Agency for Health Care Administration Approved
Temporary COVID-19 Personal Care Attendant Program

The Agency for Health Care Administration (AHCA) has approved to temporarily allow Personal Care Attendants (PCA) to perform resident care procedures currently delivered by Certified Nursing Assistants (CNA) in skilled facilities* (Chapter 400 F.S.). The goal is to provide *nursing centers with additional staff to care for residents during the period of the State of Emergency and to train new workers to obtain the skills necessary to become a CNA. The program is effective March 28 through May 1, 2020, or until such time AHCA finds it necessary to extend or discontinue the program to meet the needs of the crisis.

Per the AHCA PCA program approval, Personal Care Attendants who complete the 8-hour preservice course meet the provisions of Section 400.211 Florida Statutes:

1) To serve as a nursing assistant in any nursing home, a person must be certified as a nursing assistant under part II of chapter 464, unless the person is a registered nurse or practical nurse licensed in accordance with part I of chapter 464 or an applicant for such licensure who is permitted to practice nursing in accordance with rules adopted by the Board of Nursing pursuant to part I of chapter 464.

2) The following categories who are not certified nursing assistants under part II of chapter 464 may be employed by a nursing facility for a period of 4 months:
   a. Persons who are enrolled in or have completed, a state-approved nursing assistant program

Examples of What a Personal Care Attendant Can Do:

- Make an Occupied or Unoccupied Bed
- Pass Fresh Ice Water
- Pass Meal Trays/Open cartons & packets
- Check Resident Temps
- Perform One (1) Person Transfers
- Reposition the Resident in Bed/Float Heels
- Transfer the Resident to a Wheelchair using a Gait Belt
- Use a Gait Belt to Assist with Ambulation
- Oral Care/Denture Care (alert residents)
- Provide a Bed Bath/Perineal/Catheter Care
- Change an Incontinent Brief
- Assist the Resident with Getting Dressed
- Assist with Hearing Aids
- Assist the Resident to Bathroom or to use a Urinal (1 Person Assist)
Temporary COVID-19 Personal Care Attendant

Eight (8) Hour Preservice Course

5-Hour Classroom & 3-Hour Simulation/Competency Check-Off

with Continued On-the-Job Training

Overview
This program permits a skilled facility (Chapter 400. FS) to employ a trained Personal Care Attendant (PCA) to assist direct care staff with resident’s activities of daily living in accordance with their training. The resident care tasks allowed of a PCA are those defined as the competencies trained in the preservice 8-hour course. This program will enable the PCA to further obtain skills and training toward the goal of successfully passing the CNA exam and moving into a career as a Certified Nursing Assistant (CNA).

The goal is to provide nursing homes with additional staff to care for residents during the period of the State of Emergency and to train new workers to obtain the skills necessary to become a CNA. The Personal Care Attendant program is established under section 400.211 (2)(a) Florida Statutes addressing “persons who are enrolled in or have completed a state-approved nursing assistant program” to be “employed by a nursing facility for a period of 4 months.”

Scope
The PCA position is a temporary accommodation made by the State of Florida to address work increases and staffing shortages caused by the 2020 COVID-19 pandemic. The position and its attendant training are implementations by the Agency for Health Care Administration (AHCA) for the purposes and directives of Governor Ron DeSantis on March 1, 2020, “Declaration of Public Health Emergency for Coronavirus Disease 2019 Outbreak” (Executive Order). The PCA position will be authorized from March 28 through May 1, 2020, or until such time the Agency for Health Care Administration finds it necessary to extend or discontinue the program to meet the needs of the crisis.

Personal Requirements
A candidate for training must be at least eighteen (18) years of age. There are no minimum educational requirements.

Training Standards
Completion of all training and documentation requirements for PCA candidates is the ultimate responsibility of the training/hiring facility.

The PCA training course must be taught by an RN.

Training must consist of five (5) hours of classroom teaching and three (3) hours of supervised simulation in which the PCA candidate exhibits competency in all areas of training.

PCA program must be developed using applicable portions of the Nurse Aide Curriculum. The curriculum may be supplemented with additional resources relevant to current industry concerns and regulatory directives or guidance concerning COVID-19.
Upon the completion of instruction, PCA candidates must simulate and demonstrate competency in all required care procedures.

Under observation by the instructor, PCA candidates will first simulate procedures while working together in pairs or teams. Next, the instructor (or the instructor with the assistance of a licensed nurse) must observe each candidate’s simulation of required skills and document the candidate’s competency.

Upon completion of the eight (8) hour course, the facility will maintain a record of all PCA candidates who complete training and demonstrate required competencies to AHCA. When requested by AHCA, the facility will provide the names of all PCAs working in the facility at the time of the request.

The facility must fully notify its certified and licensed staff members that PCAs have a limited scope of permissible work, and detail what duties may not be delegated to PCAs. If the facility learns that any PCA is performing duties outside the limited scope of permissible work, it must immediately intervene, stop the PCA, and reassign those duties to authorized personnel.

PCAs shall report to the facility’s Charge Nurse/Manager on Duty.

**Required Areas of Instruction/Competency**

I. **Resident Rights/HIPAA/Abuse & Neglect (15 minutes)**
   - A. Response to a witnessed (or reported) breach
   - B. Immediate reporting of Abuse and Neglect to Nurse/Manager on Duty

II. **Infection Control (30 minutes)**
   - A. How infection is spread (chain of infection/modes of transmission)
     1. COVID-19 and facility policy for screening
   - B. Hand Hygiene (Handwashing, ABHR, Cough Etiquette)
   - C. Standard Precautions/Personal Protective Equipment
   - D. Handling of clean and soiled linens
   - E. Disinfection of common use articles/equipment/high touch objects/areas

   *Note: The PCA will not be assigned or provide care or services to a resident in Isolation Precautions.*

III. **Emergency Procedures (15 minutes)**
   - A. What to do when a Resident is found on the floor
   - B. Choking: Heimlich Maneuver

IV. **Activities of Daily Living (120 minutes)**
   - A. Initial Steps/Responding to a call light
   - B. Obtaining a temperature (all routes other than rectal), reporting/documentation
   - C. Making an unoccupied bed/handling of linens
   - D. Turning and repositioning the Resident while in bed
   - E. Making an occupied bed
   - F. Transfer from bed to chair/wheelchair/Use of Gait belt- One person standby/transfer

   *Note: For anything beyond a one-person transfer, the PCA may only assist and must be directed by a certified/licensed staff member.*
G. Assistance with Bed bath/partial bath and Dressing/Undressing
H. Incontinence/Perineal Care
I. Assist to Toilet/Use of urinal (only for a resident requiring one person/standby assistance)
J. Oral Care - conscious residents only
K. Devices/Use/Storage
   1. Hearing Aids
   2. Eyeglasses
   3. Dentures
   Note: Emphasis on orthotics and prosthetics must be placed by a certified nursing assistant.
L. Final Steps/Observations to report to the Nurse

V. Skin Care/Pressure Prevention (15 minutes)
   A. Basic care/interventions/devices
   B. Offloading/floatating heels
   C. Observations to report to the Nurse/Manager on Duty
      4. Open area or skin condition observed to be lacking a dressing
         a. Emphasis on no dressing applied by the Personal Care Attendant
      5. Observed bruises, abrasions or skin tears

VI. Oxygen Use/Safety (15 minutes)
   A. Nasal cannula/tubing/storage/observing liter flow
   B. Potential hazards/safety

VII. Nutrition/Hydration (15 minutes)
   A. Mechanically Altered Diets/Thickened Liquids/Adherence to Diet
   B. Passing Trays/Retrieving Trays (set up/opening packages for residents who can consume meals independently)
   C. Passing ice water
   D. Food storage/safety

VIII. Dementia Care (30 minutes)
   A. Stages of Dementia/Overview
   B. Tips on communicating with cognitively impaired Residents
   C. Recognition of when to seek additional staff assistance

IX. Mental Health/Challenging Behaviors (30 minutes)
   A. Responding to a challenging behavior
   B. Recognition of when to seek additional staff assistance
   C. Reporting a challenging behavior to Nurse/Manager on duty

X. Review of Resident Rights, Abuse & Neglect Reporting, and Reporting to the Nurse (15 minutes)
   A. Sample scenarios of situations involving Resident Rights, abuse and neglect
   B. Review of immediate protection of Resident until assistance arrives, if abuse is in process
   C. Review of duty to immediately report to the Nurse/Manager on Duty
**Continued On-the-Job Training**

Upon completion of the initial 8-hour course, the Personal Care Attendant will work under the direct supervision of the nursing staff and in collaboration with the Certified Nursing Assistants providing ADL services to the residents. During this on-the-job training period, facilities will work with the Personal Care Attendant to further improve and expand his/her resident care skills. Facilities are further encouraged to provide continued educational training so that those Personal Care Attendants who seek a career as a Certified Nursing Assistant rise to the competency level in which they can become a Certified Nursing Assistant.
Temporary COVID-19
Personal Care Attendant Program
Training Guidance
RESIDENTS RIGHTS - Florida Statute: 400.022

Each resident shall have the right:
- Civil and religious beliefs
- Private and uncensored communication
- Visitation by any individual providing health, social, legal, or other services and the right to deny or withdraw consent at any time
- Present grievances and recommend changes in policies and services free from restraint, interference, coercion, discrimination, or reprisal
- Organize and participate in social groups (this is limited with the CDC guidance)
- Participate in social, religious, and community activities
- Examine results of recent facility inspections by federal and state agencies including the plan of correction if applicable
- Manage his/her own financial affairs
- Be fully informed, in writing and orally, of services available at the facility and of related charges for such services
- Refuse medication and treatment and to know the consequences
- Receive adequate and appropriate health care, protective and support services
- Privacy
- Be informed of medical condition and proposed treatment and be allowed participation in planning
- Be treated courteously, fairly, and with the fullest measure of dignity
- Be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints
- Be transferred or discharged only for medical reasons, the welfare of other residents, or for nonpayment of a bill
- Receive a thirty-day notice of discharge or relocation, and challenge such notice
- Choose physician and pharmacy
- Retain and use personal clothing and possessions
- Copies of rules and regulations of the facility
- Notification prior to room change
- Information concerning room reservation policy for hospitalizations

HIPAA

No sharing of resident information except with care team members
- Health Insurance Portability and Accountability Act (HIPAA) – law to keep health information private
- Social Media – posting of resident’s is considered abuse

Follow facility policy to comply with HIPPA.
INFECTION CONTROL

Novel Coronavirus (COVID-19) was first detected in Wuhan City, Hubei Province, China. The first infections were linked to a live animal market, but the virus is now spreading from person-to-person. It’s important to note that person-to-person spread can happen on a continuum. Some viruses are highly contagious (like measles), while other viruses are less so.

The virus is thought to spread mainly from person-to-person between people who are in close contact with one another (within about 6 feet) through respiratory droplets produced when an infected person coughs or sneezes.

Clean Your Hands Often to Help with Prevention of Spread

- Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, had any resident contact, or after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow.
- Throw used tissues in the trash.
- Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Each facility will have its basic Infection Control Policy. Each Personal Care Attendant (PCA) should follow the facility specific policy for screening and infection control.

The most basic activity to perform in relation to infection control is to wash your hands. The basic procedure to wash your hands is here:

Wash Hands

1. Turn on water at sink.
2. Wet hands and wrists thoroughly.
3. Apply soap to hands (if bar soap, rinse the soap first).
4. Work up lather cleansing in front and back of hands, between fingers, around cuticles, under nails and up wrist (hands-width).
5. Wash hands, applying constant friction, for at least 20 seconds.
6. Rinse all surfaces of hands and wrists while holding fingers lower than wrists.
7. Dry hands with paper towel and limit contact of towel to cleansed skin surfaces.
8. Use paper towel to turn off faucet, without contaminating hands by touching sink.
9. Disposes of used paper towel(s) in wastebasket immediately after shutting off faucet.
10. Do not contaminate hands by touching any part of the sink, your hair, your clothes, scratching your elbow, etc.
During the COVID-19 crisis, each PCA will comply with the Agency for Health Care Administration guidance from 3/19/2020:

Effective immediately staff of residential and long-term care facilities are to implement universal use of facial masks while in the facility. All staff, essential healthcare visitors and anyone entering the facility are to don a mask upon the start of their shift or visit and only change it once it becomes moist. It is important to keep hands away from the mask and only touch the straps of the mask. Gloves are to be worn when providing care to the resident. Continue to perform hand hygiene prior to donning gloves, after removing gloves, and anytime there is contact with the resident environment.

Follow facility policy for Personal Protective Equipment and Standard Precautions.

Follow facility policy for handling clean and soiled linens.

Follow facility policy for disinfecting common use articles, equipment and high use articles.

PCAs will not be allowed to provide care or services to residents with isolation precautions.

Each PCA should follow all other facility specific infection control policies.

SUDDEN EMERGENCY SITUATIONS

Emergencies can happen anywhere and at any time. In a nursing center, residents are being treated for serious diseases and conditions. Sometimes an emergency happens when a resident’s condition suddenly takes a turn for the worse or a resident has a bad reaction to a new medication. Other times a resident may be unexpectedly hurt as in a fall or other injury. A PCA may be the first person who sees an emergency situation, and his/her response can make a big difference. Your nursing center will have emergency procedures and emergency equipment; they will help you learn what to do in an emergency situation that occurs in the center.

The PCA’s role in emergency situations is to:

- Be able to recognize an emergency situation.
- Know what comes first in responding to it (for example, calling for help or making sure the resident is safe).
- Know how to protect yourself (standard precautions).
- Keep the resident safe from further harm and comfortable.
- Pay attention so that you can report what you see before, during, and after the emergency situation.
- Stay calm and control your voice; always reassure the resident.
SUDDEN CHANGE OF CONDITION

Residents may have small changes that may not be noticed unless you know what to look for. It’s important to know what to look for and what to report to help the nursing staff and physicians take better care of an older adult. Missing small changes can mean a resident may not receive the attention they need that could possibly prevent a more serious problem. A stroke may be the reason a resident is having a change in their condition.

These sudden changes in condition might mean the resident has had or is having a stroke:

- Weakness on side of the body
- Difficulty speaking
- Vision gets suddenly worse (pupils may be unequal)
- Change in mental status
- Difficulty breathing
- Seizures
- Puffing the cheeks when breathing out

General rules for reporting one of these changes in condition include:

- Call for help.
- Watch to make sure the resident’s airway stays open so they can continue to breathe
- Protect the resident’s arms, legs, and head from injury.
- Pay attention to what is happening so you can report it to the nurse supervisor.

Safety is everyone’s responsibility. It is important to make the environment as hazard-free as possible to reduce the chance of incidents and accidents to residents or health care workers. The resident feels safe, both physically and mentally, in a secure, comfortable, and well-lit environment.

These physical changes can make people more likely to have accidents:

- Decreased mobility due to decreased muscle strength
- Decreased hearing, sight, and smell
- Medications that cause dizziness or weakness
- Impaired balance due to changes in posture and center of gravity
- Decreased sense of touch
- Confusion, disorientation
- Poor judgement
- Memory loss
- Having a chronic disease
FALL PREVENTION

- Lock wheels when moving residents to and from the bed. Make sure resident is wearing non-skid shoes or slippers before transferring them from the bed or a chair.
- Lock the wheels on wheelchairs before transferring residents to and from them.
- Put the resident’s feet up on the feet of the wheelchair before unlocking and moving the wheelchair.
- Leave the resident’s bed in the lowest position (closest to the floor) when a clinical skill is finished and before leaving.
- Leave the resident’s call-light within easy reach when a clinical skill is finished and before leaving.

Falls are the most common type of accident among older adults.

Always watch areas in the facility to make sure they are free from obstructions and hazards.

Some environmental reasons for causing falls include:
- Liquid on the floor (spilled liquid or a puddle of urine)
- Inadequate lighting
- Cords or other objects which match the floor or rug
- Shoes that don’t fit
- Obstructions in the resident’s room or hallway

Use side rails when they are ordered. Make sure your resident is wearing non-skid shoes or slippers when they are walking. Also check to see that the non-skid tips have not worn off canes or walkers. Be sure to lock the wheels on wheelchairs, Geri-chairs and other equipment when transferring residents to and from them.

Most resident rooms have a night-light on the wall. Turn it on in the evening for their safety and yours if you must go in their room during the night.

Follow your facility policy for what to do when a resident is found on the floor.
OBSTRUCTED AIRWAY

An obstructed airway occurs when food or an object is lodged in the throat, cutting off the airway. Airway obstruction (choking) can lead to cardiac arrest. Most people choke during eating, with meat being the most common food that causes airway obstruction. Many elderly residents have swallowing problems. When they have difficulty swallowing, they are at a higher risk for choking. Some adults have been known to choke on their dentures.

Facility policies vary, but there are times when you may have to help a choking resident. Choking most commonly occurs when residents are laughing, talking and eating at the same time. When the food (or object) goes down the throat, it usually slips too far down for the fingers to reach. The object obstructs the airway so that the resident is unable to speak or breathe. The resident may put one or both hands to the neck. This is the universal sign for choking.

If you suspect a resident is choking, ask, “Are you choking?” If the resident signals yes, you must do something right away. The resident will be scared, pale, and cyanotic. A choking victim will lose consciousness and die of strangulation in four minutes if you do not act to save them. Abdominal Thrusts (aka The Heimlich Maneuver) is the technique used to dislodge food from the throat of a choking victim. These can be performed with the victim standing, sitting, or lying down.

FIRST, call for help and then begin Abdominal Thrusts:

1. Stand behind the victim (victim either sitting or standing)
2. Wrap your arms around the victim’s waist.
3. Make a fist with one hand.
4. Place the thumb side of the fist against the abdomen.
5. Place fist on the victim’s abdomen, centered above the navel and below the end of the sternum.
6. Grasp your fist with your other hand.
7. Press your fist and hand into the victim’s abdomen with a quick, upward thrust.
8. Repeat the abdominal thrusts until the object has been expelled or the victim loses consciousness.
9. If the victim loses consciousness, place them on their back.
10. Continue repeating abdominal thrusts while kneeling beside the victim.

Note: Abdominal Thrusts are not effective with extremely obese persons and with pregnant women. Chest thrusts are used with them instead.
ACTIVITIES OF DAILY LIVING

Room Setup

Different nursing homes provide a variety of rooms for resident comfort and care. For each resident admitted to the facility, the following is commonly provided:

- **Bed**: A bed that can either be adjusted manually (hand cranks) or electrically (push button) that causes the head of the bed to be raised and lowered, the knee section to be raised and lowered, and the entire bed to be raised and lowered. Beds come with side rails for safety, and wheels to allow them to be moved around the facility and locked for safety.
- **Privacy Curtain**: A curtain that can be pulled completely around the resident’s bed to provide privacy.
- **Call Light**: A push button apparatus attached to a 4 to 5-foot cord. When the button is pressed, it sends a signal to the nurses’ station, a light over the resident’s doorway will turn itself on, and usually, a continuous, loud beep will sound until the call light is turned off.
- **Bedside Stand**: A small cabinet next to the head of the resident’s bed. It usually contains a drawer for personal items and shelves.
- **Chair**: Either a straight back or reclining chair.
- **Over-bed Table**: A table on wheels. It can be placed over the resident’s bed or in front of the resident while he or she is sitting up in the chair. It is generally used for eating meals or as a worktable.
- **Closet**: Each resident has a separate closet and shelf for storing personal belongings.
- **Wastebasket**: Each resident has his or her own waste basket within convenient reach of the bed.

Keep the call light within reach at all times. Make sure the resident can reach the bedside stand and overbed table. Adjust room lighting, temperature, and ventilation to accommodate the resident’s comfort before leaving the room. Be aware if the door should be left open or closed due to the residents needs and requests. Seek your supervisor if unsure.

Answer call lights per the facility policy being aware of which rooms require isolation and when to not enter a room due to this reason.
MEASURING TEMPERATURES

Temperature is the measurement of body heat. The temperature at the center of the body is much higher than temperature at the surface of the body. Body temperature is at its lowest in the morning. When the resident is sick or has an infection, the body works hard to overcome the disease-causing pathogens. This causes the temperature to rise. The temperature also rises if the resident has become dehydrated. Any elevated temperature indicates that there is a problem. Report it to your supervisor right away.

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<th>Axillary</th>
<th>Tympanic</th>
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**Oral**
Do not take an oral temperature right after the resident had something hot or cold to drink. Wait 15 minutes to take the temperature if the resident has been recently:
- Eating
- Drinking
- Smoking

Do not take oral temperatures if the resident:
- Has difficulty breathing
- Is receiving oxygen
- Is unable to breathe through the nose
- Is coughing

**Axillary**
The axillary temperature is measured in the armpit. This method is not nearly as accurate as oral or rectal methods, but sometimes it is the only method possible. Loosen clothing so you have access to the resident's armpit. The armpit should be dry. Place the arm at the resident's side and wait for the digital thermometer to indicate readiness.

**Digital and Glass Thermometers**
Digital thermometers are most commonly used now in long term care facilities to take oral temperatures. To use a digital thermometer, follow the instructions and any demonstration given to you or that are in the manufacturer's directions. Follow the directions for the digital thermometer for how long to leave the thermometer in place for oral, or axillary sites.

Follow the facility’s specific thermometer operating instructions and infection control practices.

Report and document as per facility instructions.
**BEDMAKING**

Bedmaking is an important aspect of keeping the resident comfortable. As part of your morning routine, you will be making beds of the residents assigned to you. Facility policy will dictate how often the bed is completely stripped of all linens. Generally, complete bed changes are done three times a week on the resident's bath days or anytime the linens become soiled between changes. Keeping the bed clean, dry and wrinkle free promotes comfort and helps prevent pressure ulcers. Bed linens should be checked and straightened after meals and at bedtime.

You will learn two basic methods for making a resident's bed:

- **Unoccupied Bed:** when the resident is not in bed.
- **Occupied Bed:** when the resident is in bed.

Follow facility policy for procedure.

The following linens are used to make the resident's bed:

1. **Sheets:** Most facilities have fitted or contoured sheets for the bottom sheet.
2. **Pillowcases:** Some residents require several pillows in order to obtain a comfortable position in bed.
3. **Draw Sheet:** Also called a pull sheet or lift sheet; it is either a small sheet or a regular top sheet folded in half and placed sideways across the bed to cover the area from the resident’s upper back to the thighs.
4. **Underpads:** Also called protective pads; these are used to protect the linens from getting soiled by an incontinent resident. They may be disposable or made of cloth
5. **Blanket/Spread**

Follow facility policy for how often to change the bed linens.

**Change Bed Linen While the Resident Remains in Bed**

1. Wash hands before contact with resident.
2. Greet the resident, identify self to resident and address resident by name.
3. Explain the procedure to the resident, speaking clearly and slowly, maintaining face-to-face contact whenever possible. Continue to explain the procedure to the resident as you provide the care or service.
4. Ask resident about their comfort and preferences during care.
5. Place clean linen on clean surface within candidate's reach (e.g., bedside stand, overbed table, or chair)
6. Provide for resident's privacy throughout procedure with curtain, screen, or door.
7. Throughout procedure, avoid pulling sheets that may create friction and risks skin shearing.
8. Lower head of bed before moving resident. Raise bed to comfortable level for working.
9. Loosen top linen from the end of the bed and on working side avoiding exposing the resident. Try not to touch the clean linen with the linen you plan to change.
10. Assist resident to turn onto side, turning away from candidate toward the farther side of bed. Ask resident if he/she can assist you in turning and steadying themselves.
11. Loosen the tucked bottom soiled linen on working side.
12. Roll bottom soiled linen toward center of the bed and tuck underneath resident.
13. Place and tuck the clean bottom linen or fitted bottom sheet on working side, securing under the mattress at head of bed and along working side. Tuck the clean linen underneath resident without contaminating the clean sheet with the soiled.
14. Assist resident to turn back onto clean bottom sheet.
15. Candidate moves to other side of bed, now the working side.
16. Assist resident to turn onto side, turning away from candidate toward the far side of the bed. Ask resident if he/she can assist you in turning and steadying themselves.
17. Remove soiled bottom linen from bed, avoiding contact with clothes and clean linen.
18. Pull and tuck in clean bottom linen, finishing with bottom sheet free of wrinkles.
19. Cover resident with clean top sheet and appropriately remove soiled top sheet.
20. Finish with the clean linen anchored and centered. Clean top sheet is loosely tucked at the foot of the bed to allow foot movement. Clean top sheet is untucked on sides.
21. Replace pillowcase.
22. Before leaving resident, place call button within resident’s reach.
23. Leave bed in lowest position.
24. Dispose of soiled linen in soiled linen container.
25. Avoid contamination of clean linen throughout procedure.
26. Avoid unnecessary exposure of resident throughout procedure.
27. Wash hands as final step.

Always wash your hands before handling clean linens and after handling dirty linens. When removing soiled linens, roll the linens away from you so that the side that was against the resident is inside the roll. When carrying linens, always hold them away from your body and uniform. Never shake linens in the air. Shaking causes the spread of microbes.

Gather linens in the order that you will use them in and bring the right amount of linens to the resident’s room. Leftover linens in the resident’s room are considered contaminated and cannot be used for other residents.

Place clean linens on a clean surface and never put dirty linens on the floor. Before changing linens, place the bed in the highest horizontal position possible to reduce bending or stooping.

Making as much of one side of the bed as possible before going to the other side will save you time and energy. Be sure that the handles on manually operated beds are tucked under the bed for safety before leaving the room.
POSITIONING OF RESIDENTS

Residents need to be positioned according to promote comfort and general well-being, as well as to prevent pressure ulcers. For residents who spend a great deal of time in bed, proper positioning on a timely basis is extremely important to prevent complications such as pressure ulcers.

The basic positions for residents are:

• Fowler’s position: Resident is in a semi-sitting position on a 45° to 60° angle; a high Fowler’s would be up to a 90° angle. In a Fowler’s position, the resident tends to slide down, causing shearing. Placing small pillows under the thighs or behind the knees would help the resident stay comfortable and positioned.
• Lateral position: Resident is lying on his or her side with knees flexed.
• Prone position: Resident lies on the abdomen with head turned to one side.
• Semi-Fowler’s position: Resident is in a semi-sitting position with the head raised 30° to 45° and the knee portion is raised to 15°. This is a more comfortable position and the resident tends to slide down in bed less. However, since raising the knees may interfere with circulation, semi-fowler’s position may not be appropriate for all residents.
• Sim’s position: A side-lying position in which the upper leg is flexed at a sharp angle so that it does not rest on the lower leg, and in which the lower arm is behind the resident.
• Supine position: Lying flat on the back, with face up.

Turn and position residents per the specific care plan guidelines for your assignment. Any special considerations must be followed.

Transfer from Bed to Chair/Wheelchair/Use of Gait Belt/One Person Standby Transfer Note: For anything beyond a one-person transfer, the PCA may only assist and must be directed by a certified/licensed staff member.

BODY MECHANICS

Body alignment refers to the correct positioning of the major movable body parts: head, trunk, arms, and legs. The body works more efficiently when it is properly aligned.

Definition of Proper Posture:
While standing, your feet are flat on the floor about 12 inches apart and your back is straight. Your arms hang loosely at your sides and your knees are slightly flexed. Standing with your feet apart also gives you a good base of support. A good base of support is needed for balance and stability.
A gait belt, also known as a transfer belt or safety belt, is a heavy canvas belt used to safely transfer residents. Before transferring semi-helpless or helpless residents, it is placed around the resident’s waist and buckled snugly.

The belt acts as a “handle” to hold on to when lifting the resident as opposed to lifting the resident under the arms. While ambulating an unsteady resident, the belt should be held in back with a firm, underhand grasp. This helps steady the ambulating resident and can be used to guide the resident to the floor in case of a fall.

**Ambulate the Resident Using a Gait Belt**
1. Wash hands.
2. Greet resident, addressing resident by name, and introduce self.
3. Explain the procedure to the resident, speaking clearly and slowly, maintaining face- to- face contact whenever possible. Continue to explain the procedure to the resident as you provide the care or service.
4. Ask resident about their comfort and preferences during care.
5. The resident should be in a sitting position on the side of the bed.
6. Check that the resident is wearing non-skid footwear.
7. Before standing resident, place bed at a safe and appropriate level for the resident.
8. Before standing resident, apply gait belt securely around waist without restricting circulation or breathing or injury to skin. Only flat fingers/hand should be able to slide/fit under belt. Make sure the belt doesn’t catch skin or skin folds.
9. Stand in front of and facing resident.
10. Brace resident’s lower extremities to prevent slipping.
11. With the belt around resident’s waist, grasp the belt, while assisting resident to stand. Hold onto the belt.
12. Ask resident about dizziness upon standing.
13. Walk slightly behind and to one side of resident for at least 10 steps, while holding onto the belt in back of the resident or at farthest side of resident.
14. While walking, match your pace to the resident’s and ask them now and again how they feel or if they are dizzy or tired.
15. Assist resident to turn and position them to sit back into a chair. Have back of resident’s legs positioned against the seat of the chair before the resident sits.
16. Provide controlled, gentle lowering of resident into chair.
17. Remove gait belt gently without harming the resident.
18. Before leaving resident, place call button within resident’s reach.
19. Wash hands as final step.

Ensure gait belts are not shared so not to spread infection.

Some residents are unable to reposition themselves in bed and need to be turned at least every two hours. Periodically residents “slide down” in bed and then need to be lifted and repositioned higher up in the bed.

Remember the principles of proper body mechanics when moving or lifting residents.
If the resident cannot assist you in repositioning, ask other caregivers to help you. Make the bed as flat as possible before starting. You stand on one side of the bed while your co-worker stands on the other. Place a pillow against the headboard to prevent bumping the resident’s head. Use the draw sheet for lifting. On the count of 3, move the resident up in bed. (Never lift a resident by the arms because you could dislocate the shoulder.) Try not to rub the resident’s skin against the sheet when moving him up in bed. Friction can cause shearing and result in pressure ulcers.

When a resident lies flat for many hours, sitting up in bed can be quite a challenge. Many older people become dizzy or feel faint when sitting or standing up quickly. For this reason, residents are assisted in sitting on the side of the bed and dangle.

Dangling involves deep breathing and moving the legs in circles to stimulate circulation. Some residents may need to sit for up to 5 minutes before attempting to walk or transfer.

Any change in condition for the resident during a transfer, gently lower the resident to the bed, chair or floor as necessary and immediately get help. When in doubt, do not attempt to get the resident up. Lay the resident back down and go get a nurse.

**Remember:**
- Use caution when moving, lifting or transferring residents with severe arthritis or osteoporosis. Always ask for help when moving these residents to avoid causing pain or injury. Be very gentle.
- Maintain the dignity of the residents by keeping them covered and their privacy curtain pulled when moving them.
- Check the footwear of the residents to ensure they are wearing non-skid shoes or slippers.
- Be sure the wheels of beds, wheelchairs or stretchers are locked in place before use.
- Do not allow residents to place their arms around your neck for support as this can cause injury to you.

Follow facility policy for use of gait belts.

Ambulation devices assist the resident when walking. Some of the more common devices used are:

- **Walkers:** They have 4 rubber tipped legs. The resident uses the walker when extra support and stability is needed. With each step, the walker is picked up and moved forward about 6 inches. The resident then steps forward and repeats the process. Some walkers have wheels if the resident is too weak to lift the walker when stepping.
- **Canes:** Provide support to one side of the body and help balance the resident when walking. A cane is held on the strong side of the body. It is held approximately 6 to 10 inches to the side of the foot and approximately 6 inches in front of the foot. The cane grip should be level with the hip. To walk, the cane is moved forward approximately 1 foot. The weak leg is then moved forward even with the cane. The strong leg is then brought forward ahead of the cane and the process repeats.
Despite every precaution, a resident may begin to fall while ambulating. When a resident is falling, one has the tendency to try to catch the resident to prevent the fall. However, to prevent the fall could cause injury to you and the resident. When a resident starts to fall, help him/her to the floor. Easing them down this way controls the direction of the fall and allows you to be in a better position to protect their head and body from injury.

Wheelchairs

- Each resident should have a wheelchair assigned to them if that is their mode of transportation.
- Brakes should always be locked before transferring the resident to the wheelchair or when transferring the resident out of the wheelchair.
- Some residents can lock and unlock their own wheelchair breaks, but do not assume they will.
- Always check the brakes.
- Some residents need their wheelchair locked when sitting and some will propel themselves around their room.
- Please ask before caring for a resident to ensure safety.

Transfer Resident from The Bed into A Wheelchair Using A Gait Belt And A Pivot Transfer Technique

1. Wash hands.
2. Identify self to resident by name and address resident by name.
3. Explain the procedure to the resident, speaking clearly and slowly, maintaining face-to- face contact whenever possible. Continue to explain the procedure to the resident as you provide the care or service.
4. Provide for resident’s privacy throughout procedure with curtain, screen, or door.
5. Place the wheelchair near bed.
6. Before transferring resident, lock wheels on wheelchair.
7. Before transferring resident, fold footrests out of the way or remove them.
8. Before transferring resident, put non-skid footwear on resident and securely fasten.
9. Supporting the resident’s hips and back, assist the resident to a sitting position on side of bed and give them a moment to adjust to the position change before beginning transfer.
10. Apply gait belt securely around waist; avoid restricting circulation or breathing, or injury.
11. Make sure the resident’s feet are flat on the floor.
12. Position wheelchair close to bed with front interior wheel close to bed to help make the pivot transfer before beginning the transfer.
13. Stand in front of the resident, brace their legs to prevent slipping, reach under the resident’s arms to grasp and hold gait belt at back.
15. Provide instructions to enable resident to assist in transfer.
16. Count to three (or say another prearranged signal) to alert resident to begin transfer.
17. On signal, gradually assist resident to stand. Assist resident to pivot to front of wheelchair with back of resident’s legs against wheelchair. This is the pivot technique. The pivot is completed without having resident take steps to reach the wheelchair. Make sure the back of resident’s legs is against the seat of the wheelchair before sitting down.

18. Provide support for controlled gentle lowering of resident into seat of wheelchair.

19. Position the resident in proper body alignment in wheelchair with resident’s hips against back of seat.

20. Place resident’s feet on footrests.

21. Remove gait belt without causing injury to resident.

22. Before leaving resident, place call button within resident’s reach.

23. Say goodbye and remind the resident they can call if they need help.

24. Wash hands as final step.

**BED BATH/PARTIAL BATH**

Bathing is an important part of resident care. Bathing cleans the skin and mucous membranes of the genital and anal areas by removing microorganisms, excess oils, perspiration and dead skin. However, bathing has other purposes besides cleansing. A bath can be relaxing and refreshing. A partial bath consists of bathing the resident’s face and hands, axillae (underarms) and perineum.

There are certain general safety rules that need to be observed when preparing the resident’s bath:

*Provide A Partial Bed Bath and Back Rub*

1. Wash hands.

2. Identify self to resident and address the resident by their name.

3. Explain the procedure to the resident before and throughout providing care, speaking clearly and slowly, maintaining face-to-face contact whenever possible.

4. Provide for resident’s privacy throughout the procedure with curtain, screen, or door.

5. Remove or fold back top bedding, keeping resident covered with bath blanket (or top sheet).

6. Remove resident’s gown, exposing only the area that’s necessary for washing.

7. Test water temperature and ensure it is safe and comfortable before bathing resident; adjust as needed.

8. Cleanse eyes by using soap-free washcloth wiping eye from the inside corner to the outside corner, changing to clean area of washcloth before returning to inner corner and before cleansing the other eye.

9. Wash resident’s face using a soap-free wet washcloth, unless resident’s prefers using soap on face.

10. Contain corners of washcloth while washing and rinsing (forming mitt).

11. Dry face with towel, using a blotting motion.

12. Protect bedding by repositioning towel under resident throughout washing and rinsing.

13. Wash neck, hands, arms, chest, and abdomen using small amount of soap applied directly to washcloth (avoid soap applied directly into bath basin).

14. Rinse neck, hand, arm, chest, and abdomen removing soap residue.

15. Dry neck, hand, arm, and chest.
16. Using proper technique, assist resident to turn on side in order to wash back. Ask resident if he/she can assist you with turning.
17. Wash, rinse, and dry back.
18. Warm lotion in hands before applying to resident's back.
19. Provide back rub using strokes to cover from base of spine and working towards neck and shoulders using gentle long gliding and circular motions.
20. Put clean gown on resident and secure gown in back.
21. Pull up bed covers.
22. Before leaving resident, place call button within resident's reach.
23. Empty, rinse, and wipe bath basin, and return to proper storage.
24. Dispose of soiled linen in soiled linen container.
25. Leave bed in lowest position.
26. Avoid unnecessary exposure of resident throughout the modified bed bath.
27. Move resident’s body gently and naturally, avoiding force and over-extension of limbs and joints throughout the procedure. Keep resident positioned a safe distance from edge of the bed at all times.
28. Wash hands as final step.

ASSISTING WITH DRESSING/UNDRESSING

Residents in long-term care facilities usually get dressed in street clothes every day, following morning care. Residents are encouraged to wear their own clothes because it contributes to their sense of identity. Encourage the resident to choose an outfit for the day. This enhances their personal image and improves self-esteem.

Some residents will be able to dress themselves independently. Others will need some assistance and some will need total help with dressing. Clothing changes may be more frequent for incontinent residents. Special care is taken when changing the clothes of a resident with an I.V., arm injury, cast or paralysis. It is your responsibility to see that your resident looks clean and neat and clothing is in good repair. There are certain basic rules to follow when dressing residents:

- Provide for privacy and do not unnecessarily expose the resident.
- Give residents as much independence in dressing and undressing as they are physically able to manage.
- Allow the resident personal choice in what they choose to wear for the day.
- Assist residents with putting on shoes and stockings. Bending over can cause dizziness.
- Put clothing on the residents weak or paralyzed side first when dressing the resident. Never force movement. Seek guidance from supervisor.
- Support the arm or leg when putting on or removing clothing.
- Remove clothing from the strong or “good” side first when undressing the resident.

Follow facility policy.
INCONTINENCE AND PERINEAL CARE
Assist resident with incontinence as needed, per care plan, and per facility policy.
Urinary incontinence is the inability to control the passing of urine from the bladder.
Incontinent products used vary from resident to resident and facility to facility. Follow the guidelines of perineal care outlined below.

Bowel incontinence is the inability to control the passing of stool from the bowel.

Residents can have incontinence of only urine, only bowel or both.

Give Perineal Care for Female Resident Who Is Incontinent of Urine
1. Wash hands.
2. Greet resident, addressing resident by name, and introduce self.
3. Explain the procedure to the resident, speaking clearly and slowly, maintaining face-to-face contact whenever possible. Continue to explain the procedure to the resident as you provide the care or service.
4. Provide for resident’s privacy during procedure with curtain, screen, or door.
5. Test water temperature and ensure it is safe and comfortable before washing, and adjust if necessary.
6. Put on gloves before contact with linen, incontinent pad, and/or resident. Keep them on until finished with the procedure.
7. Replace soiled pad under resident’s buttocks with a fresh, dry pad before beginning perineal care (e.g. roll pad into itself with wet side in/dry side out).
8. Expose perineal area.
9. Wash entire perineal area with soapy washcloth (adding soap directly to cloth, keeping rinse water from being soapy), moving from front to back, while using a clean area of the washcloth for each stroke. First stroke should be over urinary meatus (the opening at the end of the urethra to the body surface).
10. Using a fresh, wet washcloth, rinse entire perineal area, moving from front to back while using a clean area of the washcloth for each stroke.
11. Dry entire perineal area moving from front to back, using a blotting motion with towel.
12. Replace basin of water if it becomes cold or soapy.
13. Turn resident on side.
14. Wash, rinse, and dry buttocks and rectal area without contaminating perineal area.
15. Remove wet incontinent pad or protective linen after drying buttocks.
16. Place a dry incontinent pad underneath resident.
17. Reposition resident.
18. Dispose of linen and incontinent pad.
19. Empty, rinse, and wipe basin and return to proper storage. Before touching any knobs to store items, either remove gloves or use a barrier like a paper towel to touch knobs. Dispose of any soiled linen or trash.
20. Before leaving resident, place call button within resident’s reach.
21. Leave bed in lowest position.
22. Avoid unnecessary exposure of resident throughout procedure.
23. Wash hands as final step.
**Assist Resident Toileting and Use of Urinal (Only for residents that require one person assist or standby assistance)**

Follow facility policy and procedure for one-person transfer to toilet or bedside commode, cleaning and storage.

Follow facility policy and procedure for urinal use, cleaning and storage.

Always provide privacy for residents during toileting or urinal use.

**Oral Care (Conscious residents only)**

Many residents can perform their own oral hygiene. Follow Care Plan.

Others need help gathering materials but can brush their teeth themselves. Still others may wish to perform oral hygiene while still in bed, with or without assistance. Prevent choking by having the resident sit up. Brush all surfaces of the resident’s teeth, gums and tongue. Use gentle strokes when brushing or flossing the resident’s teeth.

**Provide Mouth Care to the Resident with Teeth**

1. Wash hands before contact with resident.
2. Greet resident, address by name, and introduce self.
3. Explain the procedure to the resident, speaking clearly and slowly, maintaining face-to-face contact whenever possible. Continue to explain the procedure to the resident as you provide the care or service.
4. Ask resident about their comfort and preferences during care.
5. Provide privacy during this procedure with curtain, screen, or door.
6. Put on gloves before providing mouth care.
7. Position resident in a sitting position (at least 60° angle) before beginning mouth care.
8. Protect resident clothing before beginning mouth care.
9. Moisten toothbrush with water and apply toothpaste before brushing teeth.
10. Brush sides and biting surfaces of teeth and the gum line with a gentle motion.
11. Offer resident the opportunity to rinse mouth and spit into emesis basin or disposable cup.
12. Leave area around resident’s mouth clean and dry.
13. Remove protective clothing cover from resident.
14. Rinse toothbrush, rinse and dry basin, store equipment, and dispose of soiled linen and trash when procedure is completed. Leave overbed table dry. Before touching any knobs to store items, either remove gloves or use a barrier like a paper towel to touch knobs.
15. Maintain clean technique with placement of dentures and toothbrush throughout procedure.
16. After completing procedure, remove gloves without contaminating self and dispose of gloves appropriately.
17. Reposition head of bed to resident’s choice.
18. Before leaving resident, place call button within resident’s reach.
19. Leave bed in lowest position.
20. Wash hands as final step.
Devices/Use/Storage

Hearing Aides
- Follow facility policy for storage.
- Some facilities keep hearing aids in a locked storage location and chart they are present.
- Some residents have one hearing aide and some have two.
- Be sure to follow care plan and report concerns to the supervisor.

Eyeglasses
- Many residents have glasses and need to wear them when awake.
- Follow residents care plan and facility policy for storage.

Dentures
- Many residents have partial or full dentures.
- Follow care plan and facility policy for storage.
- Dentures are cleaned the same way natural teeth are cleaned.
- Dentures are cleaned for residents who cannot do so themselves.
- Be very careful when handling dentures.

Dentures are considered personal property and can easily be broken if dropped. To avoid embarrassment, always provide for privacy when removing, cleaning and replacing dentures. Use cold or lukewarm water and toothpaste or denture cleaner to clean dentures. Hot water can warp them and harden protein material that may have adhered to the dentures.

Dentures may be cleaned with a denture brush or a regular toothbrush. When the resident is not wearing the dentures, they should be immersed in cool water in a denture cup, covered and stored in a safe place. The cup should be clearly labeled with the resident's name. Soaking solution does not replace cleaning dentures.

Note: Orthotics and Prosthetics must be placed by a certified nursing assistant.

FINAL STEPS/OBSERVATIONS TO REPORT TO THE NURSE

Note: Any time a resident reports pain, has a problem arise, change in condition, found on the floor, elevated temp per facility policy, increase in behaviors, any allegations of abuse, safety concerns, or any problem, it must be reported to the manager on duty/nurse supervisor. This is not an all-inclusive list, but to inform you that your role is to report promptly. Follow facility policy in reporting and documentation.
SKIN CARE AND BASIC PRESSURE PREVENTION

A serious complication of immobility or bed rest is pressure sore. Pressure sores are also referred to as pressure ulcers, bedsores or decubitus ulcers (decubs or decubiti), and result from constant pressure or friction. If not treated, they can become large, painful and could be life-threatening to the resident. Pressure sores are very difficult to heal and may take weeks and even months to heal once they are formed. It is therefore best to prevent them from forming in the first place.

As a PCA, one of the most important tasks you will have is helping to prevent pressure ulcers from developing in your residents. As the primary caregiver, you have a greater opportunity to observe the resident’s skin than anyone else on the health care team does.

Some residents are more at risk for pressure ulcers than others, such as residents who are:
- Bed and chair-bound residents
- Residents with impaired ability to reposition themselves
- Incontinent
- Diabetic
- Altered level of consciousness
- Very thin
- Obese
- Inadequate dietary intake
- Impaired nutritional status
- Dehydrated

Bony areas are the most common place for pressure sores to begin. When bathing or cleaning your residents, check the skin around all bony prominent areas. A bony prominence is described as an area where the skin is thinner, and bones tend to stick out. Prominent areas would be hip bones, sacrum (tail bone), shoulder blades, knees, ankles and toes.

Pressure sores can also develop on the ears and the back of the head. In obese people, pressure sores can develop where skin covers skin, resulting in friction. Pressure sores have formed under breasts and in abdominal folds.

Friction and shearing are other causes for skin breakdown. Friction can scrape the skin off, leaving an open area for germs to enter the body. Shearing occurs when the skin moves in one direction while the tissue and bones under the skin stay fixed or move in the opposite direction. This can happen when a resident slides down in a wheelchair or slides while sitting in a Fowlers position in bed. The tissue beneath the skin becomes damaged and can lead to breakdown of the skin.
As a PCA, you have many opportunities to help prevent pressure ulcers in your residents:

- Skin should be cleaned at the time of soiling and at routine intervals.
- Avoid hot water and use a mild cleansing agent that minimizes irritation and drying of the skin.
- Minimize the force and friction applied to the skin.
- Dry, flaky, or scaling skin is at an increased risk for pressure ulcers.
- Dry skin should be treated with moisturizers.
- Minimize skin exposure to moisture due to incontinence, perspiration, or wound drainage.
- Adequate dietary intake of protein and calories should be maintained.
- Maintain activity level as possible per care plan.

PCAs will have the opportunity to work with many different techniques and devices designed to help prevent or improve pressure ulcers:

- Heel and elbow protectors (if ordered). These are thickly padded quilt-like devices that wrap around the elbow or heel and are secured with a Velcro strap.
- Pillows and foam pads
- Foam mattresses, or specialty mattresses.
- Air mattresses (also known as alternating pressure mattresses). Air continuously circulates, constantly changing the points of pressure on the residents' body.
- Reposition resident at least every two hours.
- Positioning devices such as pillows or foam wedges should be used to keep bony prominences from direct contact with one another.
- Gel mattresses, gel cushions for wheelchairs or other needed areas.

Follow the residents care plan and report any signs or redness, bruising, or open skin areas to the nursing supervisor immediately. If a dressing is found off a resident's skin or loose, notify the supervisor immediately. PCA's are not allowed to apply dressings.

Each facility will have different positioning products, so follow facility policy and protocols.

**OXYGEN USE/SAFETY**

Even though every effort is made to prevent a fire, unfortunately once in a while, fires may occur in health care facilities. PCAs must know what to do during such situations. Know the location of fire alarms, emergency exits and fire extinguishers. Defective electrical equipment and wiring, overloaded electrical circuits, and smoking are major causes of fire. Smoking is not allowed inside any building. Oxygen is highly flammable. Residents and staff who smoke can only do so in designated areas. Residents must be supervised while smoking. Follow facility policy and note that some facilities are smoke free campuses.
If the fire alarm goes off, remain calm. Remember the meaning of the acronym R.A.C.E. as to the critical steps to follow in case of a fire emergency:

R - Remove residents
Rescue whoever is in immediate danger. Move residents in the immediate area of the fire to a safe place. Do not use elevators.

A- Activate Alarm
Alert the entire facility by pulling the nearest alarm.

C- Confine Fire
Close all doors and windows. Clear hallways and emergency exits of all equipment. Turn off oxygen and electrical equipment being used in the area of the fire.

E- Extinguish the Fire
Use a fire extinguisher on a small fire that has not spread. Remove the safety pin, push down on the top handle and aim the hose at the base of the fire.

Follow facility policy for safety.

Many residents in a nursing home need oxygen therapy continuously or intermittently. PCAs should be able to know which residents they are assigned to that need oxygen therapy. Ensure the resident has the nasal cannula in their nose properly and the tubing is kept up off the floor as per infection control policy. The PCA should know what liter flow of oxygen a resident should have but should not touch the oxygen settings. If the flow of oxygen is not at the ordered level, immediately notify the nursing supervisor.

There are oxygen storage rooms in all nursing homes. Be aware of safety related to these rooms and follow facility policy concerning same.

If a resident has symptoms of shortness of breath, or concerns with oxygen therapy, the PCA should notify the nursing supervisor immediately.

**NUTRITION/HYDRATION**

Most residents have a regular diet. A regular diet is one that is not restricted in any way. It gives them a balance of foods from the recommended guidelines and allows most spices and types of cooking preparation. Other residents have special diets for a nutritional deficiency, disease, and weight control or to decrease or eliminate certain substances in the diet. These diets are called therapeutic diets.
When a therapeutic diet is ordered, you must make sure that the right resident is getting the right meal tray. Diet cards are usually present on the meal tray when the meal is served. These cards contain the residents’ names and room numbers, the type of diet they require and any restrictions or special additions. The card also relates whether the resident is on normal or double portions of food. If you have any questions about a resident’s diet, see the nurse.

The most commonly ordered therapeutic diets are:

1. Clear liquid: Includes only liquids you can see through. They are non-irritating and non-gas forming. May be ordered when a resident is suffering from nausea and vomiting or if acutely ill.
2. Full-liquid: Includes all liquids in addition to clear liquids and may be used for residents with infections, those with trouble digesting food and difficulty chewing or mouth tenderness.
3. Mechanical soft: Includes liquids, foods that are ground or chopped for easier consumption and digestion. Could be used for residents with difficulty chewing, infections, fevers or trouble digesting food.
4. Low-sodium: Is a diet low in salt. The diet does not permit prepared foods containing a lot of salt or foods that naturally contain a lot of salt.
5. Diabetic: Consists of a diet in which calories, carbohydrates, fats and proteins are controlled for residents with diabetes mellitus.
6. High-Calorie: A calorie-controlled diet for residents who need to gain weight.
7. Low-Calorie: A calorie-controlled diet for residents who need to lose weight.
8. Low-Fat: Used to control the amount of fat in the diet with increased proteins and carbohydrates. Used for residents with hardening of the arteries, liver, gallbladder or vascular heart disease.

Residents living and being cared for in nursing homes have the right to make their own choices about the food they eat. PCAs will always encourage residents to eat, but it is the resident's decision.

If a resident refuses to eat the food that has been recommended for him/her, the nurse supervisor needs to be informed so that she/he can document the decision, provide resident education, and inform the doctor.

Try to make the meal experience as pleasant as possible. Be sure the resident’s eyeglasses, dentures, and/or hearing aids are in place for each meal; provide appropriate hygiene before meals, i.e. oral care and toileting your residents prior to serving their meal or taking them to the dining room. Residents in bed should be clean, dry and in a comfortable position to eat.

Make the following observations of residents during mealtimes:

- How much food and fluids did they consume?
- Are they having trouble feeding themselves?
- How well can they see, chew, and swallow food?
- If they refused a particular food, why?
- Did they request a substitution?
- Are they having a problem with dentures? Sore mouth?
Encourage residents to eat as much as they can from all the food groups served. Encourage your residents to do as much as they are capable of themselves. Record the meal intake percent promptly. Do not rely on memory and wait until the end of shift to record.

When passing trays out to the residents, follow facility policy for trays and infections control. Some residents will need assistance to open cartons to set up their food.

Follow the facility policy for passing water to residents. Always check which residents are on restricted fluid intake or needs thickened liquids.

Follow the facility policy for food storage.

Note: PCAs cannot feed a resident.

**DEMENTIA CARE**

Dementia is an “umbrella” term that describes the loss of intellectual functions such as thinking, remembering, and reasoning of sufficient severity to interfere with a person’s daily functioning. Dementia is not a disease by itself, but a constellation of symptoms. When a person has dementia, he/she will lose the ability to think, reason and remember and will inevitably need assistance with everyday activities such as dressing and bathing. Changes in personality and mood are also symptoms of Alzheimer’s dementia.

*Signs and Symptoms of Dementia*

- Memory loss (short and long term)
- Confusion
- Loss of reasoning and intuition
- Inability to learn new things
- Poor judgment
- Loss of ability to use knowledge
- Loss of ability to carry out motor tasks or follow directions
- Inability to recognize people or objects
- Personality changes
- Frustration, withdrawal, suspiciousness, or restlessness
- Disturbance of sleep cycle
- Inability to perform activities of daily living
- Inability to recognize friends or family
- Emotional instability
**Mild Alzheimer’s Disease**

As the disease progresses, memory loss worsens, and changes in other cognitive abilities are evident. Alzheimer’s disease is often diagnosed at this stage. Problems can include:

- 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
- Mood and personality changes
- Performance issues in social and work settings
- Decline in ability to plan or organize
- Decreased knowledge of recent occasions or currents
- Impaired ability to perform challenging mental arithmetic: such as counting backwards

**Moderate 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 tasks that involve multiple steps (such as getting dressed)
- Hallucinations, delusions, suspiciousness, and paranoia
- Impulsive behavior, repetitive behaviors
- Unable to recall any important details—address, phone number or high school they attended.
- Tend to wander and become lost.
- Recollect their personal history imperfectly.

**Severe Alzheimer’s Disease**

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

- Inability to communicate
- Weight loss
- Difficulty swallowing
- Garbled speech
- Increased sleeping
- Lack of control of bowel and bladder
When people lose their word skills, nonverbal communication becomes critical. Sometimes people with Alzheimer’s disease who no longer understand spoken words depend on body language for their information. It is especially important that caregivers be aware of their own body language and the messages it sends. In addition, caregivers should learn to read the body language of people with Alzheimer’s disease to identify their needs and how they are feeling.

Some guidelines related to nonverbal communication include:

1. If you are in a hurry, frowning, or speak quickly or angrily, a person with Alzheimer’s disease will react to your emotions - this conflict is within the control of the caregiver or the organizational system of care and is avoidable.
2. Use all senses, such as vision, hearing, touch, smell and taste.
3. Be aware of your only body language, what is message you are communicate. Alzheimer’s residents are more likely to pick body language over what you are saying.
4. If a person seems to ignore you and is unreceptive, leave him or her alone for a few minutes. Tell the person that you understand he or she wants to be alone and that you will return. Sometimes having another staff member approach resident may help.
5. Be sensitive to nonverbal messages. Be aware of your own nonverbal communication and use it to help calm, cheer, or encourage.
6. Make nonverbal messages match your words. Smile when you greet someone, wave when you are saying goodbye.
7. Adopt positive, pleasant nonverbal behaviors to reassure and encourage. Notice facial expressions and body posture to determine what is pleasurable or uncomfortable. Remember that you may be conveying emotions, such as sadness or irritation, through your actions more than through your words.
8. Beware of resident’s personal space. Do not crowd resident’s personal space and explain all activities to resident before performing them.

Some guidelines for verbal communication with residents with Dementia:

9. Use simple, short sentences. Organize your thoughts in the shortest sentence possible. For example: “Come for a walk,” NOT “Isn’t it a nice day outside to go for a walk and watch the squirrels and birds?”
10. Say the person’s name. Establish eye contact. Speak clearly, calmly, and repeat as needed. Be aware of hearing difficulties.
11. Look for clues, such as eye contact or facial expression, that the person heard you. Does the person respond appropriately? Which of the person’s words or actions are the actual response?
12. Do not argue or try to contradict the Alzheimer’s patient.
13. Don’t overreact or take false accusations personally.
Challenging Behaviors

- First, check the resident for physical and/or emotional discomfort
- Provide a constructive task that interests the resident, such as folding towels, sweeping, or holding an object
- Experiment with activities, such as music or exercise, until you find an activity the resident likes
- Reduce noise in the environment
- Break tasks into simple steps
- Be calm when approaching the resident

Aggression

- Try preventive measures to avoid injury. For example, make sure all sharp objects are out of the resident’s reach
- Respond to clues of distress
- Stop what you are doing with the resident, move other residents to a safe location, and reassess your approach. Come back later and try another way of doing something
- Try to be consistent in approaches as well as with staffing
- Use distractions. Offer food, remove the resident from a tense situation
- Reassure the person, speak calmly, listen to his/her concerns, and frustrations

If a resident’s behavior is increasing, do not wait until the resident is aggressive, report it to the nursing supervisor for the resident’s safety and the staff’s safety. There are times that a staff member that is more familiar with the resident will be able to provide an intervention to minimize the behavior. Other times, it will require nursing interventions. Always stay between the resident and the exit door to a room so not to be blocked from exiting if needed.

MENTAL HEALTH/CHALLENGING BEHAVIORS

Some residents have mental health diagnosis that are not related to Dementia. These residents may be having increased anxiety due to the stress of the current situation related to COVID-19, change of routine, sense of loss, or other contributing factors.

As a PCA, you are expected to report changes in behaviors and not feel that you must handle them on your own.

Some basic tips to manage a resident with increased behaviors is to:

Notify your nursing supervisor

- Remain calm. Never confront, argue or try to reason
- Respond to feelings. Say: “you seem upset”, or “You seem worried.”
- Reassure the person. Say: “it’s OK Mr. Green (resident’s name). You are in a safe place.
- Remove yourself for a moment and take a deep breath.
- Return when the resident begins to calm down as directed by the nursing supervisor
Review Residents Rights, Abuse & Neglect Reporting and Reporting to the Nurse

It is the responsibility of the PCA to honor all resident’s rights. During this time of challenge staff can be very focused on getting the “tasks” required completed. It is imperative that you do not loose honoring the rights of residents. If there is a time that you feel a resident’s rights are not being honored, it must be reported to the nursing supervisor immediately. This includes any allegation of abuse or neglect.

As discussed, all concerns, out of normal range for temperatures, concerns of pain, or any other item that does not go smoothly in alignment with the residents’ care plan should be reported. If a question arises about care, you always have the responsibility to ask before proceeding for safety for the residents and staff alike.
About Florida Health Care Association

Florida Health Care Association (FHCA) is a federation representing over 82% of the state's 690 nursing centers. Our membership includes more than 1,000 individuals and nearly 600 long term care centers that provide skilled nursing, post-acute and sub-acute care, short-term rehabilitation, assisted living and other services to the frail elderly and individuals with disabilities in Florida. FHCA also has more than 400 associate members/companies that provide valuable products and services to long term care providers.

Governed by its Board of Directors, FHCA furthers its mission of advancing the quality of services, image, professional development and financial stability of its members. The Association works to promote the importance of investing in the well-being of Florida's frail elders and individuals with disabilities and to ensure their continued access to high-quality long term care.

The Temporary COVID-19 Personal Care Attendant Program Instructor's Manual is compiled and edited by Kim Broom, FHCA Director of Clinical & Regulatory Affairs. Special appreciation to the Indiana Health Care Association and RB Health Partners, Inc. for their guidance and support with developing materials for this program.

For questions about this curriculum, please contact Kim Broom at FHCA at kbroom@fhca.org.

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Temporary COVID-19
Personal Care Attendant Program

Supplemental Materials
Education for Certified and Licensed Staff on Limited Scope of Permissible Work for Personal Care Attendants

Patient Care Attendants (PCAs) are allowed to perform the duties listed. Any duty outside the permissible work, I must immediately intervene, stop the PCA, and reassign those duties to authorized personnel.

The duties allowable are:

- Make an Occupied or Unoccupied Bed
- Pass Fresh Ice Water
- Pass Meal Trays/Open cartons & packets
- Check Resident Temps
- Perform One (1) Person Transfers
- Reposition the Resident in Bed/Float Heels
- Transfer the Resident to a Wheelchair using a Gait Belt
- Use a Gait Belt to Assist with Ambulation
- Oral Care/Denture Care (alert residents)
- Provide a Bed Bath/Perineal/Catheter Care
- Change an Incontinent Brief
- Assist the Resident with Getting Dressed
- Assist with Hearing Aids
- Assist the Resident to Bathroom or to use a Urinal (1 person assist)

Name (Print): ________________________________________________________________
Signature: ___________________________ Date: ________________