26
Subacute Care

1. Define important words in this chapter
2. Discuss the types of residents who are in a subacute setting
3. List care guidelines for pulse oximetry
4. Describe telemetry and list care guidelines
5. Explain artificial airways and list care guidelines
6. Discuss care for a resident with a tracheostomy
7. Describe mechanical ventilation and explain care guidelines
8. Describe suctioning and list signs of respiratory distress
9. Describe chest tubes and explain related care
10. Describe alternative feeding methods and related care
11. Discuss care guidelines for dialysis

Supplemental Tools
TRANSPARENCY 26-1 TUBE FEEDINGS
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CHAPTER 26: EXAM

Assignments
TEXTBOOK READING, PP. 457-468
WORKBOOK EXERCISES, PP. 139-142

Overview of Teaching Strategies
This chapter provides an introduction to the NA’s role in subacute care. Students need to be acquainted with types of residents they will see in subacute care. An emphasis should be made that students’ responsibilities are mostly observing and reporting and helping when needed. It is also important for them to be reassuring and calm with subacute residents who may feel fear and anxiety about their situation, especially residents on mechanical ventilators.

It would be helpful to bring in some of the devices students will see in a subacute unit, e.g., pulse oximeter, telemetry unit. If possible, have someone who has a tracheostomy come talk to the class about challenges they face. Students can prepare a list of questions ahead of time.

1. Define important words in the chapter

Meeting the Learning Objective
TEXTBOOK P. 457
WORKBOOK P. 139

Lecture
Pronounce and define each of the key terms listed in the Learning Objective on page 457.

2. Discuss the types of residents who are in a subacute setting

Meeting the Learning Objective
TEXTBOOK PP. 457-458
WORKBOOK P. 139

Lecture
Pronounce and define the following key term:
- Mechanical ventilator

Review types of residents found in subacute units:
- Residents who need more care and observation than other residents
- Residents having had recent surgery and chronic illnesses, such as AIDS and cancer
- Residents on dialysis or with serious burns
3. List care guidelines for pulse oximetry

**Meeting the Learning Objective**
- **Textbook** pp. 458-459
- **Workbook** p. 139

**Lecture**
- Pronounce and define the following key term:
  - Pulse oximeter

Review the following points about the pulse oximeter:
- Warns of low blood oxygen level before signs develop
- Normal pulse oximeter reading is 95% and 100%, but it can differ.
- Report to nurse any change in oxygen levels.

Discuss the following guidelines for pulse oximetry:
- Tell the nurse right away if alarm sounds.
- Be careful when moving and positioning so oximeter does not move or come off.
- Report difficulty breathing.
- Report pale, cyanotic, darkening, or grayish skin, or mucous membranes.
- Report signs of skin breakdown from the device.
- Check vital signs as ordered, and report changes to the nurse.

**Demonstration**
- Demonstrate the procedure: Applying a pulse oximetry device. Include all the numbered steps in your demonstration.

Have the students return the demonstration. Procedure checklists are located at the end of the Student Workbook.

4. Describe telemetry and list care guidelines

**Meeting the Learning Objective**
- **Textbook** pp. 460-461
- **Workbook** p. 140

**Lecture**
- Pronounce and define the following key term:
  - Telemetry

Discuss the following guidelines for telemetry:
- Do not get the unit, wires, pads, or electrodes wet during bathing.
- Report to nurse if alarm sounds.
- Check vital signs, as ordered.
- Report if pads become loose.
- Check for signs of skin irritation under or around electrodes.
- Remind resident not to leave the monitoring area.
- Report change in vital signs, chest pain or discomfort, rapid pulse, sweating, shortness of breath, dyspnea, or dizziness to the nurse.

5. Explain artificial airways and list care guidelines

**Meeting the Learning Objective**
- **Textbook** pp. 460-461
- **Workbook** p. 140

**Lecture**
- Pronounce and define the following key term:
  - Intubation

Discuss the following guidelines for artificial airways:
- Tell nurse if tubing comes out.
- Follow orders for positioning.
- Perform oral care often, at least every two hours.
- Tell nurse if you see biting and tugging on the tube.
- Write notes, draw pictures, and use communication boards and hand and eye signals if resident cannot speak.
- Be supportive and reassuring.
- Report drainage, change in vital signs, wheezing or difficulty breathing, secretions in tubing, cyanosis, pale, gray, or darkening skin or mucous membranes, or nervousness or anxiety to the nurse.
6. Discuss care for a resident with a tracheostomy

Meeting the Learning Objective
Textbook pp. 461-462
Workbook p. 140

Lecture
Discuss why tracheostomies are necessary:
• Airway obstruction
• Cancer
• Infection
• Severe injuries
• Serious allergic reaction
• Coma
• Facial burns
• Gunshot wounds
• To prevent aspiration in an unconscious person

Remind nursing assistants to use alternate methods of communication if the resident cannot speak and to answer call lights promptly. Emphasize that, even if tracheostomy care isn’t an NA duty, careful observation and reporting is necessary.

Discuss the following guidelines for tracheostomies:
• Answer call lights promptly.
• Use alternate methods of communication.
• Follow orders for positioning.
• Inspect ties or tape often.
• Report kinks or disconnected tubing.
• Keep the dressing dry, and do not cover the tracheostomy opening.
• Provide careful skin care.
• Perform oral care often, at least every two hours.
• Observe for mouth sores, cracks, breaks or sores on skin.
• Observe for pale, bluish, or darkening skin or mucous membranes.
• Check vital signs as ordered.
• Do not tire resident.
• Do not move spare tracheostomy tubes or bag valve mask.
• Report cyanosis, pale, gray, or darkening skin or mucous membranes, mouth sores or discomfort, cracks, breaks, or sores on skin, gurgling sounds, dyspnea or shortness of breath, change in vital signs, disconnected tubing, or loose or wet tape to the nurse.

7. Describe mechanical ventilation and explain care guidelines

Meeting the Learning Objective
Textbook pp. 462-463
Workbook pp. 140-141

Lecture
Pronounce and define the following key term:
• Sedation

Make the following points about mechanical ventilators:
• Resident will not be able to speak, which can greatly increase anxiety.
• Being on a ventilator has been compared to breathing through a straw.
• Be supportive. Enter the room so the resident can see you often.
• Use other methods of communication.
• Act and speak as if resident can understand everything, even if he or she is unconscious or heavily sedated.

Discuss the following guidelines:
• Tell nurse right away if alarm sounds.
• Report kinks or disconnected tubing right away.
• Report biting on the tube.
• Answer call lights promptly.
• Give oral care often. Report mouth sores or discomfort.
• Reposition at least every two hours. Follow positioning orders.
• Give regular skin care to prevent pressure ulcers.
• Allow time for rest.
• Be patient during communication.
• Provide emotional support.
• Do not move spare artificial airway tubes or bag valve masks.
• Report the alarm sounding, a collection of secretions in tubing, mouth sores or discomfort, cracks, breaks, or sores on the skin, change in vital signs, nervousness or anxiety, or depression to the nurse.
**Case Study**
Mrs. G is on a mechanical ventilator. She is sedated, but she is conscious. She bites on her tube sometimes and looks anxious when the NA enters the room.

- What can the NA do to reassure Mrs. G?
- What care can the NA give to help increase Mrs. G's comfort?

**Lecture**

Pronounce and define the following key term:
- Sepsis

Review the signs of sepsis:
- Elevated heart rate and respiratory rate
- Slightly elevated temperature or low temperature
- Chills
- Excessive sweating
- Feeling of sickness or weakness
- Low blood pressure
- Decreased urine output
- Headache
- Skin rash
- Shortness of breath
- Confusion or change in mental status

Emphasize that NAs should be familiar with residents’ normal vital signs in order to better recognize changes.

8. Describe suctioning and list signs of respiratory distress

**Meeting the Learning Objective**

TEXTBOOK PP. 463-464
WORKBOOK P. 141

**Lecture**

Review the following points about suctioning:
- Necessary when a person has increased secretions that he cannot expel
- Suctioning can be performed orally, nasally, and through the trachea and bronchi.
- Nursing assistants do not perform suctioning.
- Suction comes from wall or pump and bottle collects suctioned material.
- Sterile water or sterile saline is used to rinse suction catheter.
- Signs of respiratory distress are gurgling, high respiratory rate, shortness of breath, dyspnea, pallor or cyanosis.

Discuss the following guidelines for assisting with suctioning:
- Follow Standard Precautions.
- Follow orders for positioning.
- Place pad or towel under chin before suctioning.
- Give oral and nasal care after suctioning.
- Report signs of respiratory distress immediately.
- Answer call lights promptly.
- Observe for pale, bluish, or darkening skin or mucous membranes.
- Monitor vital signs closely.
- Give emotional support during difficult periods.
- Report change in vital signs; gurgling sounds; change in color, amount, or quality of secretions; dyspnea or shortness of breath; cyanosis; pale, gray, or darkening skin or mucous membranes; or nervousness or anxiety to the nurse.

9. Describe chest tubes and explain related care

**Meeting the Learning Objective**

TEXTBOOK PP. 464-465
WORKBOOK P. 141

**Lecture**

Pronounce and define the following key term:
- Chest tubes

Review the following points about chest tubes:
- Can be inserted at bedside or during surgery
- Drain air, blood, pus, or fluid
- Allow a full expansion of the lungs
- Conditions requiring chest tubes include pneumothorax, hemothorax, empyema, surgery, injuries
- Chest tube is connected to bottle of sterile water.
- System must be airtight when attached to suction.
Discuss the following guidelines for chest tubes:

- Be aware of where chest tubes are located.
- Check vital signs as directed and report changes.
- Report signs of respiratory distress and pain.
- Keep drainage system below level of chest.
- Keep drainage containers upright and level.
- Make sure tubing is not kinked.
- Report disconnected tubing.
- Do not remove equipment in the area.
- Observe chest drainage for amount, color, and consistency.
- Report clots in tubing.
- Observe dressings for drainage, saturation, or bleeding.
- Follow orders for positioning.
- Provide rest periods.
- Follow fluid orders and measure I&O carefully.
- Encourage deep breathing exercises.
- Report complaints of pain, signs of respiratory distress, change in vital signs, change in oxygen levels or if alarm sounds, an increase or decrease in bubbling, disconnected or kinked tubing, clots in the tubing, changes in amount, color, or consistency of chest drainage, wet or loose dressings, or odor to the nurse.

10. Describe alternative feeding methods and related care

Meeting the Learning Objective

Textbook pp. 465-467
Workbook p. 142

Lecture

Pronounce and define the following key terms:
- Nasogastric tube
- PEG tube
- Gastrostomy

Discuss the types of tube feedings and emphasize that the NA’s role is assisting the nurse and positioning the resident. Careful observation for problems and changes is important.

Display Transparency

26-1 TUBE FEEDINGS

Discuss the following guidelines for tube feedings:

- Observe carefully for signs of aspiration.
- Follow orders for positioning.
- Be aware of NPO orders.
- Give frequent mouth and nose care.
- Do not pull or tug on tubing. Keep tubing free of kinks.
- Observe for clip falling off.
- Notify the nurse if the alarm sounds.
- Make feeding time a social time.
- Report mouth or nose sores; plugged tubing; kinked, cracked, broken, or disconnected tubing; tubing comes out of abdomen; leaking or empty bag; loose tape; dyspnea or shortness of breath; cyanosis, pale, gray, or darkening skin or mucous membranes; nausea, vomiting, and cramping; fluid gathering at mouth; signs of infection at the tube site; bleeding or drainage; signs of aspiration; resident pulling on tube; or alarm sounds to the nurse.

Pronounce and define the following key terms:
- Total parenteral nutrition
- Central venous line

Review what to observe regarding TPN:
- Fever
- Headache
- Swelling
- Redness
- Bleeding
- Leaking at insertion site

Distribute Handout

26-1 GASTROSTOMIES

Distribute this handout and discuss the information with students.

11. Discuss care guidelines for dialysis

Meeting the Learning Objective

Textbook p. 467
Workbook p. 142
**Lecture**

Review points about dialysis:

- Can be done via the arm or the neck
- Follow I&O orders.
- Report difficulty breathing, shortness of breath, change in vital signs, pain, drainage or bleeding, as well as change in I&O, and edema.

**Chapter Review**

**Exam**

Distribute chapter 26: exam

(Appendix C, pp. 341-342)

Allow students enough time to finish the test. See Appendix D for answers to the chapter exams.

**Answers to Chapter Review in Textbook**

1. Answers include: recent surgery, chronic illnesses, serious burns or dialysis
2. Blood oxygen level and pulse rate
3. Answers include: Do not get the unit, wires, pads, or electrodes wet during bathing. Report to nurse if alarm sounds. Check vital signs, as ordered. Report if pads become loose. Check for signs of skin irritation under or around electrodes. Remind resident not to leave the monitoring area. Report change in vital signs, chest pain or discomfort, rapid pulse, sweating, shortness of breath, dyspnea, or dizziness to the nurse.
4. Artificial airways help maintain an airway and facilitate ventilation.
5. Answers include: communication boards, writing notes, drawing pictures, and hand or eye signals
6. General tracheostomy care includes keeping the skin around the opening, or stoma, clean, assisting with dressing changes, and helping with the cleaning of the inner part of the device.
7. Answers include: Answer call lights promptly. Use alternate methods of communication. Follow orders for positioning. Inspect ties or tape often. Report kinks or disconnected tubing. Keep the dressing dry, and do not cover the tracheostomy opening. Provide careful skin care. Perform oral care often, at least every two hours. Observe for mouth sores, cracks, breaks or sores on skin. Observe for pale, bluish, or darkening skin or mucous membranes. Check vital signs, as ordered. Do not tire resident. Do not move spare tracheostomy tubes or bag valve mask. Report cyanosis, pale, gray, or darkening skin or mucous membranes, mouth sores or discomfort, cracks, breaks, or sores on skin, gurgling sounds, dyspnea or shortness of breath, change in vital signs, disconnected tubing, or loose or wet tape to the nurse.
8. Answers include: Residents on ventilators cannot speak, which can cause intense anxiety. The resident may think that no one will know if he has trouble breathing.
9. Answers include: Tell nurse right away if alarm sounds. Report kinks or disconnected tubing right away. Report biting on the tube. Answer call lights promptly. Give oral care often. Report mouth sores or discomfort. Reposition at least every two hours. Follow positioning orders. Give regular skin care to prevent pressure ulcers. Allow time for rest. Be patient during communication. Provide emotional support. Do not move spare artificial airway tubes or bag valve masks. Report the alarm sounding, a collection of secretions in tubing, mouth sores or discomfort, cracks, breaks, or sores on the skin, change in vital signs, nervousness or anxiety, or depression to the nurse.
10. Answers include: elevated heart rate and respiratory rate; elevated temperature; chills; feeling of sickness or weakness; low blood pressure; decreased urine output; headache; skin rash; shortness of breath; or confusion or a change in mental status
11. Signs of respiratory distress include gurgling, high respiratory rate, shortness of breath, dyspnea, or pallor, or cyanosis.
12. Air, blood, pus, or fluid
13. Answers include: changes in amount, color, or consistency of chest drainage
14. A nasogastric tube is inserted into the nose, down the back of the throat through the
esophagus and into the stomach. A PEG tube is placed through the skin directly into the abdomen.

15. Nursing assistants do not insert tubes, give the feedings, or clean or suction the tubes.

16. With TPN, nutrients are received intravenously, bypassing the digestive tract.

17. Answers include: difficulty breathing, shortness of breath, change in vital signs, pain, drainage, bleeding, changes in I&O, or edema