menu to the resident
3. Position their food on the plate according to hands of a clock. Explain where food items are on plate
4. If feeding the resident, ask them to open their mouth at appropriate time
5. If feeding the resident, tell them what food you are giving them

E. History of stroke

1. Place food in resident's sight
2. Supply assistive device(s), as appropriate, to unaffected side
3. Report any difficulty swallowing and observe for signs of choking
4. Report to nurse coughing and/or observed pocketing of food
5. If feeding the resident, make sure the resident swallows before giving more food
6. If resident's mouth is paralyzed, place food on the unaffected side when feeding

F. History of Parkinson's Disease

1. Supply assistive devices, as appropriate
2. Food and drinks should be placed within reach
3. Assist the resident as needed; promote independence

III. Caring for a Resident with a Tube Feeding and the Resident at Risk for Aspiration

A. Tube Feedings

1. Feeding tubes are used when food cannot pass normally from the mouth into the esophagus and then into the stomach. The resident who is unable to take food or fluids by mouth, or is unable to swallow, may be fed through a tube.

The two types of tubes most commonly used in long-term care facilities are nasogastric tubes and gastrostomy tubes.

2. A nasogastric (NG) tube is a tube that is placed through the nose into the stomach. (“Naso” is the medical term for nose and “gastric” means stomach.) It may also be called a Levine tube or be abbreviated as NG tube. An NG tube may also be used by the nurse to suction and remove fluids from the body
3. A gastrostomy tube (g-tube) is a tube that is placed directly into the stomach for feeding. A small surgical opening is made through the abdominal wall into the stomach, and the tube is sutured to hold it in place. This type of tube is often used for a resident who may need tube feedings for a long time. The abbreviation for a gastrostomy tube is G-tube.
4. Usually the NG tube or the G-tube will be attached to an electronic feeding pump that controls the flow of fluid. Most pumps have an alarm that sounds when something is wrong. You must notify the nurse immediately if the alarm sounds
5. The resident who has a feeding tube should be observed frequently. If the pump is not working properly, the resident may receive the wrong amount of food or the fluid may enter too quickly. This can cause nausea, vomiting, and aspiration. The NG tube may have moved out of the stomach and into the lungs. Aspiration pneumonia may result if feeding enters the lungs
6. Residents with feeding tubes are often NPO. NPO is the abbreviation for nothing by mouth. PO is the abbreviation used when a person can have something by mouth
7. Do not give the resident who has a feeding tube anything to eat or drink without checking with the nurse
8. The NG tube is uncomfortable and irritating to the nose and throat. The G-tube may become dislodged from the stomach, or the skin may become irritated at the site of insertion. Infection can occur with either tube, if infection control practices are not carefully followed

9. The resident with a feeding infusing should not lie flat. The head of the bed should be elevated at least 30°. Some procedures will need to be changed slightly for the resident with a feeding tube. For example, an occupied bed cannot be flattened to change the linen or to provide incontinence care with the feeding infusing. If the bed must be flattened, seek the nurse's assistance to turn off the pump prior to the procedure and turn the pump back on after the procedure. Your major responsibility concerning the resident with a feeding tube is to make regular observations and promptly report any problem
10. Report any choking or coughing to the nurse immediately

B. Observations to be reported to the nurse immediately

1. Nausea
2. Discomfort during the tube feeding
3. Vomiting
4. Diarrhea
5. Distended (enlarged and swollen) abdomen
6. Coughing
7. Complaints of indigestion or heart burn
8. Redness, swelling, drainage, odor, or pain at the tube insertion site
9. Elevated temperature
10. Signs and symptoms of respiratory distress
11. Increased pulse rate
12. Complaints of flatulence (gas)

C. Comfort Measures

1. The resident with a feeding tube is usually NPO. Dry mouth, dry lips, and sore throat are sources of discomfort. The resident's care plan will include frequent oral hygiene and lubricant for the lips

D. Risk of Aspiration

1. Any resident with ordered thickened liquids, a pureed or mechanical soft diet, or having a diagnosis of esophageal reflux, GERD, or respiratory difficulty is a resident who is at risk of aspiration. The caregiver must

always elevate the head of the bed or assist the resident to an upright position prior to offering food or fluids if the resident is at risk of choking/aspiration. Should a resident begin to cough, gurgle or regurgitate, attempts to feed should STOP and the nurse should be alerted immediately to assess the resident

2. Residents at risk of choking/aspiration should be encouraged to sit up or remain with the head of the bed elevated for at least 30 minutes (or as long as tolerated) following consumption of food or fluids
3. Know your residents and ensure residents receive snacks, meals and fluids at the ordered consistency

### **Visual Aides:**

- Meal Consumption Record
- Thickener (Fluids thickened to nectar, honey and pudding thick consistency)

### **RCPS:**

- Thickened Liquids
- Passing Fresh Ice Water
- Feeding
- Assist to Eat

### **Review Questions**

1. Name two symptoms of dehydration
2. What is the most essential nutrient for life?
3. What are the three types of thickened liquid?
4. When a tube feeding is infusing, the head of the bed must be elevated. True or False?

## Lesson #15

### **Title: Skin Care/Pressure Prevention**

#### **Lesson Objectives:**

- I. The student will be able to explain the importance of an intact integumentary system and basic skin care.
- II. The student will be able to describe residents at risk for skin breakdown.
- III. The student will be able to describe the need for pressure reducing devices.

#### **Key Terms:**

**Bony Prominence** – area of the body where the bone is in close proximity to the skin (e.g., ankles, hip bones, elbows, etc.).

**Dermis** – inner layer of skin.

**Epidermis** – outer layer of skin.

**Friction** – skin repeatedly rubs another surface.

**Integumentary System** – skin

**Offload** – assisting a resident to stand up to completely remove the pressure from the area.

**Pressure Point** – any area on the body that bears the body's weight when lying or sitting and where a bone is close to the skin's surface.

**Pressure Sore (also called “Bed Sore” or “Decubitus Ulcer”)** – a localized injury to the skin and/or underlying tissue. Usually occurs over a bony prominence as a result of pressure, or pressure in combination with shear and/or friction.

**Reverse Push-Up** – asking a resident to lift up off their buttocks using their arms in a reverse push-up.

**Shear** – skin stays in one position, but underlying bone and tissue roll in the opposite direction.

**Subcutaneous tissue** – the lowest layer of skin; fatty tissue.

#### **Content:**

- I. Understanding the Integumentary System and Basic Skin Care
  - A. The Integumentary System
    1. The structure

- a. Skin
  - 1) Epidermis
  - 2) Dermis
  - 3) Subcutaneous tissue
- b. Hair
- c. Nails
- d. Glands
  - 1) Oil
  - 2) Sweat
- e. Nerve endings

## 2. Function

- a. Largest organ of the body
- b. Sense organ
  - 1) Heat/cold
  - 2) Pain
  - 3) Pressure
  - 4) Touch
- c. Internal organ protection
- d. Body temperature regulation
- e. Bacterial protection
- f. Excretes waste
- g. Prevents loss of too much water
- h. Vitamin D production

## 3. Changes with age

- a. Skin dries
- b. Skin becomes more fragile
- c. Subcutaneous (fatty) tissue thins
- d. Brown spots develop
- e. Wrinkles appear
- f. Hair grays and becomes thin
- g. Nails thicken

#### 4. Care of the skin

##### a. Skin should be clean and dry

- 1) Provide frequent care for residents who are incontinent
- 2) Change linens/clothing
- 3) Check resident at least every 2 hours for needed care and encourage to reposition

##### b. Observe for:

- 1) Rashes
- 2) Abrasions
- 3) Dryness
- 4) Changes in skin color
  - a) Pale
  - b) Red
  - c) Purple/Blue
- 5) Pressure areas
  - a) Reposition at least every 2 hours
  - b) No wrinkles in bottom sheet
- 6) Temperature
  - a) Complaints of warmth or burning
- 7) Bruising
- 8) Swelling
- 9) Blisters
  - a) Ensure resident has proper fitting shoes/slippers
- 10) Scratching
- 11) Broken skin
- 12) Drainage
- 13) Wound or ulcer
- 14) Redness or broken skin between toes or around nails

## II. Risk Factors for Skin Breakdown

### A. Sensory Perception

1. The ability to feel pressure. In general, people move regularly to keep pressure from building up
2. Individuals with limited sensory perception may not realize they have not moved for a while, which increases their risk for pressure ulcers. Medications, medical conditions, or mental status may all cause an individual's sensory perception to change

### B. Moisture

1. Healthy skin stays clean and dry. Individuals at risk of pressure ulcers may have skin that stays moist because of incontinence (urine or stool) or perspiration (sweat). When an area at risk for a pressure ulcer is moist, a pressure ulcer is more likely to form

### C. Activity

1. Activity means an individual's ability to physically move (like walking).  
Individuals who can walk rarely get pressure ulcers. Individuals who are bedfast or chair bound are at higher risk of developing pressure ulcers

### D. Mobility

1. Mobility refers to the ability to change and control body position. Individuals with good mobility move their bodies regularly. Individuals who are immobile or have limited mobility are at greater risk for developing pressure ulcers because they cannot move to relieve the pressure

### E. Nutrition

1. Everyone needs to eat the right food and drink enough liquids to stay healthy.  
Individuals who do not eat enough of the right foods or drink enough of the right liquids are at greater risk for pressure ulcers because their bodies do not have the energy they need

### F. Friction and Shear

1. Friction happens when skin rubs another surface over and over (like a rough wheelchair seat rubbing the back of the individual's leg). Shear is similar to friction, but it occurs when skin stays in one position but the underlying bone

and tissue roll in the opposite direction (like someone sliding across a bed). The rubbing and pulling of friction and shear break down the skin, which contributes to pressure ulcers. Pressure ulcers are more likely to develop when there is increased shear or friction

#### G. Additional Risk Factors

1. Chronic conditions or illnesses (diabetes, cancer)- Higher risk due to body is fighting several problems at once
2. Age- Higher risk due to with age, skin becomes fragile and breaks down easily
3. Medical devices- Higher risk due to the device may rub the skin over and over or cause pressure to that area
4. Depression or mental illness- Higher risk due to individuals neglect their own care
5. History of pressure ulcers- Higher risk due to old pressure ulcer scars make the skin in that area weaker and more likely to break down

### III. Pressure Ulcer Development

- A. Skin breakdown can develop when individuals stay in one position for too long (as little as two hours) without shifting their weight
- B. The pressure of body weight reduces blood supply, causing skin and surrounding tissue to become damaged or even die
- C. Pressure ulcers can be painful. They can cause infection, damage to muscle and bone, and even death
- D. Treatment can take weeks, months, or years

### IV. Prevention

- A. Observe skin upon admission and during the provision of daily care

1. Skin Inspection

- a. Drape resident to allow you to see, feel and smell the area you are inspecting. This can easily be done when the individual is dressing or undressing

- b. Remove pressure-Lift heels, turn or move the individual to inspect the skin. Remove medical devices (with the permission or under the direction of the nurse) to view the skin under the device
- c. Inspect- Focus on bony prominences, where pressure ulcers are most likely to develop. Observe and prevent skin-to-skin contact. Additional areas at risk are the ears, under the breasts, and the scrotum and any skin-to-skin contact
- d. Note observations and report to the nurse- When a potential problem is observed, notify the nurse for assessment of the area

B. Encourage and maintain nutrition and hydration

C. Manage moisture by providing prompt care

D. Minimize pressure

1. Pressure-reducing mattress

2. Pressure-reducing cushion to chair

- a. Heel boots- specialty devices that surround the feet and calves and create a cushion between the heels and the bed. They should not be used with residents who walk. The manufacturer's instructions must be followed
- b. When using any device, check the other areas of the legs to ensure you are not moving the pressure to another area, like the calves.

E. Identify residents who have been assessed by nursing as "at risk"

1. Braden Scale- standardized risk assessment tool completed by the nurse

### **Visual Aides:**

- ISDH Pressure Ulcer Resource Center/Education Modules  
<http://www.in.gov/isdh/24558.htm>
- Pressure-reducing devices (mattress, overlay, cushion, heel/elbow protectors, bed cradle, etc.)
- Braden Scale

### **RCPS**

- Inspecting Skin

- Float Heels
- Bed Cradle

### **Review Questions**

1. Most pressure ulcers develop within a few weeks of admission. True or False?
2. Pressure ulcers can lead to life-threatening infection. True or False?
3. Caregivers should use draw sheets to turn, lift or move the resident up in bed to prevent skin damage caused by shearing. True or False?