HYBRID COURSE MODEL TOOLKIT

1. What is it

The Basic Skills/Specialty Course Hybrid is a teaching model that fully integrates basic skills enhancement services with a specific, community college vocationally focused specialty course. The basic skills component lays the foundation for and prepares participants to be successful in the vocational specialty course.

2. Partners and their Roles

Capitol Region Education Council (CREC) (basic skills) and Capital Community College (clinical specialty course) collaborated in the hybrid course for the long term care project. Instructors met prior to the start of the Basic Skills class to plan the course design and to select appropriate vocational reading material to include in the basic skills segment and to assist with student writing assignments in the specialty course. Teachers shared course curriculum that included student expectations. In addition, teachers met briefly each week before the specialty class. The purpose of these meetings was to share assignments and discuss student progress. Since additional students were enrolled in the clinical specialty course that did not attend basic skills course, this provided the community college clinical specialty instructor the opportunity to have a weekly check on the needs of the basic skills students.

3. Course Design

Basic skills classes are 2 hours, twice each week for 15 weeks; clinical specialty course meets 2 hours per week for 6 weeks. The clinical specialty course was encapsulated in the basic skills class (weeks 6-12), therefore reducing the basic skills class to once per week during those 6 weeks. The basic skills instructor attended all specialty classes to develop an understanding of the course content. She provided review, guidance and assistance in comprehending clinical specialty course material and provided support to students. Her role evolved during the 6 weeks and she took an active role in working with students to help with problem areas and increase student confidence. She observed that, although students had a general understanding of the specialty lesson, they were having a very difficult time recalling specific facts or labels. This led the teacher to initially be the class "note taker," providing copies of the notes in the following basic skills class to review with students. This also led her to include the skill of note taking into the writing curriculum. (Course Curriculum is included).

4. Goals & Objectives of Hybrid Design

The hybrid design was initially developed as a way to ensure student success & completion in the clinical specialty course and to better contextualize vocational material in the basic skills course. Historically, students were having difficulty in the specialty course with the writing assignments. The writing section of basic skills attempted to prepare students by practicing weekly case study writing, with the instructor modeling good writing habits. The teacher provided oral and written evaluation of the students' writing, and students were expected to edit and rewrite to correct errors.

The reading material that was used in the class included articles on the specialty course topic and identifying information relevant to the Certified Nursing Assistant (CNA) position. This intended to provide a vocabulary foundation and an initial understanding of the material to be covered in the specialty and application to present job situation.

5. Outcomes

A. Objective

*100% of students that enrolled in the basic skills course completed the class. In addition, once the specialty course began, additional students began attending basic skills and still others requested copies of the weekly specialty notes.

*Student test scores increased by an average of 9.8 points in Reading and 5.3 points in Math. This compared to 3.0 and 2.6 points, respectively in a comparable non-hybrid class in another employer location.

*Student writing skills (measured by teacher-made evaluation) improved dramatically

B. Anecdotal

*Students who attended the basic skills course were more engaged in the specialty course. They were consistently prepared with their assignments and were willing to volunteer to share their case studies with the class.

*Participants were more willing to take additional course after completing hybrid

*Students claimed they felt "special" and that they increased their level of confidence

INTEGRATING ADULT BASIC EDUCATION AND COMMUNITY COLLEGE CLINICAL SPECIAL COURSES IN CURRICULA FOR HYBRID COURSE

1. **Reading Comprehension**
   Reading comprehension lessons are derived from articles relevant to Certified Nursing Assistant (CNA) work or special course topics. Reading selections may be suggested or provided by nursing home administration or special community college clinical course instructor. Vocabulary lists relevant to special courses will also be provided and discussed.

Reading Comprehension Strategies from ABE Curriculum

- *Pre Reading Strategies
- *Reading for Main Idea
- *Identifying Supporting Ideas
- *Using Context to Determine Vocabulary Meaning
- *Identifying Inferences and Drawing Conclusions
- *Summarizing
- *Written Responses to Text

Activities Specific to Special Course

- *Introduce Special Course Vocabulary
- *Focus on Vocabulary in Articles Identified on Clinical Special Course Vocabulary List
- *Emphasis on Identifying and Understanding Information Relevant to CNA position and clinical specialty course
- *Understanding of Reading Material in the Clinical Specialty Course
- *Use articles for reading material that provide introduction to specialty course material

2. **Writing Activities**
   Writing activities will emphasize the application of basic skills to job or special course-related topics. Writing expectations for CNAs may be provided by nursing home administrator. Case studies and other written requirements for the special course will be suggested by the instructor.

Writing Strategies from ABE Curriculum

- *Recognizing subjects and predicates
- *Identifying and writing complete sentences
- *Identifying and correcting sentence fragments
- *Identifying and correcting run-on sentences
- *Capitalization
- *Punctuation
- *Writing focused paragraph with main idea and supporting details
- *Using a dictionary or other spelling aid

*Editing for spelling, punctuation and capitalization
*Editing for grammar and sentence construction

Activities Related to Special Course

Present and Practice "DO IT" Case Study Model (attached)
*Assist in Writing of Case Studies as Required by Special Course Instructor
*Expect Use of Special Course Vocabulary in Witten Assignments
*Write Incident Reports
*Write Report of Maintenance Issue and Incident Reports
*Instruction in Note Taking Strategies

3. **Math Activities**

For the Math component, there will be emphasis on mastering basic operations for whole numbers, decimals and fractions, and problem solving. Class instruction will include the following:

*Basic Skills pre-test
*Place value
*Rounding
*Operations with Whole Numbers (Addition, Subtraction, Multiplication, Division
*Operations with Decimals
*Operations with Fractions
*Calculate percentage
*Measurement
*Converting Units of Measurement
*Calculating Average
*Interpreting Graphs and Charts
*Problem Solving Strategies
*Application of Skills to Word Problems
*Calculator Usage

*This model was developed by and is the property of Capital Workforce Partners

GUIDELINES FOR THE CARDS

"DO IT"*

D **ESCRIPTION** – Tell us about the resident – history, diagnosis, how long they have been at the facility, a little about their life.

O **BSERVATIONS** – What do you see? Is what you observe a physical, psychosocial, or quality of life aspect of aging? How is it impacting the resident, how are they coping/dealing with this issue of aging?

I **NTERVENTIONS** – What are some possible ways to address the issue of aging being observed?

T **RIED AND TRUE** – What did you try in an attempt to address the issue of aging observe? How did it work? What might you try the next time? How did the resident react?

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SAMPLE NOTES FROM 11/24/09 GRIEF & BEREAVEMENT

Grieving process
*Starts even before patient dies
*Family may also be grieving additional losses as well as loss of patient
*Relationships that were not good & can't be fixed
*Loss of payck/support, companionship
*Brings up other losses
*May come out as anger
*May be felt when another patient takes the bed when your patient dies
*When you give undivided attention to grieving person for even short time-it is comfort
*People grieve in different ways-may be influenced by culture or religion
*Person feels out of place w/ happy people, feels other people's concerns/feelings significant
*No "should" in feeling grief
*Unresolved grief causes emotional stress
*When you lose a family member you are unable to be a caregiver – you are mourner

*Loss issues affect
**patient-loss of independence, being needed, their role
**family
**professionals-have relationship w/ patient-feelings of loss may be unexpected

*Anticipatory grief

*Normal reactions to grief
**experience pain of loss
**accept reality of loss
**adjusting to life w/o loved one
**brings up previous losses-how did you deal w/ it before? Remembering other people who have died

*Early stages of grief
**stomach in knots
**shock & disbelief
**numbness
**agitation/restlessness
**nausea
**panic
**hearing/seeing loved one cry quickly/often

11/24/09 Notes continued

*Emerging awareness of grief
*Adjusting to new life
**fear
**guilt
**anger
**crying spells
**withdraw from life
**mood swings
**changes in sleep/appetite
**trouble concentrating
**trouble concentrating
**personality shifts

*Complicated grief
**absence of expressions of grief
**denial
**stoicism
**prolonged grief (many years)
**excessive fear, anger, guilt

*Risk factors
**poor support systems
**multiple losses & stresses
**ambivalent (poor or stressful) relationship between deceased & bereaved

SAMPLE READING

MATERIALS

HOSPICE

What Is Depression?

Everyone occasionally feels blue or sad, but these feelings usually pass within a couple of days. When a person has a depressive disorder, it interferes with daily life and normal functioning. It also causes pain for both the person with the disorder and those who care about him.

Depression is a common but serious illness. Most people who experience it need treatment to better, although many people with a depressive illness never seek treatment. The vast majority, however, even those with the most severe depression, can get better with treatment.

Signs and symptoms of depression

People with depressive illnesses do not all experience the same symptoms. The severity, frequency, and duration of symptoms vary depending on the individual.

Symptoms can include:

- Persistent sad, anxious, or "empty" feelings.
- Feelings of hopelessness and/or pessimism.
- Feelings of guilt, worthlessness, and/or helplessness.
- Irritability; restlessness.
- Loss of interest in activities or hobbies once enjoyed, including sex.
- Fatigue and decreased energy.
- Difficulty concentrating, remembering details, and making decisions.
- Insomnia, early morning wakefulness, or excessive sleeping.
- Overeating, or appetite loss.
- Thoughts of suicide, or suicide attempts.
- Persistent aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment.

Causes of depression

There is no single known cause of depression. Rather, it likely results from a combination of factors.

Research indicates that depressive illnesses are disorders of the brain. Brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people who have depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleep, appetite, and behavior appear to function abnormally. In addition, important neurotransmitters—chemicals that brain cells use to communicate—appear to be out of balance.

Some types of depression tend to run in families. However, it can occur in people without any family history of depression. In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode.

Depression in women

Depression is more common among women than among men. Researchers have shown that hormones directly affect brain chemistry that controls emotions and mood. For example, women are particularly vulnerable to depression after giving birth, when hormonal and physical changes, along with the new responsibility of caring for a newborn, can be overwhelming. Many new mothers experience a brief episode of the "baby blues," but some develop postpartum depression. This is a much more serious condition that requires active treatment and emotional support for the new mother. Some studies suggest that women who experience postpartum depression often have had prior depressive episodes.

Some women also may be susceptible to a severe form of premenstrual syndrome (PMS). This is a condition resulting from the hormonal changes that typically occur around ovulation and before menstruation begins. During the transition into menopause, some women experience an increased risk for depression.

Finally, many women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It remains unclear why some women develop depression when faced with enormous challenges while others with similar challenges do not.

Depression in men

Men often experience depression differently than women and may have different ways of coping with the symptoms. Men are more likely to report fatigue, irritability, loss of interest in once-pleasurable activities, and sleep disturbances. Women are more likely to say they have feelings of sadness, worthlessness, and/or excessive guilt.

Men are more likely than women to turn to alcohol or drugs when they are depressed. They may also become frustrated, discouraged, irritable, angry, and sometimes abusive. Some men throw themselves into their work to avoid talking about their depression with family or friends. They may engage in reckless or risky behavior. And even though more women attempt suicide, many more men die by suicide in the United States.

Depression in older adults

Depression is not a normal part of aging, and studies show that most seniors feel satisfied with their lives, despite increased physical ailments. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms, and they may be less inclined to experience or acknowledge feelings of sadness or grief.

Detection and treatment

Depression, even the most severe cases, is a highly treatable disorder. As with many illnesses, the earlier that treatment can begin the better.

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What Is Depression?

continued from page 7

The first step to getting appropriate treatment is to visit a doctor. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities. If the doctor can eliminate a medical condition as a cause, he or she should conduct a psychological evaluation or refer the patient to a mental health professional. Once diagnosed, a person with depression can be treated with a number of methods. The most common are medication and psychotherapy.

Medication

Antidepressants work to normalize naturally occurring brain chemicals called neurotransmitters, notably serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists studying depression have found that these particular chemicals are involved in regulating mood.

For all classes of antidepressants, patients must take regular doses for at least three to four weeks before they are likely to experience a full therapeutic effect. If one medication does not work, patients should be open to trying another. Research has shown that patients who did not get well after taking a first medication often got better after they switched to a different medication or added another medication to their existing one.

Psychotherapy

Several types of psychotherapy (or "talk therapy") can help people with depression.

For mild to moderate depression, psychotherapy may be the best treatment option. However, for major depression or for certain people, psychotherapy may not be enough and should be combined with medication.

Researchers are looking for ways to better understand, diagnose, and treat depression among all groups of people. New potential treatments are being tested that give hope to those who live with depression that is particularly difficult to treat. Researchers also are studying the risk factors for depression and how it affects the brain.

This information is intended to supplement your HHA training. However, your first duty is always to follow the policies and procedures prescribed by your current employer and/or state law. For more information, or if you have questions about this topic, consult your supervisor.

The information for this article was provided by the National Institute of Mental Health (NIMH) and was edited for use in Home Health Aide Digest.

HOW CAN I HELP Someone Who Is Depressed?

If you know someone who is depressed, it affects you too. The first and most important thing you can do to help is to get an appropriate diagnosis and treatment. You may need to make an appointment on the person's behalf and go with him or her to see the doctor. Encourage the person to stay in treatment, or to seek different treatment if no improvement occurs after six to eight weeks.

Here are some steps to take:

- Offer emotional support, understanding, patience, and encouragement.
- Talk with the person and listen carefully.
- Never criticize feelings the person expresses, but point out realities and offer hope.
- Never ignore comments about suicide. Report these comments to the person's therapist or doctor.
- Invite the person out for walks, outings, and other activities. Keep trying if he or she says no at first. But don't push. Although diversions and company are needed, too many demands may increase the person's feelings of failure.
- Remind the individual that with time and treatment, the depression will lift.

"Fear cripples the soul, so you just have to fight it."

— Diane Keaton

Symptoms:

- Patients need reassurance that symptoms will never be overwhelming
- Sometimes the fear that a symptom will worsen can be more crippling than the symptom itself, and reassurance that effective treatment is available may be all a patient needs.

Dyspnea:

- Dyspnea is one of the most feared symptoms and is extremely frightening to dying patients.
- O_2 may continue to be psychologically comforting to patients and family members.
- If patients are already taking opioids for pain, dosages that relieve dyspnea must often be more than double the patient's usual dosages.
- Useful nondrug measures include providing a cool draft from an open window or fan and maintaining a calming presence.

Airway congestion :is best managed with drugs that dry secretions (eg, topical scopolamine, levsin)

Anorexia:

- Family members should understand that neither food nor hydration is necessary to maintain the patient's comfort.
- IV fluids, TPN, and tube feedings do not prolong the life of dying patients. All of these measures seem to increase discomfort and may hasten death.
- The only reported discomfort due to dehydration near death is dry mouth, which is easily relieved with oral swabs or ice chips.

Nausea and Vomiting

- Many seriously ill patients experience nausea, frequently without vomiting. Etiology – increased intracrainial pressure, constipation, gastritis.

Constipation

- Regular bowel movements are essential to the comfort of dying patients, at least until the last day or two of life.

Pressure Ulcers

- Prevention requires relieving pressure by rotating the patient or shifting the patient's weight every 2 h; a specialized mattress or continuously inflated air-suspension bed may also help.
- Incontinent patients should be kept as dry as possible.

Confusion

- Mental changes that can accompany the terminal stage of a disorder may distress patients and family members; however, patients are often unaware of them.
- Simple causes of confusion and agitation should be sought.
- Agitation and restlessness often result from urinary retention, which resolves promptly with urinary catheterization.

Depression

- Providing psychologic support and allowing patients to express concerns and feelings are usually the best approach.
- A skilled social worker, physician, nurse, or chaplain can help with these concerns.

Pain

- About ½ of patients dying of cancer have severe pain. Yet, only ½ of these patients receive reliable pain relief. Many patients dying of organ system failure and dementia also have severe pain.
- Sometimes pain can be controlled but persists because patients, family members, and physicians have misconceptions about pain and the drugs (especially opioids) that can control it, resulting in significant underdosing.
- "The fear of these patients was that morphine suggested imminent death (and also possibly hastened death) and that once commenced would mean that they would not be able to function normally. However, morphine if used properly, can actually promote quality of life by allowing patients with pain to function better."
- Oral opioids reach maximum serum concentration within an hour, peak effects and peak side effects also
- As long as adverse effects of sedation or respiratory depression aren't observed, additionally medication, including breakthrough doses can be administered every one to two hours.
- There is no convincing scientific evidence that administering opioids, even in very high doses, accelerates death
- Respiratory depression and other changes in breathing are part of the dying process and are more likely from disease and multisystem organ failure than from opioids.
- Nurses may be reluctant to provide adequate doses of opioid analgesic, even when they know that their patients are dying, in part because of fears that they will be held legally or professionally liable for contributing to an earlier death.
- Nurses administer these meds after their assessment of the patient's pain level; their intent is to relieve the patient's pain or distress.
- Death of a terminally ill patient cannot be prevented that it's the nurse's obligation to control the patient's pain. The patient death is beyond nurse's control.
- To leave a person in avoidable pain is a fundamental breach of human rights.
- Patient in pain respond differently to opioids than do persons without pain and pain is a powerful antagonist to the respiratory depressant effect of opioids, and as pain increases and the level of opioid necessary for pain relief goes up, so does the tolerance to the respiratory side effects.

Myth: People who take morphine die sooner because morphine causes them to stop breathing.

- Fortunately, patients quickly adjust to any effect that morphine may have on their breathing. We prescribe a small initial dose, gradually increasing it if needed. So rarely do breathing problems occur, they are usually not even listed as side effects. In fact morphine is a drug of choice for breathing distress in people with end-stage heart or lung disease: it makes their breathing more comfortable.

Myth: People should wait until their pain is bad to take morphine so it will be effective when it's really needed.

- There is no upper dose limit to the use of morphine or other opiates. If pain increases we can increase the dose; this is true of very few other medications. Using it when it's needed early in the course of a terminal illness does not mean that it won't continue to work later in the disease.
- Morphine, one of the oldest drugs in existence, has found a well-deserved place in the new field of palliative care: the relief of pain and other symptoms. We recommend opiates for pain control only if they are needed. When they are needed, they are often successful in controlling the pain and suffering of terminal illness.

Stress

- A few people approach death peacefully, but more patients and family members experience stressful periods.
- Sedatives should be used sparingly and briefly.
- The clinical team should identify such high-risk situations so that they can mobilize the resources needed.

Grief

- For patients, grief often starts with denial caused by fears about loss of control, separation, suffering, an uncertain future, and loss of self.
- Members of the clinical team can help patients accept their prognosis by listening to their concerns, helping them understand that they can control important elements of their life.

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Hospice Care

What is Hospice Care?

Hospice programs are available to help terminally ill individuals live their remaining days with dignity. These programs can assist the family (or other designated caregiver) in making the patient as comfortable as possible, and assistance is available around the clock, seven days a week.

Hospice is primarily a concept of care, not a specific place of care. Hospice care usually is provided in the patient's home. It also can be made available at a special hospice residence. Hospice is a combination of services designed to address not only the physical needs of patients, but also the psychosocial needs of patients, their loved ones. Hospice combines pain control, symptom management and emotional and spiritual support. Seniors and their families participate fully in the health care provided. The hospice team develops a care plan to address each patient's individual needs. The hospice care team usually includes:

- The terminally ill patient and his or her family caregiver(s)
- Doctor
- Nurses
- Home health aides
- Clergy or other spiritual counselors (e.g., minister, priest, rabbi)
- Social workers
- Volunteers (if needed, and trained to perform specific tasks)
- Occupational, physical, and/or speech therapists (if needed)

When Is Hospice Care Appropriate?

As with many end-of-life decisions, the choice to enroll in a hospice care program is a deeply personal thing. It depends almost as much on the patient's philosophy of living and spiritual beliefs as it does on his or her physical condition and the concerns of family members. The following case study shows how one patient decided that hospice care was what she wanted and why it was right for her:

How Can I Pay for Hospice Care?

Medicare, private health insurance, and Medicaid (in 43 states) cover hospice care for patients who meet eligibility criteria. Private insurance and veterans' benefits also may cover hospice care under certain conditions. In addition, some hospice programs offer health care services on a sliding fee scale basis for patients with limited income and resources. To get help with your Medicare questions, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the speech and hearing impaired) or look on the Internet at http://www.medicare.gov.

Case Study

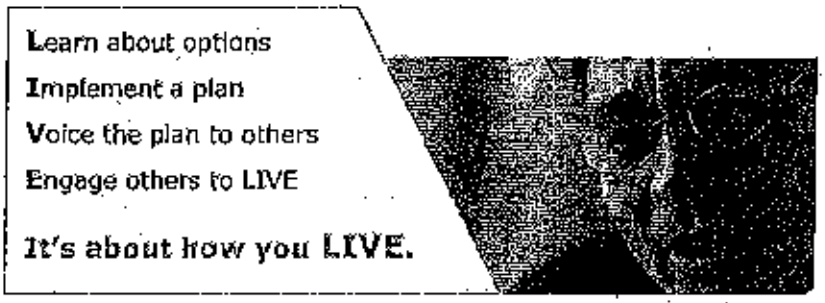
Lynda was 57 years old when she was diagnosed with liver cancer. In spite of the best medical treatment her doctors could provide, her cancer proved incurable. Although the prospect of dying frightened her, Lynda wanted to receive professional assistance to prepare herself and her family for her death.

She realized that she wanted to be cared for at home by her sister, Sara. The local hospice service made the arrangements so that this would be possible. Hospice staff made sure that Lynda's family would have the equipment they needed, and trained Sara in how to administer medications to relieve Lynda's pain.

The hospice program also sent a registered nurse to the house to oversee Lynda's care, and the nurse consulted with a doctor to make sure Lynda was as comfortable as she could be during her final weeks. In addition, the hospice service sent a personal care attendant to bathe Lynda twice a week, and a social worker and a clergyman to provide spiritual and grief counselling for Lynda and Sara.

Lynda lived the last six weeks of her life at home before she passed away surrounded by Sara and the rest of her family.

Caring Connections



Frequently Asked Questions

What Does Grief Feel Like?

Following a death or loss, you may feel empty and numb, as if you are in shock. You may notice physical changes such as trembling, nausea, trouble breathing, muscle weakness, dry mouth, or trouble sleeping and eating.

Feelings of deep sadness and sorrow are common in grief. These and other feelings and thoughts are common. Often, people find themselves engaging in behaviors that are different or unusual, or thinking in ways that are unfamiliar and disturbing. Finding their beliefs challenged in grief, many people experience a kind of "spiritual crisis" following loss.

You may become angry - at a situation, a particular person, or just angry in general. Guilt is a common response which may be easier to accept and overcome by looking at the experience in terms of "regret." When we think "I regret I was not in the room when he died" or "I regret I was not able to speak more openly about dying" it is less critical than "I feel guilty about my behavior."

People in grief may have strange or disturbing dreams, be absent-minded, withdraw socially, or lack the desire to participate in activities that used to be enjoyable. While these feelings and behaviors are normal during grief, they will pass.

In general, grief makes room for a lot of thoughts, behaviors, feelings and beliefs that might be considered abnormal or unusual at other times. Following significant loss, however, most of these components of grief are, in fact, quite normal.

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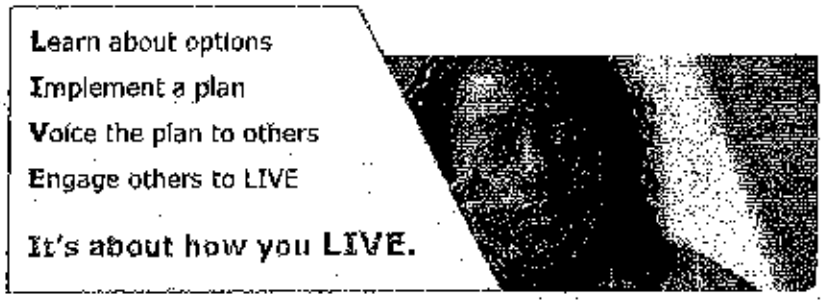

Frequently Asked Questions

How Long Does Grief Last?

Grief lasts as long as it lasts. Although this statement may not seem helpful to you, it is true. It is different for each person. It is important to realize that, while grief and its intensity will subside, most find that it is replaced with a "sweet sadness" that comes at times of remembrance. This is simply the acknowledgement that significant loss has occurred. That the loss, and the person who is gone, matters and affects our lives.

There are many factors that affect how long a person grieves, including age, maturity, personality, physical and mental health, coping style, culture, spiritual and religious background, family background, other stressors and life experiences. The time spent grieving may also depend on how prepared a person was before the loss was experienced.

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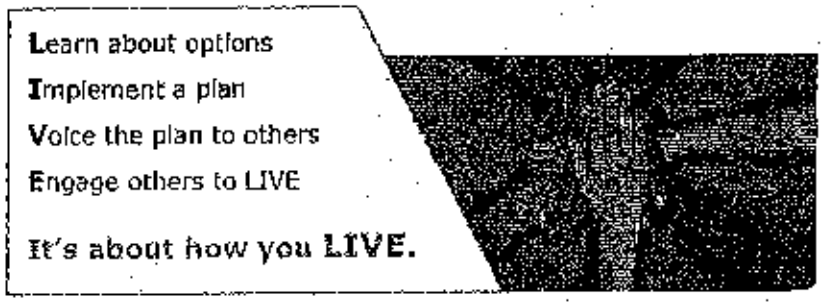

Frequently Asked Questions

How Will I Know When I'm Done Greiving?

After a significant loss, you may be consumed and overwhelmed by the grief reactions you are experiencing. In time, as the reality of the loss sinks in, and all the changes as a result of the loss have been experienced, you will learn to adjust to living with your loss. Eventually, even after significant loss, you will realize you are grieving less as you discover renewed energy in living. You will become less consumed by the impact of the loss and begin to draw comfort rather than pain from the memories. In a sense, you are never "finished grieving." With a significant loss, there will always be moments when you will remember the loss, and perhaps you experience some of the feelings of grief, as in the times of "sweet sadness" mentioned above. Fortunately, the time period between these surges will lengthen considerably as you learn how to cope with your loss.

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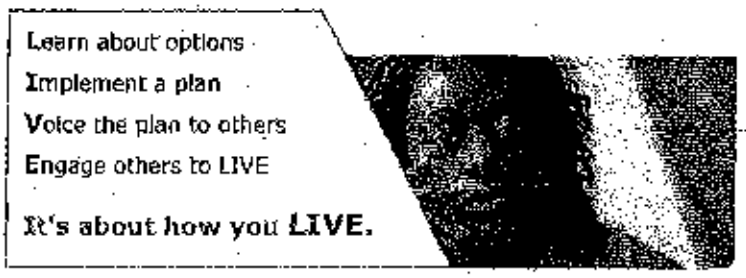

Types of Grief and Loss

Anticipatory Mourning

When a person or family is expecting death, it is normal to begin to anticipate how one will react and cope when that person eventually dies. Many family members will try to envision their life without that person and mentally play out possible scenarios, which may include grief reactions and ways they will mourn and adjust after the death.

Anticipatory mourning includes feelings of loss, concern for the dying person, balancing conflicting demands and preparing for death. Anticipatory mourning is a natural process that enables the family more time to slowly prepare for the reality of the loss. People are often able to complete unfinished "business" with the dying person (for example, saying "good-bye," "I love you," or "I forgive you").

Sudden Loss

Grief experienced after a sudden, unexpected death is different from anticipatory mourning. Sudden, unexpected loss may exceed the coping abilities of a person, which often results in feelings of being overwhelmed and/or unable to function. Even though one may be able to acknowledge that loss has occurred, the full impact of loss may take much longer to fully comprehend than in the case of an expected loss.

Complicated Grief

There are times when grief does not progress as expected; the intensity and duration of grief is prolonged and dramatically interferes with a person's ability to function. Symptoms of depression and anxiety may be prevalent and prolonged. Thoughts, feelings, behaviors and reactions may seem to persist over long periods of time with little change or improvement. In these situations, it is important to seek help from a qualified professional who can assess your individual situation and make recommendations that will help. It is important to seek help; complicated grief does not subside on its own.

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VOCABULARY WORDS FROM HOSPICE/HEALTH RELATED ARTICLES

1. *What Is Depression?*
   Severity
   Frequency
   Duration
   Persistent
   Pessimism
   Worthlessness
   Irritability
   Restlessness
   Fatigue
   Insomnia
   Abnormally
   Trauma
   Episode
   Vulnerable
   Postpartum
   Hormonal
   Ovulation

2. *Symptoms*
   Reassurance
   Secretions
   Hydration
   Agitation
   Etiology
   Intracranial
   Imminent
   Accelerates
   Multisystem
   Fundamental
   Antagonist
   Terminal
   Prognosis

3. *Hospice Care*
   Psychosocial
   Philosophy
   Absent-minded
   Abnormal
   Renewed
   Surges
   Anticipatory
   Intensity
   Prolonged
   Anxiety

Vocabulary

Hospice Care for CNAs

1) **Hospice** (n) 1: a lodging for travelers, young persons, or the underprivileged, esp when maintained by a religious order 2: a facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill

2) **Dyspnea** (n) difficult or labored respiration

3) **Emotional** (adj)

   Emotion (n) 1: the affective aspect of consciousness: feeling 2: a state of feeling

4) **Symptom** (n) 1: subjective evidence of disease or physical disturbance 2: something that indicates the presence of bodily disorder

5) **Interdisciplinary** (adj) involving two or more academic, scientific or artistic disciplines

6) **Bereavement** (n) the state or fact of being bereaved; the loss of a loved one by death

7) **Anxiety** (n) 1a: painful or apprehensive uneasiness of mind usually over an impending or anticipated ill b: fearful concern or interest 2: an abnormal and overwhelming sense of apprehension and fear often marked by physiological signs (as sweating, tension and increased pulse), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it

8) **Delirium** (n) 1: a mental disturbance characterized by confusion, disordered speech and hallucinations 2: frenzied excitement

9) **Process** (n) a natural phenomenon marked by gradual changes that lead toward a particular result

10) **Cognitive** (adj)

    Cognition (n) the act or process of knowing, including both awareness and judgment

Definitions derived from Webster's New Collegiate Dictionary

Hospice

1. What are the different decisions that must be made as a person nears the end of life? 2. Using your experience, explain some of the barriers that you have seen to making end of life decisions.
1. What are some of the common symptoms that occur with end of life processes? 2. Explain 3 ways that symptoms may be helped with the intervention of the CNA.
1. What do you think are the major components of effective communication? 2. Explain a situation in which social worker intervention may have helped an emotional crisis on the unit.
1. Discuss the difference between religion and spirituality. 2. Identify 4 things that you would want to be remembered by.
1. Discuss the stages of grief. 2. Identify the role that the CNA may play in helping a patient/family through grief.
1. Discuss how attending this program has changed the way that you take care of patients. 2. Explain what you might do to prevent job stress from causing you to "burn out".

What are 5 diseases which may progress to hospice.

List 3 important aspects in communicating with a hospice family.

List 5 "don'ts" in communication with resident.

What are common types of pain your residents experience.

How would you know when a patient with dementia is uncomfortable? What would you do about it?

How is food important in your family.

What are common types of pain your residents experience.

What are symptoms patients may experience when they are in impending death. How would you answer "how much longer does my loved one have?"

List signs of nearing death awareness in discussing a patient or family member.

How are religion and spirituality different?

What are common fears about death?

What do you do to deal with workplace grief?