Unlicensed Assistive Personnel

UAP Curriculum

In Nursing Care Settings

2013

State of New Jersey
Department of Law and Public Safety
Division of Consumer Affairs
New Jersey Board of Nursing
Homemaker-Home Health Aide

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Unlicensed Assistive Personnel (UAP) Curriculum

Introduction

The New Jersey Board of Nursing's Unlicensed Assistive Personnel (UAP) Task Force, comprised of representatives from nursing and health care organizations, in the 1990s was charged with developing a UAP Curriculum to be used to educate unlicensed assistive personnel (UAPs) to function in a variety of health care settings.

The purpose of the UAP Curriculum is to offer a uniform and standardized curriculum including specific clinical skills required to prepare one to competently provide select delegated nursing services. The program is designed to educate individuals to provide delegated nursing services including personal – care to clients in acute, long-term, home health and hospice care service environments. The curriculum consists of the basic UAP curriculum, which can be supplemented with the site-specific home health/hospice or long term care modules.

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Unlicensed Assistive Personnel (UAP) Curriculum
Section I. Role of the UAP in Nursing Care Settings

Section I. Role of the UAP in Nursing Care Settings

Performance Objectives:

Upon completion of Section I, the student will demonstrate the job knowledge and related skills needed to define the role of the UAP within the health-care setting(s).

Enabling Objectives:

The student will:

- Differentiate the roles of health-care team members;
- Describe delegation with the nurse-UAP-client relationship;
- Discuss the Five Rights of Delegation;
- Identify the responsibility of the UAP if he/she lacks the necessary skill or knowledge required to perform a delegated activity;
- Explain the role of communication throughout the delegation process;
- Summarize the characteristics of an effective UAP;
- Identify the requirements of certification and recertification for the UAP;
- Identify the purpose of the plan of care;
- Discuss the UAP's accountability in following care plans, procedures and directions given by the nurse;
- Identify actions that protect or promote the rights of the client;
- Identify ways of providing privacy for a client;
- Identify client-related information that must be kept confidential;
- Describe the UAP's responsibilities in protecting client rights;
- Discuss the role of the UAP in reporting abuse; and
- Describe how and to whom an identified client abuse situation is reported.

Content Map:

I. Role of the UAP in Nursing Care Settings
  A. Settings utilizing UAPs in the health-care continuum
    1. Long-term care
    2. Acute care
    3. Subacute care
    4. Outpatient services
    5. Rehabilitation centers
    6. Home-care agencies
    7. Assisted living

        8. Hospice

   B. Role of the UAP

      1. Health-care team

         a. Physicians

         b. Nurses

         c. Unlicensed assistive personnel

         d. Therapists: physical, speech-language, occupational, respiratory

         e. Dietician, nutritionist

         f. Pharmacist

         g. Social workers

         h. Others (e.g. clergy)

      2. Nursing team

         a. RN: role/responsibilities/*scope of practice*

            (1) Utilizes the nursing process in providing and directing client care

               (a) Assess

               (b) Diagnose (nursing diagnosis)

               (c) Plan

               (d) Implement

               (e) Evaluate

            (2) Monitors and evaluates changes in client status

            (3) Establishes priorities of care

            (4) Communicates plan of care to other caregivers, including UAPs

            (5) Coordinates activities of client care and <u>delegates</u> duties as appropriate

               (a) Delegation: transferring to a competent individual the authority to perform a selected nursing task in a selected situation

                   i. *Five Rights of Delegation*: RN considerations before delegating the task to the UAP:

                      (i) Is there a match between the client's needs and the skills, abilities and the experience of the UAP?

                      (ii) What is the client setting and the level of client stability?

                      (iii) Is the UAP the right person to do the activity?

                      (iv) Can the nurse provide the UAP with appropriate direction and communication to support the UAP's effort?

(v) Is the nurse available to provide the supervision, support and assistance that the UAP needs?

(b) Nurse retains accountability for the delegation

(c) Nursing activities that require specialized knowledge, judgment and skills <u>may not</u> be delegated

b.　LPN: role/responsibilities/scope of practice

(1) Contributes and supports the nursing process through case findings and performing client care including teaching, and providing supportive and restorative care as delegated by the RN.

c.　UAP: role/responsibilities

(1) Contributes and supports the nursing process through case findings and performing client care including teaching, and providing supportive and restorative care as delegated by the RN.

(2) Key elements of the UAP role:

(a) Client care responsibilities are delegated to the UAP, but the RN retains accountability for the care. Therefore, the UAP must expect supervision

(b) The job duties and responsibilities of the UAP are limited based on the level of preparation and competency of the UAP, and the complexity of the client's needs.

　　i.　Questions to be considered by a UAP before accepting a delegation:

(i) Do I have all the information I need to do this job? Are there questions I should ask? (When in doubt, talk it out.)

(ii) Do I believe that I can perform this activity? (In other words, do I possess the necessary skill?)

(iii) Do I have access to the necessary supplies, equipment and other needed support?

(iv) (e.g. someone to assist in turning a large, immobile client?

(v) Do I know who my supervisor is, and how to reach him/her?

(vi) Have I informed my supervisor of my special needs for assistance and support?

(vii) Do we both understand who is doing what?

(c) Characteristics of an effective UAP

  i. Competent with knowledge of:
    (i) Job description, facility/agency policies and procedures
    (ii) Reportable observations and changes in client status
    (iii) Basic nursing/personal care procedures

  ii. Applies principles of safety, infection control and client rights to all aspects of care

  iii. Understands basic human needs and supportive responses

  iv. Utilizes communication skills in all levels of job interactions

  v. Provides care as directed by the nurse

  vi. Recognizes limitations

  vii. Participates in continuing education to ensure current knowledge base

  viii. Possesses positives personal attributes:
    (i) Trustworthy, honest ethical
    (ii) Reliable, dependable, responsible
    (iii) Patient
    (iv) Respectful
    (v) Appearance
      ▪ Practices personal hygiene
      ▪ Complies with dress code, including wearing required identification
      ▪ Maintains neat appearance

  ix. Practices self-assessment: need for objectivity and self-review
    (i) Recognizes stress and utilizes appropriate stress reduction interventions
    (ii) Utilizes self-care to reduce risk of work-related stress or injury
    (iii) Practices principles of safety to prevent work-related injury and illness
    (iv) Learns and applies principles of time management to prioritize, organize and complete assignments

                                (v) Utilizes problem-solving skills and appropriately refers issues and concerns to the nurse in charge

                                (vi) Recognizes own emotional responses (including grief) to clients

C. Legal and ethical consideration for the UAP
1. Regulatory/licensing
    a. Federal requirement's
        (1) HCFA: Medicare and Medicaid
        (2) OSHA
    b. New Jersey State requirements
        (1) Licensure for health facilities and agencies
            (a) Department of Health and Senior Services
            (b) Consumer Affairs
                i. Regulated Business
                ii. New Jersey Board of Nursing
        (2) Certification for UAPs
            (a) Eligibility for certification
                i. Course completion
                ii. Competency testing
                iii. Criminal background check
                iv. SAVE review (foreign nationals)
            (b) Maintaining certification
                i. Employment by agency required
                ii. Criminal background check and self-report of all arrests, convictions or sanctions by any other licensing body
                iii. Fees
                iv. Responsibility for keeping registry informed of changes of address
            (c) Employment (work under the supervision of a Registered Professional Nurse)
2. Accountability
    a. Provide care as directed by the nurse
        (1) Sources of direction and delegation to the UAP (written and verbal)
            (a) Plan of care
            (b) Assignment
            (c) Report (written and/or verbal)
        (2) Report any changes in the client's condition to the nurse

        (3) Inform the nurse of lack of skill and/or knowledge base or changes in circumstance that could affect the UAP's ability to perform safely and effectively

    b. Knowledge and adherence to policies and procedures

    c. Define: standard of care, malpractice and negligence

3. Client rights

    a. Vary according to setting (regulatory standards)

    b. Basic rights:

        (1) To civil and religious liberties

        (2) To file a complaint, without fear

        (3) To be informed of one's rights and the rules on admission

        (4) To inspect one's own records

        (5) To be informed of medical conditions and treatments, and to take part in planning care

        (6) To refuse medication and treatment

        (7) To obtain information from agencies providing inspection services

        (8) To receive information about responsibilities for charges and services

        (9) To receive adequate and appropriate health care

        (10) To be free from verbal, mental, sexual or physical abuse

        (11) To be free from unnecessary physical or chemical restraints

        (12) To personal privacy and confidentiality of information.

        (13) To be treated respectfully, fairly and with dignity

        (14) To send and receive mail that is unopened

        (15) To have private communications

        (16) To have equal policies and practices regardless of sources of payment

4. Confidentiality (include discussion of HIV test results)

5. Client abuse

    a. Types

        (1) Physical

        (2) Verbal

        (3) Emotional

        (4) Neglect

        (5) Misappropriation

    b. Responsibility for reporting (*varies according to setting*)

        (1) Reporting requirements

        (2) Reporting process

            (a) Within organizational framework

            (b) Protective services

          i.   Division of Youth and Family Services (DYFS)

          ii.   Adult Protective Services

          iii. Office of the Ombudsman for Institutionalized Elderly

          iv. Police

      (c) New Jersey regulatory agencies

          i.   Board of Nursing/Division of Consumer Affairs

          ii.   Regulated Business/Division of Consumer Affairs

          iii. Department of Health and Senior Services

   (3) Legal findings/ outcomes/consequences

      (a) Revocation of certification if found guilty of charges of abuse

      (b) Criminal charges and prosecution

  c.   Prevention of abuse (*discussed in greater detail in Section III*)

    (1) Recognize and reduce risk factors

    (2) Create a climate of intolerance for abuse (reporting abuse)

6.   Documentation

  a.   Follow policies for recording and reporting information

    (1) Client's record as a legal document

  b.   Rules for recording

    (1) Accuracy

      (a) Record only care that has been given

      (b) "If care is not recorded, care is not given…"

    (2) Use a pen, not a pencil (ink required)

  c.   Incident reporting process

Section II. Foundations for Working with People

A. Communication

Performance Objectives:

Upon completion of Section II, the student will demonstrate communication and psychosocial skills needed to function as an effective UAP within the health-care setting.

Enabling Objectives:

The student will:

- Give examples of (or identify) barriers to communication;
- Give examples of (or identify/demonstrate) verbal and nonverbal techniques that enhance communication;
- Describe or demonstrate ways to communicate with clients who are:
  - i.   Visually impaired;
  - ii. Hearing impaired;
  - iii. Speech impaired
  - iv. Cognitively impaired; or
  - v.   Experiencing stress
- Identify strategies to communicate with people from another culture; and
- Give examples of techniques of reality orientation, validation and reminiscing used in communication.

Content Map:

II.   Foundations for Working with People
- A.   Communication
  - 1.   Purpose-means of
    - a.   Interacting in a work setting with supervisors, co-workers, clients and families or significant others
    - b.   Providing, eliciting and receiving information and feedback
    - c.   Responding to the emotional and physical needs of a client
  - 2.   Components of communication (*communication model*)
    - a.   Sender
    - b.   Receiver
    - c.   Feedback
    - d.   Message
    - e.   Listening
      - (1) Techniques

      (a) Neutral

      (b) Exploratory

      (c) Validation

      (d) Reflective

      (e) Summarizing

  f. Types of communication

    (1) Verbal

    (2) Nonverbal

3. Factors that affect communication

  a. Background (ethnic, cultural)

  b. Attitudes/values

  c. Perceptions

  d. Emotions

  e. Opinions

  f. Life experience

  g. Expectations

  h. Setting (health-care facility vs. home0

4. Potential barriers to effective communication

  a. Impairments

    (1) Speech

    (2) Hearing

    (3) Visual

    (4) Cognitive

  b. Distractions

  c. Emotional triggers

  d. Language (including confusing medical terms or use of slang)

  e. Physical barriers

  f. Lack of preparation

  g. Lack of conciseness

  h. Fear/stress/anxiety

  i. High-pressure environment

  j. Poor timing

  k. Insensitivity

  l. Nonverbal behavior

  m. Tone of voice

  n. Preconceived ideas

5. Basic communication skills

  a. Introduce yourself

  b. Ask the client and family members how they would like to be addressed

    c.   Ask for an interpreter if the client and/or family members are unable to speak or understand English

    d.   Use a respectful and considerate tone

    e.   Speak slowly, directly and clearly

    f.   Explain all tasks before performing them

    g.   Use attentive eye contact and body language

    h.   Use words the person can understand

    i.   Listen to the client's responses and acknowledge his/her concerns

    j.   Maintain confidentiality

    k.   Show sensitivity to the client's needs

    l.   Demonstrate patience

    m.   Avoid holding conversations with co-workers or others while "speaking over" or ignoring the client (including speaking in a different language)

6.   Techniques to facilitate and enhance communication

    a.   Ask open-ended questions

    b.   Provide privacy

    c.   Minimize distractions

    d.   Be sensitive to timing

    e.   Maintain eye contact and awareness of body language (cultural sensitivity)

    f.   Listen attentively

    g.   Provide feedback to ensure accuracy of message

    h.   Ask for clarification

    i.   Avoid use of medical lingo and slang

    j.   Utilize communication techniques to respond to the client's sensory or cognitive impairments (See number 8 a-e bellow)

7.   Communication with staff members

    a.   Identify yourself in all forms of communication

    b.   Use a respectful and considerate tone

    c.   Work towards building a team

    d.   Exercise tact and good timing

    e.   Communicate emergency medical situations, safety hazards, and/or changes in the client's condition to the nurse immediately

    f.   Report and document according to facility policy

    g.   Obtain your assignment

       (1) Listen to the report (change of shift)

       (2) Follow the plan of care

       (3) Listen carefully to the directions given by the nurse

       (4) Establish/clarify priorities

8.   Guidelines for communicating with individuals who are:

a. Visually impaired
  (1) Identify yourself when you enter the room
  (2) Ensure adequate lighting, avoid glare
  (3) Face the person when speaking
  (4) Use touch, such as a hand on the client's arm or shoulder, to maintain contact
  (5) Give an explanation of the procedures to be performed
  (6) Tell the person when you are leaving the room
  (7) Related needs of the visually impaired client
      (a) Describe surroundings and location of personal items, as indicated
      (b) When ambulating, allow the client to hold your arm while you walk slightly in front of the client, cuing for steps, doors, furniture or other possible obstacles
      (c) Assist with food placement and explain the location of food and beverages using the face –of-a-clock method as a guide
      (d) Address sensory needs for providing recorded or large-print books, music, braille materials or other items as requested
      (e) Provide glasses or other adaptive equipment
          i.   Care of eyeglasses

b. Hearing impaired
  (1) Gain the client's attention and alert him/her to your presence
  (2) Face the person directly when speaking
  (3) Stand or sit in sufficient light
  (4) Speak in a normal tone of voice and avoid over enunciating words
  (5) Use short sentences and simple words
  (6) Repeat or rephrase statements as needed, using different words to vary pitch
  (7) Reduce or eliminate background noise
  (8) Speak to the better ear, as applicable
  (9) Use handwritten messages, a communication board or hand gestures/sign language
  (10) Related needs of the hearing-impaired client
      (a) Hearing aid
          i.   Care of hearing aid
          ii.   Battery insertion/removal aid
          iii. Placement/insertion of hearing aid

(b) Address sensory needs of providing visual stimulus, aromatherapy or other items as requested

c. Speech impaired
 (1) Listen and give the client your undivided attention
 (2) Become familiar with the client's speech patterns
 (3) Ask the client to repeat or rephrase statements if necessary
 (4) Ask the client to write down key words if he/she is able
 (5) Watch the person's lip movements
 (6) Observe facial expressions, gestures and body language for clues to what is being communicated
 (7) Allow the client the opportunity to respond to a question or to complete his/hers sentence, and avoid limiting communication to questions which require only a "yes" or "no" response
 (8) Avoid completing sentences for the client, unless he/she is fatigue
 (9) Reinforce the speech therapist's guidelines/plans, if applicable
 (10) Use communication boards, if needed

d. Cognitively impaired (causes: dementia(s) such as Alzheimer's, delirium, post anesthesia, post-trauma/ head injury, sedatives/medication, mentally disabled, etc.)
 (1) Face the client and speak clearly, slowly and calmly
 (2) Call client by his/her name
 (3) State your name
 (4) Provide reality orientation
   (a) Use cues such as name, age, room, time and/or recent events
   (b) Have calendars and clocks with large numbers available
 (5) Keep explanations, directions and responses simple
 (6) Always tell the client what you are going to do
 (7) Ask clear and simple questions, and allow enough time for the client to respond
 (8) Be aware of your tone of voice, body language and touch when interacting with the client
 (9) Be aware of the client's need for space and recognize signs of feeling threatened, fearful or agitated
 (10) Attempt to reduce environmental stimuli if client becomes agitated
 (11) Avoid arguing with the client
 (12) Utilize validation techniques
   (a) Acknowledge the client's concerns and feelings
 (13) Provide activities as a diversion

(14) Use techniques such as reminiscing

    (a) Rely on long-term memory and associations

e. People who are experiencing stress

    (1) Try to understand the individual's experience, situation and stress factors

    (2) Use nonverbal communication such as body language to convey concern, empathy and patience

    (3) Recognize that stress and needs may affect ability to hear/listen

    (4) Maintain nonjudgmental approach

    (5) Recognize that the individual's perceptions frame his/her reality

    (6) Use familiar words when communicating

    (7) Exercise sensitivity to timing, if possible

    (8) Try to be clear and concise

    (9) Provide information in a logical order

    (10) Avoid bombarding the client with multiple questions or information at one time

    (11) Observe the individual's body language and elicit feedback to ensure comprehension of instructions and to ascertain his/her concerns

    (12) Avoid arguing or discounting the client's concerns

    (13) Report client/family concerns to the nurse

f. Transcultural considerations

    (1) Review/learn about cultures served by the region and understand:

        (a) Health practices

        (b) Cultural influences on health choices, priorities and needs

    (2) Strategies for communicating with the non-English-speaking client

        (a) Review the situation with your supervisor to establish the best communication techniques and approaches for the client's abilities and needs

            i.   Communication board

            ii.   Sign language/gestures

            iii.   Utilize an interpreter as needed and when possible

            iv.   Consult language resources for common words and phrases

            v.   Others

        (b) Utilize guidelines for effective communication techniques.

B. Introduction to Human Behavior

Enabling Objectives:

The student will:

- Discuss how emotional and physical needs can influence a person's sense of well-being;
- Discuss factors that may affect the physical and emotional health of the older adult;
- Describe losses that may be experienced by the elderly client with life changes;
- Provide examples of support that assist the client when adjusting to relocation; and
- Provide examples of activities that address the emotional needs of the older adult.

Content Map:

II. Foundations for Working with People

    A. Introduction to human behavior

        1. Human needs

            a. Physical

                (1) Air

                (2) Water food

                (3) Elimination

                (4) Sleep

                (5) Shelter

                (6) Sex

            b. Emotional

                (1) Security and safety

                (2) Love

                (3) Self-esteem

                (4) Approval

                (5) Acceptance

                (6) Recognition of individuality

                (7) Respect

                (8) Hope

                (9) Independence

                (10) Personal space

                (11) Privacy

                (12) Other

            c. Priority or significance of any need can be influenced by culture, religion, living situations, life changes and crises

            d. How physical and emotional needs generally affect a person's sense of well-being

2. Understanding mental health
    a. Definition: sense of well-being; ability to function within society
    b. Characteristics of emotionally healthy individuals
        (1) Give and receive love and affection
        (2) Feel a sense of well-being
        (3) Tolerate stress to varying degrees
        (4) Adapt to changes
        (5) Distinguish between reality and fantasy
        (6) Control impulses until they can be satisfied in an acceptable manner
        (7) Accept responsibility for one's own decisions, actions and feelings
3. Emotional growth and needs through the life span
    a. Infancy (birth to one year) (needs: learning to trust)
    b. Toddler (one to three years) (needs: beginning to exert independence-recognizing autonomy)
    c. Preschool (three to five years) (needs: energetic, curious)
    d. School age (6 to 12) (needs: decreasing dependence on family, learning about school and peers)
    e. Adolescence (12 to 18) (needs: conflicts and adjustments, establishing identity and independence)
    f. Adulthood (needs: productivity)
    g. Older adulthood (needs: integrity vs. despair)
        (1) Factors affecting emotional health
            (a) Individual responses to the aging process
                i. Potential physical changes
                    (i) Slower healing and longer period of recovery from illness and injury
                    (ii) Physical changes associated with normal aging
                    (iii) Health problems and physical limitations
                ii. Potential mental changes
                    (i) Capacity to remember, learn and be self-directed
                    (ii) Increased reaction time
            (b) Life changes 9retirement, change in finances, death of loved ones and relocation)
                i. May result in loneliness, confusion, loss of a sense of personal worth, depression and/or anxiety
                ii. Potential losses

(i) Loss of identity (e.g. retirement, changes in family situation and/or anxiety)

(ii) Loss of independence

(iii) Loss of mobility

(iv) Loss of health

(v) Loss of loved ones (e.g. friends/ spouse)

(vi) Loss of personal possessions and space (moving in with family, change in living space, or with institutionalization)

(vii) Loss of real-world experiences (lace of community involvement)

iii. Relocation (transfer, admission, move institutionalization, etc.)

(i) Emotional impact
- Reason for transfer
- Associated losses
- Short-term versus permanent change

(ii) Providing emotional support
- Offer reassurance
- Orient to nurse surroundings
- Introduce to staff, roommates, neighbors, etc.
- Recognize need to feel control in the new environment; assist client in making decisions about placement of personal belongings
- Assist in care and protection of personal belongings
- Policies for handling valuables inventory of personal belongings
- Labeling
- Report client/family concerns about missing items
- Assist in locating missing belongings

(2) UAP's role in addressing the emotional needs of the older adult

(a) Provide privacy

(b) Encourage choice and decision making

(c) Encourage independence

(d)   Treat with respect and dignity

(e)   other

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Section II. Foundations for Working with People

C. Behavior as a Response to Stress or Unmet Needs

Enabling Objectives:

The student will:

- Discuss how emotional and physical needs can influence a person's behavior;
- Provide an example of client behavior that may require/need nursing intervention; and
- Identify appropriate and inappropriate responses to a client's behavior(s).

Content Map:

II. Foundation for Working with People

    B. Behavior as a response to stress or unmet needs

        1. Examples of behaviors indicating stress or unmet needs

            a. Denial

            b. Displacement

            c. Anger

            d. Withdrawal

            e. Attention seeking

            f. Other

        2. UAP responses to client behavior

            a. Try to understand the behavior and the need it is filling

            b. Remain calm

                (1) Ensure immediate physical and emotional safety

                (2) UAP must control emotional reaction to client behavior, removing oneself f it necessary (*discussed in greater detail in Section III*)

            c. Do not take behavior personally

            d. Report behavior(s0 to the nurse

            e. Interventions to modify behavior of the client

                (1) Communication skills

                    (a) Listening

                    (b) Validation

                    (c) Provide an opportunity for the client to explore his/her feelings and needs

                (2) Identify an alternate means to address his/her need

                (3) Distraction or redirecting

                (4) Limit the setting

                (5) Recognize that it is <u>never</u> appropriate to punish

                (6) Reward and/or reinforce the desire behavior(s)

D. Responses to Changes in Health

Enabling Objectives;
- The student will:
- Provide examples of reactions to changes in health; and
- Provide examples of responses that support the emotional needs of a client when he/she is grieving

Content Map:

II.   Foundations for Working with People

    D.   Responses to changes in healthClient responses to changes in health status are influenced by:

        a.   Physical effects of a change in health
           (1) Predicted outcome
              (a)   Recovery
              (b)   Permanent disability
              (c)   Chronic illness
              (d)   Terminal/death
           (2) Perception of ability vs. disability
           (3) Body image
        b.   Coping skills
        c.   Life experiences
        d.   Alterations in life-style
        e.   Age
        f.   Timing with other life events
        g.   Spiritual or religious beliefs
        h.   Culture
        i.   Resources
           (1) Support systems
           (2) Financial
              (a)   Insurance coverage
           (3) Community

    2.   Emotional reactions to changes in health
        a.   Shock and disbelief
        b.   Emotional release
        c.   Depression and loneliness
        d.   Physical distress
        e.   Panic
        f.   Guilt
        g.   Hostility and resentment
        h.   Dejection

          i.   Reconciliation

          j.   Adaptation

          k.   Grief and grieving (Include a discussion of grief responses using the Kubler-Ross model of the stages of grief: denial, anger, bargaining, withdrawal/depression, and acceptance.)

3. Supportive care to address emotional needs in dealing with changes in health

    a.   Expect emotional reactions (a variety of manifestations)

    b.   Try to understand and empathize with the experience and issues the client/family is confronting

    c.   Understand displacement and projection of emotions at UAP (health-care provider) who is considered "safe" (*Do not take reactions personally*.)

    d.   Provide support by listening and allowing client/family an opportunity to express thoughts, feelings and fears

    e.   Remain nonjudgmental

    f.   Report concerns and changes to the nurse

    g.   other

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Section II. Foundations for Working with People

E. Spiritual Needs of the Client

Enabling Objectives:

The student will:

- Provide examples of religious/spiritual customs or rituals;
- Describe indicators of spiritual crisis and needs of the clients; and
- Provide examples of activities by the UAP that address the client's spiritual needs.

Content Map:

II.   Foundations for Working with People

    A.   Spiritual needs of the client

        1.   Concepts

            a.   Spirituality-mind, body, spirit

                (1) Give life meaning: values in regard to self, others, nature, life and whatever one considers to be the "ultimate"

                    (a) Experience connection and hope

                    (b) Hardiness

                    (c) Purpose

            b.   Religion

                (1) Framework and community for sharing beliefs, worship

                (2) Celebration of life

            c.   Right to choose one's own beliefs

            d.   Respect for customs, beliefs and rituals

                (1) Examples of various religious practices seen in health-care settings

                    (a) Visitation by ministry/clergy

                          (i)   Supportive

                        (ii) Communion

                        (iii) Rites (illness or death)

                    (b) Religious services

                    (c) Prayer

                    (d) Dress

                    (e) Jewelry, such as a cross or a star of David

                    (f) Display in room: statues, Bible, pictures, etc.

                    (g) Dietary preference and practices

                    (h) Planning funeral

                    (i) Other

                (2) Spiritual experience is defined by the individual and may be found in activities such as solitude, nature, music, relationships and/or meditation

2. Indicators of spiritual crisis or need
    a. Loss of meaning or purpose in life
    b. Disrupted spiritual trust
    c. Feeling remote from God or higher power
    d. Anger towards staff, family, God or higher power
    e. Loss of hope
    f. Death wish
3. UAP responses supporting the spiritual needs of the client
    a. Report the client's spiritual requests
    b. Assist the client to prepare for visits from clergy
    c. Provide privacy during visits by clergy
    d. Handle client's religious/spiritual belongings respectfully (e.g. Bibles, rosary, etc.)
    e. Report to the nurse any indicators of a spiritual crisis
    f. Read spiritual passages to the client on request
    g. Allow the client to share and discuss beliefs
    h. other

Section III. Safety

A. General Safety: Environmental, Physical and Emotional

Performance Objectives:

Upon completion of Section III, the student will demonstrate the job knowledge and the skills necessary to provide a safe environment for the client.

Enabling Objectives

The student will:

- Identify common safety hazards, environmental, physical and emotional;
- Discuss the major causes of accidents in a health-care setting;
- Describe safety measures related to fire prevention;
- Describe safety measures that reduce the risk for client injury;
- Demonstrate methods of protecting clients from injury;
- Identify hazards that must be reported or corrected immediately; and
- Discuss risk factors for client abuse.

Content Map:

III.   Safety

    A.   General Safety: Environment, Physical and Emotional

        1.   Conditions that increase the risk of accidents or injury to the client

            a.   Environmental conditions

                (1) Potential hazards and causes of accidents in health-care settings

                    (a) Electrical

                    (b) Physical (e.g. obstacles, poor lighting, wet floors, ventilation and/or structural)

                (2) Safety measures

                    (a) Electrical/fire

                        i.   Inspect electrical equipment before using

                        ii.   Report broken or malfunctioning equipment (do not use electrical equipment with frayed or damaged cords, plugs or parts)

                        iii. Do not use electrical equipment near water

                        iv.   Do not overload circuits

                        v.   Avoid the use of extension cords

                        vi.   Store flammable liquids safely

                        vii. Dispose of waste materials safely

   viii. Enforce smoking policy and report violations and monitor clients as required

   ix. Oxygen safety

    (i) Never use flammable liquids such as alcohol or nail polish remover in the presence of oxygen

    (ii) Follow policy for using electrical equipment around oxygen

    (iii) Avoid the use of blankets and clothing made of nylon and other synthetic materials that are likely to produce static electricity

    (iv) No smoking or open flames around oxygen

    (v) Secure oxygen tanks with a chain to prevent accidents

   x. Other

 b. Physical (environmental)

  (1) Reduce the risk of falls

   (a) Reduce clutter to ensure clear traffic areas

   (b) Spills: ensure immediate safety of area until spills are wiped up (do so promptly)

   (c) Supervise/mark hazardous areas such as around housekeeping tasks: cords, wet floors, etc.

   (d) Other

  (2) Reduce risk of burns

   (a) Check for safe water temperature before bating or submerging any part of a client's body (Department of Health and Senior Services regulation: water temperature not greater than 110 degrees in health-care facilities.)

   (b) Check temperature of hot foods and drinks before serving and allow time to cool to a safe temperature before permitting the client to eat or drink

   (c) Monitor and supervise clients who smoke, as required

   (d) Report the malfunctioning or any problems with electrical equipment

   (e) Protect clients from overexposure to sunlight

   (f) When using a hair dryer on a client, check temperature frequently and use on lower setting to avoid any risk of burns

(g) Other

(3) Reduce risk of misidentification

(a) Check a client's identification before any procedure (Do not rely on self-identification by a client.)

(b) Report missing armband identification

(4) Other safety measures

(a) Report broken or malfunctioning equipment

(b) Ensure adequate ventilation when chemical products are being used

(c) Supervise client safety in areas around delivery, food and medication/treatment carts

(d) Store and secure cleaning products, and other potentially hazardous products out of the reach of a client

(e) Monitor confused, aggressive or agitated clients

c. Physical condition of the client

(1) Conditions increasing the risk of falls, accidents or injury to the client

(a) Immobility and/or decreased strength

(b) Mental status changes

(c) Sensory impairment

(d) Communication impairments

(e) Discomfort

(f) Other

(2) Safety measures

(a) Reduce the risk of falls and injury

i. Closely monitor clients who have been identified as high risk for falls

ii. Anticipate a client's physical needs for toileting, hydration/nutrition, repositioning, alignment and comfort to ensure that they are being met

iii. Respond promptly to a request for assistance

iv. Ensure that the client is wearing proper footwear when ambulating (skid proof bottoms, proper fit, no dangling laces)

v. Ensure proper fit of clothing so that the client's movement is not impeded

vi. Ensure that the client is using his/her glasses/eyewear, and the glasses/eyewear are clean

vii. Apply the brakes when using equipment with wheels before engaging in procedures involving the transfer or movements of clients

viii. Keep the call signal within reach (institutional) and personal belongings within reach

ix. Use safety devices, as ordered

x. Keep walkers, canes, etc., within the reach of the client

xi. Ensure proper positioning and body alignment using postural supports, as ordered

xii. Return the client's bed to its lowest position when the UAP is not working at the bedside

xiii. Provide an opportunity for the client to sit with his/her legs in a dangling position when moving from a reclining to a standing position to prevent light-headedness due to a sudden drop in blood pressure

xiv. Other

(3) Identify the behavior(s) of a client (such as wandering, rummaging, visual impairment, etc.) that increase the risk of an accident, and the level of supervision required for client safety

d. Emotional conditions: risk factors for client abuse

(1) Potential hazards for client

(a) Factors in clients associated with an increased risk of client abuse

i. Distress

(i) Physical (pain, fatigue, etc.)

(ii) Emotional (behavioral such as acting out; verbal, physical or sexual aggression; dependency; lack of support systems; stress; etc.)

ii. Substance abuse

(b) Factors in caregivers associated with an increased risk of client abuse

i. Distress

(i) Physical (pain, fatigue, etc.)

(ii) Emotional (emotional triggers, lack of support systems, stress, etc.)

ii. Substance abuse

(2) Examples of protective measures

(a) Discuss the client's behavior with the nurse, and attempt to understand the client's needs and interventions to address provoking behaviors

(b) Avoid arguing with clients

(c) Recognize stressful situations; if a feeling of anger escalates remove yourself from the area to ensure the client's safety, and report your concerns immediately

(d) Ask for assistance

(e) Be aware of the emotional needs of both the client and the caregiver

(f) Request reassignment or break/time-out from client's situation

(g) Recognize and set limits with clients

(h) Report abuse situations

(i) If client care situation presents potential for abuse, step in or get help

(j) Be an active member of a support s system to colleagues and co-worker when they are dealing with difficult clients

(k) Practice self-care

   i.   Recognized individual tress reaction

   ii. Ensure adequate rest (limit overtime, sufficient hours of sleep, etc.)

   iii. Stress reduction activities

      (i) Immediate interventions (deep breath, break, humor, etc.)

      (ii) Promoting a healthy life-style (exercise, support systems, counseling, etc.)

Unlicensed Assistive Personnel (UAP) Curriculum
Section III. Safety

B. Fire and Disasters

Enabling Objectives:

The student will:

- Describe the steps to be taken in response to a fire;
- Demonstrate or explain how to use a fire extinguisher;
- Describe the principles of evaluation; and
- Select and demonstrate the appropriate lifesaving carry for a non-ambulatory client for a given scenario.

Content Map:

III. Fire and Disasters

    A. Fire and disasters

        1. Types of possible disasters

        2. Responding to a fire emergency or disaster

            a. General policy and procedures

                (1) Ensuring immediate life safety of self and clients

                (2) Obtaining directions from the nurse in charge

                (3) Reassuring clients

                (4) Other

            b. Measures to ensure a timely and safe response

                (1) Know the location of alarms

                (2) Ensure that access to alarms and extinguishers is not blocked

                (3) Ensure that fire doors are not blocked and can close freely

                (4) Know your expected role and your assignment when responding to an alarm

                (5) Know the facility code and announcement for the location of a fire

                (6) Know the procedure for notification of the fire department (backup in institution)

                (7) Remain calm

                (8) Other

            c. Order of response to fire emergency: **R.A.C.E.**

                (1) **R** emove

                (2) **A** larm/**A**lert

                (3) **C** onfine/**C**ontain

                (4) **E** extinguish

             d. Fire extinguishers

                (1) Kinds

                (2) Use

(3) Return demonstration: **P.A.S.S.**

    (a)   **P** ull

    (b)   A im

    (c)   **S** queeze

    (d)   **S** sweep

e. Evacuations

  (1) Order (secure immediate life safety)

    (a)   Ambulatory

    (b)   Wheelchair

    (c)   Clients in bed (lifesaving carries for non-ambulatory clients/evacuation techniques: return demonstrations)

  (2) Fire zones

  (3) Removing clients from building and/or to an off-site location

    (a)   Types of off-site locations (local schools, churches, etc.)

    (b)   Supplies and records

    (c)   Addressing basic physical and emotional needs of the client

f. Fire safety considerations

  (1) Danger of smoke

    (a)   Stay low

    (b)   Block doorways

    (c)   Protective face coverings

  (2) Checking for heat before entering doorway

  (3) Elevators disengaged

  (4) Stop, drop and roll

  (5) Uses for blankets during fire emergency

    (a)   Pull out client as a fire-carry during an evacuation

    (b)   Temporary restraint during evacuation

    (c)   Suffocate flames

Recommended Content/Hour Allocation Outlines

C. Standard Precautions for Infection Control

Enabling Objectives:
The student will:

- Discuss how infections are spread;
- Describe ways to prevent the spread of infection;
- State the meaning and purpose of universal precautions;
- Provide examples of how and when universal precautions are used;
- Demonstrate hand-washing procedure;
- Identify when hand washing is necessary;
- Demonstrate the use of personal protective equipment (PPE);
- Describe the purpose of maintaining a clean environment;
- Identify materials considered hazardous waste;
- Implement safety practices in the handling of hazardous wastes;
- Describe the rules for handling clean and dirty linens;
- Describe the methods of cleaning equipment; and identify the importance of the application of friction in cleaning procedures.

Content Map:
III. Safety
    B. Standard Precaution for Infection Control
        1. Chain of infection
            a. Microorganisms
            b. Modes of transmission
            c. Signs and symptoms of infection
        2. Protecting the client and health-care worker from disease-causing organisms
            a. Hand washing (return demonstration)
                (1) Procedure
                (2) When necessary
            b. Universal precautions
                (1) Components of universal precautions
                    (a) Hand washing
                    (b) Identifying risk of exposure to blood and body fluids
                    (c) Personal Protective Equipment (PPE) – (apply and remove PPE (return demonstration): gloves, gown and mask, and/or goggles or shield)
            c. Cleanliness of the client
                (1) Personal care and hygiene
                    (a) Bathing
                    (b) Perineal care

        (c)   Hand washing

        (d)   Nail care

        (e)   Hair care – (signs and symptoms of lice infestation)

        (f)   Clothing/attire

    d. Cleanliness of environment

        (1) Importance of a clean environment

        (2) Storage and cleanliness of equipment (see number 4 below)

    e. Special infection precautions/isolation categories

        (1) Guidelines

            (a)   Respiratory isolation

            (b)   Strict

            (c)   Other

3. Hazardous waste

    a. Definition

    b. Examples

    c. General policies and procedures

4. Cleaning equipment

    a. Personal care items (disposable equipment such as bed pans, bath basins, etc.)

        (1) Rinse to remove residue

        (2) Soap, apply friction, rinse, dry and store

    b. Shared equipment (wheelchairs, shower chairs, stretchers, etc.)

        (1) Requires chemical disinfection

            (a)   Rinse and remove residue

            (b)   Apply disinfectant

            (c)   Apply friction

            (d)   Rinse

            (e)   Dry

            (f)   Store

5. Clean vs. dirty

    a. Client environment and equipment

    b. Handling clean linen

    c. Clean vs. dirty utility rooms/areas

    d. Handling and disposing of

        (1) Dirty linens

        (2) Soap, apply friction, rinse, dry and store soiled linens, incontinence pads and briefs

        (3) Soiled disposable briefs

        (4) Items from isolation unit

6. Special concerns; TB, HIV, Hepatitis B

    a. Prevalence

b. Modes of transmission

c. Means of protection

d. Follow-up post-exposure

Recommended Content/Hour Allocation Outlines

D. Body Mechanics

Enabling Objectives:

The student will:

- State the factors that are needed to maintain a health back'
- Discus the basic principles of proper body mechanics; and
- Demonstrate lifting and moving objects safely.

Content Map:

III. Safety

    D. Body Mechanics

        1. Basic anatomy of the spinal column

            a. Potential for injury

            b. Maintain a healthy back

                (1) Posture

                (2) Basic rules of body mechanics

                (3) Lifting and moving objects safely

Recommended Content/Hour Allocation Outlines

E. Emergencies

Enabling Objectives:
The student will:

- Discuss guidelines for responding to client-related emergencies;
- Indicate the importance of calling for help when discovering an emergency; and
- Demonstrate the Heimlich maneuver (for children and adults) according to AHA or ARC standards.

Content Map:
III. Safety

    E. Emergencies

        1. Define emergency

        2. Emergency preparedness and response

        3. Guidelines for handling emergencies

            a. Falls

            b. Assessing ABCs

            c. Choking

                (1) Heimlich maneuver/abdominal thrust

                (2) Respiratory

                (3) Chest pain

                (4) Shock

                (5) Cardiac arrest

Recommended Content/Hour Allocation Outlines

Section IV. Systems and Related Care

A. Musculoskeletal System

Performance objectives

Upon completion of Section IV, the student will perform personal care procedures, applying the principles of safety while protecting the client's rights.

Enabling Objectives:

The student will:

- Discuss the need for proper body alignment during range-of-motion (ROM) exercises:
- State the role of the UAP in performing ROM exercises;
- Identify the importance of encouraging maximum independence of the client with movement, transferring and ambulation activities;
- Demonstrate the following procedures, utilizing proper body mechanics, while also ensuring the client's safety and respecting the client's rights at all times:
    1) Performing ROM exercises;
    2) Turning and moving the client;
    3) Transferring the client;
    4) Utilizing a mechanical lift;
    5) Ambulating a client with assistance;
    6) Assisting a client to ambulate utilizing various forms of supportive equipment; and
    7) Transporting a client in a wheelchair or Gerichair.
- Identify client care needs to be considered when caring for clients with the following, a:
    1) Splint;
    2) Sling;
    3) Prosthesis; and
    4) Cast.
- Provide examples of musculoskeletal system changes to report to the nurse.

Content Map:

IV.   Systems and Related Care
    A.   Musculoskeletal System
        1.   Overview of anatomy and physiology
            a. Structure
                1) Bones
                2) Joints
                3) Muscles
            b. Function
            c. Age-related changes

Recommended Content/Hour Allocation Outlines

2. Common conditions/disorders
   a. Arthritis
   b. Fractures
   c. Osteoporosis
   d. Contracture
   e. Muscles wasting
   f. Loss of a limb
3. Examples of changes to report to the nurse
   a. Changes in movement
   b. Changes in posture
   c. Changes in strength
   d. Pain
   e. Other
4. Equipment related to care of the musculoskeletal system
   a. Purpose, use/operation and safety features
      1) Wheelchairs
         a) Foot rest
      2) Gerichairs
      3) Hospital bed
      4) Trapeze
      5) Mechanical lift
5. Client care needs related to musculoskeletal system
   a. Exercise/activity
      1) Multi-disciplinary tem; rehabilitative and restorative goals
         a) Plan of care
      2) Benefits of maintaining physical activity
         a) UAP activities to encourage
            i. Activity
            ii. Maximum level of functioning/independence
      3) Complications associated with inactivity and disuse
   b. Alignment
      1) Postural supports
   c. Range of motion (ROM)
      1) General guidelines
      2) Exercises
         a) Active
         b) Passive
   d. Turning and moving the client
      1) Turning the client towards you
      2) Turning the client away from you
      3) Moving client up in bed

   a) One person

   b) With assistance

  4) Moving client up in chair

   a) One person

   b) With assistance

 e. Transferring a client

  1) Bed to chair/chair to bed (pivot transfer to wheelchair)

   a) One person

   b) With assistance

  2) Mechanical lift

  3) Slideboard

 f. Ambulation

  1) Assisting with ambulation

   a) Minimal assist

   b) Maximal assist

   c) Special assistive devices

    i. Cane

    ii. Walker

    iii. Crutches

    iv. Gait/transfer belt

  2) Assisting the client who has fallen

 g. Wheelchair/Gerichair

  1) Alignment

  2) Protective devices

   a) Postural supports

   b) Foot pedals

   c) Other

  3) Safety guidelines

   a) General

   b) Transporting

 h. Splints

  1) Purpose

  2) Types

  3) Client-care needs

   a) Assisting with the application and removal

  4) Observations

 i. Slings

  1) Purpose

  2) Types

  3) Client-care needs

   a) Assisting with the application and removal

    4) Observations

j. Amputation/prostheses

    1) Types

    2) Client-care needs

        a) Assisting the client with the application of a prosthesis and stockings

        b) Storing prostheses

    3) Observations

k. Fracture/cast care

    1) General description

    2) Care guidelines

        a) Keep cast dry

        b) Do not cover the cast

        c) Turn the client as directed by the nurse

        d) Use pillows for positioning

        e) Protect client's skin from rough edges of the cast

        f) Avoid inserting anything into the cast

        g) Other

    3) Examples of changes to report to the nurse

        a) Pain

        b) Swelling

        c) Change of skin color: redness, cyanosis

        d) Pale skin

        e) Odor

        f) Numbness

        g) Temperature change of skin

        h) Drainage

        i) other

Recommended Content/Hour Allocation Outlines

B. Integumentary System

Enabling Objectives:

The student will:

- Identify signs of a pressure sore;
- Identify conditions that increase the risk of skin breakdown;
- List personal care activities that promote the care of the skin
- Describe special skin care considerations required for age-related changes in skin;
- Provide examples of integumentary system changes to report to the nurse; and
- Demonstrate the following procedures applying the principles of safety, while respecting the client's rights at all times:
    1) Bed bath;
    2) Partial bed bath;
    3) Shower;
    4) Back massage;
    5) Perineal care (including incontinence care);
    6) Hair care;
    7) Shaving;
    8) Beard care;
    9) Nail care;
    10) Foot care;
    11) Mouth care;
    12) Dressing and undressing;
    13) Transfers;
    14) Positioning; and
    15) Bed making.

Content Map:

IV.   Systems and Related Care

        B.   Integumentary System

                1.   Overview of anatomy and physiology

                        a.   Structure

                        b.   Function

                        c.   Age-related changes

                2.   Common conditions/disorders

                        a.   Pressure ulcers

                            (1) Signs

                                (a) Grading of ulcers (Stages I-IV)

                          (2) Conditions that increase the risk of skin breakdown

                                (a) Pressure

                                (b) Immobility

             (c) Compromised nutritional status

             (d) Inadequate hydration

             (e) Incontinence

             (f) Poor circulation

             (g) Other

    b. Rashes

3. General skin care

    a. Need for repositioning

        (1) Tracking position changes

    b. Keeping skin clean and dry

    c. Nutrition

    d. Hydration

    e. Preventing injuries

        (1) During transport

        (2) Alignment

        (3) Protective devices and equipment

            (a) Bed cradle

            (b) Footrests

            (c) Foam cushions

            (d) Specialized beds and mattresses

                i. Eggcrate/foam

                ii. Alternating air pressure

                iii. Water other

            (e) Positioning devices

                i. Pillows

                ii. Wedges

                iii. Cushions

                iv. Other

    f. Inspecting pressure points

    g. Considerations when working with the elderly

        (1) Less frequent bathing

        (2) Soap

            (a) Use moisturizing soap

            (b) Use less soap

            (c) Ensure removal of soap residue

4. Examples of changes to report to the nurse

    a. Bruising (patterns)

    b. Rashes

    c. Open areas

    d. Draining, bleeding

    e. Skin temperature

  f. Pain/discomfort

  g. Other

 5. Client-care procedures related to integumentary system

  a. Personal hygiene

   (1) Purpose

   (2) Benefits

    (a) Emotional

    (b) Physical

   (3) General guidelines

    (a) Safety considerations

    (b) Comfort

     i. Environmental conditions

      (i) Preventing hypothermia

    (c) Ensuring rights: privacy and dignity

   (4) Procedures

    (a) Bed bath

    (b) Partial bed bath

    (c) Shower

    (d) Back massage

    (e) Perineal care (male and female; include incontinence care)

    (f) Hair care

     i. Types of hair

     ii. Styling needs

      (i) Preferences,

       ▪ ethnically appropriate preferences

     iii. Daily hair care

     iv. Shampooing (shower and bed)

    (g) Shaving

    (h) Beard care

    (i) Nail care,

     i. special consideration in diabetic client

    (j) Mouth care

     i. Oral hygiene

     ii. Denture care

     iii. Unconscious client

    (k) Dressing and undressing

    (l) Morning care

  b. Positioning

   (1) Sitting

           (2) Supine

           (3) Lying on one side or the other

           (4) Prone

           (5) Fowler's

  c. Bed making

           (1) General guidelines

                (a) Universal precautions when handling linens

                      i.   Clean

                      ii.   Soiled

           (2) Procedures

                (a) Unoccupied

                      i.   Closed bed

                      ii.   Opened bed

                (b) Occupied bed

Recommended Content/Hour Allocation Outlines

C. Upper Gastrointestinal System

Enabling Objectives:

The student will:

- Give examples of foods contained in each of the groups that comprise the food pyramid;
- Give examples of foods that would be included or restricted in selected therapeutic diets;
- Provide examples of upper gastrointestinal system changes to report to the nurse;
- Provide example of assistive devices used to encourage self-feeding;
- Identify the importance of reporting changes in the client's weight;
- Identify activities that promote appetite; and
- Demonstrate the following procedures applying the principles of safety, while respecting the client's rights:
  1) Prepare the client for mealtime;
  2) Set up and provide assistance with meals and feeding, and assist with feeding;
  3) Feed the dependent client;
  4) Measure, report and record intake (food and fluid);
  5) Measure and record height; and
  6) Measure and record weight.

Content Map:

IV.   Systems and Related Care

        C.   Upper Gastrointestinal System

              1.   Overview of anatomy and physiology

                  a.   Structure

                  b.   Function

                  c.   Age-related changes

              2.   Common conditions/disorders

                  a.   Obesity

                  b.   Anorexia

                  c.   Needs assistance with feeding

                  d.   Dysphagia

                  e.   Vomiting

                  f.   Heartburn

              3.   General care

                  a.   Nutrition

                        1)   Nutrients

                        2)   Metabolism

                        3)   Food pyramid

                        4)   Hydration/fluids

                  b.   Nutrition across the life-span (brief overview)

                        1)   Infant

2) Toddler

3) Preschool

4) School-age

5) Adolescent

6) Adult

7) Elderly

c. Factors affecting nutrition

1) Finances

2) Cultural/religious

3) Allergies

4) Preferences

5) Dentition

6) Swallowing abilities

7) Emotional stress

8) Tissue repair

9) Physical limitations

10) General health and illness

11) Dietary restrictions

12) Activity

13) Environment

d. Therapeutic diets

1) Clear liquid

2) Full liquid

3) Soft

4) Pureed

5) Regular

6) Diabetic

7) Low fat/low cholesterol

8) Sodium restriction

9) Thickened fluids

10) Special diets

a) Supplemental nutrition

e. Alternative nutrition sources

1) Tube feedings

2) Intravenous fluids

a) Hyperalimentation

4. Examples of gastrointestinal changes to report to the nurse

a. Difficulty chewing

b. Difficulty swallowing

c. Vomiting

d. Changes in appetite or eating habits

  e. Weight loss or gain

  f. Discomfort in chest or abdomen

  g. Other

5. Promoting appetite at mealtime

  a. Address elimination and hygiene needs

  b. Ensure proper positioning

  c. Adjust environmental conditions

   1) Noise

    a) Benefits of music

    b) Odors

    c) Visual distractions: exposed dressings, drainage bags, etc.

    d) Other

  d. Provide for social needs

6. Promoting independence with feeding

  a. Assistive/adaptive devices

7. Client-care procedures related to upper GI system

  a. Prepare the client for mealtime

  b. Set up and provide assistance with meal and feeding

  c. Feed dependent client

  d. Measure, report and record intake (fluid and food)

  e. Measure and report height

  f. Measure and report weight

Recommended Content/Hour Allocation Outlines

D. Lower Gastrointestinal System

Enabling Objectives:

The student will:

- Provide examples of lower gastrointestinal system changes to report to the nurse;
- Identify measures that encourage bowel movements; and
- Demonstrate the following procedures applying the principles of safety, while respecting the client's rights;:
    1. Assist a client with a bedpan, urinal and commode;
    2. Collect a stool specimen;
    3. Provide perineal care
    4. Provide care for incontinence; and
    5. Apply/change a protective brief and pad.

Content Map:

IV.   Systems and Related Care

      D. Lower Gastrointestinal System

            1. Overview of anatomy and physiology

                a. Structure

                b. Function

                    (1) Transport

                    (2) Absorption

                    (3) Elimination

                c. Age-related changes

            2. Common conditions/disorders

                a. Incontinence

                b. Constipation

                c. Impaction

                d. Flatulence

                e. Diarrhea

                f. Ostomy

                g. Hemorrhoids

                h. Hepatitis

            3. General care

                a. Elimination

                    (1) Factors affecting bowel elimination

                        (a) Privacy

                        (b) Disability/functional ability

                        (c) Aging

                        (d) Diet

                        (e) Fluids/hydration

   (f) Activity

   (g) Medications

   (h) Timing and opportunity

  b. Promoting regularity (include concept of bowel and bladder training)

   (1) Provide opportunity

   (2) Provide privacy

   (3) Hydration

   (4) Diet/fiber

   (5) Activity

4. Examples of gastrointestinal changes to report to nurse

  a. Vomiting

  b. Changes in stool (e.g., blood, colored mucus)

  c. Diarrhea

  d. Discomfort during elimination

  e. Abdominal discomfort

  f. Other

5. Client-care procedures related to lower GI system

  a. Assist client with bedpan, urinal and commode

  b. Obtain stool specimen

  c. Provide perineal care

  d. Provide care for incontinence

  e. Apply-change protective pad and brief

  f. Report and record bowel elimination

  g. Ostomy care

Recommended Content/Hour Allocation Outlines

E. Urinary System

Enabling Objectives:

The student will:

- Provide examples of urinary system changes that must be reported;
- Discuss the need and method for maintaining or attaining adequate fluid hydration;
- Explain general care guidelines to be followed for the client with an in-dwelling and external catheter;
- Discuss the emotional needs of the client experiencing incontinence; and
- Demonstrate the following procedures applying the principles of safety, while respecting the client's rights:
    1. Provide external catheter care;
    2. Apply external catheter;
    3. Provide in-dwelling catheter care;
    4. Assist the client with the bedpan, urinal, commode;
    5. Provide perineal care;
    6. Provide care for incontinence;
    7. Apply/change protective brief and pad;
    8. Collect a urine specimen; and
    9. Measure and record intake and output

Content Map

- E. Urinary System
    1. Overview of anatomy and physiology
        a. Structure
        b. Function
        c. Age-related changes
    2. Common urinary tract disorders
        a. Cystitis/UTI
        b. Renal failure/dialysis
        c. Decreased urinary output
            (1) Fecal impaction
            (2) Medications
            (3) Decreased fluid intake
        d. Incontinence
            (1) Definition
            (2) Causes
                (a) Aging
                (b) Confusion
                (c) Medications
                (d) Physical limitations

(e) Prostate problems (men)

(f) Prolapsed bladder/uterus (women)

(g) Spinal cord injury

(h) Fecal impaction

(i) Central nervous system disorder

3. Examples of urinary changes to report to the nurse

   a. Abnormal appearance of urine

   b. Complaints of urgency, frequency, pressure in area of bladder, burning or difficult y urinating

   c. Change in amount of urinary output (increase/decrease)

   d. Change in odor: fruit y or foul

   e. Changes in clarity, color and/or consistency

4. General care related to the urinary system

   a. Encouraging urinary elimination

      (1) Ensuring adequate hydration

      (2) Providing opportunities for voiding

         (a) Respond promptly to requests for assistance

   b. Reduce risk of UTI

      (1) Adequate hydration/encourage fluids

      (2) Avoid retention by routinely offering opportunities for elimination

      (3) Encourage activity out of bed (OOB)

      (4) Ensure perineal care/hygiene

      (5) Other

   c. Incontinence

      (1) Effects

         (a) Physical

         (b) Emotional

            i. Sensitivity of UAP

            ii. Treat client with dignity

            iii. Avoid calling incontinence briefs "diapers"

            iv. Do not scold client for incontinence

      (2) Needs

         (a) Reduce risk of skin breakdown (refer to text in Section IV. B)

         (b) Opportunities for routine toileting (if appropriate/possible)

            i. Bladder retraining

            ii. Indications

            iii. Procedures

5. Client-care procedures related to urinary system

Recommended Content/Hour Allocation Outlines

    a. Provide fluid intake/hydration
    b. Assist client with use of bedpan, urinal and commode
    c. Provide perineal care
    d. Provide care for incontinence
    e. Apply/change protective brief and pad
    f. Collect urine specimen
    g. Measure and record fluid intake and output
    h. Provide catheter care: in-dwelling and external catheter
        (1) General care and guidelines
        (2) Empty collection bag
        (3) Proper techniques for changing and caring for leg and bed bags.

Recommended Content/Hour Allocation Outlines

F. Cardiovascular and Respiratory Systems

Enabling Objectives:

- Provide examples of cardiovascular changes to report to the nurse;
- Provide examples of respiratory changes to report to the nurse;
- Demonstrate the following procedures applying the principles of safety while respecting the client's rights:
    1) Measure and report body temperature;
    2) Count and report pulse; and
    3) Apply antiembolism stockings.
- Identify normal ranges for temperatures, pulse and respiration; and
- Identify locations on the body where the pulse can be taken.

Content Map

F. Cardiovascular/Respiratory Systems
   1. Overview of anatomy and physiology
      a. Structure
      b. Function
      c. Age-related changes
   2. Common conditions/disorders
      a. Heart attack
      b. Angina
      c. Pacemaker
      d. AICD (Automatic Internal Cardiac Defibrillator)
      e. ASHD (Arterial Sclerotic Heart Disease)
      f. Stroke (brain injury)
      g. Cardiac bypass
      h. Heart failure
      i. Chronic obstructive pulmonary disease: emphysema and asthma
      j. Tuberculosis
      k. Blood clots (lungs, legs, brain)
   3. Examples of cardiovascular or respiratory changes to report to the nurse
      a. Swelling
      b. Weight gain (gain or lose three pounds or more in three days or less)
      c. Shortness of breath
      d. Changes in skin color
      e. Restlessness, confusion, anxiety
      f. Changes in vital signs
      g. Changes in sputum (amount, color or consistency)
      h. Change in temperature of extremities
      i. Sweating

      j.   Chest pain/pressure

      k.   Other

4. General care related to the cardiovascular and respiratory systems

      a.   Activity level

         (1) According to plan of care

         (2) Pacing activities according to energy reserves

             (a)   Balance rest periods with periods of activity

         (3) Report changes to the nurse

      b.   Positioning for comfort

         (1) Respiratory

         (2) Circulatory

      c.   Oxygen

         (1) Equipment

             (a)   Delivery systems

                 i.   Tanks

                 ii.   Liquid

                 iii.   Concentrator

             (b)   Cannula/masks

             (c)   Humidification

         (2) Safety considerations

         (3) Related skin care

      d.   Monitoring vital sighs: (TPR) temperature, pulse and respiration

         (1) Purposes

         (2) Normal ranges and characteristics

         (3) Factors that can cause changes

         (4) Changes and characteristics to report to the nurse

5. Client-care procedures related to cardiovascular/respiratory systems

      a.   Vital signs

         (1) Measure and record body temperature

             (a)   Oral

             (b)   Rectal

             (c)   Axillary

             (d)   Tympanic

         (2) Count and record pulse

             (a)   Locations where pulses can be taken

         (3) Count and record respirations

      b.   Apply antiembolism stockings (daily removal; skin inspection)

Recommended Content/Hour Allocation Outlines

G. Neurological System

Enabling Objectives:

The student will:

- Provide examples of neurological system changes to report to the nurse;
- Give examples of special client-care needs for clients with the following disorders; and
    1) A stroke – Cerebral Vascular Accident (CVA);
    2) Confusion (Alzheimer's/dementia); and
    3) Seizure disorders.
- Identify safety considerations when caring for clients with selected neurological impairments.

Content Map:

G. Neurological system
1. Overview of anatomy and physiology
    a. Structure: central nervous system
        (1) Brain
        (2) Spinal cord
    b. Functions
    c. Age-related changes
2. Common conditions/disorders
    a. Stroke (brain injury)
    b. Seizure disorder/epilepsy
    c. Trauma (head and spinal cord injury)
    d. Alzheimer's/dementia/delirium
    e. Parkinson's
    f. Multiple sclerosis
3. Examples of neurological changes to report to the nurse
    a. Confusion
    b. Change in ability to communicate
    c. Weakness/paralysis/tremors
    d. Agitation/restlessness
    e. Seizures
    f. Difficulty swallowing
    g. Other
4. Client care related to the neurological system
    a. Care needs of the client with cognitive impairment (*3C's*)
        (1) Communication needs; simple directions, repetition, calm tone
        (2) Caution: maintain a safe environment and conduct more frequent monitoring

(3) Comfort: assist with activities of daily living (ADL), anticipate needs and ensure physical needs are met (e.g., elimination, hydration, repositioning, nutrition, etc.)

b. Care of the client with a seizure disorder

(1) Protective needs

(2) Responding to a seizure

c. Care of the client following a stroke (brain injury)

(1) Rehabilitation/restorative

(a) Multidisciplinary approach; plan of care

i. Encouraging independence (ability not disability

ii. ADL

(i) Feeding

- Swallowing precautions (*relate to text concerning feeding in Section IV. C.*)
- Positioning
- Mobility
- Maintaining muscle strength and movement (range of motion exercises (ROM

iii. Communication

d. Safety and care considerations for clients experiencing difficulty with coordination or balance.

Recommended Content/Hour Allocation Outlines

H. Endocrine System

Enabling Objectives
The student will:

- List symptoms of diabetes;
- List the symptoms of hypoglycemia and hyperglycemia;
- Describe the emergency treatment of hypoglycemia; and
- Discuss the special care needs of the client with diabetes including
  1) Foot care;
  2) Skin care, and
  3) Nutrition

Content Map
H. Endocrine
  1. Overview of anatomy and physiology
      a. Structure
          (1) Endocrine glands and hormones
      b. Function
      c. Age-related changes
  2. Common conditions/disorders
      a. Thyroid disorders
      b. Diabetes
          (1) Types
          (2) Symptoms (hyperglycemia)
  3. Examples of changes to report to the nurse
      a. Hypoglycemia
          (1) Causes
              (a) Too little food or skipped meals
              (b) Too much activity
              (c) Too much diabetes medication
          (2) Symptoms
              (a) Confusion
              (b) Shakiness
              (c) Sweating
              (d) Fatigue
              (e) Hunger
              (f) Irritability
              (g) Rapid heart beat
              (h) Loss of consciousness

(i) "Hypoglycemia unawareness" – identify client's symptoms experienced in previous hypoglycemic episodes

(3) Emergency response

    (a) Report signs and symptoms to nurse <u>immediately</u>

    (b) Nurse may direct UAP to feed <u>conscious</u> client a food source of sugar or protein:

        i. Sugar sources, such as orange juice, sugar cubes, milk, candy

        ii. Protein sources, such as peanut butter and crackers, a cheese sandwich, cereal and milk

(4) Client care related to endocrine system

    (a) Diabetic care

        i. Foot care (risk of amputation)

        ii. Skin care

        iii. Nutrition

            (i) Failure to follow individualized diet plan

Recommended Content/Hour Allocation Outlines

I. Reproductive System

Enabling Objectives:

The student will:

- Provide examples of reproductive system changes to report to the nurse.

Content Map:

I. Reproductive System

    1. Overview of anatomy and physiology

        a. Structure

            (1) Male

            (2) Female

        b. Function

            (1) Male

            (2) Female

                (a) Menstruation

                (b) Pregnancy

                (c) Menopause

    2. Common conditions/disorders

        a. Male

            (1) Disorders of prostate

            (2) Cancer of the testes

        b. Female

            (1) Menstrual irregularities

            (2) Fungal infections

            (3) Benign and malignant tumors of the uterus, breast and ovaries

        c. Male and female

            (1) Sexually transmitted diseases (STD)

            (2) Gonorrhea

            (3) Syphilis

            (4) Herpes

            (5) HIV

            (6) Other

    3. Examples of changes that must be reported to the nurse

        a. Changes in appearance of genitalia

        b. Bleeding/discharge

        c. Complaint of pain/burning when urinating

        d. Decrease in urine output

Recommended Content/Hour Allocation Outlines

J. Immune System

Enabling Objectives:

The student will:

- Indicate the difference between the terms human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS);
- Provide examples of changes in the AIDS client to report to the nurse;
- Discuss factors that contribute to the development of cancer;
- List at least four of the seven warning signs of cancer;
- Discuss the three common treatments for cancer; and
- Provide examples of changes in the client with cancer to report to the nurse.

Content Map:

IV. Systems and Related Care
  J. Immune System
    1. Overview of anatomy and physiology
       a. Structure
       b. Function
       c. Age-related changes
    2. Common conditions/disorders
       a. HIV/AIDS
          (1) Definition
          (2) Transmission
          (3) Prevention of infection
          (4) Progression of HIV infection
          (5) Examples of change to report to the nurse:
             (a) Fever
             (b) Changes in eating habits
             (c) Weight loss
             (d) Skin breakdown
             (e) Confusion/agitation
             (f) Pain in mouth or swallowing or changes in oral mucosa such as white patches
             (g) Other
       b. Cancer
          (1) Definition
             (a) Uncontrolled growth of abnormal cells in the body tissues and organs
             (b) Interference with normal body function

(c) Common sites: skin, lungs, colon, rectum, breast, prostate, uterus

(2) Terminology

    (a) Tumor

    (b) Benign

    (c) Malignant

    (d) Metastasis

(3) Contributing factors

    (a) Family history

    (b) Exposure to radiation or certain chemicals

    (c) Environmental factors

    (d) Smoking

    (e) Alcohol

    (f) Food additives

    (g) Exposure to certain viruses

(4) Seven warning signs of cancer (CAUTION)

    (a) **C:** change in bowel or bladder function

    (b) **A:** a sore that does not heal

    (c) **U:** unusual bleeding or discharge

    (d) **T:** thickening or lump in breast or elsewhere

    (e) **I:** indigestion or difficulty swallowing

    (f) **O:** obvious changes in a wart or mole

    (g) **N:** nagging cough or hoarseness

(5) Treatments

    (a) Surgery

    (b) Radiation therapy

    (c) Chemotherapy

(6) Examples of changes to report to the nurse

    (a) Decreased appetite, constipation, nausea, vomiting, diarrhea

    (b) Bleeding

    (c) Changes in weight

    (d) Complaints of pain, discomfort and/or dysfunction

    (e) Behavioral changes

    (f) Activities that cause discomfort

3. General care of the client related to the immune system

    a. Emotional needs of the client (refer to text in Section II. D.)

    b. Protect client from infection

    c. Protect skin

        (1) Keep skin clean and dry

        (2) Repositioning, as tolerated

    d.   Keep mouth clean and encourage fluids

    e.   Provide nourishment, small quantities frequently if client has lost appetite

    f.   Balance need for rest and essential and meaningful activities

        (1) Considerations of energy reserves

        (2) Pain management considerations

    g.   other

Recommended Content/Hour Allocation Outlines

K. Rest and Sleep

Enabling Objectives:
The student will:

- Describe the function of rest and sleep for the client;
- Identify interventions that promote rest and sleep for the client; and
- Describe activities included in evening care.

Content Map:
IV.   Systems and Related Care
      K.   Rest and Sleep
          1.   Purpose
              a.   Renew physical energy
              b.   Renew mental energy
          2.   Characteristics of sleep
              a.   Body system changes
                  (1) Consciousness partially or completely interrupted
                  (2) Decreased body functions
                      (a) TPR decrease
                      (b) Kidneys are less productive (ADH)
                      (c) Digestive secretions diminish and peristalsis slows
                      (d) Muscles relax
                      (e) Basal metabolic rate decreases
                      (f) Reflexes (except coughing) weaken or disappear
                  (3) Stages of sleep (rapid eye movement (REM))
              b.   Factors affecting/causing sleep disturbances
                  (1) Napping patterns: napping may be important for the elderly as sleep patterns change during the night; however, napping also can increase the chances of developing a problem with insomnia
                  (2) Physical/medical conditions
                      (a) Alzheimer's: sundown syndrome
                      (b) Pain
                      (c) Frequent urination
                      (d) Coughing
                      (e) Medications
                      (f) Other
                  (3) Emotional/psychological
                      (a) Depression is a common cause of sleep disturbances
                      (b) Nightmares/fears (fear of dying, heart attack, etc.)

(c) Bereavement

(4) Environmental: lack of restful environment

(5) Diet

c. Effects of lack of sleep (50% of the elderly who are over 60 report sleep disturbances)

(1) Fatigue

(2) Irritability

(3) Increased sensitivity to pain

(4) Slower healing

(5) Lethargy

(6) Distress

(7) Emotional lability

3. Promoting sleep

a. Evening care

(1) Physical needs

(a) Elimination/toileting

(b) Personal hygiene

i. Partial bath or perineal care as needed

(i) Lifetime rituals – evening bath or shower

ii. Opportunity to wash hands and face

iii. Mouth care

(c) Bed padding (incontinence)

(d) Undressing and assisting into attire for sleeping

(e) Backrub

(f) Assist to position of comfort, adjusting pillows and covers as needed (provide for warmth if cold, make necessary environmental adjustments)

(2) Emotional needs

(a) Reassurance of the availability of staff members

(b) An opportunity to verbalize closure of each day, and to have someone say goodnight

(c) Emotional security of caring gestures with bedtime rituals such as rubbing head to soothe; "tucking in" or holding a hand for a few moments, etc.

(3) Environmental considerations

(a) Signal/bell/call light secured and accessible to client

(b) Adjust lighting

(c) Adjust noise level

Recommended Content/Hour Allocation Outlines

L. Death and Dying

Enabling Objectives:

The student will:

- Identify the physical and emotional needs of the dying client;
- Discuss the role for the UAP in addressing the emotional and physical needs of the terminally ill client;
- Describe the physical signs and changes that occur as death approaches;
- Provide an example of the client Self-Determination Act; and
- Demonstrate the procedure for postmortem care

Content Map:

IV.   Systems and Related Care

      L.   Death and Dying

          1.   Terminal illness

              a.   Responding to the needs of the client and family

                  (1) Physical needs

                      (a) Sensory

                      (b) Communication

                      (c) Oral hygiene

                      (d) Skin care

                      (e) Nutritional and hydration

                      (f) Comfort

                      (g) Elimination

                    (2) Emotional needs (refer to text of Section II.D. re: grieving)

                      (a) Influences

                          i.   Life experience

                        ii.   Age

                        iii.   Culture

                        iv.   Religious/spiritual beliefs

                        v.   Resources, including support systems

                        vi.   Pain/physical discomfort

                      (b) Quality of life

                        i.   Self-defining

                          (i) Maintaining a sense of control

                        (ii) Addressing unfinished business or last wishes

                            ▪ Permission to "let go"

                      ii.   Pain management

                      iii.   Legal issues

Recommended Content/Hour Allocation Outlines

           (i) Self-Determination Act
- Advance directives
- Living will
- Do-not-resuscitate order

    b. Role of hospice care

2. Signs of impending death
3. Postmortem care

    a. Cultural/religious considerations

Recommended Content/Hour Allocation Outlines

Appendix A

Responsibility of the Agency to the Homemaker-Home Health Aide

A. Licensed home-care agency or facility is to provide the following:

1. Compliance with federal and state employment laws;
2. Mandatory taxes to be withheld;
3. Mandatory in-services for the homemaker-home health aide;
4. Job description;
5. Personnel policies;
6. Identify service policies and procedures; and
7. Policies on client/family/homemaker-home health aide confidentiality

B. Supervision by a professional registered nurse

1. Client-specific Plan of Care

Appendix B

Recommended Content/Hour Allocation Outlines

I. UAP Curriculum Content Outline

I. UAP Curriculum Content Outline			Hours
Section I		Introduction to the role of the UAP in nursing care settings	2.00
Section II		Foundations for working with people	6.00
Section III		Safety	
	A	Conditions	1.50
	B	Fire	2.00
	C	Standard Precautions for Infection Control	2.00
	D	Body Mechanics	0.50
	E	Emergencies	1.50
Section IV		Systems and Related Care	
	A	Musculoskeletal	6.00
	B	Integumentary System	9.75
	C	Gastrointestinal System: Upper	4.00
	D	Gastrointestinal System: Lower	2.00
	E	Urinary System	3.00
	F	Cardiovascular and Respiratory System	4.00
	G	Neurological System	0.75

Recommended Content/Hour Allocation Outlines

H	Endocrine System		1.00
I	Reproductive System		1.00
J	Immune System		1.00
K	Rest and Sleep		0.50
L	Death and Dying		1.50
		Classroom Hours	50.00
		Clinical/Laboratory Hours	16.00
		Curriculum Total	66.00
	Training of UAP transferring from another setting i.e. NA or H-HHA		
Step 1	Establish Competency of Knowledge and Skills by facility.		
Step 2	Optional: Knowledge and Skill Competency remediation plan.		
Step 3	Module (institutional, LTC or Home Care)		
Step 4	Competency testing and application to state registry (as applicable: NA or H-HHA)		

II. Home Care/Hospice Recommended Hour Allocation Outline

II. Home Care/Hospice Recommended Hour Allocation Outline	Hours
UAP Curriculum Classroom Hours	50.00
UAP Curriculum Clinical/Laboratory Hours	16.00
UAP Curriculum - Total Course Hours	66.00
Home Care - Module Hours	10.00
Curriculum Total	76.00
Training of UAP transferring from another setting with Home Care Module	
Step 1 Establish Competency of Knowledge and Skills by facility.	
Step 2 Optional: Knowledge and Skill Competency remediation plan.	
Step 3 Home Care Module	
Step 4 Agency Competency testing, H-HHA Application and CBI	

III. Long Term Care Recommended Hour Allocation Outline

III. Long Term Care Recommended Hour Allocation Outline	Hours
UAP Curriculum Classroom Hours	50.00
UAP Curriculum Clinical/Laboratory Hours	16.00
UAP Curriculum - Total Course Hours	66.00
Long Term Care - Module Hours	6.00
Long Term Care - Clinical Hours	18.00
Long Term Care - Total Module Hours	24.00
Total Course Hours	90.00
Training of UAP transferring from another setting as NA with LTC Module	
Step 1 Establish Competency of Knowledge and Skills by facility.	
Step 2 Optional: Knowledge and Skill Competency remediation plan.	
Step 3 Long Term Care Module	
Step 4 Agency Competency testing, H-HHA Application and CBI	

Appendix C

Unlicensed Assistive Personnel Core Curriculum

Checklist for Demonstration of clinical Skill Competencies

Directions:

When the Unlicensed Assistive Personnel (UAP) completes the theory and clinical components of the UAP CORE Curriculum, the instructor may use the Clinical Skills Competency Checklist to validate the UAP's knowledge and clinical skill application.

Validation of the UAP's clinical competencies is required for the UAP to:

1. Demonstrate safe execution of selected nursing tasks which the Registered Professional Nurse may delegate for client care in acute care, long-term care and home health care/hospice care settings.
2. Successfully complete the UAP CORE Curriculum.

The CORE Curriculum requirement for the UAP to successfully validate his or her clinical skills is the achievement of 100% of the competencies listed in the Clinical Skills Checklist within 12 months of commencing the UAP CORE Curriculum Program, and with the understanding that remediation will be necessary if any item on the Clinical Skills Checklist is failed three times.

UAP CORE Curriculum

Student's Name: _____

                         Last   First   Middle

Course Dates: _____

Checklist for Clinical Skill Competencies

Instructions: The student must demonstrate competency in the skills listed below. The skills listed below are **required skills** must be demonstrated on an individual in a supervised practical training setting[1] The skills listed as **recommended skills** may have competency demonstrated in the classroom or lab setting.

Required Skills	Pass Date (Instructor's Initials)	Fail Date (Instructor's Initials)	Required Skills	Pass Date (Instructor's Initials)	Fail Date (Instructor's Initials)
1. Hand washing			12. Pivot Transfer		
2. Applying and removing gloves			13. Assist client to ambulate		
3. Bed bath			14. Feed dependent client		
4. Assist client to shower			15. Backrub/skin care		
5. Routine mouth care			16. Incontinence/perineal care		
6. Denture Care			**Recommended Skills**		
7. Shave			1) Measure and record I&O		
8. Bed making 9. □ Unoccupied □ Occupied			2) Indwelling catheter care		
			3) Empty catheter drainage bag		
10. Move and position client in bed			4) Apply a condom catheter		
11. Range-of-Motion exercises			5) Collect a urine specimen		

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[1] "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of an RN.

17. Assist with elimination: □ Bedpan □ Urinal			6) Apply and remove personal protective equipment □ Gown □ Mask/Shield/Goggles			
18. Vital Signs: □ Temperature □ Pulse □ Respirations			7) Shampoo hair in bed			
			8) Apply antiembolism hose			
19. Fingernail care			9) Transfer client with mechanical lift			
20. Foot care			10) Mouth care for unconscious or debilitate client			

Theory Instructor(s):

Instructor's signature (1): _____   Instructor's signature (2): _____

Student's signature _____   Date: _____

Clinical Instructor(s):

Instructor's signature (1): _____   Instructor's signature (2): _____

Student's signature _____   Date: _____

Appendix D

Skills Laboratory Equipment List:

Equipment	Number of items	Comments
1. Adult scale		
2. Alternating mattress or the like, egg crate mattress		
3. Assistive devices/equipment (e.g. extension stick, sock donner, button loop		
4. Bedpan (regular and fracture pan)		
5. Cane		
6. Catheter equipment (tubing, drainage bags, leg bags)		
7. Colostomy/ileostomy equipment		
8. Commode		
9. Crutches		
10. Enteral feeding equipment		
11. Feeding utensils (e.g. plate guard, rocking spoon)		
12. Gowns/gloves/masks/face shields		
13. Hi-rise toilet seat		
14. Hospital bed		
15. Hoyer lift		
16. Infant/child equipment (e.g. bathtub, formula, scale, hi-chair)		
17. Old clothes for practice with dressing and donning		
18. Over-the-bed table		

Equipment	Number of items	Comments
19. Oxygen equipment (nasal cannula, mask, tank, concentrator)		
20. Personal care items (e.g. emesis & bathing basins, toothettes, denture cups combs)		
21. Shower chair/bench/hand rail		
22. Sink (for hand washing RDC)		
23. Slide board		
24. Slings/immobilizers (e.g. leg immobilizer, ace wraps)		
25. Thermometer (electronic)		
26. Transfer belt		
27. TV, AV equipment		
28. Urinal		
29. Walker(e.g. rolling, platform		
30. wheelchair		