

Appendix “A”

WORK PROCESS SCHEDULE RELATED INSTRUCTION OUTLINE

Appendix A

WORK PROCESS SCHEDULE

Certified Nurse Assistant

O*NET-SOC CODE : 31-1012.00 RAIS CODE: 0824CB

This schedule is attached to and a part of these Standards for the above identified occupation.

1. TERM OF APPRENTICESHIP

The term of the occupation shall be 3½ years with an OJL attainment of (see below) supplemented by the required hours of related instruction.

Competency-based

Advanced CNA	1,350 to 2,000 hours
Restorative Aide	1,350 to 2,000 hours
Dementia Specialty	825 to 1,200 hours
Geriatric Specialty	1,300 to 1,800 hours

2. RATIO OF APPRENTICES TO MENTORS

The ratio of apprentices to mentors shall be 1:1

3. APPRENTICE WAGE SCHEDULE

Apprentices shall be paid a progressively increasing schedule of wages based on a defined increase of their base wage to current mentor rate. Base wage for a CNA is \$11.00

Apprentices starting wage is \$8.50 and upon completion of each specialty:

Advanced CNA =	\$.50
Restorative Aide =	\$.50
Dementia Specialty =	\$.50
Geriatric Specialty =	\$.50

4. SCHEDULE OF WORK EXPERIENCE (See attached Appendix A)

The Sponsor may modify the work processes to meet local needs prior to submitting these Standards to the appropriate Registration Agency for approval.

5. SCHEDULE OF RELATED INSTRUCTION (See attached Appendix A)

WORK PROCESS SCHEDULE
 Certified Nurse Assistant, Advanced
 O*NET-SOC Code: 31-1012.00 RAIS Code: 0824A

Description: Performs any combination of the following duties in assisting with care of residents/patients in hospital, skilled nursing/long term care or other medical facility; under the direction of a licensed nurse and/or professional medical staff. Integrate into the practice of a personal care “assisting” role the advanced knowledge of working effectively within interdisciplinary healthcare teams, state nursing laws, and federal regulatory standards. Assist with care giving activities as indicated by quality care indicators, customer satisfaction, policies and procedures, facility prevention guidelines, individualized plans of care, and Center of Disease Control standard precautions regarding infection control. Incorporates appropriate individualized toileting plans, turning/repositioning schedules to avoid incontinence and prevent skin breakdown. Incorporates advanced skills and knowledge to recognize and report changes in maximizing functional status related to mobility, nutritional and emotional well-being. Maintains respect and dignity in all aspects of care and serves as resident/patient advocate according to resident rights, free choice and advanced directives. Participates in the care planning process and documents responses to interventions according to policy and procedures. Demonstrate proficiency in all basic personal care skills and nursing assistant tasks. May be assigned to specific area of hospital, skilled nursing/long term care or medical facility.

Term: Competency-based (1,350-2,000 Minimum Hours)

On-The-Job Learning: The following core competency skill areas have been identified to increase the focus and direction toward the professional development of Certified Nursing Assistants. The apprentice will attain a basic level of mastery across all core competency areas before receiving certification. Basic mastery will be represented by the apprentice being able to articulate their knowledge and understanding of each core competency area and to demonstrate that they have successfully applied all the competencies of their work processes on-the-job. The order in which the apprentices learn will be determined by the work processes on-the-job and will not necessarily be demonstrated in the order listed. Hours allotted to these work processes are estimated for an average apprentice to successfully demonstrate and develop mastery of each competency area of the occupation. These hours are intended only as guidelines to indicate the high-quality training provided to care for older adults and their families and the ability of an apprentice to apply this training on-the-job in an average amount of time.

Core Competencies Skill Areas	Approximate Hours (Min/Max)
A. Functions as a member of the health team within the health care facility <ul style="list-style-type: none"> • Participates as a responsible member of the nursing team to provide essential “assisting” duties, in providing quality resident care. • Interacts effectively within interdisciplinary teams and facility departments. • Demonstrates accountability and intervenes appropriately in situations involving unsafe practices, inappropriate skills or inadequate care. • Performs and completes resident assignments related to workload, certification, and other duties within established job descriptions, scope of practice, and facility policies. • Demonstrates knowledge of and reinforces facility policy, procedures and safety precautions. • Demonstrates ability to monitor plans of care and implement “assisting” care plan interventions. 	150-200

- Participates in the care planning process to promote health, well-being and prevent decline in status.
- Completes nursing “assisting” tasks without “rushing” the resident and encourages the resident’s highest level of participation.
- Documents in the medical record using accurate, objective information and appropriate medical terminology, according to facility guidelines.
- Serves as a team member to support other healthcare team members including other nursing assistants.
- Involves family members as part of the healthcare team.
- Takes scheduled on-the-job paid “rest” breaks and scheduled unpaid meal period(s), per policy guidelines, for nourishment, revitalization, and stress management.
- Engages in stress relief relaxation techniques during paid employee rest breaks to reduce common workplace stressors.
- Participates and supports problem-solving activities to reduce multiple on-the-job stressors for self and team members.
- Alert for care giving processes that need improvement.
- Aware of the need for continuous process improvement in delivery of care, increasing communication with other team members, developing team cohesiveness, initiating consistencies, etc.
- Participates in a “group think” small work group to create a care giving improvement design.
- Participates in a work group process improvement intervention to “pilot” test for effectiveness.

B. Demonstrates effective use of communication and documentation skills150-200

- Demonstrates appropriate care and application of resident hearing and vision assistive devices (hearing amplifiers, eye glasses, magnifying glass, etc.).
- Uses verbal and nonverbal communication skills to present information in a positive and meaningful way.
- Introduces self and explains procedures.
- Speaks clearly, simply and uses language familiar to the resident, family members or visitors.
- Demonstrates the ability to use caring, therapeutic and supportive communication in all client interactions.
- Offers reminiscence, life review, as conversation during care.
- Demonstrates effective communication skills with residents who have cognitive and sensory deficits (i.e., a resident who has dementia, Alzheimer’s disease, traumatic brain injuries, cerebral stroke; blind, visual field deficits, hard of hearing).
- Demonstrates the ability to use communication devices (i.e., orientation boards, magic slate, paper/pencil, etc.).
- Demonstrates the ability to provide information and keep residents/family members aware of scheduled facility activities of the day (i.e., daily menu, theme meals, pre-dining trivia games, social soiree’s, pet therapy, religious services, musical sing-a-longs, exercise groups, etc.).
- Introduces self and role to family members during the admission process.
- Promotes customer service skills for positive customer perceptions in response to family and visitor requests.
- Responds promptly and effectively to resident and family members requests.

- Responds with concern to provide appropriate responses/answers to requests/questions, if uncertain or unknowledgeable and/or refers family and visitors to appropriate individuals as indicated (i.e., “That is a good question – let me find out this information for you,” “I don’t have an answer, but I know someone who can provide the answer for you”).
- Documents/lists personal items upon admission, discharge and transfer of residents on facility resident personal inventory forms.
- Uses clear and legible handwriting with appropriate medical terminology in all documentation including approved abbreviations in medical charting and/or on medical data collection flow sheet forms.
- Communicates to the licensed nurse the residents’ needs, preferences.
- Documents observations objectively and accurately on flow sheets to describe resident observations and responses to care to identify the effectiveness of care interventions (i.e., moods: anxious, complaining, sad, tearful; inappropriate behaviors: wandering, resists care, unrealistic fears, persistent anger; ADLs: independence, supervision, limited assist, extensive assist; total dependence).
- Reports status of resident’s physical/functional conditions) and emotional/behavioral changes (including slight changes) to the license nurse, in support of maintaining individualized care planning that prevents decline of health.
- Attaches documentation of accident/incident general statements of knowledge with objective observations (“What did you see?”) and the summary of known actions prior to the incident (“What did you do?”), following any accident or incident during your shift of duty.
- Provides an on-going status report on a resident’s condition to the license nurse, as needed or until a desirable function is restored, according to the care planning goals.
- Answers the telephone professionally; greets the caller by identifying the facility, unit and self; makes the caller feel welcome and offers assistance.
- Assists in transferring calls and directs callers to appropriate staff member(s) that can be helpful to meet the caller’s need and asks to place callers “on hold” before transferring the call.
- Takes a telephone message and writes down important information (caller’s name, date, time, correct phone number and a brief message, if the caller is asking for someone who is unavailable).
- Avoids making or receiving personal telephone calls on the job.

C. Demonstrates Scope of Professional Practice, Nursing Laws and Regulatory Standards of Care150-200

- Wears a facility name identification tag as part of the professional uniform.
- Demonstrates professional behavior according to the nursing assistant scope of practice, resident rights, advance directives, facility guidelines, and regulatory standards.
- Interprets, explains, and applies the constitutional Resident Bill of Rights and right to self-determination.
- Respects resident’s advance directives.
- Promotes resident rights to be free from physical and chemical restraints in accordance with current federal and state standards.
- Provides for client choice, well-being, privacy and dignity at all times.

- Maintains quality of life, client confidentiality and adheres to the Health Insurance Portability and Accountability Act (HIPAA) regulations of 1996 for medical information and confidentiality provisions.
- Compliant with medical privacy rules and protects resident personal information by refraining from talking openly about residents in hallways, nurse's station, break rooms, etc. regarding resident care.
- Promotes the resident's right to make personal choices and accommodates their needs.
- Provides privacy in resident room, during care and not in common areas.
- Uses resident room cubicle curtains, closes window blinds and shuts resident's room door.
- Maintains privacy by draping exposed areas of the resident, during care.
- Ensures residents are properly clothed in clean/odor free clothing in room, on unit or off unit.
- Ensures residents are properly covered in transport to/from shower area.
- Covers urinary collection bags with a urinary collection bag cover to protect privacy.
- Gives assistance immediately in resolving grievances and disputes and seeks other healthcare team members to assist.
- Maintains care and security of residents' personal possessions.
- Promotes the resident's right to be free from abuse, mistreatment, and neglect.
- Reports any sudden changes in resident behavior, expressions of fear of a staff member, injuries of unknown source: bruises, skin tears, burns, or swelling on parts of the body that are not vulnerable to casual injury.
- Reports resident-to-resident incidents where psychological or bodily harm (including pain) results, according to federal and state reporting requirements.
- Protects resident from further harm.
- Reports any observations, allegations, or suspicions of potential abuse, mistreatment, or neglect to the appropriate supervisor.

D. Applies Policy and Procedures.....200-300

- Orients a new admission to self, room, unit, call light system and bedside personal care supplies.
- Makes new admissions and family members feel welcome to your shift and unit.
- Participates in admission, discharge and transfer of residents; labels, identifies and/or gathers personal items.
- Obtains accurate vital signs and consistent weights on all new admissions and hospital re-admissions, per facility protocol.
- Documents correct height/weight accurately on facility specific clinical data collection forms.
- Obtains and calculates accurate fluid intake and measures urinary output for 72 hours, after admission or re-admission.
- Documents adequate fluids consumed and eliminated on an *Intake and Output* form.
- Monitors and documents voiding patterns for 72 hours on the Voiding Pattern Assessment form, after admission or re-admission.
- Monitors bowel movements, characteristics of stool and reports absence or minimum of stool, after 3 days to the licensed nurse.

- Documents bowel movements and records observations (amount, color, consistency), according to facility guidelines on the specific clinical data collection form.
- Monitors delivery of first meal tray, appetite and meal consumption.
- Ensures the new admission's information care card (NAILS) is present inside the resident closet or per facility policy.
- Records all ADL performance levels, especially within the first 8 hours and up to the first 10-day assessment period.
- Monitors and is "on alert" for fall risk behaviors/patterns (i.e., vision impairments, bed mobility, transfers, need or use of mobility appliances, balance, range of motion ambulation/locomotion in room and/or off unit, dressing/undressing including donning/removing prosthesis, eating, toileting, and behavioral safety concerns).
- Observes condition of skin, on admission and reports all skin issues (i.e., scratches, abrasions, scaly patches, rashes, excoriation, skin tears, bruises, red areas, black areas, open or surgical wounds, wound dressings, swelling, insect bites, etc.).
- Inspects condition of oral gums, teeth or presence of artificial teeth (i.e., missing teeth, dentures, broken dentures, partial bridges, etc.) and labels dental prosthetics with resident name.
- Inspects visual appliances and hearing devices for operational function, working order, intact status, repair needs (i.e., eye glasses broken, hearing aid battery missing, lost magnifying glass during admission transport, etc.) and labels with resident name.
- Monitors and observes emotional status/behaviors that may place resident at risk for maladaptive coping or loss of well-being (i.e., withdrawn, sadness, tearfulness, fear, depression, wanders), or inappropriate behaviors that put other vulnerable resident's at risk for psychological or physical harm (i.e., aggression, threatening, or combative).
- Maintains supportive admission MDS and Skilled Nursing Services documentation of data collection on flow sheets in the medical record for Medicare payments and Medicaid case-mix reimbursement system (i.e., replaced nasal cannula 4 times, repositioned every 2 hours with 6-8 deep breathing exercises, coughed up large amounts of brown-colored sputum and consumed 90cc fluid intake after each repositioning activity; ambulated 15 feet with walker with minimum assistance of one CNA with constant cueing, transfers from supine in bed to sitting with moderate assistance and constant cueing from one CNA and from sitting to standing with moderate maximum assistance of one CNA with constant cueing and encouragement).
- Follows fire drill Rescue Alarm Contain Extinguish (RACE). procedures: clears hallways of equipment, corridors of residents; places residents behind smoke barrier doors; closes windows and doors, opens blinds; assures residents & visitors and asks residents and visitors to remain behind smoke barrier doors until resolution of fire drill and announcement of "ALL CLEAR".
- Demonstrates the ability to operate a fire extinguisher properly (i.e., pulls pin, aims hose, spray contents, and sweeps area about 6 feet away from fire.)
- Verbalizes earthquake procedures: during shaking moves residents away from windows shattering, doors slamming, and tall objects that can fall; after shaking reassures and calms residents, prepares for after shocks and listens for administrative instructions.
- Verbalizes severe storm nursing preparations (i.e., empties resident rooms & large rooms, moves residents from window areas to closed corridors, close window shades/drapes to prevent movement of shattered glass, distributes blankets for

warmth & protection against flying glass, remains calm and attentive to resident needs, etc.).

- Verbalizes designated specific evacuation areas for residents requiring minimal nursing care and residents requiring maximum nursing care.
- Articulates the order of priority for total resident evacuation (i.e., independent ambulatory resident first, independent wheelchair mobile residents second, resident needing wheelchair assistance fourth, and bed dependent residents are removed last).
- Articulates appropriate “search” steps to follow when a resident is found missing from the facility without staff knowledge.
- Recognizes alert “codes” for specific emergency situations and demonstrates the ability to respond to proper personnel or assigned stations (i.e., fire, medical emergency, storm warnings, bomb threat, elopement/missing person, etc.).

E. Demonstrates advanced understanding of principles of infection control.....150-200

- Identifies the infectious process and modes of transmission of disease: contact transmission, droplet transmission, airborne transmission, common vehicle transmission, and vector-borne transmission.
- Identifies signs/symptoms of the infectious process (i.e., increased body temperature, complaints of chills, poor appetite, cloudy urine, foul odor, thick drainage, irritable or confused behaviors, etc.).
- Demonstrates general principles of asepsis and uses proper solutions and concentrations to sanitize surfaces, floors; utility re-usable urinals, bedpans, basins, nail clippers; mattresses, shower chairs, pump stands, etc.
- Demonstrates Center for Disease Control (CDC) guidelines related to standard precautions: using personal protective equipment (i.e., gloves), practicing personal hygiene (i.e., hand washing) and handling/disposing of sharps (i.e., razors) appropriately.
- Uses barriers to separate a clean surface from a dirty surface (i.e., places a paper towel on the sink counter to protect a personal item (toothbrush/nebulizer) from the contaminated counter; places open plastic bag(s) at the foot of the bed for soiled disposable incontinent products and another bag for soiled clothing/linens to prevent cross contamination and protect clean bed linens.).
- Separates personal care items in bedside drawers in containers that prevent cross contamination (i.e., hair brushes/combs/nail clippers in plastic bags separated from tooth brushes in placed kidney basins; dentures stored, soaking and contained in clean denture cups with lids snapped closed; urinals/bed pans cleaned after use and stored dry in plastic bags on back of toilet or in bottom drawer at bedside.)
- Sanitizes over the bed tables after removing a urinal before a meal tray is delivered, if a urinal presents as a source of contamination when a resident eats in room.
- Demonstrates proper hand-washing techniques including the use of hand sanitizing agents.
- Washes hands before reporting on the job, after toileting, smoking, coughing, and sneezing, before/after feeding self, and before leaving the workplace.
- Washes hands between each new resident and prior to donning clean gloves.
- Avoids wearing gloves in common areas i.e., hallways, nurses stations, dining rooms, etc.
- Dons clean gloves before touching body fluids, secretions, mucous membranes, non-intact skin, blood, soiled linen/clothing, or handling contaminated equipment.

- Removes gloves properly after gloves are soiled/contaminated and changes gloves between each contaminated task and procedure on the same resident.
- Removes gloves from the inside out and places gloves in proper containers for disposal and washes hands after glove removal.
- Handles and holds resident's soiled linen away from uniform and rolls up soiled linen to enclose in an impervious plastic bag.
- Transports soiled linen in a closed plastic bag into the designated closed soiled linen containers.
- Discards any contaminated disposables: wound dressings materials, used gloves, removed urinary catheters, urinary collection bags, suctioning secretion containers, etc., per "bagging" disposing facility guidelines.
- Uses red bio-hazard bags for visibly "bloody" contaminated materials or materials saturated with infectious body fluids (i.e., blood-saturated disposable pads, drainage-saturated dressings from infectious wound, etc.).
- Eliminates solid organic material from linens, clothing, and reusable containers in the commode or utility hopper (i.e., bowel movements in bed pans, stool in under garments or bedding).
- Maintains urinary collection bags covered for privacy and off the floor to prevent cross contamination.

F. Incorporates Quality of Care interventions to maximize resident functioning and minimize resident risks for decline in health status200-300

- Knows the daily activity schedule, informs and invites the resident to facility scheduled activities which meet their functional and psychosocial needs.
- Assists client to participate in activities of their choice.
- Knocks before entering a resident's room and introduces self and "assisting" role upon entering.
- Explains care giving procedures prior to giving care.
- Assists with the resident's functional capacity to facilitate an optimal level of function for achieving their highest level of independence.
- Maintains call light within reach and promptly responds to resident call light signals.
- Demonstrates ability to accurately take an oral temperature, count a radial pulse, count respirations, measure and record a correct blood pressure, per facility guidelines or as needed.
- Assists with basic personal care functions: oral care, cleaning and storing dentures; cleansing face, hands, underarms, skin folds, perineum; showering/bathing per resident choice schedule; shaving, combing hair, dressing/undressing, toileting, and providing non-diabetic (or non-altered peripheral vascular conditions) fingernail/toenail care.
- Applies a gait belt during all assisted transfers and ambulation, unless otherwise contraindicated on the plan of care.
- Provides fresh water pitchers bedside every shift, unless contraindicated.
- Ensures resident's with fluid restrictions or on thickened liquids receive adequate fluids, as ordered by physician on the plan of care.
- Offers fluids between meals (i.e, before, during and after care activities) to maintain proper hydration, as determined by the dietitian.
- Reports abnormal fluid losses to the licensed nurse (i.e., diarrhea, vomiting, excessive perspiration, rapid respiration, etc.).

- Monitors and reports signs of dehydration (dry tongue, lips and gums; irritability, confusion, generalized weakness, abnormal vital signs, etc.).
- Documents and calculates total fluid intake in cubic centimeters (cc) per shift on data collection forms, as indicated by facility protocol.
- Meets nutritional needs by providing nutritional snacks, as ordered by the physician or dietitian.
- Elevates head of bed to 45 degrees during enteral “tube” feedings and for two (2) hours afterwards.
- Monitors resident weights accurately and regularly, as per facility protocol (i.e., daily, weekly or monthly depending on weight loss/gain status).
- Documents resident weights carefully and consistently (i.e., using the same scale, residents wearing same clothing, weighed on the same shift at the same time of day, etc.).
- Obtains verification of re-weights from the licensed nurse.
- Performs a “re-weigh”, with 24 hours, if weight appears incorrect or a weight variance is present (i.e., 5 lbs/30 days; 3 lbs/7 days).
- Communicates a weight variance/re-weigh with the licensed nurse on duty.
- Monitors plan of care for new interventions to ensure that resident’s at risk for unplanned weight loss are properly managed.
- Monitors the delivery of meals and accuracy of diet cards, during the dining experience.
- Serves all meals within 15 minutes of scheduled/posted meal time.
- Assists residents with various dining skill levels: Independent, Intermediate, Assisted, and Dependent.
- Offers an alternative menu, if resident intake is poor.
- Demonstrates the ability to accurately calculate and document total meal/food consumed into percentages (%) and convert total fluid volume intake into cubic centimeters (cc), after each meal for all residents in the meal monitor record.
- Demonstrates the ability to recognize and monitor the residents at risk for falls.
- Participates pro-actively in the Fall Prevention Program (i.e., Falling Stars, Falling Leaves, etc.) and maintains an awareness of potential fall risks.
- Recognizes the Fall Prevention Program’s visual identifier and ensures the visual identifier remains affixed to room nameplate, wheelchair, walker, and ID band.
- Responds immediately to a resident’s specific patterns (new admission, visual impairment, abnormalities in gait, impaired balance, weakness, unsteadiness, poor muscle coordination, dizziness upon standing, etc.), situations (strange surroundings, new medication administration, elimination needs, inability to call for assistance, uneven surfaces, wet floors, etc.) and behaviors (confusion, disorientation, lightheadedness, poor safety judgment, etc.) that are associated with fall risks.
- Monitors plan of care for new interventions that prevent or reduce repeated falls for residents at risk for falls and implements planned prevention strategies (i.e., use of perimeter mattresses, placement of bedside commode, individual meaningful diversional activities, frequent ambulation exercise, pillow in lap, moving resident closer to nurses station, etc).
- Performs frequent safety checks of resident’s for potential fall hazards (i.e., call light out of reach, cluttered floors, bed/chair alarms disconnected, unanticipated needs, etc.).
- Monitors physical restraints for safe placement and effective function.

- Demonstrates proper passive and active range of motion exercises.
- Demonstrates the ability to recognize contracture risks, reports, and follows plan of care to prevent or minimize joint immobility.
- Demonstrates the use and care of assistive devices in contracture management such as braces, splints, and other orthotics.
- Demonstrates the proper use of assistive devices in ambulation (i.e., walkers, canes, and wheel chair).
- Reinforces the use of assistive devices in positioning/transferring residents (i.e., gait belt, mechanical lift, slide board, lift sheet).
- Recognizes need for and implements appropriate use of footboards, hand rolls, bed cradles, and abductor pillows.

G. Beyond basic care duties: Implements appropriate interventions to maintain skin integrity and continence and minimize problems related to mobility and elimination impairments.....200-300

- Prevents pressure ulcers by managing tissue loads: reducing pressure, friction & shear.
- Inspects skin daily for change in condition (i.e., redness, abrasions, blistering, etc.).
- Keeps skin clean and dry to prevent maceration.
- Moisturizes skin daily to prevent skin dryness.
- Maintains head of bed at lowest degree of elevation to prevent shearing forces, according to care planned medical conditions and/or other restrictions.
- Uses pillows or foam wedges for pressure reduction around heels, ankles, knees, hips, and shoulders to avoid direct contact on or between boney prominences.
- Floats heels properly from mid calf to ankle for immobile residents in bed.
- Uses positioning device to raise a pressure ulcer up off the supportive mattress surface.
- Avoids or limits “sitting” positions, if a resident has an existing pressure ulcer on a “sitting” surface.
- Monitors postural alignment and distribution of weight, balance, upper body stability and pressure relief when positioning residents in wheelchairs and beds.
- Turns and repositions bed dependent residents properly every two hours or less, unless otherwise contraindicated on the plan of care (i.e., side lying or lateral position, supine position, high and low Fowlers position, Sims position).
- Turns and positions orthopedic residents properly, as care planned (i.e., log rolling, abduction wedge, less than 90 degree hip/knee/waist flexion, etc.).
- Repositions properly wheelchair dependent residents at least every hour.
- Encourages residents who can adequately move on their own in their wheelchairs to shift weight every 15 minutes.
- Uses a draw sheet properly to move residents up in bed and to avoid friction when moving or repositioning immobile residents.
- Checks overlay mattresses for an adequate support surface by placing an outstretched hand (palm up) *under* the overlay mattress and *below* various anatomical pressure points for more than 1” of support material between any pressure point and the bottom of the bed.
- Checks pressure reduction wheelchair cushions for proper placement and distribution of weight over seated posture.
- Anticipates toileting needs to avoid macerated skin breakdown or reduce incontinent episodes.

- Monitors open wound dressings for intact status and protects existing pressure ulcers from fecal contamination.
- Bathes for comfort and cleanliness per showering schedule or as resident prefers.
- Preserves resident dignity and privacy care efforts in managing continence or after episodes of incontinence.
- Reinforces bowel and bladder training programs and implements scheduled toileting plans according to plan of care.
- Uses appropriate interventions and adaptations to restore or maintain normal bladder and bowel functions (i.e., adequate hydration, body movement activities, high-rise toilet seat, developing toileting routines every two hours).
- Follows appropriate treatment plans of care to restore urinary continence.
- Reports changes in bowel activity patterns (i.e., frequency rate, hard dry stool, pain or straining during stool passage, black/tarry colored stool, blood-streaked stool, thin ribbon stool, diarrhea, increased flatulence, abnormal bowel incontinent episode, complaints of abdominal cramping, shortness of breath, or “bloated” abdomen to the licensed nurse.
- Prevents perineal skin breakdown by keeping skin around genital areas clean and dry.
- Performs routine female perineal care: exposes perineum only, separates labia for cleansing, cleanses one side of labia from top (pubic bone) to bottom (anus) with one stroke, turns cleansing cloth to another clean side, repeats – using one stroke to cleanse the other side of the labia from top (clean) to bottom (dirty), rinses (if necessary) the perineum from top to bottom with one stroke, pat dry with dry towel.
- Performs proper male perineal care, including retracting foreskin, cleansing around the meatus using one circular stroke motion clockwise, turns cleansing cloth to another clean side, and repeats another circular stroke counterclockwise around the meatus and returning the foreskin over the male penis.
- Cleanses (with soap/water and a clean folded wash cloth) the indwelling catheter from the meatus, (inside the female inner labial folds or under the foreskin of the male penis) down 4” with one stroke covering the anterior and posterior sides of the catheter. Opens up the wash cloth and uses a different clean part of the wash cloth and repeats another 4” one stroke downwards to cover the medial and lateral sides of the catheter while checking for urinary leaks, crust, or secretions.
- Uses perineal moisture barriers, skin moisturizers and/or no-rinse perineal cleansers, after incontinent episodes to prevent skin breakdown.
- Reports changes in skin condition to licensed nurse and “assists” in adapting treatment plans that meet resident care needs (i.e., incontinent products that “wick” away moisture, if maceration is present and skin moisturizers are used sparingly).
- Monitors ostomy care: belts, drains, clamps, odors, etc.
- Assists in stoma care, properly emptying, removing ostomy pouches and disposing of the fecal or urinary contents in toilet/bed pan, and replacing new adhesive ostomy pouches, according to your state specific regulations.
- Maintains indwelling catheter urinary drainage bags positioned below the bladder for gravity drainage and to prevent urine’s backward flow into the bladder.
- Monitors patent urinary drainage and alert for obstructive kinks or pressure collapse from the weight of body parts in urinary tubing.
- Secures urinary catheter end/connection tubing with slack at inner thigh area with a catheter strap to prevent pressure or friction around the urethra.
- Coils urinary drainage tubing and secures on the bed/ to prevent hanging from the bed or wheelchair, at risk for hazardous foot/wheel entanglement and dragging on the contaminated floor.

H. Assists with treatments and procedures, and specimen collection50-100

- Articulates the dangers of using flammable oxygen gas therapy, oxygen cylinders, placement of bottom metal cylinder skirt, and tubing entanglement safety issues.
- Demonstrates the capacity to use a pulse oximeter and reports observations and SpO2 results to the licensed nurse.
- Demonstrates the capacity of performing abdominal thrust technique correctly for the choking/obstructed airway victim (Heimlich maneuver).
- Demonstrates the capacity of performing adult cardiopulmonary resuscitation (CPR) properly.
- Monitors whirlpool treatments by inspecting safe positioning (i.e., positioning wounds away from high-pressure water jets during wound debridement).
- Assists the licensed nurse in turning/positioning the resident for dressing changes.
- Collects, labels, and sends stool specimens for culture and sensitivity; ova and parasites; occult blood/guic. **(Note* applicable only in California, Kansas, Kentucky, Maine, Nevada, New York, Oregon, Rhode Island, and South Dakota.)**
- Collects, labels, and sends sputum specimens. **(Note* applicable only in California, Kansas, Kentucky, Nevada, New Mexico, New York, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Virginia, and Wyoming.)**
- Collects, labels, and sends urine specimen for routine analysis, 24 hour specimens and clean-catch or midstream specimens under the direction of a licensed nurse. **(Note* Applicable only in California, Kansas, Kentucky, Maine, Nevada, New York, Oregon, Rhode Island, and South Dakota.)**
- Applies anti-embolism stockings/devices correctly with concern for resident's circulation and skin integrity.
- Demonstrates the ability to calibrate scales and/or "zero out" scale before using.

I. Pain recognition & non-medical interventions implemented100-200

- Demonstrates ability to recognize behaviors associated with discomfort/pain and reports to the licensed nurse.
- Listens to resident's descriptive words about quality of pain and asks the resident to identify location of pain by encouraging the resident to point to the location of pain on their body.
- Monitors behavior of the cognitively impaired resident suggesting pain is present.
- Reports responses to physical modality treatments to licensed nurse and/or physical therapist.
- Monitors the status of pain and observes the effects of routine pain treatment on a regular basis.
- Consults with the license nurse and/or physical therapist if pain or the suggestion of pain is not relieved by currently ordered medication, treatment modalities or non-pharmacological comfort measures.
- Monitors plan of care to identify location, type of pain, and non-pharmacological interventions, for effectiveness of pain management.
- Implements non-pharmacological interventions according to plan of care.
- Utilizes pain scale appropriately, when necessary.

Total Approximate Hours.....1,350-2,000

RELATED INSTRUCTION OUTLINE
 CERTIFIED NURSE ASSISTANT, ADVANCED
 O*NET-SOC CODE: 31-1012.00 RAIS CODE: 0824A

Description: The following competence standards represent the core learning objectives for the safe and competent practice in the occupation of the Advanced Certified Nursing Assistant role. Competence implies transference of knowledge and development of understanding that transcends the on-the-job skill competencies in pre-nursing preparation. These Core Competence Standards are intended for supplemental theoretical related instruction and lists learning objectives that are designed to advance skill performance and technical ability. It is through a combination of both on-the-job learning and related theoretical instruction that the apprentice can reach a higher capacity skilled level in the occupation. The following are core competence learning objectives that are to be completed during the term of apprenticeship.

Core Competence Learning Objectives	Approximate Hours
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| A. Interdisciplinary Healthcare Team Responsibilities | 20 |
| <ul style="list-style-type: none"> • Identifies and lists the essential functions of the health care facility and states the differences in care giving needs between hospital acute care, sub acute care, short-stay rehabilitative care, long-term care, assisted living, and home care. • Identifies and describes the essential roles and functions of an interdisciplinary healthcare team, ancillary members and other facility staff. • Identifies the essential members of an “Action Team” (i.e.; Director of Nursing Services, MDS Coordinator, Dietary Manager or Registered Dietician, Unit Resident Care Manager, Activities Director, Certified Nursing Assistant, Physical/Occupational Therapists or Speech Pathologist) and discusses the Action Team’s role and function to act as a change agent to improve resident outcomes. • Describes elements of an Action Team Meeting: identification of resident problems/issues (i.e., accidents/incidents, resident characteristics, analysis of facility quality indicator profiles, falls trends, weight variance reports, weekly skin assessments, fluid intake/output, voiding pattern assessment tools, bowel movements, infection control reports, dining room issues, resident council minutes, etc.); development of a solution (i.e., strategies, improvements, alternatives, assignments, training needs, etc.); development of an action plan (i.e., define/redefine specific goals, modifications to treatments or services, change functions/tasks, new assignments of responsibilities for improvement in care); and evaluate effectiveness (i.e., documentation, improved resident outcomes, improved staff performance). • Relates to the importance of the “assisting” role of the certified nursing assistant, as a valued member of the healthcare team. • Reviews federal and state agencies that target prevention of elder abuse. • Discusses warning signs of abuse in resident care (i.e., bruises, pressure marks, abrasions, broken bones, depression, unexplained withdrawal from normal activities, bed sores, poor hygiene, weight loss, belittling, name calling, arguments, resident-to-resident altercations, etc.). • Describes types of elder abuse: physical abuse, emotional abuse, sexual abuse, exploitation, neglect, and abandonment. • Explains the abuse/neglect reporting process and understands the purpose, according to state/federal laws. • Reviews resident’s Constitutional Bill of Rights for those entrusted to the care of a nursing facility. • Discusses the relationship between quality of life, quality of care and resident rights. | |

- Discusses how to involve family members in care practices by sharing (i.e., what is being done to avoid risks such as frequent monitoring; what is being done to prevent decline such as providing an on-going status reports to the licensed nurse; or what is being done to reduce negative outcomes such as participation in the care planning process).
- Relates to care activities that enhance health, protection, safety, nutrition, socialization, activity, dignity, privacy and choice.
- Lists stressors in the work place (i.e., heavy workload, time management, dealing with difficult people, lack of teamwork, lack of support, etc.).
- Describes affects of stressors on an individual (i.e., poor health, bad attitude, negative self-talk, performance issues, dissatisfaction, etc.).
- Differentiates between creating stress talk and constructive smart talk: focusing on negative complaints versus seeing positive outcomes.
- Recognizes sources of stress (i.e., feeling under pressure, heavy workloads, feeling mentally/physically/emotionally exhausted) and coping efforts of the autonomic nervous system (i.e., “fight or flight”, blood sugar rises, blood pressure rises, shallow breathing accelerates, digestive activity shuts down causing bowel irritability, stomach contents regurgitate, blood supply moves in muscle tissues, and muscles tense).
- Describes approaches to stress relief (i.e., seeking support proactively amongst team members and/or the licensed nurse for problem-solving, going for a short walk in the fresh air, using deep breathing exercises, listening to soothing music, reading for pleasure, using meditation or positive guided imagery.).
- Lists stress relieving principles (i.e., time management organization techniques, prioritization, energizing self mentally, physical exercise regimen, nourishing self with complex carbohydrates, eliminating nicotine/caffeine/refined sugars, adequate rest after hours, relaxation techniques, etc.).
- Lists problem-solving activities that support reduction of multiple on-the-job stressors for self and other team members. (i.e., re-evaluate priorities, adjust timelines, breakdown multiple tasks into smaller manageable parts, etc.).
- Constructs problem-solving steps: explores feelings, stays positive, doesn’t take problems personally, expresses empathy, gathers pertinent information, mutually agrees on a solution, and follows up for satisfaction.
- Recognizes signs of stress leading to employee “burn out” (i.e., unstable blood-sugar levels, indigestion problems, irritable bowel syndrome, high blood pressure, insomnia, anxiety, emotional/irritable mood swings, muscle pain, tension headaches, migraines, dissatisfaction on-the-job, etc.).
- Examines process improvement methods that support high quality care services and adds value to healthcare providers, residents, and family members.
- Discusses an idea of exploring alternative ideas for a process improvement opportunity.

B. Effective use of Communication and Documentation Skills 16

- Discusses basic characteristics of communication (i.e., exchange of messages, reciprocal in nature, establishes a relationship, quality of interpretation, influences of past experiences and feelings, etc.).
- Describes factors that are important in using appropriate communication methods (i.e., attitude, using meaningful/familiar words, avoid unnecessary information, clarity of message, specific factual information, etc.).
- Identifies different forms of communication (i.e., verbal, nonverbal, body language, touch, eye contact, facial expressions, posture, use of gestures, sounds, silence, etc.).

- Explains use of different communication techniques (i.e., therapeutic conversation: tone and quality of voice, confidence in topic, clear and concise statements; active listening skills: patience to listen, acknowledges speaker, validation of genuine concern; silence: opportunity to observe, explore inner feelings, time to think, escape from threat; questions: opened ended, response to themes, seeking more information, clarifying comments, etc.).
- Compares interpersonal skills with effective communication skills (i.e., open minded, accessible, approachable, warm, friendly, caring, supportive, empathetic, and competent, culturally sensitivity, etc.).
- Discusses factors affecting effective communication (i.e., language barriers, cognitive and sensory deficits, environmental stimuli, background noise, lack of privacy, fear, etc.).
- Lists different types and uses of communication devices necessary for effective communication (i.e., hearing aides, vision devices, orientation boards, magic slate, writing with paper/pencil, etc.).
- Relates to customer service and compares common customer needs (i.e., accessible staff, offers alternative options, attentive care givers present, displays caring attitudes, maintains a safe and comfortable environment, surrounded by cheerful personnel, essence of a committed workforce, demonstrates consistent routines, provides cost effective value, promotes sincere and courteous behaviors, prides experienced and skilled employees, friendly, flexible and helpful staff, professional image, reliable, respectful and responsive to customer requests, continues to strive for a reputation for delivering excellent care, etc.
- Reviews the word elements (prefixes, roots suffixes) of medical terminology and approved medical abbreviations.
- Reviews rules for recording medical information (i.e., uses black ink, writes neat and legible with correct spelling, records measurable and accurate data, charts slight changes in condition from normal, describes changes in mood/behaviors on flow sheets, etc.) and informs the charge nurse.
- Reviews MDS terminology in the areas of activities of daily living (ADLs) with regards to bed mobility, lifting feet up into bed, moving them up in bed, walking with on-hand control, contact guard, eating, toileting, hygiene assistance, transferring, uses gait belt, locking wheelchair brakes, (i.e., independent or “no touch assistance”, supervision or “oversight, cueing, encouragement”, limited assistance or “ resident does more than staff”, extensive assistance or “ staff does more than resident”, one-person assist, two-person assist) and Mood/Behaviors (i.e., wandering, physical abuse, verbal abuse, unpleasant mood in morning, inappropriate behavior, resists care, insomnia, changes in usual sleeping pattern, sad, pained, worried, crying, tearfulness, repetitive health complaints or movements, recurrent statements about something that is troublesome, anxiety, withdrawal from activities of interest, reduced social action, unrealistic fears, negative statements, persistent anger with self or others, self-depreciation “I am too old-take me out and shoot me”, etc.).
- Defines the MDS term “significant change in condition” (improvement & decline) and discusses change in conditions that: Is not self-limiting; Impacts on more than one area of the resident’s health status; requires an interdisciplinary healthcare team review or revision of the care plan.
- Lists areas of decline in a resident’s health status for supportive documentation (i.e., decision making, cognitive patterns, mood alterability, behavior symptoms, ADL physical functioning, incontinence pattern, emergence of unstable disease/condition, unplanned weight loss, pressure ulcer, overall deterioration) and areas of improvement (i.e., decision making, behavior symptoms, mood persistence, ADL physical functioning, incontinence pattern, overall improvement).
- Reviews rules for reporting resident medical information using specific descriptive observations related to changes from normal, accidents/incidents, slight change in

functional/physical/emotional conditions, resident needs or preferences to the licensed nurse (i.e., resident's ability to respond, moods/behaviors, mobility movement, edema changes, condition of feet, vision/hearing changes, oral/dental issues, pain/discomfort, skin condition, respiration changes, bowel movements, bladder elimination, appetite, variations in weight, activity of daily living functioning, etc.).

- Describes guidelines for answering in-coming calls on the telephone (i.e., answers with a courteous professional greeting, provides information & assistance to the caller and takes correct messages for others).
- Explains how to transfer telephone calls to other departments and/or directs callers to appropriate staff members for customer assistance.
- Asks permission to place caller "on-hold", if necessary before transferring caller or summoning assistance.

C. Scope of Practice, Nursing Laws and Regulatory Standards of Care 6

- Reviews Omnibus Budget Reconciliation Act (OBRA) Federal law as related to governing nursing assistant care in nursing homes.
- Reviews State regulations as related to the nursing assistant scope of practice and the role of "assisting" in nursing care under the supervision of the licensed nurse.
- Reviews certified nursing assistant and advanced certified nursing assistant job descriptions, role functions and on-the-job responsibilities.
- Examines the Constitutional Resident Bill of Rights and Advanced Directives (i.e., privacy and confidentiality; highest level of independence and personal choice; disputes and grievances; participation in resident and family groups; care and security of resident personal possessions; freedom of abuse, mistreatment and neglect; freedom from restraint; quality of life).
- Explains different forms, effects and symptoms of elderly abuse (i.e., physical abuse, verbal abuse, mental abuse, sexual abuse, involuntary seclusion, and neglect to avoid harm).
- Lists abuse reporting requirements and the role of the nursing assist in preventing harm, pain or mental anguish.
- Reviews the Health Insurance Portability and Accountability Act (HIPPA) as related to respecting resident privacy and protecting resident confidentiality of personal or medical information.

D. Policies and Procedures20

- Reviews the admission and re-admission process (i.e., hospital referral, telephone inquiry, payer types, payer eligibility, notification of admission, receiving admission paperwork, admitting physician orders, room preparation and set up, welcome tour, staff introductions and room orientation, family conference, 72 hour data collection, MDS nursing assessment, developing nursing/dietary/rehabilitation treatment plans.).
- Reviews the importance of the Minimum Data Set (MDS) assessment schedule and how accurate and measurable data collection is in 24-hour, 72-hour, 14-day, and 21-day time periods.
- Defines the basic elements of providing Medicare daily skilled nursing services including documentation of residence performance and staff assistance on the daily flow sheet regarding ADL activities: bed mobility (to from lying/sitting/dangling; turning, positioning); eating (oversight, cueing, encouragement, etc.); toileting (using toilet, commode, bedpan, urinal including transfer on/off, cleansing, wiping, changing incontinent products, managing ostomies, catheters, and/or adjusting clothing: transfers to/from bed/chair but does not include transfers to/from toilet, bath or shower chair.

- Reviews region/division specific *Welcome Packet* and/or the region/division specific Admission's Welcome Program (i.e., room "name" plate, welcome balloons, daily/weekly meal menu, weekly activity schedule, etc.).
- Reviews abuse prohibition, falls management, nutritional management, pain management, resident (admission) assessment process, restraint management, skin care management, and the urinary management of the Resident Care Management Systems.
- Explains why not using gait belts on all assisted transfers and ambulation can be considered as negligence.
- Explains the policies of accident/incident identification, reporting and investigation.
- Describes the contents of a written incident summary of a witnessed event.
- Discusses areas of investigation concerning falls, skin issues, bruises, and resident-to-resident altercations (i.e., "When was the resident last checked?," "when was the resident last toileted?," "What was the resident doing prior to the incident?," "Was the resident attempting a routine task?," "What are the resident's abilities?," "What is the resident's normal routine?," "Any change in behavior?," "Did the resident have access to their call light?," "Was adaptive equipment or a personal alarm used?," "Are there sharp objects near the resident?," "Was the resident out of the facility recently?," "Any significant life changes?," "What was the environmental stimuli like in the area?," "What was the noise level?," and "How does the resident act when staff or other residents approach?").
- Discusses basic care expectations (i.e., answering call lights promptly, A.M. care; P.M. care; shower/tub bathing schedules; fingernail/toenail care; following nursing assistant instruction list sheets (NAILS); turning/repositioning, toileting/hygiene care before/after meals and hour of sleep; oral care before/after meals; incontinent care after each episode; bowel monitoring, vital signs; weights; gait belt use on all assisted transfers and ambulation, monitoring call light access; adequate nutrition/hydration in accordance to physician ordered diet or dietician recommendations, etc.).
- Explains how the promotion of resident independence is related to providing care of the resident's personal possessions (i.e., maintenance/storage of visual/hearing aids, properly storing/labeling dentures, labeling personal clothing items, etc.).
- Names the different emergency procedures related to disaster preparedness (i.e., fire drill, earthquake procedure, severe storm warnings, bomb threat, missing person or elopement, and evacuation plan).
- Reviews emergency procedures and disaster preparedness.
- Reviews the operations of using a fire extinguisher effectively.

E. Principles of Infection Control.16

- Describes types of microbes including those identified as infection-causing pathogens (i.e.; bacteria, viruses, fungi, protozoa, and rickettsiae).
- Explains the "chain of infection" process and defines each element (i.e.; source, reservoir, portal of exit, method of transmission, portal of entry, and susceptible host).
- Lists common observable signs and symptoms of infection (i.e., increased temperature, increased pulse/respirations, pain or tenderness, fatigue of loss of energy, loss of appetite, change in behavior, disoriented, confusion, nausea/vomiting, diarrhea, rash/sores, redness/swelling, foul odor, and discharge/drainage/crust).
- Defines the term "nosocomial infection" and verbalizes methods of transmission (i.e. feces contamination, poor hand washing, air-borne respiratory inhalation, etc.).
- Defines "medical asepsis" practices (clean technique).

- Lists common medical asepsis practices (i.e.; proper hand washing, bagging toothbrushes, covering dentures, rinsing/air drying aerosol equipment, properly sanitizing reusable equipment in utility rooms, properly sanitizing the shower chair after each use, etc.).
- Demonstrates proper hand washing technique including donning/removing/disposing gloves including between tasks on the same resident.
- Discusses limitations of using hand sanitizing agents and recommendations for use.
- Reviews Center for Disease Control (CDC) guidelines related to standard precautions (blood-borne pathogens, bio-hazard bagging, collecting specimens, soiled linen handling/bagging/transporting, clean linen handling/covering/transporting, using protective equipment, sharps disposal, etc.).
- Describes the process for removing solid fecal waste from soiled clothing and bedding before transporting to laundry or a soiled laundry receptacle.
- Explains how proper coiling and attachment of the urinary drainage tubing is important to prevent cross contamination from the floor.
- Explains the importance of why urinary collection bags are positioned below the bladder and off the floor.
- Explains the importance of why urinary collection bags are covered with a privacy bag.
- Demonstrates aseptic technique for urinary catheter care, including emptying a urinary drainage bag (i.e.; drain does not touch the sides of a measuring container and drain is wiped with an alcohol swab before closing and replacing the clamped drain into the holder).
- Explains how to clean oral and respiratory equipment (aerosol mouth pieces, humidification devices, respiratory chambers, face masks, dentures, tooth brushes, etc.) by rinsing with water and air dry in a paper bag or on and covered by a paper towel, as organisms and bacteria can colonize in moist environments.

F. Quality of Care.....20

- Lists and describes qualities and characteristics of a “caring” professional (i.e.; dignity, respect for resident’s rights values and beliefs; polite and courteous to residents by calling them as “Mr. Tyler or Ms. Crane” and introducing self and role; considerate of private space and knocks before entering while asking permission to enter; trustworthy and explains care procedures before providing care; enthusiastic and interested in providing care for a resident, etc.).
- Describes the benefits of caring for the “whole person” and how this approach may prevent increasing loss of function (i.e. overcoming fear of dependency, minimizing frustrations due to limitations, diminishing feelings of worthlessness from disabilities, etc.).
- Defines terms of “privacy” and maintaining “confidentiality” of resident medical information and differentiates the meaning between the two terms. (Privacy means: freedom from unwanted intrusions into one’s life. Confidentiality means: protection of private information).
- Discusses why promoting resident independence in the activities of daily living, toileting, dressing, grooming, eating and ambulation programs are important (i.e., affects quality of life, dignity, positive well-being, self-esteem, and physical capacity).
- Explains how to assist residents to attain or maintain his/her optimal level of function positively to achieve their highest level of independence.

- Identifies ways to invite residents and family members to participate in scheduled activities and how scheduled activities from the activity department can meet both physiological and psychosocial needs (i.e., theme meals, bingo games, musical performances, etc.).
- Reviews the dining experience and lists the benefits of eating in the dining room for enhancing resident nutritional needs.
- Reviews healthcare team members involved in enhancing the dining experience and managing nutritional health for residents.
- Explores enhanced dining services, as related to quality of care and quality of life.
- Identifies dining service elements: menu posted, residents seated per seating chart, pre-meal beverage pass provided, delivery of meals served timely, likes/dislikes/preferences noted, alternative foods offered, special requests addressed, and adequate staff available for assistance, set up, cueing, and feeding.
- Reviews general dining service guidelines: pre-meal toileting and oral hygiene provided, visionary/auditory aids in place, walk to dine programs in place, transferring out of wheelchairs to straight back dining chairs, proper table positioning, meal delivered on scheduled time at appropriate food temperature, accuracy of diet cards monitored for proper resident identification, therapeutic diets, altered fluid consistency, assistive/adaptive feeding devices present, and altered liquids.
- Discusses the importance of enjoyable meals, “assistive” settings, therapeutic support and restorative interventions to meet individual nutritional needs.
- Explains the Registered Dietician/Physician roles in determining calorie/protein requirements, dietary restrictions, medical snacks, dietary supplements, supplemental vitamins and minerals, paraenteral nutrition, fluid consistencies and total volume intake.
- Reviews definitions and staff involvement of dining skill levels: Independent, Intermediate, Assisted, Restorative, and Dependent.
- Lists various dining skills levels and criteria for independent dining, intermediate dining, assisted dining, restorative dining, and dependent dining.
- Explains meal monitoring and documentation guidelines, after every meal.
- Explains why food, snacks and supplement intake are monitored and recorded.
- Reviews documentation requirements of food/fluid intake (i.e., meal monitoring after each meal in 0-25-50-75-100 percent (%) of total food consumed and total fluid intake calculated, converted and recorded in cubic centimeter (cc).
- Identifies problems related to nutritional issues: weight concerns, dehydration, skin breakdown, decreased dining skills, poorly fitting dentures, oral pain, pharmacological distortion of taste, complications, and dining service process.
- Reviews safety guidelines necessary in the dining room: emergency equipment, communication system for emergency response, choking prevention, adequate lighting, adequate “assisting” and licensed staff available to monitor meal service, good hand washing/hand cleansers, etc.
- Identifies proper positioning for residents eating in bed including residents receiving paraenteral (tube) feedings.
- Discusses normally recommended range of fluid intake per day.
- Discusses fluid intake interventions (i.e., water pass/bedside pitchers, fluid restrictions, thickened fluids, hydration cart, hydration reminders, monitoring fluid intake and output, etc.).
- Encourages resident’s (without fluid restrictions) to consume “sips” of water before, during and after care activities to ensure residents maintain proper hydration between meals, as determined by the physician or dietitian.
- Articulates the practical definition of dehydration, as “the rapid loss of greater than 3% of body weight”.

- Reviews characteristics of residents who are “at risk” for dehydration (i.e., cognitively impaired, swallow impairments, spell of illness, diuretic medication therapy, history of refusing fluid intake, nausea, vomiting, diarrhea, etc.).
- Describes the implications of inadequate hydration related to body system functions.
- Articulates risk factors associated with dehydration: poor cognition, dementia/stroke, impaired decision making ability, decreased sensorial, comatose condition, deterioration in health status, draining wounds, pressure ulcers, infection, renal disorders, swallowing disorders, muscular control disorders, tremors, spilling fluids, inability to grasp cup, excessive drooling, etc.
- Identifies signs and symptoms of dehydration (i.e., weight loss, decreased or concentrated amber-colored urine output, hard/dry stools, hypotension/ dizziness upon standing, decreased blood pressure, rapid pulse rate, increased respirations, generalized muscle weakness, abnormal confusion, irritability, dry mucous membranes, cracked lips, pale skin color, sunken eyes, etc.).
- Explains on-going fluid loss occurring through lungs and skin at a normal rate of 500cc per day and increases with change in condition, diet or medications (i.e., infection, wound drainage, fever perspiration, diarrhea, vomiting, increased sugar intake, alcohol consumption, diuretic therapy, laxative use, refusal to drink, etc.).
- Discusses weight monitoring protocols and reporting weight variation documentation including the requirement of the license nurse initials and 24-hour reweight follow up.
- Describes the process to obtain, record and track residents’ weights (i.e., accuracy of weight including deductions of wheelchair weight, portable oxygen, etc.; consistency of weighing at same time of day, same clothing (gown), on same scale by same caregiver, etc.)
- Explains criteria, time line and license nurse verification for re-weights (i.e. weight error, unplanned weight loss, 3lb variance over 7 days, 5lb variance over 30 days).

G. Beyond Basic Care Duties 16

- Explains why falls are the leading cause of accidents and injury in nursing homes.
- Reviews Fall Prevention Program and discusses why a fall prevention visual identifiers (Falling Stars, Falling Leaves) and caregiver fall “awareness” prevention activities are the most important factors in preventing falls.
- Relates to the National Center for Injury Prevention and Control regarding recommendations for fall prevention (i.e., alert for new admissions, aware of environmental hazards, observing for side effects of sedative drugs, replacing poorly fitting or slippery sole shoes, use of inappropriate or incorrect walking aids and gait problems).
- Identifies resident specific patterns, situations, and behaviors associated with falls.
- Lists intrinsic, extrinsic and caregiver factors that contribute to fall risks (i.e., impaired mobility, incontinence, infections, abnormal gait, hypotension, wet floors, uneven surfaces, clutter, poor response to call lights, needs not anticipated, lack of communication, failure to update or implement care plan interventions).
- Defines the definition of a fall.
- Discusses the fall reporting protocol and why identifying the cause of falls prevents similar incidents or causes harm.
- Explore why physical exercise, rehabilitation therapy, and restorative programs prevent recurrent falls.
- Explain how gait belts, task segmentation, rest between tasks, walkers, grab bars, raised toilet seats, lower bed heights, and hallway handrails enhance functional and environmental safety and reduce fall risks.

- Discusses other methods for reducing risks for falls (i.e., safety checks, frequent monitoring, low beds, functional bed/chair alarms, frequent ambulation, participation in meaningful or diversionary activities, frequent toileting, etc.).
- Defines physical restraints, according to federal law. (Any manual method or physical/mechanical device, material, or equipment attached or adjunct to the resident's body that the individual cannot easily remove which restricts movement.)
- Lists what constitutes justified medical necessity for physical restraints (i.e., gloves/mittens, oxygen/IV/enteral feeding tubing, etc.) and what physical restraints enhance greater resident self-sufficient abilities (i.e., trunk supports, geri-chairs used at meal time only enables wandering residents to attend to feeding self.) .
- Discusses complications and hazards associated with physical restraint use (i.e., side rail entrapment, wheelchair seat belt strangulation, leg straps entanglement, geri-chair fall risks, etc.).
- Lists restraint alternatives (i.e., anti-tippers on wheelchairs, hip guides, wedge cushion, etc.).
- Reviews use of ambulatory assistive devices (i.e., leg braces, ankle-foot orthosis, walk cane, quad cane, straight cane, crutches, knee immobilizers, prosthetics, shoe lifts, walkers, etc.).
- Reviews and defines the five main categories of weight bearing status (i.e., non-weight bearing, toe-touch weight bearing, partial weight bearing, full weight bearing, and weight bearing as tolerated).
- Reviews and defines stand by assist transfer, one-person pivot transfer, two-person transfer, sliding board, and mechanical lift transfer.
- Reviews performance guideline for passive/active range of motion exercises and identifies benefits of joint mobility (i.e., reduces risk of contractures, increases flexibility, promotes circulation, provides sensory stimulation, often restores capacity and may reduce joint/muscle pain.
- Explains use and care of orthotics, positioning and contracture management assistive devices (i.e., pelvic holder, postural supports, foot boards, trochanter rolls, hip abduction wedges, hand rolls, splints, bed cradles, etc.).
- Identifies complications of immobility and discusses the importance of follow through with appropriate mobility interventions according to the plan of care.
- Explains the importance and frequency of turning & repositioning immobile residents in bed and wheelchair dependent residents.
- Lists the body's pressure point areas and describes how distribution of weight affects pressure, pain and reduces tissue circulation.
- Reviews management of tissue loads through positioning, placement and use of support surfaces (i.e., postural alignment, pillows, blanket rolls, wedges, head of bed elevation, draw seats, seat cushions, mattresses and overlays).
- Reviews new Centers for Medicare/Medicaid Services (CMS) pressure ulcer guidelines.
- Defines pressure ulcer staging and describes treatment of pressure ulcers.
- Reviews conditions that place residents at risk for developing pressure ulcers.
- Discusses the National Institutes of Health guidelines for prevention of pressure ulcers.
- Describes complications of pressure ulcers (slow healing rates, high infection risk, antibiotic resistant bacteria, pain, life threatening, major factor of untimely death, etc.).
- Discusses the differences between clinically avoidable pressure ulcers and clinically unavoidable pressure ulcers or skin conditions.
- Reviews the definition and causes of rashes, skin tears, abrasions, shearing, maceration, lower extremity edema, cellulites, venous/arterial/diabetic ulcers, and eschar.

- Recognizes changes in skin conditions (burning sensation, yellow/green exudates, unpleasant odor, increased redness, swelling, pain, warm to touch, etc.).
- Explores advantages and disadvantages to compression therapy for edema: compression stockings, elastic compression, and compression pumps.
- Describes how prolonged exposure of skin to moisture and irritating substances of urine and feces breaks down skin integrity.
- Explains how incontinent products and incontinent care protects skin integrity.
- Explains the importance of monitoring and reporting to the nurse slight changes in skin integrity and wound dressings for intact status to prevent decline or infection especially from fecal contamination.
- Describes why adequate fluid and food intake are important to prevent or heal pressure ulcer formation.
- Discusses skin problems associated with urinary incontinence.
- Reviews new Centers for Medicare/Medicaid Services (CMS) urinary incontinence guidelines.
- Understands the emphasis of treating urinary incontinence as a symptom that may be reversible.
- Describes types of urinary incontinence (Urge Incontinence, Stress Incontinence, Overflow Incontinence, Functional Incontinence, Temporary or Transient Incontinence) and identifies appropriate bladder programs and interventions that address incontinence or restore as much normal bladder function as possible.
- Understands how toileting frequently and anticipating toileting needs decreases incontinent episodes.
- Explains when and how fluid output (drooling saliva, urine, diarrhea, emesis, drainage from suctioning, or linens saturated with heavy perspiration) is measured.
- Understands that the use of absorbent urinary products is not the primary approach to continence management until other alternative approaches have been considered.
- Reviews procedure and products used for providing proper routine female and male perineal care, following medical asepsis, including infection control Standard Precautions, and Bloodborne pathogens.
- Explains skin care complications associated with poor perineal hygiene, prolonged exposure moisture, and excoriating enzyme affects of protein breakdown on skin when urine mixes with stool.

H. Conditions for Special Care/Observation: Vital Signs, Elimination, Ostomies, Catheter Care & Tube Feeding Tubes..... 10

- Discusses special care and observations following a fall (i.e., frequency of monitoring of vital signs, observations of mental responses, changes in extremity movements, complaints of pain, etc.).
- Describes conditions or changes in bowel activity that require reporting to the licensed nurse and special bowel monitoring (i.e., hard dry stools, absence of or minimum stooling over 3 days, pain or straining during bowel movements, diarrhea, increased flatulence, black/tarry stool consistency, blood-streaked stool, thin ribbon stool, complaints of abdominal/intestinal cramping, “bloated” abdomen, abnormal incontinent episode, and shortness of breath).
- Explains the importance of monitoring and recording bowel movements.
- Defines “fecal impaction”.
- Describes serious complications associated with fecal impaction.
- Defines “ostomy” and “stoma”.
- Explains common conditions that necessitate a surgically created bowel stoma.
- Differentiates between a “colostomy” and “ileostomy” bowel diversion.
- Defines “catheter”.

- Explains the differences between and medically justifiable needs for a “straight catheter,” “indwelling catheter”, and “supra-pubic catheter.”
- Explains medical justifications for valid use of indwelling urinary catheters in a nursing home.
- Lists health risks associated with long-term use of indwelling catheters.
- Discusses the importance of monitoring the urinary collection bag placement of indwelling and supra-pubic catheters.
- Explains the complications associated with improper tubing placement related to pressure/friction/pulling on the draining catheter tubing.

I. Treatments, Procedures and Specimen Collection.....10

- Defines the characteristics of normal ranges for vitals signs and explains when to take a blood pressure using an aneroid manometer and cuff, count respirations and radial pulse rate, and take a temperature with an oral or tympanic membrane thermometer.
- Demonstrates how to calibrate or “zero out” digital scales before using.
- Reviews the procedure for changing ostomy appliances, if your state allows nursing assistants to perform this procedure.
- Reviews the procedure for collecting stool specimens, if your state allows nursing assistants to perform this procedure.
- Reviews the procedure for performing proper giving indwelling catheter care, following rules for medical asepsis, infection control Standard Precautions and Bloodborne Pathogens.
- Describes the treatment benefits of using perineal moisture barriers and/or no-rinse perineal cleansers after incontinent episodes.
- Reviews procedures for safe oxygen therapy (i.e., proper placement of nasal cannula, adjusting nasal cannula for comfort, checking for signs of irritation behind ears and in nares, secures tubing to ensure no risk for entanglement or kinking, and maintains an adequate water level in the humidifier.).
- Demonstrates the use of a pulse oximeter and how to record/report results and observations to the licensed nurse.
- Explains importance of keeping respiratory or oxygen delivery devices clean and free of mucous build up (i.e., incentive spirometer mouthpiece, face masks, nasal cannula, Yankauer suction catheters, nebulizer mouth pieces/chambers, etc.).
- Demonstrates the procedures for clearing an obstructed airway (Heimlich maneuver) for a conscious adult and unconscious adult.
- Demonstrates the procedure for one-rescuer cardiopulmonary resuscitation (CPR) and two-rescuer CPR.
- Demonstrates the use of an ambu bag for rescue ventilation in emergency situations.
- Reviews procedures and proper placement in tub for whirlpool treatments including use of hydraulic lifts into and out of tub.
- Reviews the procedure for collecting sputum specimens, if your state allows nursing assistants to perform this procedure.
- Reviews the procedure for collecting urine specimens, if your state allows nursing assistants to perform this procedure.
- Demonstrates the procedure for properly applying anti-embolism (elastic compression) stockings.

J. Minimizes Discomfort and Pain Recognition.....	10
<ul style="list-style-type: none"> • Defines the term “pain” (meaning that it is unique to each resident, differs from resident to resident, only the resident can express the presence and degree of their pain, and pain is a subjective experience) and describes different types/locations of pain (i.e., acute and chronic; muscle, bone, joint, etc.). • Reviews pain scales used to measure pain (i.e., 0-10 scale; 0-5 scale; faces rating; color rating; • Explains how non-pharmacological approaches are important in pain management strategies (i.e., positioning/re-positioning needs, ROM, use of adaptive devices, daily exercise, simple touch, massage, relaxation, distraction, deep breathing, appropriate humor, music, hymns, prayers, poetry, books on tape, aromatherapy, positive imagery, conversation, socialization, participation individual/group activities, etc.). • Reviews relaxation techniques: deep rhythmic breathing, touch, massage, positive imagery, and listening to music. • Examines non-verbal behaviors that suggest pain (i.e., facial expressions: sadness, grimacing, wrinkled brow; vocal expressions: sighing, moaning, groaning, screaming; body movements: guarding area of pain, distorted posture, restricted movement; routine: withdrawal from daily activities, increased resting/sleeping, seeking comfort in bed, decreased food/fluid intake; behavior: increased irritability, combative aggression, inability to focus, confusion. • Explains how to communicate a resident’s pain status to the licensed nurse or physical therapist in a manner that will result in pain management (i.e., use verbal descriptive words that the resident uses to describe pain, describes non-verbal behaviors that represent presence of pain, provide timely reporting, report on-going progress, etc.). 	
Total Hours of Related Instruction	144
Total Hours of Supplemental (Pre-Nursing) Instruction. (If Applicable).....	90

Individuals who complete the CNA, Advanced on-the-job learning and related instruction components shall receive a “Certificate of Advanced Training” credential.