Appendix

State laws and regulations for home health aide training vary. While most home health aides cannot perform the procedures listed below, some tasks may be able to be performed in special circumstances and/or with advanced training.

If an HHA has questions about whether or not a task is within her scope of practice, she should talk to her supervisor. An HHA should **never perform any task that is not listed in the care plan**. The agency's policies and procedures should be followed.

Postural Drainage

People who have chronic lung diseases may have thick mucus that is difficult to expel from the lungs. Postural drainage involves using different body positions to drain mucus from the lungs or to loosen it so that it can be coughed up. Generally this procedure is performed two to three times a day.

Instructions for assisting clients with postural drainage will vary. The HHA should follow the care plan; it will explain which positions should be used during the procedure. Some elderly people are not comfortable in certain positions.

Clients who use a medication nebulizer should use it before doing postural drainage because it will help them cough up mucus. A medication nebulizer is a small device that turns liquid medication into a fine mist so that it can be inhaled. Clients using oxygen should continue to use oxygen as ordered during the postural drainage treatment.

This activity should be done before meals when the stomach is empty. This helps prevent vomiting, gagging, or discomfort.

Guidelines: Postural Drainage

- Wash your hands before assisting with postural drainage.
- Wear proper personal protective equipment (PPE) while doing postural drainage. The required PPE is gloves and sometimes a mask.
- Count the client's pulse and respirations before beginning.
- Stand by the client who is leaning forward to prevent the client from falling.
- Be gentle when positioning the client. Be sure the client will not slip out of position and injure himself. If you cannot get a client into the correct position, notify your supervisor.
- Assist clients to change positions slowly during the procedure. Allow for rest periods, as elderly clients may tire easily. The client should not move from the position until he coughs up mucus. Then assist the client with getting into the next position.
- Encourage clients to do deep breathing. This consists of taking a deep breath, holding it for a few seconds, and then slowly letting the breath out.
- Encourage coughing during the procedure. Encourage the client to cough up mucus after doing postural drainage to help clear the lungs.
- Keep tissues nearby for the client to use. Discard used tissues immediately in the proper container.
- Stop the procedure and notify your supervisor if a client complains of fatigue, is feeling faint, is breathing rapidly, or has chest pain.
- The mucus should be a clear or white color. Report if mucus is any other color, such as red, green, or yellow, or is blood-tinged or has an odor.
- Assist with oral care after the activity is completed. This helps clear the mouth of mucus.

- The care plan may call for the chest to be clapped or vibrated to help loosen mucus so that it can be expelled. If you are required to perform this activity, you will be trained how to do so.
- Remove and discard gloves and wash your hands.
- Document the position used, the length of time of the procedure, the color, odor, and consistency of the mucus, and any problems the client had during the procedure.

CPAP Machine

The continuous positive airway pressure (CPAP) machine is a device that pushes air into the nose and keeps the airway open so that a person keeps breathing (Fig. A-1). This may be necessary to help a person who has sleep apnea. Sleep apnea is a condition in which a person stops breathing for a short period of time while asleep. When breathing stops, the person wakes up, and then continues breathing again. This condition creates a strain on the heart and lungs. Because of the interrupted sleep, these clients usually feel tired during the day.

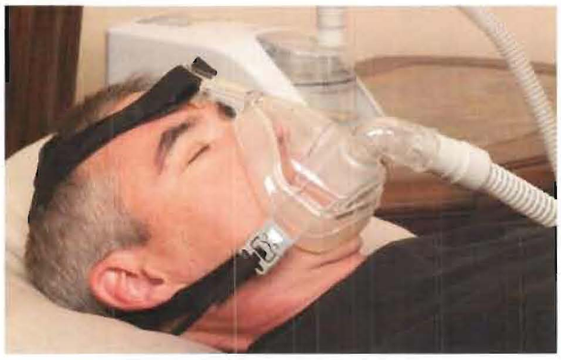

Fig. A-1. *One type of CPAP machine.*

Guidelines: CPAP Machine

- It is very important to prevent infection when assisting with a CPAP device. If microorganisms get into the mask, tubing, or humidifier, they can reach the client's lungs when he uses the machine. Always wash your hands before and after touching the mask, tubing, and humidifier.
- Before assisting with a CPAP device, wash your hands and don clean gloves.
- Follow the manufacturer's instructions for attaching the tubing to the machine and to the mask properly.
- Help the client to put on the mask and adjust straps as needed. Make sure that the mask is not too tight; it should not irritate the face. Check that the mask is not so loose that air blows into the eyes.
- Position the client comfortably in bed.
- The CPAP machine should have air flowing around it; make sure that it is not against the wall or too close to the bed.
- Observe the client for snoring, breathing, or sleep problems.
- Help the client to remove the mask after sleeping.
- Clean and care for the mask, tubing, and humidifier according to the manufacturer's and care plan's instructions. The humidifier may need to be emptied daily and filled with new distilled water.
- Remove and discard gloves and wash your hands.
- Document the use of the CPAP machine. Note any problems the client experienced, such as runny nose, dry throat, headache, or ear pain. Report signs of sleep apnea, such as being tired during the day, snoring, or client complaints of breathing or sleep problems.

Medication Nebulizer

A medication nebulizer is a device that turns liquid medication into a fine mist so that it can be inhaled (Fig. A-2). It is also known as an *atomizer.* This device helps clients who have lung

problems bring medication deep into the lungs. The medication loosens mucus in the lungs and helps the client cough it up.

Fig. A-2. *Different types of medication nebulizers.* (PHOTOS COURTESY OF PHILIPS, WWW.USA.PHILIPS.COM, 1-800-744-5477)

If indicated in the care plan, a home health aide may assist the client with the use of the medication nebulizer. Like with all care, the HHA should not perform any activity that is not listed in the care plan. If allowed to assist, the HHA's duties may include the following:

- Gathering the necessary equipment and supplies
- Properly positioning the client
- Putting normal saline in the nebulizer
- Turning on the equipment
- Timing the treatment
- Checking to make sure the client is using the equipment properly
- Turning off the equipment
- Cleaning and storing the equipment properly
- Documenting observations and reporting to the supervisor

With special, advanced training, an HHA may be required to put prescribed medication in the nebulizer.

Guidelines: Medication Nebulizers

- Be very careful to prevent infection when assisting with a nebulizer. If microorganisms get into the medicine or on the mouthpiece, they can go deep into the client's lungs when he uses the nebulizer. Always wash your hands before and after touching the air hose, medication container, or medication bottle.
- Don clean gloves.
- Help the client get into the proper position.
- Count the client's pulse and respirations before beginning. Continue to monitor pulse and respirations during the procedure.
- If your client is using oxygen, it should be left on while using the medication nebulizer. Observe all oxygen safety precautions.
- After turning on the compressor, check for a visible mist coming from the nebulizer. If it is not working properly, contact your supervisor. Do not try to repair the equipment if it is not working.
- Remind the client to inhale slowly, hold his breath for a short time, then exhale.
- Observe the client for the following signs that he is not getting enough oxygen while using the medication nebulizer:
  - Rapid pulse and respirations
  - Difficulty breathing
  - Cold, clammy skin
  - Blue or darkened lips, fingernails, eyelids
  - Inability to sit still
  - Lack of response when you call his name

If your client shows any of these signs, stop the procedure immediately and notify your supervisor.

- Once the ordered time has passed, turn off the machine, and count pulse and respirations.
- Clean and care for the nebulizer and mouthpiece according to manufacturer's and care plan's instructions. Change the tubing as ordered.
- Remove and discard gloves and wash your hands.
- Document the use of the nebulizer. Note signs the client was not getting enough oxygen, as well as an increase in pulse rate, or if the client will not use the device as ordered in the care plan.

Vaginal Irrigation (Douche)

Putting a solution into the vagina in order to clean the vagina, introduce medication to treat an infection or condition, or to relieve discomfort is called a vaginal irrigation, or douche. After the solution is introduced, it immediately drains out of the vagina.

Guidelines: Vaginal Irrigation

- Provide privacy for this procedure.
- Wash your hands before assisting with vaginal irrigation.
- Don clean gloves.
- Inspect the nozzle or tip for any breaks, cracks, or rough edges before use. This helps prevent injury to the vagina. If you observe any problems with the nozzle, do not use it and notify your supervisor.
- Clean the container, tubing, and nozzle before using to prevent infection. Reusable equipment should be washed with hot, soapy water after use.
- Follow the care plan's instructions for preparing the solution and making sure it is at the right temperature.
- If using a commercially prepared irrigation, follow instructions on the package.
- Unclamp the tubing to allow some of the solution to run through the tubing, to remove air before the tubing is inserted.
- Position the client on her back and place an absorbent disposable pad under the client. You may need to place the client on a fracture pan (with the disposable pad underneath it) if tolerated and if assigned to do so. Assist the client with perineal care as needed.
- Do not force the nozzle into the vagina if you meet resistance. If you are unable to insert the nozzle, stop and notify your supervisor.
- The same amount of solution should return as was put into the vagina. The solution should be the same color as it was before it was inserted. It should be clear with a mild odor.
- Discard disposable supplies and clean and store equipment.
- Remove and discard gloves and wash your hands.
- Document the procedure. Note amount, color, odor, consistency, and type of solution. Report fatigue or pain, as well as unusual amount, color (pink or streaked with red), or foul odor of solution, or any material in solution, such as mucus or particles. Report any problems with performing the procedure.

Enemas

Putting fluid into the rectum in order to eliminate stool or feces is called an enema. Types of enemas are as follows:

- Tap water enema (TWE): 500–1000 mL of water from a faucet (nothing added to the water)
- Soapsuds enema (SSE): 500–1000 mL water with 5 mL of mild castile soap added

- Saline enema: 500–1000 mL water with two teaspoons of salt added
- Commercially prepared enema (also called *commercial enema* or *pre-packaged enema*): 120 mL solution that may have oil or other additive

The commercially prepared enema is the type most often used in the home. It may be a chemical or oil-retention enema. The chemical enema contains a solution that promotes a bowel movement. It is often used when a client is constipated or for bowel retraining. An oil-retention enema has oil in it, such as mineral oil, to soften the stool to allow it to pass more easily. It is often used when a client has been constipated for a long time, resulting in stool that is very hard.

Guidelines: Enemas

- Keep the bedpan nearby, or make sure that the bathroom is vacant before assisting with an enema.
- Provide privacy for this procedure.
- Wash your hands before assisting with enemas.
- Don clean gloves.
- Place an absorbent disposable pad under the client. Help the client into the Sims' (left-side-lying) position. If the person is positioned on the left side, the water does not have to flow against gravity.
- The enema solution should be warm, not hot or cold.
- The enema bag should not be raised to more than the height listed in the care plan.
- The tip of the tubing should be lubricated with lubricating jelly.
- Unclamp the tube and allow a small amount of solution to run through the tubing. Then reclamp the tube. This gets rid of air before it is inserted (the air could cause cramping).
- The solution should flow in slowly; the client will be less likely to have cramps.
- The client should take slow deep breaths when taking an enema to help hold the solution longer.
- Document the use of the enema. Note appearance and amount of stool. Report any of the following to the supervisor:
  - The enema was not administered according to the directions in the care plan or there was difficulty in administering the enema.
  - The client could not tolerate the enema because of cramping.
  - The enema had no results.
  - The amount of stool was very small.
  - Stool was hard, streaked with red, very dark, or black.

Sterile Dressings

Sterile dressings are those that cover open or draining wounds. Home health aides are <u>not</u> allowed to change sterile dressings. They are only allowed to change *nonsterile* dressings that cover dry, closed wounds. However, HHAs can gather and store equipment and supplies and observe and report about the dressing site. If trained, they may be allowed to clean the equipment. Duties may also include properly positioning the client, cutting the tape, and disposing of the soiled dressing.

Supplies that may be needed for changing a sterile dressing include the following:

- Special gauze has one side that has a shiny, nonstick surface, which will not stick to wounds when removed.
- Abdominal pads (ABDs) are large, heavy gauze dressings that cover smaller gauze

dressings to help keep them in place and provide absorbency.

- Cotton bandages (sometimes called *Kerlix* or *Kling* bandages) can stretch and mold to a body part and help hold it in place; these are often placed on bony areas, such as the knees and elbows.
- Binders are stretchable pieces of fabric that can be fastened. They hold dressings in place and give support to surgical wounds. Binders can also reduce swelling and ease discomfort.
- Medical-grade adhesive tape panels (sometimes called *Montgomery Straps*) help keep frequently changed dressings in place. The adhesive is not removed with each dressing change so that skin is less likely to become irritated.

Guidelines: Sterile Dressings

- If the wrapper on the supply is torn, it is no longer considered sterile and cannot be used.
- The wrapper on the supply cannot be opened and closed again. Once a wrapper is opened, the supplies inside are no longer sterile.
- If a wrapper is wet or has wrinkles or marks that indicate it was once wet, it is no longer considered sterile.
- If the date on the supply shows it has expired, it is no longer considered sterile. All commercially prepared supplies are dated. A sterile supply that has expired should not be used.
- If you are unsure whether a wrapper is sterile or not, do not use it.
- Because of the way the wound and the skin around it may look, the client may feel embarrassed about having others see the area. Promote the client's comfort and dignity when assisting the nurse with a sterile dressing change by being professional. Do not express discomfort, even if you are bothered by the appearance of the client's wound or skin.
- Observing and documenting your observations are very important parts of your job. While you are assisting with changing a sterile dressing, observe for any changes in the wound, especially the following:
  - Skin that has changed color
  - Scab that has come off
  - Bleeding
  - Swelling
  - Odor
  - Drainage
- HHAs cannot do any of the following:
  - Set up a sterile field (a sterile field is an area free of all microorganisms)
  - Remove wrapping from a new dressing
  - Remove a soiled dressing
  - Apply prescription and/or nonprescription medication to a dressing
  - Apply a new dressing
  - Apply a reinforcement dressing

Colostomies

Information about colostomies and related care was introduced in Chapter 14. Some clients with colostomies irrigate their colostomies (Fig. A-3). Irrigation is done to stimulate the large intestine to eliminate stool. Clients usually perform an irrigation in the bathroom, seated on the toilet or portable commode, or on a chair facing the toilet or commode.

With special, advanced training, an HHA's duties may include assisting a client with a colostomy irrigation. If allowed to assist, only activities listed in the care plan should be performed. The care plan will contain instructions