Age-Specific Considerations for CNAs

A Primer for CNAs

1.0 In-Service Hour

NOTE: This course is not accredited for RNs, LPNs, LVNs, or APNs. This course is approved for 1 contact hours (1 in-service hour) for Certified Nursing Assistants.

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By Michael R. Cruse, Ed.S.

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Objectives:

At the completion of this course, the learner will be able to:

- Explain organizational strategies that will help aid in patient record-keeping
- Discuss the use of advanced directives in patient care
- Name three signs of changes in patients' physical and mental functioning
- Name the five categories of need for support and additional care
- Explain how to develop and manage a support team calendar

The population of the United States has over six million people aged sixty-five or older, who are in need of long-term care. According to a survey done in 2007 by the American Association of Retired Persons and the National Alliance for Caregiving, the number of households in America providing care to persons aged fifty and older is nearly thirty-nine million.

First impressions are important with any age group. However, different generations often have different ideas and expectations about interpersonal attitudes and behaviors. Often, we hear stereotypes about older people's attitudes towards the young. Some examples of stereotypes you may have heard are, "Kids today are just plain lazy", or "Old people are afraid of technology". Peoples' experiences often determine how they treat different age groups. It is important to think about our own stereotypes, in order to avoid making assumptions when dealing with patients in your care. To start out, there are a few good rules to consider when dealing with patients from generations other than the one we are part of. The considerations below will help you to gain the cooperation and respect of your patients, regardless of their age.

Possibly the most important step in making a good first impression is being on time for your appointments. If you are running late or have to cancel an appointment, call the patient's home and let them know, or leave a message with someone else who can get in touch with the patient. When you are greeting the patient, make eye contact and smile. Let them know that you are there to help them. Older patients have lived a long life before you ever meet them. One simple way to acknowledge this experience and begin to establish good rapport with older patients is to address them by a title, such as: Dr., Mr., Ms., or Mrs., followed by their last name. This simple effort will go a long way in

building a professional relationship with your patients. It also encourages them to trust you and your experience as a caregiver.

When introducing yourself, you have the choice of using one of the same titles, or you may prefer to be called by your first name. Either way, it is a good idea to be consistent in calling the patient by their title, (for example: Dr., Mrs., Ms., Mr.) and last name, unless they ask you to call them by another name. Likewise, you should get in the routine of introducing yourself by your preferred name each time you greet them. Older patients may tend to forget names more easily, even when they remembered it the last time they saw you. Stating your name from the beginning helps them to remember and avoids any feelings of embarrassment they might have if they cannot remember your name.

Being organized is another important way for you to establish a positive relationship with patients. Keeping your notes and supplies organized is a good practice with any population, but it can be especially challenging for those who travel to patients' homes to deliver care. As more and more agencies are providing in-home care, more nursing staff are being hired to travel out in the community, often times visiting multiple sites in a day. Being organized with this type of travel schedule is something that should be decided on an individual basis, but taking the time to create this organization is very important. The following is a list of suggestions for deciding what organization system works best for you in your situation:

- Ask co-workers with similar schedules what they have tried and what has worked for them
- Ask your employer to plan a professional development activity around organization strategies for traveling nursing staff
- Ask your employer to provide low-cost supplies that will help you to stay organized
- Brainstorm new ways to do different job tasks and how that might help you to stay organized

It is a good idea for every patient to have a list of emergency contact information. Laminate the list and put it in an public space (ie. on the refrigerator, next to the phone) so it will be available for Emergency Medical Technicians (EMTs) or others who may need it. The sheet should include the following information:

- Patient's name, address, and telephone number, birth date, and medical insurance information
- Name and contact information for primary care giver or power of attorney
- Primary physician's name and contact information
- Specialized medical personnel's contact information (ie. Cardiologist or Gerentologist).

- List of all currently prescribed medications and their dosages
- Phone number of pharmacy where prescriptions are filled
- Statement of an existing Living Will or Do Not resuscitate Order

Advance directives are legal documents that communicate the kind of treatment a patient would want if they are not able to make their own medical decisions, for example, if they are in a coma. Advanced directives take many forms, depending on the state where the patient lives. However, federal law requires hospitals, nursing homes, and any agencies receiving Medicare or Medicaid funds to provide written information on advanced care directives to their patients. It is normally not a CNA's responsibility to provide this information, but a basic understanding of these two documents is helpful in providing care for patients.

Living wills are a kind of advance directive that are sometimes used when a patient is terminally ill. A living will allows the patient to choose the kind of treatment they want under specific circumstances. An example may be that a patient does not want to be treated with antibiotics in the end stages of life.

Similarly, A Do Not Resuscitate order (often abbreviated as a 'DNR' order) is a type of advance directive. A DNR specifies that if a patient's heart stops or if he or she stops breathing, CPR should not be performed. Unless otherwise directed hospitals and other healthcare facilities are responsible for trying to help all patients who have stopped breathing or whose heart has stopped to resume these functions. A patient can state that they do not want to be resuscitated and a DNR order will be entered into their medical chart. Being aware of a patient's advanced directives is critical when communicating a patient's wish with other medical and emergency personnel. If this information is not provided by your employer on a patient under your care, you have a professional responsibility to ask the employer if this information has been provided to the patient.

One of the primary tasks of anyone working with an aging population is observing changes in a patient's physical and mental functioning. A decrease in mental and physical abilities is normal as we get older. The most important consideration is whether the changes you observe are a threat to your patients' safety. Some changes that can signal the need for help are:

<u>Behavior changes</u>

- Changes in personal hygiene
- Change in cleanliness around their living space
- Mail and bills unopened or unpaid
- Unusual smells (ie. from spoiling food)
- Missed appointments
- Getting lost in familiar places
- Signs of safety risks (ie. water on the floor)
- Signs that medications are not being taken properly

Physical changes

- Weight gain or loss
- Unsteadiness when walking or getting up / down from bed or a chair
- Signs of bowel and/or bladder incontinence
- Unusual thirst
- Unusual fatigue

Symptoms of depression

- Darkened house
- A significant increase or decrease in appetite
- Sleeplessness or excessive sleeping
- Decreased contact with family and friends
- Lessened conversation with the patient

It can be tempting to want to fix what you see as a possible problem when you first notice it; however, it is best to avoid taking over the situation. If a patient is competent to participate, avoid making one-sided decisions without first talking with the patient and/or their family or guardian. If you have difficulty resolving problems with the patient, family or guardian, think of other professional contacts, such as a primary care physician, a gerontologist, a senior care specialist or a case worker who you might be able to get advice specific to your patient's condition. They will often ask you about the patient's behaviors and cognitive status. The following is a list of possible questions that you might hear:

- Is there difficulty with Activities of Daily Living (ADL) tasks such as bathing, dressing, toileting, eating, and transferring from place to place (ie. bed to chair)?
- Have there been any *significant* changes in memory, decision-making or judgment?
- Have there been any recent changes in living environment or care giving schedules?
- Have there been any changes in medical care, prescription medication or diagnosis?

The goal is to work as a team to try and determine the underlying cause of the problem(s) and possible interventions. If a patient has an acute event, such as an illness or accident requiring hospitalization, the social worker or discharge planner may offer helpful guidance. You can start developing a care plan based on your knowledge of the patient, along with the views of others in the medical community, friends and family. Developing a care plan can be done using a five-step process that you can adapt to specific patients. The following outline will help to break these four steps down into manageable parts.

1.List the needs for support and additional care. These will generally fall into five categories:

Area of Support for Seniors	Examples
Housekeeping	Laundry; Shopping; Paying bills
Safety and Social Concerns	Transportation; Companionship; Daily phone checks
Nutrition	Meal Planning; Cooking
Health Care	Nursing; Social Work; Physical Therapy; Medication checks
Personal Care	Assistance with personal hygiene; Medical equipment

2. Identify who will be helping to provide these supports. This may include paid nursing staff, family and friends. Also identify what supports each person is able to provide and their availability. This group is often called a support team.

3. List the client's specific needs and a schedule for when and how often they need to be completed. Some needs do not have specific time requirements (ie. laundry, shopping, housekeeping), while others are more time sensitive (ie. doctor's visits, cooking, personal hygiene), which need to be done at specific times of the day.

4. Get commitments from identified members of your support team on when they will provide specific types of support. For example, "Daughter: Beth will do grocery shopping on Saturday afternoons."

5. Develop a weekly/monthly calendar based on these commitments and distribute to each member of the support team, as well as any other interested parties.

Often times, a care plan may need to be revised for different reasons. For example, you may need to change the plan when:

- The patient's needs increase or decrease (e.g., recovery from a stroke).
- A member of the support team is unable to continue providing support, or has a change in their availability.
- Your employer makes a change in your assignment