Role of the Nursing Assistant

Nursing assistants are the **first line of defense** against skin breakdown. Because you provide daily handson care, you are the first to notice early changes and the first to act to prevent pressure injuries.

Why Skin Integrity Matters

- Pressure injuries can develop in **1–2 hours**.
- Skin breakdown increases risk of **infection, pain, hospitalization, and loss of mobility**.
- Prevention is a **regulatory requirement** and essential to quality care.
- Early reporting prevents minor issues from becoming serious wounds.

Daily Skin Observation

- Check skin during bathing, dressing, toileting, and repositioning.
- Focus on **bony areas**: heels, sacrum, hips, elbows, ankles, shoulder blades.
- Watch for redness, nonblanching areas, warmth, firmness, moisture irritation, tears, or pain.

Repositioning & Offloading

- Reposition **every 2 hours** in bed; **every 1 hour** in a chair.
- Use pillows, wedges, heel protectors.
- Keep heels **floating** when possible.
- Avoid lying directly on the hip bone.

Moisture Management

- Clean and dry skin promptly after incontinence.
- Apply barrier creams as directed.
- Change wet linens or clothing immediately.

Nutrition & Hydration

- Encourage fluids and meals unless restricted.
- Report poor intake or difficulty eating.

DeviceRelated Skin Protection

Check under/around: oxygen tubing, splints, braces, compression devices, catheter straps, IV tubing, masks/cannulas.
Report redness or indentations.

Reporting & Documentation

Report immediately: nonblanching redness, tears, blisters, open areas, pain at pressure points, moisture irritation.
Document: repositioning, observations, care provided, and what was reported.

When to Notify the Nurse Immediately

- Redness that does not fade when pressed
- Warm, firm, or mushy skin
- Any open wound
- New or worsening pain
- Signs of infection (odor, drainage, swelling)

True/False Competency Quiz — Circle the Correct Answer

1. Redness that does not blanch (turn white) when pressed must be reported immediately.
   Circle one: True / False
2. If a patient can move independently, routine skin checks are not necessary.
   Circle one: True / False
3. Moisture from urine, stool, or sweat increases the risk of skin breakdown.
   Circle one: True / False
4. Skin concerns should be reported at the end of the shift unless they are severe.
   Circle one: True / False
5. Pressure injuries can develop even when the skin looks intact on the surface.
   Circle one: True / False

Score__________

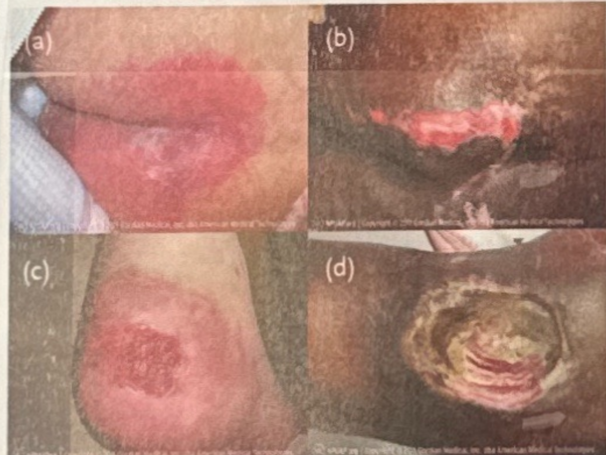
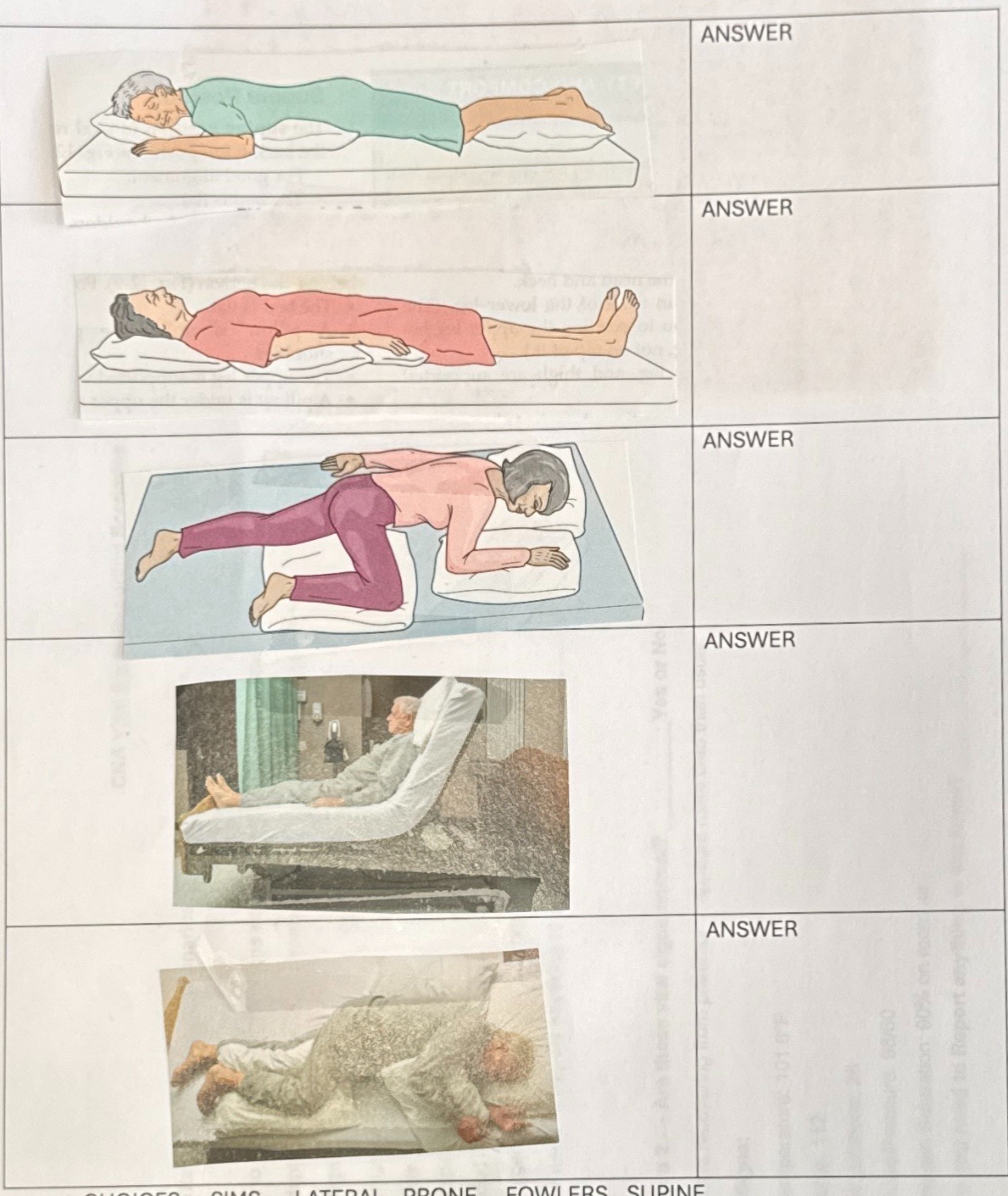


Fig. 13-3. Pressure injury stages in photos as described by the National Pressure Ulcer Advisory Panel (NPUAP):
(a) Photo of a Stage 1 pressure injury on the buttocks.
(b) Photo of a Stage 2 pressure injury on the buttocks.
(c) Photo of a Stage 3 pressure injury on the heel.
(d) Photo of a Stage 4 pressure injury on the foot.
(PHOTOS COPYRIGHT © NATIONAL PRESSURE ULCER ADVISORY PANEL, NPUAP.ORG, USED WITH PERMISSION. ALL PHOTOGRAPHS ARE REPRINTED WITH PERMISSION OF THE COPYRIGHT HOLDER, CORDIAN MEDICAL, INC. DBA AMERICAN MEDICAL TECHNOLOGIES)

POSITIONING (MATCH THE CORRECT BODY POSITION WITH THE PHOTO)



CHOICES: SIMS LATERAL PRONE FOWLERS SUPINE

CNA Vital Signs Reporting Scenarios

Scenario 1 – Are these vital signs normal? __________Yes or No

A resident finishing morning care reports feeling light-headed/dizzy when standing.

Vital Signs:

- Temperature: 98.4°F
- Pulse: 82
- Respirations: 18
- Blood Pressure: 128/76
- Oxygen Saturation: 97% on room air

Do you need to Report anything to the nurse? ____________________

Scenario 2 - – Are these vital signs normal? __________Yes or No

A resident recovering from pneumonia appears more tired than usual.

Vital Signs:

- Temperature: 101.6°F
- Pulse: 112
- Respirations: 26
- Blood Pressure: 98/60
- Oxygen Saturation: 90% on room air
- **Do you need to Report anything to the nurse?** ____________________

Ranges for Adult Vital Signs

Temp. Site	Fahrenheit	Celsius
Mouth (oral)	97.6°–99.6°	36.4°–37.6°
Rectum (rectal)	98.6°–100.6°	37.0°–38.1°
Armpit (axillary)	96.6°–98.6°	35.9°–37.0°
Ear (tympanic)	96.6°–99.7°	35.9°–37.6°
Temporal Artery (forehead)	97.2°–100.1°	36.2°–37.8°

Normal Pulse Rate: 60–100 beats per minute
Normal Respiratory Rate: 12–20 respirations per minute

Blood Pressure

Category		
Normal	Systolic Diastolic	90–119 mm Hg *and* 60–79 mm Hg
Low (hypotensive)	Systolic Diastolic	Below 90 mm Hg *or* Below 60 mm Hg
Elevated	Systolic Diastolic	120–129 mm Hg *and* Less than 80 mm Hg
Stage 1 hypertension	Systolic Diastolic	130–139 mm Hg *or* 80–89 mm Hg
Stage 2 hypertension	Systolic Diastolic	At or over 140 mm Hg *or* At or over 90 mm Hg
Hypertensive crisis	Systolic Diastolic	Over 180 mm Hg *and/or* Over 120 mm Hg

INTAKE-OUTPUT RECORD

Resident/Patient Name		Room No.
FLUID INTAKE	**URINE**	**EMESIS or DRAINAGE**
7:00 A.M. to 3:00 P.M.		
8-Hour Total		
3:00 P.M. to 11:00 P.M.		
8-Hour Total		
11:00 P.M. to 7 A.M.		
8-Hour Total		

To maintain health, the body must take in a certain amount of fluid each day. Fluid comes in the form of liquids that a person drinks and is also found in semiliquid foods like gelatin, soup, ice cream, pudding, and yogurt. The fluid a person consumes is called **intake**, or **input**.

A general recommendation for daily fluid intake is 64 ounces (or eight 8-ounce glasses) for a healthy person. However, that is not necessarily a firm guideline for health. Some people may need more than 64 ounces, while others may need less. The amount needed depends on factors such as activity, heat, and overall health. If a person's intake is not in a healthy range, he can become dehydrated. Dehydration is a serious medical condition that requires immediate attention. More information on dehydration is in the next learning objective.

All fluid taken in each day cannot remain in the body. It must be eliminated as **output**. Output includes urine, feces (including diarrhea), and vomitus, as well as perspiration, moisture in the air that a person exhales, and wound drainage. If a person's intake exceeds his output, fluid builds up in body tissues. This fluid retention can cause medical problems and discomfort.

Fluid balance is maintaining equal input and output, or taking in and eliminating equal amounts of fluid. Most people do this naturally. But some residents must have their intake and output, or I&O, monitored and documented due to illness or special diets. To monitor this, the nursing assistant will need to measure and document all food and fluids that the resident takes in by mouth, as well as all urine and vomitus produced. This information is recorded on an Intake and Output (I&O) sheet (Fig. 15-25), which may be available as a manual or electronic form.

Fluids are usually measured in milliliters (mL). Milliliters are units of measurement in the metric system. One milliliter is 1/1000 of a liter. Ounces (oz) can be converted to milliliters. One ounce equals 30 milliliters, so to convert ounces to milliliters, the number of ounces must be multiplied by 30.

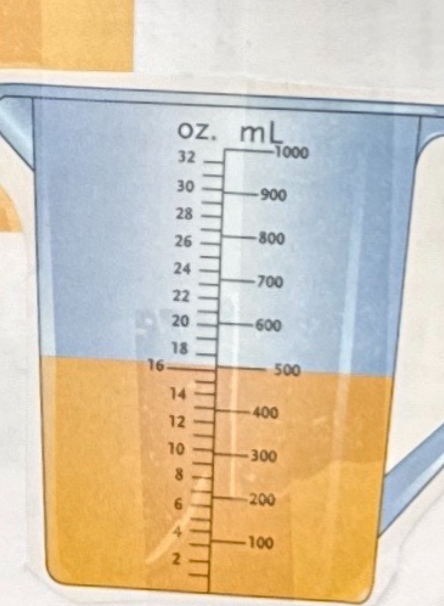
For example, an NA serves a resident an 8-ounce carton of milk. The resident finishes about half of the milk, and the NA estimates the resident drank 4 ounces of milk. To convert ounces to milliliters, the number of ounces must be multiplied by 30: 4 oz x 30 = 120 mL. The NA would document 120 mL milk on her input sheet.

Graduates are containers that measure fluid in milliliters and may also measure in ounces (Fig. 15-26). Some common conversions are listed in the orange box.

Conversions

One ounce equals 30 milliliters. To convert ounces to milliliters, the number of ounces must be multiplied by 30.

1 oz = 30 mL
2 oz = 60 mL
3 oz = 90 mL
4 oz = 120 mL
5 oz = 150 mL
6 oz = 180 mL
7 oz = 210 mL
8 oz = 240 mL
¼ cup = 2 oz = 60 mL
½ cup = 4 oz = 120 mL
1 cup = 8 oz = 240 mL



MEAL INTAKE. **DOCUMENT ON THE MEAL INTAKE RECORD HOW MUCH THE RESIDENT ATE AND DRANK**

🍽 Scenario 1 — Resident Eats Most of the Meal (Document Intake)

A resident is assisted to the dining room for lunch. They are alert, cooperative, and able to feed themselves with setup assistance. The meal tray includes baked chicken, mashed potatoes, green beans, and iced tea.

CNA Documentation Example:

"Resident consumed approximately 75% of lunch meal. Ate all chicken and mashed potatoes, half of green beans. Drank full 8 oz iced tea. No swallowing difficulty observed. Resident tolerated meal well."

🚫 Scenario 2 — Resident Refuses Meal (Document Refusal)

A resident is in bed during dinner time. When the CNA offers the dinner tray, the resident turns their head away and states, "I'm not hungry. I don't want to eat." CNA offers alternatives and encouragement, but the resident continues to refuse.

MEAL INTAKE RECORD Month/Year: ____

Meal	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BREAKFAST																															
Food																															
Fluid																															
Alt																															
Initials																															
LUNCH																															
Food																															
Fluid																															
Alt																															
Initials																															
DINNER																															
Food																															
Fluid																															
Alt																															
Initials																															
SNACK																															
AM																															
PM																															
HS																															

INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE	INITIAL	SIGNATURE/TITLE

CODING: 1 = 100% 2 = 75% 3 = 50% 4 = 25% 5 = <25% 6 = Liquids only 7 = Out of facility
SNACKS: A = Accepted R = Refused/Initials FLUIDS: 30cc = 1 ounce

ALTERNATE: A = Alternate Accepted R = Alternate Refused
*Offer alternate if resident eats <75% and report to charge nurse

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

Keeping a Nursing Home Resident's Room Clean and Safe

1. A clean and organized resident room helps prevent falls and reduces the risk of injury.
True / False

2. Regularly disinfecting high-touch surfaces, such as bed rails and call lights, helps reduce the spread of infection.
True / False

3. Clutter in a resident's room is acceptable as long as staff know where items are located.
True / False

4. Ensuring proper lighting in the resident's room is an important part of maintaining a safe environment.
True / False

5. Spills or wet areas on the floor should be left to dry on their own if the resident is not in the room.
True / False

CAN YOU LOCATE ALL THE SAFETY HAZARDS IN THE PHOTOS?

CNA Training Sheet: Protecting Resident Possessions

What Are Resident Possessions?

Resident possessions include any personal items the resident owns, uses, or keeps in their room. Examples:

- Clothing (shirts, pants, socks, shoes)
- Jewelry and accessories (rings, watches, glasses, hearing aids)
- Money, wallets, ID cards
- Electronics (phones, tablets, radios, chargers)
- Sentimental items (photos, keepsakes, religious items)
- Medical devices (dentures, eyeglasses, hearing aids, mobility aids)

Why Keeping Possessions Secure Matters

- Maintains resident dignity and rights
- Prevents emotional distress from lost items
- Avoids safety risks (e.g., lost dentures or glasses)
- Reduces family complaints and grievances
- Protects the facility from liability

How CNAs Keep Possessions Secure

- Label all clothing clearly
- **Store valuables in drawers, closets, or approved lockboxes**
- **Return glasses, dentures, and hearing aids after care**
- **Keep items off beds and meal trays to prevent loss**
- **Check pockets before sending clothing to laundry**
- Follow resident preferences for where items are kept
- **Report and document missing items immediately**
- **Notify the nurse when valuables are present or relocated**

Grievance (Complaint) & Dispute (Disagreement)

Scenario 1 — Call Light Ignored

A resident reports staff repeatedly ignore their call light for long periods. They feel unsafe and worry no one will come if they need help. They have told multiple aides, but nothing has changed.

Do I report this? A. No B. Yes C. Only if the resident insists
When do I report this? A. End of shift B. Immediately C. Next weekly meeting
Who do I report this to? A. Another CNA B. Charge nurse or supervisor C. Housekeeping

Scenario 2 — Rough or Disrespectful Care

A resident becomes upset and reports that an aide was rough during bathing and spoke to them in a rude, dismissive tone. They now feel afraid to ask for help and want someone to know what happened.

Do I report this? A. No B. Yes C. Only if there's bruising
When do I report this? A. Immediately B. After lunch C. End of shift
Who do I report this to? A. Charge nurse or supervisor B. Resident's roommate C. Dietary staff

Scenario 3 — Dignity Violation

A resident reports that staff enter their room without knocking and discuss their personal care needs loudly in the hallway. They feel embarrassed, exposed, and disrespected.

Do I report this? A. No B. Yes C. Only if the resident cries
When do I report this? A. Immediately B. End of week C. Only if it happens again
Who do I report this to? A. Charge nurse or supervisor B. Laundry staff C. Another resident

Scenario 4 — Financial Threat / Fear of Eviction

A resident says a staff member told them they might be "kicked out" if they can't pay their bill on time. The resident feels scared, pressured, and unsure what will happen to them.

Do I report this? A. No B. Yes C. Only if the resident has proof
When do I report this? A. Immediately B. Tomorrow C. Only if billing confirms it
Who do I report this to? A. Charge nurse or supervisor B. Resident's family C. Activities department

RESPONDING to BEHAVIORS

Agitation Remove triggers, keep a routine, reduce noise, focus on a familiar activity, remain calm, and soothe. **Sundowning** Avoid stressful situations, limit activities and appointments, play soft music, set a bedtime routine, plan a calming activity, limit caffeine, provide snacks, give a back massage, distract, and maintain a daily exercise routine. **Catastrophic Reactions** Avoid triggers such as fatigue, changes, overstimulation, difficult choices/tasks, pain, hunger, or need to use the toilet. Remove triggers and distract. **Violent Behavior** Call for help, block blows, never hit back, step out of reach, do not leave the resident alone, remove triggers, and use the same calming techniques as for agitation or sundowning. **Pacing and Wandering** *Causes:* restlessness, hunger, disorientation, incontinence or need to use the toilet, constipation, pain, forgetting how or where to sit down, too much napping, need for exercise. *Care:* Remove causes, give snacks, encourage exercise, maintain a toileting schedule, let pace in a safe place, redirect attention, and mark rooms with signs or pictures, such as stop signs. **Hallucinations or Delusions** Ignore if harmless; reassure, do not argue, and be calm. **Depression** *Causes:* loss of independence, inability to cope, feelings of failure and fear, facing an incurable illness, or a chemical imbalance. *Care:* Report signs, observe for triggers that cause changes in mood, encourage independence, listen to residents if they want to talk about moods and feelings, and encourage social interaction	**Perseveration** Respond with patience, do not stop behavior, and answer questions each time, using the same words. **Disruptiveness** Gain the resident's attention, be calm, direct to a private area, ask about behavior, notice and praise improvements, tell the resident about any changes, encourage the resident to join in activities, help the resident find ways to cope, and focus on activities the resident may still be able to do. **Inappropriate Social Behavior** Do not take it personally, stay calm, reassure, find out the cause, direct to a private area, respond positively to appropriate behavior, and report abuse to the nurse. **Inappropriate Sexual Behavior** Stay calm and be reassuring, try to determine the cause of the problem (is the behavior intentional?), direct to a private area, and consider other ways to provide physical stimulation. **Hoarding and Rummaging** Label belongings, place a label or symbol on the door, do not tell others that the person is stealing, prepare the family, ask the family to report unfamiliar items, and provide a rummage drawer. Emphasize that a person with AD cannot and does not steal. Pillaging and hoarding is not considered stealing. **Sleep Disturbances** Make sure the resident gets moderate exercise/activity throughout the day. Allow the resident to spend time in natural sunlight if possible. Reduce light and noise during nighttime hours. Discourage sleeping during the day.

Communicating With Cognitively Impaired Residents

Definition-A cognitively impaired resident is a person whose ability to think clearly, remember information, make decisions, or understand their surroundings is reduced due to a medical condition. This affects judgment, safety awareness, communication, and the ability to direct or participate in their own care.

Five Key Communication Points

- Use simple, clear language — short sentences, slow pace, and familiar words help residents process information.
- Maintain eye contact and face the resident — supports focus and helps them read your facial expressions.
- Give one instruction at a time — reduces confusion and increases success with tasks.
- Use a calm tone and positive body language — residents respond strongly to tone and nonverbal cues.
- Allow extra time for responses — processing may be slower; patience prevents agitation.

True or False Quiz

1. True or False: Speaking loudly helps residents with cognitive impairment understand better.
2. True or False: Giving one-step instructions reduces confusion for cognitively impaired residents.
3. True or False: A calm tone and gentle body language can help prevent agitation.
4. True or False: It is okay to rush a resident if they are slow to respond.
5. True or False: Maintaining eye contact can help the resident stay focused during communication.

Recognizes & reports emergencies and responds appropriately

Fire Emergencies (RACE & PASS)
Recognize: smoke, burning smell, flames, hot doors, alarms, electrical sparks, oxygen near heat sources.
Respond (RACE): Rescue, Alarm, Contain, Extinguish.
PASS: Pull, Aim, Squeeze, Sweep.
Report immediately: location, what you saw, who is involved, actions taken.

Natural Disasters (Tornado, Flood, Blizzard, Earthquake)
Recognize: weather alerts, shaking, structural damage, rising water, flying debris, power loss.
Respond: follow disaster plan, move residents to safe zones, close blinds, avoid windows, keep residents calm and accounted for.
Report: hazards, injuries, missing residents, structural damage.

Bomb Threats
Recognize: suspicious package, strange device, threatening call, abandoned bag, unusual smells or wires.
Respond: stay calm, do not touch item, evacuate if instructed, preserve the scene.
Report: exact words of threat, time received, description of item, location, people nearby.

Workplace Violence
Recognize: threats, intimidation, aggressive behavior, escalating anger, stalking, destruction of property.
Respond: maintain distance, stay calm, call for help, remove residents from danger.
Report: who, what, when, where, triggers, injuries, witnesses.

Active Shooter / Armed Intruder
Recognize: gunfire, weapon seen, threats, panic, sudden crowd movement.
Respond: follow facility policy, move residents out of immediate danger, stay quiet, silence noise, keep residents low and out of sight, wait for law enforcement instructions.
Report: location of threat, description of person, direction of movement, injuries, hazards.

General Safety Hazards
Environmental: spills, clutter, poor lighting, blocked exits, unsecured oxygen, overloaded outlets, sharp objects.
Resident-related: unsafe transfers, wandering, swallowing risks, medication errors.
Equipment: frayed cords, malfunctioning lifts, broken wheelchairs, faulty alarms.

What to Report in ANY Emergency
What you saw, exact location, who is involved, immediate dangers, actions taken, remaining risks, injuries, missing persons.

Your Role
Stay alert, act quickly, keep residents safe, follow facility policy, report immediately, document as required.

Emergency Codes:
Code Red-Fire
Code Yellow-Bomb threat
Code Blue-Medical emergency

Modify your own behavior in responds to the clients behaviors

You modify your behavior by calmly observing the client's actions, matching your communication to their emotional state, adjusting tone and body language, reducing environmental triggers, and using de-escalation strategies such as validation, redirection, and offering choices. This approach keeps interactions safe, supportive, and therapeutic while preventing escalation and meeting the client's underlying needs.

EMOTIONAL SUPPORT TO THE CLIENT

9. List ways to respond to emotional needs of residents and their families

Residents or family members may come to nursing assistants with problems or needs. Changes in a resident's health status can cause fear, uncertainty, stress, and anger. The nursing assistant's response will depend on many factors, including how comfortable she is with emotions in general, how well she knows the person, and what the need or problem is. The NA should try to empathize, or understand how the person feels. Every person deals with challenges differently, and the NA can consider what response might be best for any given resident. This is part of providing person-centered care. In addition, the NA can respond in the following ways:

Listen. Often just talking about a problem or concern can make it easier to handle. Sitting quietly and letting someone talk or cry may be

Make choices and dignity and needs & Promotes ability to function independence

Many long-term care facilities work to provide meaningful environments with individualized approaches to care. **Culture change** is a term for the process of transforming services for elders so that they are based on the values and practices of the person receiving care. Culture change involves respecting both elders and those working with them. Core values are promoting choice, dignity, respect, self-determination, and

Independence often means not having to rely on others for money, daily care, or participation in social activities. Activities of daily living are the personal care tasks a person does every day to care for himself. People may take these activities for granted until they can no longer do them for themselves. ADLs include bathing or showering, dressing, caring for teeth and hair, eliminating, eating and drinking, and moving from place to place. When a person loses independence, the following problems can result:

- Poor self-image
- Anger toward caregivers, others, and self
- Feelings of helplessness, sadness, and hopelessness
- Feelings of being useless
- Increased dependence
- Anxiety and depression

To prevent these feelings, NAs should encourage residents to do as much as possible for themselves. Even if it seems easier for the NA to do a task for a resident, the resident should be allowed to do it independently. NAs must encourage self-care, regardless of how long it takes or how poorly residents are able to do it. NAs should be patient (Fig. 8-5).

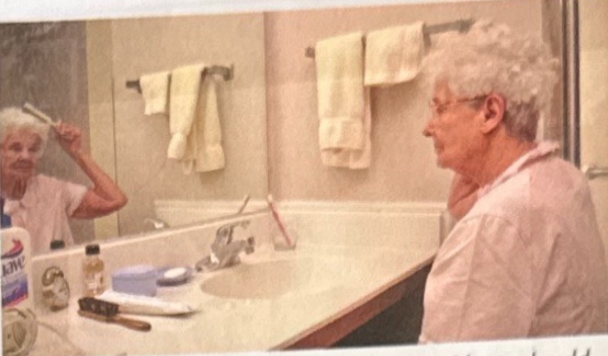


Fig. 8-5. Even if tasks take a long time, residents should be encouraged to do what they can for themselves.

Allowing residents to make choices is another way to promote independence and person-centered care. For example, residents can choose where to sit while they eat. They can choose what they eat and in what order. NAs must respect a resident's right to make choices.

Residents' Rights

Dignity and Independence

Residents are adults; they should not be treated like children. NAs should encourage residents to do self-care without rushing them. Residents have the right to refuse care and to make their own choices. Promoting dignity and independence is part of protecting their legal rights. It is also the proper and ethical way for NAs to work.

Pioneer Network is a leader in the culture change movement and was formed in 1997 by a group of people working in long-term care. Their aim is to ensure person-centered care for all elders—whether in care facilities or at home. **Person-centered care** (also known as *person-directed care*) emphasizes the individuality of the person who needs care, and recognizes and develops the person's capabilities. Person-centered care revolves around the resident and promotes her individual preferences, choices, dignity, and interests. Each person's background, culture, language, beliefs, and traditions are respected (Fig. 1-7). Improving each resident's quality of life is an important goal.

Assist the client to **ATTEND** and **PARTICIPATE** in **ACTIVITIES** of the clients **CHOICE**

7. Describe the need for activity

Activity is an essential part of a person's life; it improves and maintains physical and mental health. Meaningful activities help promote independence, memory, self-esteem, and quality of life. In addition, physical activity can help manage illnesses, such as diabetes, high blood pressure, and high cholesterol. Regular physical activity can also help by doing the following:

- Lessening the risk of heart disease, colon cancer, diabetes, and obesity
- Relieving symptoms of anxiety and depression
- Improving mood and concentration
- Improving body function
- Lowering the risk of falls
- Improving sleep quality
- Improving the ability to cope with stress
- Increasing energy
- Increasing appetite and promoting better eating habits

Think about what you do daily to keep from getting bored or to help relieve stress.

1. Do you take walks?
2. Do you have any pets?
3. Do you play games (board games or electronic games)?
4. What kind of music do you listen to?
5. Do you like friends and family to visit ?

CNA Training Sheet: Recognizing All Types of Abuse

Resident Scenario

A resident with moderate dementia has recently shown several concerning changes. The CNA notices the resident has finger-shaped bruises on the upper arm and flinches when touched, suggesting possible physical abuse. During care, the resident quietly reports that a staff member yells, calls them names, and belittles them, indicating verbal and emotional abuse. The resident is often found in soaked incontinence briefs with strong urine odor and poor hygiene, which may signal neglect. The resident also states that someone comes into their room at night and touches them in ways that make them uncomfortable, raising concern for sexual abuse. Finally, the resident's daughter reports missing cash and unexplained debit card charges, pointing to financial exploitation. All of these signs must be taken seriously, and the CNA is required to report them immediately to the nurse.

Multiple-Choice Quiz

1. Finger-shaped bruises and flinching when touched may indicate:
   i. Emotional abuse
   ii. Physical abuse
   iii. Neglect
   iv. Financial exploitation
2. A resident being yelled at, insulted, or threatened is experiencing:
   i. Neglect
   ii. Sexual abuse
   iii. Verbal/emotional abuse
   iv. Financial exploitation
3. A resident repeatedly left in soiled clothing or not assisted with meals is showing signs of:
   i. Neglect
   ii. Physical abuse

iii. Emotional abuse
iv. Financial exploitation

4. Missing money, unauthorized purchases, or stolen belongings may indicate:
   i. Sexual abuse
   ii. Financial exploitation
   iii. Neglect
   iv. Physical abuse
5. A resident reporting unwanted touching or fear of a staff member entering their room may be experiencing:
   i. Emotional abuse
   ii. Sexual abuse
   iii. Neglect
   iv. Financial exploitation

Standards Of Care For Cognitive Patient
And
Responding Appropriately & Standards To Reduce The Effects Of Cognitive Impairment

Standards of Care for Cognitive Patients

Use simple, clear communication; one-step directions; calm tone. Maintain routines to reduce anxiety and confusion. Provide a safe, clutter-free, well-lit environment. Promote dignity: knock, respect privacy, avoid talking over residents. Encourage independence: offer choices, allow extra time, support abilities. Use validation and reassurance; avoid arguing; redirect gently. Monitor and report changes in behavior, mood, or safety. Provide person-centered care based on history, preferences, and triggers.

Responding Appropriately

Stay calm and patient; your tone sets the mood. Redirect instead of confronting; guide to safe activities. Break tasks into small steps; use gestures and visual cues. Reduce noise and overstimulation. Reassure: “You’re safe,” “I’m here,” “Let’s do this together.” Identify unmet needs: pain, hunger, toileting, boredom, fatigue. Report unsafe or escalating behaviors immediately.

Reducing Effects of Cognitive Impairment

Use consistent caregivers and predictable routines. Provide meaningful activities: music, folding, sorting, walking, reminiscing. Use environmental cues: signs, pictures, memory boxes. Support hydration, nutrition, sleep, and daily exercise. Report changes early to prevent worsening symptoms.

CNA Word Search – Cognitive Care

Words to Find: ROUTINE, SAFETY, REDIRECT, CALM, DIGNITY, REASSURE, TRIGGERS, MEMORY, COMMUNICATION, PATIENCE, INDEPENDENCE, VALIDATION, WANDERING, ACTIVITIES

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C O M M U N I C A T I O N X
A T R I G G E R S L P A T I
L W A N D E R I N G E D N O
M E M O R Y V A L I D A T I
S A F E T Y C A L M R E D I
I N D E P E N D E N C E G N
G D I G N I T Y T R O U T I
N A C T I V I T I E S R E A
I R E A S S U R E M M O C R
T R O U T I N E P A T I E N
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