Bird in the Hand Healthcare Staffing
Home Nursing Training

Communication

Communication is a huge key point in taking care of a loved one/or a resident. So, yes, the way you use communication can be perceived and analysed by others so that they may react and be affected accordingly. As a result of making your job simpler, considering, things should go smoother in your communication somehow comes across as degrading or negative, then it will be viewed and taken as that, which in turn would ultimately make the job more difficult.

Communication is the process of sending and receiving a message. It consists of verbal and non-verbal communication. Verbal communication has to do with words, whether they are written, read, or said aloud.

Some examples of non-verbal communication or "body language" are: messages sent through either facial expression, gestures, tone of voice, eye contact, and touch.

Examples of good communication: be patient, listen, body language, keep things and words simple and easy to understand. Examples of bad communication: dont argue with anyone, interrupt a conversation, appear bored or impatient, pass judgment or give advice, and threaten or use harsh language.

When caring for a patient that is vision impaired, it is best to explain what you are doing as you do it, say their name to get their attention, use common sounds, such as ringing a bell, whistling, etc., make sure eyeglasses have up-to-date prescriptions and are clean.

The best way to communicate with a deaf or hearing impaired elder involves: using visual actions, get their attention before talking to them, talk at a normal pace, raise your voice some and lower your tone, absolutely no yelling, no background noises that can be distracting.

To be able to communicate fluently with a speech imparied elder there are some examples to help along the process. For example, keep it simple and clear, have patience, and pay attention to body language so you can gauge their tone and attitude.

In the event of a patient becoming angry, don't take it personally. Often, they are upset about the situation and don't know how to handle it. Give them some space and listen to their concerns.

Observation, Reporting, and Documentation

When you observe your clients, you take note of facts and events. Observations may be subjective or objective.

If a client *tells* you something, it is subjective information and should be written inside quotation marks. (For example, Mrs. Smith states, "I feel like I'm getting a cold.")

Objective observations include things you can see, hear, smell and feel.

- With your eyes, you can see a client's: Daily activities such as eating, drinking, ambulating, dressing and toileting. Body posture. Skin color, bruising or swelling. Breathing pattern. Bowel movement (including the color, amount and consistency). Urine (including color, amount and frequency). Facial expressions (such as smiling, frowning, grimacing or crying).
- With your ears, you can hear a client's: Raspy breathing. Coughing. Sneezing.
- With your nose, you can smell a client's: Breath. Body odor. Environment (such as an unusual chemical odor or gas leak).
- With your fingers, you can feel a client's: Skin temperature. Skin texture. Pulse.

The Rules of Good Documentation

- RULE #1: MAKE IT COMPLETE! In general, your documentation will be complete if you include: The correct date and time. The client's correct name. The tasks you perform with each client and how the client responds to your care. Any changes you notice in a client's condition. Any care that was refused by the client. Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.) Your signature and job title.
- RULE # 2: KEEP IT CONSISTENT! Documentation is consistent when it remains true to the client's care plan. Physician and nursing orders. The observations that your coworkers have made about the same client. Your documentation will be consistent if you: Use workplace-approved medical terms and abbreviations. Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why. **Tell your supervisor right away if you notice changes in a client's condition** so that your observations can be shared with other members of the health care team. This keeps your coworkers from documenting incorrect information. For example, you take your client's BP and it's suddenly very high. If you don't inform the nurse, she may document that the client's vital signs are normal. This can cause confusion and have a negative effect on client care. If you make home

health visits, be sure your documentation matches the visit frequency ordered by the physician.

- RULE #3: KEEP IT LEGIBLE! Remember, the purpose of documentation is to communicate with other members of the health care team. (If you are the only person who can read your handwriting, your documentation won't communicate anything to anybody!) Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed".) Watch your handwriting . . . messy documentation could come back to haunt you in a lawsuit. Print with block letters. Cursive handwriting tends to be hard to read and should not be used in a medical chart. Flow sheets are often used as a quick way to document vital signs, weights and other tasks. If you use flow sheets, make sure they are legible. Here are a couple of tips: Fill out the flow sheet properly. For example, do you circle numbers or words on the flow sheet? Or, are you supposed to make marks like X's or checkmarks? Don't try to cram long narrative documentation onto a flow sheet.
- RULE #4: MAKE IT ACCURATE. Documentation is accurate when it is true. Your documentation will be accurate if you: Use appropriate medical terms and abbreviations that have been approved by your workplace. Use correct spelling and proper English. Double check that you've written down the correct client name (and ID number, if required). Handle errors correctly. Record only the facts...not your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you guess to be true, like "Client acts like she's on drugs". Instead, stick to the facts, like "Client is unable to stand up without assistance and called me by her mother's name several times". Record what a client tells you by quoting his exact words. For example: If your client says, "I want my daughter to visit", don't put what he said in your own words such as "client misses his daughter". That's not really what he said!
- RULE #5: FINISH ON TIME! Documenting on time means writing information down as it happens and turning in your paperwork when it is due. Your documentation will be on time if you: Write information down immediately. For example, if you take a client's vital signs, document them right away. Don't wait until you finish your care and leave the room. The longer you wait, the more likely you are to forget some of the details. Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like "Day Shift". Note the time of your arrival and your departure from each client's home. Use the proper time format according to your workplace policy. For example, some healthcare organizations use a twelve hour clock, noting whether it's AM or PM. Others use a twenty-four hour clock—also called military time. Using

military time, 6:00 PM is written as 1800. All documentation must be completed prior to leaving after a shift. (Remember: completing visit notes on time helps you and your workplace get paid!)

Reading and Recording Vitals

Reading and recording a patient's temperature, pulse, and respirations is one of the most important things you will do in your career as a Certified Nursing Assistant (CNA). Why is it so important? For two simple reasons:

a. These measurements are quick, simple, and very reliable indicators of a person's basic state of health.
b. Abnormal changes in these measurements are one of the quickest, simplest, and most reliable indicators that someone is ill.

Body temperature is basically a measurement of how warm or cold we are. It represents a balance between two things: the amount of heat we produce and the heat we lose. Traditionally, normal body temperature has been defined as an oral temperature of 98.6°F. The F stands for Fahrenheit. Fahrenheit is simply the name of one of the systems of measurement that can be used to record body temperature. However, "normal" body temperature differs from person to person by as much as 1°. The body temperature can be measured a) orally, b) rectally, c) by placing the thermometer in the armpit, d) by placing the thermometer in the ear canal (the otic method), or e) by placing a thermometer against the forehead. An extremely high body temperature is called hyperthermia. The terms fever and hyperthermia are sometimes used interchangeably, but they are not the same. Hyperthermia is defined as a body temperature that is 40.5°C/104.91°F or higher. A low body temperature is called hypothermia. Hypothermia is defined as a temperature that is less than the lower limit of normal, specifically less than 97°F orally, less than 98.6°F rectally. Notify an RN or your supervisor immediately if the patient's body temperature is abnormally high or if there has been a significant change from the patient's normal baseline.

The pulse - the waves of blood the heart sends out with each beat - is a measurement of the number of heartbeats per minute. The average adult has a pulse of 60-100 beats per minute. A pulse rate that is below the lower limit of normal is called bradycardia. A pulse rate that is above the upper limit of normal is called tachycardia. An irregular pulse occurs when the interval between each heartbeat is different. In most circumstances, bradycardia, tachycardia, and an irregular pulse are considered to be abnormal. The two simplest and most commonly used sites for checking the pulse are: a) the chest, directly over the heart, using a stethoscope, and b) on the side of the wrist using the radial artery, palpating with the fingers. Make a note of the heart rate and the rhythm (regular or irregular) and record it in the proper place in the patient's chart. If the heart rate is abnormally slow or fast or irregular, notify an RN or the supervisor immediately.

Respiration is the medical term for breathing. The respiratory system delivers oxygen to the blood when we inhale and helps eliminate by-products of metabolism (specifically, carbon dioxide) when we exhale. Depending on the need for oxygen or the need to eliminate carbon dioxide, the respiratory rate - the number of breaths in a minute - can increase or decrease. The respiratory rate can be influenced by the environment, stress, drugs, illness, activity level, or injury. Look at the patient's chest, count the number of breaths the patient takes for 30 seconds and then multiply times two: that will be the respiratory rate. A respiratory rate that is below the normal limits is called bradypnea. A respiratory rate that is above the normal limits is called tachypnea. Notify the R.N. or your supervisor if the patient's respiratory rate is below or above the normal limits or is unusually slow or fast for that patient.

Infection Prevention and Control Procedures

Equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wearing gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

The following are six (6) standard precautions, identified by the Center for Disease Control and Prevention (CDC) Healthcare Infection Control Practices Committee (HICPAC), which apply during any episode of patient care: 1. Hand Hygiene; 2. Environmental Cleaning and Disinfection; 3. Injection and Medication Safety; 4. Appropriate Use of Personal Protective Equipment; 5. Minimizing Potential Exposures; and 6. Reprocessing of reusable medical equipment between each patient and when soiled.

Examples of infection control practices include monitoring work related employee illness and infections, analyzing them in relation to patient infections, and taking appropriate actions when an infection or communicable disease is present to prevent its spread among staff, patients, family and visitors.

Recognizing & Reporting Abnormal Observations

In addition to abnormal vital signs, other examples of things that need to be reported include:

- Cold or Flu symptoms: report any fever, chills, congestion, drainage from eyes or nose, or cough so treatment can be started right away before symptoms worsen.
- Trouble Sleeping: report if your client has trouble falling asleep or staying asleep. Insomnia is a common side effect of many medications and can often be corrected.

- Problems with routine ADL's: You should notice and report if your client is having new or increasing difficulty with activities of daily living. The level of care may need to be increased.
- Changes in vision or hearing: Let your supervisor know if your client has any new or worsening vision or hearing problems. Often a trip to the eye or ear doctor is all that is needed.
- Change in ability to ambulate: Be sure to report and document if your client is unable to ambulate safely. A physical therapist or new assistive equipment may be needed.
- New symptoms of one sided weakness: one sided weakness is a sign of a stroke. Report this immediately so treatment can be started and damage can be minimized.

When giving a verbal report to the nurse or supervisor, be sure to use the client's full name, and even address to correctly identify the client. Be factual in your reporting. Use objective information as much as possible. Remember, objective information is measurable and can be confirmed. It is not an opinion or a judgment.

Be sure to document your observation in the client's chart, even if you've given a verbal report to the nurse. Be sure to include the date and time of the observation in addition to the name and title of the person to whom you reported to.

Housekeeping

Always remember: protect your eyes and skin, read all label instructions, do not mix cleaning products, leave cleaners on a surface only for recommended time, change cleaning water when moderately dirty, and store all cleaning products safely.

Light housekeeping includes, but is not not limited to: tidying up of rooms in which the client spends his/her time (bedroom, living room, kitchen), washing dishes after meals (wiping spills on sink or floor, "spot cleaning), sweeping kitchen floor when needed, passing the vacuum in rooms used by client, tidying bathrooms after use by the client (rinsing tub or shower after use, wiping spills on sink or floor).

The caregiver does not provide a general housekeeping service as this should be provided by a professional home cleaning agency. It is recommended that clients engage an independent cleaning service for tasks such as: scrubbing floors in the kitchen and bathrooms, carpet cleaning, window washing, dusting behind and under furniture, drapery cleaning and heavy laundry.

Recognizing Emergencies

If you ever think a situation is too dangerous or risky to handle alone, you should always call 911 or a designated emergency number. Some examples of emergencies are:

- Cardiac emergencies: Heart attacks, Sudden Cardiac Arrest, breathing emergencies
- Choking
- Bleeding emergencies (yes nosebleeds can be an emergency too)
- Sudden illnesses: Diabetic emergencies, shock, allergic reactions, seizures
- Suspected broken bones/bruising
- Environmental emergencies: Heat related or cold related situations
- Poisoning

You should always have sound judgment and keep calm. The victim suffering is most likely experiencing not only physical pain but some type of emotional and situational turmoil in their head. As a responder, you don't need to have every answer at your disposal. It is imperative you keep the victim calm, and assure them that you have the situation under control.

Here is how to decide what the best plan of action is to respond:

1) Check the scene, then check the person
    a) Checking the scene makes sure nothing will happen to you when you respond. If you have deemed your scene safe to enter, proceed by checking the person. Make note if the victim is conscious or not and then use them to help assess the situation at hand. You can ask them all about how they got into this situation and use your first aid skills to help them out. If the victim is not conscious, CALL 911 or the designated number immediately. Furthermore, you can proceed to care within your scope of practice and certification.
2) Call the appropriate phone number
    a) 911 is the best phone contact but sometimes there are other designated numbers in place (look for emergency contacts) so be mindful of that small detail. It is important either way to call someone and alert others of the situation.
3) Care for the individual
    a) When providing care to anyone in an emergency situation always make sure to use proper PPE (Personal Protective Equipment). Furthermore, proper PPE can lower the risk for infection and the spread of disease.

Only do what you are trained to do (act within your scope of practice). When you care for someone, it is noteworthy to provide care that is consistent with your level

of training and certification. When you administer care consistent with your degree of training you are ensuring you are protecting the victim and protecting yourself.

Client-Centered Care

The patient has the right to -

Have his or her property and person treated with respect;

Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;

Make complaints to the agency regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the agency;

Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to -

Completion of all assessments;

The care to be furnished, based on the comprehensive assessment;

Establishing and revising the plan of care;

The disciplines that will furnish the care;

The frequency of visits;

Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;

Any factors that could impact treatment effectiveness; and

Any changes in the care to be furnished.

Receive all services outlined in the plan of care.

Personal Hygiene and Grooming

Bathing helps eliminate body odors, and it's cool, refreshing, and relaxing. Also, helps stimulate circulation and exercises parts of the body. Always allow the resident to try and complete things on their own. It helps them build confidence and strength. Four types of bathing: complete bed bath, partial bed bath, tub bath, and shower. confidence and strength. When giving a bed bath, you assemble equipment, wash your hands, explain the procedure to the client, offer a bedpan or urinal, cover the resident with bath blanket and fold top covers down, remove care recipient's clothing, help to the side of the bed closest to yourself, ask water temperature preference, and make a mitten out of the washcloth for easier work.

Hair Care: the caregiver may assist the client with the maintenance and appearance of their hair, including shampooing with a shampoo that does not require a physician's prescription, drying, combin, and styling. Washing the hair does not need to be done every day. The client's chart should be reviewed for specific instructions or an immediate supervisor consulted on how often this should be done.

The procedure includes:

- Wash your hands.
- Apply disposable gloves.
- Use warm, not hot water. The best temperature is 115°F, 46.1°C.
- Position the client so that his or her head is as close to the edge of the bed as is safe and practical.
- Place a towel or small pillow underneath the client's shoulder blades.
- Place a waterproof bed protector underneath the client's head and shoulders.
- Place a slightly damp washcloth over the client's eyes.
- Position a basin underneath the client's head to capture the water and shampoo.
- Wet the hair thoroughly, apply the shampoo, and then rinse it off. Using a small amount of water will help with hair drying. Dry the hair with a towel.

Nail Care is limited to soaking of nails, pushing back cuticles without utensils, and filing of nails. Caregivers are not allowed to trim nails. Nails becoming broken or brittle may be the result of improper diet. However, they can also be the result of improper care. Unless directed to, there should never be a reason for you to cut a diabetic's nails. Nail care should be done every day.

Oral Hygiene should be given every morning and after each meal. Illness and disease may cause someone to have bad breath and infections in their mouth. There are certain things to look for in/on a resident's mouth, including: dry, cracked, or blistered lips. Redness, irritation, sores, or white patches in the mouth or on the tongue. Bleeding, swelling, or extreme redness to the gums. Dentures need the same persistent care that natural teeth receive and should always be stored in a container filled with cool water. They will dry out and warp otherwise.

Toileting: the caregiver may assist the client to and from the bathroom, provide assistance with bed pans, uinals, and commodes; provide peri care; or change clothing and pads of any kind used for the care of incontinence. The caregiver may empty or change external urinary collection devices such as catheter bags or suprapubic catheter bags. The caregiver may empty ostomy bags and provide assistance with other client-directed ostomy care only when there is no need for skilled skin care, observation, or reporting to a nurse. The caregiver may not perform digital stimulation, insert suppositories, or give an enema. A bedpan is used when the resident cannot get out of bed. The bedpan should be cleaned immediately after it is used. Clean by emptying the contents in the toilet, rinsing in cold water, and wiping both the inside and outside with disinfectant. Always remember to wipe front to back and change the location of the washcloth with each wipe. Use soap and water or pre-moistened wipes. Incontinence is

defined as the lack of ability to control the bladder and/or bowels. Every two hours, the resident needs to be checked to see if a change is needed. This is also the best time to view skin. Report significant changes to the supervisor. Apply powder or lotion as directed. NEVER ever show anger or disapproval when the resident wets or soils. Be matter-of-fact and show respect towards the resident. NEVER refer to the incontinence pad or brief as a "diaper". You can help the client feel better about themselves by handling the situation properly.

Safe Transfer Techniques and Ambulation

If the patient is able to support his/her own weight, assistance may not be needed. The patient may be able to move from place to place without help, you should only stand by for safety as needed.

If the patient is able to partially support their own weight, assistance will be necessary. This may involve a stand and pivot technique and may include the use of a transfer belt. Remember, a manual transfer is intended to **assist,** NOT lift a patient.

When ambulating with a patient, you walk beside the patient and provide assistance. It is important to prepare the area before ambulating with the patient. Make sure that the room is not cluttered and remove any obstacles. A cluttered room increases the chances of trips or falls.

Sometimes a transfer belt, or gait belt, is necessary for assistance with ambulation. The belt should be fitted snugly around the client's waist. The belt is simple to apply and provides a secure grip to assist you in transferring or walking with a client.

Passive & Active Range of Motion and Positioning

Range of motion (ROM), is the full movement potential of a joint, aka, how far it can move. Passive range of motion is when you move with help from an external force like gravity, a stretch strap, or someone physically stretching you. Active range of motion is where you have a muscular contraction of the tissues producing the movement without any assistance.

Everyone positions themselves when they sit, stand, move, and lie down. The position we use for these activities affects circulation, joint pressure, and muscle use. People with limited mobility who sit or lie down for long periods of time are prone to skin breakdown and deterioration of muscles or nerves. Using correct positioning can prevent these problems. It is important to limit pressure over bony parts of the body by changing positions. Use pillows to keep knees and/or ankles from touching each other. Clients who are bedridden should avoid lying directly on their hip bones when on their sides. Assist clients to use positions that spread weight and pressure evenly, with pillows placed to provide support and comfort.

Important things to remember when positioning:

a. Always be familiar with a client's plan of care. Specific issues such as fractures, skin integrity, and health condition will determine the type of positioning that should be done.
b. Turn individuals who cannot turn themselves at least every two hours when in bed. A person in a wheelchair should change positions at least every hour. External pressure from staying in one position compresses the skin's blood vessels and obstructs circulation, especially over the bones, leading to skin breakdown.
c. When moving a client, lift rather than drag. Dragging creates friction and heat, which can lead to skin breakdown.
d. Straighten sheets and clothing to remove wrinkles.

Range of motion exercises and proper positioning can help prevent the permanent disabilities and life-threatening complications that often result from immobility. Caregivers need to intervene to prevent physical decline and deterioration. We can accomplish this by keeping clients moving.

Adequate Nutrition and Fluid Intake

Nutrition is about eating a healthy and balanced diet so your body gets the nutrients that it needs. Nutrients are substances in foods that our bodies need so they can function and grow. They include carbohydrates, fats, proteins, vitamins, minerals, and water. Good nutrition can lessen our risk of developing chronic diseases, such as heart disease, diabetes and osteoporosis and can also help us stave off colds and infections. Good nutrition can help to reduce high blood pressure and high cholesterol. Healthy eating habits can also increase your energy levels, improve your wellness & well-being and help you recover from illness or injury. The right food choices and a balanced diet provides the body with the nutrients and energy it needs to function properly and can prevent malnutrition.

Signs and symptoms of malnourishment:

- Weight loss/weight gain
- Muscle weakness
- Lethargy/tiredness
- Increased number of falls
- Constipation
- Poor skin health/pressure sores
- Depression
- Changes in behavior/cognitive problems/memory loss
- Increased infections

Good hydration is critical for maintaining bodily functions, including the heart, brain and muscles. Water is the best at rehydrating the body, however, you can supplement it with other liquids such as tea, juice or milk as needed in order to meet

fluid requirements. It is important that you promote hydration by reminding and encouraging them to drink. It is a good idea to have a glass of water within easy reach of the individual and replenish their drink regularly.

Signs and symptoms of dehydration:

- Thirst/dry mouth
- Dark concentrated urine
- Urine passed infrequently in small amounts (less than 3 or 4 times a day)
- Headache
- Muscle cramps
- Drop in blood pressure – dizziness, unbalanced
- Change in mood or mobility
- Confusion
- Constipation
- UTIs

Problem Solving for Challenging Behavior with Dementia

Because they're not able to clearly communicate their needs, people with dementia may lash out when they're afraid, frustrated, angry, or in pain or discomfort. Since you're feeling attacked, your instincts might prompt you to argue and fight back – but that only makes the situation worse.

Here are some tips for dealing with aggressive behavior:

- Be prepared with realistic expectations. Knowing that these episodes are a common part of the disease reduces your shock and surprise when it does happen and may also make it a little easier to not take the behavior personally.
- Try to identify the immediate cause or trigger. Think about what happened just before the aggressive outburst started. Something like fear, frustration, or pain might have triggered it.
- Rule out pain as the cause of the behavior. Many individuals with dementia aren't able to clearly communicate when something is bothering them. Instead, being in pain or discomfort could cause them to act out. Check to see if they need pain medication for existing conditions like arthritis or gout, if their seat is comfortable, or if they need to use the toilet.
- Use a gentle tone and reassuring touch. Staying calm and breathing slowly helps to reduce everyone's anger and agitation. Speak slowly and keep your voice soft, reassuring, and positive.If appropriate, use a gentle and calming touch on the arm or shoulder to provide comfort and reassurance.

- Validate their feelings. Try to look for clues to their emotions in their behavior and speak in a calm and comforting way. Reassure them that it's ok to feel that way and that you're there to help.
- Calm the environment. A noisy or busy environment could also trigger aggressive dementia behavior.
- Shift focus to a different activity. If the current or previous activity caused agitation or frustration, it could have provoked an aggressive response. After giving the resident a minute to vent their feelings, try to shift their attention to a different activity – something they typically enjoy.
- Remove yourself from the room. In some cases, nothing works to calm the person.If that happens, it may be best to leave the room to give them some space and to give yourself time to calm down and regain balance. They may be able to calm themselves or might even forget that they're angry.Before leaving, check to see that the environment is safe and that they're not likely to hurt themselves while you're gone.
- Make sure you and the resident are safe and call for help in emergencies. If the resident can't calm down and is becoming a danger to you or to themselves, you'll need help from others. Contact the family emergency contact(s) and your immediate supervisor.

Understanding Dementia

Dementia is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities. Some people with dementia cannot control their emotions, and their personalities may change. 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 living. People with dementia often feel alone, isolated and left out of events and social gatherings due to their inability to easily recall places and names.

The symptoms of dementia can vary and may include:

- Experiencing memory loss, poor judgment, and confusion
- Difficulty speaking, understanding and expressing thoughts, or reading and writing
- Wandering and getting lost in a familiar neighborhood
- Trouble handling money responsibly and paying bills
- Repeating questions
- Using unusual words to refer to familiar objects
- Taking longer to complete normal daily tasks
- Losing interest in normal daily activities or events
- Hallucinating or experiencing delusions or paranoia
- Acting impulsively

- ❖ Not caring about other people's feelings
- ❖ Losing balance and problems with movement

Observe your resident closely for difficulty in eating, chewing, or swallowing. The difficulty may be caused by the muscles or nerves not working properly anymore or by the resident forgetting how to do it.

Recognizing and Reporting Changes in Skin Condition

Recognizing changes in skin is done by using your senses (what you see, hear, touch, and smell). Your client may tell you what is wrong, or you may have to look closely at the client's skin during the routine care you provide. You may even touch the client's skin during your care and observe the client's skin feels hot to the touch or bumpy. You might even smell a strange odor that could be from a sore somewhere on the client's skin.

Any new change in the skin, whether it is a change in color, temperature, amount of moisture, or how it looks, feels, or smells should be recognized, reported, and recorded. Reporting changes in skin condition is the key to getting treatment started quickly. Always report to your supervisor any new problems or changes in the client's status or skin condition when providing care to a client as well as whenever else you think is necessary.

Disaster Planning

Tornadoes can form without much of a warning. Stay alert and pay attention when a tornado watch or warning is issued in the area. A funnel cloud, roaring noises, dark skies, debris, and hail are signs you need to take shelter immediately. Although there is no completely safe place during a tornado, some locations are safer than others. Safe places include a storm cellar, a basement, or an inside room without windows on the lowest floor (such as a bathroom, closet, or center hallway).

Flash floods are the most dangerous type of flooding. Flash floods can sweep away everything in their path. Most flash floods are caused by slow-moving thunderstorms and occur most frequently at night.

Terms used to describe flood threats are:

- Flood Watch: This means flooding or flash flooding is possible. Be extremely cautious when driving, especially at night.
- Flood Warning: This means flooding is occurring or will occur soon and is expected to occur for several days or weeks. If advised to evacuate, do so immediately.
- Flash Flood Warning: This means a flash flood is occurring or is imminent. Many smartphones automatically receive flash flood warnings to alert you about flash flooding nearby, even if you are traveling. Flash flooding occurs very quickly, so take action immediately.
- Flash Flood Emergency: This means severe flash flooding resulting in a severe threat to human life and catastrophic damage is happening or will happen soon.

In the event of a fire, remember time is the biggest enemy and every second counts! It is best to protect against fire by changing the batteries in smoke and carbon monoxide detectors regularly, place a fire extinguisher somewhere easily accessible, use common sense when cooking, study the electrical cords for fraying or for broken prongs. The RACE formula stands for **R**emove any people in direct danger, **A**larm by calling the fire department, **C**ontain the fire by closing doors and windows, **E**xtinguish the fire, if possible, or **E**vacuate, if needed.

What to do during a blackout? Turn off or disconnect any appliances, equipment (like air conditioners) or electronics you were using when the power went out. When power comes back on, it may come back with momentary "surges" or "spikes" that can damage equipment such as computers and motors in appliances like the air conditioner, refrigerator, washer, or furnace. Only use a flashlight for emergency lighting. Never use candles! Leave one light turned on so you'll know when your power returns.