SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.02 Home Care Statue Overview	XX/XX/XXXX

144A.45 REGULATION OF HOME CARE SERVICES

Subdivision 1. Regulations. The commissioner shall regulate home care providers pursuant to sections144A.43 to 144A.482. The regulations shall include the following:

1. Provisions to assure, to the extent possible, the health, safety, well-being, and appropriate treatment of persons who receive home care services while respecting a client's autonomy and choice;

2. Requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to 144A.482;
    - An explanation of the orientation and education requirements fall under this statute.

3. Standards of training of home care provider personnel;
    - How and why we care for our clients comes from this statute.
    - The Registered Nurse (RN) oversees the management of all medications.
    - All Unlicensed Personnel (ULP) must be trained by the RN on medication and other delegated tasks and services.
    - The RN must provide written instructions, specific to each client, for ULP, including names of medications, side effects, and potential complications of each medication.

4. Standards for provision of home care services;

5. Standards for medication management;

6. Standards for supervision of home care services;
    - All ULP, including Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), must be supervised by the RN
7. Standards for client evaluation or assessment;
    - Client assessments will be completed accurately and timely within five days of admission, then 14 days after initiation of services, and then every 90 days thereafter or with any significant change of condition.
    - The RN will work with the client to set up a service plan.
    - All staff will follow the service plan.
    - Any changes in client condition will be reported to the RN, so a reassessment can be completed, if necessary.

8. Requirements for the involvement of a client's health care provider, the documentation of health care providers' orders, if required, and the client's service plan;
    - Physician or any other prescriber’s orders will be followed and any client refusal or necessary change in medication will be reported to the RN and doctor in a timely manner.
9. The maintenance of accurate, current client records;
    - Documentation must be objective and completed in a timely manner.

10. The establishment of basic and comprehensive levels of licenses based on services provided;
    - The services that are offered to clients must fall within the scope of the Basic or Comprehensive Home Care license held by the home care provider.
    - Basic Home Care: Licensed or Unlicensed Personnel can provide the following assistive tasks:
        - Assist with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing
        - Providing standby assistance (SBA)
        - Providing verbal or visual reminders to the client to take regularly scheduled medication, which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication
        - Providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises
        - Preparing modified diets ordered by a licensed health professional
        - Assisting with laundry, housekeeping, meal preparation, shopping, or other household chores and services if the provider is also providing at least one of the above activities.
    - Comprehensive Home Care: Licensed or Unlicensed Personnel can provide the following assistive tasks and services:
        - Any of the Basic Home Care tasks listed in the box above
        - AND, must offer at least one of the following services:
        - Services of an advanced practice nurse (e.g. nurse practitioner, etc.), RN, LPN, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker
        - Tasks delegated to ULP by an RN or assigned by one of the licensed health professional above.
        - Medication management services
        - Hands-on assistance with transfers and mobility
        - Assisting clients with eating when the clients have complicating eating problems, such as difficulty swallowing or recurrent lung aspirations
        - Providing other complex or specialty health care services

11. Provisions to enforce these regulations and the home care bill of rights. Regulatory functions. The commissioner shall:
    a. License, survey, and monitor without notice, home care providers in accordance with sections144A.43 to 144A.482;
    b. Survey every temporary licensee within one year of the temporary license issuance date.
    c. Issue correction orders and assess civil penalties.

    - The Minnesota Department of Health will survey each Home Care Provider under the new statutes, starting in 2015; Home Care Providers are expected to be compliant with the new statutes upon their annual license renewal date between July 1, 2014 and June 30, 2015.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.03 Policy & Procedure Crosswalk	XX/XX/XXXX

Statutes require Home Care Providers and Housing with Services establishments to introduce and review relevant policies and procedures with staff at orientation and annually. Below is a list of recommended policies and procedures your community may find relevant.

Several recommended policies and procedures have been addressed in other topic-specific modules in this Training Orientation and Competencies Manual; the location for cross-reference is listed in the Care Providers of Minnesota Comprehensive Home Care Resource Manual (CHCRM) Location and the Housing with Services Resource Manual (HWSRM) Location columns.

****NOTE: The recommendations are designated as best practice and not intended to be an exhaustive list; add or delete to the list so it fits your community best.**

Policy and Procedure Description	Comprehensive Home Care Resource Manual (CHCRM) Location	Housing with Services Resource Manual (HWSRM) Location	Comprehensive Home Care Orientation Training & Competencies Manual Location
24 Hour Emergency Response Policy		2.05	
Acceptance of Clients policy	1.01		
Activity Programming policy		8.01	
Additional Service Referral policy	1.02		
Assessment - Schedules policy	4.03		
Bathing Assistance policy	4.20		2.02
Bill of Rights policy	1.03		1.09
Blood Sugar Testing - Shared Equipment Use policy	5.22		2.14
Blood Sugar Testing - Single Equipment Use policy	5.21		2.14
Bomb and Bomb Threats policy	7.04		
Bulletin Board Policy		8.06	
Catheter Care policy	4.21		2.17
Cell Phones policy	2.16		
Cleaning of Shared Medication Equipment policy	6.02		1.06
Client Record - Confidentiality policy	1.06		

Client Record - Documentation policy	1.07		
Client Record - Retention policy	1.09		
Client Record - Security and Storage policy	1.10		
Client Request to Discontinue Life-Sustaining Treatment policy	1.11		
Communication Book policy	1.12		
Complaint Policy		2.08	1.10
Complaints Regarding Home Care policy	1.13		1.10
Confidentiality policy	1.15		1.16
CPR DNR policy	1.17		
Death of a Client policy	1.18		
Delegated Nursing Services policy	3.05		
Delegated vs Non-Nursing Services policy	3.06		
Denture Care policy	4.22		2.07
Dining Service Policy		7.02	
Disaster Planning and Emergency Preparedness Plan policy	7.01	4.01	1.07
Disaster policy	7.03		
Disinfecting Environmental Surfaces policy	6.03		1.06
Disposal of Contaminated Materials policy	6.04		1.06
Disposal of Medication policy	5.17		
Dressing Assistance policy	4.23		2.03
Ear Drop policy	5.23		2.21
Emergency 911 policy	1.19		1.07
Emergency Contact Policy		2.04	
Eye Drop & Ointment policy	5.24		2.22
Fire policy	7.05		1.07
Food Service Policy		7.01	
Gifts and Donations policy	2.17		
Gloves policy	6.05		1.06
Guest Meal Policy		7.03	
Hand Washing policy	6.06		1.06
Handling of Client Finances and Property policy	1.20		
Heat and Humidity policy	7.06		1.07
Hospice and Dialysis policy	4.18		
Housekeeping Policy		6.02	

Incident Report - Client policy	1.22		
Inhaler policy	5.25		2.26
Initiation of Services policy	4.01		
Insulin policy	5.26		2.24
Loss or Spillage of Schedule II Medication policy	5.18		
Maltreatment - Communication, Prevention, and Reporting policy	1.24		1.08
Meal Delivery Policy		7.04	
Medication & Supplies - Reordering policy	5.06		
Medication & Treatment Orders - Implementing policy	5.03		
Medication & Treatment Orders - Receiving policy	5.04		
Medication & Treatment Orders - Renewal policy	5.05		
Medication & Treatment Orders policy	5.01		
Medication Administration - Documentation policy	5.08		
Medication Administration - Licensed Nurse policy	5.09		
Medication Administration - Outings and Unplanned Leaves of Absence policy	5.12		
Medication Administration - ULP policy	5.10		
Medication Administration - Weekly Dosage Box policy	5.11		
Medication Error policy	5.19		
Medication Record - Documentation policy	5.14		
Missing Client policy	1.25		1.07
Mouth Care policy	4.24		
Nail Care policy	4.25		2.06
Narcotic Log policy	5.16		
Nebulizer Treatment policy	5.27		2.29
Nitro Patch Administration policy	5.28		2.35
Nose Drops & Nasal Spray policy	5.29		2.28
Notice of Privacy Practices (HIPAA) Dissemination	9.01		1.16
Oxygen policy	5.30		2.41
Personal Phone Calls policy	2.18		
Rectal Medication policy	5.31		2.31

Risk Agreement - Client policy	1.28		
Service Plan - Modification policy	4.11		
Service Plan policy	4.09		
Severe Weather policy	7.07		1.07
Side Rails policy	4.19		1.17
Sign In-Out Policy		8.05	
Smoking - Tobacco Use policy	2.19		
Social Media policy	2.20		
Solicitation policy	2.21		
Special Diets Policy		7.05	
Standard Precautions policy	6.07		1.06
Statement of Home Care Services policy	1.30		
Storage of Medications policy	5.13		
Supervision of ULP policy	3.07		
Support Stockings TED Hose policy	4.26		2.45
Tenant Advisory Committee Policy		8.04	
Tenant Council Policy		8.03	
Termination of the Service Plan in HWS AL policy	4.16		
Termination of the Service Plan in Non-HWS AL policy	4.17		
Toileting Assistance policy	4.27		2.10
Topical Application of Ointment & Cream policy	5.32		
Training and Competency Evaluations for ULP policy	3.04		
Tuberculosis & Staff Screening policy	6.08		1.06
Use of Common Areas Policy		8.07	
Water Shortage policy	7.08		1.07
Welcoming New Tenants Policy		8.02	
Winter Storms policy	7.09		1.07

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.04 Policies & Procedures	XX/XX/XXXX

Location of [Name of Company] Policy and Procedures

Employee Name: _____ Date: _____

Policy and Procedures book(s) can be found and referenced in the following facility locations:

_____

_____

_____

_____

The person responsible for ensuring all Policy and Procedures book(s) are updated with current information and who can be contacted if there are questions is:

_____

RN/Designee signature _____ Date_____

Employee signature _____ Date_____

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.05 Policies & Procedures Acknowledgement form	XX/XX/XXXX

Signature Acknowledging Policy and Procedure Review

Employee Name: _____ **Date:** _____

☐ I have read and understand the following policy and procedure: _____

_____

☐ I have no questions
☐ I have the following questions: _____

_____

_____

_____

One thing I learned from this policy and procedure: _____

_____

_____

_____

RN/Designee signature _____ Date_____

Employee signature _____ Date_____

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.06 Infection Control	XX/XX/XXXX

Hand Washing
Proper hand washing technique is the number one step you can take to prevent the spread of infection. Hand washing should be completed:

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning up after someone who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal or animal waste
- After handling pet food or pet treats
- After touching garbage

PROCEDURE:
Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations.

Equipment Needed:

1. Soap
2. Water
3. Paper towels

Steps:

1. Stand away from the sink. Hands and sleeves must not touch the sink
2. Turn on water and adjust to a comfortably warm temperature
3. Wet hands and wrists
4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously
5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing 'Happy Birthday' twice)
6. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands
7. Rinse hands and wrists completely under running water to wash away suds and microorganisms
8. DO NOT TURN FAUCETS OFF WITH CLEAN HANDS – see #10 below
9. Pat hands and wrists dry with a paper towel. It is unacceptable to use client towels for drying hands
10. Turn off water using a clean paper towel to prevent recontamination of the hands
11. If leaving a washroom/restroom, use paper towels to grasp door handle upon exit to prevent recontamination of clean hands

Hand washing and Gloves
When conducting a procedure requiring the use of gloves, proper hand washing should be completed before donning gloves and after removing gloves.

Alcohol-Based Hand Sanitizers (ABHS)
ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands.

PROCEDURE:
1. Apply the ABHS product to the palm of one hand
2. Rub your hands together
3. Rub the product over all surfaces of your hands and fingers until your hands are dry

Bloodborne Pathogens
Bloodborne pathogens are microorganisms that can cause disease when transmitted from an infected individual to another individual through blood and certain body fluids. Bloodborne pathogens can cause serious illness and death.

The most common illnesses caused by bloodborne pathogens are:
- Hepatitis B (HBV)
- Hepatitis C (HCV)
- Acquired immunodeficiency syndrome (AIDS) from Human Immunodeficiency Virus (HIV)

Body Fluids That Can Transmit Infection
- Blood
- Semen
- Vaginal Secretions
- Anal tissue
- Amniotic Fluid
- Cerebrospinal and Synovial fluid
- Pleural, Pericardial, and Peritoneal fluids
- Saliva (e.g. dental procedures)
- Any unfixed human tissue or organ

Methods of Transmission of Bloodborne Pathogens (BBP)
Transmission of bloodborne pathogens can occur from variety of methods. The most common mode of transmission to Health Care Workers (HCWs) is a sharps injury from a contaminated item (scalpel blade, needle, surgical instruments, etc.).

Transmission can also occur if a BBP comes into contact with the mucous membranes of the HCW. This can result from a splash to the eyes, nose, or mouth.

Contact with blood or Other Potentially Infectious Material (OPIM) with non-intact or open skin also has been associated with transmission of BBP to HCWs.

Standard Precautions

Standard Precautions are required by law to be practiced by all Health Care Workers. This means that all blood and body fluids must be treated as if they can transmit bloodborne pathogens to the caregiver.

Standard Precautions are designed to reduce the risk of transmission of pathogenic microorganisms from both recognized and unrecognized sources of infection in the health care setting.

Using Standard Precautions means you must take steps to protect yourself and others from the risks associated with BBP.

Treat all blood and other potentially infectious body fluids as if infected

- Avoid direct contact with blood, body fluids, and other potentially contaminated materials
- Wear Personal Protective Equipment (PPE) appropriate for the task
- Practice good housekeeping and good personal hygiene
- Follow proper decontamination procedures
- Dispose of all contaminated materials properly
- Seek prompt medical attention in the event of exposure

Risk of Infection

Overall risk from workplace exposure depends on the number of infected individuals in the patient population, as well as the type and frequency of blood/body fluids you may come in contact with.

Risk factors following exposure on:

- The pathogen involved
- Type of exposure
- Amount of blood/body fluid involved
- The amount of virus present in blood/body fluid at the time of exposure

As HCWs, we are not always aware of those who are infected or carry one of the most frequent Bloodborne pathogens. In addition, some of our clients may be unaware of their infectious status, as well. Because of this, the importance of using standard precautions whenever we may come into contact with blood or bodily fluids cannot be stressed enough. This, along with good infection control techniques, can minimize your exposure and chance of infection.

Types of Bloodborne Pathogens

Hepatitis, which means “inflammation of the liver,” can be caused by drugs, toxins, autoimmune disease, and infectious agents, including viruses.

Hepatitis B

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV). Hepatitis B, formerly called “serum hepatitis,” is a life-threatening bloodborne pathogen and a major risk to employees in jobs where there is exposure to blood and OPIM. Symptoms may include:

- Feeling very tired (fatigue)
- Mild fever
- Headache
- Not wanting to eat

- Feeling sick to your stomach or vomiting
- Belly pain, especially under the rib cage on the right side
- Dark urine
- Tan stools
- Muscle aches and joint pain
- Yellowish eyes and skin (jaundice). Jaundice usually appears only after other symptoms have started to go away

There is currently a vaccine for HBV. Your employer should offer this vaccine at time of hire. Most children born in the United States are inoculated early on. The series of vaccination are available at any physician's office or medical clinic. If you are unsure if you have had the vaccine or would like to check your immunity status, a simple blood test or titer can be drawn to check.

Hepatitis C
Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). It is the most common chronic bloodborne infection in the United States and is primarily transmitted through large or repeated direct percutaneous (through the skin) exposures to blood.

Most people who are chronically infected are not aware of their infection because they are not clinically ill. Infected people can infect others and are at risk for chronic liver disease or other HCV-related chronic diseases.

Hepatitis C does not usually have symptoms, but if they are present they may include:

- Fatigue
- Joint pain
- Belly pain.
- Itchy skin
- Sore muscles
- Dark urine
- Jaundice

Currently there is no vaccine to protect against Hepatitis C. The most difficult part of the Hepatitis C viral infection is the lack of symptoms, which can lead to liver failure, cancer, and death.

Human Immunodeficiency Virus (HIV)
HIV infection has been reported following workplace exposures to HIV-infected blood through:

- Needle sticks
- Splashes in the eyes, nose, or mouth
- Skin contact

Most often, however, infection occurs from:

- Sharing needles
- Unprotected sex
- Accidently through injury or cuts

No vaccine currently exists to prevent HIV infection, and no treatment exists to cure it, however, there are treatment options to help manage the disease.

The initial symptoms, or Stage One, of acute HIV infection usually occur 2-4 weeks after exposure, and may include:

- Headache
- Diarrhea
- Nausea and vomiting
- Fatigue
- Aching muscles
- Sore throat
- Red rash that doesn't itch, usually on the torso
- Fever
- Fatigue (being tired all the time)

Stage Two, is when the body is in remission; with the use of antiviral medication, this stage may last for years.

Stage Three, when the HIV infection has progressed to AIDS (autoimmune deficiency disorder), most common symptoms include:

- Swollen lymph nodes in the neck or groin
- Fever lasting for more than 10 days
- Night sweats
- Unexplained weight loss
- Purplish spots on the skin that do not go away
- Shortness of breath
- Severe, long-lasting diarrhea
- Yeast infections in the mouth, throat, or vagina
- Easy bruising or unexplained bleeding

Personal Protective Equipment (PPE)

Personal Protective Equipment (PPE) may be required, based on the activity being performed.

Examples of PPE include:

- Gloves
- Gowns
- Aprons
- Face shields
- Masks
- Resuscitation mouth pieces
- Ambu bags

It is essential that PPE be worn when appropriate and that it is removed and disposed of correctly. This means that the PPE must not contaminate you or the environment around you.

Special PPE Precautions

- Cover open cuts, rashes, and other broken skin
- Check condition of equipment before using
- Remove all PPE carefully to avoid contaminating yourself or anything around you
- Dispose of PPE properly
- Do not mix contaminated clothing or laundry with other laundry
- Wash hands thoroughly after removing gloves and before putting on clean gloves

Gloves

- Gloves are the most frequently used type of PPE. They provide a barrier between your hands and infectious material
- Latex-free exam gloves and surgical gloves are used for medical, dental, and laboratory procedures
- Heavy duty utility gloves should be used for housekeeping activities and for laundry workers handling soiled linen
- Gloves should be examined for integrity (holes and tears) before using them
- Disposable gloves are intended for single patient use only and you should not attempt to clean or decontaminate them
- Never wear used or soiled gloves in common areas
- Dispose of gloves immediately after use

Gowns

- Gowns are worn to protect skin and prevent soiling of clothing during procedures where splashes or sprays of blood or OPIM are anticipated
- Contaminated gowns or clothing should be removed as soon as possible to prevent employee exposure
- Contaminated apparel from work areas where exposure to blood or OPIM occurs should not be worn outside of that area
- Scrub suits are not considered PPE since they offer minimal or no resistance to fluid penetration

Masks and Eye Protection

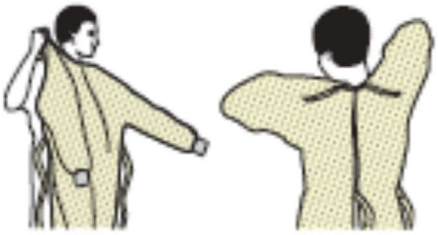
- Masks and Eye protection must be worn to protect mucous membranes during patient care activities when splashes or sprays are anticipated
- Prescription eyeglasses are not considered adequate protection because they do not protect from the potential for exposure through open areas at the top and side of the eyewear.

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

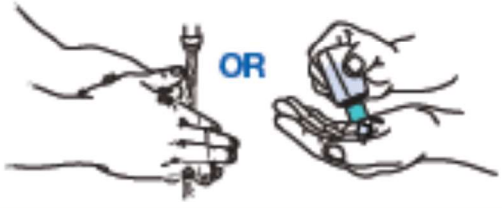
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

Engineering/Environmental Controls
Engineering/Environmental Controls are physical or mechanical systems used to eliminate hazards at their source and prevent staff exposures. Engineering controls include the following:

- Hand washing facilities and/or hand sanitizing gels must be available at or near the point of care
- Sharps containers (used to dispose of needles and other sharp instruments) are properly located, at the proper height, and not over-filled
- Sharp safety devices are used appropriately and training on their use is provided
- Biohazard waste bags should be available in patient care areas

Work Practice Controls
Work Practice Controls are specific procedures or policies that must be followed to reduce your risk of exposure to blood or OPIM. Examples of work practice controls include:

- Hand hygiene policy, which provides specific guidance on when and how to perform hand hygiene (see hand washing section above)
- Place sharps in sharps containers immediately after use
- Do not bend or recap needles
- No eating or drinking in patient care areas
- Use leak-proof specimen containers
- Proper separation and disposal of trash

Disinfection and Housekeeping
Good disinfection techniques and housekeeping protects health care workers and is every worker's responsibility. Disinfectant wipes are frequently used in clinical areas to disinfect hard surfaces., including counters, exam tables, computer keyboards, and stethoscopes.

- **PAY ATTENTION** – Some sanitizing environmental wipes require that gloves must be worn during use; refer to manufacturer directions.

General

- Each work area must be cleaned between uses and at least once per shift
- Place sharps and infectious waste in designated containers
- Decontaminate equipment before sending it for repair
- Clean and decontaminate equipment and surfaces as soon as possible after contact with blood or potentially infectious materials
- Clean up all spills immediately
- Clean and sanitize pails and other reusable waste containers regularly, per facility protocol
- Replace protective coverings immediately upon obvious contamination, or at end of work day

Laundry

- Wear PPE, handle laundry as little as possible, and carry it away from your body
- Laundry must be bagged or containerized at the location where it was used before transporting
- No sorting or rinsing of contaminated laundry at the location where it was used
- Contaminated laundry must be placed and transported in appropriately labeled or color-coded containers

Labeling
Labels must be used to warn of the presence of a bloodborne pathogen. Biohazardous labels must be placed on contaminated equipment, specimen containers, bags containing biohazardous items (red trash bags), as well as on doors to areas where infectious agents are present.

Cleaning:
- Removal of infectious agents via mechanical means is using a ***cleaning*** agent

Sanitizing:
- When applying a ***sanitizing*** agent, carefully follow label instructions
- Contaminated surfaces and equipment must be sanitized

Cleaning of Shared Surfaces
Your facility will implement and maintain processes to ensure all reusable home care client care equipment is routinely cleaned, and when appropriate, disinfected, before and after use.

Common shared home care equipment may include:
- Stethoscopes
- Glucometers that are used for multiple clients
- Mechanical lifts
- Bathing chairs
- Tubs and showers

➢ **PAY ATTENTION** to definitions:
- Cleaning – The physical removal of foreign material, e.g. dust, oil, organic material such as blood, secretions, excretions and micro-organisms. Cleaning reduces or eliminates the reservoirs of potential pathogenic organisms. It is accomplished with water, detergents and scrubbing action.
- Disinfection – The inactivation of disease-producing organisms. Disinfection does not destroy high levels of bacterial spores. Disinfectants are used on inanimate objects. Disinfection usually involves chemicals, heat or ultraviolet light. Levels of chemical disinfection vary with the type of product used.

PROCEDURE
1. All equipment must be cleaned immediately if visibly soiled, and immediately after use on patients with contact precautions (e.g. MRSA, VRE, and C-Difficile) regardless of cleaning schedule. When possible have dedicated, individual, equipment for those client with contact precautions in place.
2. Items routinely shared, which cannot be cleaned between uses, will follow a regular schedule for cleaning and disinfection.
3. Cleaning and maintenance processes will follow manufacturer's recommendations.
4. In the absence of recommendations, clean non-critical medical equipment surfaces with a mild detergent followed by cleaning with a disinfectant.
5. Follow product recommendations for disinfectants (how to apply, amount of time the product must remain on the equipment, etc.).
6. Use protective equipment such as gloves, goggles and gowns as needed.

Glucometers:
Glucometers used by multiple patients must be cleaned and disinfected in the following manner between patient uses:

- Clean the glucometer to remove blood and OPIM by following manufacturer instructions
- Disinfect the glucometer by following manufacturer instructions, making sure any product you use is effective against bloodborne pathogens.
- Follow disinfection product instructions to make sure it is applied properly and remains on the glucometer for the required amount of time. Always read labels to ensure that you are disinfecting for the correct amount of time; each product is different
- Remove gloves, dispose of gloves, and wash hands
- Store glucometer appropriately, per manufacturer direction and facility protocol

It is highly recommended that each client has their own glucometer to avoid cross-contamination.

Sharps Injury Prevention

- Evaluate and provide devices designed to prevent injury
  - Sharps containers
  - Syringes with sliding sheath that engages after use
  - Needles that retract after use
  - Shielded or retracting catheters
  - IV delivery systems w/ catheter port/needle in protective covering
- Provide training on new equipment
- Keep a sharps injury log – which includes:
  - Date and time of incident
  - Type of sharp involved
  - Description of incident
- Place contaminated sharps in Sharps container, including non-electric razors that clients use.

➢ **PAY ATTENTION** –
  - **Never** break off needles or blades!
  - **Never** attempt to retrieve sharps from a sharps container!
  - **Never** recap needles!

Despite your best efforts, exposure to blood or body fluids during an emergency response is a possibility. An exposure is defined as a specific eye, mouth, other mucous membrane, non-intact skin, or parental contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

If an exposure incident occurs, follow these steps:

1. Flush the area on your body that was exposed with warm water, then wash vigorously with soap and water if area is external (e.g. skin). It is the abrasive action of scrubbing that removes contaminates from the skin.
2. If you have an open wound, squeeze gently to make it bleed, then wash with soap and water.
3. Notify your supervisor who will initiate exposure incident procedures.
4. Seek emergency medical treatment following an exposure incident.
5. You will be counseled by a physician regarding the risk of HIV, HCV or HBV infection and any other follow-up treatment that may be needed.

Exposure Control Plan
Identifies jobs and tasks where occupational exposure to blood or other potentially infectious material may occur.
The Exposure Control Plan describes how the employer will:

1. Use engineering and work practice controls
2. Ensure use of personal protective equipment
3. Provide training
4. Provide medical surveillance
5. Provide hepatitis B vaccinations
6. Use signs and labels

The Exposure Control Plan details written protocols for exposure events and consists of:

- Written plan required
- Plan must be reviewed at least annually to reflect changes in tasks, procedures, or assignments which affect exposure, and technology that will eliminate or reduce exposure
- Annual review must document employer's consideration and implementation of safer medical devices, if necessary. For example, could facilities use different syringes or self-administered insulin devices to increase safety? A client uses an old type of razor and keeps cutting himself - could something safer be used?
- Must solicit input from potentially exposed employees in the identification, evaluation and selection of engineering and work practice controls. What suggestions and input from the nurses or if delegated, CNA, HHA, or TMA have to add to the sharps exposure plan?
- This plan must be accessible to employees.

In summary, the risk of bloodborne pathogen exposure is everywhere. As identified, some people are unaware that they are infected. We must protect ourselves by working smart and utilizing PPEs, sanitizing our environment, and being an active part of the plan. It is our responsibility to make sure that we have the equipment we need, and it is readily accessible.

****Reminder:** We must also respect the dignity and privacy of the people we care for; their diagnoses are privileged, and HIPAA protected. If you have concerns or questions regarding how to care for any of your clients, it is your responsibility to communicate that to your supervisor.

Tuberculosis (TB)
All home care staff whose essential job functions require work within the same air space of home care clients shall be screened and tested for tuberculosis. The Facility shall have an ongoing program for screening and educating staff on tuberculosis and have an infection control plan for handling persons with active tuberculosis.

The Facility will have a current infection control plan that includes:

- A person or team has supervisory responsibility for TB infection control
- A community TB risk assessment
- Written TB infection control procedures
- Health care worker education
- Health care worker screening for TB

COMMUNITY TB RISK ASSESSMENT: Your Facility will complete a written community TB risk assessment and update the assessment per MDH guidelines based on the level of risk. as needed and annually. The assessment form was developed by the Minnesota Department of Health, and is available for download at:

http://www.health.state.mn.us/divs/idepc/diseases/tb/rules/riskwksht.doc

The Facility will have written procedures to address TB infection control. Based on the Community TB Risk Assessments, Medium-risk settings should review their procedures annually and update, if necessary. Low-risk settings should review their procedures every other year and update, if necessary.

1. Early recognition: All staff of should know the signs and symptoms of TB and their role in their home care agencies TB infection control program.
2. Isolation: All healthcare facilities shall place a potentially infectious TB client in private room until physician examination; if a private room is not available, the client will be provided with a mask and instructions to minimize spread of infectious particles.
3. Referral: If the RN assesses the client's TB symptoms and determines there is a significant health risk to the client or other clients, and/ or the facility does not have the ability to appropriately manager the client, the client will be transferred to the emergency department for evaluation, confirmation of or ruling out TB, and/or treatment.

HEALTH CARE WORKER TB EDUCATION: All employees must be trained regarding TB at time of hire. The content of the training should be appropriate to the job responsibilities and professional background of the employee (licensed versus unlicensed staff). Content of the training will focus on basic information about:

1. TB pathogenesis and transmission
2. Signs and symptoms of active TB disease
3. Infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure – see above)

Based on the Community TB Risk Assessments, TB training should be conducted annually in medium risk settings. Low-risk settings should annually evaluate the need for TB training, and conduct training as needed.

STAFF TB SCREENING: All staff whose essential job functions require work within the same air space of home care clients shall be screened and tested for tuberculosis prior to the staff being exposed to clients.

Screening frequency shall be conducted based on the results of the Community TB Risk Assessments:

1. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool
2. New staff shall have a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs or an approved blood test.
3. No staff shall be permitted to begin work where the work involves sharing the air space with home care clients until the TB screen is negative and the results of the 1st step Mantoux are negative or an approved blood test result is negative and documented.

The following documented blood tests shall be an acceptable substitute for a two-step Mantoux:

- QuantiFERON TB-Gold
- QuantiFERON-TB-Gold InTube
- T-SPOT

Staff TB screening results shall be kept in each employee's medical file

HOME CARE CLIENT TB SCREENING: While clients shall be monitored for symptoms of TB, no Mantoux or Blood tests are required of home care clients.

Tuberculosis or TB Fact Sheet

Facts:

- TB is a disease caused by a bacterium called Mycobacterium tuberculosis (M. tuberculosis)
- TB normally attacks the lungs
- If TB is treated properly, most people can be cured of TB, although will remain a carrier
- If TB is NOT treated properly, people can die from TB or develop drug-resistant forms of TB
- Although TB is preventable and treatable, it is not just a disease of the past; it is still one of the world's deadliest diseases
- One third of the world's population, is infected with tuberculosis
- On average, one person dies of TB every 15 seconds

TB disease was once the leading cause of death in the United States. After the discovery of drugs that could treat TB in the 1950s, death rates began to drop dramatically.

However, even today, TB is still a problem in the United States over 9,000 people developed TB disease in 2016 and approximately 10.4 million people around the world were infected with M. tuberculosis.

Although the number of people with TB disease in the United States has been declining over the past several years, there remain continuing challenges to controlling TB:

- TB is reported in almost every state and is increasing in some areas
- TB affects racial and ethnic minorities disproportionately
- Drug-resistant TB is increasingly challenging to treat
- Management of patients with comorbidities, such as HIV, diabetes, and other immune-compromising conditions, is difficult
- More than half of all persons in the United States who have TB disease are foreign-born clients

TB is transmitted through the air from person to person. Tiny water particles containing M. tuberculosis may be expelled into the air when a person with infectious TB:

- Coughs
- Sneezes
- Speaks
- Sings

These particles, called droplet nuclei, can remain in the air for several hours, depending on the environment.

If another person inhales air that contains droplet nuclei, they may become infected. However, not every person that is exposed to TB becomes infected with M. tuberculosis.

Additionally, not everyone infected with M. tuberculosis becomes sick. People who are infected, but not sick, have latent TB infection. Some people with latent TB infection go on to develop TB disease.
Thus, there are two TB-related conditions:

- Latent TB infection. Has been exposed to tuberculosis. Usually discovered with a Mantoux skin test and chest x-ray results indicate there is no active infection. They are not contagious but must follow a preventative medication regime to prevent active TB disease.

- TB disease

About 5% to 10% of infected persons who do not receive treatment for latent TB infection develop TB disease at some point in their lives.

The risk of developing TB disease is much higher for persons with weakened immune systems than for persons with normal immune systems. For example, people with untreated latent TB infection and HIV infection are much more likely to develop TB disease during their lifetime.

HIV infection is the strongest known risk factor for progressing to TB disease among people with latent TB infection.

Other people that have weak immune systems that put them at high risk for developing TB disease include:

- Children younger than 5 years of age
- Persons who are receiving immunosuppressive therapy
- Persons with silicosis, diabetes, or cancer of the head, neck.
- Persons who weigh less than 90% of their ideal body weight
- Persons who abuse drugs and alcohol

General symptoms of TB disease:

- Fever
- Chills
- Night sweats
- Weight loss
- Appetite loss
- Fatigue
- Malaise (general bodily weakness or discomfort)

General symptoms of pulmonary TB disease:

- Cough lasting 3 or more weeks
- Chest pain
- Coughing up blood or sputum (phlegm)
- Weight loss, appetite loss

- Night sweats
- Fatigue, malaise (general body weakness)
- Fever, chills

The bacteria usually attack the lungs but can attack any part of the body such as lymph nodes, bones and joints, the brain, and other organs. Symptoms of TB disease in other part of the body depend on the area infected.

Infection Control:
Since TB is an airborne disease that can be transmitted from one person to another, it is important to practice appropriate infection control procedures to protect others from getting TB. Part of this program includes a facility risk assessment, which will be discussed later.

This is especially important for health care facilities and other congregate settings. All health care facilities need an infection-control program. This program should be designed to ensure:

1. Prompt detection of TB, by screening and testing employees and volunteers, and clients when symptoms indicate a potential of TB
2. Airborne precautions to prevent the spread of TB
3. Treatment of persons who have a suspected or confirmed TB disease

- **PAY ATTENTION –** ***it is important to know that employees and volunteers who test positive for TB Disease are not allowed to return to the health care facility until a physician knowledgeable and experienced in managing TB has determined the employee or volunteer is no longer infectious.***

If a client is exhibiting signs of TB:

1. Notify the RN immediately
2. Isolate the client, in a private room with a closed door; if a private room is not available, provide the client with a mask and education about how to minimize the risk of spreading the TB germs to others.
3. Provide the client with a surgical mask.
4. Anyone who has direct contact with the client, including staff, family, or visitors, should also wear masks, gowns, and gloves
5. The client will be transferred to a facility with respiratory isolation rooms (hospital) for further testing and treatment.

All measures should be taken to care for the client and protect others until the client can be transferred to a more appropriate setting. Your medical director and RN will determine if additional testing will be needed for anyone who encountered the client. Most often, anyone who has been in contact with the affected client would be tested and might be offered preventative medication.

Testing for TB Infection
Tuberculosis testing is an essential TB prevention and control strategy in the United States. Testing is used to identify and treat persons who are at high risk for latent TB infection or at high risk of developing TB disease once infected with M. tuberculosis.

Identifying and treating persons who have latent TB infection is important because treatment can prevent these persons from developing TB disease in the future. This helps to stop the further spread of TB in communities.

All TB testing activities should be accompanied by a plan for follow-up care, medical evaluation, and treatment for persons diagnosed with latent TB infection or TB disease.

People that are high risk for TB:

- Contact with persons known or suspected to have infectious TB disease
- People who have come to the United States within the last 5 years from areas of the world where TB is common (for example, Asia, Africa, Eastern Europe, Latin America, and Russia)
- Persons who visit areas of the world where TB is common, especially if visits are frequent or prolonged
- People who live or work in congregate settings whose clients are at increased risk for TB disease
- Health care workers who serve clients who are at increased risk for TB disease
- Populations defined locally as high risk for latent TB infection or TB disease, such as medically underserved, low-income persons, the homeless, or persons who abuse drugs or alcohol

Testing for TB Infection

Diagnostic tests that can be used to screen for suspected TB infection include:

- The Mantoux tuberculin skin test (TST)
- Interferon-gamma release assays (IGRAs) (blood test)
- Chest X-ray

A positive TST or IGRA result only indicates if someone has been infected or exposed to M. tuberculosis. These tests cannot identify if a person has active TB disease. The usual testing to confirm or eliminate active Tb are a chest x-ray and an acid-fast sputum test. Although many immigrants have been vaccinated with BCG, they must still participate in the screening process.

Mantoux Tuberculin Skin Test (TST)

All health care workers and ancillary staff, volunteers (who are volunteering more than 5-10 hours a week) are required by the State of Minnesota Department of Health to be screened and/or tested before they start working. The initial testing requires a 2-step skin test or approved IGRA (blood test). Annual testing requirements are dependent on the risk factor of the facility when the annual TB Risk Assessment is completed. However, the screening process of reviewing any signs and symptoms of TB must be completed at hire and annually.

If a positive reading is discovered, a chest x-ray is the next step to rule out any disease.

TST PROCEDURE:

1. Non-active tuberculin is injected into the intradermal area (between the layers of skin on the inner forearm). The test is read between 48 to 72 hours later to assess for a reaction.
2. Most people who have TB infection will have a reaction at the injection site. The reaction is the area of induration, NOT the redness. Induration is a firm lump with redness in the skin.
3. A person given the TST must have an RN or physician examine their forearm within 48 to 72 hours. If the person does not return within 72 hours, the test results are not valid, and the person will need another skin test.
4. For the 2-step Mantoux skin testing, the second injection must be completed 1-3 weeks after the first step has been administered. Any test administered outside these guidelines are considered invalid and the series must be repeated.

To determine whether a TST reaction should be considered positive, a trained health care worker needs to interpret the reaction based on:

- Size of induration (measured in millimeters [mm])
- Patient's risk factors for TB
- Redness around the injection site is not measured. This is because the presence of redness does not indicate that a person has TB infection.

Discoveries are documented in millimeters; note that these are testing results and not a diagnosis of Tuberculosis.

An induration of 5 or more mm is considered positive for:

- People living with HIV
- Recent contacts of persons with infectious TB disease
- Persons with chest x-ray findings suggestive of previous TB disease
- Patients with organ transplants and other immunosuppressed patient

An induration of 10 or more mm is considered positive for:

- People who have come to the United States within the last 5 years from areas of the world where TB is common (for example, Asia, Africa, Eastern Europe, Latin America, and Russia)
- Injection drug users
- Clients and employees of high-risk congregate setting
- Persons with clinical conditions that place them at high risk

An induration of 15 mm or more is considered positive for any person.

If client or health care worker has a history of a positive skin test, they must provide dates of testing, test results, current assessment for TB symptoms, and chest x-ray completed no more than 3 months prior to the positive result or after the date of the positive result. If the healthcare worker is unable to provide this documentation, they must complete the TST or IGRA just like a healthcare worker that has no previous positive results. The chest x-ray will be valid for 10 years unless the TB screen for symptoms indicates a risk of a TB. A TB screening assessment will be required annually and kept in chart or personnel file.

An alternative to the TB Mantoux skin test is a blood test that can be kept indefinitely as proof of TB testing, unless there is a suspicious annual TB screening for symptoms.

There are two IGRA tests available in the United States:

- QuantiFERON®-TB Gold In-Tube (QFT-GIT)
- T-SPOT®.TB

Additional Information:

1. For any staff who travel out of the country, especially to high risk areas, MDH and the CDC recommend that those who are gone for more than four weeks be tested within 8-10 weeks of returning. A TB screening for symptoms should be done immediately after return.
2. Pregnancy and TST testing is not contraindicated, however if the pregnant worker refuses to be tested, then an IGRA test is safe, as well. If the pregnant worker continues

to refuse, their primary medical doctor or OB/GYN must provide an exemption form to be kept on file.
3. Those with a history of a severe reaction to the TST must provide documentation as such or opt for the IGRA test.

Minnesota Department of Health and Human Services:
http://www.health.state.mn.us/divs/idepc/diseases/tb/index.html

Department of Health and Human ServicesUSA.gov:
The US Government's Official Web Portal

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA

800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 8am-8pm ET/Monday-Friday

C. diff (Clostridium Difficile) Infection
C. diff is characterized by frequent diarrhea after antibiotic use. It is HIGHLY contagious.

C. diff Facts:

- Clostridium difficile:
  - Is the most frequently identified cause of facility-acquired diarrhea;
  - Can cause life threatening inflammation to the colon; and
  - Is responsible for 29,000 deaths and $4.8 billion in excess healthcare costs annually in the United States
- The average human digestive tract is home to as many as 1,000 species of microorganisms. Most of them are harmless—or even helpful under normal circumstances. But when something upsets the balance of these organisms in your gut, otherwise harmless bacteria can grow out of control and make you sick. One of the worst offenders is Clostridium difficile (C. diff). As the bacteria overgrow, they release toxins that attack the lining of the intestines causing a condition called Clostridium difficilecolitis.
- Antibiotic use is the greatest risk factor for C. diff in elderly in long-term care facilities. The risk of Clostridium difficile infections (CDI) is elevated (7-10X) during and in the 3 months following antibiotic treatment, with 85-90% of CDI occurring within 30 days of antimicrobial exposure.
- C.diff bacteria is shed in the stool, any surface that becomes contaminated with the feces may become a reservoir for the C. diff and the spores of C. diff can live on surfaces for extended periods (up to 5 months)
- C.diff may be found on things in the environment such as bed linens, bed rails, bathroom fixtures, hallway rails and medical equipment.
- CDI can spread from person-to-person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors.
- In 2011, 94% of Clostridium difficile infections (CDI) cases were related to healthcare
- **Symptoms of CDI include watery diarrhea, fever, loss of appetite, nausea, abdominal pain and tenderness.**

Testing for CDI:

- Focus testing on patients with clinically significant diarrhea, without other identified causes
  - 3 or more liquid bowel movements in 24 hours.
- Testing requires a stool sample and results are available in a few hours (not as reliable) to a few days (more reliable). A negative result may indicate that the sample was not transported, stored or processed properly. Follow the lab's protocol for proper collection and processing.

Treating CDI:

- IF a person has positive C. diff test results, the health practitioner will typically discontinue any antibiotics that the person is taking and prescribe an appropriate 10-14-day treatment of oral antibiotic such as metronidazole, fidaxomicin or vancomycin to eliminate the C. diff bacteria. Improvement usually happens within 72 hours. Up to 20% of people with CDI experience a recurrence. When stools are firm again, CDI is currently considered resolved
- Drinking plenty of water and other fluids can help guard against dehydration from diarrhea
- Recently, stool transplants have been investigated as an effective treatment for people with recurrent C. diff infections

Preventing Transmission of CDI:

- Clean hands with soap and water or an alcohol based rub before and after caring for every patient. Washing with soap and water and drying with a clean paper towel is preferred when preventing the transmission of C.diff
- Carefully clean rooms and medical equipment that have been used
- A current list of EPA-approved disinfectants with sporicidal claim is available at http://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium
- Hold meetings, including housekeeping, to update staff on control measures and outbreak status
- Post signage about outbreak and proper hand hygiene using soap and water
- Use Contact Precautions to prevent C. diff from spreading to other patients/ residents. C. diff precautions include:
  - ✓ Whenever possible, patients with C. diff should have a single room or share a room only with someone else who also has C. diff
  - ✓ Don gloves prior to entering the room always when delivering care and anticipating contact with resident/patient's immediate environment
  - ✓ If patient/resident is incontinent of stools and staff contact with feces is possible, healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients with C. diff
  - ✓ Dedicate a personal commode to the patient/resident with C. diff if there is a roommate
  - ✓ Dedicate resident care equipment and items for single patient use, such as blood pressure cuffs, stethoscopes, thermometers, etc. If this is not possible, clean and disinfect equipment and items with 1:10 bleach/water solution between residents

- ✓ If the patient/resident is incontinent of stools, wearing an adult incontinent product may assist in containing loose stool and preventing contamination of other furniture. Recommended would be a toileting schedule and hygiene after each loose stool. Disposable under pads on the bed may reduce soiling of sheets directly
- ✓ Educate the patient/resident to use their private toilet whenever possible to decrease the potential transmission of CDI
- ✓ Teach patient/resident/visitors to wash hands with soap and water and dry with a clean dry paper towel. (hand towels can harbor bacteria and only serve to transmit C. diff)
- ✓ Visitors may also be asked to wear a gown and gloves

Housekeeping and Laundry:

- Wash hands with soap and water and dry with clean paper towel frequently and in-between each room when cleaning. Do not rely just on alcohol based hand sanitizers.
- Clean surfaces in bathrooms regularly with chlorine bleach based products
- Wash soiled laundry with detergent and chlorine bleach. Soiled laundry should have a separate basket. Handle soiled linens carefully, do not shake or hold close to the body. Clean laundry should not be returned to patient/resident's room in the "soiled linen" laundry basket
- Consider using disposable beach wipes, paper towels or cleaning clothes that can be washed in hot bleach water after cleanings
- Buckets and containers should be washed and disinfected after each use
- Remove fabric curtains- replace with plain plastic/vinyl shower liner that will be able to be cleaned with a beach product
- Remove towels hanging on hooks or stacked next to the commode
- Store toothbrushes and personal grooming items in a cabinet
- Ensure the disinfectant remains wet on surface for the entire duration of the contact time indicated on the container label
- When mixing household bleach 1:10 bleach, surfaces must remain wet with solution for 10 minutes to kill spores. Solution must be mixed fresh daily
- Cleaning and disinfecting should include horizontal surfaces such as counters, dining tables, bedside tables. Pay special attention to frequently touched areas such as door handles and bed rails (if applicable)

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.07 Emergency Preparedness	XX/XX/XXXX

Use of Emergency Services / When to Call 911

Examples of events or circumstances which warrant notification of 911 include when a client:

- Has trouble breathing or has stopped breathing
- Has no pulse
- Is bleeding severely
- Is having chest, neck, jaw, or arm pain
- Is unconscious or is losing consciousness
- Has a suspected fracture
- Has been badly burned
- Is unable to move one or more limbs
- Is having a seizure
- Is suffering from:
    - Hypothermia - below normal body temperature
    - Hyperthermia - well above normal body temperature
- Has been poisoned
- Is having a diabetic emergency
- Has suffered a stroke
- Is choking

➢ **PAY ATTENTION – If there is any doubt regarding the seriousness of the condition, call 911.**

How to use 911

1. Dial 911 from the nearest phone
2. Stay calm and give the 911 dispatcher the following information:
    - State “This is a medical emergency”
    - Give your name and the name of your facility
    - Give the address
    - Give the name of the client
    - Describe the problem and how it happened, if known; Otherwise just relate the facts and what has been observed
3. Follow directions of the 911 dispatcher
4. Hang up only when the dispatcher says you can
5. Following a 911 call, staff will get a copy of the client information sheet (sometimes called the Face Sheet), and a list of current medications to be given to the 911 responder
6. After the client is safely on the way with the emergency crew
    - Fill out incident report and/or document incident in client record (Refer to facility policy)
    - Call the client’s family with an update
    - Call and update the RN
    - Call and update the Housing Director

Emergency and Disaster Plans
Minnesota has a variety of weather activities and facilities should have the following emergency and disaster plans in place, in addition to standard emergency procedures:

- Fires
- Missing Client
- Tornadoes
- Extreme winter weather (Snow/Ice storms, cold temperatures)
- High heat and humidity
- Flooding
- Water shortage
- Any other facility and location specific needs

When home care services are being provided in a Housing With Services (HWS) setting, the home care provider coordinates emergency planning with the HWS setting. The HWS setting should have plans for both sheltering in place and evacuations.

Home care staff will be trained during orientation and annually regarding the home care provider's disaster and emergency preparedness plan.

For the safety of clients, staff will provide assistance to clients in the case of a disaster or emergency. Staff will learn and practice disaster procedures during drills. Clients will be informed of disaster procedures.

GENERAL PROCEDURE:

1. Staff will concentrate on assisting less mobile clients or clients in most immediate danger first
2. The facility will designate an individual who will assume responsibility in the event of an emergency
3. In the event of a disaster and the management is not on site, the Unlicensed Personnel (ULP) or person on call will be appointed as the person in charge
4. The person in charge shall direct the clients, visitors, volunteers, and other staff as to which emergency and/or disaster procedure to follow

Fire Emergency

In the event of a fire all staff will assist in protecting and providing safety to the clients and guests.

In the event of a fire, RACE:

R – RESCUE: Remove all clients from danger. All should be evacuated to safest exit or behind the nearest set of smoke compartment doors away from fire/smoke.
A – ALERT: Call 911. Tell them who, what, when, where. If system is sounding, fire department will be on the way, but a call to 911 should still be made. Sprinklers will activate if necessary.
C – CONFINE: Close all doors leading towards the fire. Check all rooms and then CLOSE DOORS as you are evacuating the area.
E – EXTINGUISH: Extinguish the fire – only if safe to do so and you have followed all other steps in this procedure.

When the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire. Clients should stay behind the fire doors. All other doors should be closed immediately to contain the fire or smoke unless clients need to be evacuated.

The fire department will dispatch immediately. The system is wired directly to the fire station. Once they arrive, staff will take orders and direction from them. They are in charge.

All known fires must be reported to the fire department for investigation.

Alarm is Sounding – No Apparent Fire
Remain calm and keep clients as calm as possible. If a fire panel is available, check to see where alarm box is pulled. Designate staff members to search facility for smoke or fire. The fire department needs to come and shut off the alarm. If no one comes to give you further directions, and the alarm is off, you may open the fire doors and continue operations.

***Fire Drills** – are currently not mandatory in the state of Minnesota, but it is good practice hold them on a regular basis. Fire drills are conducted at least 2-3 times per year, alternating shifts.

Sample way to conduct a planned fire drill:

1. Contact the fire department and alarm company to let them know you are going to be conducting a drill
2. Gather staff and explain the assignments and goals
3. Plant a fake fire (use a red hand towel, for example)
4. Activate the alarm
5. Allow staff to:
    a. Locate the fake fire. Remove clients from immediate danger by evacuating those closest to the fire and moving outwards
    b. Staff should account for all clients as they gather together in the designated meeting place
    c. Call 911 even if the system is automated
    d. Make a sweep of the building (except if danger is apparent.) Ensure all clients are accounted for
6. Debrief with staff about how the drill went and discuss areas for improvement
7. Take attendance and track who participated in fire drill

How to use a Fire Extinguisher
Extinguishers are classed by the type fire they can put out. Some extinguishers are Combination types that can be used on several different types of fires. Most extinguishers in healthcare settings are multipurpose suitable for class A, B and C fires.

Using a Fire Extinguisher

- **P-A-S-S**
    - Pull the pin
    - Aim at base of fire
    - Squeeze the handle
    - Sweep from side to side

- **PAY ATTENTION** – it's best to get the manufactures directions for each extinguishers model for proper training. Often fire departments will come and help educate your staff.

Types of Fires

- Class A – Combustible material such as paper and wood
- Class B – Fires involving flammable liquids such as gasoline, paint, diesel fuel or solvents
- Class C – Fires started in electrical equipment by arching or overheating
- Class D – Fires involving combustible metal powders, flakes or shavings

Smart Safety Rules

- Stand 6 to 8 feet away from the fire
- Use an extinguisher ONLY if you have been trained to use it.
- Fire Extinguishers are for small fires in the early stages.
- Know where fire extinguishers are located
- Never place a pressurized fire extinguisher upright unless you are holding it - if it falls over the nozzle can break off
- All fire extinguishers should have an inspection tag and a trigger seal and a pin
- After use, do not put a fire extinguisher back on its mounting – it must be refilled before being returned to its location

Missing Client

Some of our clients are cognitively and physically unsafe when alone outside of their homes. These clients will be identified as needing assistance in their service plan and care plan.

There also may be incidents in which a client has left the facility and does not return at the scheduled time. It is possible that there are clients that do not wish to return to the facility.

When clients are missing, staff will conduct a thorough search to locate the client.

In the event a client is missing, the following should happen:

1. The person that first notices a client missing will alert co-workers
    a. Include: name, apartment number, description of the client, and where the client was last seen
2. Immediately search inside the building for the client
3. Do not forget to check public bathrooms and other public areas, including:
    a. Activity rooms
    b. Beauty shop
    c. Smoking Room
    d. Other clients' rooms, with permission, especially those with whom the client associates with
4. Call family to ask them if they have forgotten to sign the client out or if the client has shown up to visit
5. If client is not found, notify supervisor
6. Supervisor will then assign employees to search outside the facility, covering all grounds surrounding the building
7. If the client is still not found, notify 911, notify the family and 911. Have the following information available:
    a. Name of client
    b. Description of client including what the client was wearing
    c. Time when client was last seen
    d. Update family of steps taken to locate client
8. When client is found, complete an incident report including all information concerning the disappearance. Including the following:
    a. Time of first alert concerning client disappearance
    b. Procedure taken, staff involved
    c. Time of notification of 911 and family, if involved
    d. Time when found
9. Update immediately:
    a. Family
    b. Police Department
10. Determine if alternate approaches to minimize the future risk of elopement are to be implemented, document in client's chart and in the communication book
11. RN will:
    a. Update Vulnerability Assessment and Abuse Prevention Plan, if appropriate
    b. Add additional interventions to Care Plan
    c. Provide written instructions to unlicensed personnel
    d. Educate all staff

Severe Weather / Tornado Emergency

In the event of severe weather, staff will assist in protecting and providing safety to the clients and guests.

The facility should have a weather radio located at a central location. It is your responsibility to make sure that this is plugged in and extra batteries are available.

Severe Weather/Tornado Procedures
You should be aware of weather conditions when skies are dark, heavy winds are blowing, etc. This type of weather can bring tornadoes; staff must be prepared to monitor local TV reports, local radio, and weather radio, so they can take evacuation steps, if necessary.

Definitions:
Tornado Watch: Weather conditions are ideal for development of tornadoes – stay tuned
Tornado Warning: A tornado has been identified – evacuate to designated location and prepare for tornado.

Tornado Watch Procedure:

1. Account for all clients. Request that those outdoors come indoors.
2. Remain calm and explain the situation to all clients
3. Request that those outside come indoors
4. Turn on Weather Radio and turn TVs to a local channel
5. Close all windows and blinds in common areas and client rooms
6. Get out emergency flashlights. Make sure they are in workable condition
7. Keep flashlight with you at all times, as well as a portable phone
8. If a tornado watch is occurring over a meal, serve the meal on paper products if possible.

Severe Weather/Tornado Warning (Sirens are Going Off) Procedure:

1. Instruct clients to take cover in interior hallways, bathrooms, storerooms or other designated safe areas. If an interior safe area is not available, instruct clients to go to a corner of their room, away from windows
2. If possible, clients should bring a pillow and blanket to cover their head and sit with backs to the wall
3. No one should be in a room with windows, when possible
4. Reassure clients. Keep them updated with status of weather and Tornado Warning.

If injuries or building damage has occurred following severe weather:

1. Call 911 for assistance with injuries and/or transportation to the ER
2. Take count of all clients and staff
3. Call Supervisor/Manager
4. Notify maintenance/caretaker
5. Notify family members as needed

**Severe weather drills are currently not mandatory in the state of Minnesota, but it is good practice hold them on a regular basis. Drills help everyone understand their role in case of emergency.*

Recommended Emergency Kit Items:

- First Aid Kit
- Flashlights and extra batteries
- It is recommended that there be enough flashlights for each staff to assist clients to shelter in case of power outage
- Battery operated radios and extra batteries
- Portable phone or, if unavailable, allow staff to use personal cell phones for emergency-related communication only

Flooding

Depending on where your facility is located, flooding may not be a concern. Completing the Hazard Vulnerability Analysis will indicate if this is applicable to your facility.

The following guidelines may be used by healthcare facilities and providers to answer questions regarding expectations of the Minnesota Department of Health (MDH) Health Regulations during flooding or other similar natural disaster.

General Protocol:

1. Your first and foremost priority is to your clients. Use common sense!
2. Healthcare facilities may be called upon by the community or by other healthcare providers to provide support. This might include meals, water, shelter, etc.
    a. Immediately contact your Administrator, Housing Director, and/or RN Supervisor for facility procedures in this situation
    b. Do what you can to help, per facility protocol, but remember that your primary responsibility is first to your clients, and then to others, as staff and resources permit.
3. Flooding and other natural disasters may affect water supplies.
    a. Facilities may need to reduce bedside water and regular bathing.
    b. Hydration and hygiene needs must be met, but usual procedures can be modified.
4. Staffing may also be difficult if there is a disaster in your community.
    a. Do your best to keep staffing at appropriate levels.
    b. Follow your contingency plan, as detailed on the client service plans.
    c. If staffing cannot be maintained, strong consideration must be made to transferring the clients to other facilities.

Evacuating Facility:

1. If clients need to be relocated, it is the responsibility of the evacuating facility to secure appropriate placements. If you need assistance in locating space or finding transportation for your clients, you should work with your Regional Multi-Agency Coordination Center (MAC) or contact MDH Compliance Monitoring Division. (See Public Health & Healthcare Regions and Teams attachment at the end of this module).
2. The evacuating facility does not need to write a discharge summary for the clients that are being relocated.
3. The evacuating facility should create a log of clients who are being evacuated, including relocation site.
    a. Remember to notify family or responsible parties of the need to temporarily relocate; they might be willing to take the client home as a short-term solution.
4. The evacuating facility should send the medical record, care plan, medication, and needed supplies with the clients to the receiving facility.
    a. If any of these items are not available due to the nature of the disaster, the evacuating facility must write and send a short profile of the client and their care needs, along with a list of medications with dosages.
5. The evacuating facility will continue to bill for the services and will be responsible for reimbursing the receiving facility.

6. This is a stressful time not only for staff, but for clients as well. Many clients will want to take all their belongings.
    a. Put yourself in their shoes, but remind them that this is an emergent situation and unfortunately, they can only take personal care items, changes of clothes, pictures, etc.
    b. Limit each client to one suitcase or bag. Explain that if possible, staff will return to obtain additional items.
    c. Make every attempt to place remaining belongings on a higher surface, for example, a bed, table, or closet shelf, if time permits.
7. Client pets may not be permitted at the receiving facility. Arrangements will need to be made to care for them.
    a. Contact the local Red Cross or other emergency assistance agency in your area and/or local animal shelters, veterinarian offices, or families to assist with temporary shelter.
    b. Remember to send the records of immunizations and veterinary records or the animals 'chart'.
    c. Record where each animal is placed.

Receiving Facility:

1. If your facility will be accepting relocated clients and will exceed licensed capacity, contact the MDH Health Regulation (651) 201-3567 or (651) 201-4101. Temporary waivers can be granted in an emergency.
2. The receiving facility should maintain a log of clients who have been relocated to your facility.
3. For payment purposes, the receiving facility is accepting the clients temporarily and will receive payment from the evacuation facility.
4. The receiving facility is not required to perform the usual admission procedures, nor do they need to prepare the admission assessments, service plan, and care plan.
    a. This applies for the first 30 days of the disaster.
    b. During this 30-day period, an evaluation should be made as to whether clients will be able to return to the evacuation facility.
    c. If it is determined that the evacuating facility will NOT be able to resume services, further instructions will be provided through local and state agencies.

Loss of Power

In the event that the facility loses power:

1. An emergency generator should start to provide power to most necessary areas of the facility.
2. Call your supervisor and/or maintenance director to alert them of the power loss.
3. Reassure your clients that this is temporary and that you have notified the appropriate people.
4. If you have any clients that are on air flow mattresses, oxygen concentrators, or any other piece of power-driven medical equipment, check to make sure that these are powered by the emergency outlets that are supplied by the generator.
5. Retrieve the emergency kit; it should contain multiple flashlights, extra batteries, and a battery-powered radio.
6. If the power is off, and the generator is not functioning, you may need to take other precautions; contact supervisor and/or maintenance director immediately for guidance.
7. During the cold weather months, keep all windows and doors closed to conserve heat.
8. Draw window shades and gather extra blankets to keep clients warm.
9. Alternatively, during the warm weather months, keep all windows, shades, and doors closed to conserve cooler air already in the building. However, depending on the length of the power loss, it may become necessary to open windows to encourage air flow at some point.
10. Place a large supply of bottled water or pitchers of water in the refrigerators or freezers, and then AVOID opening the refrigerators and freezers as much as possible.
11. Identify and locate food that does not require a power supply to serve (e.g. sandwiches, fruit, pre-packaged snacks, etc.)
12. Your supervisor will give you direction if further actions should be taken.

Heat Exhaustion and Heat Stroke

Risk Factors for Heat Exhaustion:

Heat exhaustion is strongly related to the heat index, which is a measurement of how hot you feel when the effects of relative humidity and air temperature are combined. A relative humidity of 60% or more hampers sweat evaporation, which hinders your body's ability to cool itself.

The risk of heat-related illness dramatically increases when the heat index climbs to 90 degrees Fahrenheit or more. So, it is important – especially during heat waves – to pay attention to the reported heat index, and to remember that the heat index is even higher when you are standing in full sunshine.

PROCEDURE:

1. Inform clients and staff when temperature and humidity reach a high level, normally reported on the local news channel and on smartphone-based weather applications (apps).
2. Consider putting a sign by entry/exit doors, reminding clients who go outside of the dangers of being outside too long during expected high heat index periods.
3. Staff will work with clients to assist in keeping air circulating in units.
4. Staff and/or clients should draw all shades, blinds and curtains in rooms when exposed to direct sunlight.
5. If need be, clients will be brought to areas of the community that are less exposed to direct sunlight and have cooler air temperatures.
6. Staff will keep outdoor activities to a minimum during high heat index periods.
7. Staff will do periodic checks to see that clients are appropriately dressed; white cotton garments are the best.
8. Staff will make available and encourage fluids
    a. Water, popsicles, and juice are ideal
    b. Avoid fluids with caffeine when possible, as caffeinated beverages do not help hydrate, and can cause thirst, rather than quench thirst.

Symptoms of Heat Exhaustion

The most common signs and symptoms of heat exhaustion include:

- Confusion
- Dark-colored urine (a sign of dehydration)
- Dizziness
- Fainting
- Fatigue
- Headache
- Muscle or abdominal cramps
- Nausea, vomiting, or diarrhea
- Pale skin
- Profuse sweating
- Rapid heartbeat

Treatment for Heat Exhaustion

If you, or anyone else, has symptoms of heat exhaustion, it is essential to get out of the heat immediately and rest, preferably in an air-conditioned room. If you cannot get inside, try to find the nearest cool and shady place.

Other recommended strategies include:

- Drink plenty of fluid (avoid caffeine and alcohol)
- Remove any tight or unnecessary clothing
- Take a cool shower, bath, or sponge bath
- Apply other cooling measures, such as fans or ice towels
- If such measures fail to provide relief within 15 minutes, seek emergency medical help, because untreated heat exhaustion can progress to heat stroke, which is more serious

Heat Stroke

Heat stroke is the most serious form of heat injury, and is considered a **medical emergency**.

If you suspect that someone has heat stroke -- also known as sunstroke -- call 911 immediately and give first aid until paramedics arrive.

Heat stroke can kill or cause damage to the brain and other internal organs. Although heat stroke mainly affects people over age 50, it can also occur in others, including healthy, young athletes.

Heat stroke often occurs as a progression from milder heat-related illnesses, such as heat cramps, heat syncope (fainting), and heat exhaustion. However, it can strike even if there are no previous signs of heat injury.

Heat stroke results from prolonged exposure to high temperatures -- usually in combination with dehydration -- which leads to failure of the body's temperature control system. The medical definition of heat stroke is a core body temperature greater than 105 degrees Fahrenheit, with complications involving the central nervous system that occur after exposure to high temperatures. Other common symptoms include nausea, seizures, confusion, disorientation, and sometimes loss of consciousness or coma.

Symptoms of Heat Stroke

The trademark symptom of heat stroke is a core body temperature above **104 degrees** Fahrenheit. **Fainting**, however, may be the first sign of heat stroke.

Other symptoms may include:

- Throbbing headache
- Dizziness and light-headedness
- Lack of sweating, despite high heat
- Red, hot, and dry skin
- Muscle weakness or cramps
- Nausea and vomiting
- Rapid heartbeat, which may be either strong or weak
- Rapid, shallow breathing
- Behavioral changes, such as confusion, disorientation, or staggering
- Seizures
- Unconsciousness

First Aid for Heat Stroke

If you suspect that someone has a heat stroke:

1. Immediately call 911 or transport the person to a hospital
2. Any delay seeking medical help can be fatal

3. While waiting for the paramedics to arrive, initiate first aid
    a. Move the person to an air-conditioned environment -- or at least a cool, shady area -- and remove any unnecessary clothing
4. If possible, use a thermometer to take the person's core body temperature and initiate first aid to cool it to 101 to 102 degrees Fahrenheit. (If no thermometers are available, don't hesitate to initiate first aid.)

Try these cooling strategies:

- Fan air over the patient while wetting his or her skin with water from a sponge or garden hose
- Apply ice packs to the patient's armpits, groin, neck, and back. Because these areas are rich with blood vessels close to the skin, cooling them may reduce body temperature
- If emergency response is delayed, call the hospital emergency room for additional instructions

Risk Factors for Heat Stroke

Heat stroke is most likely to affect older people who live in apartments or homes lacking air conditioning or good airflow. Other high-risk groups include people of any age who don't drink enough water, have chronic diseases, or who drink excessive amounts of alcohol.

Heat stroke is strongly related to the heat index, which is a measurement of how hot you feel when the effects of relative humidity and air temperature are combined. A relative humidity of 60% or more hampers sweat evaporation, which hinders your body's ability to cool itself.

The risk of heat-related illness dramatically increases when the heat index climbs to 90 degrees or more. So, it's important -- especially during heat waves -- to pay attention to the reported heat index, and to remember that exposure to full sunshine can increase the reported heat index by 15 degrees.

If you live in an urban area, you may be especially prone to develop heat stroke during a prolonged heat wave, particularly if there are stagnant atmospheric conditions and poor air quality. In what is known as the "heat island effect," asphalt and concrete store heat during the day and only gradually release it at night, resulting in higher nighttime temperatures.

Water Shortage

PROCEDURE:
The facility, to the best of its ability, will have adequate water supply on hand to supply clients with water for necessities.

1. If there is a known shortage of water, notify the Housing Manager and/or Maintenance Supervisor immediately.
2. All attempts will be made to determine the cause for water disruption and the probable length of the shutdown.
3. Food Service staff will distribute emergency meals and provide juice and other beverages that are on hand for clients.
4. The hot water in the hot water tanks will be used by the kitchen staff for cooking purposes, if necessary.
5. Disposable dishes and utensils may be used during emergencies.
6. If necessary, water will be brought in and dispensed as needed. This water supply is only for necessary circumstances and should be used conservatively.
7. If it becomes apparent that a water shortage will last for an undetermined length of time, the Housing Manger and/or Maintenance Supervisor will take appropriate emergency measures to ensure proper care for those whose care has been disrupted by lack of water supply.
8. Arrangements will be made to bring water in or transfer clients to alternate housing, as needed, until the problem has been resolved.

Winter Storm Warning

It is the responsibility of the facility, to the best of its ability, to provide safety precautions to clients and staff during a winter storm which may include blizzard, heavy snow, freezing rain, ice storms or sleet.

PROCEDURE:

1. Facility staff are responsible for identification of possible winter storms.
2. Facility staff will keep posted on all-weather bulletins and relay these to others.
3. Ensure there is a weather radio that will be on at all times, located per facility policy
4. Staff should monitor local TV reports for updates on winter storms
5. Staff and clients may need to be prepared for isolation or evacuation of at the community.
6. Make sure all emergency equipment and supplies are on hand or can be readily obtained.
7. Make sure emergency food supplies and food service equipment are on hand.
8. Make sure emergency supply of water is available.
9. Make sure heating system is operable, if problems observed call supervisor immediately.
10. Use extra blankets/quilts, etc. that the clients have available and keep clients as warm as possible.
11. Keep flashlights handy and extra batteries available, as needed.
12. To keep heat in, close drapes on cloudy days and at night.
13. Do not make any unnecessary trips outside. If you must venture outside, make sure you are properly dressed, and fully covered.
14. Call Housing Manager/Maintenance Supervisor as needed, for updates and support as needed. Management will call resources and or additional staff as needed.
15. Staff will remain on-duty until a replacement arrives.
    a. Arrangements should be made in advance on how to bring in staff, if necessary, to relieve on-duty staff.
    b. Emergency staff relief plan should include:
        i. Knowledge of staff who live near facility
        ii. Home addresses and phone numbers of all staff
        iii. List of any employee who may have access to four-wheel drive vehicles that can be used to pick up staff in an extended winter storm.

Additional Emergency Preparedness Activities

Emergency Item Scavenger Hunt
Have employees complete a facility hunt to locate fire extinguishers, fire panel, and fire doors, weather evacuation areas, emergency kit, weather radio, and emergency outlets to be used in event of a power loss.

Fire Extinguisher Practice:
Use a portable fire pit outside away from any buildings. Have participants put out a small fire, using a fire extinguisher.

YouTube Video: How to use a fire extinguisher:
https://www.youtube.com/watch?v=2Z2C13gJh-g

YouTube Video: Weather, Sheltering in Place, Heat and Humidity
This YouTube Video starts with severe weather, loss of power, followed by excess heat. The facility ends up evacuating the clients. The setting is more like a skilled environment but shows the importance of emergency preparedness in any healthcare setting.
https://www.youtube.com/watch?v=vD7u4n0OdJI

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.08 Vulnerable Adults	XX/XX/XXXX

Each year, hundreds of thousands of older persons are abused, neglected, and exploited. Older adults are often targeted because they are:

- Older
- More frail
- Vulnerable
- Often unable to help themselves
- Dependent on others to meet their most basic needs

Definition:
A Vulnerable Adult (VA) is any person 18 years of age or older who is a:

- Client or inpatient of a facility; OR
- Receives services from a facility; OR
- Recipient of services from a home care provider; OR
- Person has a physical or mental disability, or other physical, mental, or emotional dysfunction, and
    - Because of this impairment, has:
        - An impaired ability to meet basic needs without assistance, including the provision of food, shelter, clothing, health care or supervision; AND
        - An impaired ability to protect self from maltreatment

In general, elder abuse is a term that refers to any knowing, intentional, or negligent act by a caregiver or any other person that:

- Causes harm or a serious risk of harm to a vulnerable adult

WHO ARE ABUSERS OF OLDER ADULTS?

- ✓ Both men and women
- ✓ May be family members, friends, or “trusted others”

Purpose of the Vulnerable Adult Act (VAA):

- Protect adults who are particularly vulnerable to maltreatment because of physical or mental disability or are dependent on institutional services
- Assist in providing safe living environments for vulnerable adult’s
- Assist persons charged with the care of vulnerable adults to provide safe environments

Maltreatment
Adult Protection Services and the VAA define maltreatment as follows:

- **Abuse** – An act against a vulnerable adult that is in violation of, or an attempt to violate, or helping someone else violate the safety of a vulnerable adult in which the act causes or is expected to cause physical pain or injury or emotional distress to the vulnerable adult. Abuse includes physical, emotional or sexual abuse
- **Neglect** – failure or omission by a caregiver to provide a VA with care or services including, but not limited to food, clothing, shelter, medical care and/or supervision

- **Financial Exploitation** – misuse of funds, assets, or property of the VA by a caregiver or other person, or the failure to use the VA's resources to care for VA, which results in or is likely to result in detriment to the VA.

What is Abuse?

- **Physical:** The use of physical force that may result in injury, physical pain, or impairment. For example:
  - Hitting
  - Slapping
  - Kicking
  - Pinching
  - Biting
  - Restraining by physical or chemical (medication) means
- **Emotional:** Inflicting mental pain, anguish, or distress on a vulnerable person through verbal or nonverbal acts. For example:
  - Repeated or malicious oral, written, or gestured language
  - Treatment that would be considered disparaging, derogatory, humiliating, harassing, threatening by a reasonable person
  - Involuntary seclusion, including forced separation of the vulnerable adult from other persons against the will of the VA or the legal representative of the VA
- **Sexual:** Nonconsensual sexual touching of any kind with a vulnerable adult by staff, other residents/clients, or other persons. For example:
  - Unwanted touching
  - Rape
  - Coerced nudity

What is Neglect?

- Failure or omission to provide for basic care or services:
  - Food
  - Shelter
  - Medical care
  - Protection for a VA
- Absence of care or services that are essential to maintain the health and safety of the VA
- Neglect may be by a caregiver or self-neglect by the VA
  - Self-neglect is characterized as the failure of a person to perform essential, self-care tasks that threatens the vulnerable adult's own health or safety
- Neglect can also include abandonment:
  - The desertion of a VA by anyone who is responsible for the care or custody of that person

What is Exploitation?

- The illegal taking, misuse, or concealment of funds, property, or assets of a VA for someone else's benefit:
- **Financial Exploitation**
  - When a person has fiduciary (financial) relationship with the VA, for example:
    - Guardian
    - Conservator
    - Power of Attorney (POA)
    - Someone who has a joint account with the VA

        - Someone who has documented consent to manage funds
    - And this person chooses to take advantage of this relationship with the VA by:
        - Unauthorized spending of funds, or
        - Failure to use funds for the VA, and
        - The spending or failure to spend results or is likely to result in a detriment to the VA
    - Financial exploitation can also happen when the person has no fiduciary (financial) relationship and:
        - Willfully uses or withholds funds or property of the vulnerable adult
        - Obtains money for themselves to the detriment of the VA
        - Acquires possessions or controls interest in the VA's property
        - Acquires funds through harassment or undue influence, including deception and/or fraud
- **Other Exploitation**
    - Medication diversion
    - Involuntary servitude:
        - Forcing, coercing, or enticing the VA to perform services for another's advantage

Mandated Reporters
Workers in the following occupations/fields are mandated reporters and are required by law to report any actual or suspected maltreatment or abuse of a Vulnerable Adult:

- Social Service workers
- Law Enforcement
- Educators
- Licensed health & human service professionals
- Personal Care Attendants
- Employees of licensed facilities (AFC, group homes, day programs, etc.)
- Employees of health care facilities or programs (Nursing Homes, Home Health Agencies)
- Medical examiner or coroner

Reporting

- Any person making a report in good faith, is immune from civil and criminal liability
- Anyone may report, and the report is protected by law.
- **EXCEPTION:** If the court finds that a report was false and reported in bad faith, the subject of the report may compel disclosure of the reporter and allegations

Mandated reporters are required to report any actual or suspected maltreatment, abuse, or neglect immediately (defined as no longer than 24 hours from the time the incident occurred).

What are the Warning Signs of ABUSE?
While one sign does not necessarily indicate abuse, some tell-tale signs that there could be a problem include:

- ✓ The person may say that he or she is being harmed or is afraid of someone
- ✓ Injuries that are unexplained or are not consistent with the explanation given such as:
    - Bruises and skin tears
    - Black eyes
    - Broken bones
    - Burns or cuts

- Internal injuries

- ✓ Infections
- ✓ Changes in mental functioning or behavior (Such as increased agitation, combativeness, depression, or confusion)
- ✓ Injuries that are unexplained or are not consistent with the explanation given

Some examples of elder abuse:

- Bruises, pressure marks, broken bones, abrasions, and burns may be an indication of physical abuse, neglect, or mistreatment
- Unexplained withdrawal from normal activities, as sudden change in alertness, and unusual depression may be indicators of emotional abuse
- Bruises around the breasts or genital area can occur from sexual abuse
- Sudden changes in financial situations may be the result of exploitation
- Bedsores, unattended medical needs, poor hygiene, and unusual weight loss are indicators of possible neglect
- Behavior such as belittling, threats, and other uses of power and control by spouses or friends are indicators of verbal or emotional abuse
- Strained or tense relationships and/or frequent arguments between the caregiver and the VA are also signs

What are the Warning Signs of NEGLECT?

While one sign does not necessarily indicate neglect, some tell-tale signs that there could be a problem include:

- ✓ Dehydration, weight loss, and/or malnutrition
- ✓ Pressure sores, poor hygiene
- ✓ Depression, confusion, or other changes in mental functioning
- ✓ Absence of needed medical equipment or prostheses
- ✓ Repeated falls
- ✓ Increased or new incontinence
- ✓ Isolation

What are the Warning Signs of EXPLOITATION?

While one sign does not necessarily indicate exploitation, some tell-tale signs that there could be a problem include:

- ✓ The VA may say something like, “I don’t know anything about it, and my son/daughter/friend handles all my business.”
- ✓ Bills go unpaid
- ✓ The VA does not have access to their own money
- ✓ The VA is asked to sign documents but does not know what they are
- ✓ Changes are made in the VA’s will
- ✓ Assets are transferred or sold without the VA’s knowledge
- ✓ The VA is taken to the bank to make account withdrawals
- ✓ Personal property, like cash, checks, credit cards, jewelry, furniture, etc. is missing

Unfortunately, vulnerable adults who are being abused, neglected, or exploited often suffer in silence because of:

- Embarrassment

- Pride
- Scared of retaliation by the abuser
- Feelings of hopelessness
- Inability to report due to cognitive decline

Criminal Charges

- **PAY ATTENTION - A MANDATED REPORTER WHO FAILS TO REPORT IS GUILTY OF A MISDEMEANOR!**

- Criminal charges may be brought against a mandated reporter who:
  - Knows or has reason to believe that a VA is being or has been maltreated and intentionally fails to make a report, or
  - Knowingly provides false, deceptive, or misleading information, or
  - Withholds information surrounding an incident
- Penalty – up to 90 days in jail and/or a $700 fine
- More serious criminal charges and penalties may be brought against a mandated reporter who:
  - Knows or suspects that a VA has been maltreated, causing or contributing to the death or great bodily harm of the VA, and
  - Intentionally failed to report to protect his/her own interest
- Penalty – up to one year in jail and/or a $3000 fine

What to Report (as applicable):

- Time and date of report
- Name, address and phone number of reporter
- Time, date, and location of incident
- Names of the persons involved, i.e. perpetrators, alleged victims, and witnesses
- Possible risk of imminent danger to alleged victim
- Description of suspected maltreatment
- The disability, if any, of the alleged victim
- Relationship of alleged perpetrator to the alleged victim
- The name of the licensing board who oversees / licenses the facility (e.g. Minnesota Department of Health)

- **PAY ATTENTION – All facility and agency protocols MUST be followed!**

Reports are not required when the incident is:

- Client to client verbal or physical aggression, or self-abusive behavior by those clients, unless the behavior causes serious harm (e.g. requires a visit to a medical provider) **NOTE: Facility should record these incidents on an incident report to facilitate review by licensing agencies and county and local welfare agencies
- A single mistake/medication error/therapeutic conduct that:
  - Does not result in injury or harm which reasonably requires medical or mental health care, or
  - Does result in injury or harm, which reasonably requires the care of a physician but:
    - The necessary care is provided in a timely fashion as dictated by the condition of the VA

        - If, after receiving care, the health status of the VA can be reasonably expected, as determined by the attending physician, to be restored to the preexisting condition
    - The error is not part of a pattern of errors by the individual

- An accident:
    - Which is not likely to recur, and could not have been prevented by exercise of due care
    - Which occurs when the facility and the person providing services in the facility follow the laws and rules relevant to the occurrence

Examples regarding falls that do not need a report to Minnesota Adult Abuse Reporting Center (MAARC)

- Client who is independent with a walker falls while walking in hall. The client was using walker appropriately at the time of the fall.
- Client puts on call light for assistance, but no one answers the light; the client gets out of bed independently and falls, but does not suffer an injury
- Falls which are not witnessed. Just because the fall is not witnessed does not make this a reportable event. There must be serious injury or suspected or known neglect or abuse associated with the fall to require reporting.

➢ **PAY ATTENTION – Even if a report is not required to be reported to MAARC at 844-880-1574, an incident report and follow-up investigation should be completed, per facility protocols.**

Rights of the client:

- Clients can live a lifestyle that others find repulsive, even harmful, without interference from others if it does not interfere with the safety of others
- Clients can refuse services which workers believe will improve their quality of life. Our job is to discuss the risks versus benefits of their decision and document this discussion.

Retaliation

Any retaliation or "adverse action" because of a MAARC report is punishable by law, with a fine of up to $10,000.

"Adverse action"

- Transfer or discharge from facility
- Termination of employment
- Reduction in provision of services
- Restriction or prohibition of access to the facility or its clients

Where to Report

Reports are made to the Minnesota Adult Abuse Reporting Center (MAARC), which is available to take a message 24/7. The reporting number for MAARC is 844-880-1574.

Department of Health

- Investigates reports involving hospitals, home care providers, nursing homes, boarding care homes, hospice providers and intermediate care facilities that serve people with developmental disabilities.

Department of Human Services

- Investigates reports involving adult day care, adult foster care, community residential settings, programs for persons with disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, and the MN sex offender program

County Social Services

- Responsible for all other reports

Law Enforcement

Although not a lead agency, law enforcement is the primary agency to conduct investigations of any incident in which there is reason to believe a crime has been committed.

Investigation

1. Final disposition will be completed within 60 calendar days of receipt of report.
2. Final report from the lead agency will be issued in the form of a public investigation memorandum.

Report is available to:

- VA or their legal guardian or health care agent
- Reporter, if they requested notification when making the report
- Alleged perpetrator
- Facility
- Ombudsman for Long-Term Care or the Ombudsman for Mental Health & Developmental Disabilities.

Request for Reconsideration

The following persons/parties may request reconsideration of the final disposition:

- Individual or facility which a lead agency has determined has maltreated a VA
- The VA or an interested person acting on behalf of the VA.

Determinations/Data Destruction

- False reports – Three years
- Inconclusive reports – Four years
- Substantiated reports – Seven years
- Not investigated or no final disposition—Three years

Caregiver Burnout

A career as a Healthcare Worker (HCW) can be incredibly rewarding – that moment when one of your clients squeezes your hand and thanks you so sincerely for taking care of a need they were unable to manage independently warms our hearts and puts a smile on our faces.

On the other hand, there are times when the responsibilities of being a HCW and the associated demands can contribute to care giver burnout.

Signs of Burnout

- Increased stress
- Increased anxiety
- Irritability
- Changes in sleep patterns
- Compromised immune system – tendency to get sick more often
- Emotional and physical exhaustion
- Tendency to overreact to minor nuisances
- Difficulty concentrating
- Feelings of resentment toward the clients in your care

A survey conducted by Harris Interactive in 2013 regarding HCWs and burnout rates showed that 60% of HCWs felt burned out at their jobs. HCWs have unique stressors, including:

- Clients may be unable to do even simple tasks at times
- Clients may have confusion and/or memory problems; this may present as:
    - Repetition of the same request or question
    - Inability to follow simple instructions
    - Performing tasks very slowly
    - Anxiety and hyper-focus on a topic
- Clients may act out with defiance and/or behaviors, aimed at the HCW or at other clients
- The nature of a HCW's duties is often one-sided – the HCW is required to give physical and emotional support to clients, without necessarily receiving any support back
    - Some clients may have a difficult time showing gratitude or satisfaction with the tasks and services you perform for them
    - To control *some part* of their life, clients can be very demanding and particular – it may seem like you can never do enough or do a job to meet their standards
- Healthcare has stressful health risks, including:
    - Potential for spread of disease
        - Needle sticks
        - Infections
    - Potential for injury
        - Lifting
        - Injury from a client – kicking, biting, hitting, etc.
    - Staffing shortages may require pulling extra shifts
    - Many HCWs have more than one job

    - Caring for the elderly leads to end of life, and loss of a client can be difficult
- Healthcare regulation continues to increase
    - The new Comprehensive Home Care and Housing With Services statutes are a good example
    - Increased regulation may mean more work, documentation, etc. by HCWs

- The aging population of today expect a higher level of service
- Staff are expected to "do more" with the same resources

These stressors, along with the stress of everyday life, can contribute to employee burnout, which can lead to unintentional abuse or neglect of a client... Be on the lookout for signs and symptoms of caregiver burnout in yourself, your co-workers, and those you supervise.

Some suggestions when burnout is recognized in yourself or a co-worker:

- Take a break – remove yourself from the situation
- Ask a co-worker to switch assignments with you if you are having difficulty dealing with a client
- Talk to your supervisor about your stressors – s/he may be able to help you with:
    - Time off
    - Alternate ideas on how to approach clients
    - Alternate work assignments
- Try to leave home life stressors at the door while you are working
- Ensure you are eating healthy and exercising regularly
- Get enough rest and sleep
- Set aside time in your personal life to take care of yourself and enjoy the things that make you happy

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.09 Home Care Bill of Rights for Assisted Living	XX/XX/XXXX

Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers

PER MINNESOTA STATUE, SECTIONS 144A.44 AND 144A.441 THESE RIGHTS PERTAIN TO CONSUMERS RECEIVING HOME CARE SERVICES FROM LICENSED HOME CARE PROVIDERS WHO PROVIDE CARE FOR ASSISTED LIVING CLIENTS AS DEFINED BY 144G.

Statement of Rights

A person who receives home care services has these rights:

1. The right to receive written information about rights before receiving services, including what to do if rights are violated.

    - ❖ All clients are to receive a copy of this Home Care Bill of Rights (HCBOR) upon admission and annually. A signed, current copy is maintained in the client record, and is also available upon request.

2. The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services.

    - ❖ The client's service plan is reviewed with each client upon start of services and again whenever updates are made.

3. The right to be told before receiving services the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and the potential consequences of refusing these services.

    - ❖ The Registered Nurse (RN) will provide written instructions on what cares are to be provided and who will be responsible for delivering care to each client. As providers, our responsibility is to educate the client on the reasons for the cares, when asked, and the potential outcomes if cares are refused.

4. The right to be told in advance of any recommended changes by the provider in the service plan and to take an active part in any decisions about changes to the service plan.

    - ❖ Staff must notify the client or the client's representative of any changes in the service plan and/or plan of care.

5. The right to refuse services or treatment.

    - ❖ Each client has the right to refuse treatment. It is our responsibility as providers of services to educate them on the reasons the cares are being provided, as well as the potential negative outcomes if cares are refused. The RN should be notified of refusals, as well as the physician when appropriate.

6. The right to know, before receiving services or during the initial visit, any limits to the services available from a home care provider.

    - ❖ The client must be informed of which services are available from the provider. The provider cannot offer services that are not covered under the Basic or Comprehensive Home Care license.

7. The right to be told before services are initiated what the provider charges for the services; to what extent payment may be expected from health insurance, public programs, or other sources, if known; and what charges the client may be responsible for paying.

    - ❖ The service plan must contain a list of all services to be provided and the costs of those services. The client should be aware of any services that may not be covered by insurance, and therefore the client's responsibility to pay.

8. The right to know that there may be other services available in the community, including other home care services and providers, and to know where to find information about these services.

    - ❖ The provider must make information about other local home care providers available to all clients, upon admission, and per request.

9. The right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs.

    - ❖ Clients have the right to change providers at any time, without retaliation or negative consequences.

10. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.

    - ❖ HIPAA laws require that we keep all client information and records confidential. Health care providers and individuals that knowingly share clients' personal and private information are subject to significant fines.

11. The right to access the client's own records and written information from those records in accordance with sections 144.291 to 144.298.

    - ❖ Clients and/or designated responsible parties have the right to access the client

records and the information within.

12. The right to be served by people who are properly trained and competent to perform their duties.

- Home care providers are required to ensure:
  - All licensed personnel have current licenses without sanctions
  - All unlicensed personnel (ULP) have completed competency training on non-delegated tasks
  - All ULP have completed competency training AND return demonstration to an RN for all delegated tasks
  - All delegated tasks have client-specific written instructions available for the ULP to reference
  - If the ULP has not performed a delegated task within the past 24 months, new training and documentation of that training has been completed

13. The right to be treated with courtesy and respect, and to have the client's property treated with respect.

- Clients are to be treated with courtesy and respect at all times by staff. If a difficult situation arises, due to a client's diagnoses and/or behaviors (e.g. dementia), it is your responsibility to manage the situation by:
  - Removing yourself temporarily from the situation (e.g. take a break, switch assignments with a coworker, etc.)
  - Speak with your supervisor; a reassessment of the client's needs may be necessary, and you both can work to develop solutions for the situation
- Documentation should be completed in a professional and objective manner.
- Staff should NEVER borrow or use any client property.

14. The right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act.

- Clients generally fall under the Vulnerable Adult definition in the Vulnerable Adult Act. This is covered in-depth in module 5.0.
- Any employee or other individual who is found guilty of maltreatment, abuse, or exploitation of a vulnerable adult may face:
  - Criminal charges
  - Jail time
  - Significant monetary fines
  - Loss of professional license or certification
  - Being banned from ever working in a health care setting again

15. The right to reasonable, advance notice of changes in services or charges.

- Whenever a change in service or charges occurs, the client must be notified in writing. A signed copy of the new service plan must be given to the client and also filed in the client record.

16. The right to know the provider's reason for termination of services.

- ❖ If services are discontinued or terminated for any reason, the provider must provide the client with a termination notification, including the reasons for the termination. A copy of the termination, as well as client signature to acknowledgement of receipt, should be filed in the client record.

17. Clients must receive at least 10 days' advance notice when services are terminated, except in cases where:

(i) The client engages in conduct that significantly alters the terms of the contract with the Home Care Provider (HCP)

-e.g. Client seeks out and brings illegal drugs into facility, causing either extreme aggressiveness or extreme lethargy—this behavior also causes refusals of medications for a diagnosis of mental illness. You may not be able to meet the client's needs, based on his/her poor decisions and non-compliance.

(ii) The client, person who lives with the client, or others create an abusive or unsafe environment for the person providing home care services

(iii) An emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the HCP

The following provision must take the place of #17 if the Bill of Rights is being given to Assisted Living Clients:

17. The right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the hme care provider and the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider's agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided

18. The right to a coordinated transfer when there will be a change in the provider of services.

- ❖ The HCP is responsible to coordinate transfer of care when services have been terminated due to inability to care for client appropriately.

19. The right to complain about services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property.

- Each facility is required to have a complaint process in place and each client must be made aware of this process.
- Every attempt should be made to meet the client's needs, if possible, before initiating a formal complaint.

20. The right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint.

- The client should be aware of and understand the formal complaint process, including contact information of the person in charge of investigating and all attempts to resolve the complaint. Contact information for facility contact, as well as other local advocacy groups is listed on this HCBOR.

21. The right to know the name and address of the state or county agency to contact for additional information or assistance.

- Each client is give contact information for the Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities upon admission and annually.
- Other consumer advocacy services include the Managed Ombudsman at the Department of Human Services, county managed care advocates, and other relevant advocacy services.
- The Ombudsman is a client advocate and is available to assist in the complaint process if the client feels it is not resolved at the facility level. The Ombudsman does not side with the family, the facility, or even the client in some cases. Their primary responsibility is to act in the best interest of the client, which may not always be what the client is asking for!
- Each client is also given the contact information for the State Office of Health Care and Facility Complaints upon admission and annually.
- Every effort should be made at the facility level to resolve any issues.
- Our responsibility as a HCP is to make the advocacy contact information available to all clients and is located on this HCBOR.

22. The right to assert these rights personally or have them asserted by the client's representative or by anyone on behalf of the client, without retaliation.

- Client rights are to be respected and enforced by all staff.
- Clients have the right to make sure that their rights are not violated.
- If the client names a representative, that person is also able to monitor that the client's rights are not being violated.
- Finally, members of the advocacy groups described above are also able to intervene if the client rights are being violated.

23. IF YOU HAVE A COMPLAINT ABOUT THE PROVIDER OR PERSON PROVIDING YOUR HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OFFICE OF OMBUDSMAN FOR LONG-TERM CARE OR THE OFFICE OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES.

Office of Health Facility Complaints
Phone: (651) 201-4201 or 1-800- 369-7994
Fax: (651) 281-9796
Website: http://www.health.state.mn.us/divs/fpc/ohfcinfo/contohfc.htm
Email: health.ohfc-complaints@state.mn.us
Mailing Address:
Minnesota Department of Health
Office of Health Facility Complaints
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, Minnesota 55164-0970

Ombudsman for Long-Term Care
Phone: (651) 431-2555 or 1-800-657-3591
Fax: (651) 431-7452
Website: http://tinyurl.com/Ombudsman-LTC
Email: mba.ooltc@state.mn.us

Mailing Address:
Home Care Ombudsman for
Long Term Care PO Box 64971
St. Paul, MN 55164-0971

Ombudsman for Mental Health and Developmental Disabilities
Phone: 651-757-1800 or 1-800-657-3506
Fax: 651-797-1950 or 651-296-1021
Website: http://mn.gov/omhdd/
Email: ombudsman.mhdd@state.mn.us
Mailing Address:
121 7th Place East
Suite 420 Metro Square
Building St. Paul, Minnesota
55101-2117

Licensee Name: _____
Phone:_____**Email:**_____
Address: _____

Name/Title of Person to Whom Problems or Complaints May be directed:

_____

For informational purposes only and is not required in the Home Care Bill of Rights text:
MN Statute, section 144A.44 Subd. 2**. Interpretation and enforcement of rights.**
These rights are established for the benefit of clients who receive home care services. **All home care providers, including those exempted under section 144A.471, must comply with this section.** The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a client to surrender any of these rights as a condition of receiving services. This statement of rights does not replace or diminish other rights and liberties that may exist relative to clients receiving home care services, persons providing home care services, or providers licensed under sections 144A.43 to 144A.482.

MN Statute, section 144A.442 **Assisted Living Clients; Service Termination.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 144A.4791, subdivision 10;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (18);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.10 Complaints	XX/XX/XXXX

Per the Home Care Bill of Rights, clients have the right to lodge a complaint against the facility, staff, or processes for services that are provided, or fail to be provided, and the lack of courtesy or respect to the client or the client's property.

Home Care Provider Responsibilities

1. The home care provider must have a written policy and system for receiving, investigating, reporting and attempting to resolve complaints from clients or clients' representatives
2. The home care provider must document the complaint, name of the client, I investigation, and resolution of each complaint filed.
    a. These records must be kept for at least 2 years after the date of entry
3. The complaint system/policy must provide for written notice to each client or clients' representative that includes:
    a. The client's right to complain to the home care provider about the services received
    b. the name and/or title of the person or persons with the home care provider to contact with the complaints
    c. The method for submitting a complaint to the home care provider
    d. A statement that the provider is prohibited against retaliation
4. A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or concern expressed by the client or clients' representative

Complaints can take two forms:

1. **Concern:** A concern that does not rise to the level of a formal complaint and can be easily resolved to the client's satisfaction. Examples include:
    a. The soup at lunch was cold
    b. My pain pill is being delivered late
    c. There is too much noise in the hallways at night
2. **Formal complaint:** A formal complaint is more serious than a concern and must be documented on a Complaint Form, per facility and home care agency protocols. Examples of formal complaints include:
    a. There is a man coming into my bedroom at night and scaring me
    b. I am missing three pairs of pants and all my socks
    c. Someone came into my apartment and broke one of my figurines and did not let me know.

3. Both forms of complaints, whether it I a concern or a formal complaint, should be documented and followed up on per facility policy.

- **PAY ATTENTION – The decision about Concern versus Complaint is up to the client, not the staff. If a client or client's representative chooses to file a formal complaint by submitting a Complaint Form, the facility and home care provider will follow the appropriate protocols (see below).**

PROTOCOL:
Formal complaints are those that cannot be easily resolved or concerns which have not been resolved to a tenant's satisfaction. Formal complaints should be dealt with in the following way:

1. Complaint Forms must be easily accessible to clients, client representatives, and staff. Clients will be made aware of their right to file a complaint or concern and told where Complaint Forms can be found throughout the facility.
2. The client, client representative, or employee should complete a Complaint Form and direct his or her complaint or problem to a supervisor who will take responsibility for seeking resolution, involving others who can help as needed.
3. When possible and reasonable, the complaint should be resolved immediately. Safety of tenants and their belongings is always paramount.
4. An investigation surrounding the facts of the complaint will be initiated.
5. During the investigation process, employees and/or clients may be asked to participate in determining the solution and bring about resolution of the complaint.
6. After the investigation is completed, a prompt response to the client's or employee's complaint or concern will be given to the client or employee verbally and, if desired, in writing. Clients and/or employees will be given a reasonable explanation for the action taken on their behalf.
7. The resolution will be documented in the client record.
8. In the case of neglect, abuse (verbal, psychological, or physical) or exploitation, staff or management will call contact the Common Entry Point (CEP), or MAARC in a timely manner.
9. If the resolution of a complaint results in a system or procedure change, the change shall be made and communicated appropriately to employees and/or clients, keeping confidentiality in mind.
10. Complaints must be kept for two years before destruction.

CONSUMER ADVOCACY SERVICES

Office of Health Facility Complaints (OHFC):

- This is the state agency that is responsible for investigating any formal complaint that has been submitted to the Minnesota Department of Health.
- OHFC works closely with the Minnesota Department of Health (MDH), Division of Compliance, Home Care & Assisted Living Program (HCALP) to investigate and determine whether the complaint is substantiated or unsubstantiated, write deficiencies when necessary, and assign monetary penalties in some cases.

Minnesota Adult Abuse Reporting Center (MAARC):

- This agency is where all reports of maltreatment (defined as abuse, neglect, or financial exploitation) are submitted for home care/assisted living facilities.
- Reports can be submitted 24/7 by calling 844-880-1574 or by going to mn.gov/dhs/reportadultabuse/
- MAARC coordinates with OHFC and HCALP when necessary.

Office of the Ombudsman for Long-term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, and Managed Care Ombudsman at the Department of Human Services:

- Ombudsman are client advocates – they act in the best interest of the client, not the family, facility, or home care provider.
- Ombudsman make routine visits to facilities, interviewing clients for satisfaction, and observing.
- Ombudsman may come to staff directly with concerns or complaints on behalf of a client; it is ideal to develop a good working relationship with your Ombudsman, as often concerns can be reported and resolved before they become a formal complaint out of frustration from the client.
- Facilities and home care providers are required to publish and distribute contact information for the Ombudsman; clients are free to contact them at any time.

Department of Human Services:

- Investigates reports involving adult day care, adult foster care, community residential settings, programs for persons with disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs and the MN sex offender program.

County Social Services:

- Responsible for placement and approval of services for residents on Medical Assistance
- Can investigate communities

Statement of Home Care Services:

- This document specifies exactly which services are available from the home care provider so there are no questions as to what s available.
- Home Care Providers are required to publish and distribute periodically and as requested, a list of available services.
- Many clients and their families are looking for a living arrangement with “a little room to grow.” In other words, they want and need to know which services they may be able to use in the future, without having to move to a new facility.
- The Statement of Home Care Services is to be completed by the facility and/or home care provider annually. This document specifies exactly which services are available so there are not questions in the client’s mind.
- Clients will receive this Statement of Home Care Services upon admission, annually, and as requested.
- The Statement of Home Care Services is available to the public upon request.
- See example of a blank Statement of Home Care Services on the next page. [Replace the Statement of Home Care Services with the form your company uses if different than the sample given.]

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.11 Dementia Training – Module 1	XX/XX/XXXX

Module 1:
An explanation of Alzheimer's Disease and related disorders – 2.75 hours

FOR ALL STAFF:
This training is important, since interacting with client's living with Alzheimer's and other dementia disorders is one of the more challenging aspects of this work. Understanding what Alzheimer's and dementia are and what the client is experiencing is an important part of training. By the end of this module, you will understand a current explanation of Alzheimer's and other related disorders.

Note: In these four Dementia Training Modules, dementia and Alzheimer's Disease are used interchangeably. The training presented applies to your work with all persons with dementia, not just Alzheimer's.

****Note: Behaviors used in these training modules refer simply to actions and are not intended to be a negative reflection of a client's actions.***

What is Alzheimer's disease?
Alzheimer's disease was first noted in 1906 when Dr. Alois Alzheimer treated a woman who died of an unusual mental illness. Memory loss, language problems, and unpredictable behavior were some of the symptoms the woman had prior to her death. When Dr. Alzheimer examined her brain after death, he found that nerve cells, in the brain, had died and/or had stopped working, as evidenced by abnormal clumps and tangled bundles of fiber. This was unlike the brains of other deceased patients.

Alzheimer's and most other types of dementia are permanent and are not curable. Although, some types of dementia may be related to another illness, such as an infection, and the client will return to a cognitive baseline when the illness has been treated. Alzheimer's disease kills off brain cells gradually and robs an individual of memory, thinking skills, language, and the ability to care for themselves. An important characteristic when physicians are considering a diagnosis of dementia is that the decline in memory and thinking skills is severe enough to significantly interfere with life, particularly activities of daily living.

In most people with Alzheimer's, symptoms first appear in their mid-60s. According to 2018 Alzheimer's Association data, one in 10 people aged 65 and older has Alzheimer's disease and it is the most common cause of dementia among older adults. As of 2018, 5.7 million Americans have Alzheimer's. By the year 2050, that number is expected to be 14 million Americans. Almost two-thirds of American's with Alzheimer's disease are women. Older African-Americans are about twice as likely to have Alzheimer's or other dementias as older whites.

Hispanics are about one and one-half times as likely to have Alzheimer's or other dementias as older whites. Today, every 65 seconds, someone in the United States develops Alzheimer's.

Alzheimer's disease is currently ranked as the sixth leading cause of death in the United States and 1 in 3 seniors dies with Alzheimer's or another dementia.

Not every person with Alzheimer's disease has the same symptoms, but a common complaint is the inability to retain, or hold onto, new information. The inability to retain new information is caused by broken connections in the brain; short-term memory and the formation of new memories are typically the first area of the brain to be affected.

Ten Warning Signs of Alzheimer's disease:

1. Memory loss that affects daily life
2. Problem solving and/or planning challenges
3. Difficulty completing simple, familiar tasks – at home, work, or while pursuing hobbies or other enjoyable activities
4. Time and place confusion
5. Trouble understanding visual images and/or spatial relationships
6. New problems finding words while speaking or writing
7. Misplacing items and not being able to retrace steps to locate missing items
8. Decreased or poor judgment
9. Withdrawal from work or social activities
10. Changes in mood and personality

FOR DIRECT CAREGIVERS:

The abnormal clumps that Dr. Alzheimer found were later called amyloid plaques, and the tangled bundles of fibers became neurofibrillary, or tau, tangles. Amyloid plaques are caused from abnormal deposits of proteins.

In addition to plaques and tangles in the brain, scientists have also found that a loss of connection between the nerve cells in the brain (neurons) contribute to Alzheimer's Disease. Neurons transmit messages between different parts of the brain, and from the brain to muscles and organs in the body.

FOR DIRECT CAREGIVERS:
Changes in the Brain

The brain is complex, and scientists continue to research the changes that signal the onset and progression of Alzheimer's disease. They now believe the broken nerve cell connections, amyloid plaques, and tau tangles may begin at least ten years before a person starts to notice significant memory and thinking problems. During what seems like a symptom-free period, damage begins in the hippocampus, which is the part of the brain most important to making and holding memories. Throughout the symptom-free years, the brain continues to become damaged as more and more neurons cease to function, and the amyloid plaques and tau tangles increase.

FOR ALL STAFF:
Dementia – A population on the rise

Alzheimer's is the most common cause of dementia among older adults. Dementia is when thinking, reasoning, and memory (cognitive abilities) decline to the point that it interferes with daily life and activities of daily living. Scientists and doctors use a 3-level scale to describe the stages of dementia – remember that dementia is a progressive disease. The stages describe

dementia from the early, mild stage to the final, most severe stage where the person with dementia is completely dependent on others for daily tasks and nutrition. You will learn more about these stages later in this module.
Age is the primary risk factor for developing dementia, and although we tend to think of dementia as only happening in older individuals, it can strike younger adults, as well, even someone in their thirties.

With doctors being able to pinpoint and diagnose individuals sooner and more accurately, and because we have a large portion of the population (the baby boomers) growing older, the number of people with diagnosed Alzheimer's disease and other dementias is on the rise.

In a society where there are fewer stay-at-home adults, the demand for assistance with a parent or spouse with Alzheimer's disease or other type of dementia is also on the rise. Regardless of the form of dementia, the increased need for assistance for that parent or spouse can be personally exhausting and financially devastating.

What is Dementia?
Since dementia is the loss of thinking, remembering, and reasoning, in addition to behavioral abilities, it eventually interferes with a person's daily life and activities. Remember that dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage, when the person must depend completely on others for basic activities of daily living. There are specific needs in each of these stages, which we will discuss in detail throughout these training modules.

Causes of Dementia
As mentioned above, age is a risk factor for dementia. It's important to understand that while dementia is often thought of as an expected age-related circumstance, however, it is not a normal part of the aging process.

Normal aging can cause:

- A general slowdown in cognitive thinking – the thinking and reasoning
- A decrease in mental flexibility (the ability to shift a course of thought or action according to the changing demands of a situation)
- Mild word finding challenges
- A mild decrease in the ability to hold information short-term to process it and come up with an answer (also called working memory)

Individuals aging normally can typically still care for themselves including, activities of daily living, such as dressing and eating.

Experts are still not sure what exactly triggers dementia or Alzheimer's disease in some cases. However, there are other illnesses and disorders that are known to cause dementia symptoms:

- Lewy Body Disease-can affect thinking, movement, mood and behavior
- Frontotemporal injuries – can affect decision-making, behaviors, emotions, and speech
- Vascular injuries– a sudden loss of thinking and reasoning that occurs after a stroke
- Medication side effects
- Alcoholism
- Infections
- Tumors in the brain
- Blood clots in the brain

- Lack of vitamin B12
- Thyroid, liver, or kidney disorders
- Parkinson's Disease
- Sleep disturbances

It is common for people to have mixed dementia – a combination of two or more disorders, at least one of which is dementia. For example, some people have both Alzheimer's disease and vascular dementia. For the sake of these training modules, we will use Alzheimer's disease and dementia interchangeably, as the approaches you'll take will be the much the same.

Some of these conditions listed above may be treatable and possible reversible, such as in a person who has decreased cognitive abilities during a urinary tract infection; once the infection is cleared up, the client may return to his or her baseline cognitive status. You will learn how to watch for signs and symptoms of infections and more in module 2.

An increase in stress, anxiety, or depression can make a person more forgetful and can be mistaken for dementia. For instance, you may notice that someone who just lost their spouse may seem more forgetful and confused. It's important to identify possible factors like this when considering a person with dementia, as symptoms may become temporarily worse due to a life-changing event. With support from his or her caregivers, family, and friends, the client's confusion and forgetfulness may resolve. If the symptoms do not resolve, discuss this with the nurse, as the client may need to see his or her doctor.

FOR DIRECT CAREGIVERS:
What Causes Alzheimer's

Scientists have identified that genetics may play a role in who is affected by Alzheimer's disease. However, research also suggests that lifestyle and environmental factors are factors in the Alzheimer's puzzle. For example, scientists and researchers are looking at whether individuals who have had strokes or heart attacks are at higher risk for developing Alzheimer's disease.

One current area of study is if a person's unique DNA can put them at higher risk for Alzheimer's. The importance of any one of these factors in increasing or decreasing the risk of developing Alzheimer's may differ from person to person.

Scientists are continuously making strides as technology and knowledge advance. Brain imaging now allows researchers to see the development and spread of abnormal proteins in the living brain, as well as changes in brain structure and function.

Another area of exploration is trying to identify changes in the brain and body fluids in younger adults that will predict Alzheimer's before symptoms appear.

Some of the age-related changes currently being studied include atrophy (shrinking) of certain parts of the brain, inflammation, production of unstable molecules called free radicals, and a breakdown of energy production within cells.

Stories from the Floor: What you may experience
Sally lives in a secured unit in an Assisted Living community. You notice that when you are clearing the dishes after a meal, Sally has barely eaten anything off her plate. However, whenever you see her in the hall, she asks you if it will be time for breakfast soon. You explain

that she has already eaten breakfast. She nods and says okay and walks on – only to ask you again when you pass her in the hall a few minutes later.

Several times you have seen her standing in front of her open closet, staring. When you ask her what she is looking for, she names a food item, such as sandwich or rice. Sally is a very thin lady and walks up and down the halls non-stop. You wonder why she eats so little yet is constantly walking and asking about meal times and food.

A client with Alzheimer's may look for items in the wrong places. For instance, they may go looking for food in the closet, because opening the closet door is like opening a refrigerator door. When they find clothing instead of food items in the closet, they become increasingly confused.

Some clients with Alzheimer's pace or wander constantly; they may tell you they are looking for something but may be unable to verbalize what they are looking for. This restlessness may contribute to low intake at meals if the client cannot sit at the table long enough to eat an adequate amount of the meal.

Signs and Symptoms

Alzheimer's Disease	Normal aging
Making poor judgments and decisions a lot of the time	Making a bad decision occasionally
Problems taking care of monthly bills	Missing a monthly payment
Losing track of the date or time of year	Forgetting which day, it is and remembering it later
Trouble having a conversation	Sometimes forgetting which word to use
Misplacing things often and being unable to find them	Losing things from time to time

Differences between Alzheimer's Disease and normal aging

https://www.nia.nih.gov/alzheimers/publication/understanding-alzheimers-Disease/what-are-signs-alzheimers-Disease

Memory problems are usually the first sign or symptom adults notice, although it is often, incorrectly, attributed to normal aging. When memory problems are present and more significant than in a normal person of the same age, the client may be diagnosed with Mild Cognitive Impairment (MCI); at this stage, the memory problems do not interfere with normal life activities. Movement difficulties and problems with the sense of smell have also been linked to Mild Cognitive Impairment. Older people with Mild Cognitive Impairment are at greater risk for developing Alzheimer's, but not all of them do.

The first symptoms of Alzheimer's vary from person to person. For many, decline in non-memory aspects of cognition, such as word-finding, vision/spatial issues, and impaired reasoning or judgment, may signal the very early stages of Alzheimer's disease.

Not all changes in ability signal dementia or Alzheimer's Disease. However, as you get to know client, you may be among the first to notice changes in their behavior and mood. Knowing the signs and symptoms of MCI, dementia, and Alzheimer's put you in a position to alert care givers or nursing staff.

Early-Stage Alzheimer's disease
As Alzheimer's disease progresses, people experience greater memory loss and other cognitive difficulties. Problems can include:

- Wandering and getting lost
- Trouble handling money and paying bills
- Repeating questions
- Taking longer to complete normal daily tasks
- Losing things or misplacing them in odd places
- Personality and behavior changes, which may include increased anxiety and/or aggression
- Poor judgement leading to bad decisions
- Loss of spontaneity and initiative to act
- Taking longer than before to accomplish normal daily tasks
- Starting a task, such as a bath or shower, and forgetting the steps to complete the task

People are often diagnosed in this stage, and although they may appear to be perfectly healthy, or at normal baseline, scientists and researchers believe the person is having more and more trouble making sense of the world around him or her. The person may learn to compensate for memory issues they notice, so that family and friends don't notice the increase in confusion and memory recollection. It is often a relief, however, when a diagnosis of Mild Cognitive Impairment is made and the client and his or her family can put a name to the problems and can research and implement interventions to help the client function more comfortably and independently.

Mid-Stage Alzheimer's disease
In this stage, damage occurs in areas of the brain that control language, reasoning, sensory processing, and conscious thought. Symptoms may include:

- Increased memory loss and confusion
- Problems recognizing family and friends
- Inability to learn new things
- Difficulty carrying out multistep tasks such as getting dressed
- Problems coping with new situations
- Hallucinations, delusions, and paranoia
- Impulsive behavior
- A shorter attention span
- Inappropriate outbursts of anger
- Difficulty with language, reading, writing, and working with numbers
- Difficulty organizing thoughts and thinking logically
- Inability to cope with new or unexpected situations
- Restlessness, agitation, anxiety, tearfulness, wandering – especially in late afternoon or night (we'll discuss this issue, called sun downing, in module 3)
- Repetitive statements, questions, or movements; occasional muscle twitches

In this middle stage of Alzheimer's disease, memory loss and confusion become more obvious and grow worse, in addition to personality and behavioral changes, and wandering. People in this stage require more supervision to remain safe and enjoy their environment. You may notice an client having more trouble organizing, planning, and following instructions, or they may need help getting dressed and may start having problems with incontinence (they cannot control their bladder and/or bowels).

At this point, a person may not recognize family members and friends, even with prompting. They may not know where they are or what day or year it is. They also may lack judgment and begin to wander, so people with mid-stage Alzheimer's Disease should not be left alone. They may become restless and begin repeating movements late in the day (sun downing). Sun downing behaviors may make sleeping difficult and cause the client to be tired during the day. (More on this in module 3).

Personality changes can become more serious, as well. It is not unusual for people with mid-stage Alzheimer's disease to make threats, accuse others of stealing, curse, kick, hit, bite, scream, or grab things. These behaviors are a result of the broken communications between the neurons in the brain.

At times, anger is used as a defense for confusion and anxiety. Again, it's important to remember that these behaviors are a result of the client's disease, and you should not take it personally, but should slow down, use good communication skills, and reassure the client whenever needed.

Another behavior seen frequently in clients with mid-stage Alzheimer's is attaching himself/herself to a caregiver or spouse. Wherever the caregiver or spouse goes, the client follows, and gets upset if that person is out of sight. The client is relying on the caregiver or family member to help them navigate an unfamiliar world, one in which they cannot remember the past or anticipate the future. The caregiver or family member becomes a comforting and source of security for the client.

ACTIVITY (20 minutes): *Break out into smaller groups and discuss the following questions.*

Put yourself in the shoes of a person with mid-stage Alzheimer's Disease. You have just woken up in an unfamiliar room and wonder how you go there. Where are your things? Where is your dog? You hear a knocking sound but are having trouble processing what it means. Suddenly, the door opens and some stranger walks in, pretends to know you, and starts rummaging through your dresser drawers and closet – taking your clothes! What are you feeling? How do you react?

You don't want to let on that you are scared by this stranger / thief, so you start yelling at the person to GET OUT! Instead of leaving, however, the stranger starts to pull your shirt up over your head! You yell at her to stop and start kicking and hitting her.

In this example the behaviors of yelling, hitting, and kicking are likely based on fear and confusion – the world is unfamiliar and moving too fast. Staff may see you as agitated and aggressive. What would be a better way for the caregiver to act in the scenario above?

Late-Stage Alzheimer's disease

People with severe Alzheimer's cannot communicate their needs and are completely dependent on others for their care. Near the end, the person may be in bed most or all the time as the body shuts down. Their symptoms often include:

- Inability to communicate
- Weight loss
- Seizures
- Skin infections
- Difficulty swallowing
- Groaning, moaning, or grunting
- Increased sleeping
- Lack of control of bowel and bladder

This is the last stage of Alzheimer's and ends in the death of the person. Late-stage Alzheimer's is also called severe Alzheimer's disease. In this stage, clients' need help with all their daily needs. They may not be able to walk or sit up without help. They may not be able to talk and often cannot recognize family members.

Client's with late-stage Alzheimer's may have trouble swallowing and refuse to eat. According to the National Institute on Aging, "The most frequent cause of death for people with Alzheimer's disease is aspiration pneumonia. This type of pneumonia develops when a person is not able to swallow properly and takes food or liquids into the lungs instead of air."

Ultimately, damage is spread throughout the brain, and brain tissue shrinks significantly, impacting the body's ability to survive.

Words to Know

(Source: National Institute on Aging)

Aggression (uh-GRESH-un). When a person lashes out verbally or tries to hit or hurt someone.

Agitation (aj-uh-TAY-shun). Restlessness and worry that some people with Alzheimer's disease feel. Agitation may cause pacing, sleeplessness, or aggression.

Alzheimer's disease (AD) (ALlz-high-merz duh-ZEEZ). A Disease that causes large numbers of nerve cells in the brain to die. These changes make it hard for a person to remember things, have clear thinking, and make good judgments. The symptoms begin slowly and get worse over time. At some point, the client will need full-time care.

Anti-anxiety (an-tye-ang-ZYE-eh-tee) drugs. Drugs used to treat agitation and extreme worry. Some can cause sleepiness, falls, and confusion. These drugs should be taken with caution.

Anticholinergic (an-tye-KOL-in-er-gik) **drugs.** Drugs used to treat stomach cramps, incontinence, asthma, motion sickness, and muscle spasms. **These drugs should not be given to people with Alzheimer's disease.**

Anticonvulsants (an-tye-kon-VUL-sunts). Drugs sometimes used to treat severe aggression.

Antidepressants (an-tye-dee-PRESS-unts). Drugs used to reduce depression and worry.

Antipsychotics (an-tye-sye-KOT-iks). Drugs used to treat paranoia, hallucinations, sleeplessness, agitation, aggression, and other personality and behavior disorders. These drugs should be taken with caution.

Assisted living facility. Type of living facility that provides rooms or apartments for people who can handle most of their own care, but may need some help.

Caregiver. Anyone who takes care of a person with AD.

Clinical trial. A research study to find out if new treatments are safe and effective. Healthy people and people with Alzheimer's Disease can choose to take part in a clinical trial.

Cognition: (kog-**nish**-*uh* n) the ability to think, learn, and remember. It is the basis for how we reason, judge, concentrate, plan, and organize. Good cognitive health, like physical health, is very important as we get older, so that we can stay independent and keep active. Some declines in cognition and memory with age are normal, but sometimes they can signal problems.

Continuing care retirement community. Community of homes, apartments, and rooms that offer different levels of care for older people.

Deductible (dee-DUK-ti-bul). The amount of medical expenses that a per
son must pay per year before the insurance company will cover medical costs.

Dehydration (dee-hye-DRAY-shun). Condition caused by lack of fluids in the body.

Delusions (duh-LOO-zhuhns). False beliefs that someone with AD believes are real.

Dementia. (dih-**men**-sh*uh*, -shee-*uh*) Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person's daily life and activities.

Depression: (dee-**presh**-uhn) A serious medical illness that can be treated. Some signs of depression are feeling sad for more than a few weeks at a time, having trouble sleeping, losing interest in things you like to do. Depression can cause people to be confused and forgetful.

Diarrhea (dye-uh-REE-uh). Loose bowel movements.

Do Not Resuscitate (DNR) Form. Document that tells health care staff that the person with Alzheimer's disease does not want them to try to return the heart to a normal rhythm if it stops or is beating unevenly.

Durable Power of Attorney for Finances. Legal permission for someone to make legal and financial decisions for the person with Alzheimer's disease, after he or she no longer can.

Durable Power of Attorney for Health Care. Legal permission for someone to make health care decisions for the person with Alzheimer's disease, after he or she no longer can.

Hallucinations (huh-loo-suh-NAY-shuns). One possible effect of Alzheimer's disease, in which the person sees, hears, smells, tastes, and/or feels something that is not there.

Home health care. Service that provides care and/or companionship in the home for the person with AD.

Hospice services. Services that provide additional care for a person who is near the end of life, and support for families during this time.

Hypersexuality (hi-pur-sek-shoo-AL-uh-tee). Condition in which people with Alzheimer's disease become overly interested in sex.

Incontinence (in-KON-ti-nunts). Trouble controlling bladder and/or bowels.

Inpatient facility. Hospital or other medical facility where people stay in the facility.

Intimacy. Special bond between people who love and respect each other.

Living trust. Legal document that tells a person called a trustee how to distribute a person's property and money.

Living will. Legal document that states a person's wishes for end-of-life health care.

Mild cognitive impairment: (pronounced mild **kog**-ni-tiv im-**pair**-ment) Also called MCI. It is a medical condition that causes people to have more memory problems than other people their age. The signs of MCI are not as severe as those of Alzheimer's disease.

Multivitamin (mull-tee-VYE-tuh-min). A tablet, capsule, powder, liquid, or injection that adds vitamins, minerals, and other nutritional elements to the diet.

Myoclonus (mye-o-KLO-nuss). Condition that sometimes happens with AD, in which a person's arms, legs, or whole body may jerk. It can look like a seizure, but the person doesn't pass out.

Nursing home. Home for people who cannot care for themselves anymore. Some have special Alzheimer's care units.

Paranoia (pare-uh-NOY-uh). Type of delusion in which a person believes—without good reason—that others are being unfair, unfriendly, or dishonest. Paranoia may cause suspicion, fear, or jealousy in a person with AD.

Sexuality. Important way that people express their feelings physically and emotionally for one another.

Spirituality (SPEAR-uh-choo-al-ity). Belief in a higher power or in larger forces at work in the world. Going to church, temple, or mosque helps some people meet their spiritual needs. For others, simply having a sense that larger forces are at work in the world helps meet their spiritual needs.

Sundowning. Restlessness in a person with AD that usually starts around dinnertime or in the evening and may make it hard to redirect and get the person to go to bed and stay there.

Urinary tract infection (YUR-in-air-ee tract in-FEK-shun). An illness, usually in the bladder or kidneys, caused by bacteria in the urine.

Will. Legal document that tells how a person's money and property will be divided after his or her death.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.12 Dementia Training – Module 2	XX/XX/XXXX

Module 2:
Assistance with Activities of Daily Living – 3.25 hours

FOR ALL STAFF:
This training is important, since interacting with clients' living with Alzheimer's and other dementias is one of the more challenging aspects of working with clients' in your facility. Understanding what Alzheimer's disease and dementia are and what the client is experiencing is an important part of your training, and you studied that in module 1. By the end of this module, you will understand the important health and safety challenges, as well as tips for activities of daily living assistance.

Note: In these four Dementia Training Modules, dementia and Alzheimer's disease are used interchangeably. The training presented applies to your work with all persons with dementia, not just Alzheimer's.

****Note: Behavior/s as used in these training modules refer simply to actions and are not intended to be a negative reflection of a client's actions.***

What is Alzheimer's disease?
Alzheimer's disease was first noted in 1906 when Dr. Alois Alzheimer treated a woman who died of an unusual mental illness. Memory loss, language problems, and unpredictable behavior were some of the symptoms the woman had prior to her death. When Dr. Alzheimer examined her brain after death, he found nerve cells, in the brain, had died and/or had stopped working, as evidenced by abnormal clumps and tangled bundles of fiber. This was unlike the brains of other deceased patients.

Alzheimer's disease and most other types of dementia are permanent. Alzheimer's disease is not an illness that can be cured or reversed, although some types of dementia may be related to another illness, such as an infection, and the client will return to a cognitive baseline when the illness has been treated. Instead, Alzheimer's disease kills off brain cells gradually and robs an individual of memory, thinking skills, language, and the ability to care for themselves. An important characteristic when physicians are considering a diagnosis of dementia is that the decline in memory and thinking skills is severe enough to significantly interfere with life, particularly activities of daily living.

FOR DIRECT CAREGIVERS:
Assisted Living environments are a growing industry. Living with a client with Alzheimer's disease can be physically and emotionally challenging. With a higher percentage of families than in previous years where both household adults work outside the home, adding in-home care for a parent with dementia can be even more stressful. Eventually, there may come a point when families are unable to provide a quality and safe environment for their loved one and look to you to provide that home for them.

When your job is to provide a caring and safe environment for clients with dementia, meeting their needs on many levels, including nutrition, activities of daily living like dressing and bathing, can be stressful for you, as well. There are many ways to reduce stress when working with clients', especially those with dementia, and several will be discussed below.

One of the most important strategies is to educate yourself on dementia, Alzheimer's disease, and other related disorders and conditions. Your employer and the State of Minnesota are committed to dementia education for caregivers. Programs that teach employees about the various stages of Alzheimer's and about ways to deal with difficult behaviors and other caregiving challenges can be helpful. Module 1 of this training gave you a for Alzheimer's disease and its stages. Module 2 will discuss assisting with Activities of Daily Living.
As you have learned, Alzheimer's disease causes large numbers of nerve cells in the brain to die, which affects a client's ability to remember things and think clearly. People with Alzheimer's become forgetful, easily confused, and may behave in odd ways. These problems get worse as the illness progresses, making your job as part of the caregiving team harder.

Remember that caring for clients with AD can take a lot of patience and may add additional stress to a busy work day. It's important to recognize signs of stress and have a good system in place to cope with the stress.
Some of the best ways for caregivers to handle the stress of caring for a client with Alzheimer's disease include:

- Develop good coping skills
- Develop a strong support network
- Take a break when you are frustrated
- Talk with other caregivers and employees
    - Express concerns
    - Share experiences
    - Get tips
    - Receive emotional comfort

Finding good methods of reducing caregiver stress are important to keep you from getting frustrated. Speak to your supervisor if you find yourself struggling or need a break from a stressful assignment.

Stories from the Floor: What you may experience (20 minutes)

- *Mary lives in a secured unit in an Assisted Living community. You notice that when Mary is getting a shower one day, she screams continuously and hollers out, "Help! You're killing me!" You knock on the shower room door and ask if everything is okay. The health aide tells you everything is fine, but that Mary is just not happy about her shower that day. It is very disturbing to hear Mary yelling and screaming; she sounds really frightened.*

What do you do? Discuss the options below with a classmate and present your choice to the class:

1. *Since this is not behavior you have witnessed before – and you are concerned it may be a vulnerable adult report - you bring your concerns to the nurse right away.*
2. *You continue to worry about Mary, but figure the health aide knows best, since s/he works with Mary more closely than you do. You continue with your duties and don't mention Mary's behaviors to anyone else.*

3. You use your cell phone to call 911 and report that Mary is being abused.

- *Harry lives in the same secured unit as Mary. Harry was a minister and he loves to listen to old hymns, although he has trouble remembering the words. When you are cleaning Harry's room, he gets very nervous and repeatedly asks you who you are and what you are doing in his room. After patiently repeating your name and purpose in his room, you decide to try redirecting him by singing some traditional worship hymns from your church. To your surprise, Harry sits down, leans his head back against the chair, and closes his eyes in a very calm and peaceful pose. He remains that way for as long as you are singing.*

What if:
The following week, you see a caregiver trying unsuccessfully to re-focus a restless Harry on eating his lunch. You mention that Harry becomes very relaxed when he hears traditional worship hymns, and when the caregiver does not know any, you take a chair and start singing. It works! The caregiver is so excited to see how this well this works and tells you she is going to pass your idea to other caregivers.

FOR DIRECT CAREGIVERS:
Providing Everyday Care for People with Alzheimer's disease

Activity and exercise

Being active and getting exercise helps people feel better, even people with Alzheimer's disease! Exercise helps keep muscles, joints, and heart in good shape, as well as helping clients maintain a healthy weight.

You want someone with Alzheimer's disease to do as much as possible for himself or herself but be as safe as possible when active.

Here are some tips for helping a person with AD stay active:

- Take a walk together each day. Exercise is good for caregivers, too!
- Turn on the music and dance! Use music from your clients' genre.
- Watch exercise videos/DVDs/television programs made for older people. Add a group exercise activity to the daily routine.

Make sure clients with AD wear comfortable clothing and shoes that are made for exercise.

Hydration is important! Make sure everyone drinks plenty of water after exercise. Add fresh fruit to the water for a refreshing change.

Exercise Challenges
With age and the onset of disease, illnesses, and other health conditions, clients' may have a harder time getting around well. As dementia progresses, clients' may experience:

- Trouble with endurance
- Poor coordination
- Sore feet or muscles
- Illness
- Depression or general lack of interest

However, even if your clients' have difficulty walking, there are many tasks that they may still be able to do! Some examples include:

- Sweeping, dusting, folding laundry, putting clothing on hangers – these are simple tasks that can be done in the client's room and will help them remain independent and active
- Using a stationary bike or other weight room equipment, many of which allow the user to be seated
- Using large soft rubber exercise balls or balloons – these are great for a group activity – to stretch or to toss back and forth with other clients'. If there are two clients', seat them facing each other, with enough room to toss the ball or balloon to each other. If there are more than two clients', seat them in a circle.
- Using stretching bands from a seated position. Some bands have handles but need to be secured on one end. Other bands are just stretchy material. These are good for a group exercise activity but can also be used independently by a client in his or her room.

Watch this video about dancing for clients' (7 minutes)
https://www.youtube.com/watch?v=bEUqAR2Lf_w

Healthy Eating

In addition to staying active, helping clients to make smart, healthy food choices is important for overall wellness, and even more important for people with Alzheimer's disease because in the mid to late stages of Alzheimer's disease, clients' may lose interest in food or become confused with the eating process. For instance, the client may not understand how to use silverware or how to eat a chicken drumstick.

Many Assisted Living facilities offer a full three meals a day, served either restaurant style or family style (Prepared food goes on the table and everyone, including staff, are served and eat together). Because the food is prepared by staff, you know the clients are eating healthy, balanced meals. However, if you have clients' who are more independent and prefer to make some or all their meals in their apartment and may still shop for themselves, there are some ways you can assist them to plan healthy meals:

- Encourage clients' and/or assist them to purchase healthy foods such as vegetables, fruits, and whole-grain products that they like and can tolerate. For instance, if a client has a gluten intolerance, you may need to find a healthy alternative to bread.
- Buy food that is easy for the client to prepare, such as pre-made salads and single food portions.
- Encourage clients to make use of dining assistance for meals, such as:
    - Dining programs at the Assisted Living facility
    - Meals-on-Wheels lunch delivery

Watch this video on health eating (5 minutes):
https://www.youtube.com/watch?v=4K3GufyXvaY

Not much changes in the early stages of dementia, as far as eating habits. However, this is a stage where safety concerns may arise, such as clients' forgetting to eat, turning on the stove and forgetting it is on, and leaving the oven on.

In the mid to late stages of dementia, however, is when you may begin to a client having trouble eating and/or keeping weight steady. Some challenges for the client may include:

- Not feeling hungry, so he or she may not recognize normal meal times
- Not knowing when he or she is full
- Not eating enough different kinds of foods
    - The food may look unfamiliar
    - The client may fill up on less healthy choices, such as mashed potatoes or dessert
- Not eating enough food – remember that it is not unusual for client with dementia to be constantly in motion, which burns off even more calories!

These challenges mean that the client may have trouble getting all the foods with the vitamins and minerals needed to maintain wellness. Although each client has individualized needs, below are some ideas that may help your clients to eat:

- There are many types of adaptive silverware available. Make sure clients have adaptive silverware, plates, bowls, and cups if needed (e.g. built up silverware, plate guard, sloped-edge plate, etc.)

Additional suggestions:

- Have set meal times and try to stick to them. Put meal times on white boards and calendars as reminders.
- Minimize distractions at mealtime. If your clients are being distracted by a TV or music, turn these devices off. However, some clients enjoy familiar, but calm, music at mealtime. You know your clients' better than anyone, so do what work's best for them.
- Too many choices can be overwhelming. Consider offering just one food at a time; you may need to put each food item in a separate bowl or use some type of divided plate.
- Because our vision and spatial perception worsens with age and dementia, plating food on colorful plates can really help a client see his or her food.
- Make sure the client's dentures fit – no flopping, slipping, or clacking sounds. Dentures that don't fit or with bumps or cracks may cause choking or pain, making it hard to eat. With the client's permission, remove poorly fitting dentures until a repair can be made. The client may benefit from an altered diet, such as ground meat without his or her dentures.
- Offer nutritious snacks between meals unless a doctor advises against snacking.
- Let the nursing staff know if the client loses a lot of weight. For example, if he or she loses 10 pounds in a month – check your facility's policy and procedure about when to report a significant weight gain or loss.

Here are some suggestions for helping clients to get enough food and fluids:

- Give the client finger foods to eat such as cheese, small sandwiches, small pieces of chicken, fresh fruits, or vegetables
- Sandwiches made with pita bread or wrapped in a tortilla are easier to handle
- Sandwiches on bread can be cut into strips for easier handling
- Try using peanut butter or butter on the bread to hold the sandwich together
- Peanut butter and jelly sandwiches, cut into halves, are a good snack for clients, especially those who are constantly in motion; then sticky peanut butter holds the sandwich together and makes it easy to carry
- Protein milkshakes are high-calorie and nutrient dense. These are great supplemental snacks in between meals. Warning: If you give the client a supplemental milkshake with

a meal, they are more likely to drink the milkshake in place of eating the meal – always give the supplemental milkshake between meals!

- Try to use healthy fats in cooking, such as olive oil or coconut oil. However, if a client needs more calories, you can use extra cooking oil, butter, and mayonnaise to cook and prepare food. Many clients' have a history of heart disease, so be careful to limit unhealthy fats in their diets. Check with the nurse to make a meal preparation plan that is best for each of your clients'.
- A client's doctor may prescribe a multivitamin to add additional vitamins and minerals to his or her diet
- Serve bigger portions at breakfast because it is the first meal of the day; clients' may be hungrier in the morning because of the length of time since supper the previous night.

FOR DIRECT CAREGIVERS:
What to do about swallowing problems

Esther started to have problems swallowing foods and drinks. She would start coughing almost every time she tried to swallow a bit of food or a sip of water. The doctor suggested we try thicker food and drink items, like Jell-O®, applesauce, and high-protein milkshakes. These were easier for her to swallow because they were a thicker consistency. Eventually we thickened all her liquids.

As a client with dementia continues to decline, the dementia progresses to later stages, and the client may lose the skills to eat, chew, and/or swallow. Without the ability to take in proper nutrition, the client may become malnourished and lose weight. Additionally, if a client is choking on food and fluids, there is a chance the food or liquid could go into the lungs (going down the "wrong pipe"), which can cause aspiration pneumonia, and potentially lead to death.

The following suggestions may help when assisting clients with swallowing problems:

- Always keep your nurse up-to-date on new swallowing concerns and choking observations. The nurse can help you implement the appropriate interventions and will keep in touch with the client's doctor. The doctor may recommend a swallowing test and occupational therapy evaluation to help the client.
- Make sure you cut the food into small pieces or serve a mechanical soft diet where meats and vegetables are ground, and make it soft enough to eat – use gravy or broth to soften ground items
- Offer soft, thicker foods, such as ice cream, milk shakes, yogurt, soups, applesauce, gelatin, or custard to supplement meals
- Don't use straws; they may cause more swallowing problems. Instead, have the client drink small sips from a cup. A nosey cup may help.
- Limit the amount of milk the client drinks, as it tends to catch in the throat and increase phlegm, making it harder to swallow properly
- Give the client cold drinks rather than hot drinks, when possible; cold drinks are easier to swallow. Do not use ice as increases the risk of choking.
- Regular thin liquids, such as coffee, tea, water, or broth are the hardest to swallow; you can buy Thick-It® at most pharmacies. You add Thick-It® to liquids to make them thicker. You also can use ice cream and sherbet to thicken liquids. NOTE: do not thicken liquids without instruction from your nurse.

Here are some other ideas to help people swallow:

- Do not hurry the person. He or she needs time to completely chew and swallow each mouthful before taking another bite; you may need to remind the client to slow down and follow these steps with each bite.
- Do not feed a person who is drowsy or lying down. He or she should be in an upright, sitting position during the meal and for at least 20 minutes after the meal to aid in digestion and lower the chance of regurgitation (undigested food coming back up the throat), aspiration (going down the "wrong pipe"), and/or acid reflux or heartburn.
- Have the person keep his or her neck forward and chin down when swallowing.
- Stroke (gently) the person's neck in a downward motion and say, "swallow" to remind him or her to swallow. NOTE: Make sure this intervention is on the client's plan of care and that you have been trained by a nurse!
- Hold a glass up to the client's lips, but don't tip any liquid in; this will cause the client to swallow.
- Alternate one mouthful of food with one sip of liquid.
- Find out if the person's pills can be crushed or taken in liquid form; crushed meds should be mixed in with a small amount of pudding, applesauce, yogurt, or ice cream. NOTE: Do not crush or mask (mix with food) without a doctor's order and training from the nurse.

Helping a person with Alzheimer's disease eat can be time consuming and exhausting. Planning meals ahead, along with any modifications you'll need to make (e.g. grinding meat) and using adaptive equipment when necessary, will make mealtime less stressful. Also, remember that people with Alzheimer's disease may not eat much at typical mealtimes, and then feel more like eating at other times.

Watch this video about how you can help improve mealtime for clients with dementia (4 minutes):
https://www.youtube.com/watch?v=iOGv9_dIlZg

FOR ALL STAFF:
Stories from the Floor: Revisit Sally from Module One

- *Remember Sally from Module One? Sally was constantly in motion walking up and down the halls, and although she repeatedly asked when the next meal was, she did not sit long enough at mealtimes to eat much. When she does sit at meals, she uses her fingers to eat with, no matter what the food item is.*

  Sally has also been slowly losing weight and already looks very thin. Staff are concerned that she is not getting enough to eat. Upon hearing this, you suggest giving her a half of a peanut butter and jelly sandwich next time she asks when the next meal is. The team thinks this is a great idea since Sally can carry the sandwich with her as she walks back and forth.

- *What other ideas would you suggest in a team meeting about Sally's eating habits and weight loss?*
- *Share your ideas with the class.*

FOR CAREGIVERS:
Activities of Daily Living

People with mid to late-stage dementia will likely need help bathing and grooming (e.g. combing hair, brushing teeth, getting dressed, etc.). Because these cares are generally done in private, your clients' may not want help. They may feel embarrassed and/or angry about being naked in front of caregivers and not being able to complete the cares independently. Below are some suggestions for assisting clients with dementia with daily cares.

Bathing

Bath or shower time can be the most challenging part of your day and may require patience and planning of time to be successful for both you and your client.

The client with dementia may feel afraid, embarrassed, and/or angry. As we age, simple movements can cause more pain than normal; watch for signs of pain in your client during bath or shower time, as well.

If possible, ask about the client's bathing habits throughout their life (e.g. shower only in the mornings, bathe twice a week, etc.) and follow those habits as closely as possible. See the suggestions below for other bath and shower tips:

Safety tips:

- Never leave a confused or frail person alone in the tub or shower
- Always check the water temperature the before the client enters the tub or shower; ask them to test the water temperature, as well, before he or she gets in
- Use plastic containers for shampoo, conditioner, and soap to prevent them from breaking
- Use a hand-held showerhead – this makes it easy to maneuver the water around the client, rather than having the client turn around multiple times. It also keeps the water from spraying your client during washing
- Use a rubber bath mat and put safety bars in the tub or shower
- Use a sturdy shower chair in the tub or shower. Standing for the time it takes to shower can be exhausting for your client and may cause additional pain. It also helps steady the client and reduces the risk of falls. Shower chairs can be purchased form medical supply companies or drug stores, such as Walgreen's and CVS

Before a bath or shower:

- Bring the soap, washcloth, towels, shampoo, and conditioner to the shower or tub.
- Make sure the bathroom is warm and well lighted; it may be helpful to keep the bathroom door shut to retain the heat from the shower – remember to heat the room for the client who is not wearing clothing, rather than your temperature preference.
- Play soft music or sing if it helps to relax the person
- Be matter-of-fact about bathing. Say, "It's time for a bath now." Don't argue about the need for a bath or shower. If the client resists, or refuses, follow your facility protocol and specific interventions and plan of care for that client, including leaving and re-approaching them later
- Allow the client to be as independent as possible. Be gentle and respectful. Explain each process, step-by-step
- Make sure the water temperature in the bath or shower is comfortable to the client before getting in
- Don't use bath oil. It can make the shower or tub slippery and may cause urinary tract infections

During a bath or shower:

- Allow the client with dementia to do as much as possible independently. Maintaining as much independence as possible has many benefits, including reducing depression, helping the client feel more in control of his or her life and care, displays a show of respect, and protects the client's dignity.
- Put a towel over the client's shoulders and/or lap. This helps him or her feel less exposed and protects his or her privacy and dignity. You can then use a washcloth with soap to clean under the towel. You can even wet the client while the towels are in place for modesty
- Distract the client if he or she becomes upset. Some distractions might be to start a conversation about something of interest to the client or about their past or singing.
- Give him or her a washcloth to hold. This serves as a distraction and may prevent the client from being combative.

After a bath or shower:

- Prevent rashes or infections by patting, not rubbing, the person's skin with a towel – Remember that the skin on older adults is thinner and more fragile, increasing their risk for skin tears and friction injuries.
- Make sure the person is dried completely, including the areas between folds of skin.
- If the person has trouble with incontinence, use a protective barrier ointment, such as A&D Ointment®, around the rectum, vagina, or penis to protect the skin from breakdown.

Other bathing tips:

- Give the person a full bath two or three times a week, if possible. For most people, a sponge bath to clean the face, hands, feet, underarms, and genital or "private" area is all you need to do every day.
- If the client with Alzheimer's disease has trouble getting in and out of the bathtub or shower, do a sponge bath instead. This can be done in the bathroom or in the client's bed.
- Washing the client's hair in the sink may be easier than doing it in the shower or bathtub, as he or she can stand and lean into the sink. You can buy a hose attachment for the sink to make shampoos easier.

Watch these videos about assisting bathing persons with dementia (4 minutes and 5 minutes):
https://www.youtube.com/watch?v=IxwJgDg3bYU

https://www.youtube.com/watch?v=sl3Dc1kERto&index=3&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD

Grooming

For the most part, when people feel good about how they look, they feel better. Helping your clients with Alzheimer's disease brush their teeth, shave, style their hair, or put on makeup often means they can feel more like themselves. See below for tips on assisting clients with dementia with grooming

Mouth care:

- The need for good mouth care doesn't go away in client with dementia! Good oral care is important in preventing dental problems, such as cavities and gum disease.
- Show the client how to brush his or her teeth. Go step-by-step, using simple instructions. For example, pick up the toothpaste, take the top off, put the toothpaste on the toothbrush, and then brush. Remember to let the person do as much as possible promote independence and dignity.
- If your client seems confused, demonstrate brushing your teeth at the same time.
- Help the person clean his or her dentures. Make sure he or she uses the denture cleaning material the right way. Remember to pad the sink with a towel to reduce the risk of the dentures falling into the sink and breaking. Dentures are very expensive and not normally covered by insurance.
- Encourage and/or assist the person to rinse his or her mouth with water after each meal and use mouthwash once a day.
- Try a long-handled, angled, or electric toothbrush if you need to brush the client's teeth yourself.
- Clients' may still need dentist visits. Encourage and/or assist the client to see a dentist. Some dentists specialize in treating people with Alzheimer's disease. Be sure to follow the dentist's advice about how often to make an appointment.

Other grooming tips:

- Encourage a woman to wear makeup if she has always used it. If needed, help her put on powder, blusher (rouge), and lipstick.
- Encourage a man to shave and help him as needed. An electric razor is best for safety, and some clients' can maintain independence with an electric razor.
- Take the person to the barber or beauty shop. Some barbers or hairstylists may come to your facility or house.
- Have a salon morning by curling hair and painting nails. Be careful with hot curling irons, as clients with dementia may have less safety awareness and less sensation in their hands, so if they touch the hot iron, they may end up with a serious burn.
- Keep the clients' nails clean and filed. Check your facility policy – it's important that a nurse or podiatrist cut the toenails of a client with diabetes, if they are on a blood-thinner or have a bleeding disorder.

Dressing

People with Alzheimer's disease often need more time to dress. It can be hard for them to choose their clothes, and when they do, they might wear the wrong clothing for the season. They also might wear colors that don't go together or forget to put on a piece of clothing. It is important to allow the client to dress on his or her own for as long as possible. If fashion is important to a client who is wearing non-matching clothes, offer to assist him or her. If the client does not pay attention or care if clothing items match, balance that knowledge with the benefits of the client remaining independent.

Tips for dressing assistance include the following:

- Lay out clothes in the order the person should put them on, such as underwear first, then pants, then a shirt, and then a sweater.
- Hand the person one item at a time and give simple step-by-step dressing instructions.
- Reduce the number of choices for the client. For instance, present two outfits for the client to choose from.

- If possible, encourage families to buy multiple sets of favorite clothing, if the client wants to wear the same clothing every day.
- Loose-fitting, comfortable clothing, such as sweat pants, shorts with elastic waistbands, cotton socks, and loose cotton underwear are the easiest for clients with dementia to handle. Avoid girdles, control-top pantyhose, knee-high nylons, high heels, tight socks, and bras for women, unless your client prefers these items and they do not pose a safety hazard. Sports bras are comfortable and provide good support.
- Try to avoid buttons, especially small ones, buckles, and shoelaces. Instead, encourage families to look for clothing with large zipper pulls, and either slip-on shoes that won't slide off while walking, or shows with Velcro® straps. Suspenders are an easy alternative to belts for men.

Bathroom Care

As the dementia and Alzheimer's disease progress, your clients' may develop other medical problems, including incontinence, which means a person cannot control his or her bladder and/or bowels. This may happen at any stage of Alzheimer's disease, but it is more often a problem in the later stages.

Clients' with Alzheimer's and dementia will need help using the bathroom at some point. Plan if you are arranging an outing with the client. Know where restrooms are located and if possible, take an extra set of clothing in case of an accident. Help the person when he or she needs to use a public bathroom. This may mean going into the stall with the person or using a family or private bathroom.

Accidents Happen - Be understanding when bathroom accidents occur. Stay calm and reassure the person if he or she is upset.

Remember that as a client with Alzheimer's disease may develop other medical problems over time. These problems can cause even more confusion and behavior changes, as the person may not be able to explain how they are feeling.

Signs of an incontinence problem include leaking urine, problems emptying the bladder, and/or soiled underwear and bed sheets. Let the nurse know if you see any of these signs, so that a referral to the client's doctor can be arranged, if appropriate.

Incontinence supplies, such as adult disposable briefs or underwear, bed protectors, and waterproof mattress covers, may be helpful. A drainable pouch may be useful for the person who cannot control his or her bladder (called a catheter) or bowel movements (called an ostomy). Talk to a nurse about how to use these products, if used by your clients'.

Some clients' may benefit from keeping a log find it helpful to keep a record of how much food and fluid the person with Alzheimer's takes in and how often he or she goes to the bathroom. You can use this information to make a schedule for reminding and/or assisting the client to the bathroom.

Tips for Bathroom Care

- Remind the client to go to the bathroom every 2 to 3 hours. Don't wait for him or her to ask.
- Show the client the way to the bathroom or take him or her.

- Watch for signs that a client may have to go to the bathroom, such as restlessness or pulling at clothes. Respond quickly.
- Make sure that the client wears loose, comfortable clothing that is easy for them and/or you to remove.
- Discourage fluids with caffeine in the evenings, such as coffee or tea, as they may increase the need to urinate during the night.
- Fresh fruit is a great alternative before bedtime instead of fluids if he or she is thirsty.
- Mark the bathroom door with a big sign that reads “Toilet” or “Bathroom.”
- Use a stable toilet seat that is at a good height for the client. Using a colorful toilet seat may also help the person identify the toilet.
- Accidents happen, so remember to be understanding when bathroom accidents occur. Stay calm and reassure the person if he or she is upset. Incontinence supplies, such as adult disposable briefs or underwear, bed protectors, and waterproof mattress covers, may be helpful. Talk to the nursing staff if you think a client is starting to have incontinence issues or has worsening incontinence issues.
- Let the nursing staff know if you notice a client leaks urine when he or she laughs, coughs, or lifts something, if the person urinates often, or if the person cannot get to the bathroom in time.
- Let the nursing staff know if a client is urinating in places other than the bathroom or is soiling his or her clothes or bed sheets at night and how often this occurs.

ACTIVITY (20 minutes): Divide into small groups and write down the steps for brushing your teeth. The team with the most steps wins! The winning team will share their steps out loud with the rest of the class. How important is it to break tasks down into simple steps for a person with Alzheimer’s disease?

FOR ALL STAFF:
General Safety Concerns

People with Alzheimer’s disease become increasingly unable to take care of themselves. However, the disease progresses differently in each person, so your challenge as a staff member is to constantly adapt to each change in our clients’ behaviors and functioning.

The following general principles may be helpful:

1. **Prevention, prevention, prevention**. It is often difficult to predict what a person with Alzheimer’s might do. Because the disease effects each client differently, and progresses at different rates, you may find that just because something has not yet occurred does not mean it should not be cause for concern. For instance, one day your client suddenly starts rummaging in the refrigerator for food, eating anything that looks good to him or her, when they have never done that before. Even with the best-laid plans, accidents can happen. Therefore, checking the safety of your home or facility will help you take control of some of the potential problems that may create dangerous situations.

2. **Adapt the environment to fit the needs of your clients’**. It is much more effective to change the environment, in most cases, than to change most actions/behaviors of your clients’. While some Alzheimer’s behaviors can be managed with redirection and medications, many cannot. By making changes in an environment, you may be able to decrease the hazards and stressors that trigger some behaviors.

***Note: Behavior as used in these training modules refer simply to actions and are not intended to be a negative reflection of a client's actions.**

3. **Minimize dangers**. By minimizing dangers, you can maximize independence. For instance, securing a house so with a fence and locked gate is an example of minimizing the danger of a client wandering off and provides a safe environment where the client can safely enjoy the yard and patio. In this case, securing the yard allows the client to experience increased mobility and independence than he or she would in an unsecured yard.

Home Safety for People with Alzheimer's disease

Is it safe to leave a person with Alzheimer's alone? This question is often the reason the client has come to live in your assisted living setting; the client or the client's family was concerned about the safety of the client living alone without assistance. The following points are some of the questions families likely asked. Does the person: with Alzheimer's:

- Become confused or unpredictable under stress?
- Recognize a dangerous situation, such as fire?
- Know how to use the telephone in an emergency?
- Know how to get help?
- Stay content within the home?
- Wander and become disoriented?
- Show signs of agitation, depression, or withdrawal when left alone for any period of time?
- Attempt to pursue former interests or hobbies that might now warrant supervision, such as cooking, appliance repair, or woodworking?
- Have a recent history of accidents?

Families and clients' trust that you will be their extra set of eyes, their reminder of tasks that need completion, their support when needed, and their voice when they have trouble communicating.

Common Medical Problems in People with AD

As discussed earlier in this module, clients with Alzheimer's disease may have other medical problems over time, as we all do. These problems can trigger additional confusion and behavior changes. A client may not be able to tell you that something is wrong or explain what he or she is feeling. Therefore, you need to watch for signs of illness and tell the nurse about what you see.

The most common medical problems:

Fever

A fever is a body's way of fighting off infections and can be as little as two degrees above a person's normal temperature (typically around 98.6 degrees Fahrenheit). While you may not be taking a client's temperature if you are not a direct caregiver, you can alert staff to the need for this if you notice signs or symptoms of a fever. A client may have a fever if he or she:

- Feels hot to the touch
- Complains or shows signs of being hot or chilled
- Appears flushed, without another reason for being so (exertion, etc.)

A fever may be a sign of:

- *Infection caused by germs*
- *Dehydration caused by a lack of fluids*

- *Heat stroke*
- Constipation

Flu and pneumonia
Illnesses such as influenza (flu) and pneumonia can spread quickly from one person to another, and people with Alzheimer's disease are more likely to get them because their immune systems may be weakened due to poor nutrition or other health issues; clients' with Alzheimer's disease can also be less aware of their surroundings and the precautions that should be taken to prevent the spread of illness, such as picking up a used tissue or drinking out of a glass that is not theirs.

Flu and pneumonia may cause:

- Fever (Not everyone with pneumonia has a fever)
- Chills
- Aches and pains
- Vomiting
- Coughing
- Breathing trouble

Falls
As Alzheimer's disease gets worse, the client may have trouble walking and keeping his or her balance. He or she also may have changes in depth perception, which is the ability to understand distances. For example, someone with Alzheimer's disease may try to step down when walking from a carpeted to a tile floor. This puts him or her at a higher risk for falls.

To reduce the chance of a fall:

- Clean up clutter
- Remove throw rugs
- Use chairs with arms
- Use a sit-to-stand type recliner, which has a control that tips the recliner forward to aid the client to sit in and stand up more safely
- Put grab bars in the bathroom
- Use good lighting
- Make sure the person wears sturdy shoes with good traction

Dehydration
Our bodies must have a certain amount of water to work well. If a person is sick or does not drink enough fluid, he or she may become dehydrated.

Signs of dehydration to look for include:

- Dry mouth
- Dizziness
- Hallucinations (Do not forget that hallucinations may be caused by the AD itself)
- Rapid heart rate
- Lethargy (a lack of energy and enthusiasm for normal activities)

Be aware of how much fluid the person is taking in each day. This is even more important during hot weather or in homes without air conditioning. Dehydration can also occur during the winter months when heat in your home can create a lot of dry air.

Constipation

People can have constipation—trouble having a bowel movement—when they:

- Change what they eat
- Take certain medicines, including medications to help with Alzheimer's disease symptoms and pain medications
- Get less exercise than usual
- Drink less fluid than usual

Offer fluids consistently throughout the day – before and after activities, with meals, and keep a covered water cup in each room, if appropriate. Try to get the person to drink at least 6 glasses of liquid a day.

Have the person eat foods high in fiber, such as:

- Dried apricots, raisins, or prunes
- Some dry cereals that are high in fiber
- Soybeans

Besides water, other good sources of liquid can include:

- *Juice, especially prune juice if constipation is a problem*
- *Gelatin, such as Jell-O®*
- *Soup*
- *Melted ice cream*
- *Decaffeinated coffee and tea*
- *Liquid cereal, such as Cream of Wheat®*

If possible, make sure that the person gets some exercise each day, such as walking. Notify the nurse immediately if you notice a change in the person's bowel habits.

Diarrhea

Some medicines that are commonly used by clients' may cause diarrhea—loose bowel movements. Certain medical problems may also cause diarrhea. Make sure the person takes in lots of fluids when he or she has diarrhea, or they might become dehydrated. Also, be sure to let the nurses know about this problem.

Incontinence

You learned about incontinence earlier in this module and that it means a person cannot control his or her bladder and/or bowels. This may happen at any stage of Alzheimer's disease (or as part of the aging process, in general), but it is more often a problem in the later stages. Signs of this problem include leaking urine, problems emptying the bladder, and soiled underwear and bed sheets. Be sure to let the nurses know if this happens so appropriate interventions can be put in place. The nurse may also contact the client's doctor to rule out a more serious problem.

Here are some examples of problems that can be treated:

- Urinary tract infection
- Enlarged prostate gland
- Too little fluid in the body (dehydration)
- Diabetes that isn't being treated
- Taking too many water pills
- Drinking too much caffeine

- Taking medicines that make it hard to hold urine

Dental problems

You also learned earlier in this module that as Alzheimer's disease gets worse, clients' will need help taking care of their teeth or dentures. Besides needing assistance, including cueing or physical assistance, to brush their teeth or wash dentures, be aware of signs that may indicate other dental problems, such as:

- Sores on gums
- Decayed teeth
- Food "pocketed" in the cheek or on the roof of the mouth
- Lumps
- Tenderness when brushing
- Damage to dentures

Pain

Always remember that the person with Alzheimer's disease may not be able to tell you when he or she is in pain. Watch the client's face to see if it looks like he or she is in pain or feeling ill. Also, notice sudden changes in behavior such as increased yelling or striking out. If you are unsure what to do, call the nurse for help.

People with AD can also have the same medical problems as many older adults, and some heart and blood circulation problems, stroke, and diabetes are more common in people who have AD than in the general population. Diseases caused by infections are also common. Watch this video about understanding pain in clients with AD (4 minutes): https://www.youtube.com/watch?v=9kSjHtHSJCw

Conclusion

In conclusion, whether you are a direct caregiver, you are part of the care team and your clients rely on your observations when a client cannot speak for themselves. Understanding how you can help a person with AD with daily activities and what health issues to be aware of is an important part of your job. Besides being part of your job, tuning in to the personalities and routines of your clients' can greatly improve their lives!

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.13 Dementia Training – Module 3	XX/XX/XXXX

Module 3:
Problem solving challenging behaviors: Alzheimer's disease and related disorders – 3.00 hours

FOR ALL STAFF – A REVIEW:
This training is important, since interacting with client's living with Alzheimer's and other dementias is one of the more challenging aspects of working with client's in your facility. Understanding what Alzheimer's disease and dementia are and what the client is experiencing is an important part of your training. By the end of this module, you will understand a current explanation of Alzheimer's disease and other related disorders. client

Note: In these four Dementia Training Modules, dementia and Alzheimer's disease are used interchangeably. The training presented applies to your work with all persons with dementia, not just Alzheimer's.

****Note: Behavior as used in these training modules refer simply to actions and are not intended to be a negative reflection of a client's actions.***

What is Alzheimer's disease?
Alzheimer's disease (AD) was first noted in 1906 when Dr. Alois Alzheimer treated a woman who died of an unusual mental illness. Memory loss, language problems, and unpredictable behavior were some of the symptoms the woman had prior to her death. When Dr. Alzheimer examined her brain after death, he found nerve cells, in the brain, had died and/or had stopped working, as evidenced by abnormal clumps and tangled bundles of fiber. This was unlike the brains of other deceased patients.

Alzheimer's disease and most other types of dementia are permanent. Alzheimer's disease is not an illness that can be cured or reversed, although some types of dementia may be related to another illness, such as an infection, and the will return to a cognitive baseline when the illness has been treated. Instead, Alzheimer's disease kills off brain cells gradually and robs an individual of memory, thinking skills, language, and the ability to care for themselves. An important characteristic when physicians are considering a diagnosis of dementia is that the decline in memory and thinking skills is severe enough to significantly interfere with life, particularly activities of daily living.

FOR DIRECT CAREGIVERS:
Living with a client with Alzheimer's disease can be physically and emotionally challenging. With a higher percentage of families than in previous years where both household adults work outside the home, adding in-home care for a parent with dementia can be even more stressful. Eventually, there may come a point when families are unable to provide a quality and safe environment for their loved one and look to you to provide that home for them.

When your job is to provide a caring and safe environment for these individuals, meeting their needs on many levels, including nutrition, activities of daily living like dressing and bathing, can be stressful for you, as well. There are many ways to reduce stress when working with clients', especially those with dementia, and several will be discussed below.

One of the most important strategies is to educate yourself on dementia, Alzheimer's disease, and other related disorders and conditions. Your employer and the State of Minnesota are committed to dementia education for caregivers. Programs that teach employees about the various stages of Alzheimer's and about ways to deal with difficult behaviors and other caregiving challenges can help. Modules 1 of this training gave you a foundation for Alzheimer's disease and its stages. Module 2 discussed assisting with Activities of Daily Living.
Alzheimer's disease is an illness of the brain. It causes large numbers of nerve cells in the brain to die. This affects a clients' ability to remember things and think clearly. People with AD become forgetful and easily confused. They may have a hard time concentrating and behave in odd ways. These problems get worse as the illness gets worse, making your job as part of the caregiving team harder.

It is important to remember that the disease, not the client with AD, causes these changes. Also, each client with AD may not have all the problems we talk about in this module.
Remember that caring for clients with AD can take a lot of patience and may add additional stress to a busy work day. It's important to recognize signs of stress and have a good system in place to cope with the stress.
Some of the best ways for caregivers to handle the stress of caring for a client with Alzheimer's Disease include:

- Develop good coping skills
- Develop a strong support network
- Take a break when you are frustrated
- Talk with your peers and other caregivers and employees
    - Express concerns
    - Share experiences
    - Get tips
    - Receive emotional comfort

Finding good methods of reducing caregiver stress are important to keep you from getting frustrated. Speak to your supervisor if you find yourself struggling or need a break from a stressful assignment.

FOR ALL STAFF:
Changes in personality and behavior
In Module 1 you learned about the science behind Alzheimer's disease – connections in the brain become interrupted and brain cells die, which means the brain does not work as well. We discussed that Alzheimer's disease is a progressive disease, so symptoms and behaviors will increase over time. These changes will also result in personality changes in clients with Alzheimer's disease. Because you work closely with your client's, you may notice that, just like you, he or she will have good days and bad days.

Some common personality changes you may see:

- Getting upset, worried, and angry more easily – Anxiety, agitation
- Acting depressed or not interested in things - Depression
- Hiding things or believing other people are hiding things - Paranoia

- Imagining things that are not there - Hallucinations
- Wandering away from home - Elopement
- Pacing a lot of the time - Restlessness
- Showing unusual sexual behavior - Hypersexuality
- Hitting you or other people - Aggression
- Misunderstanding what he or she sees or hears - Confusion
- Also, you may notice that the stops caring about how he or she looks, stops bathing, and wants to wear the same clothes every day – Depression, confusion

You will learn more about these personality and behavior changes in this module.

Other factors that affect behaviors in Alzheimer's disease **individuals**
In addition to changes in the brain, the following things may affect how people with AD behave. Many of these may be temporary events and behaviors may resolve when the event resolves. Be on the lookout for:
Feelings or uncertainty, including:

- Sadness, fear, or a feeling of being overwhelmed
- Stress caused by something or someone
- Confusion after a change in routine, including travel
- Anxiety about going to a certain place

Changes in health or health treatments:

- Illness or pain
- New medications
- Lack of sleep
- Infections, constipation, hunger, or thirst
- Poor eyesight or hearing
- Alcohol abuse
- Too much caffeine

Changes in environment, including:

- Being in a place he or she doesn't know well.
- Too much noise, such as TV, radio, or many people talking at once. Noise can cause confusion or frustration.
- Stepping from one type of flooring to another. The change in texture or the way the floor looks may make the client think he or she needs to take a step down.
- Misunderstanding signs. Some signs may cause confusion. For example, one client with Alzheimer's disease thought a sign reading "Wet Floor" meant he should urinate on the floor.
- Mirrors. Someone with Alzheimer's disease may think that his or her mirror image is another client in the room.

Watch this video about repetitive behaviors (4 minutes):
https://www.youtube.com/watch?v=PQ7VcyEgVzw&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD&index=5

Watch this video about repetitive questions (4 minutes):
https://www.youtube.com/watch?v=hke8ek_aHkE&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD&index=6

ACTIVITY (30 minutes): *Break out into smaller groups and list as many interventions as you can for a client who appears agitated, is pacing, and is repeating, "I want to go home" over and over. Your interventions should be soothing and calm. Share your list with the class.*

Personality and Behavior Changes – How caregivers cope

Caring for individuals who struggle with memory and thinking problems can be challenging. When individuals with dementia begin to have personality and behavior changes, it's can be challenging to complete daily work tasks.

Some general rules:

- Keep things simple. Directions should be broken down into one step at a time.
- Keep a consistent daily routine, so individuals know when activities, mealtimes, etc. will happen. Keep a calendar with large writing in a common area.
- Provide emotional support and reassurance as needed. Individuals with dementia may feel uncomfortable in their surroundings, not understanding or recognizing the people around them or what is expected of them.
- Focus on the client's feelings rather than words. For example, instead of asking, "How are you doing today?" say, "You seem worried."
- Remember that clients with dementia in a world that may be filled with confusion, loneliness, and may be influenced by hallucinations and delusions. This may create an altered perception of reality, and it's important to validate and support the client emotionally, rather than attempting to correct, reason with, or argue with him or her.
    - *Henry and Beth were a married couple living in an assisted living apartment. Beth had had a stroke and it was difficult for her to speak and be understood. Henry had mid-stage* Alzheimer's disease*. Henry needed a lot of reassurance and direction, and Beth provided that for him. In return, Henry followed her around adoringly, knowing that whenever he had a question, Beth would answer him. Beth went out for a doctor's appointment one morning, and left Henry at home. Several hours later, the doctor's office called to report that Beth had been emergently admitted to the hospital. When the nurse called the hospital to check on Beth, the nurse was told Beth had passed away shortly after arriving at the hospital.*

      Staff were told immediately and huddled to determine how to tell Henry the news that his beloved wife had passed away. The couple did not have any family and the emergency contacts they had identified upon admission years ago had also passed or were in nursing homes and unable to help.

      When the nurse and a health aide told Henry, his wife had passed away, he was very upset and distraught, crying and calling out, "Beth. Beth. Where is my Beth?" Staff consoled him and were able to get him to bed that evening with some additional coaxing.

      The next day, Henry continued to ask, "Where is Beth? I'm looking for my wife," but did not appear to remember that she had passed away. However, when a staff member corrected him and told him Beth had died, Henry began to grieve once again. This happened several times that first week.

Staff huddled together again and discussed the pattern of behavior (crying, upset, sad) they were seeing, and the identified trigger (orienting him to reality by reminding him his wife had died). They decided to change their strategy and whenever Henry asked where his wife was, they would tell him she had gone to an appointment and would be back soon, then try to redirect or distract him.

For the most part, this strategy was successful and there were only a few instances when the planned answer didn't satisfy Henry. More importantly, staff were adjusting to his perception of the world, rather than insisting that he see the actual world – the one in which his wife had died.

- If you get angry or frustrated, try not to show it. If you need to, step back, take deep breaths, and count to 10. If it's safe, take a break from the task and leave the room for a few minutes.
- Use humor when you can but remember to do so in a kind way.
- Identify people who pace a lot and ensure they have a safe place to walk that is free of obstacles that may trip them up. Make sure they are wearing comfortable, sturdy shoes and remember that they are burning a lot of calories by walking so much, so offer them a snack – half a peanut butter and jelly sandwich, etc. - to eat as they walk. Always encourage fluids, as well, especially in warmer weather.

Use distractions:

- Try using distractions such as music, singing, or even dancing to redirect a client with dementia. The wife of a client found that giving her husband chewing gum stopped his cursing.
- Learn as much as you can about your clients' – what types of jobs or careers did they have? You may be able to use this information to distract and redirect a client. For instance:
    - *Tom was a great mechanic and handyman during his life; he liked to take things apart to see how they worked and put them back together. Because of this interest, staff kept an old tricycle for Tom, and some tools. For several hours a day, Tom would "work" on the tricycle, taking off the wheels, nuts and bolts, and reassembling the bike. Staff knew that if Tom started to get agitated, they could distract him by pulling out the tricycle and his toolbox.*
        - Another great tool for those clients' who like to tinker is a busy box that contains locks – a chain lock, a deadbolt, a slide lock, etc. so that the client can manipulate the locks and keep busy.
    - *Sarah is a client on a secured dementia unit. She walked a lot, but not in the traditional way; Sarah was always looking at the ground and walked in random patterns. Staff tried to ask her what she was doing, but Sarah's speech was difficult to interpret. One day Sarah's daughter was visiting, and you discussed Sarah's odd behavior. The daughter laughed and told you her mother used to be an ice skating instructor! It was now apparent that Sarah had been leading her skaters in patterns. With this knowledge, you can speak to Sarah about how good her skaters are doing, and although you cannot understand her words, you can't help but understand her smile!*
- Ask for the client's help. For instance, say, "Let's set the table" or "I really need help folding the clothes."
    - *Mary loved to "help" in any way she could. She loved to fold clothes, so staff kept a laundry basket of clean towels, washcloths, and baby clothes in an activity*

closet. Once Mary had folded the clothes and asked for more, staff would take the basket of folded laundry to the closet, out of sight of Mary, and shake out all the folded items before bringing the basket to Mary again – who happily folded them again. Staff also noticed how Mary's face would light up when she came to an item of baby clothing. The staff found that Mary loved to reminisce about her own children as babies, and the world as she knew it at that time.

Other ideas:

- Follow your facility's policy and procedure for documenting behaviors so that nursing can review and can talk to the doctor about any serious behavior or emotional problems, such as hitting, biting, depression, or hallucinations.

ACTIVITY (30 minutes): Break out into small groups and make a list of 50 activities that could be done with a group of clients with dementia. Bingo, word games, and trivia do not count since they are not usually appropriate for people with dementia. Do all your activities need to be done by an Activities staff? Are there activities that nursing, or health aides can do? Share the lists with the class, and your coworkers!

Sleep Problems

Evenings pose an extra challenge for many clients with dementia. While the client may be calm and content throughout the day, he or she may become more active, restless, and agitated in late afternoon or early evening – as the day changes into night. This is frequently identified as "sundowning" and doctors now consider it a syndrome – Sundown Syndrome. The effects of sundowning reach into the night, as well, often causing the client difficulty falling and staying asleep. The videos below show two different sides to Sundowning: the restlessness and agitation, and the sleep difficulties.

Some tips to reduce Sundowning behaviors:

- Encourage the client to get exercise during the day, and limit naps – redirecting the client to an activity may keep their attention and keep them from napping.
- Plan activities that use more energy early in the day. For example, try bathing in the morning or having the largest family meal in the middle of the day.
- Set a quiet, peaceful mood in the evening to help the client relax. Keep the lights low, try to reduce the noise levels, and play soothing music if he or she enjoys it.
- Routines are important for clients with dementia. Try to keep bedtime at the same time each night. Having a bedtime routine, such as washing up in the bathroom and changing into pajamas at the same time each night may help, as well. The consistent tasks may trigger the knowledge that it is time for bedtime and sleep.
- Use nightlights in the bedroom, hall, and bathroom. Nightlights not only reduce the risk of a client falling while trying to maneuver in a dark room but can also provide reassurance and a sense of well-being for the client's.
- Monitor diet, limiting caffeine and large amounts of sugar, particularly late in the day.

Watch these videos about sundowning (4 minutes and 7 minutes):
https://www.youtube.com/watch?v=kskiEKghjAE&index=8&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD

https://www.youtube.com/watch?v=9Ak1tgzv_0Q

Hallucinations and Delusions
As dementia and/or Alzheimer's disease progress, the client may hallucinate and/or delusions.

During a hallucination, a client sees, hears, smells, tastes, or feels something that is not there. For example, the client may see bunnies in his or her room, when none exist.

He or she also may have delusions. Delusions are false beliefs that the client thinks are real. For example, the client may think his or her spouse is in love with someone else or that a staff member of the opposite sex is their spouse.

Here are some things you can do:

- Document the hallucinations or delusions, according to your facility's policies and procedures. Be objective and detailed. Pass on the hallucinations / delusions to oncoming staff and nursing.
- Sometimes an illness or medicine may cause hallucinations or delusions, so it is important that nursing staff are aware of the type and frequency of hallucinations / delusions, so they can evaluate current medications and/or illnesses that may be contributing.
- Do not to argue about what the client with Alzheimer's disease sees or hears. Again, remember that the client's perception of reality IS his or her reality. Validate the client's' statements, provide comfort if he or she is afraid, and reassure them that you have the situation under control now.
    - *Martha grew up on a farm. Last spring, after living in your facility for more than a year, Martha started refusing to go to breakfast, stating she could not eat until all her chores were done, including feeding the rabbits who lived in her room. There were no rabbits living in Martha's room, but she was insistent and had frequently pointed them out to you, although you could not see them.*

      Your first instinct was to correct her, and insist she understand that there were not actually any rabbits in her room. However, doing that only made Martha more upset and insistent that the rabbits were there.

      After a team huddle, someone asked what the harm might be in giving Martha a small amount of lettuce each morning and allowing her to "feed the rabbits" before going down to breakfast? No one could think of anything negative, other than having to clean up lettuce off the floor, so you tried it the next morning.

      It worked like a charm! From that time on, each night the kitchen staff sends a small bit of lettuce to your unit so that Martha could have it ready in the morning to feed her rabbits. Then, while Martha happily goes off to the dining room for breakfast, a staff member scoops up the lettuce and disposes of it.

- Distract the client. Just like with other behaviors, distraction with an idea, question, or request for assistance from the client can be a successful redirection tool. Distractions can also include changing the environment – going out for a walk or turning on music.
- Pay attention to what is on the TV – both in the common areas and in the clients' rooms. Turn off the TV or change it to another station when violent or upsetting programs are on. Someone with Alzheimer's disease may think these events are to him or her.

Additionally, there may be something in the past that was traumatic and the events on the TV could trigger post-traumatic stress and fear.
    - *A documentary about Nazi Germany may trigger a flashback for a client who spent time in a Nazi concentration camp.*
    - *A documentary about the 911 attacks on the United States may evoke fear and worry that it is happening now.*
- Strive to keep common areas and personal living spaces safe. If someone is hallucinating or having delusions that someone is trying to harm them, be careful not to leave any potential weapons where they could be used to harm the client or anyone else.

Watch this video about hallucinations. While the video talks about a family member caregiver, the suggestions carry over to your job as a caregiver. (4 minutes)

https://www.youtube.com/watch?v=cpV57QGdU7I&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD&index=2

Paranoia
Paranoia is a type of delusion in which a client may believe—without a good reason—that others are acting against him or her. You may see behaviors from the client that include becoming suspicious, fearful, or jealous of others. Some of the comments you may hear from the client include that another client is mean, lying, unfair, or "out to get him or her."

Be aware!
Someone with Alzheimer's disease may have a good reason for acting a certain way. He or she may not be paranoid. There are people who take advantage vulnerable adults. Find out if someone is trying to abuse *or steal from the client with Alzheimer's disease.*

Paranoia is often linked to dementia, in that memory loss can trigger paranoia, and the worse memory loss becomes, the worse the paranoid behavior may get. For example, a client may become paranoid if he or she forgets:
- Where he or she put something. The client may believe that someone is taking his or her things.
- That you are the client's caregiver. Someone with *Alzheimer's disease* might not trust you if he or she thinks you are a stranger.
- People to whom he or she has been introduced. The client may believe that strangers will be harmful.
- Directions you just gave. The client may think you are trying to trick him or her.

In addition to being connected to memory loss, paranoia can be a symptom of other illnesses or conditions, such as schizophrenia. Paranoia may also stem from a client's inability to process situations appropriately. Finally, paranoia may be a client's way of expressing loss; he or she may blame or accuse others because no other explanation seems to make sense.

When you are working with clients with paranoia:
- Try not to react if you are blamed for something, such missing items.
- Don't argue with the client; remember that he or she is acting on his or her perception of reality, and likely on limited information. Listen and validate, if appropriate
- Reassure the client that he or she is safe.
- If the client will allow, use gentle touching or hugging to show him or her that you care.

- Remind families and co-workers that the client is acting this way because he or she has *Alzheimer's disease*, not because it's personal. Share ideas about interventions and redirection strategies that work when a client is showing signs of paranoia.
- Offer to search for missing items to distract the client; then talk about what you found. For example, talk about a photograph or keepsake you come across.
- When possible, keep extra items that are frequently lost, such as eyeglasses or a set of keys.
    - *Vern always carries his truck keys, although he no longer drives. He often takes them from his pocket and holds them, frequently looking at each individual key up close. Every couple of days the keys get misplaced and Vern will loudly accuse a client at his table of stealing them and hiding them just to be mean. You are usually able to find Vern's keys ~~quickly~~ in his room and return them to him. However, you are unable to locate the missing keys on occasion. The longer he is without his keys, the more behaviors Vern exhibits, including harassing and threatening the client at his table. Because Vern's keys play such an important role in keeping him calm and peaceful, you keep an extra set of random keys in the nursing office for the times when you can't locate the missing set. Vern does not seem to notice that the keys are different and is happy and relieved when he has a set in his hands again.*

Agitation and Aggression

Agitation and aggression are two more dementia-related behaviors. According to the Alzheimer's Association, "A client with Alzheimer's may feel anxious or agitated. He or she may become restless, causing a need to move around or pace, or become upset in certain places or when focused on specific details." Agitated client's also may not be able to sleep, or may act aggressively toward others, verbally lashing out or trying to hit or hurt someone. As discussed above, these behaviors can be related to sundowning or may to something else, including a situation they cannot easily verbalize, such as pain, being overtired, or having bowel or bladder problems.

Some other causes of agitation and aggression may include:

- Sudden changes in a well-known place, routine, or client
- Feelings of loss - for example, not being able to drive or care for a pet
- Overstimulation - too much noise, confusion, or people around
- Feeling pushed to do something - for example, to bathe or remember events or people – when memory loss or thinking problems make that activity very hard or impossible
- Feeling lonely or isolated – showing signs of isolation, as well
- Medications, illnesses, or other medical conditions can also trigger agitation and/or aggression

How do you deal with agitation and/or aggression as a caregiver?

- Get to know the clients' you care for, their personalities and habits. Do they sundown? Is there an object that brings them comfort, such as a baby doll or set of keys in the example above? Knowing these things can make it easier to spot signs of agitation and/or aggression early so you can intervene and avoid or minimize the behaviors.
- In order to successfully treat or intervene when behaviors occur, you need to identify the root cause of the behaviors. Ignoring the behavior may lead to escalation and potentially harmful situations, so gather your team and try to get to the root cause. Only then will you have the tools to work toward eliminating the agitated and aggressive behaviors.
- If you believe the client may be experiencing pain, notify the nurse promptly.

- Slow down. If you are hurried, distracted, or anxious, a client with Alzheimer's disease may pick up on that. Relax and ask for assistance if you can. If you need to take a few minutes away from a challenging situation, and can safely do so, step away and regroup.
- Allow the client to keep as much control in his or her life as possible. Offer them choices, rather than automatically choosing for them.
- Distract the client. Just like with other behaviors, distraction with an idea, question, or request for assistance from the client can be a successful redirection tool. Distractions can also include changing the environment – going out for a walk or turning on music.
- Speak and act calmly. Ask for and listen to the client's concerns and frustrations. Try to show that you understand if the client is angry or fearful and offer reassurance.
- Ask the client's family to bring in well-loved objects and photographs for the client's apartment. The familiarity of these items can make the client feel more secure and calm.
- Create a calm environment. Reduce noise, clutter, or the number of people in the room.
- If the client will allow, use gentle touching or hugging to show him or her that you care and to calm him or her. You might also try soothing music, reading, or walks.
- Build quiet times into the day, along with activities.
- Monitor diet, limiting caffeine, junk food, and large amounts of sugar, particularly late in the day.

Some important steps to take when a client becomes aggressive:

- Protect yourself and other clients from aggressive behavior. You may need to stay at a safe distance from the client until the behavior stops.
- Call for emergency services (911) if the client is posing a serious threat of injury to himself, herself, or others.
- Protect the client from hurting himself or herself if your actions can be done safely.

Watch the following video about refusing to take medication (4 minutes):
https://www.youtube.com/watch?v=-rB5-AkqpjQ&index=4&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD

Clients' Who Wander

It is not uncommon for clients with Alzheimer's disease to pace, wander, and try to exit through security doors. If the client leaves a secured or monitored environment without a family or staff escort, it is called eloping. Once a client leaves the secured environment, he or she can quickly become lost when nothing looks familiar and wander aimlessly in search of his or her "home." As a caregiver, it is extremely important to know how to limit wandering and prevent the client from becoming lost. Client's with Alzheimer's disease or other dementias are particularly vulnerable adults and your job is to keep them as safe as possible. The suggestions below will help you do that.

Before clients with Alzheimer's disease **wander (**BALANCE THE NEED TO KEEP A WANDERING CLIENT SAFE WITH HIS OR HER RIGHTS TO PRIVACY – Some of the suggestions below may not be appropriate without consent from the responsible party):**

- Families may want to put labels in the client's clothing with a phone number to aid in identification.
- Families may wish to purchase a medical alert bracelet which includes a phone number should the client become lost.

- Routinely take and keep a recent photograph of the client to help police if the client becomes lost. It is important to have a recent photo, rather than one that was taken a year or more ago, so searchers and police have an easier time identifying the missing client.
- Keep doors locked. Consider a keyed deadbolt that requires a key numbered code to unlock.
    - **Make sure you post signs warning visitors and staff to make sure no one follows them through a secured door.
    - Some clients' present as if they were a visitor and other visitors may let them out, not thinking that the client was a resident!
- Install a monitor that chimes when a door opens
    - **Again, discuss this step with the management team and make sure the alarm will not violate the rights of the wandering client or other clients'.

Here are some tips to help prevent the client with Alzheimer's from wandering away from home:

- Keep doors locked. Consider a keyed deadbolt that requires a key numbered code to unlock.
    - **Make sure you post signs warning visitors and staff to make sure no one follows them through a secured door.
- Use loosely fitting doorknob covers so that the cover turns instead of the actual knob.
- Place STOP, DO NOT ENTER, or CLOSED signs on doors. Use brightly colored paper. Medical supply companies also sell mesh barriers that stretch across a door.
- Camouflage the exit doors by painting or wallpapering to match adjoining walls, placing curtains, or brightly colored streamers across the door.
- Install safety devices found in hardware stores to limit how much windows can be opened, if necessary
- Secure the yard with fencing and a locked gate.
- Keep shoes, keys, suitcases, coats, hats, and other signs of departure out of sight. If a client who wanders sees you ready to exit a secured area, he or she may try to follow you or may become agitated and/or aggressive.
- Do not leave a client with Alzheimer's who has a history of wandering unattended in an unsecured area.

Watch this video on wandering:
https://www.youtube.com/watch?v=Sw0yEB508mI&index=7&list=PLw0lBK4PlwF5BJvKjJMTnLCQOKZfSMWXD

Searching, Rummaging, and Hiding Items

You may find that some of your clients with Alzheimer's disease like to search and rummage for items, although they may not be able to tell you what it is that they are looking for. You might find them searching through closets (theirs and others'), cabinets, drawers, and refrigerator / freezer. Additionally, the client might remove items from these areas and hide them. The reason for this, if the client can explain, is often not rational.

For instance, you find a client searching through his or her roommate's dresser drawers. When asked what the client was looking for, he or she replied, "Peanut butter."

In the situation above, it's important to process what the client has said and try to solve the cause of the searching – if the client is looking for peanut butter, they may be hungry, but unable to express that.

Here are some other steps to take:

- Do not keep cleaning supplies or other toxic supplies where a client can find them.
- Remove spoiled food from the refrigerator and cabinets. Someone with Alzheimer's disease may look for snacks but lack the judgment or sense of taste to stay away from spoiled foods.
- Search the house to learn where the client often hides things. Once you find these places, check them often, out of sight of the client.
- Keep all trash cans covered or out of sight. People with Alzheimer's disease may not remember the purpose of the container or may rummage through it.
- You also can create a place where the client with Alzheimer's disease can rummage freely or sort things. This could be a chest of drawers, a bag of objects, or a basket of clothing to fold or unfold. Give him or her a personal box, chest, or cupboard to store special objects. You may have to remind the client where to find his or her personal storage place.

Remember that many clients grew up during the depression when food and material goods were scarce. Client's you are caring for may wrap extra food in napkins and put in their pockets. They also may "collect" items, such as forks, hiding them with the intent of having one in the future.

Changes in intimacy and sexuality

Intimacy is the special bond we share with a person we love and respect, including the way we talk and act toward one another. This bond can exist not only between spouses or partners, but also between family members and friends. As a client with Alzheimer's disease continues to have memory and thinking problems, this can affect intimate relationships. For instance, a client with Alzheimer's disease may have trouble remembering they are married, especially if their spouse still lives at home.

Sexuality is just one type of intimacy, but it is an extremely important way that spouses or partners typically express their feelings physically for one another. When one of the spouses or partners has dementia, it will likely change the relationship. Couples may no longer live together or share a bed together. There may be less desire for sexual intimacy, or more (hypersexuaity). The client may become dependent and cling to his or her spouse, or he or she may not remember life with a partner and feelings toward a spouse. Sometimes the client may develop a new intimate relationship with someone else.

It may take some time to learn how to cope with these challenges, both as a person in a relationship with the client, and as a person caring for the client with Alzheimer's disease. It is easy to be hurt by the changes before learning to live with the illness and find new meaning in their relationships with people who have Alzheimer's disease.

Coping with changes in client's' intimate relationships
Remember that most people with Alzheimer's disease need to feel that someone loves and cares about them. Especially if the client's spouse or partner does not live with them, your efforts to take care of these needs can help the client with Alzheimer's disease feel cared for and secure in their environment.

It's important to reassure the client that:
- He or she is loved
- You will keep him or her safe
- Others also care about him or her, including a spouse or partner and/or children.

If a client has a spouse living at home, that spouse may feel the loss of the intimate relationship, especially if the client with Alzheimer's disease can no longer remember the spouse or children they share.

It may be difficult to see a client with Alzheimer's disease, who is married, develop an intimate relationship with another client in your care. This relationship may include holding hands, sitting together, seeking each other out, and even consensual sex. It's important to remember that these behaviors may reflect the disease more than the client he or she was before Alzheimer's disease.

If you have questions about a relationship, speak to your nurse or housing director. It's your job to protect the client's' rights, even if you don't agree with their decisions.

Hypersexuality
Sometimes, people with Alzheimer's disease are overly interested in sex. This is called "hypersexuality." The client may masturbate a lot and try to seduce others. These behaviors are symptoms of the disease and don't always mean that the client wants to have sex.

To cope with hypersexuality, it may be best to meet as a team to discuss each client's rights, and interventions, such as assisting a client to his bedroom to masturbate. Some people with hypersexual behaviors need medicine to control their behaviors. Talk to the nurse about what steps to take.

Stories from the Floor: What you may experience
- *Tony eats at a table with one other gentleman and two ladies. You are in the kitchen making final supper preparations when you hear one of the women scream. When you re-enter the dining room, you see that Tony has unzipped his pants and is masturbating in his chair, right next to the woman who screamed.*

What do you do? Discuss options with a classmate and present your opinions with the class.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.14 Dementia Training – Module 4	XX/XX/XXXX

Module 4:
Communication Skills: Alzheimer's disease and Related Disorders – 1.00 hours

FOR ALL STAFF – A REVIEW:
This training is important, since interacting with clients living with Alzheimer's and other dementias is one of the more challenging aspects of working with clients in your facility. Understanding what Alzheimer's disease and dementia are and what the client is experiencing is an important part of your training. By the end of this module, you will understand a current explanation of Alzheimer's disease and other related disorders.

Note: In these four Dementia Training Modules, dementia and Alzheimer's disease are used interchangeably. The training presented applies to your work with all persons with dementia, not just Alzheimer's.

****Note: Behavior/s as used in these training modules refer simply to actions and are not intended to be a negative reflection of a client's actions.***

What is Alzheimer's disease?
Alzheimer's disease was first noted in 1906 when Dr. Alois Alzheimer treated a woman who died of an unusual mental illness. Memory loss, language problems, and unpredictable behavior were some of the symptoms the woman had prior to her death. When Dr. Alzheimer examined her brain after death, he found nerve cells and, in the brain, had died and/or had stopped working, as evidenced by abnormal clumps and tangled bundles of fiber. This was unlike the brains of other deceased patients.

Alzheimer's disease and most other types of dementia are permanent. Alzheimer's disease is not an illness that can be cured or reversed, although some types of dementia may be related to another illness, such as an infection, and the client will return to a cognitive baseline when the illness has been treated. Instead, Alzheimer's disease kills off brain cells gradually and robs an individual of memory, thinking skills, language, and the ability to care for themselves. You learned about Alzheimer's disease and other related dementias in module 1, activities of daily living in module 2, and problem-solving challenging behaviors in module 3. Although each of the first three modules discussed communication, in module 4, you will learn more about communication challenges in clients with dementia.

FOR ALL STAFF:
Stories from the Floor - Activity – discuss as a group (15 minutes):

- *Sue is a client with dementia. You have noticed in the past year that she has had a lot of trouble finding the right words. For instance, when you ask her if she wants oatmeal or Cheerios for breakfast, she hesitates, then answers, "Cheese." You repeat the question, but Sue is not able to answer with either of your suggestions. What is your next step?*
    - *Some clients, especially in earlier stages of dementia, realize he or she is having trouble remembering details, such as his or her children's' names. The clients*

may then try to compensate with more generic words. To some people, this may go unnoticed and the conversation can appear completely appropriate. An example is:

- *Ms. Peters is a client who sits in the lobby most of the day; if asked, she will say she is waiting for her son to visit. She loves company and you always try to spend a few minutes a day visiting with her. Your conversation goes like this:*

You: *Hello Ms. Peters! How are you today?*
Ms. Peters: *Good, good.*
You: *What are you up to today?*
Ms. Peters: *It's so out there (points out front window) with the sun.*
You: *It is! Did you go outside this morning?*
Ms. Peters: *I may go outside later.*
You: *Is Joe or Matt visiting tonight?*
Ms. Peters: *We always take a walk outside and drink root beer. The kids love root beer.*

- *On the surface, the conversation flowed well, and Ms. Peters had responses to all your questions. However, if you look deeper, you will see she never actually answered any of your questions! By responding with subtle topic changes and more broad statements, she kept up the appearance of having a pleasant, appropriate conversation, without drawing attention to the fact that she may not remember why she was sitting in the lobby, whether she had been outside that morning, or which of her children were visiting that night. She also may be referring to her sons as "the kids" rather than trying to recall their names.*
- *Does it matter that Ms. Peters did not answer any of your questions? Has her day gotten better because of her pleasant conversation with you?*

Communication Challenges
You have likely had days when you have trouble finding the right words. Communication is especially hard for clients with Alzheimer's disease because they not only have trouble finding the right words, but also have trouble remembering things, such as what they wanted to say. It's easy to feel impatient and wish the client could just say what they want, but they honestly cannot. It may help you to know more about common communication problems that clients with AD struggle with, so you can better understand and manage – which reduces stress and benefits everyone!

Communication problems associated with dementia include:

- Trouble finding the right word when speaking
- Problems understanding what words mean
- Problems paying attention during long conversations
- Loss of train-of-thought when talking
- Trouble remembering the steps in common activities, such as cooking a meal, paying bills, getting dressed, or doing laundry
- Problems blocking out background noises from the radio, TV, telephone calls, or conversations in the room
- Frustration if communication isn't working
- Being very sensitive to touch and to the tone and loudness of voices

In addition to the common communication problems described above, dementia can also cause some people to get confused about language. For example, the person might forget or no

longer understand English if it was learned as a second language. Instead, he or she might understand and use only the first language he or she learned, such as Spanish.

How to manage changes in communication skills

As the saying goes, knowledge is power! Understanding that dementia can cause the decline in communication skills that you and your clients are facing is key. The second step is to try proven tips that might make communication with your clients easier. See below for some suggestions.

To connect with a client who has Alzheimer's disease:

- Make a connection with eye contact and calling the client by his or her name.
- Be aware of the tone and volume of your voice, how you look at the client, and your "body language (non-verbal messages you send out without meaning to)." For example, if you stand with your arms folded very tightly, you may be sending a message by your posture that you are tense or angry.
- Always encourage a two-way conversation with the client and allow plenty of time for the client to respond. This can help the client feel valued, respected, and more confident.
- If the client is having trouble putting his or her words together to communicate, try asking Yes or No questions and encourage the client to nod or shake his or her head in response.
- A communication book, or translation book, may help some clients, particularly if they have reverted to a language that is not English. A communication book typically has pictures that illustrate the answers to commonly asked questions, such as bathroom, tired, hungry, pain, etc., along with the word(s) written in both English and the client's language. The client may be able to communicate their needs and answer your questions by pointing to pictures in his or her communication book.
- Use other methods besides speaking to connect to the client, such as gentle touching and/or guiding him or her – to the dining room, for instance.
- Try distracting the client with Alzheimer's disease if communication problems cause the he or she to become frustrated, anxious, or agitated.

How to encourage a person with dementia to communicate with you:

- Show the client a warm, loving, matter-of-fact manner.
- Hold the person's hand while you talk, palm to palm – you saw a video about the power of a palm to palm connection to clients with dementia in module 2.
- "Listen" to the client's concerns, even if they are hard to understand. You may not be able to understand what he or she is trying to tell you from the words they may or may not be able to use, so watch their body language, or the non-verbal messages the client's body is telling you.
- Keep encouraging the client to make decisions, when able, to stay involved with his or her own care and maintain independence for as long as possible.
- Be patient with angry outbursts by the client. Remember, it's the illness "talking." The client may be feeling frustrated because he or she cannot find the words to effectively communicate with you.
- If you become frustrated, and it is safe to do so, excuse yourself and take a quick break to "re-set" before re-approaching the client.
- Offer simple, step-by-step instructions.
- Repeat instructions and allow additional time for a response. Try not to interrupt the client while they are trying to come up with a response.
- Don't talk about the person as if he or she isn't there.

- Don't talk to the person using "baby talk," a "baby voice," or endearments, such as "Honey," "Dear," etc. Help the client focus in on you by using their preferred name.

Instead of:

- Pointing out mistakes, say, "Let's try this way."
- Saying, "Don't do this," try "Please do this."
- Sighing because the was not able to answer your question, try "Thanks for helping" with a smile and/or a gentle touch.
- Asking open-ended questions that require the client to come up with an answer entirely on his or her own, ask questions that require a yes or no answer. For example, you could say, "Are you tired?" instead of "How do you feel?"
- Waiting for a client to come up with an open-ended question, offer him or her a limited number of choices. For example, you could say, "Would you like a hamburger or chicken for dinner?" instead of "What would you like for dinner?" It might also be helpful to show him or her examples of each plate to choose from, in this example.
- Repeating the same question in the exact same words, try rephrasing the question or use different words if the client does not seem to understand what you say the first time. For example, if you ask the person whether he or she is hungry, and you don't get a response, you could say, "Dinner is ready now. Let's eat."

**Try not to say, "Don't you remember?" or "I told you."

Helping an Client Who Is Aware of His or Her Memory Loss

Alzheimer's disease is being diagnosed at earlier stages and because of that, there are potentially many people are aware of how the disease is affecting their memory and thinking abilities. This knowledge can be frightening and stressful for him or her and the client may need your help maintaining his or her dignity and independence. Review the suggestions below on ways you can support your clients.

- Take time to listen. The client may need to talk about the changes he or she is experiencing.
- Be as sensitive as you can. Don't just correct the person every time he or she forgets something or says something odd, and try to remember that it's a struggle for the person to communicate.
- Be patient when someone with Alzheimer's disease has trouble finding the right words or putting his or her feelings into words.
- Help the client find the words to express his or her thoughts and feelings by trying to decipher the context of his or her statements. For example, Dorothy was upset and cried after she forgot about her book club meeting. She finally said, "I wish they stopped." You try a clarification question, "You wish your friends had stopped by for you." Dorothy nodded and repeated some of the words. Then Dorothy said, "I want to go." Again, you decipher her statement and ask a clarification question, "You want to go to the book club meeting." Again, Dorothy nodded and repeated the words.
- Be careful not to put words in the person's mouth or "fill in the blanks" too quickly.
- As people lose the ability to clearly speak, they may rely on other ways to communicate their thoughts and feelings. For example, their facial expressions may show sadness, anger, or frustration. Grasping at their undergarments may tell you they need to use the bathroom.

Conclusion: You will find many challenges working in health care, and especially in working with clients who have Alzheimer's disease or other types of dementias. You have learned, through these modules, about dementia and AD, tips and suggestions for communicating and

caring for your clients and challenges you may face and tips to overcome those challenges – all while doing your best to encourage, support, and promote dignity and independence for your clients.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.15 Clean and Safe Environment	XX/XX/XXXX

There are many ways staff can prevent injuries and accidents to self and clients:

- Know your clients
- Know your limits
- Respond to emergency calls immediately
- Follow your assignment sheet, care sheet, or task record, if available
- Report unsafe equipment
- Know procedures:
  - Ask questions if you are not sure
  - Do not perform a task you have not been taught
- Get help when necessary
- Know the fire safety policies and procedures of the facility (refer to Emergency Preparedness training module and policy and procedures)
  - Be alert to fire safety violations (smoking rules, oxygen safety, electrical equipment, unsafe wires, and overuse of extension cords)
- Maintain your own health
  - Staff should stay away from facility when ill; call facility when illness prevents you from being available for work
- Use proper precautions when working with contaminated items (refer to Infection Control training module and policies and procedures)
- Be alert to client's safety at all times
  1. Clean up spills immediately
  2. Be alert for sharp objects and remove as able
  3. Be aware that glaring bright, or dim light may affect the vision of the client
  4. Clutter in the hallways pose a tripping threat to clients, remove clutter when possible
  5. Be on the lookout for unsafe electrical use and extension cords

MERTKA: Minnesota Employee Right To Know Act

Be aware of the "Right-to-Know Act" (Minnesota Statute 182.65), which ensures employees are aware of the dangers associated with hazardous substances, harmful physical agents, or infections agents they may be exposed to in their workplace.

A written Employee Right-to-Know (ERTK) program is required in every facility. The facility will identify hazardous substances, harmful physical agents, and infectious agents that are present in the workplace and provide information and training to employees who are "routinely exposed" to those substances or agents.
"Routinely exposed" means that a reasonable potential exists for exposure to hazardous substances, harmful physical agents, or infectious agents during the normal course of the employees' work assignments.

The written ERTK program includes:

- An inventory of hazardous substances and/or agents that exist in the workplace
- Identification of employees who are routinely exposed to those substances or agents
- A system for obtaining and maintaining written information about the substances and agent's employees may be exposed to in the workplace
- Methods for making ERTK information readily accessible to employees in their work areas
- A plan for providing initial, pre-assignment, and annual training of employees
- Implementation and maintenance of a labeling system or other warning methods

This information is usually kept in a book with all the safety data sheets (SDS) sheets (previously known as material safety data sheets- MSDS) which should be kept in a common area in case of emergency exposure. Follow the directions on the SDS sheet or call poison control. (Attachment)

The location of this book in your facility is: _____.

A Workplace Accident and Injury Reduction (AWAIR) Act

All Comprehensive Home Care (CHC) and Housing with Services (HWS) facilities will have a written, comprehensive workplace safety and health program designed to comply with Minnesota Statue §182.653, subd. 8 (known as A Workplace Accident and Injury Reduction (AWAIR) Act).

The AWAIR program must address an accident and injury reduction program that promotes safe and healthful working conditions and is based on clearly stated goals and objectives for meeting those goals.

The program will include:

1. How managers, supervisors and employees are responsible for implementing the program and how continued participation of management will be established, measured, and maintained
2. The methods used to identify, analyze, and control new or existing hazards, conditions, and operations
3. How the plan will be communicated to all affected employees so that they are informed of work-related hazards and controls
4. How work place accidents will be investigated, and corrective action implemented
5. How safe work practices and rules will be enforced

Your facility will conduct and document a review of the work place accident and injury reduction program at least annually and document how procedures set forth in the program are met and if they are effective. It is encouraged that all staff actively participate. It is the responsibility of ALL employees to report any unsafe conditions that may cause injuries to our clients and/or staff.

General Safety Guidelines

There are certain safety rules and guidelines related to the workplace that can help to keep employees safe and healthy.

The following safety guidelines support and encourage employees to keep safety as a priority for themselves and the people we serve.

- Come to work mentally alert and prepared to work safely
- Keep safety as a priority in all your work routines
- Report unsafe working conditions to your manager/supervisor immediately
- Report all accidents and injuries to your manager/supervisor immediately
- Know the specific safety requirements and equipment of your assignment and work locations
- Keep work areas, entryways, and high traffic areas neat, orderly, and free of obstacles
- Know where to find and how to use your work site fire extinguisher
- Periodically perform safety checks of equipment and keep all safety guards in place
- Wipe up spills immediately
- Use protective equipment when necessary
- Use proper lifting techniques always

Other common work-place safety hazards include, but are not limited to:

- Wet Floors
- Uneven surfaces
- Coffee or other hot beverages that may cause burns, are they too hot or do certain clients need assistance
- Handrails that are loose

IN THE EVENT OF A WORK-RELATED INJURY OR ILLNESS:

- Employees should immediately report the incident/injury/illness to a supervisor or manager and seek medical attention if appropriate.

Proper Lifting Techniques:

Improper lifting technique can lead to back, leg, and arm pain. Poor technique can cause both acute injury and serious chronic effects. Learning the right way to lift will help you avoid these problems.

Here's how to practice good lifting techniques:

1. Plan ahead before lifting
    a. Knowing what you are doing and where you are going will prevent you from making awkward movements while holding something heavy
    b. Clear a path, and if lifting something with another person, make sure both of you agree on the plan
2. Lift close to your body
    a. You will be a stronger, and more stable lifter if the object is held close to your body, rather than at the end of your reach. Make sure you have a firm hold on the object you are lifting, and keep it balanced close to your body
3. A solid base of support is important while lifting.
    a. Holding your feet too close together will create instability, while feet too far apart will hinder movement. Keep your feet about shoulder width apart and take short steps
4. Bend your knees and keep your back straight (See pictures above)
    a. **HINT: Keeping your eyes focused upwards helps to keep your back straight
5. Practice the lifting motion before you lift the object and think about your motion before you lift. Focus on keeping your spine straight - raise and lower to the ground by bending your knees
6. Tighten your stomach muscles
    a. Tightening your abdominal muscles will hold your back in a good lifting position and will help prevent excessive force on the spine
7. Lift with your legs
    a. Your legs are many times stronger than your back muscles - let your strength work in your favor. Again, lower to the ground by bending your knees, not your back
8. If you're straining, get help
    a. If an object is too heavy, or awkward in shape, make sure you have someone around who can help you lift
9. Wear a belt or back support
    a. If you are lifting often, either in your job or at home, a back belt can help you maintain a better lifting posture.

Tips to Remember:

- Never bend your back to pick something up
- Injuries can lead to short- or long-term disability and can end your career. It is just not worth the damage that improper lifting technique can cause
- Always hold the object close to your body
- You are a much more stable lifter if you are not reaching for an object
- Do not twist or bend
- Face in the direction you are walking. If you need to turn, stop, turn in small steps, and then continue walking
- Keep your eyes up
- Looking slightly upwards will help you maintain a better position of the spine

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.16 HIPAA	XX/XX/XXXX

What is HIPAA?
HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs
- Reduces health care fraud and abuse
- Mandates industry-wide standards for health care information on electronic billing and other processes
- Requires the protection and confidential handling of protected health information
- Calls for unique health identifiers for individuals, employers, health plans, and health care providers

HIPAA Privacy Rule
The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

The Privacy Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.

The Privacy Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

HIPAA Security Rule
The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information (PHI) that is created, received, used, or maintained by a covered entity.

The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

HIPAA Breach Notification Rule
The HIPAA Breach Notification Rule requires HIPAA covered entities and their business associates to provide notification to affected individuals following a breach of unsecured protected health information. A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information.

Similar breach notification provisions implemented and enforced by the Federal Trade Commission (FTC), apply to vendors of personal health records and their third party service providers, pursuant to section 13407 of the HITECH Act.

Identifier Standards for Employers and Providers
HIPAA requires that employers have standard national numbers that identify them on standard transactions. The Employer Identification Number (EIN), issued by the Internal Revenue Service (IRS), was selected as the identifier for employers and was adopted effective July 30, 2002

HIPAA requires that health care providers have standard national numbers that identify them on standard transactions. The National Provider Identifier (NPI) is a unique identification number for covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

HIPAA Enforcement Rule
The HIPAA Enforcement Rule contains provisions relating to:

- Compliance and investigations
- The imposition of civil money penalties for violations of the HIPAA Administrative Simplification Rules
- Procedures for hearings

FAQs from U.S. Department of Health & Human Services:
https://www.hhs.gov/hipaa/for-professionals/faq/index.html

Protection and Confidential Handling of Health Information

- The HIPAA Privacy regulations require health care providers and organizations, as well as their business associates, develop and follow procedures that ensure the confidentiality and security of protected health information (PHI) when it is transferred, received, handled, or shared.
    - This applies to all forms of PHI, including paper, oral, and electronic, etc.
- Furthermore, only the minimum health information necessary to conduct business is to be used or shared.

Simple tips to remain compliant:

- Close and lock computer screens when you walk away.
- Do not leave care sheets or other client identifying papers laying out.
- Be aware of your surroundings when speaking to coworkers regarding client care, do not discuss confidential information in public spaces or in front of other clients.
- Ensure client information is only give to those that the client has given permission to receive health information.

Notice of Privacy Practices

It is the responsibility of all health care providers to distribute a written notice (Notice of Privacy Practices) to all home care clients, which addresses the health care provider's policies and procedures regarding:

- The treatment, use, and disclosure of individually identifiable health information
- The home care provider's legal duties with respect to such information

The notice of Privacy Practices must include all elements and statements that are required by law. In summary, the Notice of Privacy Practices will inform the clients about the potential uses

and disclosures of their health information, as well as their rights with respect to that information, including:

1. A description of each of the purposes for which the home care provider is permitted to disclose a client's health information, including, for example:
    a. Treatment
    b. Payment
    c. Health care operations
2. A description of when written authorization is required before the home care provider may disclose the client's health information in other instances.

EXPECTATIONS OF THE HOME CARE PROVIDE:

1. The home care provider will provide the Notice of Privacy Practices to each client at the time of admission or when service is first provided to the client, whichever is first, and obtain written acknowledgment of receipt of the notice
2. A signed copy of the Notice of Privacy Practices will be kept in the client's record
3. The home care provider will provide a copy of the Notice of Privacy Practices to clients and to any other person upon request
4. The home care provider will post a copy of the Notice of Privacy Practices in the following locations:
    a. In the home care provider's office
    b. On a bulletin board in a public area of a HWS community
    c. On the home care provider and HWS websites
5. If there is a material change in the home care provider's use and disclosure policy that affects the rights of home care clients, legal duties imposed, or the practices of the Home Care Agency, then a new Notice of Privacy Practices will be posted.
    a. Material changes will not be implemented until a revised notice has been posted.
    b. Updated Notices ~~do~~ will not be provided to clients but will be made available upon request.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.17 Siderails	XX/XX/XXXX

Siderails – Many Names and Types - Definitions

Adult Portable Bed Rails are defined by the U.S. Food and Drug Administration as:

- Any bed rail product or device that is attachable and removable from a bed, not designed as part of the bed by the manufacturer and is installed on or used along the side of a bed. They are available in a variety o shapes and sizes; some bed rails run the entire length of the bed, half the length of the bed, or a quarter or less the length of the bed.
- These rails are used on beds intended for consumers and are intended to:
    - Reduce the risk of falling from the bed;
    - Assist the consumer in repositioning in the bed; or
    - Assist the consumer in transitioning into or out of the bed

Hospital Bed Rails are defined by the U.S. Food and Drug Administration as:

- Bed rails that are intended to be either part of or an accessory to a hospital bed or other FDA-regulated bed
- These are considered medical devices

Siderails in the Home Care, Housing with Services, and Assisted Living world have many names, although they are ALL considered siderails:

- Siderails
- Grab bars
- Grab rails
- Bed mobility devices
- Hand rails
- Transfer bar/pole
- U-bar

Entrapment is when an individual is caught, stuck, wedged, or trapped

- Between the mattress/bed and the siderail
- Between the siderail bars
- Between the floor and siderail
- Between the headboard and siderail

Falls (related to siderail use) occur when an individual:

- Falls off the siderail
- Climbs over a siderail
- Falls and hits the siderail

Potential Benefits of Siderail Use

When installed, used, and maintained properly, siderails may be very helpful to the client

- Maintaining independence

- Getting in and out of bed
- Turning and repositioning
- Reducing the risk of falling out of bed

Risks with Siderail Use

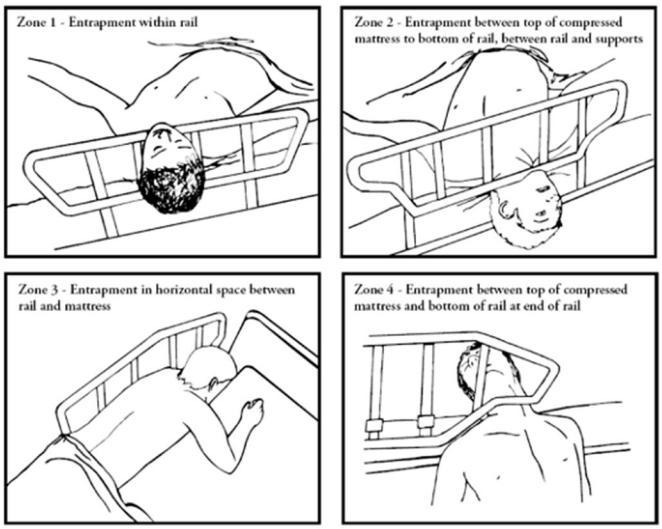
- Injury
- Death

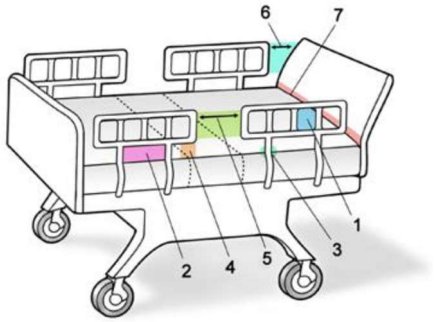
The FDA and the U.S. Consumer Product Safety Commission (CPSC) track injury and death reports from entrapment or falls related to the use of siderails.

Siderail Guidance

The U.S. Food and Drug Administration (FDA) has published dimensional guidance for siderails (2006 FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment), and these guidelines are considered the current industry standards, which Home Care, Housing with Services, and Assisted Living providers are held to. The 2006 FDA dimensional guidance identifies "zones" – openings and gaps – that should not exceed 4.75 inches, to reduce entrapment.

- **PAY ATTENTION – Siderail zones 1,2, and 3 must not exceed 4.75", and zone four – under the siderail, at the end of the rail should not exceed 2.375**





Client Rights versus Provider Responsibility

The Home Care Bill of Rights and the basic Tenant/Landlord relationship allows your clients and/or their families or representatives to use siderails for any variety of reasons – or no reason at all!

The responsibility of Home Care, Housing with Services, or Assisted Living providers is to:

1. Assess the client's cognitive and physical abilities, including their ability to call for help if entrapment occurs

2. Assess compliance with and maintain the siderails, according to manufacturer's instructions and the 2006 FDA dimensional guidance
3. Educate the client and/or representatives on the risks of entrapment, including injury and death

- **PAY ATTENTION – All staff should be watchful and report new siderail devices to the RN immediately!**

Assessments:

- When siderails are in use, the RN conducts an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail.
- If the siderail is acting as a restraint, appropriate action should be taken to educate staff and families, if appropriate, that this is not an acceptable use for siderails.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.18 Fall Risk & Prevention	XX/XX/XXXX

Objective: Staff will understand the risks of falls among the elderly and be able to:

- Identify fall risks
- Encourage client awareness to manage risk of falls
- Understand the risks of restraints

Falls Among the Elderly

Falls are common among the elderly. In fact, many of the clients you care for may have chosen to move in, so they can benefit from the extra care you can provide to minimize the risks and outcomes of falls.

A 2016 MDH report on adverse events in Minnesota showed that Minnesota hospitals reported 67 cases of falls which resulted in serious injury or death in 2015. Serious injuries include, but are not limited to:

- Hip fractures
- Broken bones
- Head injuries

Other, less serious injuries include:

- Abrasions
- Bruises
- Lacerations
- Skin tears

Additionally, falls often:

- Reduce independence
- Reduce mobility
- Increase fearfulness

Reduced mobility and increased fearfulness can also lead to depression and social isolation – these behaviors can lead to less activity, which can weaken the client further and lead to additional falls. It can be a never-ending cycle!

Fall Risk Factors (also referred to as Causative Factors when investigating a fall)

Physical and medical risk factors for the elderly include, but are not limited to:

- Weakness and/or loss of strength in muscles and bones
- Vision changes, including decreasing depth perception, sensitivity to light/glare, and trouble adjusting to lighting changes
- Balance problems
- Weakening and slowing of reflexes
- Medical issues, which can lead to:
    - Numbness in legs and feet
    - Loss of blood to the brain, causing dizziness and fainting
    - Poor eyesight

- Medications, which can affect:
    - Balance
    - Judgement
    - Coordination
    - Sleep patterns
    - Alertness

Environmental risk factors can include:

- Clutter
- Throw rugs
- Slippery surfaces
- Inadequate lighting

Episodic risk factors can include:

- Short-term illnesses, such as colds, flu, urinary infections, etc.
- Stressful situations, such as moving from their homes or changes in routines
- Recent falls

Awareness and Managing Fall Risks

More than half of falls occur in the home, particularly in bedrooms and bathrooms. Be aware and look out for environmental dangers, such as loose rugs/area rugs, excess clutter, clients who ambulate without shoes or non-skid socks, etc. It's important to encourage your clients to:

- Eliminate or minimize fall risks in their apartment
- Be as independent as possible with ambulation and mobility to build and maintain strength
- Participate in regular exercises to build and maintain strength
- Appropriately use grab bars in showers, next to the toilet, etc.

It is important that after each fall, including near-falls (e.g. client is lowered to the floor by staff), an incident report is completed and forwarded to the RN. The RN is responsible for following up on all falls, including completing a fall risk assessment, if necessary, and attempting to identify the causes of the fall and implement interventions to reduce the risk of future falls and injury.

Risks of Restraints

FDA evidence shows that use of restraints, including siderails, can increase the risk of injuries and/or death in elderly clients. Staff should attempt to minimize the use of restraints, in addition to monitoring environmental, physical, and medical risks. Less restrictive interventions may include toileting programs, a lowered bed, more frequent monitoring during the night, and other individualized interventions.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.19 Recognition of Client Needs	XX/XX/XXXX

Recognition of Physical, Emotional, Cognitive, and Developmental Needs of the Client

Physical Needs:
Physical needs are those that are involved with human survival.

- Food/ Drink
- Shelter
- Sleep
- Oxygen
- Hygiene

Signs of unmet physical needs may include weight loss, homelessness, insomnia, shortness of breath, unkempt appearance, chronic illness.

Emotional Needs:
Emotional needs are those that are involved with a sense of well-being. Security and safety

- Connection to others- socialization and meaningful relationships
- Community, being a part of something
- Leisure-recreation, meaningful engagement opportunities

Signs of unmet emotional needs may include anxiety, depression, isolation, suicidal thoughts.

Cognitive Needs:
Cognitive needs are those that are involved with the brain and carrying out simple to complex tasks. Processing Information

- Attention Span
- Memory
- Language
- Visuospatial Abilities-refers to a person's capacity to identify visual and spatial relationships among objects.
- Executive Functioning- managing self and resources available to achieve a goal.

Signs of unmet cognitive needs may include memory loss, poor judgment, difficulty speaking/ word finding difficulties, forgetfulness, clumsiness/ unsteadiness, inability to conduct activities of daily living.

Developmental Needs:
Developmental needs are those that are involved with the act or process of growing, progressing, developing or even declining.

- Affiliating with own age group
- Adapting to decreases in health/ strength
- Adapting to retirement/ reduced income
- Securing appropriate housing arrangements
- Death of a spouse
- Meaning of life, and facing own death

Signs of unmet developmental needs may include, loneliness, isolation, depression, anxiety, homelessness, grief, veering from or becoming closer to faith.

Observing, Reporting, and Documenting of Client Status

One of the most important tasks of a caregiver is identifying a change in a resident's condition and communicating this change to the nurse. As the front-line worker and the caregiver, it is important to identify changes while caring for or visiting a resident.
Some changes may seem so subtle but may be very significant. Changes may come on suddenly and be an obvious marked change in usual symptoms and signs. Follow your employer's protocol for notification of your nurse and documentation of change of condition.
Examples of changes to document **and** to notify your nurse of are:

- Seems different than usual
- Talks or communicates less
- Personality or mood change: for example, a change or fluctuation in behavior, memory, or mood from usual, new onset of talking of wanting to die.
- Participates less in activities than usual
- Change in speech (for example slurred speech)
- Overall needs more help: Needs more help with cares, walking, transferring, toileting, eating.
- Change in stability with walking (for example, less steady or seeming to favor one side).
- Pain – new or worsening; Moans or grimaces (for residents with severe dementia)
- Eating less than normal (no intake for 2 consecutive meals)
- Complains or observation of difficulty swallowing or coughing with fluids at meals.
- Nausea/ Vomiting
- Drinking less than normal
- New or worsening swelling in one or both lower extremities
- No bowel movement in 3 days or diarrhea
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused or drowsy
- Change in pattern of sleep
- Complains of dizziness
- Change in skin color or condition (skin tears, new open area, bruising, redness, rash)
- Change in the appearance of an existing wound: for example, a recent minor wound is now developing redness, swelling or pain.
- Using the toilet more frequently or change in continence
- Change in urine appearance (for example: blood in urine)
- Change in stools: for example, appears to have blood in stool or stools are loose when normally they are formed
- New or persistent cough
- Shortness of breath: New or Increased.
- Fever

DOCUMENTATION

For all staff making an entry into client records, the following elements are required

1. Each page in client's record contains client's first and last name.
2. All entries are dated with month, day and year.
3. The record is legible to someone other than the writer.
4. All entries in the medical record contain the 3 key elements of author's identification:

a. First Name
b. Last Name
c. Credentials (for example: RN, LPN, CNA, TMA, PCA, ULP)

5. Document *objectively* (e.g. who, what, when, why, how – just the facts) versus subjectively (e.g. Sally was out of control last night!)

* Entries requiring initials will contain the first initial of both first and last names, and should be on a master signature sheet in each clients' chart (or located per facility policy) to identify the owner of each set of initials

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.20 Communication & Professional Boundaries	XX/XX/XXXX

Objectives: Provide Unlicensed Personnel with effective communication skills that include preserving the dignity of the client and showing respect for the client's preferences, cultural background, and family. Identify the difference between healthy and unhealthy boundaries between clients and staff.

Effective Communication with Clients
Purpose of Communication: to exchange information AND to maintain relationships with other people. Communication is:

- ✓ A fundamental aspect of all human relationships
- ✓ The way we "connect" with other people

Caring and communication are inseparably linked. You cannot hope to communicate effectively if you do not care about the person on the receiving end.
– P. Morrison & P. Bernard, 1997

Key Components of the Communication Process
Sender: person sending the message
Receiver: person taking in the message
Verbal message: the words that are spoken.
Nonverbal message: the way that the words are spoken, including the look on your face, your tone of voice, the posture of your body, and gestures that you use.
Feedback: the return of information to the sender
Context: the physical and social environments or settings in which messages are sent
Perception: our ability to select, organize, and interpret sensory information into an understandable and meaningful picture of the world;
-- perception is affected by our sensory abilities.
-- there may be differences between our perception and "reality."
-- behaviors and responses depend on what is perceived!

Changes to Communication: Age-Related Changes
With advancing age, all five senses tend to decline. Changes in hearing and vision are most likely to affect communication.
Hearing: A general loss of hearing may result from disease, excessive loud noise, or bone changes; gradual
loss of ability to hear certain sounds such as "S, SH, and CH" and high frequencies is common
Vision: Changes in vision often include reduced ability to see distant objects, objects that are too close (even faces) and certain colors; loss of ability to see to the sides (peripheral vision) is common
With age, reaction time slows: More time is needed to "process" the information and come up with "the
answer"

Barriers to Communication: Language

- Do you speak the same language as your client?

Barriers to Communication: Disease and Disability

Many different types of disease, illness, and even medication side-effects may alter the person's abilities to communicate.

- Dysarthria: A medical term that is used to mean that a person has difficulty speaking because they can't form (articulate) the words; speech may be slurred or difficult to understand
- Oral Health: Loss of teeth may impair speech; medication side-effects that decrease saliva and cause "dry mouth" may also impair speech
- Lung disease: Inadequate "wind" or decreased respiratory capacity to speak can make the person difficult to hear or understand; e.g., emphysema, asthma, COPD
- Brain Injury: Several different types of brain disease and injury may result in loss of language abilities; e.g., stroke, dementia, trauma to the head
- Aphasia: A medical term that is used for disease-related loss of language; may be either receptive or expressive; this type of impairment includes the loss of ability to name items, put together sentences, understand and act on what is heard, read or written
- Expressive aphasia: involves the loss of ability to express oneself through speech
- Receptive aphasia: involves the loss of ability to understand the spoken word
- Stroke: Cardiovascular accident (CVA), commonly called stroke, destroys brain cells in specific areas of the brain; losses tend to be stable; may create either receptive or expressive aphasia
- Head trauma: Injury that causes brain cell death; losses tend to be permanent and stable
- Dementia: Alzheimer's and other types of dementia destroy brain cells gradually with loss of language occurring over time; losses are permanent and interfere with every aspect of the person's ability to communicate

Interventions to Improve Communication: Apply Principles of Person-Centered Care:

- Let the person know you care through your tone of voice, facial expressions, words and gestures.
- Listen to criticism, complaints, sadness without disagreeing, "correcting," retaliating, or withdrawing
- Listen without interrupting, cutting the person off, or "tuning out" what is being said
- Listen for MEANING. What is the real problem or the real message?
- Take time to be interested in the things that are right (positive parts of their life) as well as to talk about their problems
- Show interest in positive attributes/strengths while talking about problems
- Listen thoughtfully to personal stories, experiences: What is the person saying?
    - Each person has a lifetime of experiences possibly similar but still different then our own
    - Each culture has its own unique beliefs, practices and acceptable and unacceptable behavior
    - Each religion has its own unique history and core values. For example: Is the client not eating because of a religious belief?

    - Each family has its own unique history and family dynamics. Are we being respectful of the family and still maintaining the safety and wellbeing of the client?
- Reinforce strengths, abilities, what is going well for person
- Slow down and focus on the PERSON, what he/she is saying, doing, communicating!
- Talk with the client while cares are being provided, and not ONLY about the care itself!
- Provide more light so that the older person can see you, if necessary
- Avoid standing too close so that you don't get blurry
- Stay in front of the person where they can see you
- Use yellows & reds vs. greens and blues for signs or markers
- Make sure that glasses are clean, comfortable, and ON the person!
- Accommodate changes in hearing
- Make sure that the person can read your lips, face the client and do not cover your mouth
- If you need to talk louder, try to lower your tone of voice.
- Make sure hearing aides are IN and batteries are fresh!
- Are they afraid that someone else will hear what they are saying, or that you will be interrupted? (e.g. Is their privacy being respected?)
- Assess the person's level of personal comfort: Are they physically comfortable?
- Are they distracted by hunger, thirst, pain, or needing to use the toilet?
- Use words that are familiar and understandable; avoid medical jargon and slang
- Be clear and concise; avoid long, wordy explanations or instructions
- Use "yes/no" questions if needed to help participation
- Try large-print instructions on signs to improve function
- One-step instructions may increase comprehension and cooperation.
- DO the instructions need to be translated to that resident's primary language?
- Add physical gestures to verbal cues to get the person started
- Limit choices to two options as needed to promote success
- Take responsibility for misunderstandings; apologize and explain what you were thinking/experiencing
- Respond to the person's emotional tone and validate feelings (e.g., understandable to feel frustrated, angry)

"Boundaries are mutually understood, unspoken physical and emotional limits of the relationship between the patient and the nurse." (Farber, 1997)

The health and well-being of clients depends upon a collaborative effort between the caregiver and the client. Clients are extremely vulnerable to boundary violations because they trust us as their healthcare providers. They come to us in a time of need, presenting with physical, and often emotional, distress. Some patients demand continuous attention but are unaware of their insatiable neediness. (Muskin and Epstein, 2009)

When you speak ill of coworkers or the facility/agency, you are looking for sympathy from the client, so they feel sorry for your situation, whatever that may be. However, by speaking ill of coworkers and/or the facility you also instill fear and/or distrust against the staff and facility in the client. For instance, if you speak to a client about the poor staffing ratio or your inability to perform a task, in order to receive that sympathy and/or achieve a power position you instill fear

and/or distrust towards the staff and/or facility in the client. You are using their situation, vulnerabilities, and caregiver-client relationship for personal gain.

SECTION	FORM	EFFECTIVE/REVISED DATE
Training	1.21 Basic Knowledge of Body Function	XX/XX/XXXX

Changes in Body Functioning:
Recognizing changes in a client's condition requires a team approach to monitoring the wellbeing of clients. Changes in functioning may be subtle at first.
Changes in functioning may be a result of an injury or may be related to the recent onset of a new condition or the increase in symptoms related to a chronic condition. To recognize a change in condition, it is helpful to gain a basic understanding of body functioning.

Basic Knowledge of Body Functioning and Systems:

- The job of the **circulatory system** is to move blood, lymph fluid, nutrients, oxygen, and hormones around the body, and remove waste products such as carbon dioxide. It consists of the heart, blood, and blood vessels which include arteries, capillaries, and veins. The lungs also play a role in the circulatory system as this is where the blood picks up oxygen and drops off carbon dioxide.

- The **digestive system** consists of a series of connected organs that together, allow the body to break down and absorb food, and remove waste. It includes the mouth, esophagus, stomach, small intestine, large intestine, rectum, and anus. The salivary glands, liver, pancreas and gallbladder also play a role in the digestive system because they produce digestive juices.

- The **endocrine system** consists of nine major glands that secrete hormones into the blood. These glands include the pituitary gland, pineal gland, pancreas, adrenal gland, thyroid gland, parathyroid gland, hypothalamus, ovaries, and testes. These hormones, in turn, travel to different tissues and regulate various bodily functions, such as metabolism, growth and sexual function. The gastrointestinal tract (part of the digestive system) also has glands that secrete hormones that help regulate the digestive process.

- The **immune system** is the body's defense against bacteria, viruses and other pathogens that may be harmful. It includes lymph nodes, the spleen, bone marrow, lymphocytes (which are a type of white blood cell), the thymus and leukocytes, which are white blood cells.

- The **lymphatic system** includes lymph nodes, lymph ducts and lymph vessels, and the spleen. This system plays a role in the immune system and circulatory system. Lymph is a clear fluid that contains white blood cells, glucose, protein molecules, and salts. Its main job is to keep bodily fluid levels in balance and help defend against pathogens. It keeps bodily fluid levels in balance by helping to remove excess lymph fluid from bodily tissues and returns it to the blood. It helps defend against infection because it carries foreign bodies, like bacteria, into lymph nodes where white blood cells can fight off the bacteria.

- The **nervous system** controls both voluntary action (like conscious movement) and involuntary actions (like breathing) and sends signals to different parts of the body. The central nervous system includes the brain and spinal cord, and nerves. The peripheral

nervous system consists of sensory neurons, and nerves that connect to one another and to the central nervous system.

- The body's **muscular system** consists of about 650 muscles that aid in movement, helps maintain posture, and helps circulate blood flow throughout the body. There are three types of muscle: skeletal muscle which is connected to bone and helps with voluntary movement, (meaning we have to think about the movement we want to make before moving), smooth muscle which is found inside organs and helps to move substances through organs (this muscle is involuntary, meaning we do not have to think about the movements they make), and cardiac muscle which is found only in the heart and helps pump blood (this muscle is also involuntary).

- The **reproductive system** allows humans to reproduce. The male reproductive system includes the penis, scrotum and the testes, which work together to produce sperm. The female reproductive system consists of the vagina, uterus, fallopian tubes and, ovaries, which produce eggs. During conception, a sperm cell fuses with an egg cell, which creates a fertilized egg that implants and grows in the uterus. The mammary glands and breasts are also a part of the reproductive system.

- Our bodies are supported by the **skeletal system**, which consists of 206 bones and is the framework of the body. The skeleton not only helps us move and provides protection to vital organs, but it's also involved in the production of blood cells, the storage of calcium and other minerals, and the release of hormones. The teeth are also part of the skeletal system, but they aren't considered bones.

- The **respiratory system** main function is to take oxygen and expel carbon dioxide. The respirator system is made up of two “tracts”, the upper respiratory tract and the lower respirator tract. The upper respiratory tract consists of the nose, sinuses, pharynx, and larynx, which plays a role in speech. The lower respiratory tract consists of the trachea, lungs, bronchi, and diaphragm. The lower respiratory tract is where air intake, gas exchange, oxygenation of the blood, and expelling of carbon dioxide occurs

- The **urinary system** eliminates waste from the body (urine), regulates blood volume and blood pressure, and controls levels of electrolytes. The whole system includes two kidneys, two ureters, the bladder, two sphincter muscles and the urethra. Urine produced by the kidneys travels down the ureters to the bladder and exits the body through the urethra.

- The **skin, or integumentary system**, is the body's largest organ. It protects us from the outside world, and is our first defense against bacteria, viruses and other pathogens. Our skin also helps regulate body temperature, generates Vitamin D through sun exposure, and eliminates waste through perspiration. In addition to skin, the integumentary system includes hair and nails.

Vital Organs

Humans have five vital organs that are essential for survival, meaning a person could not survive if one or the pair of them were entirely removed. These are the brain, heart, kidneys, liver and lungs.

- The human **brain** is the body's control center, receiving and sending signals to other organs through the nervous system and through secreted hormones. It is responsible for our motor skills, balance, behavior, sleep, organ function, language, vision, hearing, thoughts, feelings, memory storage, and general perception of the world.

- The human **heart** is a responsible for pumping blood and providing oxygen throughout our body.

- The job of the **kidneys** is to remove waste and extra fluid from the blood. The kidneys take urea out of the blood and combine it with water and other substances to make urine. The kidneys also release hormones that regulate blood pressure and produce red blood cells.

- The **liver** has many functions, including detoxifying of harmful chemicals, breakdown of drugs, filtering of blood, secretion of bile, storage of vitamins and minerals, breakdown of storage of fat in your diet, breakdown of protein, storage of extra blood sugar, production of immune system factors, and production of blood-clotting proteins.

- The **lungs** are responsible for removing oxygen from the air we breathe and transferring it to our blood where it can be sent to our cells. The lungs also remove carbon dioxide, which we exhale.

Our **Physical Needs** are those that must be met for our bodies to function and be healthy. According to Maslow, a physical need is something critical to the survival of the human body.

Physical needs could be described as:

- Food
- Sleep
- Air
- Shelter from Heat and Cold
- Hydration
- Disposal of body waste

Our **Emotional Needs** are those that must be met for our emotional and mental sense of well-being. We think of emotional needs as feeling loved, appreciated, understood and supported. When our emotional needs do not feel fulfilled, we may feel frustrated, anxious, depressed, angry, fearful. In Healthcare, we need to be aware of changes in the emotions of those to whom we are providing services. Also, be aware that residents may have existing diagnoses of physical conditions that effect their emotions.

Our **Cognitive Needs** are the needs we have related to being able to carry out brain-based skills, from the simplest task to the most complex. Diseases such as Alzheimer's and other dementias impact the ability for people to complete brain-based skills. Tasks that used to seem simple, may become too complex and require simplification.

Our **Developmental Needs** can be described as the needs we have for functioning at our optimal capacity and continuing to move forward in personal growth and abilities.