



Principles of Caregiving

CAREGIVING FUNDAMENTALS

A training program
for caregivers, personal
attendants and direct
support professionals.

THE ARIZONA DIRECT CARE CURRICULUM PROJECT.

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For more information about the curriculum project, please visit the Arizona Direct Care Initiative website at www.azdirectcare.org.

PREFACE TO THE PRINCIPLES OF CAREGIVING

The Development of Standardized Direct Care Professional Training in Arizona

The need for home and community-based caregiving is one of the most compelling issues of our time. It will affect nearly every family in America. In order to be ready to meet the increasing demand for home and community-based services, Arizona must develop a capable and compassionate workforce of caregivers. We are better prepared to meet these challenges through the *Principles of Caregiving* training for caregivers, personal attendants, and direct support professionals.

In 2004, Governor Janet Napolitano appointed the Citizens Work Group on the Long Term Care Workforce (CWG) to further develop and provide recommendations for improving the quality of the long-term care workforce. In 2005, the CWG laid out ten recommendations. One called for the implementation of a standardized, uniform, and universal training curriculum for the direct care workforce.

The Direct Care Curriculum Project is a partnership between the Arizona Department of Economic Security, the Arizona Health Care Cost Containment System, the Developmental Disabilities Planning Council (formerly the Governor's Council on Developmental Disabilities), the Arizona Department of Health Services, and the Direct Care Workforce Committee. The *Principles of Caregiving* training manuals were created to help establish a high-quality training program for direct care and direct support professionals in Arizona. Many individuals and agencies were involved, representing home care providers, community colleges, advocacy organizations, and state agencies. Refer to the Appendix for a list of acknowledgments.

NOTES TO THE STUDENTS

Principles of Caregiving: Fundamentals is the first part of the *Principles of Caregiving* series. It contains the material that is most likely needed by all direct care and direct support professionals. Additional training is available if you provide personal care or assistance with activities of daily living.

Fundamentals and any one of the modules listed below can be taken together in one class or they can be taken separately. Fundamentals should be completed first, and some review may be necessary before completing the additional module.

Depending on the needs of your employer and the clients served, you may not need all the knowledge and skills presented in Fundamentals, but are encouraged to study the whole program. The *Principles of Caregiving* curriculum is designed to provide a well-rounded introduction to caregiving and direct supports, and you will be prepared to work for a variety of clients and employers.

Principles of Caregiving includes the following modules:

- Level 1: Fundamentals
- Level 2: Aging and Physical Disabilities
- Level 2: Developmental Disabilities
- Level 2: Alzheimer’s Disease and Other Dementias

Competencies for Arizona Direct Care Workers

The competencies are the basis for the training and testing of any staff providing housekeeping or homemaker services, personal care, or attendant care services for a state-funded program in Arizona. The *Principles of Caregiving* books address all of the competencies and help you prepare for the Arizona DCW tests. For a list of competencies, see the Appendix of this module, or refer to the Arizona Direct Care Initiative website at www.azdirectcare.org, click on Competencies.

Learning Objectives

Each chapter of the *Caregiving Fundamentals* begins with an introductory page that lists the learning objectives and the key terms for that particular chapter. Some sections also list skills; these are procedures that you should practice and demonstrate to your instructor. The following symbols are used to identify certain components:



Exercises and activities.



Procedures that you need to practice and demonstrate.

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PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 1 - OVERVIEW

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- B. Direct Care Services and Programs in Arizona
 - 1. Definitions
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- C. Service Settings
- D. Philosophy of Providing Direct Care and Supports
 - 1. Basic Principles
 - 2. Independent Living and Self-Determination Statement
 - 3. Working with Older Adults
 - 4. History of Treatment of Individuals with Disabilities
 - 5. The Independent Living Movement Philosophy
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OBJECTIVES

1. Describe what direct care workers (DCWs) do and where they may work.
2. List five or more job titles used to differentiate various direct care worker functions.
3. Describe the continuum of care, service settings, and job opportunities for DCWs in various community settings.
4. Describe the philosophy, history, and benefits of the Independent Living Movement.
5. Define the term *scope of practice* and list three or more factors that determine the scope of practice for DCWs.

KEY TERMS

Activities of daily living (ADL)	Direct care
Agency	Direct care worker (DCW)
Assisted living facility	Independent living movement
Care plan	Scope of practice
Consumer-directed care	Support plan
Continuum of care	

A. ROLES AND RESPONSIBILITIES OF DIRECT CARE WORKERS (DCWS)

1. Definition

A direct care worker (DCW) is a person who provides assistance or support with daily activities. This can include bathing and grooming, housekeeping, help with meals, and encouragement of behaviors that enhance community involvement. This training focuses on the skills, knowledge, and abilities that have been identified as critical.

Possible job titles for a Direct Care Worker

- Home care aide
- Personal care aide
- Direct support professional
- Attendant
- Personal care assistant
- Respite worker
- Companion
- Caregiver
- Care associate

? Can you think of any more titles?

2. Responsibilities

Job descriptions

The list of things a DCW can and cannot do depends on the setting and the specific job. It is not possible to write one job description. These are some common tasks for DCWs:

- Personal care: helping a person in the bath, getting dressed, and with eating
- Running errands and shopping; taking a client to appointments
- Chores around the house: cleaning, meal preparation
- Help a person to become more self-sufficient; teach and encourage them to live the most independent lifestyle

In order to know job expectations and responsibilities, a DCW should attend agency orientation and in-services, and read the job descriptions. DCWs also need to become familiar with service plans, also called *care plans* and *support plans*. Such a plan is created for each client. It describes exactly what services should be provided. The fact that a DCW knows how to do a lot of things does not mean that the DCW will provide all these services to every person.



If you have questions about your job duties, contact the supervisor.



Independent Living is My Choice! – Thank you Attendant Care!

My association with the Personal Attendant Program began in March of 1986. I had just had hip replacement surgery at Good Samaritan Hospital. During my discharge planning session I was asked by the social worker what my plans were when I went home. I told her that I was going home temporarily, because at the time I was working with a social worker at Phoenix Indian Medical Center in locating a nursing home for me to move into. I wanted to live in a place where I would be able to receive proper physical care and where I could live until whenever. As a person with arthritis, this was very vital for me, as my arthritis pain was flaring up, causing me 24-7 pain. It was at my discharge plan meeting that I first heard of the Personal Attendant Program. The social worker said that I didn't have to live in a Skilled Nursing Facility (SNF) until whenever, she said, "There is a program in town that could help you live on your own, in your own place, and provide home care assistance to help you with your Activities of Daily Living (ADL)".

After staying at a nursing home for six months, I moved out and into my own apartment. I had a roommate who had Muscular Dystrophy (MD) who also was a power chair user. Our first attendant was a young man who had just finished taking the Personal Attendant Class and was looking for a live-in position. My life as a real independent person began.

My freedom depends on others, and because of my disability, always will. Coming from a small community in Arizona, I have no family living anywhere in the Valley. All my attendants have been non-family members/strangers who come into my life and become the most important part of my freedom/life.

My being able to do the things I do depends on the person who is my attendant at the time. At first just being able to live freely outside of a nursing home was a scary experience. There was always a fear of things going wrong. Will my attendant be late? Will he or she make it at all? Will I have enough money to pay my bills? There were many other fears, which are too many to mention.

I have been very lucky to have had attendants who I could depend on as well as trust. Without these people I wouldn't have accomplished in my life goals that I would have never fathomed, coming from where I came from. Without the Attendant Program I would have never been able to attend college, earn three degrees (AAA, BSW and an MSW), go where I have gone, and see what I have seen (NCIL in Washington D.C., three times), and have a full-time job.

Without my attendant being there for me day in and day out, dreams would only be dreams and not reality. It is hard to imagine what life would be like without my attendant. It is very difficult to think of having to live in a nursing home for the rest of my life. Thanks to this program, I am free. I am someone with a disability who came from a small Tohono O'odham Village. I am my own person who decides how to live my life day to day. I make my own choices in life, (what to have for breakfast, when to get up or go to bed, etc...) things others take for granted.

I often acknowledge and thank those who are willing to give of their time and of themselves in assisting individuals with disabilities to live freely, as freely as one can be.

Fernando C., recipient of attendant care



Factors that influence the DCW's responsibilities

Agency policies and procedures

Each agency has its own policies and procedures. What a DCW may do when working for one agency may not be the same for another agency. For example, what to do if a client falls.

Agency licenses and contracts

Agencies working with public programs have contracts. These describe what the agency must do for clients and what the DCWs can do. Some agencies have a license for certain services. For example, home health care agencies may require more training for their staff.

Type of care settings

The scope of what a DCW will do is also based on the type of care setting. For example, a person's private home is different from an assisted living home.

The service team

For any person receiving support, a service team helps to coordinate the services. Each person on the team has certain functions. Each situation is different, but often the following are on the team:



1. Family members (spouse, parents, children)
 - a. Provide emotional support.
 - b. Encourage the person to do as much as possible for themselves for as long as possible to prevent atrophy of the mind and body.
 - c. Communicate with the case manager/support coordinator about changes in the person's needs.
2. Case manager/support coordinator
 - a. Determine the needs of the person and arrange for the needed services.
 - b. Monitor for changes in the person's needs.
3. Agency representative (agency supervisor, staffing coordinator)
 - a. Arrange compatible, reliable direct care workers for the needs of the consumer.
4. Direct care worker
 - a. Provide assistance with tasks listed in the service plan.
 - b. Report observations to supervisor.
5. Supervisor
 - a. Monitor the direct care worker's performance.
 - b. Answer questions and direct the DCW in his/her role.

6. Primary care physician
 - a. Monitor and manage the physical health of the consumer.
 - b. Communicate with the case manager/support coordinator about changes in the client's needs.
7. Others (therapists, teachers, psychologist, etc.)
 - a. Communicate with the case manager/support coordinator about changes in the client's needs.

The DCW is an important member of the service team. As a DCW, you may spend more time with a client than others. When providing assistance in the person's home, observe any changes and problems. If you notice anything unusual—both positive and negative—report it to your supervisor.

3. Training and Orientation

a. General training and orientation

All DCWs need training that helps them to do their jobs well. This also means being safe and effective, and keeping the client safe. If you work for an agency, your employer may provide the training. Classes are also offered by some colleges and other training programs.

When a DCW is hired by an agency, he or she will attend the agency's orientation. This is required even if the DCW has completed this course. The orientation to the agency is much more specific to the particular organization. It includes policies, paperwork requirements, the agency's history, job expectations, etc.



b. Training requirement for public programs

Many agencies are providers for public programs. These are programs paid by the government, including the Arizona Long Term Care System (ALTCS) and the Department of Economic Security (DES). See Section B.2, Public Programs in Arizona, below.

Agencies that provide services for ALTCS and DES have specific requirements. This includes training and standardized tests. The appendix of this module lists the Arizona Direct Care Worker Competencies. This is the list of what DCWs must know or be able to do. They are also posted at www.azdirectcare.org. You cannot work for an ALTCS or DES provider agency until you have passed the tests. An exception is made for workers in the ALTCS Self-Directed Attendant Care Program.

Initial training

This is the training you complete before you start working.

- Level 1 (Fundamentals): Required of all direct care workers.
- Level 2 (one specialized module): Required for personal care and attendant care workers. An exception is family members, who will get person-specific training. Agencies can choose to require Level 2 training.

The *Principles of Caregiving* course includes all the material required for the training. The Fundamentals module is Level 1, and any one of the following modules can be used for Level 2:

- Aging and Physical Disabilities
- Developmental Disabilities
- Dementia and Alzheimer's Disease

Most direct care workers will take Fundamentals and at least one other module. Completing more than one module may create more opportunities for DCWs to work in a variety of settings.

Continuing education

Professional standards dictate the importance of continuing education. It helps you keep abreast of changes in the field. Ongoing training also helps improve the quality of care.

Each agency will offer continuing education. In agencies providing services for state-funded programs, DCWs must complete 6 hours of continuing education per year. Agencies with a behavioral health license must offer 24 hours per year.

c. DCW professional standards

In addition to training, a DCW needs high professional standards. Your behavior also affects your relationship with the client. The DCW and the client need respect for each other and a professional relationship. The persons for whom you provide services must be able to rely on you. Your services help keep people safe and independent.

Learn more about professionalism and boundaries in Chapter 5, Job Management Skills. Here is a list of important standards:

- Carry out responsibilities of the job the *best* way you can—take pride in a job well done.
- Get the training you need; get continuing education each year.
- Be dependable and reliable.
- Maintain a high standard of personal health, hygiene and appearance.
- Show respect for the client's privacy when you enter his/her home.
- Do not use the client's things for yourself (phone, food, medications, etc.).

Chapter 1 - Overview

- Recognize and respect the right of self-determination and lifestyle.
- Keep your professional life separate from your personal life.
- Control any negative reactions to chronic disability or living conditions.
- Maintain safe conditions in the work environment.
- Do not bring your family or friends to the client's home.



It is better to ask questions than do something that may be unsafe, cause disciplinary action, and/or a liability issue.

B. DIRECT CARE SERVICES AND PROGRAMS IN ARIZONA

1. Definitions

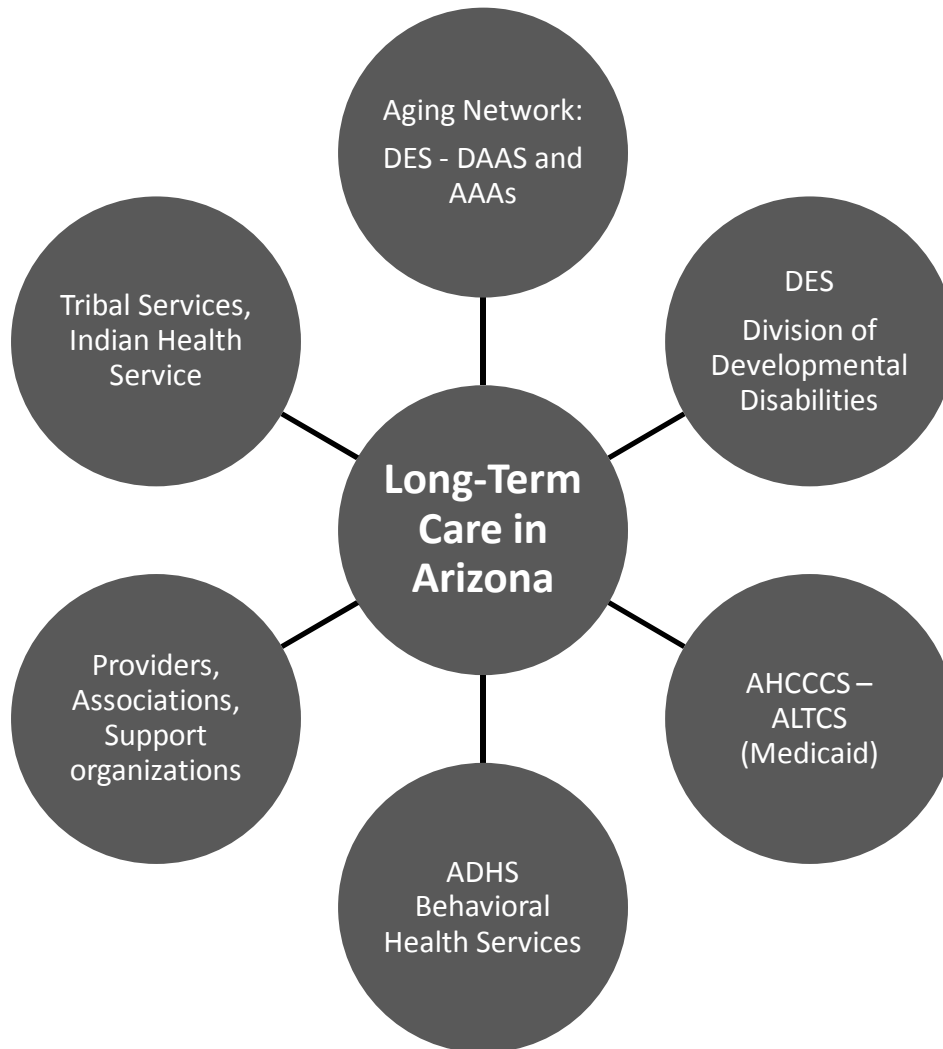
- **Long-term care (LTC):** Services for people who need support for a longer period of time. Examples: A person with a disability; an older person who cannot walk alone.
- **Acute health care:** Services for people who are suddenly ill or had an accident. Examples: seeing a doctor for the flu; going to the hospital after a heart attack.
- **Home and community based services (HCBS):** Many LTC services can be offered in a person's home or in assisted living. Most people are happier in their own homes.
- **Private pay:** Anyone can pay for direct care services privately. There are private duty nurses and private caregivers.
- **Public programs:** Programs paid by a government. These can be state, county, city, or federal government programs. Most of these programs are for people with low incomes.

2. Public Programs in Arizona

a. Government agencies

- Arizona Health Care Cost Containment System (AHCCCS) www.azahcccs.gov
 - Acute health care (Medicaid): medical services for low income persons.
 - Arizona Long Term Care System (ALTCS): care and support for low-income older adults and people with disabilities who need services for a long time.
- Arizona Department of Economic Security (DES) www.azdes.gov
 - Division of Aging and Adult Services (DAAS): assistance for low-income older adults and people with disabilities. Programs are provided through Area Agencies on Aging (AAA).
 - Division of Developmental Disabilities (DDD): information and support for children and adults with developmental disabilities.
- Arizona Department of Health Services (ADHS) www.azdhs.gov
 - Division of Licensing: licensing and inspection of assisted living facilities, nursing homes, clinics and hospitals.
 - Behavioral Health Services (BHS): Works with Regional Behavioral Health Authorities (RBHAs) to provide services for people with addiction or mental health challenges.

b. The Arizona Network of Long Term Care Services



c. Who can get public services

- **Older adults**, over the age of 60, who are frail or vulnerable. This means they need help with daily activities, or they are at risk for injury and illness.
- **Persons with disabilities**. Examples are a person in a wheelchair after an accident or someone with a mental illness.
- **Children and adults with a developmental disabilities**. Examples are autism, cerebral palsy, epilepsy, and cognitive disabilities.

d. DCW services available in the home

- **Personal Care:** Assistance with routine personal activities. Helping people be as self-sufficient as possible. This can be eating, dressing, bathing, and moving about.
- **Housekeeping/Homemaker:** Assistance with chores in the home: cleaning, picking up things, laundry.
- **Attendant Care:** Includes personal care and housekeeping.
- **Respite:** Bringing a DCW to the home so that the family caregiver can take a break.

e. AZ Links – Arizona’s Aging and Disability Resource Center

AZ Links is a special project to provide information and assistance to people in Arizona. Information is free on www.azlinks.gov, and counseling on personal options is available through AZ Links sites.

3. Support Organizations

These organizations are often non-profit agencies, and many work with government agencies to offer information and assistance.

- **Area Agencies on Aging (AAA):** Information on long term care, home delivered meals, case management, and support for family caregivers. Arizona has eight AAAs.
- **Centers for Independent Living (CIL):** Information and resources for people with disabilities. The CILs also advocate for people with disabilities and help them become more independent.
- **Consumer organizations:** The Alzheimer’s Association, Arizona Autism United, and the Arizona Spinal Cord Injury Association are some examples.

Did you know?

- | | | |
|--|------|-------|
| 1. All DCWs in Arizona need the same training. | True | False |
| 2. All older adults in Arizona get public benefits. | True | False |
| 3. A standardized test is required for DCWs in agencies that work for ALTCS and DES programs | True | False |
| 4. Six hours of continuing education per year are required by these agencies..... | True | False |
| 5. Most people prefer to live at home and get assistance there | True | False |

C. SERVICE SETTINGS

This training is for DCWs who work in a person’s home. There are other places where direct care is provided. More training may be needed, but the DCW training is a good foundation.

Service Settings	Work Environment
<p>The individual’s home (or a relative’s home). The individual may also attend adult day services or school.</p>	<ul style="list-style-type: none"> • Staff works in the person’s home • Staff usually works alone • Training: DCW training
<p>A group home, usually for a specific group of disabilities, such as a group home for individuals with developmental disabilities</p>	<ul style="list-style-type: none"> • Working in a home-like setting • Limited number of co-workers • Staff is responsible for assisting more than just one individual • Training: DCW plus specialized training for group homes
<p>An assisted living home</p> <ul style="list-style-type: none"> • Provides 24 hour care in a home-like setting for 1-10 residents • May or may not be owner occupied • An adult foster care home is owner occupied and cares for 1-4 residents 	<ul style="list-style-type: none"> • Similar to group home • Working in a home-like setting • Limited number of co-workers • Staff is responsible for assisting more than just one person • Up to 10 individuals and all are adults with various disabilities • Training: DCW and/or Assisted Living Caregiver
<p>An assisted living facility</p> <ul style="list-style-type: none"> • Individuals usually live in individual apartments and pay for the services they require • Larger facilities, can be up to 100 or more units • Often the larger facilities are divided into functional units depending on how much assistance the person needs 	<ul style="list-style-type: none"> • Usually care is provided in the individual’s apartment • Staff usually works alone in the individual’s apartment but has co-workers working in the same complex • Staff may work for one client or several depending on the needs of the person • Clients may privately pay for staff assistance above and beyond the services offered by the facility. The staff would be working for the individual, not the facility • Training: Assisted Living Caregiver
<p>A dementia specific unit</p> <ul style="list-style-type: none"> • Similar to an assisted living facility but is specific to the care of persons who have dementia • These units are usually locked so that persons cannot wander away 	<ul style="list-style-type: none"> • Staff works on the unit with other co-workers (number depends on how large the unit is) • Staff assigned to assist more than one individual • Training: DCW and/or Assisted Living Caregiver
<p>A skilled nursing facility (nursing home)</p> <ul style="list-style-type: none"> • Skilled nursing care 24/7 	<ul style="list-style-type: none"> • Staff works with co-workers in the facility. The supervisor is a nurse. Training: Certified Nursing Assistant (CNA) • There are also support positions (e.g., activities or dietary). Training: DCW and/or specialized training

D. PHILOSOPHY OF PROVIDING DIRECT CARE AND SUPPORTS

1. Basic Principles

There are basic principles—beliefs—that all people have rights, abilities, and freedom of choice. Arizona state agencies and the providers that helped write this curriculum support these principles.

- **Independence:** Freedom to direct one’s life; able to do things for yourself when possible.
- **Choice:** Each person chooses what to do and when to do it; caregivers do not tell them what to do.
- **Dignity:** Each individual is a person; each person needs respect, privacy and is treated the way he or she wants to be treated. When people need assistance, they still need to feel they are valued and in control of their lives.
- **People can learn:** Some people may be slower, some need assistance, some have only a little energy. All can learn and change.
- **Person-centered approach:** Assistance or support is given when or how the person needs it. Examples: a person from another culture may prefer certain foods; some people want a lot of treatments, others want less help.
- **Consumer-direction:** When possible, the client tells the caregivers what to do, when and how. There are some public programs with *consumer direction*. This means that the person interviews, hires, trains, and supervises the DCW.

Care, Support, Assistance—Does it matter?

Many DCWs are *caregivers*—they provide care for another person. Family members and friends can be caregivers.

Some people need assistance, perhaps because they are in a wheelchair. They do not feel ill, they do not need to “be cared for.” They just need help with some activities. These individuals may prefer to use the terms *assistance* or *in-home supports*. The DCW may be called a *personal care assistant* or an *attendant*.

Use the person-centered approach: find out what the person expects and wants.

2. Independent Living and Self-Determination Statement

Independent living and self-determination are values that stress dignity, self-responsibility, choices and decision making. Independent living is the freedom to direct one's own life. Each individual has the right to optimize his or her personal ability and fully integrate into the community.

What does this mean? You get to be in charge of your own life. You might seek advice, but you make decisions for yourself. You know what is best for you. It does not mean

doing everything all by yourself. You might need assistance around your home. You choose who assists you. You pursue your dreams. You explore your potential, talents and abilities. It means having the freedom to fail and learn from your failures as well as experience successes, just as non-disabled people do. The opportunity for independent living and self-determination is essential to the well being of people with disabilities.

- We promote and value equal opportunity, full integration and consumer choice.
- We promote the achievement of full rights and empowerment of all persons with disabilities.
- We promote the full participation of people with disabilities in the cultural, social, recreational and economic life of the community.
- We promote consumer choice/control—the individual’s right to make informed decisions regarding his or her best interests in all aspects of life.
- We promote the involvement of people with disabilities in the decision-making process of community programs and services.

3. Working with Older Adults

As people get older, they tend to slow down a little. Unfortunately, younger people sometimes show disrespect or simply become impatient. Ageism—or age discrimination—is all too common in our society: many products or movies are about and for younger people; we are always in a hurry and we see older adults as being too slow. If you work with older adults, it is important to have the right mindset. Keep in mind a few principles:

- Older adults can do a lot and learn new things. Like all people, they feel better when they can do things for themselves.
- Older people have experience and wisdom. They may not know everything you know, but they know a lot.
- Always treat an older adult as an adult. Adults are not like children.
- Older people have interests and likes and dislikes. They want to make their own choices.

4. History of Treatment of Individuals with Disabilities

Ancient Times

- People with disabilities were discarded.
- They may have been thought unworthy to feed.

Middle Ages

- People with disabilities were thought to be possessed by evil spirits.
- Disabilities were thought to be caused by sins of the parents.

1700-1800s

- Schools were being formed.
- Braille was established.

1900s

- Institutions were established for “genetic mistakes.”

1930s

- Hitler was striving for the “Super Race” and proposed sterilizing people with hereditary disabilities so that they could not have children. Gas chambers were used to kill over two hundred thousand people with disabilities.

1950s

- Television represented people with disabilities with a negative stereotype, creating “The Pity Soap Box.”
- Support organizations were founded:
 - March of Dimes
 - Muscular Dystrophy Telethon

1990s

- Americans with Disabilities Act (ADA) becomes law. Justin Dart is considered the father of the ADA, which had an impact on many aspects of life:
 - Access to public buildings
 - Telecommunications
 - Transportation
 - Job opportunities

5. The Independent Living Movement Philosophy

In the early 1960's a handful of students with disabilities at the University of California, Berkeley, decided they were tired of living in a hospital setting and being isolated from community activities. They felt that as human beings they had a right to choose their own lifestyle. After examining the risks and accepting the responsibilities, they moved into apartments in the community, arranged for assistant care, and won for themselves the freedom to choose. The freedom for individuals who experience a disability to make decision concerning their lives and being given the opportunity to develop fully according to their potential are essential elements in what has become known as "Independent Living."

With the passage of the 1978 amendments to the Rehabilitation Act of 1973, Congress recognized the value of Independent Living and allocated money to fund programs which assist persons who experience a disability in meeting their needs.

Independent Living became a reality in Arizona in 1977 when a group of residents who experience disabilities attended the White House Conference on Handicapped Individuals. They were introduced to the Independent Living concept and were inspired to return to Arizona to begin a legislative and advocacy group. They organized the Arizona Congress for Action, a private, non-profit affiliate of the American Coalition of Citizens with Disabilities (ACCD). Their ideal was to bring together representatives from various groups concerned with issues relating to individuals with disabilities in order to stimulate cross-disability communication, to increase awareness of difficulties faced by persons with disabilities, and to make the Independent Living concept a reality among the disabled population of Arizona.

Toward this end, federal funds were applied for and a proposal was written to establish an Independent Living Center. In 1980, federal funds were received and divided between the two larger urban areas of Arizona. In Tucson, the Metropolitan Independent Living Center (MILC) was established, and in Phoenix, Arizona Bridge to Independent Living (ABIL) became a reality.

Used with permission from *Personal Assistant Training Manual*, Arizona Bridge to Independent Living (ABIL)

Did you know?

1. Mrs. Brown is eating lunch. She wants cereal and a banana.
 - a. You help her with the cereal and banana.
 - b. You fix her a sandwich because that is a better lunch.
2. Mr. Jones needs to get dressed.
 - a. You show him several shirts and let him pick one.
 - b. You take a shirt from the closet and start putting it on him.
3. Mrs. Green often spills milk when she opens the carton.
 - a. You let her open the carton of milk.
 - b. You do it for her to avoid the mess.
4. Mrs. Miller tends to fall asleep in front of the TV.
 - a. You leave the TV on her program.
 - b. You change the channel to your favorite show.
5. Mr. Houston spilled coffee on his shirt.
 - a. You ask him if he wants to change.
 - b. You go to him and start to unbutton the shirt.
 - c. You tell him to change.
 - d. Nothing needs to be done.
6. John G. has a cognitive impairment. He wants to heat up soup, but he has problems with the stove.
 - a. You heat up soup for him.
 - b. You tell him to fix a sandwich.
 - c. You assist him with heating soup in the microwave.
7. Mrs. Lang just asked for the third time how to take photos with the cell phone.
 - a. You tell her it's too hard to learn.
 - b. You change the subject; she is too old to learn this.
 - c. You show her again.

E. RESOURCES

For more information about direct care workers, visit:

- Arizona Direct Care Workforce Initiative, www.azdirectcare.org
- Paraprofessional Healthcare Institute (PHI), www.paraprofessional.org/
- National Clearinghouse on the Direct Care Workforce, www.directcareclearinghouse.org
- Iowa Caregivers Association, www.iowacaregivers.org

For more information about assistance programs, visit

- AZ Links www.azlinks.gov
- Area Agencies on Aging
- Independent Living Centers
- Arizona Department of Economic Security, www.azdes.gov
- Arizona Department of Health Services, www.azdhs.gov
- Arizona Health Care Cost Containment System, www.azahcccs.gov

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 2 – LEGAL AND ETHICAL ISSUES

CONTENTS

- A. Legal Terms and Definitions
- B. Distinction Between Law and Ethics
- C. Avoiding Legal Action
- D. Ethical Principles
- E. Client Rights
- F. Direct Care Worker Rights
- G. Confidentiality (HIPAA)
- H. Adult and Child Abuse
- I. Advance Directives
- J. Do Not Resuscitate Order (DNR), the Orange Form
- K. Resources

OBJECTIVES

1. Describe and explain legal and ethical issues.
2. Describe guidelines for avoiding legal action and list methods for protecting consumer rights.
3. Identify, describe, and differentiate cases of abuse, neglect, and exploitation; describe preventive measures; state the reporting requirements and identify legal penalties.
4. Describe techniques for incorporating and promoting consumer rights, dignity, independence, self-determination, privacy and choice.
5. Describe and explain ethical behavior in caregiving.
6. Describe advance directives and the significance of the “orange form.”

KEY TERMS

Note: Also see the legal terms on the next page.

Advance directives	Law
Abuse	Legal action
Confidentiality	Living will
Do not resuscitate order (DNR)	Need to know
Durable power of attorney	Neglect
Ethics	Orange form
Exploitation	Privacy
Health Insurance Portability and Accountability Act (HIPAA)	Support plan (care plan)

A. LEGAL TERMS AND DEFINITIONS

- **Abandonment** is when a family or agency leaves an individual without care or support.
- **Assault** takes place when an individual intentionally attempts or threatens to touch another individual in a harmful or offensive manner without their consent.
- **Battery** takes place when an individual harmfully or offensively touches another individual without their consent.
- **False imprisonment** takes place when you intentionally restrict an individual's freedom to leave a space.
- **Fraud** means that a person intentionally gives false information in order to make money or gain an advantage.
- **Invasion of privacy** is revealing personal or private information without an individual's consent.
- **Liability** refers to the degree to which you or your employer will be held financially responsible for damages resulting from your negligence.
- **Malpractice** is a failure to use reasonable judgment when applying your professional knowledge.
- **Negligence** is when a personal injury or property damage is caused by your act or your failure to act when you have a duty to act.



B. DISTINCTION BETWEEN LAW AND ETHICS

- **Law:** rules written by the legislature or a government agency.
- **Ethics:** a system of moral values; a set of principles of conscientious conduct.

Some laws are also ethical (for example, abuse laws), some are not (speeding). But not all ethical principles are laws (for example, being honest).

C. AVOIDING LEGAL ACTION

- **Keep personal information confidential.** Do not discuss confidential information with others except your supervisor or other colleagues who are directly involved with the client’s care. Confidential information may include medical, financial, or family issues.
- **Only perform work assigned.** If you perform a task that was not assigned by your supervisor, you become liable for those actions. A plan is developed for each client that describes exactly what services should be provided. This is called a care plan or support plan. It lists the tasks you should do for this individual.
- **Do not do less work than assigned.** When you fail or forget to do all the tasks assigned, you may put your client at risk. As a result of your failure to act, you might be found negligent. Again, it is important that you understand the care or support plan for the client. You must do all the tasks assigned to you as described in the plan—not more and not less.
- **Avoid doing careless or low-quality work.** Performing tasks carelessly might make you liable for the damages or injuries that result.
- **Report abuse** and make sure your actions are not considered abusive.



Your primary legal responsibility is to avoid legal action for you and the company you work for.

D. ETHICAL PRINCIPLES

- **Honesty:** Do not be afraid to politely say “no” to a task you are not assigned to do. Also, do not be afraid to admit that you do not know an answer to a question or how to do a task. Never steal, take a client’s possessions, or falsify documents or reports.
- **Respect:** An individual’s religious or personal beliefs and values may differ from yours. You should respect those differences.
- **Reliability:** Arrive for assignments on time. Always finish your shift, even if a client is being difficult or the workload is difficult. You can address those problems with the supervisor after you have finished your shift.
- You should not take gifts or tips.
- Follow the client’s service plan unless you consult with your supervisor.
- Take pride in doing your job well.

E. CLIENT RIGHTS

Clients have the right to:

- Considerate and respectful treatment and care.
- Not be abused emotionally, sexually, financially, or physically.
- Design their treatment or service plan, decide how their services will be provided, and who will deliver those services (including requesting a change of caregiver).
- Receipts or statements for their fee-based service.
- Refuse treatment.
- Privacy.
- File a complaint with the agency.
- Confidential handling of their personal information.

These client rights are based on principles of *self-determination* and *client choice*. Clients choose which services they want to receive. They may also choose how services are provided. For example, each person chooses what clothes to wear and what foods to eat. Having choices improves well-being and makes the person more independent.

The DCW should respect the client's choices. When a person is not allowed to make decisions about services, that takes away from his/her rights. As a DCW, if you are concerned about a choice, explain why you are concerned, discuss an alternative, contact your supervisor for instructions, and document what you did.

F. DIRECT CARE WORKER RIGHTS

DCWs have the right to:

- File a complaint without the fear of retaliation.
- Not be abused emotionally, sexually, financially, or physically.
- Work in a safe environment.
- Provide input for changes to a client's service plan.
- Be informed when a client files a complaint against him or her.
- A confidential investigation, a fair hearing, and be told the outcome when addressing complaints against him or her.
- Receive timely payment for services including salary and mileage, where appropriate.

G. CONFIDENTIALITY (HIPAA)

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a law that keeps the identifiable health information about our clients confidential. It includes what must be done to maintain this privacy and punishments for anyone caught violating client privacy. The Office of Civil Rights of the U.S. Department of Health and Human Services is the agency authorized to enforce HIPAA's privacy regulations. The regulations took effect on April 14, 2003.

What is confidential?

All information about our clients is considered private or *confidential*, whether written on paper, saved on a computer, or spoken aloud. This includes their name, address, age, Social Security number, and any other personal information. It also includes the reason the client is sick, the treatments and medications he/she receives, caregiver information, any information about past health conditions, future health plans, and why the client is open to services.

Spoken communication runs the gamut from conducting client interviews, paging clients, whispering in corridors, to talking on telephones. Written communication includes the hard copy of the medical record, letters, forms, or any paper exchange of information. Electronic communication includes computerized medical records, electronic billing and e-mail.

If you reveal any of this information to someone who does not *need to know*, you have violated a client's confidentiality, and you have broken the law.

What are the consequences of breaking the law?

The consequences will vary, based on the severity of the violation, whether the violation was intentional or unintentional, or whether the violation indicated a pattern or practice of improper use or disclosure of identifiable health information. Depending on the violation agencies may be fined by the government if they are found to be in non-compliance with HIPAA regulations. Agencies and their employees can receive civil penalties up to \$25,000 for the violation. Agencies and their employees can also receive criminal penalties up to a \$250,000 fine and/or 10 years in prison for using information for commercial or personal gain or malicious harm.

Why are privacy and confidentiality important?

Our clients need to trust us before they will feel comfortable enough to share any personal information with us. In order for us to provide quality care, we must have this information. They must know that whatever they tell us will be kept private and limited to those who need the information for treatment, payment, and health care operations.

What is the *need to know* rule?

This rule is really common sense. If you need to see client information to perform your job, you are allowed to do so. But, you may not need to see all the information about

every client. You should only have access to what you need to in order to perform your job. There may also be occasions when you will have access to confidential information that you don't need for your work. For example, you may see information on whiteboards or sign-in sheets. You must keep this information confidential. There's no doubt that you will overhear private health information as you do your day-to-day work. As long as you keep it to yourself, you have nothing to worry about. In the course of doing your job, you may also find that clients speak to you about their condition. Although there's nothing wrong with this, you must remember that they trust you to keep what they tell you confidential. Do not pass it on unless it involves information the professional staff needs to know to do their jobs. Tell the client that you will be sharing it with the professional staff or encourage them to tell the information themselves.

What are the client's HIPAA rights?

Each client has certain rights under the HIPAA regulations. Unless the information is needed for treatment, payment, and health care operations, we cannot release any information without a written authorization from the client. The client must also give you verbal/written permission to discuss information with family members. This permission should be documented in the client's chart. The client also has the following rights:

- To inspect and copy his/her medical record.
- To amend the medical record if he/she feels it is incorrect.
- To an accounting of all disclosures that were made, and to whom, except those necessary for treatment, payment, or health care operations.
- To restrict or limit use or access to medical information by others.
- To confidential communications in the manner he/she requests.
- To receive a copy of the agency's Notice of Privacy Practices.

If the client feels the agency or its staff has not followed the HIPAA regulations, the client can make a formal, written complaint to the agency's Privacy Officer or to the Department of Health and Human Services, Washington, DC.

Adapted from the HIPAA training at the Foundation for Senior Living

What are ways to protect confidentiality?

a. Spoken communications

- **Watch what you say, where you say it, and to whom.**
- Speak in a quiet voice when you share information.
- Close doors when discussing private information.
- Do not talk about health information matters in front of others.
- If someone asks you a question involving personal information, make sure that person has a *need to know* before answering.



b. Telephone communications

- Never leave personal health information on an answering machine regarding a consumer's conditions, test results, etc.
- If you are leaving a message on an answering machine/voice mail, only leave the name of the person calling and the agency's telephone number with your contact phone number, and request a call back.
- Do not leave messages with anyone other than the client or a responsible party.

c. Medical records

- Make sure medical records are viewed only by those who need to see them.
- Store them in an area not easily accessible to non-essential staff and others.
- Do not leave medical records lying around unattended or in an area where others can see them. Don't leave files on car seats; lock them in the trunk.
- Return the medical record to its appropriate location when you are finished viewing it.



d. Trash

- Shred all papers containing personal health information.
- Put trash cans and shredders as close as possible to fax machines and desks where personal health information is used.
- If you see un-shredded paper discarded in a trash can, remove it and bring it to your supervisor.

e. Fax transmissions

- Fax machines should be in a secure area.
- Do not leave papers containing private health information on the fax machine unattended.
- Pre-program frequently faxed numbers into the fax machine to reduce dialing errors.

- Periodically check on the pre-programmed numbers to make sure they are still correct.
- If possible, notify the receiver when you are sending a fax.
- Have a fax cover sheet with a statement that the fax contains protected health information, re-disclosure is prohibited, and what to do if the wrong person gets it.

f. Computers

- Develop a personal password which is not a guessable name and change it as instructed.
- Never share your password or write down your password.
- Position your monitor so it is not facing where someone could view identifiable health information.
- Never leave a computer unattended without logging off.
- All e-mails sent, which contain identifiable health information, should be encrypted and the sender/receiver should be authenticated.
- Double-check the address before sending any e-mail.
- Never remove or discard computer equipment, disks, or software without your supervisor's permission.



If you notice a breach of confidentiality, inform your supervisor or privacy officer.

H. ADULT AND CHILD ABUSE

1. Definition

Adult and child abuse refers to any form of maltreatment of a person by a caregiver, family member, spouse, or friend. Categories of abuse include:

a. Abuse

Intentional infliction of physical harm or unreasonable confinement.

b. Sexual abuse or sexual assault

Sexual contact with any person incapable of giving consent or through force or coercion, which means by force or threatening.

c. Neglect

Failing to provide a person food, water, clothing, medicine, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health. Shelter refers to housing but also the environment. Leaving a person in unsafe or hazardous environments can be neglect. For children this also applies to parents leaving a child with no one to care for him/her or leaving a child with a caretaker and not returning or making other arrangements for his/her care. When a person does not care for his/her own well-being or safety, this is called self-neglect.

d. Financial exploitation

The improper or unauthorized use of a person's funds, property, or assets. This includes forgery, stealing money or possessions, or tricking a person into signing documents that transfer funds, property, or assets. For children this also includes using a child for material gain, including forcing a child to panhandle, steal or perform other illegal or involuntary activities.

e. Emotional abuse

Psychological abuse such as name-calling, insults, threats, and intimidation.

2. Risk Factors

a. Adult abuse

- Previous incidents of domestic violence by spouse.
- Financial dependency on the adult by the abuser.
- Mental illness of abuser.
- Adult children living with older parent.
- Abuser isolates adult to prevent the abuse from being discovered.

b. Child abuse

- Child living in area with high poverty, unemployment or crime rates.
- Child has physical and/or mental disability.
- Abuser has history of physical or sexual abuse as a child.
- Abuser has low self-esteem, abuses drugs or alcohol, or suffers from depression or mental illness.

3. Signs

a. Adult abuse

- **Physical:** bruises, broken bones, cuts or other untreated injuries in various stages of healing.
- **Sexual:** bruises around breast or genital area; signs of sexually transmitted diseases (STDs).
- **Emotional:** adult is upset or agitated, withdrawn, non-communicative, or paranoid.
- **Neglect (including self-neglect):** dehydration, malnutrition, pressure ulcers, poor personal hygiene, and unsafe or unsanitary living conditions.
- **Financial:** unusual banking activity, missing financial statements or other personal items such as jewelry; signatures on checks that do not match adult's signature.

b. Child abuse

- **Physical:** bruises, broken bones, cuts or other untreated injuries in various stages of healing.
- **Sexual:** bruises around breast or genital area, signs of sexually transmitted diseases (STDs), pregnancy.
- **Emotional:** eating disorders, speech disorders, developmental delay, cruel behavior, behavioral extremes.
- **Neglect:** poor hygiene; absenteeism; hunger; tiredness, begging for or collecting leftovers; assuming adult responsibilities; reporting no caretaker at home.



APS Made a Difference with My Client

I have been a caregiver for eight years. I love providing care to the elderly. It feels so good when I come home from work knowing that I made a difference. I will never forget Marion who lived alone in her own little modest mobile home. Marion was quite independent. She had no family who lived close to her. Her family lived out of state. I provided care to Marion for a little over a year. In the last six months of providing care I started to see changes happen.

Marion loved to listen to the radio, but now she would tell me that these people lived in the box “radio” and she would need to put some plates out for them to eat dinner. In the beginning it was just little things, but then I noticed more serious events start to happen. I would arrive and the burner on the stove was left on. I reported this to my supervisor and after some calls it was suggested that the knobs be taken off the range so this would prevent Marion from possibly starting a fire by leaving the burner on. Using the microwave was the way to go. All went okay for a short time but more changes were happening. I remember one time when I arrived at work, the neighbor came and talked to me and told me that Marion was sitting on the front stairs of the front porch at 11 pm the night before. She could not figure out how to get inside. The neighbor said this had happened several times before. The neighbor stated she had called Marion’s family that was out of state, and the family’s response would be: “We have talked to Marion, and yes, she might be a little confused at times, but this is where she wants to live”. I called my supervisor about this concern and she told me to call Adult Protective Services. It took several calls to address the concerns about Marion living by herself, but in time it did pay off. Today, Marion is living in an assisted living apartment. It is a win/win situation. Marion is still independent, but she has people looking out for her and assisting her when she needs assistance. I have to say I was a little scared when I called Adult Protective Services, but that call made a big difference in Marion’s safety. The family realized that Marion had more than a little confusion going on, so with the intervention of Adult Protective Services, this experience had a happy ending.

Marie P, caregiver



4. Prevention

- Community awareness.
- Public and professional education.
- Caregiver support groups.
- Stress management training.
- Respite care or in-home services.
- *The Parent Assistance Program* is a service designed to help parents or guardians. This program, operating through the Administrative Office of the Courts, provides a 24-hour toll-free hotline to assist parents with their questions and concerns about Child Protective Services (CPS). Through the hotline, parents may obtain information about legal assistance, the juvenile court system and their legal rights and responsibilities. Trained hotline staff may also provide crisis counseling and referrals to appropriate agencies or individuals.

**To contact the Parent Assistance Program call
602-542-9580 (Phoenix) or 1-800-732-8193 (Statewide toll-free)**

5. Reporting Requirements

- All persons responsible for the care of an incapacitated or vulnerable adult or child **have a duty to report** suspected abuse and neglect. This is called *mandatory reporting*.
- Reports must be made immediately (by phone or in person) to Adult Protective Services or Child Protective Services (depending on the person's age) or to the police. **Failure to report is a misdemeanor.**
 - If the individual is in immediate danger, call 911.
 - If the abuse is not life-threatening, report it to your Supervisor who will assist you in making the report to either of the 24-hour statewide reporting lines:
 - Adult Protective Services: 1-877-SOS-ADULT (1-877-767-2385)
 - Child Protective Services: 1-888-SOS-CHILD (1-888-767-2445)
- **Immunity**
All persons reporting are immune from any civil or criminal liability if the report does not involve any malicious misrepresentation, according to Arizona statutes (ARS § 46-453).

6. Legal penalties

Any person who has been employed to provide care to an incapacitated or vulnerable adult or child and who causes or permits the person's life to be endangered or his/her health to be injured or endangered by neglect can be found guilty of a felony.



An individual who is found guilty of a felony will not only face jail time. A felony conviction also limits the type of jobs the individual can hold in the future. For example, convicted felons are unable to work in most healthcare or educational systems.



7. Reporting Activity

Read the following scenarios and discuss what you would do in these situations.

- You are assigned to provide personal care services for Mabel including a shower. Mabel is living in a poorly maintained home. She has a son who pays her bills and stops by a few times a week. When you arrive at Mabel's home, Mabel is complaining of being cold. The thermostat for the heater registers 60 degrees. You talk to Mabel's son who tells you that the furnace is broken but, "it is okay because I have just given Mom some blankets. She doesn't need it any warmer."

What would you do?

- You are assigned to provide respite care for Jimmy, a 10-year-old boy with autism. When you arrive at Jimmy's home, Jimmy is outside wandering in the street. No one is at home except Jimmy's 10-year-old brother, who is watching TV.

What would you do?

I. ADVANCE DIRECTIVES

Advance directives are documents specifying the type of treatment individuals want or do not want under serious medical conditions. The documents are used when a person is unable to communicate his or her wishes. They provide written proof of the expressed wishes of the individual, rather than making the family guess what is desired. Making one's wishes known in advance helps everyone. It keeps family members from making such choices at what is likely one of the most stressful times in their lives. It also means that the physician knows whose direction is to be followed in the event the family disagrees as to what medical treatment the individual desires.

Generally, two forms are involved with advance directives:

- **Living will:** Legal document that outlines the medical care an individual wants or does not want if he or she becomes unable to make decisions. An example would be the use of a feeding tube.
- **Durable medical power of attorney:** Legal document that designates another person to act as an *agent* or a *surrogate* in making medical decisions if the individual becomes unable to do so.

Advance directives can be completed by an individual. The writing does not need to be done by an attorney, but it must be done while the person is still competent. In Arizona the forms do not have to be notarized. If the individual moves to another state that requires notarization, the forms would be invalid.

J. DO NOT RESUSCITATE ORDER (DNR), THE ORANGE FORM

The *Pre-Hospital Medical Care Directive*, also known as the “orange form” or a DNR, is a special advance directive. This form says that if the heart stops beating or breathing stops, the individual **does not want to receive cardiopulmonary resuscitation (CPR) under any circumstances**. This special form, which is bright orange in color, notifies the paramedics and emergency medical services people that this choice has been made.

1. Agency-Specific Policies and Procedures

The policies and procedures for honoring an orange form vary from agency to agency. Some agencies have policies that mandate that the DCW would provide CPR measures (if certified) whether the individual has an orange form or not. Other agencies have a procedure to follow if the individual you are caring for has a valid orange form.

When the DCW notes that the consumer has an orange form, the DCW should contact his/her supervisor to determine the policies and procedures related to CPR for the consumer.

It is also important to **remember that the orange form only covers cardiac and respiratory arrest**. If the consumer has another type of medical emergency, the DCW should provide first aid measures, including calling 911 as indicated.

2. Display of the Orange Form

Because the paramedics respond quickly to an emergency medical situation, the *Pre-Hospital Medical Care Directive* must be immediately available for them to see. It should be displayed someplace where the paramedics will be able to see it should the individual have a cardiac and/or respiratory arrest. Such places would be the refrigerator or behind the front door or living room door.

Did you know?

1. Liability means:
 - a. You cannot share personal information.
 - b. You are responsible for damages is something goes wrong.
 - c. You must decide what to do in an emergency.

2. Mr. Jones does not want to bathe or eat.
 - a. You tell him he must bathe and eat because it is on the schedule.
 - b. He has the right to refuse.

3. When you suspect abuse or neglect of an older adult, you:
 - a. Call your supervisor and then call APS.
 - b. You make a note in your report to check back next week.

4. You can share personal information about a client with:
 - a. Everyone in the office at your agency.
 - b. Visiting family members.
 - c. People who call from the doctor’s office.
 - d. The neighbors.
 - e. Your own family.
 - f. None of the above.
 - g. All of the above.

5. Mrs. Cline has a DNR (orange form). What are her wishes?
 - a. She breaks her arm. She should get medical help. True False
 - b. She has a heart attack. She should get CPR. True False
 - c. She has a hard time breathing. She should get oxygen..... True False
 - d. She has a lot of pain. She should get pain medicine. True False

K. RESOURCES

- Advance directives information for individuals residing in Arizona can be obtained from:
 - Health Care Decisions: www.hcdecisions.org
 - Arizona Attorney General's Website: www.azag.gov/life_care/index.html
- Adult Protective Services: 1-877-SOS-ADULT (1-877-767-2385)
Website: www.azdes.gov/aaa/programs/aps/
- Child Protective Services: 1-888-SOS-CHILD (1-888-767-2445)
Website: www.azdes.gov/dcyf/cps/reporting.asp
- Parent Assistance Program: 602-542-9580 (Phoenix), 1-800-732-8193 (Statewide toll-free)
- Pamphlet on Child Abuse, Child Protective Services, Arizona Department of Economic Security
- Pamphlet on Elder Abuse, Area Agency on Aging Region One

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 3 – COMMUNICATION

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- A. Components of Effective Communication
 - 1. The Communication Process
 - 2. Verbal Communication
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 - 1. Aggressive Communication
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 - 3. Assertive Communication
- C. Attitude
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 - 1. Open-Ended Questions
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 - 1. Vision Impairment
 - 2. Hearing Impairment
 - 3. Language Impairment (Aphasia)
 - 4. Emotional/Mental Health Impairment
 - 5. Cognitive/Memory Impairment
- H. A Guide to Wheelchair Etiquette
- I. People First Language
- J. Resources

OBJECTIVES

1. Describe and explain the communication process.
2. Explain the importance of non-verbal language.
3. Identify different communication styles and explain the importance of assertive communication.
4. Identify and explain barriers to communication.
5. Describe and explain effective techniques for therapeutic communication and conflict resolution.
6. Identify and explain techniques for communicating with individuals with disabilities.

KEY TERMS

Assertive communication	People first language
I–messages	Platinum rule
Non-verbal communication	Verbal communication
Open-ended question	Wheelchair etiquette

A. COMPONENTS OF EFFECTIVE COMMUNICATION

1. The Communication Process

Communication in homecare is the link between you, the client, and the agency. Sharing accurate information and observations with family and the agency improves the care for the client.

The communication process involves the:

- Sender (for example, the speaker)
- Receiver (for example, the listener)
- Message
- Feedback

The goal of communication is the acceptance of the sender's message by the receiver. If the receiver understands the meaning of a message and perceives it the same as the sender, the goal of communication is achieved. The sender gets input as to how the receiver perceived the message via feedback from the receiver. If the feedback never comes or if the feedback is not what the sender expects, communication is ineffective.

Effective communication happens when the intended meaning of the sender and the perceived meaning of the receiver are virtually the same.

2. Verbal Communication

Verbal communication uses words. Often we use the word verbal to mean oral, or spoken, language. But verbal communication also includes writing and different ways of expressing words. Sign language and Braille are also verbal communication. Braille is the writing system that uses raised dots to express the letters of the alphabet.

3. Non-Verbal Communication

Non-verbal communication does not use words. There are several categories: facial expressions, head movements, hand and arm gestures, physical space, touching, eye contact, and physical postures. Even a person's emotions or how she dresses can influence the communication process.

As much as 90% of communication can be non-verbal. Non-verbal means no words are used.

Have you ever visited a country and didn't speak the language? How important was non-verbal communication?

When verbal and non-verbal communication are combined, a stronger message can be sent. A completely different message is sent if the verbal and non-verbal do not agree.

Example #1: While asking a client to sign your time sheet, you hold the timesheet and pen in your hand. → Your actions support the verbal message.

Example #2: You ask a person, “How are you today?” and she replies, “I’m okay,” but she is sobbing into a tissue. → Two different messages are being sent.

Facial expressions – What they can mean in different cultures

Smiling is an expression of happiness in most cultures. It can also signify other emotions. Some Chinese, for example, may smile when they are discussing something sad or uncomfortable.

Winking has very different meanings in different cultures. In some Latin American cultures, winking is a romantic or sexual invitation. In Nigeria, Yoruba people may wink at their children if they want them to leave the room. Many Chinese consider winking to be rude.

In Hong Kong, it is important not to blink one’s eyes openly. This may be seen as a sign of disrespect and boredom.

Some Filipinos will point to an object by shifting their eyes toward it. Or they may purse their lips and point with their mouth, rather than using their hands.

Some Venezuelans may use their lips to point at something, because pointing with a finger is impolite.

Expressions of pain or discomfort such as crying are also specific to various cultures. Some cultures value being *stoic*, showing no emotion. Others may encourage a more emotive state. Expressions of pain or discomfort are also learned from one’s family illness experiences and expressions of distress.

Source: “Non-verbal Communication,” Management Sciences for Health, www.msh.org.

B. COMMUNICATION STYLES

The main types of communication styles are:

- Aggressive: Meeting needs of self and not of others.
- Passive: Meeting needs of others and not self.
- Assertive: Meeting need of both others and self.

1. Aggressive Communication

What is aggressive communication? It may be physical, non-verbal (if looks could kill, ridicule, disgust, disbelief, scorn), or verbal (insults, sarcasm, put downs). It is used to humiliate or demean another person, for example, with profanity or blaming.

Why people behave in an aggressive way

- They anticipate being attacked and overreact aggressively.
- They are initially non-assertive. Their anger builds until they explode.
- They have been reinforced for aggressive behavior. It got them attention and/or what they wanted.
- They never learned the skills for being assertive. They do not know how to appropriately communicate their wants and needs to others.
- They were socialized to win, be in charge, be competitive, and be top dog.

Consequences

- They get their own way but often alienate others.
- They are often lonely and feel rejected.
- They receive little respect from others.
- They may develop high blood pressure, ulcers, have a heart attack, or other related ailments.

2. Passive Communication

The word *passive* refers to “not resisting” or “not acting.” It comes from the Latin word “to suffer.” A verbally passive person keeps quiet and may withhold feedback. This makes communication harder and puts relationships at risk. When you withhold needed information and create an atmosphere of uncertainty, the other person does not really know what you think or feel—no one is a mind reader. It can lead to misunderstandings, strained relationships and suffering.

Why people behave in a passive way

- They believe they have no rights.
- They fear negative consequences (someone being angry, rejecting, or disapproving of them). They mistake being assertive as being aggressive.
- They do not know how to communicate their wants, and assume others should know these.

- They were socialized to always be compliant, accepting, accommodating, non-demanding, and selfless.

Consequences

- They avoid conflict but often appease others.
- They lose self esteem.
- They develop a growing sense of anger and hurt.
- They may develop headaches, ulcers, backaches, depression, and other symptoms.

What is passive-aggressive communication?

Passive-aggressive behavior is often used when we try to avoid doing something, but we do not want to cause a conflict. We may just try to postpone or procrastinate. Passive-aggressive communication is subtle and may appear underhanded and manipulative. This can include forgetting, pouting, silent treatment and manipulative crying.

3. Assertive Communication

Assertiveness is the ability to say what you want to say, but still respect the rights of others. When you are assertive, you are honest about your opinions and feelings. At the same time you try not to criticize or put others down. Assertive communication is respectful of both the sender and the receiver of the message. As a direct care worker, you should strive to use assertive communication at all times.

- It is respectful of yourself and others
- It recognizes your needs as well as others. You are not a doormat, and you are not a bully.
- It is constructive, honest, open direct communication because you:
 - have options,
 - are proactive,
 - value yourself and others,
 - stand up for yourself without excessive anxiety, and
 - accept your own and other's limitations.



Assertiveness is a win-win situation.

C. ATTITUDE

Attitudes influence our communication in three ways:

- Attitudes toward ourselves (the sender).
- Attitudes towards the receiver.
- Attitudes of the receiver towards the sender.

Attitudes toward ourselves determine how we conduct ourselves when we transmit messages to others:

- Unfavorable self-attitude → receivers notice uneasiness .
- Favorable self-attitude → receivers notice self-confidence.
- When favorable self-attitude is too strong → receivers sense brashness and overbearing attitude. Then our communication loses much of its effect with the receiver.

Attitude toward the receiver or the receiver's attitude toward the sender also influences our communication. Our messages are likely to be very different when communicating the same content to someone we like than to someone we dislike. We also structure our messages differently when talking to someone in a higher position than ours, in the same position, or in a lower position, regardless of whether we like them or not.

The words may be the same, but how you deliver them may affect how the message is understood. Are you assertive or defensive? Angry or thoughtful?

D. BARRIERS TO COMMUNICATION

1. Poor Listening Skills

Poor listening skills contribute to ineffective communication. Listening involves not just hearing the message, but the ability to understand, remember, evaluate and respond. Be an active listener!

Steps to improve your listening skills

- Be quiet. Pay attention to what the other person is saying.
- Stop all other activities. Focus on the speaker.
- Look and sound interested.
- Do not interrupt the speaker. Let the speaker finish, even if it takes a long time.
- Do not try to think of a response while the person is speaking.
- Do not finish sentences that the speaker begins.
- Listen for feelings.
- Clarify what the speaker has said.
- Ask open ended questions that encourage the speaker to continue.



2. Other Barriers

There are numerous other barriers to communication. Avoid the following:

- Giving advice.
- Making judgment.
- Giving false reassurances about your client’s physical or emotional condition.
- Focusing on yourself.
- Discussing your own problems or concerns.
- Discussing topics that are controversial such as religion and politics.
- Using clichés or platitudes (for example, “*Absence makes the heart grow fonder*”).

Did you know?

1. Communication is effective when two people:
 - a. Understand one another.
 - b. Agree with one another.
2. Non-verbal communication can include:
 - a. Singing
 - b. Facial expressions
 - c. Written notes
3. Listening is important True False
4. Assertive communication is rude True False

E. THERAPEUTIC COMMUNICATION

Good communication between the DCW and the client is important to provide services that meet the needs of the person. Therapeutic communication is a process designed to involve the client in conversation that is beneficial to her or his physical or mental well-being. Useful techniques:

- Use open-ended comments to encourage conversation. This keeps a person from just answering yes or no.
- Learn more about the person to meet the person’s needs.
- Use paraphrasing or reflective responses to clarify information (explained below). Use this method to direct the conversation to specifics.

1. Open-Ended Questions

Use open-ended questions. This lets others engage in the conversation and share information. It gives them the chance to tell you what is important to them.

Closed-ended questions are answered by “yes” or “no”:

- *Did you eat breakfast today?*
- *Are you feeling okay?*

Better

Open-ended questions ask for details:

- *What did you have for breakfast today?*
- *Could you describe how you are feeling today?*

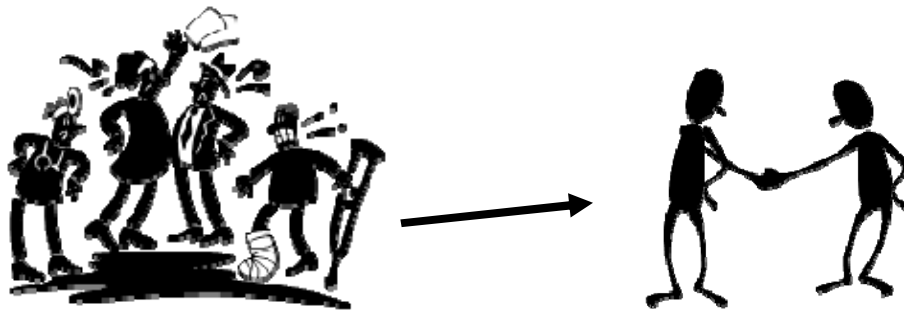
2. I – Messages

Use “I” messages instead of “You” messages. You-messages can put the blame on the others, but an I-message is assertive. It shows that you take responsibility for your own feelings.

- You-message: *You make me worry when you don’t talk to me.*

Better:

- I – message: *I feel worried when I cannot communicate with you.*



3. Reflective Responses

Using reflective responses can help the speaker clarify his or her own meanings. There are several specific techniques you can use.

- Restate what the speaker has said: *“So you think that you don’t get enough sleep.”*
- Pay attention to feelings: *“It seems you are upset about this.”*
- Don’t guide the conversation or make suggestions. Don’t say, *“Perhaps you should...”*

4. Conflict Resolution

Sometimes a client or family member gets upset when you are in the home. It is important for you as the DCW to not get angry. You must be polite and professional, and you must respond in a way that is not threatening.

- Use listening skills and therapeutic communication techniques listed above.
- Listen intently. This lets the person know that what he has to say is very important.
- If the person knows that what he has to say has value, he/she will begin to diffuse anger.
- Do not respond with anger or become defensive.
- Empathize. See it from his/her perspective.
- Then, once he sees you are an ally, not an enemy, fill him in on your challenges, feelings, roadblocks, and/or perspective.
- Put your own emotions on hold. Take a few minutes of time out, if needed. This lets you calm down and gather your thoughts.

5. Other Communication Tips

- Stick to the point at hand—don’t add, *“And another thing...”*
- Turn a negative into a positive.
- Set limits.
- Understand that people respond with different emotions to the same situation.
- Do not react when you feel your emotions are rising:
 - Listen first.
 - Speak in “I” and “I want”.
 - Own your feelings – no one can make you feel something.
 - Feelings are not right or wrong – they just are.



Scenarios

How would you respond (communicate feedback) in these situations?

- Client: “That is not how my other worker folded my laundry!”

- Client’s mother: “It does not matter what they told you at the office. I need to have you here by noon.”



Good Listening Skills Made a Difference

I remember teaching a class for caregivers quite a few years ago. I remember this one girl who really stood out. She was so young, yet so wise. She knew what it took to be a good caregiver. She aced the test and when she took her first assignment she was working for a consumer who required a lot of care. She put a smile on our face. She just knew how to handle everything.

Well, one morning I was listening to one of the supervisors who was having one of those crazy days when quite a few people were calling in sick. Our star caregiver called in also that day stating she is leaving the position and it would be immediately. I told the supervisor to play the message again. I said something is not right here. I told the supervisor that this caregiver was an awesome worker, she was an overachiever. I asked the supervisor to call her and see if she was okay. She called and left a message for the caregiver to let her know all was okay with the consumer, but that we were also concerned that she was okay herself.

Well, later that evening we received a call from the caregiver’s mother thanking us for the nice caring call we left for her daughter. She told us that her daughter had a lot happen to her, that she was working two jobs and going to school. She was having a break down and was considering suicide. Thanks to our understanding call, her daughter was able to talk things out and get herself the help she needed. The supervisor and I just looked at each other and were thankful that we took that extra time to listen to what was not being said.

We all get those days when it seems like everything is going wrong. We need to be aware that we could be getting a call for help and not even know it if we don’t take the time to really listen. Listen, not only listen to the words, but listen to the feelings that are being communicated.

—Attendant Care Manager/Instructor



F. RESPECTFUL COMMUNICATION

1. Addressing Another Person

One of the most basic forms of communication is using a person's name. Some people want you to use their first name, others prefer to be addressed formally (for example, Mrs. James or Mr. Gant). As a DCW, you should ask your client how he or she wants to be addressed. Also learn to pronounce the name correctly.



Always ask clients how you should address them – then learn to say the name correctly. Never call a person “dear” or “sweetie.”

2. Showing Respect

It is also important to treat adults as adults. As a DCW, you may work with people who have a hearing or speaking disorder. Perhaps they take longer to respond. Sometimes you may have to repeat the message. It is disrespectful to treat an adult person as a child.

- Do not talk down to a person who has language difficulties.
- Use adult language; don't use baby talk.
- Use adult words. For example, adults use “briefs” (not diapers).
- Choose adult books and TV programs for your clients.
- Let each person make choices. Don't decide for them.

G. COMMUNICATING WITH INDIVIDUALS WITH DISABILITIES

1. Vision Impairment

- It is appropriate to offer your help if you think it is needed, but don't be surprised if the person would rather do it himself.
- If you are uncertain how to help, ask the one who needs assistance.
- When addressing a person who is blind, it is helpful to call them by name or touch them gently on the arm.
- Do not touch the person's guide dog.
- Let the person hold on to you versus you holding them.
- When walking into a room, identify yourself.

2. Hearing Impairment

- If necessary, get the person's attention with a wave of the hand, a tap on the shoulder, or other signal.
- Speak clearly and slowly, but without exaggerating your lip movements or shouting (with shouting, sound may be distorted).
- Give the person time to understand and respond.
- Be flexible in your language. If the person experiences difficulty understanding what you are saying, rephrase your statement rather than repeating. If difficulty persists, write it down.
- Keep background noise at a minimum—turn off the TV, step away from others who are talking.
- Place yourself in good lighting. Keep hands and food away from your face.
- Look directly at the person and speak expressively.
- When an interpreter accompanies a person, speak to the person rather than to the interpreter.
- Encourage the person to socialize. Some people with a hearing impairment tend to isolate.
- Use Voice-to-TTY: 1-800-842-4681 (Arizona Relay Service) for people who either use a TTY or want to communicate with someone who does.
- Maintain amplifier/hearing aids.

3. Language Impairment (Aphasia)

Some people can speak but not write. Others can write but not speak. Such language disorders are called aphasia. It is often the result of a brain injury from an accident or a stroke, but it does not affect intelligence.

- Get the person's attention before you speak.
- Reduce background noise. Turn off the TV.
- Use simple communication, but keep it adult. An example is yes/no choices.
- Don't speak louder and don't talk down to the person.
- Use and encourage different communication techniques: writing, drawing, gestures.
- Give the person time to respond.
- Give feedback to encourage the person; don't correct or criticize.

4. Emotional / Mental Health Impairment

A person with an emotional or behavioral health issue may have distorted thinking. He or she may hear voices, see things that aren't there, be paranoid, or have difficulty communicating. Usually this does not mean the person is aggressive unless he or she feels threatened. Here are some communication guidelines to use:

- **If the person has difficulty having a conversation with you**, he or she may be able to enjoy your company in other ways. Consider watching television, listening to music, playing cards or being read to. Talk about childhood events.
- Allow the person to have personal space in the room. **Don't stand over him or her or get too close. This includes touching the person.** The person may hit you if you try a soothing touch.
- Don't block the doorway.
- Avoid continuous eye contact.
- Try to remain calm with a soothing approach. Speak with a slow-paced and low-toned voice.
- Use short, simple sentences to avoid confusion. If necessary, repeat statements and questions using the same words.
- Establish a structured and regular daily routine. Be predictable. Be consistent. Do not say you will do something and then change your mind.
- Offer praise continually. If the person combs his or her hair after three days of not doing so, comment on how attractive he or she looks. **Ignore the negative and praise the positive.**
- Avoid over-stimulation. Reduce stress and tension.
- Respect his or her feelings. Saying, *"Don't be silly. There's nothing to be afraid of,"* will get you nowhere. Allow the person to feel frightened by saying something like, *"It's all right if you feel afraid. Just sit here by me for awhile."*

5. Cognitive / Memory Impairment

A person with cognitive or memory impairment has difficulty thinking, reasoning, and remembering. These individuals can become very embarrassed or frustrated if you ask them names, dates, what they had to eat, who called, etc. Since their long term memory is much more intact, they may dwell on events in the past and not remember such things as a relative's death or that a child has grown and married.

The two most important factors in working with the individual with a cognitive impairment are:

- Your actions.
- Your reactions to the individual and his/her behavior.

When communicating with these individuals, remember:

- Use a calm voice and be reassuring. The person is trying to make sense of the environment.
- Use redirection.
- Give honest compliments.
- **Do not argue** with the person. If the person tells you he is waiting for his wife to come and you know that his wife died several years ago, do not state, “You know your wife died several years ago.” The person may get mad because he feels you are wrong or become grief stricken because he has just learned his wife died. It would be better to reassure the person that everything is all right; his wife has just been delayed. Then divert his attention to an activity.
- Treat each person as an individual with talents and abilities deserving of respect and dignity. Individuals can usually tell if they are being talked down to like a child, which can make the situation worse.

H. A GUIDE TO WHEELCHAIR ETIQUETTE

- **Ask permission.** Always ask the person if he or she would like assistance before you help. It may be necessary for the person to give you some instructions. An unexpected push could throw the person off balance.
- **Be respectful.** A person’s wheelchair is part of his or her body space and should be treated with respect. Don’t hang or lean on it unless you have the person’s permission. When a person transfers out of the wheelchair to a chair, toilet, car or other object, do not move the wheelchair out of reaching distance.
- **Speak directly.** Be careful not to exclude the person from conversations. Speak directly to the person and if the conversation lasts more than a few minutes, sit down or kneel to get yourself on the same level as the person in the wheelchair. Also, don’t be pat a person in a wheelchair on the head as it is a degrading gesture.
- **Give clear instruction.** When giving instructions to a person in a wheelchair, be sure to include distance, weather conditions, and physical obstacles which may hinder travel.
- **Act natural.** It is okay to use expressions like “running along” when speaking to a person in a wheelchair. It is likely the person expresses things the same way.

- **Wheelchair use doesn't mean confinement.** Be aware that persons who use wheelchairs are not confined to them.
- **Questions are okay.** It is all right for children (or adults) to ask questions about wheelchairs and disabilities. Children have a natural curiosity that needs to be satisfied so they do not develop fearful or misleading attitudes. Most people are not offended by questions people ask about their disabilities or wheelchairs.
- **Some persons who use a wheelchair for mobility can walk.** Be aware of the person's capabilities. Some persons can walk with aids, such as braces, walkers, or crutches, and use wheelchairs some of the time to conserve energy and move about more quickly.
- **Persons who use a wheelchair for mobility are not sick.** Don't classify persons who use wheelchairs as sick. Although wheelchairs are often associated with hospitals, they are used for a variety of non-contagious disabilities.
- **Relationships are important.** Remember that persons in wheelchairs can enjoy fulfilling relationships which may develop into marriage and family. They have physical needs like everyone else.
- **Wheelchair use provides freedom.** Don't assume that using a wheelchair is in itself a tragedy. It is a means of freedom which allows the person to move about independently. Structural barriers in public places create some inconveniences; however, most public areas are becoming wheelchair accessible.

I. PEOPLE FIRST LANGUAGE

A very useful concept for communication is *people first language*. This concept was developed by Kathie Snow. She reminds us that words are powerful. Poorly chosen words can lead to negative stereotypes and create barriers. A person with a disability is a person—not a condition. The illness or disability is often just a small part of who they are.

Example: Anna is a 5-year-old girl. She has autism.

Mr. Barnes uses a wheelchair.

The People First Language document on the next page offers more examples for you to use.

EXAMPLES OF PEOPLE FIRST LANGUAGE

BY **KATHIE SNOW**

VISIT WWW.DISABILITYISNATURAL.COM TO SEE THE COMPLETE ARTICLE

SAY:	INSTEAD OF:
People with disabilities.	The handicapped or disabled.
He has a cognitive disability/diagnosis.	He's mentally retarded.
She has autism (or a diagnosis of...).	She's autistic.
He has Down syndrome (or a diagnosis of...)	He's Down's; a mongoloid.
She has a learning disability (diagnosis).	She's learning disabled.
He has a physical disability (diagnosis).	He's a quadriplegic/is crippled.
She's of short stature/she's a little person.	She's a dwarf/midget.
He has a mental health condition/diagnosis.	He's emotionally disturbed/mentally ill.
She uses a wheelchair/mobility chair.	She's confined to/is wheelchair bound.
He receives special ed services.	He's in special ed.
She has a developmental delay.	She's developmentally delayed.
Children without disabilities.	Normal or healthy kids.
Communicates with her eyes/device/etc.	Is non-verbal.
Customer	Client, consumer, recipient, etc.
Congenital disability	Birth defect
Brain injury	Brain damaged
Accessible parking, hotel room, etc.	Handicapped parking, hotel room, etc.
She needs . . . or she uses . . .	She has a problem with . . . She has special needs.

Keep thinking—there are many other descriptors we need to change!

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Excerpted from Kathie's People First Language article, available at www.disabilityisnatural.com.

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VISIT WWW.DISABILITYISNATURAL.COM FOR OTHER NEW WAYS OF THINKING!

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Did you know?

1. When a person has difficulty reading, give them children’s books True False
2. Mr. Kranz has difficulty understanding you.
 - a. You repeat everything 2 or 3 times.
 - b. You give him extra time to understand.
3. You are trying to encourage Mr. Harding to talk more. You ask:
 - a. Did you watch TV last night?
 - b. What happened in the movie you watched?

J. RESOURCES

- Disability is Natural, a website with articles and information on new ways of thinking about disabilities. www.disabilityisnatural.com
- Tips for First Responders. Center for Development and Disability. University of New Mexico, 2005. http://cdd.unm.edu/products/tips_web020205.pdf

Principles of Caregiving: Fundamentals

Chapter 4 – Cultural Competency

CONTENTS

- A. Definitions
- B. Awareness of Cultural Differences
 - 1. Examples of Cultural Differences
 - 2. The Cultural Competency Continuum
 - 3. Perceptions
- C. Different Cultures in Arizona
- D. Cross-Cultural Communication
 - 1. Potential Barriers
 - 2. Cultural Diversity and Health
 - 3. Communication Tips
- E. Resources

OBJECTIVES

1. Define culture and give examples of different cultural concepts and practices.
2. Explain the importance of self-awareness and cultural competency.
3. Identify and describe potential barriers to communication due to cultural differences.
4. Identify, describe and explain the importance of appropriate methods for addressing cultural and religious diversity.

KEY TERMS

Bias

Culture

Cross-cultural communication

Platinum rule

Cultural competency

Stereotype

A. DEFINITIONS

- **Culture:** Behavior patterns, arts, beliefs, communications, actions, customs, and values. They are linked to racial, ethnic, religious, or social groups.
- **Cultural competency:** Sensitivity and respect given to people regardless of their ethnicity, race, language, culture or national origin. It enables professionals to work effectively in cross-cultural situations.
- **Cultural awareness:** Developing sensitivity and understanding of another ethnic group without assigning values such as better or worse, right or wrong. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others.
- **Cross cultural:** Interaction between individuals from different cultures.
- **Ethnicity:** Belonging to a common group with shared heritage, often linked by race, nationality, and language.
- **Race:** A socially defined population that is derived from distinguishable physical characteristics that are genetically determined.

B. AWARENESS OF CULTURAL DIFFERENCES

Cultural awareness and sensitivity are an important part of providing care to the people being served by DCWs. We need to respect other cultures and try to learn more about the different cultures. Then we can better understand the individuals being served. Keep in mind not all people from one culture are the same. The following examples are generally true, but they may not apply to all people.

1. Examples of Culture Differences

a. Native American

- Usually want a DCW from their own tribe
- Believe in non-traditional medicine

b. Asian

- Prefer more space between speaker and listener
- Limited contact, no hugging or back slapping

c. Latino

- Comfortable with close conversational distance
- More expressive

d. East Indian

- Believe the head is fragile and should not be touched

e. Muslim

- Woman will not shake the hand of a man

Examples of some innocent gestures that could be misunderstood:

- Use of the left hand to touch or hand something to a person. Some cultures use their left hand for personal hygiene and think of it as being unclean.
- Nodding the head up and down is considered a sign of understanding and agreeing, but among other cultures it is simply saying, “I hear you are speaking.”
- Strong eye contact can be appreciated by one culture but by another it could be a sign of disrespect.

2. The Cultural Competency Continuum

- **Fear:** Others are viewed with apprehension and contact is avoided.
- **Denial:** The existence of the other group is denied. This belief may reflect either physical or social isolation from people of different cultural backgrounds.
- **Superiority:** The other group exists but is considered inferior.
- **Minimization:** An individual acknowledges cultural differences but trivializes them. The person believes human similarities far outweigh any differences.
- **Acceptance:** Differences are appreciated, noted and valued.
- **Adaptation:** Individuals develop and improve skills for interacting and communicating with people of other cultures. This is the ability to look at the world with different eyes.
- **Integration:** Individuals in this stage value a variety of cultures. They are constantly defining their own identity and evaluating behavior and values in contrast to and in concert with a multitude of cultures.

A culturally competent person acknowledges and values diversity and accommodates differences by seeking a common vision (for example, the need for assistance). **Diversity is viewed as strength.** Cultural competency encompasses more than race, gender, and ethnicity—it includes all those *differences* that make us unique. With adequate time, commitment, learning, and action, people and organizations can change, grow, improve—to become more *culturally competent*.

3. Perceptions

In order to become culturally competent, we need to understand our own culture and our own perceptions. Ask yourself these questions:

- How have my experience and my culture impacted how I see and respond to others?
- How do my perceptions of and response to others impact them?

As you consider your answers, keep the following in mind:

- No one is born with opinions or biases; they are learned.
- When children learn about the world, they learn both information and misinformation about people who are different from them and their families. The differences can be gender, race, religion, sexual orientation, class, or other ways.
- Some of this information is about stereotyping. This is where stereotyping takes root.
- People we learned from were simply passing on to us messages that had been handed down to them. Besides our family and friends, we received some of the messages from society through the media and our everyday surroundings such as television, textbooks, advertisements, etc. Sometimes the messages are overt, sometimes more subtle.

Examples:

- My mother would say, “*Lock the door*” when driving through a certain neighborhood.
- Adults say, “*Change the radio station*” when certain topics were being discussed.

These influences in our lives basically have the effect of putting us on “automatic.” When we encounter certain situations or people, we automatically respond (usually due to fear) rather than rationally thinking through the situation. **This process of being on automatic is stereotyping.**

As adults, most of us are still on automatic; we still form new “mental tapes” and respond with knee-jerk reactions to people who are different from us. Stereotyping is very difficult to undo. **We all do it!** Freeing ourselves of the tendency to stereotype allows us to work more positively and effectively with people who are culturally different from ourselves.

Through self-awareness and efforts, it is possible to control the automatic response. We can become conscious of our reactions, and respond to differences in a clear-headed, rational manner without fear and apprehension. We may not be able to undo our stereotypes, but we can begin to manage them. We can become more culturally competent.

Example: You walk into a home and you see photos from a different country and objects you don’t recognize. You also hear people speaking in a language you don’t understand. Your first thought is not to take the position. You talk with your supervisor and she informs you that the client is from India. She has only one son who lives in the same town. It is important to her to remember her home country. Speaking her native language with her son feels natural to her.

Now you know a little more about the situation. You can understand that it is important to stay in touch with one’s culture. You can learn about the culture. You now are in a position to really make a difference in this individual’s life.

	Awareness is the key to attaining cultural competency.
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C. DIFFERENT CULTURES IN ARIZONA

1. Arizona Population

Arizona is a good example of a state with many cultures and ethnic groups. More than 10% (1 in 10) of the population was born in another country. One quarter of the people (1 in 4) speaks a language other than English at home. The U.S. Census Bureau breaks down the Arizona population by self-reported categories of race as follows:

Arizona Population 2008	
White persons	86.5%
Black persons	4.2%
American Indian and Alaska Native persons	4.9%
Asian persons	2.5%
Native Hawaiian and Other Pacific Islander	0.2%
Persons reporting two or more races	1.8%
Persons of Hispanic or Latino origin	30.1%

Source: <http://quickfacts.census.gov/qfd/states/04000.html>

Keep in mind that not all speakers of a language are the same. People may speak a language (for example, Spanish) but come from different countries. It is important to be aware that cultural differences exist. Also, you want to become comfortable with asking people about their preferences and customs. For more information see Section D, Cross-Cultural Communication, in this chapter.

2. Refugees in Arizona

Under United States law, a refugee is a person from another country who is persecuted for a reason such as race, religion, or political opinions. Refugees do not come here because of disasters or economic reasons.

Arizona has refugees mostly from these locations:

- Iraq
- Bhutan
- Somalia
- Burundi
- Cuba

Remember, that not all people from one country are the same. Some are from cities, others from the country. Education and work experience can be very different. They can speak different languages and have different religions.

Refugees have to adjust to life in this country. Challenges often include the following:

- Having no home and little money.
- Having to look for employment.
- Learning English.
- Transportation.
- Learning about the healthcare system.
- Learning about government bureaucracies.
- Adapting to American culture and values.
- Physical health—some have injuries.
- Mental health—many suffer from stress or fear.

D. CROSS-CULTURAL COMMUNICATION

1. Potential Barriers

To work effectively in a culturally diverse environment, we need to have an understanding of some of the potential barriers to effective cross-cultural communication and interaction.

When communication between people breaks down, it is frustrating. It often appears to be a difference in communication style. However, the more fundamental cause is often a difference in values, which are shaped by culture and experiences.

How is communication influenced or shaped by our individual culture and experiences? Examples are tone of voice, regional accents, gestures, showing emotions (affect), formality, and personal distance.

Watch out for:

- **Assumed similarity.** We assume that words and gestures have a set meaning if we speak the same language, but they may be different. For example, when you talk about supper, some people may think of a meal of bread and cold cuts. Others envision a warm dinner with meat and vegetables.
- **Non-verbal communication.** Approximately 70% to 90% of our communication is affected by non-verbal cues. This includes smiling, silence, gestures, nodding, eye contact, body language, and touch. Because non-verbal cues mean different things to different cultures, we need to be cautious of the interpretations we attach to these behaviors. For example, not making eye contact can be seen as being passive

and untrustworthy, but to others making eye contact may appear as polite and respectful.

- **Verbal language**, the most obvious barrier. Slang and idioms can be hard to understand. Phrases such as “*run that by me*” or “*cut the check*” may be unfamiliar to some people. Also, technical jargon (“*to Fed Ex a letter*”) or sports references (“*out in left field*”) are not always clear.

2. Cultural Diversity and Health

Direct care workers need to know that people have different views of health and illness depending on their cultural background and upbringing. This can affect how clients feel about receiving help from others. Some prefer family members to provide assistance; others have strong preferences about working only with a male or female DCW.

There are different views of dealing with illness or disability. Here are some examples:

- Traditional remedies vs. modern medicine and technology
- Aggressive treatment vs. gentle, mild treatments
- Acceptance (a wait-and-see approach) vs. taking action

3. Communication Tips

a. Communication do’s

- Learn and use the correct pronunciation of a person’s name.
- Give examples to illustrate a point.
- Look at the situation from the other person’s perspective.
- Simplify or rephrase what is said.
- Use language that is inclusive.
- Pause between sentences.
- Ask for clarification.
- Remain aware of biases and assumptions.
- Be patient.

b. Communication don’ts

- Don’t pretend to understand.
- Don’t always assume that you are being understood.
- Don’t rush or shout.
- Don’t laugh at misused words or phrases.
- Don’t overuse idioms and slang (e.g., “*pay the piper,*” or “*beat around the bush*”).
- Don’t assume that using first names is appropriate.
- Don’t assume that limited language proficiency means limited intelligence.

c. Summary

There are many cultural differences with the people being served. The best way to work through these differences is communicating with your clients and learning from them about their customs, traditions, etc. and how that impacts the assistance you are providing.

- Take the time to learn about an individual’s needs, strengths, and preferences.
- Do not assume that you know what is best.
- The manner in which you support individuals should reflect their needs, strengths, and preferences, not yours (for example, giving choices and showing respect).

The old rule was the Golden Rule: Treat others the way you would want to be treated.

The new rule is the Platinum Rule: Treat others as *they* want to be treated.

What do you do when you are preparing to provide care to a person from a culture other than yours?

- Do not be judgmental.
- Talk to the person (or family members) being served about his/her customs, so you do not unintentionally offend him/her.
- Avoid body language that can be offensive.
- Avoid clothing that can be offensive.

Source: Adapted with permission from “Introduction to Cultural Competency”, Value Options 2004
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Did you know?

1. All people from one country share the same culture. True False
 2. Cultural differences affect how people think. True False
 3. It helps to know your own culture if you need to understand others. True False
 4. It is normal to feel confusion or fear when people do things in a different way..... True False
 5. 20% of Arizonans (1 in 5 people) were born outside of the U.S. True False
 6. A good way to treat people is:
 - a. The way you want to be treated. (Golden Rule)
 - b. The way they want to be treated. (Platinum Rule)
 7. You are providing services to Mr. Chang. He is usually quiet and does not look at you much.
 - a. He is not interested in talking to you. You are not sure he respects you.
 - b. In his culture, it is not polite to look directly at people for a long time.
 8. You do chores for Mrs. Green. Her apartment is often very warm and a little stuffy.
 - a. You open the windows when you get there.
 - b. You ask her if you can open the window to let cool air in.
 9. Mrs. Kim has been very ill. She says she will speak to her daughter and son-in-law about it.
 - a. She seems not interested in getting medical care.
 - b. She may prefer to make decisions together with her family.
- *Note: In any case, the DCW should inform the supervisor about the illness.

E. RESOURCES

- Cultural Profiles. Funded by Citizenship and Immigration Canada. Select from a long list of countries to learn about customs and beliefs. www.cp-pc.ca/english/
- University of Michigan, Program for Multicultural Health. Information on cultural competency, different cultures, and resources. www.med.umich.edu/multicultural/ccp/tools.htm
- National Center for Cultural Competence, Information on cultural awareness, teaching tips and links to more resources. www.ncccurrecula.info/awareness/index.html
- Cultural Diversity in Nursing. A list of cultural resources on different cultures. <http://www.culturediversity.org/links.htm>

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 5 – JOB MANAGEMENT SKILLS

CONTENTS

- A. Stress Management
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 - 2. Coping Strategies
 - 3. Taking Action
 - 4. Relaxation Techniques
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 - 1. Importance of Time Management and Organizational Skills
 - 2. Prioritizing Duties
 - 3. Developing a Work Schedule
 - 4. Time Management Activity
- C. Boundaries
 - 1. Personal and Professional Boundaries
 - 2. Knowing Your Personal Boundaries
 - 3. Guidelines for Professional Boundaries
- D. Principles of Body Mechanics
- E. Safety Tips for the DCW
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OBJECTIVES

1. Identify components of stress.
2. Identify and describe causes, effects and indicators of stress.
3. Describe appropriate coping strategies.
4. Explain the importance of time management.
5. Identify and describe techniques for prioritizing duties and developing a work schedule.
6. Explain the term *boundaries* and relate it to professional standards.
7. Give examples of guidelines for professional boundaries.
8. List safety tips.

KEY TERMS

Boundaries	Priority
Coping strategies	Procrastination
Imagery	Relaxation
Personal space	Stress

A. STRESS MANAGEMENT

1. Identification of Causes of Stress

Stress is a daily component of our lives. Learning to manage stress is essential, not only to be effective in the workplace, but also to protect your health.

Stress is a person’s response to difficult situations: feeling irritated, anxious, or sick. When the stress level is manageable or when we have developed effective coping mechanisms, the impact of stress on our lives is minimal. Unfortunately, we do not always recognize the degree of impact. Perhaps we simply start feeling out of control of our lives. Unmanageable levels of stress can cause new problems or make problems worse. Sometimes this affects totally unrelated areas such as relationships, financial concerns, and work.

Stress is like getting ready to hit a baseball and wearing a blindfold to hit the ball. There are common signs and symptoms that are indicators of stress, including:

- crying
- depression
- no energy
- not sleeping
- stomach pains
- anxiety

Causes of stress

Stress is often negative, but it can be positive. Stress can occur from too much work, unrealistic deadlines, and financial pressures. Perhaps you are dealing with family issues while working a heavy schedule. If you have health problem or can’t sleep, things just get worse. This is negative stress.

Stress is also triggered by some of life's happiest moments. This can include getting married, having a baby, buying a home, or starting a new job. These events are often associated with positive outcomes, and they are very meaningful. This means they require a lot of personal energy and investment. In these situations, stress acts as a motivator—it is positive stress.

Effects of stress

The research shows that some stress is good. Stress “revs up” the body, creating naturally-occurring performance-enhancing chemicals like adrenalin and cortisol. These are hormones that get us prepared for emergency action. This gives a person a rush of strength to handle an emergency (fight or flight). It can heighten the ability to “fight tigers” in the short term.

If severe stress goes unchecked for a long time, performance will decline. The constant bombardment by stress-related chemicals and stimulation will weaken a person's body.

What happens when you are stressed?

	Normal: You are relaxed	You are under some pressure	You feel a lot of acute pressure	There is chronic pressure → stress
Brain	blood supply normal	blood supply up	thinks more clearly	headaches or migraines, tremors and nervous tics
Mood	happy	serious	increased concentration	anxiety, loss of sense of humor, crying, depression, rage, difficulty sleeping
Saliva	normal	reduced	reduced	dry mouth, lump in throat
Muscles	blood supply normal	blood supply up	improved performance	muscular tension and pain
Heart	normal rate and blood pressure	increased rate and blood pressure	improved performance	hypertension and chest pains
Lungs	normal respiration	increased respiration rate	improved performance	coughs and asthma
Stomach	normal blood supply and acid secretion	reduced blood supply and increased acid secretion	reduced blood supply reduces digestion	ulcers due to heartburn and indigestion stomach pain
Bowels	normal blood supply and bowel activity	reduced blood supply and increased bowel activity	reduced blood supply reduces digestion	abdominal pain and diarrhea
Bladder	normal	frequent urination	frequent urination due to increased nervous stimulation	frequent urination, prostatic symptoms
Sexual Organs	Men: normal. Women: normal periods, etc.	Men: impotence (decreased blood supply) Women: irregular periods	decreased blood supply	Men: impotence Women: menstrual disorders
Skin	Healthy	decreased blood supply - dry skin	decreased blood supply	dryness and rashes
Biochemistry	normal: oxygen consumed, glucose and fats released	oxygen consumption up, glucose and fats consumption up	more energy immediately available	rapid tiredness, no energy

Adapted from: "Stress – How it Affects Us." The Stress Management Society, Harrow, United Kingdom, www.stress.org.uk/4617/9903.html.

Ultimately that leads to degenerating health. In extreme cases, it can cause psychological problems such as post traumatic stress disorder or cumulative stress disorder.

When stress becomes too much to handle, it can have an effect on physical health. The table on the previous page describes what happens when a person experiences too much stress.

2. Coping Strategies

There are a number of techniques that help you deal with stress. Specific actions and relaxation exercises are suggested below. Unhealthy coping strategies include drugs, alcohol, and cigarettes. These mask the problems and only delay finding a solution and implementing an action plan.

If you find that the individual or family you are assisting is having any of the symptoms listed above, report your observations to your supervisor. If you find you are having any of these symptoms, try to identify the reason or cause of the stress. Then develop an action plan to manage the stress. Following are some effective, healthy stress management coping strategies.

3. Taking Action

Reason for Stress	Action to Take
Unrealistic expectations	Set realistic goals.
Negative thinking	Consciously choose to think positively. Think of the positives in your life.
Feeling of being out of control	Act—do not react. Make an action plan.
Someone else setting limits for you, being domineering	Understand what you are responsible for. Evaluate and then take the appropriate action. Be assertive (refer to Assertive Communication in Chapter 3).
Not feeling confident of what you are doing	For job related: Talk to your supervisor for direction, take advantage of in-services, ask questions (this is referred to as professional growth). All employers would rather you ask questions than handle the aftermath of mistakes. For personal advice: Seek out a valued friend, clergy, or counselor.
Feeling overwhelmed	ASK FOR HELP! Make a plan to break up the task into smaller pieces.

Components of effective stress management include:

- strong social support
- exercise
- diet
- rest
- relaxation techniques
- realistic expectations
- positive self-talk
- time-management
- effective communication
- realistic expectations

4. Relaxation Techniques

Deep control breathing

Take a deep breath of air through the nose and slowly release the air through your mouth. Good air in, stressed air out.

Get in a comfortable position. You can do this either sitting or lying down. When lying down put your hand on your stomach, take a deep breath through your nose and then let it out through your mouth. Let your hand feel your abdomen go up and down while taking the deep breaths.

You can do this while sitting in traffic, on hold on the phone, watching TV at commercial time, etc.



Progressive muscle relaxation

- Get in a comfortable position. If possible lay down. Let your whole body relax gradually.
- Breathe slowly through your nose. Feel the cool air as you breathe in and out. Let your awareness turn away from your daily cares and concerns. Close your eyes and let your awareness turn inward to the physical sensations of your body.
- Tighten the muscles of your face. Feel the tension in your face. Hold for ten seconds. Release. Feel the tension flow outward.
- Tighten your eyebrows by squeezing them. Feel the tension by your eyebrows. Hold for ten seconds. Release and feel the tension flow outward.
- Clench your jaw tight. Feel the tension in your jaw. Hold for ten seconds. Release. Feel your jaw drop. Allow your jaw to drop.
- Squeeze your neck muscles and hold for ten seconds. Release. Feel the tension leave your face. You feel relaxed. You are relaxed.
- Take a deep breath and hold. Feel the tension in your chest from holding your breath. Exhale and feel the tension leave your body. Repeat.

- Tighten your fists or your arms. Feel the muscle tension. Hold for ten seconds. Release and feel the tension travel down your arms.
- Open your fingers on your hands and feel the tension slip out from your fingers. You are feeling so relaxed. You are relaxed.
- Stretch and tighten your toes. Hold. Release. Feel the tension leave your toes.
- Squeeze your legs together and feel the tension in your legs. Hold for ten seconds. Release and feel the tension leave your body. You feel relaxed. You are relaxed.
- Breathe in through your nose and slowly say, “I am”, exhale through your mouth and say, “relaxed”.

Autogenic Imagery

You can use the autogenic exercise in several different positions. This is useful if you are at the office or in a meeting. Sit in an armchair with your head, back, and arms in a comfortable, supportive position. Sit as relaxed as possible. If you are at home, lie down with your head supported, legs about eight inches apart, toes pointed slightly outward, and arms resting comfortably at the side of your body without touching it. If at home close your eyes. Let your mind be like a quiet pool, with no thoughts rippling the surface.

Simply say these phrases to yourself. Repeat each phrase slowly three to four times:

My head is heavy and calm

My face is warm and relaxed

My eyelids are heavy and warm

My jaw is heavy and relaxed

My shoulders are heavy and warm

My right hand is heavy and warm

My left hand is heavy and warm

My chest is heavy and relaxed

My abdomen is soft and warm

My right leg is heavy and warm

My left leg is heavy and warm

My breathing is calm and regular

My heartbeat is calm and regular

My stomach is calm and relaxed

My body feels quiet and comfortable

My mind is quiet and refreshed

I am relaxed and refreshed

Be creative in using your own symbols for how your body can heal itself.

Guided Imagery

Guided imagery is fun to do. Go to your happy place, your own private happy place. *I am relaxed!* If you are on the beach:

It is a perfect day at the beach
The sand is warm.
You can feel the gentle breeze caress your face.
Feel the gentle warmth of the sun all over your body.
You can even feel the warm sand run through your fingers.
Can you hear the waves gently lapping onto the shore?
You can see the water as if there were diamonds sparkling.

As you look at the ocean you see the endless horizon.
This is real. This is real. This is real.
I am relaxed. I am relaxed. I am relaxed.
Focus on your special place and feel every aspect of your happy place.

5. In Summary

There are many benefits of being able to manage stress:

- Looking forward to getting up in the morning.
- Having more energy, feeling less burdened.
- Starting the day with a positive attitude.
- Being able to make better decisions.

Remember to practice your favorite relaxation technique on a regular basis. Doing your favorite relaxation technique is like working out at a gym to build more muscle. You need to do it regularly.

Did you know?

- | | | |
|---|------|-------|
| 1. All stress is bad | True | False |
| 2. Positive things can cause stress (e.g., a new baby)..... | True | False |
| 3. Stress can cause physical health problems..... | True | False |
| 4. Breathing techniques can help you relax | True | False |
| 5. You can learn techniques for dealing with stress | True | False |

B. TIME MANAGEMENT AND ORGANIZATION

1. Importance of Time Management and Organizational Skills

It is very important to work smart and be organized. You want to prioritize tasks and try to plan ahead. This will give you time for unforeseen emergencies.

It is easy to spend too much time responding to immediate problems. Then you might be moving into the danger zone of high stress levels and possible burn-out. People whose lives seem always to be at the mercy of circumstances are usually those who wait for things to happen, and then react to them. Other people seem more on top of things. They are usually those who see things coming and act in good time to guard against them (or benefit from them).

Do not neglect activities just because they are not urgent, otherwise they soon will be. An example is putting off getting gas until the last minute and then not being able to find a gas station. You should aim to schedule at least half your time planning ahead, leaving the rest of your time available for reactive and maintenance tasks (e.g. keeping things running smoothly), as well as unexpected interruptions. An example is deciding what you will wear the next day and laying it out the night before, cutting down the last minute rush in the morning.

Remember, one of the biggest robbers of time is *procrastination*. You need to develop the skill of not putting off unpleasant tasks until later, because later can become URGENT! You can develop **good organizational skills** by planning ahead, prioritizing, and making lists and schedules.



2. Prioritizing Duties

Before you can develop a work schedule, you should make a list of all the tasks that need to be done. Prioritize your daily tasks list by assigning a value (*A*, *B*, or *C*) to each item on the list. Place an *A* next to items that must be done. Place a *B* next to any task that is important and should be done. After all the *A* tasks are completed, and you have time, you would work on the *B* items. Finally, write a *C* next to any task that is less important and could be done later. That is, after the *A* and *B* tasks have been completed, you'll do the *C* tasks.

Category A – Must be done: Activities include those that possibly affect the health and safety of the client. Examples would be bathing for an individual who is incontinent or washing soiled bed linens.

Category B – Important and should be done: Category B activities allow you to plan ahead but can wait until A tasks are done. Care must be taken because Category B can quickly become Category A. Examples would be grocery shopping for supplies and shampooing hair for a family outing.

Category C – Less important and could be done: Activities in this category can be done when the A and B tasks are done. Examples would be rearranging dresser drawers or polishing silverware.

You may even want to prioritize further by giving a numerical value to each item on the list. In other words, determine which A task is most important and label it A-1. Then decide which A item is next most important and label it A-2, and so on. Do the same for B and C tasks.

3. Developing Work Schedules

Procedures for developing and implementing a work schedule:

- a. Establish a time for planning at the beginning of a shift or each week.
- b. Enter all fixed activities in your schedule (for example, the person has an assigned wash time in the community laundry on Wednesday mornings).
- c. Develop a priority tasks list, as described earlier, to identify and prioritize all the tasks you have to complete.
- d. Complete your schedule by transferring the items on your priority tasks list to your schedule. Put the A items first, followed by the B items, and finally as many of the C items you think you can accomplish.
- e. Each evening, check your schedule for the next day and make modifications as needed (for example, changes in appointments, unexpected assignments, or unusual demands on time).
- f. Combine activities. Use the "two-fer" concept: begin two tasks, using downtime on one to work on the other (for example, washing dishes while clothes are in the dryer).
- g. **Make room for entertainment and relaxation for both you and the client.** Plan fun activities in your priority list.

As you plan the schedule for the client make sure you plan time for yourself. Use these same tips to schedule tasks for your personal life. Make room for entertainment and relaxation.

Make sure you have time to sleep and eat properly. Sleep is often an activity that DCWs use as their time management *bank*. When they need a few extra hours for activities or work, they withdraw a few hours of sleep. Doing this makes you tired, less productive, stressed out and burned out.

REMEMBER THAT FLEXIBILITY IS EXTREMELY IMPORTANT. But you need to contact the supervisor if:

- The client is piling too many tasks on you (being unreasonable with expectations).
- You are being asked to do something that is not on the care/support plan.



4. Time Management Activity

Break into groups and plan a work schedule for this scenario.

You have been assigned to Kathy three mornings a week (M-W-F) from 8 to 11 a.m. Kathy needs assistance with showering. She occasionally soils the linens at night. She needs help in preparing breakfast and lunch but can feed herself. You need to prepare breakfast and put something in the refrigerator for lunch (her relative fixes dinner for her). You need to do the shopping and pick up her meds. She has a doctor's appointment at 9:30 a.m. on Wednesday and a relative will be picking her up at 9:15. The following cleaning tasks are listed on her service plan:

Daily cleaning tasks

- Pick up toys, magazines, newspapers, etc., especially if in the walkway.
- Make beds.
- Empty wastebaskets and take out trash.
- Do dishes and wipe off counters.
- Clean top of the stove.
- Sweep kitchen.

Weekly cleaning tasks

- Change bed linens.
- Dust furniture.
- Clean shower and tub.
- Clean switch plates.
- Clean mirrors.
- Vacuum floors and carpets.
- Mop floors.

C. BOUNDARIES

Direct care professionals have professional standards. You also know your role as a DCW and the importance of following the service plan or support plan for the client. Review the roles and responsibilities and professional standards of DCWs in Chapter 1, Overview, in this course manual. All of these guide your work and behavior.

- **Roles and responsibilities:** Understand your duties, know how to do your job, learn policies and procedures.
- **Professional standards:** Behavior and attitude that show respect and get respect back. This includes honesty, reliability, respect for privacy and cultural differences. It also means that you always strive to do the best job possible.
- **Boundaries:** Set limits to personal involvement, feelings, and sharing of personal information. Having boundaries is part of maintaining professional standards.

1. Personal and Professional Boundaries

- **Professional boundaries** are guidelines for DCWs at work. They describe how to speak and react to the client and family members. This can include the use of first names or last names, participation at family events, and sharing personal information.
- **Personal boundaries** are about your own expectations. How do you want to be addressed and treated? Often the professional and personal boundaries overlap.

2. Knowing Your Personal Boundaries

There are many ways to define boundaries. Dr. Vicki Rachner describes them as fences around your body and soul.¹ Boundaries are the lines that define your own personal space. *Crossing the line* means violating a personal boundary. Another way to say it is knowing where you end and somebody else begins, what you're responsible for and what you're not, and what is your need and what is somebody else's need.²

If you want people to treat you the way you want to be treated, you need to tell them about your boundaries.

- **Identify your boundaries:** How do you want people to speak to you? What behaviors are acceptable? Will you tolerate people raising their voices or making jokes?

¹ Vicki Rachner, MD, "Setting Limits as a Caregiver."

www.strengthforcaring.com/manual/stress-relief-stress-management-tips/setting-limits-as-a-caregiver/

² "Taking Care of Yourself – Having Healthy Boundaries." Pauktuutit Inuit Women of Canada.

<http://www.pauktuutit.ca/caregivers/downloads/Boundaries.pdf>

- **Tell people what your boundaries are:** Learn to say no. Tell people how to treat you, using an assertive communication style. Remind yourself how you want to be treated, for example, that you are a mature person and a professional caregiver.
- **Enforce your boundaries:** Don't let others invade your space. Don't let them make you uncomfortable. Tell them in a polite and assertive way when they cross the line.

Based on "Focus on: Boundaries" Caregiver News, HSI Caregiver Support Services, January 2008, Missy Ekern www.hsicare.org/programs/eldercare/documents/CaregiverNews-January2008.doc

3. Guidelines for Professional Boundaries

a. Sharing personal information

- Share personal information only if you think it may help the individual.
- Don't talk about your own problems; the client may start worrying about your problems.

b. Personal relationships

- As a DCW you are in the person's home as a professional, not as a friend.
- Do not tell sexually oriented stories or jokes. Don't flirt.
- Don't use terms like *honey* or *sweetie*. They can be disrespectful and they can create the impression that you are showing a personal interest.
- Maintain professional demeanor when you witness the client's disability, pain, or personal problems. If you feel yourself getting emotional or worried personally, speak to your supervisor or seek guidance from another trusted individual.

c. Touch

- Use touch sparingly. When you provide personal care, be respectful of the other person's modesty and sense of privacy.
- Don't assume that people like to be hugged.
- Don't let clients touch you in a way that makes you feel uncomfortable.

d. Personal appearance

- Choose clothing that makes a professional impression. Clothes should be neat and not too casual or revealing.
- Choose personal hygiene products (make-up, cologne, after shave) carefully. Keep your hair and nails groomed without appearing flashy. Limit jewelry.

e. Gifts and favors

- Follow your agency’s policies on gifts. Report offers of large gifts to your supervisor.
- Don’t use the client’s personal items (clothes, telephone, etc.) for your personal use.
- Don’t ask for a loan of money, car, or other items.
- Don’t buy or sell items from or to your client.

f. Work schedule

- Stick to your scheduled work time. You should be on time, and you should expect to leave on time, unless the client cannot be left alone.
- If you spend unscheduled time with the individual, boundaries may be crossed. If the person needs more assistance, tell your supervisor. If you feel you want to stay, you may be crossing the line between work and personal relationship.
- Don’t feel guilty for leaving when your work is done.

g. Secrets and confidential information

- Don’t share information about your agency or co-workers. Don’t express frustration about your job.
- Do not keep personal or professional secrets with a client.

Based on “Boundaries” The Wisconsin Caregiver Project, Train-the-trainer handouts.
<http://www.uwosh.edu/ccdet/caregiver/Documents/Plummer/Handouts/paulabndrscrgvr.pdf>

Did you know?

- | | | |
|--|------|-------|
| 1. Professional boundaries are the same for all DCWs | True | False |
| 2. You should never talk with a client about yourself..... | True | False |
| 3. If you are friends with a person, you can help them better..... | True | False |
| 4. Touching a person is a good way to build trust | True | False |

D. PRINCIPLES OF BODY MECHANICS

Some of the most common injuries sustained by healthcare workers are severe muscle strains. Many injuries can be avoided by the conscious use of proper *body mechanics* when performing physical labor. Body mechanics is the utilization of correct muscles to complete a task safely and efficiently, without undue strain on any muscle or joint.

Using correct body mechanics is an important part of a DCWs job because:

- The individual with a disability depends on the DCW for hands-on assistance. If the DCW does not take care of his/her back with correct body mechanics, the DCW will not be able to provide that assistance.
- Not using correct body mechanics puts the safety of the client and DCW at risk.
- Some injuries cause permanent disabilities.

Just as lifting, pushing, and pulling loads can damage your back, so can bending or reaching while working in an individual's home. As a DCW, you may have witnessed firsthand the pain and misery a back injury can cause. The good news is that you can learn some simple ways to reduce the risk of injury.

Body mechanics principles that play an integral part of this section are:

- **Center of gravity over base of support.** It is important for the DCW to be aware of center of gravity over base of support in working with a client. Usually a person's center of gravity is right behind a person's navel (belly button). A good base of support is being in a standing position where the feet are slightly apart and knees slightly bent.
- **Principles of body leverage.** Using leg and arm muscles is important, but so is applying body leverage. Mirror posture of the client. Use body as a whole and not just one part.



Procedure: Lifting Objects with Good Body Mechanics

1. Start with good standing position; feet are shoulder width apart.
2. Keep knees bent slightly.
3. Keep your center of gravity (which is usually right behind the navel) over base of support (which is the proper stance the person is in).
4. Squat with the chest and buttocks sticking out. This position will keep your back flat.
5. When you squat down or squat back up, place your elbow or hand on your thigh or the counter to take some pressure off your back.
6. Use leg and upper body muscles when elevating/lowering an object, keeping body in alignment (keep your buttocks behind you, no twisting). Utilize the whole body to complete the task.

7. Keep object close to body (a 10 pound weight at arm's length will put 150 pounds of pressure on your back).

Practical tips

- Maintain good stance – be aware of your center of gravity over base of support.
- Keep objects close to you.
- Keep your bottom behind the activity! Don't twist from side to side.
- Bend your knees. Lift with your legs (not with the back). Squat with your back in neutral position.
- Don't lift objects that are too heavy.
- Use a stool or ladder to retrieve items above your head.
- Think before you do. Mentally plan and practice your task.
- Maintain your natural spinal curves. Maintain neutral posture when you are sitting, standing, lifting, pushing or pulling.
- Pivot, don't twist. Turn your feet rather than twist your body.

Don't forget!

- Keeping your feet too close together results in poor leverage; you may lose your balance.
- Rounded back results in stress on the back.
- Twisting your upper body can result in a strained back.
- Carry items close to your body.



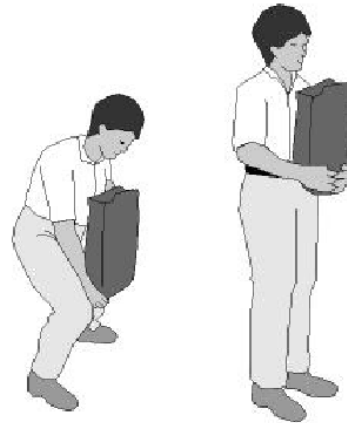
I Just Didn't Listen

I am a caregiver and I thought I knew all about body mechanics. I took a four-hour class about how to stand, transfer, use a mechanical lift, etc. I really thought I knew what to do. I remember my instructor telling me she was going to give us some “tools” in how to interact with our environment. Some of the “tools” were to keep our center of gravity over our base of support, and she really emphasized to make sure you keep your butt behind you. She even added, to push this point stronger, to keep your butt behind all your activity. We all chuckled when she made this statement. She challenged us for the next two weeks to focus on keeping our butts behind all our activity. I thought I had this down pat. Well, I messed up and messed up BIG TIME! I was sitting on the couch watching TV and my three year old niece was sitting next to me. I love my niece, she sure puts a smile on my face. Well, I just turned to pick her up to put her on my lap to snuggle and POW! I felt the twinge in my back. I couldn't believe it, I just couldn't believe it. I needed to set up an appointment with my doctor. “Yes,” he said, “it looks like you pulled a muscle.” I was lucky it was not any worse than the pulled muscle. I thought back at what I did, and I realized I did not have my butt behind me. I actually twisted myself. It was so easy not to follow the directions. I am now really challenging myself to focus on the tools my instructor gave me, and I think I have it this time. Next time I will just tell my niece to snuggle up on my lap rather than have me twist and lift. No more twisting for me. Well, maybe on the dance floor!



When holding, lifting or carrying items

- Before lifting boxes and cases, check to see if the weight is given so you can prepare to lift properly.
- Keep the item close to your body.
- Turn with the feet, not the torso.
- Keep your back straight.
- Use your legs to do the lifting.
- Get close to where you want to set the item down.



Source: United States Dept. of Labor, <http://osha.gov/ergonomics/guidelines/grocerysolutions/index.html>

E. SAFETY TIPS FOR THE DCW

1. Before leaving your home, know how to change a tire and take emergency supplies with you. Always use reliable transportation with plenty of fuel.
2. Always inform your office regarding the address you are visiting and the anticipated length of time you will be there.
3. Alert the client (when possible) that you are coming and have him or her watch for you.
4. Have accurate directions to the street, building, or apartment. Obtain a map to identify the location to which you are traveling.
5. Drive with the windows closed and all car doors locked. Keep your purse or wallet in the trunk.
6. As you approach your destination, carefully observe your surroundings. Note location and activity of the people; types and locations of cars; conditions of buildings (abandoned or heavily congested buildings).
7. If you see a gathering of people, do not walk through them. Walk on the other side of the street.
8. Before getting out of the car, once again thoroughly check the surroundings. If you feel uneasy, do not get out of the car and notify your office.
9. Park your car in a well-lit, heavily traveled area of the street. Lock your car and lock your personal items in the trunk.
10. Do not enter the home if the situation seems questionable (for example, drunk family members, family quarrel, combativeness, unleashed pets, etc). If your instinct tells you to leave, you may want to say, *"I am leaving now. I forgot I have another appointment."* You should call 911 if in danger. Never try to take care of such situations on your own!
11. Note your exits when you enter a client's residence. Try to always have a safe way out.
12. You should remain cautious when approaching pets within the home/community setting. They may be territorial and protective of their owners. It may be necessary to ask a family member to confine them briefly while you are completing your assessment and/or visit.
 - **Be alert**
 - **Be observant**
 - **Trust your own instincts**
 - **Know how and when to call 911**

Did you know?

1. You are going to a person's home for the first time.
 - a. You don't tell anyone when you are going there.
 - b. You tell someone in the office where and when you go.
2. You are walking to work. There is a group of 5 people on the sidewalk, talking loudly.
 - a. You walk by them and say hello.
 - b. You walk on the other side of the street if possible.
3. You ring the doorbell at a home and hear a dog.
 - a. You are cautious because the dog could be dangerous.
 - b. You have nothing to fear because dogs protect people.
4. You need to move a box from the floor to the counter.
 - a. You bend your knees and pick up the box with both hands.
 - b. You reach down with one hand and lift, using the free arm as a counterweight.

F. RESOURCES

- The Wisconsin Caregiver Project <http://www.uwosh.edu/ccdet/caregiver/>
- National Association for Regulatory Administration
<http://naralicensing.org/displaycommon.cfm?an=1&subarticlenbr=22>
- "Focus on: Boundaries" Caregiver News, HSI Caregiver Support Services, January 2008, Missy Ekern,
www.hsicares.org/programs/eldercare/documents/CaregiverNews-January2008.doc

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 6 – OBSERVING, REPORTING AND DOCUMENTING

CONTENTS

- A. Purpose and Importance of Observing and Reporting
- B. Observing and Monitoring
 - 1. Recognizing Changes – The DCW as Detective
 - 2. Signs and Symptoms of Illness and Injury
 - 3. Changes in Mental or Emotional Status
 - 4. Changes in Home Environment
- C. Care Plans and Support Plans
- D. Reporting
- E. Documenting
 - 1. Significance of Documentation
 - 2. Documentation Guidelines
 - 3. Documenting and Reporting Facts
 - 4. Documentation Activity
 - 5. Standardized Medical Abbreviations and Acronyms

OBJECTIVES

1. Explain the purpose of reporting and documentation.
2. Describe the purpose of care and support plans.
3. Explain the importance of observing changes in a person and describe observation techniques.
4. Identify and explain signs and symptoms that need to be reported.
5. Prepare written documentation following documentation guidelines.

KEY TERMS

Care plan

Sign

Charting

Reporting

Documentation

Support plan

Progress notes

Symptom

A. PURPOSE AND IMPORTANCE OF OBSERVING AND REPORTING

The purpose of observing, reporting, and documenting is to communicate any changes or status that may be occurring with an individual and/or the family. Since the individual may even be unaware of changes, it is vitally important for the DCW to communicate with other team members (including the person's family, as appropriate). This can be accomplished through **observing** and monitoring for any changes, and **reporting** and **documenting** those changes.



Report and document only things that you saw or did YOURSELF. The information that is communicated will help the supervisor act appropriately. The DCW becomes the “eyes and ears” for the supervisor. The DCWs *accurate* input is vitally important.

B. OBSERVING AND MONITORING

1. Recognizing Changes – The DCW as Detective

- Early identification of changes in an individual's daily routines, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life.
- You get to know a person by spending time with him or her and learning what is usual for them. If you don't know what is normal for a person, you won't know when something has changed.

Tools the DCW may use

- **Observation:** Use all of your senses: sight, hearing, touch and smell.
- **Communication:** Ask questions and listen to answers. A good listener hears the words and notices other ways of communicating, including behavior.

2. Signs and Symptoms of Illness or Injury

Signs are what can be observed; *symptoms* are what the person experiences or feels.

Physical Health: Changes in physical health are often identified by changes in a particular part of the body. Some are changes you may observe, and others are changes an individual may tell you. For example, you may observe that an individual is pulling his ear or an individual may tell you that his ear hurts.

Ask yourself: Is there any apparent change to the individual's skin, eyes, ears, nose, or any other part of the body?

Physical changes to pay attention to include:

- **Skin:** Redness, cut, swelling, rash.
- **Eyes:** Redness, yellow or green drainage, swelling of the eyelid, excessive tearing, or the individual reports pain and/or that eyes are burning.
- **Ears:** Pulling at ear, ringing in the ears, redness, fever, diminished hearing, and drainage from the ear canal, the individual reports dizziness or pain.
- **Nose:** Runny discharge (clear, cloudy, colored), rubbing of nose.
- **Mouth and throat:** Refusing to eat, redness, white patches at the back of the throat, hoarse voice, fever or skin rash, toothache, facial or gum swelling, gum bleeding, fever, individual reports pain when swallowing.
- **Muscles and bones:** Inability to move a leg or an arm that the individual could previously move, stiffness, limited range of motion, individual reports pain in the arms, legs, back.
- **Breathing (lungs):** Chest pain, cough, phlegm (mucous), shortness of breath or wheezing, fever, rash, stiff neck, headache, chills, nasal congestion, individual reports pain in nose or teeth, dizziness.
- **Heart and blood vessels:** Numb or cold hands or feet, swelling of ankles, chest pain, shortness of breath.
- **Abdomen, bowel, and bladder (stomach, intestines, liver, gallbladder, pancreas, urinary tract):** Constant or frequent abdominal pain, bloating, vomiting, loose stools or diarrhea, constipation, blood in vomit or stools, fever, fruity smelling breath, difficult, painful and/or burning urination, changes in urine color (clear to cloudy or light to dark yellow), fruity smelling urine, nausea, pain on one or both sides of the mid-back, chills.
- **Women's health:** Vaginal discharge, itching, unusual odor, burning, changes in menses, such as change in frequency, length, and flow.
- **Men's health:** Discharge from penis, pain, itching, redness, burning.

Warning signs of injury that require medical attention:

- **Joint deformity:** Limb is out of alignment with the rest of the extremity.
- **Joint pain or tenderness:** Finger pressure to the area causes pain.
- **Swelling:** Swelling within a joint causes pain and can even cause a clicking noise as the structural tendons and ligaments get pushed into new positions.
- **Decreased range of motion** of the affected joint or limb.

- **Numbness or tingling:** This may be a sign of nerve compression.

For treatment of injuries, refer to Chapter 9, Fire, Safety and Emergency Procedures.

3. Changes in Mental or Emotional Status

- **Behavior:** An individual who is usually calm starts hitting and kicking; appears more or less active than usual.

Ask yourself: *Does the individual appear more or less active than usual?
Is the individual acting aggressively to himself or to others?*

- **Ways of communicating:** An individual who usually talks a lot stops talking; speech becomes garbled or unclear.

Ask yourself: *Has the individual's ability to talk or communicate changed?*

- **Appearance:** An individual who is usually very neat in appearance now has uncombed hair; is wearing a dirty, wrinkled shirt. There are changes in color or appearance (a sudden redness on the hands or an ashy tone and clammy feel to the skin); any changes in weight, up or down.

Ask yourself: *Does it seem like the individual has lost interest in things?
Is the individual taking less care in his or her dress?*

- **General manner or mood:** Someone who is usually very talkative and friendly becomes quiet and sullen; an individual who usually spends her free time watching TV with others suddenly withdraws to her room and wants to be alone.

Ask yourself: *Has the individual's mood changed? Does the individual want to be alone all the time?*

- **Family/social relationships:** The individual may act distant or afraid when family members or visitors are around.

Ask yourself: *Is there someone interacting with the person who appears to causing emotional distress? If you notice any signs of drug activity, or verbal or physical abuse, inform your supervisor immediately.*

4. Changes in Home Environment

- **Finances:** Are there unpaid bills? Have utilities been cut off? Is there sufficient food on hand?
- **Cleanliness:** Has there been a change in housekeeping routines? Can the individual continue doing household chores?
- **Home maintenance/safety:** Are there repairs that need to be done that could cause a health or safety hazard?

Source: The section on observing and monitoring was adapted from: Direct Care Worker Training, California Department of Developmental Services.



Reporting Equal Win/Win for Client and Caregiver

Learning to communicate effectively with an individual and your supervisor is key to maintaining a good caregiving relationship. As a caregiver, you learn to adapt and respect each client's daily routine; however, as a client's level of care may begin to change, there may need to be adjustments to ensure the safety of the person and the caregiver are not compromised. As a caregiver, your communication and reporting is very valuable to identify any changes so that your supervisor can respond with a plan of action and also communicate with client's case manager.

As a caregiver supervisor working in this field over eight years, I recall a win/win situation for one client and caregiver based on effective communication and reporting.

My story begins with the caregiver who has been providing care for her client for over four years. Over time Mary began noticing that managing the daily routine began taking longer and longer as her client's abilities were lessening. The caregiver reported her concerns with her supervisor, and the supervisor scheduled a home visit to meet with the client and caregiver to observe the morning routine. Upon completing the home visit, it was apparent to the supervisor that the caregiver did not have the tools and time necessary to meet the client's needs. The supervisor contacted the client's case manager. Another visit was scheduled with the case manager, supervisor, client, client's daughter, and caregiver to meet together in client's home to discuss face to face what changes could be implemented into the client's routine, so both client and caregiver were safe and the client would be receiving good care. The case manager completed a new assessment and submitted orders for the client to receive a hospital bed, Hoyer lift, new wheelchair and cushion and a new shower chair. The client's hours of service were increased to have coverage seven days a week, with a morning and evening schedule. Communication and reporting got this snowball going and it all paid off in the end with the win / win for both client and caregiver.

Bonnie Zanardi, caregiver supervisor



C. CARE PLANS AND SUPPORT PLANS

- A *care plan* or *support plan* (depending on the agency terminology) is a written plan created to meet the needs of the person. It may also be called a service plan.
- The plan is usually created during an in-home assessment of the individual's situation, the strengths and care being provided by family and friends.
- The plan defines the needs and objectives/goals for care.
- The plan lists the actions to be provided by the DCW.
- Any deviations from a care or support plan may put the DCW at risk for disciplinary action. **Therefore, any changes need to be approved by the supervisor.**
- Care/support plans are reviewed by the care team. The DCW may be asked for input as to how the plan is working. Reporting and documenting are very critical in evaluating whether the plan is working or if it needs revision.

D. REPORTING

Now that you have observed changes or monitored the person's status the DCW needs to *report* the changes. *Reporting* is the verbal communication of observations and actions taken to the team or supervisor, usually in person or over the phone. A verbal report is given to a supervisor when the need arises, or for continuity of care (for example, giving a verbal report to the next shift).

It is always better to report something than to risk endangering the person, the agency, and yourself by not reporting it.

Reporting helps your supervisor act accordingly.

E. DOCUMENTING

Documenting, also called *charting*, is the written communication of observations and actions taken in the care of the individual.

1. Significance of Documentation

- A record of what was done, observed, and how the person reacted.
- Used for evaluation by other team members of the care plan.
- Used to clarify complaint issues.

Remember two important phrases:

- “If it wasn’t documented, it wasn’t done.”
- “The job is not over until the paperwork is finished.”



Always remember that the client record is a legal document.

2. Documentation Guidelines

Your agency will tell you about policies and procedures you need to know. Some agencies have specific forms you need to use. You may learn specific rules for reporting information and incidents. The following is a list of general guidelines.

- Always use ink.
- Sign all entries with your name and title, if any, and the date and time.
- Make sure writing is legible and neat.
- Use correct spelling, grammar, and punctuation and abbreviations (Refer to the Standardized Medical Abbreviations list on the following pages).
- Never erase or use correction fluid. If you make an error, cross out the incorrect part with one line, write “error” over it, initial it, and rewrite that part.
- Do not skip lines. Draw a line through the blank space of a partially completed line or to the end of a page. This prevents others from recording in a space with your signature.
- Be accurate, concise, and factual. Do not record judgments or interpretations.
- Make entries in a logical and sequential manner.
- Be descriptive. Avoid terms that have more than one meaning.
- Document any changes from normal or changes in the person’s condition. Also document that you informed the person’s physician or your supervisor as indicated.
- Do not omit any information.
- Try to relate your charting to the objectives/goals on the person’s plan. For example, if walking more is a goal, write “*walked 3 times today without assistance from bedroom to kitchen*” instead of “*had a good day today*”.

3. Documenting and Reporting Facts

When you document or report your observations and actions, it is important that you are objective. Write down facts and describe exactly what happened. What exactly did you see or hear? What exactly did the client say? Write down the words that the client said, not what you think he or she meant. Opinions are less useful because you may interpret a situation one way, but another person may have a different opinion.

Example: “Mrs. Jones said: ‘I don’t want to eat anything.’ She did not touch the chicken sandwich I prepared for lunch; she only drank ice tea.”

Don’t try to explain why you think she does not want to eat. Just write what she said and did. When you don’t stick to the facts, your opinion may cause a client to lose his or her much-needed services.



4. Documentation Activity

Practice documentation, using the documentation guidelines. Here is an example:

Sara (client) has not been eating much lately so the goal is to increase her intake. During your shift today, she ate all of her lunch.

The documentation may look something like this:

Client Name: *Sara Jones*

Date/Time	Action/Observation
<i>9/29/05 3:15pm</i>	<i>Sara ate all of her chicken salad sandwich and 1/2 cup jelly w/ bananas for lunch. Sara stated she liked the bananas and enjoyed using her good china and having flowers on the table.</i>
	<i>Jessie Walker</i>

What would your documentation look like in these situations? What would you report? You can use the form on the next page.

- When you arrived at Sara’s house today she stated that she had fallen during the night. She is not complaining of pain except for a bruise on her leg.
- While you were washing dishes you broke a plate.
- During your shift Sara had an episode of chest pain. She took a nitroglycerin tablet and the pain went away.

5. Standardized Medical Abbreviations and Acronyms

Every agency has different needs. For some positions you may have to learn some of these abbreviations. Use this table as a reference.

A		COPD	chronic obstructive-pulmonary disease
abd	abdomen	CPR	cardiopulmonary resuscitation
ac	before meals	CVA	cerebrovascular accident
AD	right ear	D	
ADL	activities of daily living	dc,d/c	discontinued
ad lib	as desired	dias	diastolic
AM	between 12 midnight & noon	DM	diabetes mellitus
AP	apical pulse	DOA	dead on arrival
AROM	active range of motion	Dx	diagnosis
AS	left ear	E	
ASAP	as soon as possible	ECF	extended care facility
ASHD	arteriosclerotic heart disease	ECG, EKG	electrocardiogram
as tol	as tolerated	EEG	electroencephalogram
AU	both ears	EENT	eyes, ears, nose, & throat
ax	axillary	EMG	electromyogram
B		ER	emergency
bid	two times a day	F	
BM	bowel movement	FBS	fasting blood sugar
BP	blood pressure	Fe	iron
BRP	bathroom privileges	Fib	fibrillation
BS	bowel sounds	ft	feet
C		Fx	fracture
ċ	with	FWB	full weight bearing
CAD	coronary artery disease	G	
Cal	Calorie	GI	gastrointestinal
cap	Capsule	gm	gram
CBC	complete blood count	gr	grain
cc	cubic centimeter	gtts	drops
C & DB	cough and deep breath	GU	Genitourinary
CHF	congestive heart failure	Gyn	Gynecology
Chol	cholesterol		
CNS	central nervous system		

Chapter 6 – Observing, Reporting and Documenting

H

H ₂ O	water
H ₂ O ₂	hydrogen peroxide
hgb	Hemoglobin
hr	Hour
hs	hour of sleep
ht	Height
Hx	History

I

ICU	intensive care unit
I & O	Intake and output
IPPB	intermittent positive pressure breathing device
I/S	instruct and supervise

K

K	potassium
---	-----------

L

lab	laboratory
lb, #	pound
liq	liquid

M

MD	medical doctor
med	medication
mEq	milliequivalents
mg	milligram
MI	myocardial infarction
min	minute
mi	mile
mm	millimeter
MOM	milk of magnesia
MS	multiple sclerosis
MSW	medical social work, or Master of Social Work

N

Na	sodium
Neg	negative
Neuro	neurology
No.#	number
NPO	nothing by mouth
NS	normal saline
nsg.	nursing
N & V	nausea and vomiting
NWB	no weight bearing

O

O ₂	oxygen
OD	right eye
OR	operating room
ortho	orthopedics
os	oral
OS	left eye
OT	occupational therapy
OU	both eyes
oz	ounce

P

pc	after meals
peri	perineal
PM	after 12 noon
po	by mouth
pre op	preoperative
pm	as necessary
PROM	passive range of motion
pt	patient
PT	physical therapy
PVD	peripheral vascular disease

Q

q every
 qd everyday
 qh every hour
 qid four times a day
 qod every other day
 qt quart
 quad quadriplegic

R

RBC red blood count
 reg regular
 ROM range of motion
 Rx prescription

S

s without
 SO significant other
 ST speech therapy
 Stat. at once/immediately
 SQ/subq subcutaneous
 syst systolic
 Sx symptoms

T

TB tuberculosis
 Tbsp tablespoon
 temp temperature
 TIA transient ischemic attack
 tid three times a day
 TPR temperature, pulse,
 respirations
 Tx treatment

U

UA urinalysis
 URI upper respiratory infection
 UTI urinary tract infection

V

via by way of
 VS vital signs

W

WBC white blood count
 W/C wheelchair
 wk week
 WNL within normal limits
 wt weight

Y

yr year

Symbol

İ one of something
 İİ two of something



Mix and Match Exercise: Medical Abbreviations

- | | | | |
|-----|--------|-------|-------------------|
| 1. | a.c. | _____ | twice a day |
| 2. | A.M. | _____ | before meals |
| 3. | b.i.d. | _____ | four times a day |
| 4. | cc | _____ | immediately |
| 5. | DC | _____ | right eye |
| 6. | gtts | _____ | morning |
| 7. | h.s. | _____ | cubic centimeter |
| 8. | NPO | _____ | every 2 hours |
| 9. | OD | _____ | teaspoon |
| 10. | OS | _____ | three times a day |
| 11. | OU | _____ | every other day |
| 12. | p.c. | _____ | as needed |
| 13. | P.M. | _____ | drops |
| 14. | PO | _____ | discontinue |
| 15. | p.r.n. | _____ | every day |
| 16. | q.d. | _____ | after meals |
| 17. | q2H | _____ | both eyes |
| 18. | q4H | _____ | by mouth |
| 19. | q.i.d. | _____ | hour of sleep |
| 20. | q.o.d. | _____ | left eye |
| 21. | stat | _____ | nothing by mouth |
| 22. | t.i.d. | _____ | every 4 hours |
| 23. | tsp | _____ | afternoon |
| 24. | ml | _____ | milligram |
| 25. | mg | _____ | grain |
| 26. | gr | _____ | milliliter |
| 27. | ‡ | _____ | two |
| 28. | ‡‡ | _____ | one |

Did you know?

1. Mr. Chang seems different. He normally reads the paper or watches TV; today he just sits quietly.
 - a. You ask him how he is feeling.
 - b. You don't disturb him.
2. Mrs. Green does not want to eat lunch. You remember that she did not eat lunch the last time you were there.
 - a. You are not concerned; sometimes people are not hungry.
 - b. You document that she did not eat lunch and also report it to your supervisor.
 - c. You document that she did not eat lunch.
3. Mrs. Brown complains she always feels cold.
 - a. You write in your notes *"Mrs. Brown stated 'she always feels cold'."*
 - b. You write in your notes *"Mrs. Brown is cold."*
4. Mr. Jones did not want to get out of bed.
 - a. You write in your notes: *"Mr. Brown stayed in bed; I think he is sick."*
 - b. You write in your notes: *"Mr. Brown stayed in bed."*

Principles of Caregiving: Fundamentals

Chapter 7 – Infection Control

CONTENTS

- A. The Spread of Diseases and Prevention
- B. Common Bloodborne Pathogens
 - 1. Hepatitis B
 - 2. Hepatitis C
 - 3. Human Immunodeficiency Virus (HIV)
 - 4. Other Bloodborne Pathogen Diseases
- C. Other Common Conditions
 - 1. Tuberculosis (TB)
 - 2. Lice
 - 3. Scabies
- D. Policies and Guidelines
 - 1. Bloodborne Pathogen Standard
 - 2. Universal Precautions
- E. Procedures
 - 1. Hand Washing
 - 2. Gloves and Other Personal Protective Equipment
 - 3. Handling and Disposal of Infectious Wastes
 - 4. Linens
 - 5. Cleaning the Environment
- F. Resources

OBJECTIVES

1. Explain how infectious diseases are spread, and list common preventive measures.
2. Identify and describe common bloodborne diseases.
3. Identify and describe other communicable diseases and conditions.
4. Explain the role of immunizations for direct care workers.
5. Identify components of the Bloodborne Pathogen Standard.
6. Explain the purpose of infection control measures and describe techniques for infection control.

SKILLS

1. Hand washing
2. Applying gloves / removal and disposal of gloves

KEY TERMS

Bloodborne pathogen	Scabies
Confidentiality	Sharps
Hepatitis B and C	Standard precautions
HIV	Symptom
Infectious disease	Tuberculosis (TB)
Lice	Transmission
Pathogen	Universal precautions
Personal protective equipment (PPE)	

A. THE SPREAD OF DISEASES AND PREVENTION

Preventing the spread of disease depends on how the disease is transmitted and the source of the infection. Germs, also called *microorganisms*, are tiny living particles. They can be found anywhere: in the air, on the ground, in our bodies. *Pathogens*—the germs that cause diseases—often live in a specific environment. Some diseases are spread by touching objects that an infected person has touched. Other diseases are spread when you come into contact with the body fluids of an infected person, for example blood or saliva.



Sources of infection

- Air
- Eating and drinking utensils
- Dressings
- Food
- Personal hygiene equipment
- Insects
- Water
- Direct contact
- Animals

Healthy individuals with healthy immune systems will stay healthy because their immune system will fight the germs. To help the body fight off diseases, there are simple things you can do every day. You can reduce the spread of infectious microorganisms by:

- Washing your hands after urinating, having a bowel movement, or changing tampons, sanitary napkins or pads.
- Washing your hands after contact with any body fluid or substance, whether it is your own or another person's.
- Washing your hands before handling, preparing, or eating food.
- Washing fruits and raw vegetables before eating or serving them.
- Covering the nose and mouth when coughing, sneezing or blowing the nose.
- Bathing, washing hair, and brushing teeth regularly.
- Washing cooking and eating utensils with soap and water after use.
- Germs multiply rapidly in warm, dark, moist environments so keep those areas on a person's body (for example, groin folds) and in living areas (shower corners) clean.

Risk factors

People are at greater risk for getting infections if they:

- Have weakened immune systems such as very young or elderly persons. Young children have not yet developed a strong immune system. The immune system becomes less efficient as a person ages. That is why very young children (age 6 months to 2 years) and elderly persons should get flu shots annually.
- Are on medication that suppresses the immune system (for example, organ transplant patients).
- Are on prednisone or similar medications.
- Have HIV/AIDS.
- Are not eating healthy foods, not sleeping enough, and are under increased stress.

B. COMMON BLOODBORNE PATHOGENS

Bloodborne pathogens are disease-causing microorganisms present in human blood or other potentially infectious material (OPIM). These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV). According to the Centers for Disease Control and Prevention (CDC), hepatitis C is the most common chronic bloodborne infection in the United States. Some symptoms are similar for these diseases, but not all.

Symptoms of Hepatitis B and C	Symptoms of HIV
Flu-like	Flu-like
Fever	Fever
Lack of energy	Weight loss
Dark urine	Rash
Yellow skin & sclera	Diarrhea
Abdominal discomfort	Night sweats
	Swollen lymph nodes

Note: Hepatitis B: 30% of cases have no signs and symptoms.

Hepatitis C: 80% of cases have no signs and symptoms.

1. Hepatitis B

Hepatitis B virus (HBV) is a potentially life-threatening bloodborne pathogen. The CDC estimates there are approximately 280,000 HBV infections each year in the U.S. Approximately 8,700 health care workers each year contract hepatitis B, and about 200 will die as a result. In addition, some who contract HBV will become carriers, passing the disease on to others. Carriers also face a significantly higher risk for other possibly fatal liver ailments, including cirrhosis of the liver and primary liver cancer. HBV infection is transmitted through exposure to blood and other infectious body fluids and tissues. Anyone with occupational exposure to blood is at risk of contracting the infection.

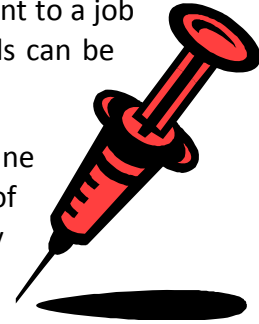
Employers must provide engineering controls; workers must use work practices and protective clothing and equipment to prevent exposure to potentially infectious materials. However, the best defense against hepatitis B is vaccination.

Vaccination

The new OSHA standard covering bloodborne pathogens requires employers to offer the three-injection vaccination series free to all employees who are exposed to blood or other potentially infectious materials as part of their job duties. This includes health care workers, emergency responders, first-aid personnel, law enforcement officers, and others.

The vaccination must be offered within 10 days of initial assignment to a job where exposure to blood or other potentially infectious materials can be "reasonably anticipated."

The hepatitis B vaccination is a noninfectious, yeast-based vaccine given in three injections in the arm. There is no risk of contamination from other bloodborne pathogens nor is there any chance of developing HBV from the vaccine. The second injection should be given one month after the first, and the third injection six months after the initial dose. More than 90 percent of those vaccinated will develop immunity to the hepatitis B virus. To ensure immunity, it is important for individuals to receive all three injections. At this point it is unclear how long the immunity lasts, so booster shots may be required at some point in the future.



The vaccine causes no harm to those who are already immune or to those who may be HBV carriers. Employees may opt to have their blood tested for antibodies to determine need for the vaccine.

Workers who decide to decline vaccination must complete a declination form. Employers must keep these forms on file so that they know the vaccination status of everyone who is exposed to blood. At any time after a worker initially declines to receive the vaccine, he or she may opt to take it.

Adapted from: "Hepatitis B Vaccination – Protection for You." Bloodborne Fact Sheet No. 5. U.S. Department of Labor, Occupational Safety and Health Administration (OSHA). www.osha.gov/OshDoc/data_BloodborneFacts/

2. Hepatitis C

Hepatitis C is a liver disease, caused by the hepatitis C virus (HCV), found in the blood of persons infected with this disease. Hepatitis C can be serious for some persons, but not for others. Most people who get hepatitis C will carry the virus the rest of their lives. Many do not feel sick from the disease, but most of these persons will have some liver damage. Eventually, some patients may develop cirrhosis of the liver and liver failure.

There is no vaccination for hepatitis C. However, many persons with hepatitis C are at risk for hepatitis A and hepatitis B, and should be vaccinated for these diseases.

Preventing the spread of hepatitis C

Hepatitis C is spread through contact with the blood of an infected person. Sharing of needles, syringes and other equipment used in intravenous drug use can spread the disease. Do not share razors, toothbrushes or other personal care articles that may have blood on them. Rarely, it may be spread by unprotected sex.

Hepatitis C is NOT spread by breast feeding, hugging, kissing, food or water, sharing eating utensils or drinking glasses, casual contact, sneezing, coughing.

DCWs should follow barrier precautions and use caution with needles, syringes and other sharps.

Adapted from: Hepatitis C Prevention, Department of Health and Human Services, August 2003, <http://www.cdc.gov/hepatitis/HCV/index.htm>.

3. Human Immunodeficiency Virus (HIV)

If you are going to be caring for someone with HIV infection, you need to understand the basic facts about HIV and AIDS. Acquired immunodeficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV). People who are infected with HIV can look and feel healthy and may not know for years that they are infected. HIV slowly wipes out parts of the body's immune system. The HIV-infected person gets sick because the body can't fight off diseases.

Signs of HIV infection are like those of many other common illnesses, such as swollen glands, tiring easily, losing weight, fever, or diarrhea. Different people have different symptoms.

HIV is in people's blood, semen, vaginal fluid, and breast milk. The only way to tell if someone is infected with HIV is with a blood test. There is no vaccine to prevent HIV infection and no cure for AIDS. There are treatments that can keep infected people healthy longer and prevent diseases that people with AIDS often get. Research is ongoing.

HIV slowly makes an infected person sicker and sicker. Someone with AIDS can feel fine in the morning and be very sick in the afternoon. It can seem like riding a roller coaster, slowly climbing up to feeling good, then plunging down into another illness.

How HIV is spread

HIV is commonly spread by:

- Having unprotected anal, vaginal, or oral sex with one who is infected with HIV.
- Sharing needles or syringes ("works") with someone who is infected with HIV.
- Mothers to their babies before the baby is born, during birth, or through breast-feeding.

Early in the AIDS epidemic some people became infected through blood transfusions, blood products (such as clotting factors given to people with hemophilia), or organ or tissue transplants. This has been very rare in the United States since 1985, when a test for HIV was licensed. Since then, all donated blood and donors of organs or tissue are tested for HIV.

How HIV is NOT spread

You don't get HIV from the air, food, water, insects, animals, dishes, knives, forks, spoons, toilet seats, or anything else that doesn't involve blood, semen, vaginal fluids, or breast milk. You don't get HIV from feces, nasal fluid, saliva, sweat, tears, urine, or

vomit, unless these have blood mixed in them. You can help people with HIV eat, dress, even bathe, without becoming infected yourself.

Adapted from “What You need to Know About HIV and AIDS.” Centers for Disease Control and Prevention, Division of HIV/AIDS Prevention,
<http://www.cdc.gov/hiv/resources/brochures/creathome/care3.htm>

4. Other Bloodborne Pathogen Diseases

There are other diseases caused by bloodborne pathogens such as malaria, syphilis, and Ebola, but all these are much less common than hepatitis B and C, or HIV.

Did you know?

- | | | |
|---|------|-------|
| 1. Some diseases can spread through air | True | False |
| 2. Children and older adults are more at risk for infection | True | False |
| 3. You can get hepatitis B from another person’s blood | True | False |
| 4. You can get vaccinated to protect against hepatitis B | True | False |
| 5. You can get HIV/AIDS from another person’s sweat. | True | False |

C. OTHER COMMON CONDITIONS

There are many other diseases that are not caused by bloodborne pathogens. These diseases may spread through the air, perhaps when someone sneezes. Other pathogens live on the skin or other surfaces. Some conditions are caused by small parasites, such as lice.

1. Tuberculosis (TB)

Tuberculosis (TB) is still a problem. Eight million new cases occur each year in the world. In the U.S., the 30-year decline in TB cases has ended. Since 1985, the number of U.S. cases reported each year has remained above 22,000. Millions of people have TB infection and have no symptoms of the disease, but they can transmit the disease to others. An estimated 10-15 million persons in the U.S. are infected with TB bacteria. That is why TB screening is needed, especially for those who work in a health care setting.

Anyone can contract TB, but those at high risk include:

- People living in substandard housing and the homeless.
- Immigrants from areas where TB is common.
- Residents of supervised living facilities and group homes (especially nursing homes).
- Prisoners.
- People who have immunosuppressant diseases, such as HIV/AIDS, or those who have had a recent organ transplant.
- IV drug abusers.

Health care workers

TB is transmitted via the airborne route. This means that the TB pathogens are in the air and can be inhaled. Repeated, prolonged exposure is usually necessary to contract TB. The disease is not spread through sharing belongings or touching something that a sick person has touched.

Symptoms of the disease include:

- Cough
- Fatigue
- Weakness
- Fever
- Weight loss
- Night sweats
- Blood in sputum

Screening for the disease is done with a skin test. If the result of the skin test is positive, it means you have been exposed to TB bacteria. **THIS DOES NOT MEAN YOU HAVE AN ACTIVE CASE OF TB. You will need to seek medical advice to see if you have active TB. Once you have a positive skin test, you will need a chest x-ray to screen for the presence of TB even if you are healthy.** A chest x-ray and possibly a sputum analysis are done to determine if TB disease is present and what kind of treatment is indicated. In some areas, active TB cases are reported to the county health department.

2. Lice

Lice are tiny insects (one is called a *louse*) that live on humans and survive by feeding on blood. When a large number of lice live and reproduce on a person, it is called an infestation. Three different kinds of lice infest humans: head lice, pubic lice (“crabs”) and body lice. Infestations are easily spread from one person to another through close bodily contact or through shared clothing or personal items (such as hats or hair brushes). Lice cannot jump or fly.

Symptoms

The most common symptom of lice infestation, called *pediculosis*, is itching in the affected areas. Symptoms vary depending on which type of lice is present.

Diagnosis and treatment

A close visual examination for live lice or their eggs, called *nits* in the hair is usually all that is needed to diagnose an infestation of head lice. A health professional may confirm the diagnosis with microscopic examination. Pubic lice and body lice can also be diagnosed with a close visual examination of the affected areas or the person's clothing. Use a fine tooth dark colored comb and comb the person's hair. Nits are like very small grains of rice.

Both lice and nits must be destroyed to get rid of an infestation. The most common treatment is a topical nonprescription or prescription cream, lotion, or shampoo to kill the lice and eggs. Sometimes a second treatment is needed to make sure that all the eggs are destroyed. When two or more topical treatments have failed to get rid of the lice, a prescription pill called ivermectin can be taken.



Call your supervisor to get directions on how to proceed if you suspect there is an infestation.

3. Scabies

Scabies are tiny, eight-legged mites that are hard to see without a magnifying glass. They dig underneath the skin and cause itching so severe it may make it difficult for the person to sleep at night. An early scabies rash will show up as little red bumps, (looks like hives), tiny bites, or pimples. Later the bumps may become crusty or scaly. Scabies usually starts between fingers, on elbows or wrists, buttocks, or waist. Sometimes the person will have long red marks from where the mite has been crawling under the skin and the person has been scratching.

People in group settings such as nursing homes or group homes are more likely to get scabies.

Diagnosis and treatment

Usually a dermatologist will be able to tell if a person has scabies just from looking at the skin. If not, he/she can do a simple diagnostic test.

- Scabies is easy to treat with special creams and lotions.
- Wash all of the person's clothes, sheets, and towels in hot water. Dry the clothing and linens completely in the dryer.
- Vacuum the whole house and throw out the vacuum cleaner bag.
- ***Treat all family members for scabies at the same time, whether they itch or not. That will keep scabies from spreading.***

D. POLICIES AND GUIDELINES

Direct care workers, like all health care professionals, must take precautions to help prevent the spread of diseases and infestations. There are policies and guidelines that describe the actions required or recommended. The Occupational Health and Safety Administration (OSHA) is concerned with transmission of all bloodborne pathogens, and has created guidelines specifically for preventing or minimizing an employee's exposure to hepatitis B (HBV) and HIV. OSHA regulations mandate the implementation of *universal precautions* and the *Bloodborne Pathogen Standard*.



1. The Bloodborne Pathogen Standard

On December 6, 1991, OSHA issued its final guideline on occupational exposure to bloodborne pathogens (29 CFR 1910.1030). It is called the *Bloodborne Pathogen Standard* and explains what agencies have to do to help prevent the spread of infections. The standard covers these topics:

- Exposure control plan
- Training
- Maintaining training records
- Labels
- Implementation and monitoring compliance with guidelines (e.g. universal precautions)
- HBV vaccination
- Post-exposure follow-up
- Personal protective equipment (PPE)

Your agency will provide more information about the Bloodborne Pathogen Standard if it is needed for the work you will be doing.

2. Universal precautions

Universal precautions, sometimes called *standard precautions*, are infection control procedures. As a DCW, you use precautions every day:

- Washing your hands properly.
- Keeping your work environment clean.
- Using PPE, such as gloves.

Universal precautions are designed to prevent health care workers from transferring infections to patients, and from infecting themselves. Disease causing agents may be present in body substances, even when a person does not look or act sick. Therefore, universal precautions should be used whenever you come into contact with body fluids from any other person.

- The purpose of universal precautions is to prevent or minimize exposure to bloodborne pathogens. To be safe, universal precautions apply to any fluid emitted from the body.
- Approach all clients as if they were HIV or HBV infectious.
- Universal precautions apply to tissues, blood, and other body fluids containing visible bloods.
- Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the workplace.
- Plan ahead when you are working with a client and use the appropriate personal protective equipment (PPE), such as gloves.
- Know the limitations of the PPE you are using, when the equipment can protect you and when it cannot.
- Do not recap needles. Do not break or otherwise manipulate needles.
- Place contaminated sharps in puncture-resistant containers.
- Wash hands immediately after contamination or removing gloves.

E. PROCEDURES

1. Hand Washing

Hand washing is one of the easiest and most effective ways to prevent the spread of infection when proper techniques are used at the appropriate times when working with clients. It is imperative that all steps are demonstrated for proper hand washing techniques.

Wash your hands:

- Immediately upon arrival and before leaving a client's home.
- Immediately if contaminated by blood or any other bodily fluid.
- Before and after contact with a new client.
- Before and after use of gloves.
- After handling soiled linens or waste.
- Before and after contact with any wounds.
- After using the restroom.



Procedure: Hand Washing

1. Collect items needed for hand washing.
2. Remove all jewelry on hands, fingers, wrists - *recommended*.
3. Turn on the water and adjust the temperature. Water should be warm but not hot.
4. Wet hands under running water with fingertips pointed down.
5. Apply soap to hands (liquid soap in a pump is best).
6. With fingertips pointing down, lather hands well. Rub your hands together in a circular motion to generate friction. Wash carefully between fingers, palms, the back of hands and under/around any jewelry.
7. Rub your fingernails against the palm of the opposite hand to push soap under the nails.
8. Remember: You need to wash your hands a minimum of 20 seconds. (Sing "Happy Birthday" twice, or "Twinkle-Twinkle Little Star", to yourself as a timer.)
9. Wash a full hand's distance up both wrists as well.
10. With fingertips pointed down, rinse off all soap thoroughly.
11. Dry hands with a clean paper towel.
12. Use paper towel to turn off the water and to open the restroom door if needed.
13. Drop paper towel in trash container.

Practical Tips

- Use soap – it breaks the surface tension of the water, making the water work harder.
- Friction (rubbing hands together) loosens bacteria and dirt. Remember it is the friction that kills and loosens the germs, not the soap or water temperature.
- Use plenty of water to wash away the contaminants: dirt, germs and the soap.
- Do not use chemicals such as bleach or alcohol to wash hands. They may damage the skin.
- Do not use a nail brush or any kind of brush. This can damage the skin and cross-contaminate.

Don't forget!

- You must wash your hands for at least 20 seconds for effective decontamination.
- Keep fingers pointed down into the sink. Do not allow water to run up the arm, off the elbows.
- Don't forget to wash the wrists.
- Either remove jewelry or wash under items. Germs hide under rings and bracelets.
- Don't touch the faucet, sink, surfaces, or doorknobs with hands after washing. This will re-contaminate your clean hands.



**Remember: Intact skin is your best defense
against bacteria. Treat your hands well!**

Are you washing your hands correctly?

1. Collect the items needed for hand washing.

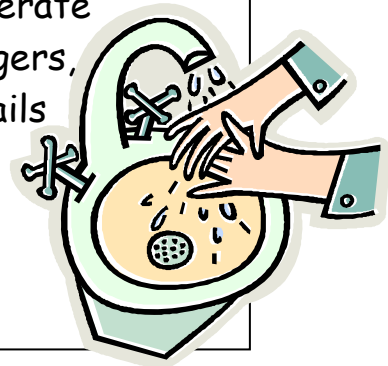


2. Use a clean paper towel to turn on water and adjust temperature. Wet hands with fingertips pointed down.



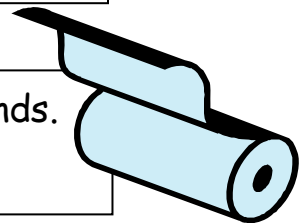
3. Apply soap - liquid soap in a pump is best

4. With fingertips pointing down, lather well. Rub your hands together in a circular motion to generate friction. Wash carefully between your fingers, palms, and back of hands, and rub fingernails against the palm of the other hand to force soap under the nails. Keep washing for 20 seconds (Sing "Happy Birthday" 2 times).



5. With fingertips pointed down rinse off all the soap.

6. With clean paper towel or clean hand towel dry hands. Use a clean paper towel and turn off the faucet.



2. Gloves and Other Personal Protective Equipment (PPE)

Personal protective equipment (PPE), such as disposable gloves, allows you to create a barrier between yourself and germs. By using disposable gloves you are preventing the spread of infectious diseases like the common cold, the flu, MRSA or HIV, just to name a few. Wearing gloves is not just for your protection but the protection of others as well.

Disposable gloves should be worn when:

- Touching blood or body fluids.
- You or the individual you are caring for has cuts, sores or other skin openings.
- There is possible contact with feces, urine, vomit or wound drainage.
- Handling soiled clothing or linens.
- Cleaning the bathrooms.



Procedure: Putting on Gloves

1. Wash and dry your hands following proper procedures.
2. Remove a pair of gloves from the glove box.
3. Use care when pulling gloves on. If a glove tears or becomes punctured take it off and start again with a new glove.
4. Interlace fingers to remove wrinkles, air pockets and achieve a comfortable fit.
5. You may want to consider double gloving if your nails are longer and at risk of puncturing the gloves or if the gloves will become heavily soiled. Double gloving simply means wearing two pairs of gloves.



Procedure: Removing and Disposing of Gloves

1. From the outside, pinch the rubber glove just below the cuff using your thumb and index finger to lift the glove away from your wrist area.
2. Using your middle and ring fingers, scoop the glove away from the wrist; pulling it off inside out. Ball that glove tightly into palm of gloved hand.
3. Now with ungloved hand slide your index and middle finger under the cuff of the other glove; again pulling it off inside out. The first glove you removed should now be inside the second glove.
4. Follow your agency's policies in disposing of the gloves.
5. Wash your hands following proper procedure.

Practical Tips

- Disposable gloves should NEVER be washed or re-used.
- Always replace if they become ripped, torn or contaminated.
- Always wash hands *before* and *after*.
- Know your agency's policies on disposing of gloves. Policies may differ between agencies.
- Wear gloves that fit properly. If they are the wrong size, they can tear or fall off.

Don't forget!

- Contamination can happen when:
 - touching unclean areas (the wrist, other surfaces)
 - placing gloves on contaminated surfaces or in your pocket
- removing gloves
- You must wash hands when you replace gloves
- Long nails can puncture gloves

General rule: Touch the outside of a glove only with a glove.

3. Handling and Disposal of Infectious Wastes

Home medical sharps disposal

In a person's home, you may see syringes, needles or lancets. They are used by individuals with certain medical conditions. These items are called *sharps* and need to be disposed properly.

- Do not touch sharps (for example, syringes) with your bare hands. Use gloves, and if possible use a tool to pick them up.
- Sharps need to be thrown away properly so that nobody is injured or infected. This includes DCWs and garbage haulers.
- Ask your supervisor if you are responsible for disposing of sharps. If yes, follow these guidelines for Arizona:
 - Use a purchased medical sharps container (from a pharmacy or health care provider) or a heavy-plastic or metal container. Do not use a clear or glass container. The containers should be puncture-proof with a tight-fitting lid. Household containers such as plastic detergent bottles can be used if the following precautions are observed:

- Write the words "Not Recyclable" on the container with a black indelible marker. This helps to ensure the container will not be inadvertently mingled with recyclable materials.
- Fill the medical sharps container to approximately 3/4 full. Do not over-stuff the container.
- Keep out of reach of children and pets.
- When full, use heavy-duty tape to secure the lid to the container (duct tape or electrical tape). Then throw away with regular trash.
- Always wash your hands after handling or touching medical sharps.

Source: Arizona Department of Environmental Quality,
<http://www.azdeq.gov/environ/waste/solid/ic.html#sharps>

Handling of wastes other than sharps

- Body wastes such as urine need to be flushed down the toilet.
- Soiled incontinent pads or disposable gloves need to be placed in plastic bags, tied, and taken out to trash immediately so that they do not create odors or grow bacteria in the home.
- Mop water needs to be flushed down the toilet or thrown outside—**never put it down the kitchen sink.**



Syringe and Paper Towel Did Not Mix

“Ouch!” is what I heard coming from the room of Mary, who was my client. Her granddaughter was visiting and she went to pick up a crinkled paper towel and stuck herself from the syringe that was inside the paper towel. I told her granddaughter that she needed to call her doctor or go to a medical facility to tell them what happened. I then called my supervisor and told her of the incident.

Now was my chance to share with Mary and her family about the importance of disposing syringes/sharps in the right containers. I found a heavy plastic laundry bottle and placed this next to Mary’s bed. I told Mary that she should always place her syringe in this bottle. I then explained why this was so important. I talked about hepatitis C. They knew that hepatitis was very serious, but they were surprised when I told them that hepatitis C stays alive in dried blood for two weeks, and prior to 1989/1990 donated blood was not tested for hepatitis C. The blood banks tested for AIDS but not hepatitis C. If a person had a blood transfusion from surgery, accident, etc., at that time they could have received tainted blood with hepatitis C. I told them that a person who has hepatitis C can have it many, many years without knowing they have it. I was fortunate that Mary and the family took this serious and even thanked me for sharing the information.

I continued to provide care to Mary and there has never been another incident. Mary’s family even went out to the drug store and picked up a red container that was specifically used for syringes/sharps. When it is filled up they bring the container back to the drug store for them to dispose of and then they receive a new container at no cost. I love working with the Mary and her family. I feel that we are all on the same team for all our safety.

Emily, caregiver for 14 years



4. Linens

If feces or vomit are present in laundry, put on gloves. Put linens or clothes in a plastic bag – don’t put them on the floor – and take them to the toilet. Rinse off the large solids in the toilet and put the items back into the plastic bag. Wash linens and clothes immediately, separately from the rest of the household laundry. Add bleach if clothes can be bleached. Otherwise, just dry them completely in the dryer. The heat of the dryer will kill the bacteria. Hanging clothes out on a clothesline will also kill the bacteria.



MRSA - Methicillin-Resistant Staphylococcus Aureus

I have been a caregiver for many years. I am the caregiver who will often go to clients that others have refused. One time I was providing care for this client who had an incontinent rash that just got worse. I told my client that she needed to go to her doctor and get this rash re-examined. My suspicion was MRSA. Her doctor took a culture of her rash. The test came out that she did have MRSA. I was aware about MRSA and the importance of going above Universal Precautions. I double gloved myself. I used a bleach solution and washed all equipment, door knobs, counters, and light switches. I did this on a daily basis. I had a small abrasion on my arm and I made sure I had a four sided band-aid. I changed my clothes before I went to my next client and sprayed my shoes with Lysol. I kept both myself safe and my other clients safe. My client started to get better when she started her antibiotics. It is so important for caregivers to be observant with the changes of a rash and then follow through with the appropriate people.

Anita Frasier, caregiver



5. Cleaning the Environment

Universal cleaning and disinfecting solution – bleach diluted 1:10

One part bleach to 10 parts water (1:10) means that whatever measuring device you use (1/3 cup, 1 cup, a tablespoon), you mix 1 measure of bleach and 10 measures of water. For example, you could pour 1/4-cup of bleach and ten 1/4-cups of water (2-1/2 cups) into a spray bottle and label the bottle.

Contact time (the amount of time needed for the bleach to work) is the amount of time it takes the surface to air dry after you have sprayed it with the bleach solution. Bleach can act as a sanitizer in stronger solutions or a disinfectant in a weaker solution. However, remember that fragile skin can be very sensitive to bleach and water solution. If a client gets the solution on his/her skin, flush the area with water.

Bleach solution needs to be put into a spray bottle, labeled, and a fresh supply made every 24 hours.

Note: Chapter 10, Home Environment Maintenance has more information on cleaning the home. Chapter 8, Nutrition and Food Preparation covers food safety.

Did you know?

- | | | |
|--|------|-------|
| 1. Hand washing helps reduce risk of infection | True | False |
| 2. Gloves are required only when a person is ill..... | True | False |
| 3. You should wash your hands for at least 10 seconds | True | False |
| 4. It is never safe to touch another person’s blood | True | False |
| 5. To be safe from infection, use bleach on your hands | True | False |

F. RESOURCES

- For more information on diseases, visit the Centers for Disease Control and Prevention, <http://www.cdc.gov/DiseasesConditions/>
- Easy to read introductions to Hepatitis A, B, and C. Also in Spanish. National Institutes of Health, <http://digestive.niddk.nih.gov/ddiseases/ez.asp>

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 8 – NUTRITION AND FOOD PREPARATION

CONTENTS

- A. Basic Nutrition
 - 1. Role and Importance of Nutrition
 - 2. Essential Nutrients
 - 3. Hydration
- B. Menu Planning
 - 1. Consumer Rights
 - 2. Food Groups
 - 3. Food Labels
 - 4. Portions and Servings
 - 5. Food Label and Portion Activity
- C. Food Safety
 - 1. Foodborne Illness
 - 2. Food Preparation
 - 3. Storage
- D. Special Dietary Needs and Diets
- E. Menu and Shopping Tips
- F. Menu Planning Activity

OBJECTIVES

1. Describe and explain basic concepts of nutrition and hydration.
2. Explain the importance of observing consumer rights in regard to food preferences.
3. Describe basic principles of menu planning and explain how to read food labels.
4. Identify and explain food safety techniques for preparing and storing food.
5. Describe special diets.

KEY TERMS

Calorie	Nutrients
Fluid intake	Portion
Foodborne illness	Serving
Food label	Sodium
Hydration	Thaw law

A. BASIC NUTRITION

1. Role and Importance of Nutrition

If you have good eating habits and are well nourished, you will have all the nutrients you need for energy and good health. The eating habits of a lifetime can have a great effect on an older person. Many health problems common among older people are related to lifelong diet patterns. These include heart disease, diabetes, stroke, high blood pressure, osteoporosis (thinning bones), atherosclerosis (fatty deposits in blood vessels), and digestive problems. Good nutrition is important in the care of ill and frail persons. **It speeds up healing, recovery from illness, and helps maintain health.**

All peoples have individual preferences for certain foods. They may need a certain diet. Some have food allergies, and others may need more time chewing the food. Be observant. Ask questions, and be respectful of the person's wishes. Special diets will be discussed later in this chapter.

2. Essential Nutrients

Nutrients	Food Sources	Body Uses Them For:
Proteins	Meat, poultry, fish, eggs, cheese, milk, peas, nuts	Growth and strength, cell repair, builds bones and body tissue
Carbohydrates	Breads, cereals, rice, pasta, potatoes, corn, fruits, sugars, flour	Energy
Fats	Butter, margarine, oil, ice cream, dressings, meats, nuts, mayonnaise	Energy, protection of body organs, nerves, cells
Vitamins	Fruits and vegetables, milk, liver, cereals, breads	Growth, healing, resistance to sickness, healthy skin, eyes, teeth, gums, hair and bones
Minerals	Milk, cheese, yogurt, green leafy vegetables, meat, eggs, breads, cereals	Bones, teeth, blood, nerves, muscles
Water	Water and other liquids	More than half of the human body is made up of water. The body uses water to carry nutrients to the cells, flush wastes from the cells, and help control body temperature
Fiber	Raw fruits and vegetables, whole grain cereals	Digestion, getting rid of wastes

3. Hydration

Water is important because it prevents dehydration, reduces stress on the kidneys, and helps maintain regular bowel functions. An adequate amount of daily water intake is by far the most important of all the dietary requirements for the body and is essential to life. A person may live for several weeks without food, but can only survive for a few days without water. That is because our bodies are 55% to 75% water, and we lose about 10 cups of water each day through sweating, going to the bathroom, and breathing.

The amount of water we lose each day increases when the temperature is higher.

Increased fluid intake is required for people who:

- Experience heavy sweating/perspiration.
- Use tranquilizers, seizure medications, or some behavioral health medications.
- Experience heavy drooling.
- Experience urinary tract infections (kidney and bladder).

Signs and symptoms of dehydration:

- Dry skin, especially around mouth/lips and mucous membranes.
- Less skin flexibility/elasticity.
- Dark, concentrated urine with decreased urination.
- Less/absent sweating.
- Leads to electrolyte imbalance, disorientation, even death if untreated.

To encourage an individual to drink fluids:

- Have water within reach, encourage intake.
- Use other fluids as well, such as shakes, fruit drinks, soups, puddings, and gelatins.
- Avoid caffeine and sugar in fluids, if possible, since caffeine and sugar are dehydrating to the body. If you drink a lot of coffee, cola (even diet cola) and other similar liquids, you need to drink more water than the average person.

People who are on diuretics (water pills) often do not like to drink water. They feel it makes them have to go to the bathroom more frequently. However, not drinking enough fluids will send a message to the brain to retain fluids. This makes the condition being treated even worse. Diuretics are often used to treat heart and circulation problems.

B. MENU PLANNING

1. Consumer Rights

Consumer rights dictate that each person has the choice of which foods to eat and choice of meal times. However, what happens if the person wants to eat something that is not on their prescribed diet?

The DCW should try to come to an agreement with the individual in order to follow the diet. For example, if the person is diabetic and is demanding chocolate cake, maybe the person can have a small piece and freeze the rest. If you cannot resolve differences or if you have any questions, contact your supervisor.

General guidelines

- **Note any food allergies.** Some food allergies can cause a severe allergic reaction, which can quickly lead to death.
- **Note any special diet orders.** Plan and prepare the meal according to the dietary restrictions
- Make sure client uses good oral hygiene. Assist with oral care if needed. Poor dental hygiene can lead to inflammation of the gums and sensitive teeth, causing pain and difficulty with chewing. It also can decrease the person's appetite.
- Make sure dental appliances such as dentures and bridges fit and are used properly.

Cultural and religious issues

Most people have foods they like and don't like. Some food preferences relate to what the person ate while growing up. Cultural and religious traditions also can influence what foods people prefer to eat or avoid. For example, people of the Muslim faith do not eat pork. In many Asian cultures rice is included with most meals. **It's best to ask and not assume anything about what someone wants to eat.** Typically, the DCW can respond sensibly to preferences, unless whole classes of important foods are ruled out. If you have any questions, talk to your supervisor.

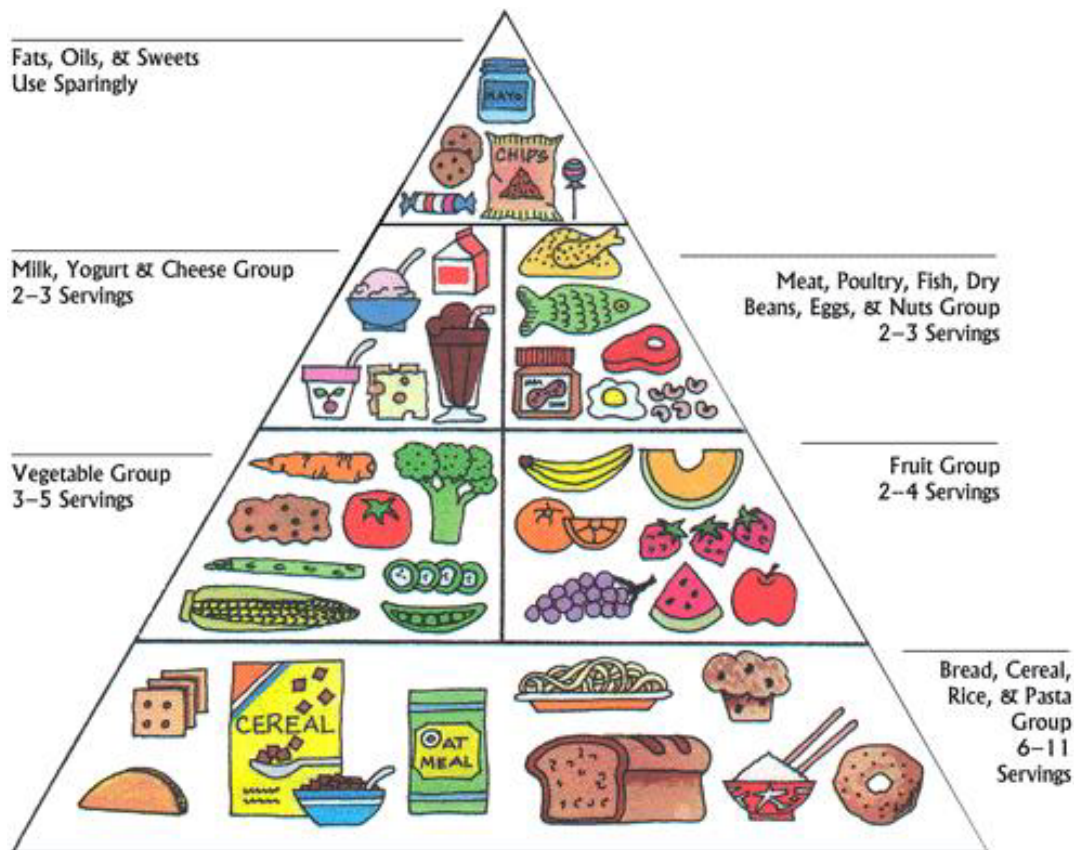
2. Food Groups

- **Breads and cereals** are a good source of fiber, vitamins, and minerals. Whole grain products such as whole wheat bread, oatmeal, and brown rice are good choices. Look for dry breakfast cereals that are low in sugar.
- **Fruits and vegetables** are good sources of fiber and are generally low in fat. Include dark leafy greens and yellow or orange vegetables in the daily diet as these are rich in vitamins, minerals, and cancer-preventing chemicals. Citrus fruits/juices such as oranges, grapefruits, and tangerines are rich sources of vitamin C.

- **Proteins**, animal (beef, pork, poultry, fish, and eggs) and/or vegetable (beans, lentils, nuts, and seeds), need to be included in the diet daily. Look for lean meats and trim off visible fat.
- **Dairy products** are good sources of calcium and protein. Unless being underweight is a concern, choose fat free milk and low-fat cheese. If milk causes diarrhea or gas, yogurt or cheese may be acceptable, or try enzyme-treated milk (Lactaid).
- **Fats and sweets** should be limited to small amounts.

The food guide pyramid

- The food guide pyramid is an outline of what to eat each day based on dietary guidelines.
- No one food group is more important than another – you need them all for good nutrition and health.
- Start with plenty of breads, cereals, rice, pasta, vegetables and fruits.
- Add 2 – 3 servings from the milk group and 2 – 3 servings from the meat group.
- Go easy on fats, oils and sweets, and other foods found at the top of the pyramid.



3. Food Labels

Most packaged food has a food label. It lists the calories per serving and specific nutrients. An example of a food label is on the next page. Look at the sample labels as you read the following explanations:

- Ingredients are listed from highest to lowest by volume or weight (most to least).
- The number of calories in a serving and the calories from fat are listed.
- Vitamins and minerals are only listed if there is enough in the food to make it significant.
- Percent Daily Values (DV) are based on a 2,000 calorie diet. Older people usually need 1600 to 2000 calories based on their activity level (males usually require the higher number of calories)
- Total fat, cholesterol, sodium, total carbohydrate and dietary fiber are listed both by weight in grams and percentages of daily value.
- You may also want to compare the labels to see which foods are high in fat, good sources of vitamin C. Are any high in cholesterol? High in fat? Which has the lowest sugar?

The recommendations for the daily intake of total fat, saturated fat, cholesterol, and sodium are:

- Total fat: less than 65 grams or 30% of caloric intake
- Saturated fat: less than 20 grams
- Cholesterol: less than 300 mg
- Sodium: less than 2,400 mg

These two labels are very similar. The one on the left is for reduced fat milk; the one on the right is for non-fat milk. Study the circled numbers to see the differences.

Reduced Fat Milk (2%)

Nutrition Facts	
Serving Size 1 cup (236ml)	
Servings Per Container 1	
Amount Per Serving	
Calories 120	Calories from Fat 45
% Daily Value*	
Total Fat 5g	8%
Saturated Fat 3g	15%
<i>Trans Fat</i> 0g	
Cholesterol 20mg	7%
Sodium 120mg	5%
Total Carbohydrate 11g	4%
Dietary Fiber 0g	0%
Sugars 11g	
Protein 9g	17%
Vitamin A 10% • Vitamin C 4%	
Calcium 30% • Iron 0% • Vitamin D 25%	
*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.	

Nonfat Milk

Nutrition Facts	
Serving Size 1 cup (236ml)	
Servings Per Container 1	
Amount Per Serving	
Calories 80	Calories from Fat 0
% Daily Value*	
Total Fat 0g	0%
Saturated Fat 0g	0%
<i>Trans Fat</i> 0g	
Cholesterol Less than 5mg	0%
Sodium 120mg	5%
Total Carbohydrate 11g	4%
Dietary Fiber 0g	0%
Sugars 11g	
Protein 9g	17%
Vitamin A 10% • Vitamin C 4%	
Calcium 30% • Iron 0% • Vitamin D 25%	
*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.	

Note: The amount of nutrients and protein per serving stays the same but the calories, fat percentage, and cholesterol are decreased with the Nonfat Milk.

Adapted from “How to Understand and Use the Nutrition Facts Label”, U.S. Food and Drug Administration, <http://www.cfsan.fda.gov/~dms/foodlab.html>.

4. Portions and Servings

For many people, a portion is the amount of food they can put on a plate. Over time, people get used to certain portion sizes. Some eat large portions, others eat small portions. With nutrition, it is important to think of portions in a standard size. These are called *servings*. If a meal plan suggests 2 servings of vegetables, then that could be 1 cup of raw leafy vegetables plus ½ cup of other chopped vegetable. Serving sizes are not related to a person’s hunger or appetite. **A serving is a standard amount of food.**

Examples of various food serving sizes are listed below. If you eat a larger portion, count it as more than one serving. For example, eating a whole bagel from a bakery (usually a large bagel) would equal four servings of bread.

Food Group	Common serving sizes
Milk, Yogurt and Cheese	
1 cup of milk or yogurt	1-1/2 ounces of natural cheese
2 ounces of processed cheese	1-1/2 cups of ice cream, ice milk
2 cups cottage cheese	
Meat, Poultry, Fish, Dry Beans, Eggs and Nuts	
2-3 ounces of cooked lean meat, poultry, or fish	1/2 cup of cooked dry beans
2 tablespoons of peanut butter	1/3 cup of nuts
2 slices of bologna (1 oz slices)	1 egg
Vegetables	
1 cup of raw leafy vegetables	3/4 cup of vegetable juice
1/2 cup other vegetables, cooked or raw	10 French fries
Fruit	
1 medium apple, banana, orange	3/4 cup of fruit juice
½ cup of chopped, cooked, or canned fruit	1/4 whole avocado
Bread, Cereal, Rice and Pasta	
1 slice of bread	1/2 medium doughnut
1 ounce of ready-to-eat cereal	4-inch pancake
4 small crackers	1/2 small bagel
1/2 cup cooked cereal, rice, or pasta	

Here is a handy reference card showing what serving sizes look like.

SERVING SIZE CARD

<p>1 Serving Looks Like . . .</p> <p>GRAIN PRODUCTS</p> <p>1 cup of cereal flakes = fist </p> <p>1 pancake = compact disc </p> <p>½ cup of cooked rice, pasta, or potato = ½ baseball </p> <p>1 slice of bread = cassette tape </p> <p>1 piece of cornbread = bar of soap </p>	<p>1 Serving Looks Like . . .</p> <p>VEGETABLES AND FRUIT</p> <p>1 cup of salad greens = baseball </p> <p>1 baked potato = fist </p> <p>1 med. fruit = baseball</p> <p>½ cup of fresh fruit = ½ baseball </p> <p>¼ cup of raisins = large egg </p>
<p>1 Serving Looks Like . . .</p> <p>DAIRY AND CHEESE</p> <p>1½ oz. cheese – 4 stacked dice or 2 cheese slices </p> <p>½ cup of ice cream = ½ baseball </p> <p>FATS</p> <p>1 tsp. margarine or spreads = 1 dice </p>	<p>1 Serving Looks Like . . .</p> <p>MEAT AND ALTERNATIVES</p> <p>3 oz. meat, fish, and poultry = deck of cards </p> <p>3 oz. grilled/baked fish = checkbook </p> <p>2 Tbsp. peanut butter = ping pong ball </p>

Adapted from the National Institute of Health: National Heart, Lungs and Blood Institute
<http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/eat-right/distortion.htm>



5. Food Label and Portion Activity

Divide into small groups. Each group will be given a food label. Read the label and answer the following questions. Be prepared to share information from the food label with the class.

Name of Food: _____

a. How many servings does your package contain?

How many calories per serving?

When eating this food, do you think a person normally eats more or less than the serving size?

b. What is the main ingredient of your food?

How do you know?

c. Would you serve this food to someone who is trying to:

- Reduce his or her cholesterol? Why or why not?
- Increase fiber? Why or why not?
- Limit salt (sodium)? Why or why not?

d. What food group or groups does this food belong to on the Food Guide Pyramid?

e. Is this food a good source of any vitamins and minerals? If yes, list them:

Used with permission from: California Department of Developmental Services-Direct Care Worker Training.

Did you know?

- | | | |
|--|------|-------|
| 1. Good nutrition is important for good health | True | False |
| 2. Meat and milk products are good sources of fiber | True | False |
| 3. A portion is the same as a serving | True | False |
| 4. The food label shows how much salt is in the food | True | False |
| 5. Water is an important part of nutrition..... | True | False |

C. FOOD SAFETY

1. Foodborne Illness

Foodborne illness is transmitted to people by food or beverages, sometimes called *food poisoning*. The very young and the very old are at increased risk for foodborne illnesses for different reasons:

- The immune system is not as efficient.
- Stomach acid decreases with aging.
- Underlying conditions such as diabetes, cancer treatments, kidney disease, HIV/AIDS, and a history of an organ transplant increase the risk for illness.

To reduce the risk of illness from bacteria in food, individuals who are at greatest risk are advised not to eat:

- Raw fin fish and shellfish, including oysters, clams, mussels, and scallops.
- Raw or unpasteurized milk or cheese, and soft cheese (Brie, Camembert).
- Raw or lightly cooked egg or egg products including salad dressings, cookie or cake batter, sauces, and beverages such as eggnog. Foods made from commercially pasteurized eggs are safe to eat.
- Raw meat or poultry.
- Raw sprouts (alfalfa, clover, and radish).
- Unpasteurized or untreated fruit or vegetable juice (these juices will carry a warning).



Recognizing foodborne illness

- The bacteria in unsafe food are hard to detect. Often the individual cannot see, smell or taste the bacteria.
- Foodborne bacteria may take 20 minutes to six weeks to make you ill depending on the type of bacteria.
- Symptoms of foodborne illness may be confused with other types of illness, but are usually nausea, vomiting, diarrhea, or a fever, headache and body aches.

2. Food Preparation

Washing your hands

Washing your hands following correct procedures before preparing food is very important. A DCW may see several clients and/or do different tasks such as cleaning, bathing and food preparation. When preparing food for a client, the DCW needs to clean fingernails (fake nails) and contain hair (pull back or wear a hairnet). Wear disposable gloves to reduce contamination and cover broken skin areas (cover with a bandage first). Remember to wash your hands before applying and after removing gloves. Refer to the handwashing skill in Chapter 7, Infection Control.

Sanitizing surfaces, dishes and equipment

- Use only clean utensils for tasting food.
- Thoroughly sanitize all dishes, utensils and work surfaces with a bleach solution (1:10, 1 part bleach, 10 parts water) after each use.
- Use bleach solution (1:10) to clean cutting boards, knives, counter tops, sink, meat grinders, blenders and can openers.
- To sanitize dishes and utensils water must be **at least 170°F**, or add bleach to the wash water.
- If a dishwasher is used, do not open the door to stop the dry cycle. The dry cycle is an effective sanitizer.
- Sponges used to clean the kitchen where food is prepared should NOT be used to clean up bathroom-type spills. Dirty looking sponges should not be used to wash dishes or clean food preparation areas.
- Sponges can be disinfected by soaking in a bleach solution (1:10) for five minutes (any longer and the sponges may disintegrate).
- Clean the inside of the refrigerator with soap and water to control molds.

Washing and preparing food

Preparing vegetables

Prepackaged salads and other vegetables that are not cooked before eating are considered a current leading source of foodborne illness in the U.S. Do not serve salad greens or raw vegetables unless you have washed them. It is also acceptable to soak them in a weak bleach solution as follows:

- Fill a sink halfway with cool water. Add 2 ounces (4 tablespoons or 1/4 cup) of chlorine bleach. Soak produce for no more than 5 minutes. Rinse the produce in plain cool water, drain, pat dry and store. This also makes the produce last longer in the refrigerator.

Other guidelines

- Fresh vegetables should be eaten soon after being purchased.
- Some veggies such as potatoes need scrubbing to remove the dirt. It is better not to peel such vegetables, because nutritional value will be lost.

- Avoid boiling vegetables because nutrients will end up in the water. Instead you can microwave, steam, or stir-fry vegetables in water or a little bit of oil.
- Frying vegetables (or any other items) can improve taste, but excess oil adds calories.
- If possible, have two cutting boards; one for raw meat, poultry and fish, and the other for vegetable and cooked foods. A hard nonporous (acrylic) cutting board is better than a wooden one for preventing the spread of bacteria. Thoroughly wash boards with soap and water and then rinse with diluted bleach solution.

Defrosting meat

There are three safe methods to thaw frozen meat (the *Thaw Law*):

- Leave it in the refrigerator.
- Place the frozen food in a watertight plastic bag under cold water and change the water often.
- Microwave the meat. Follow the manufacturer's directions.

Caution: It is NOT a safe practice to thaw meat, poultry or fish on the kitchen counter. Bacteria can multiply rapidly at room temperature.

3. Storage

- **Meat** — Store fresh or thawed raw meat, poultry and fish in the refrigerator. Store cooked meat or poultry products in the freezer if you want to keep them longer than a few days.
- **Canned foods** – If a commercially canned food shows any sign of spoilage—bulging can, leakage, spurting liquid, off odor or mold—throw it out. DO NOT TASTE IT.

Two-hour rule

Discard (throw away) any perishable foods left at room temperature longer than 2 hours. When temperatures are above 90°F, discard food after 1 hour!

Did You Know?

At room temperature, bacteria in food can double every 20 minutes!

Store leftovers in the refrigerator or freezer immediately after the meal.

Caution: Do not rely on reheating to make leftovers safe. Staph bacteria produce a toxin that is not destroyed by heating.




**Refrigerated leftovers need to be tossed
after 3 days.**

Refrigerator and freezer temperatures

- Refrigerator temperatures should be kept between 40 degrees and 32 degrees.
- Freezer temperatures should be kept at 0 degrees or less.
- Check temperatures with a thermometer. Don't rely on the refrigerator dials.

Open containers

- Avoid storing foods in cabinets that are under sinks, drains or water pipes.
- Wash the tops of cans and jars with soap and water before opening.
- All open containers should be stored in a dated, closable container within four hours of opening, stored a minimum of four inches off the floor.

	<ol style="list-style-type: none">1. Keep food clean2. Keep hot food hot3. Keep cold food cold4. When in doubt, throw it out!
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D. SPECIAL DIETARY NEEDS AND DIETS

1. General Guidelines

READ LABELS. Most special diets require that certain foods or nutrients are limited or avoided. The DCW will have to read labels to make sure the food does not contain ingredients that are not allowed, or more than the allowed amounts.

Use fresh foods. Fresh foods have more flavor, color and texture than canned or frozen foods. Additionally, processed, packaged foods often have extra salt, sugar, and/or fat, and may have decreased amounts of vitamins and minerals.

In general, a well-balanced meal, such as the heart healthy diet, can be served to all persons including those on diabetic, low-salt, low-fat or other similar special diets.

2. Low-fat/Low-sodium (salt) – A Heart Healthy Diet

Every day you should have:

- 8 to 10 percent of total calories from saturated fat.
- 30 percent or less of total calories from fat.
- Less than 300 milligrams (mg) of dietary cholesterol.
- No more than 2400 milligrams (mg) of sodium.



To reduce salt in your diet:

- Choose low or reduced-sodium, or no-salt-added versions of foods and condiments when available.
- Choose fresh, frozen, or canned (low-sodium or no-salt-added) vegetables.
- Use fresh poultry, fish, and lean meat, rather than canned or processed types.
- Use spices instead of salt. In cooking and at the table, flavor foods with herbs, spices, lemon, lime, vinegar, or salt-free seasoning blends.

3. Diabetic Diet

There have been many changes recently in diabetic diets. Current diabetic management includes counting carbohydrates. Concentrated sugars can be eaten as long as the portion size and frequency are limited. Specific dietary guidelines should be obtained from the client's physician. Ask your supervisor if dietary guidelines are available for the client.

4. Modified Diet

You can change the texture, or puree foods to accommodate an individual's difficulty with chewing or swallowing. Try putting regular food into a blender/food processor instead of using baby food. This way the client can eat what the rest of the family is eating, only the consistency has been changed. Sometimes it helps just to cut the food into very small bite-sized pieces.

For individuals who have had a stroke:

- Sometimes a thickener is added to liquids to reduce choking on liquids.
- Encourage chewing on the unaffected side of his/her mouth.

5. Other Diets

Following are some of the special diets a DCW might need to know. Get information from your supervisor or ask the client/family about specific guidelines.

High fiber: To improve digestion, elimination and overall health. Fiber is the part of a plant that cannot be digested. Fiber is found in whole grains, fruits, vegetables, nuts and dried beans. The recommended amount is 25 to 35 grams of fiber a day.

Renal: For people with reduced kidney function. Generally the person needs to limit foods high in protein, salt and potassium. These foods include meats, whole grains, milk and cheese. Salt substitutes are used with caution since they are generally high in potassium. Clients on dialysis will also have to limit their fluid intake.

Gluten-free: For people who have celiac disease, an intestinal disorder, or a wheat allergy. The person is not able to have any food with wheat, barley or rye in it. They may be able to have rice, corn or potatoes. Note: Some foods use wheat as a thickener. Read the list of ingredients on the labels to avoid the ingredients that are not allowed.

Lactose intolerant: For people who have difficulty digesting lactose, a sugar found in milk and milk products. As people age, lactose intolerance may increase. Symptoms can include stomach pain, gas, nausea, and diarrhea. People can avoid milk and milk products, but they should increase their dietary intake of foods high in calcium such as fish with soft bones (salmon and sardines) and dark green vegetables such as spinach. There are also lactose-reduced milk products and pills to take with regular milk. Processed cheese and yogurt are usually well tolerated.

Did you know?

- | | | |
|---|------|-------|
| 1. You should not keep any meat leftovers | True | False |
| 2. Hot food should be cooled completely before it's put in the fridge | True | False |
| 3. Bagged vegetables need to be washed | True | False |
| 4. For people on a special diet, personal choice must be disregarded | True | False |



How Important is Good Nutrition and Following Your Diet?

During 10 years of observing different dialysis units, there was one thing that seemed to matter the most and that was how people that were diabetic felt if they followed their prescribed diets. Unfortunately, kidney dialysis treatment units were the last place they wanted to be. Most people I spoke with, and I can tell you it was in the hundreds, wished they had just followed their diet. Some were there just on dialysis, some had become blind, some lost toes and some even legs from the complications of diabetes. How sad, I thought, when in many cases all a person had to do is stay on a diet and their meds. I saw some diabetics who were just on dialysis but were so tired and sick they had to go to the hospital more often, because they still were not following their diet.

Yes, I love my chocolate as much as the next person, but is it worth this type of lifestyle?

I know an attendant who was diabetic and she was one of those diabetics that took her diagnosis seriously. Good nutrition was very important to her. When she was given a position with a client who was also diabetic and insulin dependent she talked to the family about her diabetes. The family was 100% supportive in having the attendant cook a healthy diabetic meal plan for the client. Did this make a change? Well, it sure did. Today, the client's diabetes is controlled by just diet and exercise alone without any medications! Can an attendant and good nutrition make a difference? This attendant sure did!

Cathie Martin, caregiver supervisor



E. MENU AND SHOPPING TIPS

Weekly meal planning saves time for the DCW and saves money for the client. There is not as much impulse buying. Planning menus with the client and the family gives the client control over food preferences and fosters independence.

- Organize the list into groups found in the same area of the store, such as meat, dairy, etc.
- Check prices in the newspaper and clip coupons. Read labels and compare store brands.
- Do not buy large quantities if they cannot be stored, handled or used before expiration date.
- Do not shop sale items if you don't normally use the item and cannot store it. **A bargain you can't use is no bargain.**
- Buy easy-to-prepare foods for times when you are not there to cook. Note special diets.
- Consider buying smaller portions in the deli instead of preparing large quantities and throwing it away.

- Consider freezing bread and cheese and take out only the amount that is needed.
- Eggs have the same nutritional content whether they are jumbo or small, brown or white.
- Cheaper cuts of meat have the same nutritional content—ground beef, for example.
- When buying poultry compare prices on parts or whole chicken.
- Consider how much freezer space the individual has and buy larger quantities to freeze. Wrap pieces or portions individually in freezer wrap before freezing. Be sure to label and date items.
- Make sure meats and fish are fresh. Look at the color and smell the item.
- Do not buy damaged canned items.
- Purchase perishable foods last. Don't let ice cream melt while shopping.



F. MENU PLANNING ACTIVITY

Shopping and meal preparation is an important part of the DCW's job. Healthy nutrition and adequate hydration can be as beneficial as the right medication in maintaining proper health. A proper diet can speed up healing, recovery from illness, increase blood supply and help maintain one's health. A basic knowledge of restrictive diets, as well as how to read a food label and how to shop and plan meals using the food pyramid are necessary skills for the DCW.

Planning and preparing meals while considering the client's limited finances, cultural preferences and decreasing appetite can be a challenge, but one that must be addressed each and every day. Allowing family members and the client to have input in food selection make for a positive meal experience.

Practical Tips

- When planning and preparing meals, ask the client what he or she would like.
- Don't forget to include a variety of fluids when planning menus.
- Remember fresh over frozen over processed.
- Be aware of the dietary restrictions when planning meals.
- Serving sizes are generally smaller than what people eat (1/2 sandwich, 1/2 cup vegetables, 4 crackers).
- Remind the client to wear dentures if he/she has them.

- Meal time is a social time, sit and visit with client if they like. Make meal time pleasant.
- Request recipes from client or family so that you can prepare favorite meals.

Common Mistakes

- Preparing meals without asking the client what he/she prefers.
- Preparing large portions is wasteful, costly and unhealthy.
- Preparing processed foods and soups, which are high in fat and sodium.
- Forgetting fluids as essential parts of meals and snacks.

Practice Scenario

Mr. Wilson is 76 years old and lives with his wife in a small apartment. Mr. Wilson has mid stage dementia and is unable to provide for his own care. Mrs. Wilson is very active in his care and likes to be involved in the decisions of the household. Both Mr. and Mrs. Wilson are very health conscious and prefer fresh fruits, vegetables and limited high fat meats. They always eat a late breakfast and a lighter dinner, with the largest meal being lunch mid day. Mr. Wilson’s doctor has expressed that he would like to see Mr. Wilson put on a few more pounds. The doctor has also suggested that he watch his sodium content to help in keeping his blood pressure manageable.

Plan lunch, dinner and an evening snack for the Wilsons.

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 9 – FIRE, SAFETY AND EMERGENCY PROCEDURES

CONTENTS

- A. Emergency Planning
 - 1. General Guidelines
 - 2. Emergency Plan
 - 3. The Service Plan
 - 4. Procedure: Calling 911
- B. Medical Emergencies
- C. Falls
 - 1. Responding to a Fall
 - 2. Fall Prevention
- D. Fire Safety
 - 1. Responding to a Fire
 - 2. Fire Prevention
- E. Activity: What Would You Do?
- F. Resources

OBJECTIVES

1. Describe and explain the importance of an emergency plan.
2. Describe and explain the principles of environmental, fire, and medical emergency procedures.
3. Identify and explain safety techniques for direct care workers.
4. Explain the use of a fire extinguisher.

SKILLS

1. Procedures for calling 911
2. How to use a fire extinguisher

KEY TERMS

911	Emergency medical technician (EMT)
CPR	Fall prevention
Electrical safety	Fall risk
Emergency	Fire safety
Emergency plan	Non-responsive
Emergency medical system (EMS)	P.A.S.S.

A. EMERGENCY PLANNING

Good safety precautions can help prevent falls, fires, and other emergencies. Keep appliances in good repair, practice personal safety, and prepare a plan for emergencies. Direct care workers (DCWs) need to know how to respond to emergencies and how to help prevent them. Elderly persons and people with disabilities are more at risk for injuries.

- Living longer may bring more frailty or cognitive impairment.
- Illness or medications can cause dizziness or unsteadiness.
- Decreased mobility makes response times slower.
- Slower response times can increase accident risk. This includes driving.
- Safety hazards (rugs, pets) often exist in homes. A frail person may fall more easily when tripped.

1. General Guidelines

- **STAY CALM.** You help the individual just by your calm demeanor. It can give reassurance.
- Yell for someone to assist you if possible.
- **DO NOT LEAVE** the individual unless it is to call 911. Then return immediately.
- Keep the individual's airway open.

If the individual is not responding and not breathing:

- Yell for help. Have someone call 911, or you leave the individual briefly and call 911.
- Don't leave the individual alone except to call for help.
- Begin a CPR assessment and procedure.
- Do not stop CPR until help has arrived.
- Take medicine or medicine bottles with you to the emergency room.

If the individual is not responding but is breathing:

- Call 911 for emergency assistance.
- Place the person on his/her side if possible. This helps to keep the person's airway open.
- If you can't get emergency assistance, take the individual to the nearest emergency center.
- Take medicine or medicine bottles with you to the emergency room.

Cell phone use: If you call 911 from a cell phone, be prepared to describe your exact location. The fire department cannot always locate your cell phone. **Use a fixed land line if possible.**

Call your supervisor after the paramedics have been called and the client is no longer in danger.

2. Emergency Plan

Every individual—especially if living alone—should have an *Emergency Plan*. It should be posted in an obvious place such as the refrigerator. The plan should be kept up to date with *current* medications (recommend attaching it to the back of the plan) in case the individual is unable to give the paramedics the information in an emergency. Below is an example of an Emergency Plan.

EMERGENCY PLAN	
Name:	_____
Address:	_____
Phone:	_____
Responsible Party/Emergency Contact(s)	
Name:	_____ Phone(s): _____
Name:	_____ Phone(s): _____
911: Fire/Police/Paramedics	
Hospital Preference:	_____
Physician:	_____ Phone: _____
Allergies:	_____
Living Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No
CPR:	<input type="checkbox"/> Yes <input type="checkbox"/> No (If No, my orange form is located (where): _____
My current medication list is located (where):	_____
Comments:	_____ _____ _____
Signature:	_____ Date: _____

3. The Service Plan

Every client has a service plan (or care plan). It describes what services should be provided. The plan also lists the needs of the client and the tasks for the DCW. You should be familiar with the service plan and know about the following:

- Risk factors.
- Safety precautions.
- Instructions for assisting the client.



4. Procedure: Calling 911

Emergency situations can be very stressful for everyone involved. It is important that you remain as calm as possible. Then get help as quickly as possible. Individuals with disabilities and those who are elderly are vulnerable. They are more likely to injure themselves in the home or become seriously ill. They may require immediate medical attention. It is very possible a situation may arise where the DCW must make an emergency 911 call.

Some situations that would require you to call 911 would be:

- Chest pain.
- Shortness of breath.
- Suspected heart attack or stroke.
- Suspected heat stroke.
- Non-responsiveness.
- Confusion that is not common with individual.
- Individual falls and cannot get up.
- Fire.
- Safety issues, such as gas leaks.



Supplies

Land line phone (preferred over cell phone).

Description of procedure

1. **Stay calm.** The more calm you remain, the quicker you will be able to get help. Take a deep breath and proceed.
2. Assess the client for responsiveness. Ensure the client is safe in the environment.
3. Call 911. If possible, use a land line phone.
4. State the nature of the emergency in plain, concise tone.
5. State the location of the emergency with the nearest cross streets.
6. Give your name and telephone number.
7. Remain on the line until dispatch tells you to hang up.

8. Render first aid as needed to the client.
9. Stay alert to your surroundings, staying with client, rendering assistance. Reassure and calm the client until the emergency medical services (EMS) team arrives.
10. Notify your supervisor as soon as possible.

Practical tips

- Remain calm.
- Call from a land line. There are fewer dropped calls, and some emergency systems cannot locate you when you use a cell phone.
- Have someone else call if possible. Remain focused on client and his/her needs.
- Render appropriate care for the conditions you find, within the scope of your training.
- Stay with the client until transported and explain what is happening.
- Know the agency's policy for reporting emergency situations.
- Be available to answer questions from the emergency response system (EMS) team.

Don't forget!

- Do not leave the client unattended for a long period. Be sure to render assistance to the client while waiting for EMS.
- Remember to communicate to the client throughout.
- Know the full address where you are. Response time is longer if EMS has to search for the location.

Practice scenarios

- You are at a client's home and he becomes non-responsive. Upon checking, he is not breathing, no heartbeat is detected, and he remains slumped over in his chair. What do you do?

- You are assisting your client with ambulation when she trips over her dog. The client falls to the floor. The client has a lot of pain in her right hip region and is not able to get up on her own. After getting her as comfortable as you can, what will you need to do?

B. MEDICAL EMERGENCIES

If there is a medical emergency or an injury, the DCW needs to decide how to react. If you have first aid and *cardiopulmonary resuscitation (CPR)* training, you may be able to provide assistance. Call 911 for emergencies, and handle minor scratches or insect bites on a case-by-case basis. The chart on the next page lists many medical emergency situations. It also tells you how to react.

For many jobs, training is required in first aid and CPR. Even if it is not required, it is good practice to have this training.

First Aid Chart		
Injury or Emergency	Symptoms	Recommended First Aid Technique
Anaphylaxis – severe allergic reaction to food, medicine	Swelling of throat, lips, tongue, wheezing, respiratory and cardiac arrest, hives	Call 911. Begin CPR assessment and procedure.
Bleeding		Use a pressure bandage or direct pressure on wound. Use sterile dressing or clean cloth. Elevate the extremity.
Breathing stoppage	Look, listen and feel for 10 sec and no breathing noted, bluish gray skin	Call 911. Clear the airway if it is blocked. Give two rescue breaths and continue with CPR assessment and procedure.
Burns		Stop the burn by removing the heat source and immerse in or apply cold water. Do not apply grease or oil
Cardiac arrest (heart attack)	No pulse or obvious signs of circulation, bluish gray skin	Call 911. Begin CPR procedure.
Choking	Unable to talk or cough forcefully Do not do anything to the individual that is able to cough forcefully	Heimlich Maneuver For infant, turn child upside down on forearm with head pointed down, give 4 back blows between shoulder blades and then four two-fingered thrusts along nipple line, keeping the head pointed down.
Diabetic emergency	Hypoglycemia (low blood sugar), slurred speech, uncoordinated movements, change in behavior or responsiveness	If person is responsive give sugar, honey, orange juice, soda. If person is unresponsive squirt sugar (can use tube of cake decorating frosting) inside the mouth. When person comes to, follow with protein snack.
Fractures	Painful movement, joint deformity	Keep affected area from moving. Apply support under and around affected limb with hands and/or clothing. Call 911.
Heat exhaustion	Warm, clammy skin, nausea, weakness	If the person is unresponsive, Call 911. If individual is conscious give fluids and salt.

First Aid Chart		
Injury or Emergency	Symptoms	Recommended First Aid Technique
Heat stroke	Hot, dry skin, elevated body temp, rapid pulse, disorientation	Call 911. First and foremost, cool the victim. Possibly spray with a water hose or apply cool towels.
Insect bites, stings		Treatment depends on reaction: Mild → apply ice, soap and water, antihistamine to help with itching. Severe reaction → Epi Pen; Call 911. For scorpion, black widow, brown recluse spider bites, call physician.
Poisoning		Call local Poison Control.
Possible heart attack	Heavy pressure mid sternum Pain radiating down left arm, jaw, extreme heart burn	Call 911. Have person rest, take nitroglycerin tablets as directed if prescribed.
Seizures		Protect from injury. DO NOT RESTRAIN or put anything in mouth. Make sure breathing is restored after the seizure.
Shock	Nausea, low pulse, cool clammy skin, restlessness	Call 911. Position of comfort, elevate extremities 10 inches, cover with blanket.
Stroke	Weakness or drooping on one side of the body or face, slurred speech	Call 911. Critical to have individual seen in ER within 2 hours of onset of symptoms.

C. FALLS

- According to the Centers for Disease Control and Prevention (CDC), more than one-third of adults age 65 and older fall each year.
- In 2005 more than 1.8 million persons age 65 and older were treated in emergency departments for fall-related injuries. More than 400,000 were hospitalized.
- Among older adults, falls are the leading cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma.



All men and women are at risk for falling. Women fall more often than men, but men are more likely to die from a fall (CDC 2005). Women are more at risk for hip fractures. For both men and women, age is a risk factor for hip fractures. People age 85 and older are 10 times more likely to break a hip than at age 60 to 65.

Researchers have identified a number of risk factors:

- Weakness of the lower body.
- Problems with walking and balance.
- Poor vision.
- Diseases such as arthritis, diabetes, Parkinson's disease, and dementia.
- Medications or alcohol.

1. Responding to a Fall

- If you are able, when the individual starts to fall, attempt to lower the individual gently to the floor. Take care not to injure yourself in the process.
- Have the individual lie still while you look for any injuries.
- If the individual is not complaining of any pain, you may assist the individual in getting up.



Some agencies want staff to call the paramedics after every fall. Ask your supervisor about agency protocols before going out on assignments.

If the individual has already fallen when you find him/her, or is complaining of pain after falling:

- Do not move the person. Make the person comfortable without moving any affected body parts.
- Call 911. The paramedics will evaluate the individual when they arrive.
- Call your supervisor for any further instructions.

If the individual is not responsive, call 911 immediately

2. Fall Prevention

Because older adults spend most of their time at home, one-half to two-thirds of all falls occur in or around the home. Many injuries occur when a person trips and falls. Therefore, it makes sense to reduce home hazards and make living areas safer.

To make living areas safer, seniors and people with disabilities should:

- Remove tripping hazards such as throw rugs and clutter in walkways.
- Use non-slip mats in the bathtub and on shower floors.
- Have grab bars put in next to the toilet and in the tub or shower.
- Have handrails put in on both sides of stairways.
- Improve lighting throughout the home. Keep a flashlight near the bed or wheelchair.

Useful tip: Keep the telephone within reach of the bed or wheelchair for emergencies.

- Exercise to improve strength and balance. Tai Chi is one type of exercise program that has been shown to be very effective.
- Have their eyes checked at least once a year.

Ask the person's doctor or pharmacist to review all the person's medicines (both prescription and over-the-counter). The goal is to reduce side effects and interactions and perhaps reduce medications. This particularly includes tranquilizers, sleeping pills, and anti-anxiety drugs, also Benadryl.

Information adapted from: CDC Website: Falls Among Older Adults – an Overview, <http://www.cdc.gov/ncipc/factsheets/adultfalls.htm>, and <http://www.strengthforcaring.com/articles/safety-and-mobility-preventing-falls-and-injuries/risk-factors-for-falling/>



Good Intentions But Made a Mistake

My Mom was living by herself in an assisted living unit. My Mom was quite independent but changes were starting to happen. One change was my Mom was having toileting accidents. She had around ten feet to go from her bed to the bathroom. I thought I would help. Again, I had good intentions. I thought it would be a good idea for me to get some plastic runners to put down, leading from the bed to the bathroom. This way if Mom had an accident it would be easy to clean up. Caregivers work so hard and I just thought I would make it a little easier for everyone. It was not long after I put the plastic runners down that I got a call from one of the aides at the facility stating that my Mom tripped on the runner and that they were removing them. I really felt bad. I was lucky my Mom only bruised her head. It could have been so much worse. Today, when I see someone trying to have the same good intentions, I share my story. Rugs and runners do not mix when it comes to safety in the home of anyone!

Rose P.



Did you know?

- | | | |
|--|------|-------|
| 1. Falling is a big safety issue for older adults | True | False |
| 2. A fall can lead to more serious health issues..... | True | False |
| 3. Keeping rugs and runners helps to soften the fall | True | False |
| 4. Poor vision can lead to more falls. | True | False |

D. FIRE SAFETY

1. Responding to a Fire

Three key elements of a fire

- **Oxygen:** It is always present in the air.
- **Heat:** It is present in sources such as heaters, stoves, appliances, electrical connections, fireplaces and lighted cigarettes.
- **Fuel:** Anything combustible—like cloth, paper, wood, upholstery, and gasoline—that will burn when exposed to heat.

A fire needs all three elements to ignite and burn. To extinguish a fire you need to take at least one of the elements away. You can put out a very small flame with a heavy blanket. If there is a fire in a cooking pot or a garbage can, put a lid on it. Use a fire extinguisher. Without fresh oxygen, the fire will go out.

Fire extinguishers

Fire extinguishers are categorized by the type of fire they put out (Class A, B, or C fires). If only one extinguisher is available, make sure that it is an ABC type that will put out most types of fires.



- **Class A** extinguishers are for ordinary combustible materials such as paper, wood, cardboard, and most plastics.
- **Class B** fires involve flammable or combustible liquids such as gasoline, kerosene, grease and oil.
- **Class C** fires involve electrical equipment, such as appliances, wiring, circuit breakers and outlets. Never use water to extinguish electrical fires—there is a serious risk of electrical shock! The C classification means the extinguishing agent is non-conductive.



**If you are in immediate danger from flames or smoke,
GET OUT and stay out. Call 911.**



Procedure: How to Use a Fire Extinguisher

Supplies

- Fire extinguisher

Description of procedure

1. Ensure client is safe and free from possible injury/smoke damage.
2. Determine if the fire is fightable.
3. Do not fight the fire if:
 - The fire is spreading.
 - The type or size of the extinguisher is wrong.
 - The fire is too large.
 - If you do not know how to use a fire extinguisher.
4. Retrieve the fire extinguisher.
5. Use the **P.A.S.S.** acronym:
 - **P**ull the pin from the handle area at the top of the Fire Extinguisher and remove the hose from the clamp (if applicable).
 - **A**im the hose nozzle at the base of the fire. (You should be at least 10 ft. from the fire).
 - **S**queeze the lever in order to release the chemical.
 - **S**weep the hose nozzle from side to side at the base of the fire. (You will have about 10 seconds of extinguishing power.)

Practical tips

- Know the location of the fire extinguisher.
- Know the type of fire extinguisher to use (ABC puts out *most* types of fires).
- Check to see if the fire extinguisher is fully charged.
- Remember the extinguisher is heavy and only blasts for a few seconds.
- Stand at least 10 feet from the fire.
- Aim the spray of the extinguisher at the base of the fire. Aiming high spreads the fire.

Don't forget!

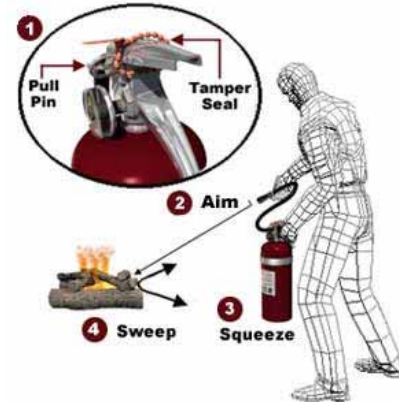
- Use the P-A-S-S acronym.
- **Don't forget the client.** Where is the client? Is the client safe and free from smoke contact? Do you need to assist or rescue the client?

When you fight a fire, remember P.A.S.S.:

1. **PULL...** Pull the pin. This will also break the tamper seal.
2. **AIM...** Aim low, pointing the extinguisher nozzle (or its horn or hose) at the base of the fire.

Note: Do not touch the plastic discharge horn on CO₂ extinguishers, it gets very cold and may damage skin.

3. **SQUEEZE...** Squeeze the handle to release the extinguishing agent.
4. **SWEEP...** Sweep from side to side at the base of the fire until it appears to be out. Watch the area. If the fire re-ignites, repeat steps 2 - 4.



Source: United States Department of Labor, www.osha.gov/SLTC/etools/evacuation/portable_use.html

When not to fight a fire:

- If the fire is spreading too quickly!
- If the fire could block your only exit!
- If the type or size of the extinguisher is wrong!
- If the fire is too large!
- If you don't know how to use your fire extinguisher!



If you have the slightest doubt about your ability to fight a fire, EVACUATE IMMEDIATELY!

- Leave the building as soon as possible.
- Do not gather any personal possessions.
- Stay low because the air above the flames can be extremely hot. Crawl and stay under the smoke if you are able. If not, try to cover your nose and mouth to avoid breathing toxic fumes.
- Once out, **do not go back inside**. Call 911 from a cell phone or a neighbor's home.

2. Fire Prevention

Preventing a fire is better than fighting fires. Fire alarms and safe handling of fire and other heat sources are important. The U.S. Consumer Product Safety Commission has targeted these principal consumer products associated with fires:

- Home heating devices
- Upholstered furniture
- Bedding
- Cigarette lighters
- Matches
- Wearing apparel (clothes)

The most important **fire safety measure** is to make sure the client has at least one working fire alarm on every floor preferably near the bedrooms and/or kitchen. **Test the battery monthly.**



Safety Tips for the Direct Care Worker

How to be prepared for a fire

- Identify the nearest emergency exit. Be familiar with the escape route.
- Have an emergency plan and practice leaving the building. Practice in darkness or using blindfolds.
- Install smoke alarms on each floor and next to sleeping areas. Check batteries monthly and replace them every six months.
- Have a fire extinguisher and know how to use it. Keep it near the kitchen.
- If someone uses a wheelchair, consider extra steps: Mount a small personal-use fire extinguisher on the wheelchair and/or keep a flame-resistant blanket nearby.
- Live or sleep near an exit. Try to sleep on the ground floor.
- Keep a phone near the bed or wheelchair.

Cooking

- Never leave the stove unattended while cooking. If you need to step away, turn it off or carry a large spoon with you to remind you that food is on the stove.
- Wear tight-fitting clothing when cooking over an open flame. Keep towels and potholders away from the flame.
- If food or grease catches fire, smother the flames. Slide a lid over the pan and turn off the heat. **Do not try to use water to extinguish a grease fire.**
- Make sure the stove is kept clean and free of grease buildup. When deep-frying, never fill the pan more than one-third full of oil or fat.

- Turn pot handles away from the front of the stove. Then they cannot be knocked off or pulled down.
- Never put foil or other metals in the microwave.

Smoking

- A person should not smoke in bed. Make sure the client is alert when smoking.
- Do not smoke near oxygen or an open flame.
- Do not smoke while under the influence of alcohol or if you are taking prescription drugs that can cause drowsiness or confusion.
- Never leave smoking materials unattended, and collect them in large, deep ashtrays. Soak the ashes in the ashtray before discarding them.
- Check around furniture, especially upholstered furniture, for any discarded or smoldering smoking materials.

Heating

- Keep electrical space heaters at least 3 feet from anything that can burn, including people. Turn them off when you leave the room or go to sleep.
- Make sure kerosene heaters are never run on gasoline or any substitute fuel. Check for adequate ventilation to avoid the danger of carbon monoxide poisoning.
- The heating systems and chimneys should be checked and cleaned once a year by a professional.
- Open fireplaces can be hazardous; they should be covered with tempered glass doors and guarded by a raised hearth 9 to 18 inches high.
- Never store fuel for heating equipment in the home. Keep it outside or in a detached storage shed.

Electrical safety

- Never use an appliance with exposed wires. Replace all cords that have exposed or broken wires.
- If an appliance begins to smell suspicious or you see smoke, unplug it immediately.
- Never overload extension cords or outlets: Don't plug in several items. Keep extension cords out of traffic areas.
- Electric blankets or heating pads should conform to the appropriate standards and have overheating protection. Do not wash electric blankets repeatedly. This can damage their electrical circuitry.

- Use only tested and UL-listed electrical appliances.
- Consider using new heat generating pads or blankets in place of electric ones.
- Turn heating pads off when the person falls asleep.

Using oxygen

- Oxygen should not be flowing near open flames or a heat source.
- Don't smoke near oxygen. A client using oxygen should not smoke with tubing in place and oxygen on.
- Oxygen should be at least three feet from an electric space heater.
- Put up signs stating that oxygen is in use and asking visitors not to smoke.
- Secure oxygen tanks so that they cannot be knocked over or be bumped into. Strap the tank to a closet wall or into the backseat of a car in the upright position.
- To move an oxygen tank, carry it or use a cart. Don't knock over or bump the oxygen tank. Don't put the tank on its side to roll it. If the valve is damaged, the tank can act like a torpedo.



E. Activity: What Would You Do?

Break into groups. Review the situations below and decide the course of action.

A Call 911, and then call your supervisor as soon as possible

B Call Supervisor

Put the letter of the action above next to the situation:

1. _____ Onset of fever of 101 degrees or higher
2. _____ New or sudden onset of incontinence
3. _____ Rash lasting several days or getting worse
4. _____ Bleeding that cannot be controlled
5. _____ Severe sore throat/difficulty swallowing
6. _____ Infection at injury site
7. _____ Unusual difficulty in arousing
8. _____ Scratching/holding one or both ears
9. _____ Diarrhea or vomiting lasting more than four hours
10. _____ Has a seizure lasting 5 minutes or continuous seizures, paralysis, confusion
11. _____ Onset of limping, inability to walk, or difficulty in movement
12. _____ Intense itching with no other symptoms
13. _____ Has trouble breathing or is breathing in a strange way
14. _____ Is or becomes unconscious not related to seizure
15. _____ Has no pulse
16. _____ Has symptoms of pain or discomfort
17. _____ Has chest pain or pressure
18. _____ Severe injuries as a result of accidents such as broken bones
19. _____ Has injuries to the head, neck, or back
20. _____ Has gone into shock

Did you know?

1. Mrs. Brown put her cigarette in the ashtray. A piece of paper is catching fire.
 - a. You cover it with a blanket or a pot.
 - b. You try to blow the fire out.
2. Mr. Jones asks you to bring his oxygen tank.
 - a. You carry it upright and gently set it down.
 - b. You lay it flat and kick it forward with your foot.
3. Mr. Kranz uses a wheelchair. Where can he probably escape a fire more easily?
 - a. On the second floor.
 - b. On the ground floor.

F. RESOURCES

- Banner Poison Control Center for Arizona 1-800-222-1222
- First Aid Guide, Mayo Clinic, <http://www.mayoclinic.com/health/FirstAidIndex/FirstAidIndex>
- First Aid Kit, Kids' Health for Parents, http://kidshealth.org/parent/firstaid_safe/home/firstaid_kit.html
- Information on fire safety and prevention:
 - www.firesafety.gov/index.shtm
 - www.emd.wa.gov/preparedness/videos/video_using_a_fire_extinguisher.shtml
 - www.hanford.gov/fire/safety/extingrs.htm

PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 10 – HOME ENVIRONMENT MAINTENANCE

CONTENTS

- A. Deciding what to Do
 - 1. Care and Service Plans
 - 2. Client Rights
 - 3. Planning and Organizing Tasks
- B. Supplies
- C. Cleaning
- D. Laundry
- E. Bed Making
- F. Cultural and Religious Issues
- G. Activity: Planning and Prioritizing Chores

OBJECTIVES

1. Explain the relevance of the care or support plan for home maintenance.
2. Describe the importance of client rights and cultural or religious issues in regard to home maintenance.
3. Demonstrate the ability to plan and organize tasks according to the care plan and the client's wishes.
4. Identify home maintenance tasks and describe procedures for maintaining a safe and clean home environment.

KEY TERMS

Appliance

Manufacturer's directions

Care plan

Prioritizing

Chore

Service plan

A. DECIDING WHAT TO DO

1. Care and Service Plans

- The *care plan* or *service plan* usually lists general tasks, such as, clean the kitchen or wash clothes. It does not list the procedures. That is up to the DCW and the client.
- **FOLLOW THE SERVICE PLAN.** If a client wants you to do something that is not listed in the plan, you need to contact your supervisor. **You may be held liable if you do something for the client that is not on the service plan and an accident occurs.**
- With some services, especially those that are government funded, the DCW is only allowed to provide service for the client and not for his/her family or others living in the home. For example, if cleaning the client's bedroom, kitchen and living room is on the service plan, you would not be cleaning the daughter's bedroom. Cleaning common areas that all household members (including the client) use, such as the living room, should be cleaned. However, washing dishes for the entire family instead of just the client may be an issue. Ask your supervisor if you have any questions.
- Make a list of tasks that need to be done according to the care plan.
- Ask the client to prioritize the tasks that need to be done. If the client lists more tasks than what can be accomplished in your allotted time, try to negotiate with the individual to do it another day.

2. Client Rights

- Be considerate and cautious of client's supplies, equipment, and furnishings. Conserve whenever possible.
- **Show the same respect for the client's property as you would for your own.** Take care during use so that things do not get broken or damaged. **If there is something that does get damaged, do not try to hide it! Contact your supervisor.**
- The client has a right to be a hoarder. Do not throw anything out without first checking with the client. What is trash to you may be treasures to your client. The client has the right to refuse housekeeping tasks. If the task is necessary to avoid a health and safety risk such as clutter in a pathway, explain your concern to the client. If the client still refuses, contact your supervisor.
- The client has the right to refuse service. If the task is something that might be a health or safety risk for the client, explain why the task should be done. If the client still refuses, talk to your supervisor.



Stick with the Policies!

Let me start by saying it is amazing how easily things can become a mess when one does not follow the service plan. When a new worker comes through orientation it is emphasized what can and cannot be done. The same is true when a new client is opened. There are times, however, when caregivers believe they are doing a “good” thing by completing extra things for their client, but after awhile the “good” things become expected things.

When instructing about homemaking services, it is stated that the service is for the client and the client only. I have often stated, “Be careful what doors you open, because once a door is opened it is extremely hard to close.” I have found this to be true in several situations.

When a caregiver is asked to go outside their homemaking responsibilities “just this once” and they agree, they have opened a door. I once had a caregiver that was cleaning out birdbaths, watering lawns, preparing meals for the entire family, and cleaning up after the client’s grown son. Then she left the position. The new caregiver came in and wouldn’t complete these tasks, stating, “It’s not allowed, I’m here for you and you alone.” The client was upset to say the least, stating, “My other worker did this stuff and so should you.” When the new worker wouldn’t, the client made life hard for the caregiver.

It is reasons like this that it is so important to stick to the service plan. If your client asks you to go beyond the service plan, then call you supervisor.

Once again, be careful what doors you open, because you may find yourself regretting what you’ve started.

Marie Adams, Supervisor



3. Planning and Organizing Tasks

- Follow the client’s directions when performing tasks, even if you know a better way.
- Plans may also change depending on the client’s needs or health status.
- Use a tray to carry dishes to and from the table.
- Carry cleaning supplies from room to room in a shopping bag or basket (keep a small plastic bag for trash with you while cleaning—saves steps to the trash can).
- *Sample plan:* A load of laundry can be put in the machine just before lunch. While the machine is running, prepare and serve lunch to the client. Dry and fold clothes while client is resting after lunch.

B. SUPPLIES

- Maintain list of items in short supply.
- Have a shopping list posted on the refrigerator door for the client and family members to use.
- Adapt to the client's household. Clients have their equipment and their own favorite cleaning products. Unless instructed differently, the DCW should be using the equipment and cleaning products that are supplied by the client.
- **When using cleaning products or appliances, read labels and directions carefully.** Look for warnings, use protection (e.g. gloves), and follow all manufacturer directions.
- If equipment is faulty, notify client and/or supervisor.
- **Be considerate of the client's financial resources. Buy and use cleaning supplies sparingly.**



C. CLEANING

1. Cleaning Appliances

- **Dishwasher:** Clean exterior and interior.
- **Freezer:** Defrost once a year. Wipe inner surface with a damp cloth. Check for outdated food, and dispose of food with the client's permission.
- **Refrigerator:** Clean inside and outside with soft wet cloth and mild soap or baking soda. Check for spoiled food and dispose of food with the client's permission.
- **Trash compactor:** Replace bags as needed.
- **Garbage disposal:** Run cold water during use and for one minute after. Oranges, lemons, and ice can be used to maintain freshness.
- **Microwave oven:** Wipe with wet cloth and soap. Rinse and wipe dry.
- **Stove/oven:** Wipe up spills and grease immediately! Clean oven with vinegar in water to remove grit.
- **Washing machine:** Wipe exterior and interior with soft wet cloth. Clean lint filter.
- **Dryer:** Clean lint filter. A heavy buildup of lint can catch fire.

2. Dishwashing

Hand wash dishes in the following order:

- Glasses
- Silverware
- Plates and cups
- Pots and pans
- Rinse with hot water and allow to AIR DRY



3. Dishwasher

- Run only full loads to conserve water, soap and power costs.
- Do not interrupt the dry cycle to save money if sanitizing the dishes is needed.

4. Bathroom

- Wear gloves.
- Clean from cleanest areas to dirtiest (toilet is considered the dirtiest).
- Clean sink, countertops, and shower/tub with disinfectant (bleach solution 1:10 works well).
- Use a brush to clean the toilet, and brush under the rim.



DO NOT COMBINE cleaning chemicals, especially AMMONIA AND BLEACH. This forms a toxic gas!

5. Floors

- Use a clean mop and change mop water frequently. Flush dirty water down toilet.
- **Vinyl:** Use mild soap and rinse with clean warm water.
- **Ceramic floors:** Use vinegar and water. Check with client if soap can be used.
- **Carpets:** Vacuum frequently. Be sure the bag does not get overfilled. To remove stains, a carpet stain remover like Spot Shot works well.

6. Trash removal

- Empty trash on a daily basis to decrease mold and bacterial growth.
- Rinse out and clean household trash containers with a bleach solution on a regular basis.

- If the client recycles, use appropriate recycle containers and empty into the appropriate recycle bins. Do not mix regular trash with recycle trash.
- **In dealing with clutter:** The client must at least have clear pathways from the bed to the bath and for all exits. This also means the pathway must be wide enough for the client and any assistive mobility device he/she is using, such as a walker or a wheelchair.

D. LAUNDRY

Washer use

- Check labels for special washing instructions. Check the clothes for stains and pre-treat. Check the pockets. Zip pants and skirts.
- Turn dark clothes, beaded, or appliquéd garments inside out.
- Take care when washing red or vibrant colors. There are products that can be put in the wash water to pick up any excess dye in the water. These can be re-used a couple of times depending on how much dye residue is in the sheet.
- Sort clothes by colors (whites and colors), lint generators such as towels, lint magnets (corduroy), and delicates.
- Use liquid bleach for white cotton materials only.
- Do not overload the washer. This decreases the agitation and cleaning power.
- Distribute clothes evenly in the wash drum.

Dryer use

- Do not put delicates in the dryer unless directed by the client.
- Remove clothes immediately when dry, and hang up or fold.
- Some permanent press clothes will be less wrinkled if taken out of the dryer while still slightly damp and hung on a hanger.
- **Clean lint filter after every load.** Clogged lint filters cause the dryer to overheat and catch fire.
- If the client uses fabric softener sheets, be aware that some of these sheets create a film on the filter. This will block the flow of air causing the dryer to overheat and catch fire. Try running water through it. If the water stays on the surface, clean the filter with soap and water.

E. BED MAKING

- Place clean linens near the bed.
- Strip the bed gently to avoid spreading pathogens into the air. Fold blanket(s) and place nearby. Place linens to be washed in a plastic bag or hamper.
- Open sheets gently. Do not shake.
- Put the fitted sheet or flat sheet at the head of the bed working toward the bottom. Only work on one side at a time to save time and energy.
- Square off the corners and tuck the sheet under the mattress.
- Place top sheet over the clean bottom sheet wrong side up with the top edge of the hem even with the top edge of the mattress.
- Place any blanket(s) back on the bed with the top edge of the blanket(s) about 12 inches from the top of the mattress.
- Tuck both the top sheet and blanket(s) under the mattress.
- Repeat procedure on the other side of the bed.
- Place blanket with top at bed head and extend to foot.
- Remove surface wrinkles.
- Fold excess top sheet over top of blanket and cover with spread if desired.
- Put clean pillowcases on pillows. Arrange side by side on top of folded top sheet.
- Take soiled linens to bathroom or laundry.
- If you have linens that are soiled with body fluids (feces, urine, vomit):
 - Put on gloves before handling soiled linens and carry at arm's length (not against your clothing).
 - Put linens in a plastic bag (NOT THE FLOOR) and take them to the bathroom.
 - Rinse the large solids out in the toilet and place the soiled linens back in the plastic bag.
 - Launder immediately, using bleach if linens are white. If the sheets are colored, make sure they are dried completely in the dryer (the heat is as effective as bleach in killing the bacteria).



Note: See Chapter 7, Infection Control, for more instructions on handling infectious waste and soiled linens.

F. CULTURAL AND RELIGIOUS ISSUES

Be aware of the following issues that may affect how and what you clean:

- Culture affects a person's belief in how things are treated (e.g., money, time, animals).
- Religious beliefs affect holiday observations, cooking, and cleaning and handling of religious artifacts.



G. ACTIVITY: PLANNING AND PRIORITIZING CHORES

Break into groups and discuss the following scenario:

You are assigned to provide eight hours of housekeeping and personal care services for an incontinent client. When you arrive you encounter piles of laundry, dirty floors, soiled bed linens, dirty dishes in the sink, and no food in the refrigerator. The client needs a bath and is hungry but wants to go for a walk in the park. How would you respond to the client's request? How would you organize and prioritize the other chores on your care plan?

What would you do if you only had three hours scheduled?

APPENDIX

Arizona Education Requirements for Direct Care Workers

Direct care workers (DCWs) must meet training and testing requirements if they work for agencies that provide services for publicly funded programs in Arizona.

This training requirement applies to these services provided in a person's home:

- Attendant care
- Personal care
- Housekeeping / homemaker

It applies to programs offered by these agencies:

- Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care Services (ALTCSS)
- Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD)
- Arizona Department of Economic Security (DES), Division of Aging and Adult Services (DAAS), and its programs offered by the Area Agencies on Aging (AAA).

Note: There are different training requirements for caregivers in assisted living facilities. Please contact the Arizona Department of Health Services for more information.

Education standards and requirements include:

- Obtain certification in cardio-pulmonary resuscitation (CPR) and first aid.
- Demonstrate skills, knowledge and ability *prior* to providing care as a paid caregiver:
 - Pass required knowledge tests.
 - Demonstrate skills.
- Training and testing is based on the Arizona Direct Care Worker Competencies.
- A DCW may be exempted from the initial training and testing process if the DCW meets one of the following:
 - A DCW with an initial hire date prior to January 1, 2011 is deemed to meet the training and testing requirements with the DCW agency where they are currently employed. If the DCW becomes employed with another agency on or after January 1, 2011, he or she will have to complete the competency testing.

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- A caregiver who is a registered nurse (RN), licensed practical nurse (LPN), or certified nursing assistant (CNA) is exempt from the DCW training and testing requirements. This exemption allows the DCW agency the discretion to test and train their employees as desired.
- A DCW who has not worked as a DCW or has not had work experiences similar to that performed by DCWs in the last two years will be required to demonstrate competency by passing both a knowledge and skills test prior to providing services.
- DCWs with prior experience may take a *challenge exam*. If they pass, no additional training is required at that level. The challenge exam may be taken only one time.
- In order to offer the Arizona Standardized DCW Test, an organization must be an *approved training program*. This can include agencies that hire DCWs and provide services, community colleges, and private vocational programs.

ARIZONA DIRECT CARE WORKER COMPETENCIES (KNOWLEDGE AND SKILLS)

Fundamentals of Direct Care and Support (Level 1)

Topic Areas

- A. Roles and Responsibilities within the Agency and/or Community
- B. Ethical and Legal Issues
- C. Observing, Reporting and Documenting
- D. Communication and Cultural Competency
- E. Job Management Skills and Self-Care
- F. Infection Control
- G. Safety and Emergencies
- H. Nutrition and Food preparation
- I. Home Environment Maintenance
- J. Body Mechanics and Techniques for Maintaining Back Safety

Skills

- Demonstrate proper hand washing technique.
- Demonstrate how to apply, remove and dispose of gloves.
- Describe or simulate (role play) the use of a fire extinguisher.
- Describe procedures for calling 911.
- Describe and/or role-play general procedures for common homemaking skills:
 - Washing dishes
 - Doing laundry (including use of washer/dryer)
 - Cleaning the bathroom
- Describe and demonstrate creating a menu (choice of scenarios with different dietary needs).
- Demonstrate effective communication techniques.
- Describe and demonstrate good technique for moving objects with good body alignment.

Roles and Responsibilities within the Agency and/or Community

1. List different settings where direct care and support services can be provided.
2. List different types of services that are offered to individuals and families in their home.
3. List different individuals who may receive services, such as homemaking, companion services, personal care or attendant care.
4. List Arizona agencies or programs that offer direct care services and require training for direct care workers (DCWs).
5. Identify and describe activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
6. List members of the service team and their essential functions.
 - a. Family members, e.g. spouse, parent(s), children
 - b. Case manager / support coordinator
 - c. Primary care physician
 - d. Agency representative
 - e. Supervisor
 - f. Others (therapists, teachers, psychologist etc.)
7. Describe the training requirements for DCWs. Speak about:
 - a. Level I and level II competencies
 - b. Annual continuing education
8. Explain that job responsibilities for DCWs may vary from agency to agency.
9. Describe positive caregiver traits.
10. Identify behavior that shows high professional standards, for example, appearance and being on time.
11. Explain how professional standards influence the relationship between the DCW and the person receiving services.
12. Explain why it is important to notify the agency / supervisor as soon as possible when you are unable to report to work as scheduled.
13. Explain the importance of team work in providing services.
14. Describe the role of the supervisor when there are questions about procedures.

Ethical and Legal Issues

1. Define legal terms that apply to direct care and support. Provide examples of what each term means in the direct care setting and the legal consequences of each.
 - Abuse, neglect and exploitation
 - Fraud
 - Assault and battery
 - Abandonment
 - Negligence
 - Liability
 - Invasion of privacy
 - False imprisonment, including improper restraint
2. Describe what *mandatory reporting* means, and how to report. Refer to statute/rule from Adult Protective Services (APS) and Child Protective Services (CPS).
3. Describe the role and purpose of service plans (care plan, support plan).
4. Explain how following a person's service plan can assist in avoiding legal action.
5. Identify consumer rights, for example, the right to privacy.
6. Explain why privacy and confidentiality are important for individuals.
7. Define confidentiality and the legal responsibility of the DCW to safeguard consumer information.
 - a. Explain what the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is and state the consequences of breaking this law.
 - b. Identify information that should be kept confidential.
 - c. Explain how to maintain confidentiality in conversations and on the telephone.
 - d. Explain what to do in the event of a breach of confidentiality.
 - e. Explain how direct care professionals can practice the *need to know* rule.
8. Explain how not allowing a person to make decisions about services takes away from the person's rights.
9. Explain how DCWs can promote an individual's independence and the right to make personal choices.
10. Name and describe documents generally used for health care planning (advance directives):
 - a. Living will
 - b. Durable medical power of attorney
 - c. Pre-hospital medical directives / do not resuscitate order (DNR), the orange form

11. Explain the phrase *do not resuscitate*.
12. Explain what health events the orange form exclusively covers.

Observing, Reporting and Documenting

1. Explain the purpose of reporting and documenting.
2. Describe how to record accurate information.
3. Describe the difference between documenting and reporting facts vs. opinions or feelings.
4. Explain the importance of documenting and reporting observed changes in individuals.

Communication and Cultural Competency

1. Describe *effective communication*.
2. Explain the difference between verbal and non-verbal communication, and give examples of non-verbal communication.
3. Describe barriers to effective communication and list examples, such as making judgments about a person based on perceptions or poor listening habits.
4. Give examples of aggressive communication, passive communication and assertive communication, and explain the importance of assertive communication.
5. Give examples of respectful interactions, for example respecting personal preferences and avoiding unprofessional forms of address.
6. Identify and explain techniques for communicating with individuals with disabilities, including persons who:
 - a. are blind or have low vision,
 - b. are deaf or hard of hearing,
 - c. have aphasia (difficulty with using language),
 - d. have a mental illness,
 - e. have a cognitive disability,
 - f. do not use spoken language to communicate.
7. Give examples of person first language.
8. Explain the importance of responding in a non-threatening way to another person's behavior.
9. Give examples of problem-solving and conflict resolution techniques, such as active listening, open-ended questions and empathy.

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10. Define the term *culture*, and give examples of culture-specific concepts or practices.
11. Explain the impact of culture on a person's needs and preferences.
12. Identify cultural barriers to communication, such as one's own upbringing or perceptions.
13. Define the term *cultural competence*.
14. Describe actions that support culturally competent care.
15. Demonstrate effective communication techniques.

Job Management Skills and Self-Care

1. Define the term stress and distinguish between positive and negative stress.
2. List causes and effects of unwanted stress.
3. Identify appropriate strategies for coping with stress and reducing work related stress.
4. List ways to practice good time management, for example by prioritizing tasks.
5. Identify strategies to improve organizational skills.
6. Define the term *boundaries* and give examples of personal and professional boundaries.
7. List the rights of DCWs.
8. List personal safety tips for DCWs.

Infection Control

1. Describe measures that promote prevention and control of infections.
 - a. Give examples of how germs are spread.
 - b. List ways to reduce the spread of infection.
 - c. Identify the most effective method for reducing the spread of infection.
 - d. Identify individuals who are at greater risk for getting infections.
2. Describe universal precautions (standard precautions).
 - a. Define the term *universal precautions* (standard precautions) and state the purpose.
 - b. Give examples of adherence to universal precautions (standard precautions).
 - c. List the appropriate times to wash one's hands.
 - d. Demonstrate proper hand washing technique.
 - e. Give examples of when gloves should be worn.
 - f. Demonstrate how to apply, remove and dispose of gloves.

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3. Describe the procedures for handling and disposing of sharps and other waste.
 - a. Describe the handling, cleaning and/or disposal of soiled linen, incontinence pads, urine, mop water, and other waste.
 - b. Describe the proper disposal of sharps.
 - c. State the appropriate dilution and use of a bleach solution.
4. Describe common infectious diseases
 - a. List the symptoms of hepatitis B and Hepatitis C and discuss how these infections are transmitted.
 - b. Identify benefits of hepatitis B vaccinations and the recommended timeframes for administration.
 - c. Discuss HIV, its symptoms and its transmission.
 - d. Identify and discuss tuberculosis, its transmission, high risk individuals, and skin test screening.

Safety and Emergencies

1. Identify common emergency situations.
2. Explain general guidelines for emergencies, including when to call 911.
3. Describe procedures for calling 911.
4. List parts of an individual emergency plan.
5. Describe when to contact the family and/or the supervisor.
6. Explain how to use the service plan to determine risk factors, safety precautions, and how to assist the person receiving services.
7. Describe fire safety techniques and fire risks.
8. Describe and simulate (role-play) the use of a fire extinguisher.
9. Identify potential hazards in the home, such as frayed cords and poisonous cleaning materials.
10. Identify risk factors for falls.
11. Describe ways to promote oxygen safety.

Nutrition and Food Preparation

1. Identify the food groups, nutrients and hydration needed for a healthy diet (for example, grains and fat).
2. Explain how good eating habits can increase good health.

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3. Identify why ingredients are listed on the food label, and what the order of the ingredients means.
4. Explain the terms *portion* and *serving*.
5. Describe how to plan a menu based on a person's individual preferences and/or recommendations for a modified diet.
6. List health issues a person could have that may require a certain diet.
7. Identify nutrients that may have to be monitored for certain diets.
8. Explain how to encourage a person to eat and/or comply with a medically recommended diet.
9. Identify assistive devices that could enable the person to be more independent and feel more in control of the meal planning and eating process.
10. Discuss proper food preparation and storage.
11. Define foodborne illness and describe ways to reduce foodborne illness.
12. Demonstrate/describe creating a menu (choice of scenarios with different dietary needs).

Home Environment Maintenance

1. Explain how to use the service plan to determine which cleaning tasks have to be completed and how.
2. Identify who is responsible for cleaning of areas specific to the person served.
3. Identify who is responsible for cleaning of common areas.
4. Explain the difference between personal choice and the need to complete necessary tasks to avoid health and safety risks.
5. Identify proper cleaning solutions to use and proper concentration of these solutions.
6. Explain procedures for trash disposal and cleaning up clutter.
7. Describe and/or role-play general procedures for common homemaking skills:
 - a. Washing dishes
 - b. Doing laundry (including use of washer/dryer)
 - c. Making a bed
 - d. Cleaning floors, countertops, and appliances
 - e. Cleaning the bathroom
 - f. Disposing of trash

Body Mechanics and Techniques for Maintaining Back Safety

1. Explain the importance of good body mechanics and lifting techniques.
2. Describe elements of good body mechanics, such as proper use of leg muscles and keeping the center of gravity over the base of support.
3. Describe and demonstrate good technique for moving objects with good body alignment (scenario).
4. Identify assistive devices.

Note: Lifting refers only to lifting and moving items, such as boxes or furniture. Direct Care workers providing assistance with hands-on personal care or transfers of clients must complete Level 2 training and testing. Family members who only complete Level 1 must receive client-specific training as needed.

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