



MODULE 8



MEDICAL ISSUES

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*IT'S ABOUT WHAT'S
IMPORTANT TO THEM, NOT
WHAT'S IMPORTANT FOR
THEM.*

Source: Nancy Thaler

Introduction

The medical status of an individual can dramatically impact his/her quality of life. As a QIDP, you are responsible for coordinating and/or providing supports to enhance an individual's capacity for health and safety. Where necessary, you will need to develop supports to fill gaps for an individual who cannot manage each of these independently.

First and foremost in evaluating health services is to know the individual. A basic physical assessment needs to be done to provide a baseline. This establishes what is normal for the individual. Variations above or below the baseline range are indicators of potential problems or emergencies which require interventions. Inform appropriate staff, family, administrators, etc. Make sure the information is passed on to those that have a need to know.

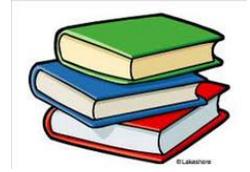
Although 98.6 degrees is the average body temperature, your personal baseline temperature may be lower or higher. Know normal ranges for temperature, blood pressure, pulse rate, bowel movement patterns, etc.

Even changes in behavior can often be indicators of health issues. If a person who is usually active is now very quiet or if a person who is usually cooperative and compliant becomes aggressive or self-abusive, changes in health status may be the underlying cause of these behavior changes.

The remainder of this module will focus on a variety of aspects related to health and safety. In each case, always ask yourself, "How can I relate this to an individual?" You may want to keep Rachel in mind.

Background Reading

Developing Staff Competencies For Supporting People With Developmental Disabilities: An Orientation Handbook, By James Gardner. Chapter 17



Developing Staff Competencies For Supporting People With Developmental Disabilities: An Orientation Handbook, By James Gardner. Chapter 14

Developing Staff Competencies For Supporting People With Developmental Disabilities: An Orientation Handbook, By James Gardner. Chapter 12

In your position as a QIDP you will be coordinating individuals' access to medical consultations and medical services. Agencies' policies and affiliations with medical professionals differ and may be based on location or personal preference; i.e., small towns may have only one doctor; some individuals may have their own private medical professionals that they use for consultations, etc.

Medical Consultation

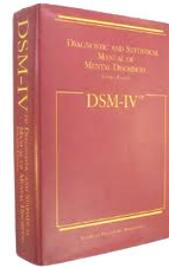
Directions: List below the professionals you can consult on health related issues and services.



- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖

Medical References/Resources

- ❖ DSM-IV
- ❖ Physicians Desk Reference
- ❖ Nursing and Health Services Procedure Manual
- ❖ Agency specific policies and procedures
- ❖ Nurse Drug Guide (various publishers)
- ❖
- ❖



Many times a disease or medical condition affects the person’s temperature, plus, respiration, and/or blood pressure. An individual may also lose or gain weight or fail to grow normally. Even if you are not required to measure these, this information is available in an individual’s record and you will need to understand what it means.

Basic Physical Assessment

List the individuals in your organization who are responsible for completing basic physical assessments.

- ❖
- ❖
- ❖
- ❖
- ❖

COMPONENTS OF A BASIC PHYSICAL ASSESSMENT

The following components are included in a basic physical assessment. It is important temperature, pulse, respiration and blood pressure be taken occasionally when an individual is in his or her usual state of health. This data will assist in establishing a baseline. Otherwise, there are no data for comparison when the person is ill.

Temperature:

Temperature is the degree of heat maintained by the body.

Normal Body Temperature (Averages)	
Oral	98.6° F
Axillary	97.6° F



Temperatures varying from 97 degrees to 99 degrees F are considered normal and compatible with health.

Factors causing an increase in heat production and a rise in temperature are:

- ❖ Exercise- muscles working increase heat production and cause feelings of warmth throughout the body.
- ❖ Shivering- another form of muscular activity.
- ❖ Ingestion of food- increasing fuel supply increases amount of heat.

- ❖ Strong emotions- excitement, anxiety, nervousness and similar emotions cause increased activity of secretory glands to increase heat production in body.
- ❖ Increased temperatures of environment- high room temperature or hot bath may increase temperature.
- ❖ Brief exposure to cold- stimulates body to increased heat production.
- ❖ Very high external temperature- may upset balance of heat regulation and produce high body temperature, as in sunstroke.
- ❖ Illness - an increased metabolic rate, used to fight infection, may cause an increase in body temperature.

Factors causing a decreased heat production and a lower temperature are:

- ❖ Illness - muscular activity curtailed and less heat is produced.
- ❖ Fasting - inadequate supply of food or fuel leads to decreased heat production.
- ❖ Lowered vitality- in conditions of illness or injury in which body resistance is lowered, body functions are slowed and muscular activity diminishes so heat production is decreased.
- ❖ Prolonged exposure to cold - reduces body temperatures
- ❖ Sleep - when body is less active, less heat is produced and body temperature is lowered.
- ❖ Depression - of the nervous system, mental depression, unconsciousness, use of narcotic drugs, all act to lessen activity and thus decrease heat production.

Fever

**Fever is the elevation of body heat above normal.
Technical name – pyrexia.**

Cause of fever: disturbance in heat-regulating mechanism.

Symptoms of fever:

- ❖ Flushed face with dry skin and hot.
- ❖ Eyes bright and anxious in expression.
- ❖ Rapid, shallow breathing and increased pulse rate.
- ❖ Unusual thirst, loss of appetite, headache and complaints of nausea.

In extreme temperature:

- ❖ Urine scant and concentrated
- ❖ Diarrhea
- ❖ Constipation
- ❖ Delirium

Nursing care of people with fever:

- ❖ Depends on disease causing the fever.
- ❖ Specific orders of doctor.
- ❖ Accurate taking and recording of temperature at regular intervals.
- ❖ Cool water sponging.
- ❖ Dry bed linens.
- ❖ Force fluids.
- ❖ Proper diet.
- ❖ Good oral hygiene.

Note: Fever is one of the body's defense mechanisms to fight illness. Consult medical personnel before using medication to control fever.

Thermometer

A thermometer is an instrument used to measure the temperature of the body.

Digital Pacifier Thermometer

With the digital pacifier thermometer you can easily get a reading within 90 seconds. This thermometer resembles a regular pacifier. When the thermometer reaches the maximum temperature it beeps.

No-touch thermometer

A no-touch thermometer allows you to get a temperature reading without having direct contact with the skin. You press a button on the thermometer, which releases two safe LED lights approximately three centimeters from the forehead. Within seconds the temperature appears on the display screen.

Tympanic Thermometer

Another popular thermometer is the tympanic or ear thermometer. This thermometer provides accurate readings when it is aligned in the ear canal.

Pulse

Pulse is the rhythmic expansion of an artery produced by increased volume of blood forced into it by contraction of left ventricle at each heartbeat.

Locations for taking pulse:

- ❖ Radial artery - thumb side of wrist (usually used).
- ❖ Temporal artery - just above and to the outer side of eye orbit.
- ❖ Carotid artery - either side of neck directly in front of ear lobe.
- ❖ Femoral artery - in the groin.

Do not use your thumb when taking pulses; your thumb has a pulse of its own.

Factors causing variation in pulse rate:

- ❖ Age.
- ❖ Gender (females faster pulse than males).
- ❖ Physique - short and heavy people more rapid pulse than thin person.
- ❖ Exercise - increased muscular activity causes temporary increase.
- ❖ Food - slight increase for a few hours.
- ❖ Posture - increased when standing, lowered when sitting or reclining.
- ❖ Mental or emotional disturbance - temporarily increases pulse rate.
- ❖ Increased body temperature - pulse usually elevated 10 beats per each degree of elevated temperature.
- ❖ Disease condition - heart, thyroid disturbance, infections are examples.

- ❖ Drugs - stimulant drugs increase pulse rate; depressant drugs decrease pulse rate.
- ❖ Blood pressure - when blood pressure is low, pulse rate increases in attempt to increase flow of blood and therefore increase blood pressure; in high blood pressure, pulse is decreased.

Characteristics of pulse:

- ❖ Rate - number of detectable pulsations per minute.
- ❖ Rhythm
 - Regular - beats are of uniform force and separated by equal intervals of time.
 - Irregular or intermittent - beat missed at regular or irregular intervals.
- ❖ Volume - full or large volume of blood in circulatory system is constant. Small, feeble, weak, thready, or flickering - volume decreased (example - hemorrhage).
- ❖ Pounding - pulse is large or full and rapid in rate.

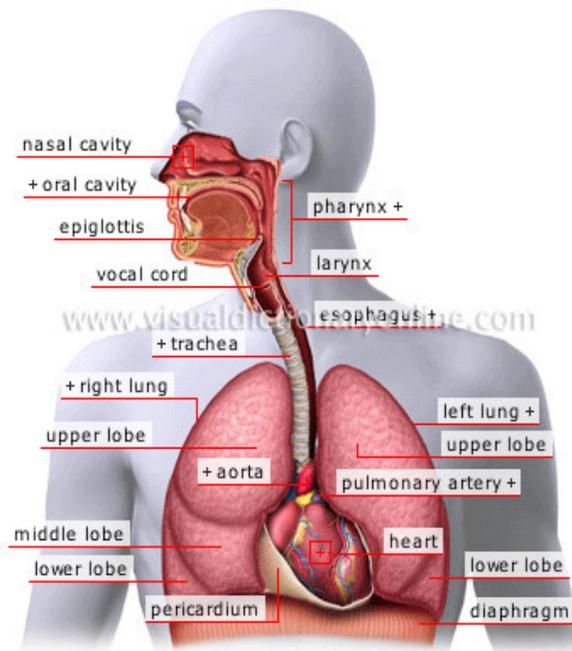
Volume of pulse is determined by size of pulse wave against fingers being used to take pulse.

Respiration

Respiration is the act of breathing. It is a continual process of drawing in and expelling air from lungs; the taking in of oxygen and elimination of carbon dioxide, water and other products of oxidation. Oxidation is process of substance combining with oxygen. Respiration is exchange of gases between an organism and its environment. This is common characteristics of all living things. It is essential for chemical changes of metabolism which must take place if life is to be maintained.

Organs of Respiration:

- ❖ **Lungs**
- ❖ **Nose** - external organ in which air is inhaled and exhaled. Purpose: warms, moistens and filters air before it enters respiratory tract.
- ❖ **Pharynx** - muscular membranous tube between mouth and larynx.
- ❖ **Larynx** - structure of muscle and cartilage, lined with mucous membrane and located at the top of the trachea.
- ❖ **Trachea** - cylindrical, cartilaginous tube extending from larynx to bronchi.
- ❖ **Bronchi** - two main branches of trachea which extend into lungs.
- ❖ **Bronchioles** - subdivisions of bronchial tree within lungs leading to alveoli.
- ❖ **Alveoli** - functional units of respiration. Resembling microscopic sacs. This is where exchange of gases takes place.



Mechanics of Respiration:

- ❖ Each cell in body requires oxygen and food for maintenance of life and normal functioning.
- ❖ Chemical processes of metabolism takes place within cells so food and oxygen must be supplied to all body cells. Universal waste product of metabolism is carbon dioxide, which must be eliminated not only from cells, but from the body itself.
- ❖ Exchange of gases in man is a combined action of respiratory and circulatory systems.
- ❖ Usual ratio of respiration and pulse is approximately 1 to 4.

Factors causing variation in respiration:

- ❖ Age
- ❖ Gender (females slightly more rapid than males.)
- ❖ Rate - increased respiratory rate causes breathing to be shallow. If respiration rate is decreased, depth of respiration may increase.
- ❖ Exercise - muscular activity causes temporary increase in respiration.
- ❖ During digestion - due to muscular and metabolic activity.
- ❖ Disease conditions - depends on disease.
- ❖ Drugs - depressant drugs, i.e., morphine and general anesthetics cause respiration to be slower and deeper. Caffeine and atropine stimulate respiration, thereby increasing respiration rate and shallow breathing.
- ❖ Emotion - strong emotion i.e., fear, causes increased rate.
- ❖ Application of cold - stimulates nerve endings in skin and therefore breathing may be fuller and deeper.
- ❖ Application of heat - may increase respiratory rate temporarily and cause shallow breathing.
- ❖ Pain - severe pain causes increased respiratory rate and depth.
- ❖ Toxins - acute infections stimulate respiratory center and cause increased respiratory rate and sometimes depth.
- ❖ Fever - causes increase in pulse and respiratory rate.

- ❖ Hemorrhage - decreased volume of blood with subsequent decrease in oxygen carrying capacity causes increased respiratory rate and depth.
- ❖ Change in atmosphere pressure - in high altitudes, respiratory rate and depth increases as insufficient oxygen is available for external respiration. Normal amount of oxygen in the air is ample to meet needs of the body.
- ❖ Shock - when blood pressure falls below life sustaining levels, it causes increased respiratory rate and depth.

Conditions related to respiration:

- ❖ Apnea - a usually temporary period when breathing has ceased.
- ❖ Dyspnea - difficult or painful breathing.
- ❖ Cyanosis - blueness of skin and mucous membrane caused by lack of oxygen.

Blood Pressure

Blood pressure is the force exerted by the blood against the walls of the blood vessels as it flows through them. It is produced by a combination of heart rate, amount of blood ejected from the heart each time it contracts, body blood volume and blood vessel size.

- ❖ Systolic pressure is the highest degree of pressure exerted by the blood against the artery walls as the left ventricle contracts and forces the blood from it into the aorta.
- ❖ Diastolic pressure is the lowest degree of pressure or the point of lessened pressure when the heart is in its resting period which is just before contraction of the left ventricle. It is produced by body blood volume and vessel size.
- ❖ Pulse pressure is the difference between systolic and diastolic pressure and represents volume output of the left ventricle. Pulse pressure indicates tone of the arterial walls and is valuable in diagnosis and treatment.
- ❖ Hypertension is a condition of abnormally high blood pressure.
- ❖ Hypotension is a condition of abnormally low blood pressure.

- ❖ Blood pressure readings may vary by time of day and body position. Blood pressure readings are taken for the purpose of comparison, therefore, they should be taken daily at the same time and with the individual in the same position each time (i.e. sitting).

Normal Blood Pressure

- ❖ Blood pressure readings are recorded as a number of millimeters of mercury.

- ❖ Equipment used:

- Sphygmomanometer - (mercury or aneroid) - device used to measure blood pressure. It is a device which may have a dial on which blood pressure is recorded, or a graduated scale on which the height of a column of mercury is indicated.
- Stethoscope - various types are available. These are used basically for amplification and tone control.
- Electronic sphygmomanometer - device that records BP and pulse on a digital display; no stethoscope is needed.



Factors Causing Variation in Blood Pressure:

- ❖ Age: Blood pressure is lower in children than in adults; i.e., blood pressure of a young adult - 120/80; blood pressure of an older adult - 140/90
- ❖ Gender: Men usually have higher blood pressure than women in the same age bracket.
- ❖ Body Build: Obese people usually have higher blood pressure.
- ❖ Exercise: Muscular exertion will increase blood pressure, although return to normal will occur shortly after exercise is discontinued.
- ❖ Pain: Severe pain may cause a temporary and marked increase in blood pressure.
- ❖ Emotions: Fear, worry, excitement and other emotions will cause blood pressure to rise sharply.

- ❖ Disease: Diseases affecting the circulatory system may cause an increase in blood pressure; e.g., arterio or athero sclerosis, kidney diseases and diseases caused by bacterial toxins; diseases that weaken the heart action may lower blood pressure.
- ❖ Hemorrhage: This causes lower blood pressure by decreasing volume of blood in the vessels.
- ❖ Intra cranial pressure: Increased pressure within the cranium usually produces an increased blood pressure.
- ❖ Shock: lowered blood pressure is a symptom of shock and requires emergency treatment.

QIDP's should know their agency's procedures and staff responsibilities concerning ordering medication, filling prescriptions, and administering and recording medication administration. Know what your specific role is in these procedures. Some of all of the following Medication Tips may apply to you:

Medical Protocols & Guidelines

Protocols are written instructions for caregivers to follow when individuals have specific or frequent problems from a health concern that usually has a predictable outcome. Protocols give guidance to caregivers on signs and symptoms to look for, when and how to intervene and who to notify.

Protocols are sometimes confused with procedures.

Procedures are task oriented. They provide step-by-step instructions on how to do a task.

Protocols are problem oriented. They explain what to do about a health problem.

Common Health Problems for Individuals with Developmental Disabilities

There are four major health issues that are more common in people with developmental disabilities than in the general population that can lead to severe morbidity and even death. They are frequently referred to as the “fatal four” risks:

- ❖ Aspiration
- ❖ Dehydration
- ❖ Constipation
- ❖ Epileptic seizures.

Aspiration, dehydration and constipation may be insidious conditions that often go unrecognized. Many of the symptoms are subtle and persons with disabilities may not be able to express their discomfort or give indications that they are not feeling well.

Dysphagia/Aspiration

Dysphagia is the medical term which means difficulty swallowing. Aspiration is when bits of food, fluid, saliva or other materials are inhaled into the lungs. Aspiration often happens as a consequence of dysphagia. These two important medical problems are often not recognized promptly in people with developmental disabilities. The following information is meant to increase the awareness of these issues and help to recognize the signs and symptoms of these serious medical conditions.

Factors that place individuals at risk for aspiration:

- ❖ Being fed by others.
- ❖ Inadequately trained caregivers assisting with eating/drinking.
- ❖ Weak or absent coughing/gagging reflexes, commonly seen in persons who have cerebral palsy or muscular dystrophy.
- ❖ Poor chewing or swallowing skills.
- ❖ Gastroesophageal reflux disease (GERD, GER) which can cause aspiration of stomach contents.
- ❖ Food stuffing, rapid eating/drinking and pooling of food in the mouth.
- ❖ Inappropriate fluid consistency and/or food textures.
- ❖ Medication side effects that cause drowsiness and/or relax muscles causing delayed swallowing and suppression of gag and cough reflexes.
- ❖ Impaired mobility that may leave individuals unable to sit upright while eating.
- ❖ Epileptic seizures that may occur during oral intake or failure to position a person on their side after a seizure, allowing oral secretions to enter the airway.

Mealtime behaviors that may indicate aspiration

- ❖ Eating slowly.
- ❖ Fear or reluctance to eat.
- ❖ Coughing or choking during meals.
- ❖ Refusing foods and/or fluids.
- ❖ Food and fluid falling out the person's mouth.
- ❖ Eating in odd or unusual positions, such as throwing head back when swallowing or swallowing large amounts of food rapidly.
- ❖ Refusing to eat except from a "favorite caregiver."

Signs and symptoms that may indicate aspiration

- ❖ Gagging/choking during meals.
- ❖ Persistent coughing during or after meals.
- ❖ Irregular breathing, turning blue, moist respirations, wheezing or rapid respirations.
- ❖ Food or fluid falling out of the person's mouth or drooling.
- ❖ Intermittent fevers.
- ❖ Chronic dehydration.
- ❖ Unexplained weight loss.
- ❖ Vomiting, regurgitation, rumination and/or odor of vomit or formula after meals.

Interventions for aspiration

- ❖ Chin-down position
- ❖ Nectar-thickened liquids
- ❖ Honey-thickened liquids
- ❖ Dental soft diet
- ❖ Pureed diet

Individuals who may exhibit these behaviors or who are at risk for dysphagia and aspiration should be seen by a medical provider for further work up and treatment as indicated. The evaluation generally consists of a swallowing evaluation done by a speech language pathologist.

Constipation

Constipation is when an individual has difficulty passing stool; the stools are hard, dry and often look like marbles. The frequency of bowel movements varies greatly from person to person. Bowel movements are considered normal as long as the feces is soft, normal sized and is passed easily out of the bowel.

Factors that place individuals at risk for constipation:

- ❖ Neuromuscular degenerative disorders that impair the central nervous system's response for the need to eliminate.
- ❖ Spinal cord injuries or birth defects that affect neural responses needed for elimination such as spina bifida.
- ❖ Individuals with muscle weakness who lack the strength and tone needed for adequate bowel function.
- ❖ Diets that do not contain enough fiber and fluids.
- ❖ Poor swallowing skills with aspiration risk making it difficult to eat and drink adequate amounts of fiber and fluid.
- ❖ Inadequate or inconvenient access to the bathroom.
- ❖ Immobility and poor body alignment that does not allow for optimum positioning for bowel elimination.
- ❖ Poor toileting habits and routines or lack of privacy and time for toileting.
- ❖ Medications that slow down gastric motility or draw too much fluid from the GI tract.
- ❖ Hemorrhoids or other conditions that make bowel elimination painful.
- ❖ History of frequent bowel stimulant use leading to decreased bowel reactivity.
- ❖ Repression of the urge to defecate due to psychiatric issues.

Signs and symptoms of constipation

- ❖ Spending a lot of time on the toilet.
- ❖ Straining and grunting while passing stool.
- ❖ Refusing to eat or drink.
- ❖ Hard, small, dry feces.
- ❖ Hard, protruding abdomen (usually an emergency).
- ❖ Vomiting digested food that smells like feces (is an emergency).
- ❖ Bloating and complaints of stomach discomfort.

Interventions for Constipation issues

- ❖ Dietitian consultation regarding the type of food, texture, fiber content and fluid requirements to enhance elimination.
- ❖ Implement an individual constipation protocol and train caregivers how to identify constipation symptoms, what to do if they occur and who to notify.

Observations that should prompt concern

- ❖ No bowel movement for more than three days.
- ❖ Last two bowel movements were hard and/or small.
- ❖ In the last three days, only small bowel movements recorded.

Observations that should prompt a review by a health professional

- ❖ Abdomen firm to touch and/or looks distended and bloated.
- ❖ Complaints of stomach pain.
- ❖ Vomiting without any fever or flu-like symptoms and/or vomiting material that smells like fecal material (call 911).
- ❖ Runny liquid stools after several days of passing small hard stools, small liquid stools or no bowel movements.

Dehydration

Dehydration occurs when an individual does not drink enough fluids. Fluids are needed for temperature control, chemical balance and for cells to make energy and get rid of waste products. Dehydration occurs when the body loses more fluid than is replaced.

Factors that place individuals at risk for dehydration

- ❖ Unable to access fluids without assistance.
- ❖ Needing assistance with drinking.
- ❖ Dysphagia with coughing and choking during meals.
- ❖ Food, fluid and saliva falling out of a person's mouth.
- ❖ Frequently refusing food and fluids.
- ❖ Suppression of thirst mechanism that results in the inability to recognize thirst.
- ❖ Unable to effectively communicate thirst to caregivers.
- ❖ Medical conditions where fluid loss can potentially cause dehydration, such as kidney disease or diabetes.
- ❖ Conditions where the individual loses body fluids, such as drooling, diarrhea, sweating and vomiting.
- ❖ Taking medications that affect body fluid balance, such as diuretics.

Signs and symptoms that an individual may be dehydrated

- ❖ Dry skin and poor skin elasticity.
- ❖ Extreme thirst.
- ❖ Dry, sticky mucous.
- ❖ Lethargy and decreased alertness.
- ❖ Fever.
- ❖ Increased heart rate and decreased blood pressure.
- ❖ Decreased urination, dark colored urine and concentrated urine smell.

Interventions for Dehydration

- ❖ Offer fluid intake if the individual is alert and able to drink safely.
- ❖ If unable to take fluid safely, call health care professional for administration of intravenous fluids.

Seizure Disorder (Epilepsy)

Epilepsy is a disorder of the brain that is characterized by recurring seizures. Individuals with developmental disabilities are more likely to have epilepsy because of an underlying brain dysfunction. Head injuries, brain tumors, and brain congenital abnormalities are some causes of epilepsy. The clinical expression of an epileptic seizure varies according to where it starts in the brain.

Factors that place individuals at risk for epilepsy

- ❖ Prenatal and postnatal brain injury, such as trauma, anoxia, infection.
- ❖ Congenital brain malformations.
- ❖ Brain tumors, clots, hemorrhage, and aneurysms.
- ❖ Traumatic brain injuries.

Immediate interventions when an individual has a seizure

- ❖ Stay with the person and guide gently away from or prevent access to dangerous areas.
- ❖ Do not place anything in the person's mouth.
- ❖ Move objects away from the person to prevent injury.
- ❖ Only move the person if in an unsafe area such as a roadway or stairwell.
- ❖ If in water, keep the person's head above the water.
- ❖ Don't restrain the person's movements.
- ❖ Pad under the person's head, arms and legs.
- ❖ Keep track of how long the seizure lasts.

After the seizure

- ❖ Loosen clothing.
- ❖ Check for injuries and treat appropriately.
- ❖ Document the seizure on a seizure calendar or record.
- ❖ Allow the person sufficient time to recover before returning to activities.

General interventions

- ❖ Keep an accurate description of seizures and track all seizures in a consistent manner.
- ❖ Monitor for medication side effects.
- ❖ Keep the environment safe. Precautions must be considered when bathing/swimming if there has been a seizure in the past 12 months or antiepileptic medications have been changed within the last 6 months.
- ❖ Individualized seizure protocol with caregiver trainings.

Incontinence and Urinary Tract Infections (UTI)

Some people that you help support, like millions of others, may experience the frustration and embarrassment of urinary tract infections, otherwise known as UTIs. When this happens, clothing gets wet, odors develop, and the person gets uncomfortable. Being incontinent is beyond the person's control and dealing with it as a professional requires understanding, kindness and patience.

Urinary Incontinence

This is the inability of the person to contain urine in the bladder. The extent can range from an occasional leakage of urine, to a complete inability to hold any urine.

Common Causes of Incontinence

There are a number of reasons someone you support may be incontinent. Incontinence can develop suddenly, be only temporary or be ongoing. Some causes of sudden or temporary incontinence include:

- Urinary tract infection or inflammation
- Prostate infection or inflammation
- Stool impaction from severe constipation which causes pressure on the bladder
- Side effects of medications

Causes that may be more long term include:

- Spinal injuries
- Alzheimer's disease
- Enlarged prostate
- Neurological conditions (multiple sclerosis)
- Weakness of the sphincter (the round muscle of the bladder responsible for opening and closing it)
- Bladder cancer
- Cognitive disability

Fecal Incontinence is loss of control of the bowels. This may lead to stool leakage from the rectum. Muscle damage is a common cause of fecal incontinence. Damage to the nerves that are responsible for rectal sensation is also a common cause. Diseases such as diabetes, spinal cord tumors and multiple sclerosis can cause nerve injury which can cause fecal incontinence.

Interventions for Fecal Incontinence

- ❖ Adequate fluid intake daily
- ❖ Regular exercise
- ❖ Positive mental outlook
- ❖

www.oregon.gov/DHS/spd/provtools/.../ddmanual/companion.pdf

Bedsore

Definition

Bedsore, more accurately called pressure sores or pressure ulcers, are areas of damaged skin and tissue that develop when sustained pressure cuts off circulation to vulnerable parts of your body, especially the skin on your buttocks, hips and heels. Without adequate blood flow, the affected tissue dies.



Although people living with paralysis are especially at risk, anyone who is bedridden, uses a wheelchair or is unable to change positions without help can develop bedsore.

Bedsore can develop quickly, progress rapidly and are often difficult to heal. Yet health experts say many of these wounds don't have to occur. Key preventive measures can maintain the skin's integrity and encourage healing of bedsore.

Bedsore fall into one of four stages based on their severity. The National Pressure Ulcer Advisory Panel, has defined each stage as follows:

Stage I. A pressure sore begins as a persistent area of red skin that may itch or hurt and feel warm and spongy or firm to the touch. In blacks, Hispanics and other people with darker skin, the mark may appear to have a blue or purple cast, or look flaky or ashen. Stage I wounds are superficial and go away shortly after the pressure is relieved.

Stage II. At this stage, some skin loss has already occurred — either in the outermost layer of skin (the epidermis), the skin's deeper layer (the dermis), or in both. The wound is now an open sore that looks like a blister or an abrasion, and the surrounding tissues may show red or purple discoloration.

Stage III. By the time a pressure ulcer reaches this stage, the damage has extended to the tissue below the skin, creating a deep, crater-like wound.

Stage IV. This is the most serious and advanced stage. A large-scale loss of skin occurs, along with damage to underlying muscle, bone, and even supporting structures such as tendons and joints.

People who use a wheelchair are most likely to develop a pressure sore on:

- tailbone or buttocks
- shoulder blades and spine
- backs of your arms and legs where they rest against the chair

When people are bed-bound, pressure sores can occur in any of these areas:

- The back or sides of the head
- The rims of the ears
- Shoulders or shoulder blades
- Hipbones, lower back or tailbone
- Backs or sides of your knees, heels, ankles and toes

Contact a doctor if you notice any broken skin or open sores, signs of infection such as fever, drainage from the sore, a foul odor, or increased heat and redness in the surrounding skin on the individuals you support.

The first step in treating a sore at any stage is relieving the pressure that caused it. You can reduce pressure by:

Changing positions often. Carefully follow a schedule for turning and repositioning — approximately every 15 minutes for people in a wheelchair and at least once every two hours when they are in bed. Using sheepskin or other padding over the wound can help prevent friction when people are moved.

Using support surfaces. These are special cushions, pads, mattresses and beds that relieve pressure on an existing sore and help protect vulnerable areas from further breakdown.

Other nonsurgical treatments of pressure sores include:

Cleaning. It's essential to keep wounds clean to prevent infection. A stage I wound can be gently washed with water and mild soap, but open sores should be cleaned with a saltwater (saline) solution each time the dressing is changed. Avoid antiseptics such as hydrogen peroxide and iodine, which can damage sensitive tissue and delay healing.

Controlling incontinence as far as possible is crucial to helping sores heal.

Prevention

Bedsore are easier to prevent than to treat, but that doesn't mean the process is easy or uncomplicated. Although wounds can develop in spite of the most scrupulous care, it's possible to prevent them in many cases.

The first step is to work with your agency's nurses and doctor to develop a plan that caregivers can follow. The cornerstones of such a plan include position changes along with supportive devices, daily skin inspections and a maximally nutritious diet.

Skin inspection

Daily skin inspections for pressure sores are an integral part of prevention. Pay special attention to the hips, spine and lower back, shoulder blades, elbows and heels.

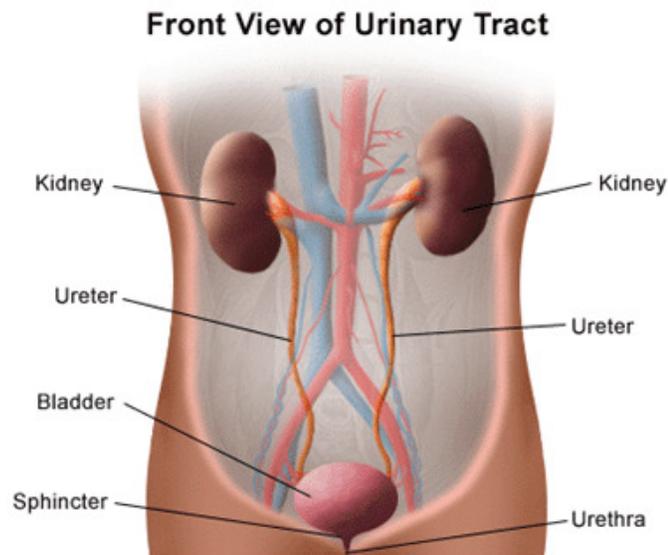
Source: <http://www.mayoclinic.com/health/bedsores/DS00570>, downloaded 3/30/11.

Urinary Tract Infection

A urinary tract infection (UTI) is an infection anywhere in the urinary tract. The urinary tract is the system of organs that collect and store urine and release it from the person's body. A UTI is caused by bacteria that can live in the digestive tract, the vagina, or around the urethra, which is the entrance to the urinary tract. These bacteria can enter the urethra and travel to the bladder and kidneys. Usually the person's body removes the bacteria during urination and people have no symptoms, but some people are more prone to infection.

Why are some people more prone to infection?

- Blockage in the urinary tract that obstructs the flow of urine
- An enlarged prostate gland
- Any disorder that suppresses the immune system
- Poor hygiene
- Catheters
- Diabetes



Interventions for UTI

- ❖ Wash hands frequently.
- ❖ Encourage intake of protein- and calorie-rich foods.
- ❖ Encourage fluid intake of 2000 ml to 3000 ml of water per day (unless contraindicated).

Unplanned Weight Change

Unplanned significant loss of weight can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. Unplanned weight loss is an indicator of declining nutritional status.

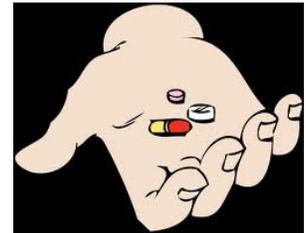
- Determine if the service plan was evaluated and revised based on the response, outcomes, and needs of the resident.
- Determine if the person has experienced an emotional trauma or loss.
- Observe the delivery of care as described in the service plan, e.g., staff providing assistance and/or encouragement during dining; serving food as planned with attention to portion sizes, preferences, nutritional supplements, and/or between-meal snacks, to determine if the interventions identified in the service plan have been implemented.
- Observe at least two meals during the survey.
- For each sampled resident being observed, identify any special needs and the interventions planned to meet their needs.
- Observe whether each resident is properly prepared for meals. For example:
 - Resident's eyeglasses, dentures, and/or hearing aids are in place;
 - Proper positioning in chair, wheelchair, geri-chair, etc., at an appropriate distance from the table (tray table and bed at appropriate height and position);
 - Assistive devices/utensils identified in service plans provided and used as planned.
- Observe the food service for:
 - ❖ Appropriateness of dishes and flatware for each resident, as applicable;
 - ❖ Delivery to residents in a timely fashion;
 - ❖ If a substitute was needed or requested, did it arrive timely; and
 - ❖ Were diet orders, portion sizes, preferences, and condiment requests being honored.
- Determine whether residents were being promptly assisted to eat or provided necessary assistance/cueing in a timely manner after their meal was served. Note whether residents at the same table or in resident rooms, are being served and assisted concurrently.

- Determine how much of the meal the sampled resident consumed.
- Interview the resident, family and/or significant other regarding food quality, eating habits, preferences, weight change, etc.
- Interview staff regarding the residents ability to eat, preferences, assistance needed, usual consumption of food, etc.
- Determine if the meals served were palatable and nutritious and met the needs of the resident. Note the following:
 - Whether the resident voiced concerns regarding the taste, temperature, quality, quantity and appearance of the meal served;
 - Whether mechanically altered diets, such as pureed, were prepared and served as separate entree items (except for combined foods, e.g., stews, casseroles, etc.);

http://www.oregon.gov/DHS/spd/provtools/ralf/weight_chg.pdf

Self-Medication

Some individuals have been taught to take their own medication. Others may be capable of learning this valuable skill. The ability to handle one's own medication allows an individual to have more choices of living arrangements.



An assessment should be made of each individual's ability to self medicate. The assessment of the IDT and the physician will determine whether the individual is currently independent and whether or not he/she would benefit from training. A physician's order is required, as well as, the approval of the IDT.

If the individual is determined not to be fully competent in self medicating, a training program must be implemented. Almost any individual could benefit from some level of training, something as simple as identifying their own medication to something as complicated as making their doctor's appointments and filling their own prescriptions.

Ten Medication Principles to Remember

- I. Medications may not always work as intended.
- II. Medications may produce an effect that is different from the effect that was desired.
- III. Medications may produce no effect.
- IV. Medications may produce an opposite effect than the desired effect.
- V. Medications may make a problem worse. These are called adverse effects (life threatening) or side effects (undesirable).
- VI. Some medications can have good or bad reactions with other medications already being taken.
- VII. Many medications taken for mood and behavior may take time to work (such as antidepressants).
- VIII. Be patient when new medications are started. They may take 3-4 weeks to work and side effects may begin at once.
- IX. Give medications on time and as prescribed.
- X. If someone has kidney or liver problems, medications may make these conditions worse. For any person taking medications, monitor and report the following:
 - changes in the color of the stool
 - changes in the color of the white part of the eye
 - changes in the color of tissue under the tongue
 - stomach pain or increase in size of the stomach
 - weight gain or swelling (edema)
 - cloudy urine with increased odor
 - blood in the urine or stool
 - increased, frequent, or decreased urine output.

<http://www.irtces.com>

TARDIVE DYSKINESIA

What is Tardive Dyskinesia?

Tardive dyskinesia is a neurological syndrome caused by the long-term use of neuroleptic drugs. Neuroleptic drugs are generally prescribed for psychiatric disorders, as well as for some gastrointestinal and neurological disorders. Tardive dyskinesia is characterized by repetitive, involuntary, purposeless movements. Features of the disorder may include grimacing, tongue protrusion, lip smacking, puckering and pursing, and rapid eye blinking. Rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano.

Is there any treatment?

There is no standard treatment for tardive dyskinesia. Treatment is highly individualized. The first step is generally to stop or minimize the use of the neuroleptic drug. However, for patients with a severe underlying condition this may not be a feasible option. Replacing the neuroleptic drug with substitute drugs may help some patients. Other drugs such as benzodiazepines, adrenergic antagonists, and dopamine agonists may also be beneficial.

What is the prognosis?

Symptoms of tardive dyskinesia may remain long after discontinuation of neuroleptic drugs; however, with careful management, some symptoms may improve and/or disappear with time.

Source:

National Institute of Neurological Disorders and Stroke
National Institutes of Health
Bethesda, MD 20892

<http://www.ninds.nih.gov/disorders/tardive/tardive.htm>

Infection Control

See the Occupational Safety & Health Administration link below for comprehensive information on preventing the transmission of blood borne pathogens.

<http://www.osha.gov/SLTC/bloodborne pathogens/index.html>

In order to understand the basic principle of infection control, the QIDP must have completed a basic course in Universal Precautions and Blood borne pathogens.

It is imperative to exercise good infection control procedures and to model those principles for the individual so that he/she will also practice those principles. Infection control promotes good health and dramatically reduces frequency of illness.

The most important guideline that the QIDP can stress is good and frequent hand washing. Encourage hand washing: after toileting, before eating, drinking or smoking, before preparing food, before taking medication, before and after tooth brushing, after handling unclean items, after petting animals, after blowing nose, or coughing/sneezing, etc.



Preventing the Occupational Transmission of Blood-borne Disease

Healthcare-associated infections (HAIs) are infections caused by a wide variety of common and unusual bacteria, fungi, and viruses during the course of receiving medical care.

Wherever patient care is provided, adherence to infection prevention guidelines is needed to ensure that all care is safe care. This includes traditional hospital settings as well as outpatient surgery centers, long-term care facilities, rehabilitation centers, and community clinics. The information on this website is intended to inform staff concerning reducing the risks of contracting HAIs.

<http://www.cdc.gov/hai/>

CURRENT REGULATIONS

Four currently existing standards have been coordinated to provide an enforcement strategy to prevent the occupational transmission of blood-borne disease. These standards are:

29 CFR 1910.132 – Personal Protective Equipment

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9777

29 CFR 1910.22(a)(1) and (a)(2) – General Requirements/Housekeeping

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9714

29 CFR 1910.141(a)(4)(I) and (ii) – Sanitation; Waste Disposal

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9790

29 CFR 1910.145(f) – Specifications for Accident Prevention Signs and Tags

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9794

29 CFR 1910.132 - Personal Protective Equipment

Occupational Safety and Health standards mandate Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact.



Disposable gloves are to be worn when employees are exposed to blood or body fluid. This is particularly important in the following instances:

- ❖ If the health care worker has abraded, chapped, cut, or otherwise non-intact skin.
- ❖ During instrumental examination of the oropharynx, gastrointestinal or genitourinary tracts.
- ❖ When examining non-intact skin or active bleeding.
- ❖ During all invasive procedures.
- ❖ During cleaning or disinfection of articles or surfaces contaminated with blood or body fluid.

Gloves are not required for routine care or support activities.

Gloves must be appropriate fit and type. Surgical and exam gloves must not be washed for reuse. General purpose rubber gloves used for housekeeping duties may be decontaminated for reuse. However, they must be discarded when signs of deterioration develop. For those with a latex allergy, hypo-allergenic gloves are available.

Gowns should be worn whenever the potential for splashing exists. They are to be made from or lined with impervious material, and should cover all exposed skin surfaces.

Face and eye protection such as masks and safety goggles or full face shields are required when mucous membrane exposure may occur from splashing or aerosolization. Examples of these situations include surgical and dental techniques. Gowns are not required for routine care or support activities.

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9777

29 CFR 1910.22(a)(1) and (a)(2) – Housekeeping

All work areas are to be kept clean, orderly and in a sanitary condition, cleaning as often as necessary. Germicides and disinfectants approved as tuberculocidal are acceptable for HBV and HIV decontamination. A solution of 5.25% Sodium Hypochlorite (household bleach) in a dilution between 1:10 to 1:100 is also effective.

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9714

29 CFR 1910.141(a)(4)(I) and (ii) – Sanitation: Waste Disposal

The disposal of contaminated needles, blades, and other sharp objects need to be a major focus of the infection control program. These objects must be immediately disposed in a puncture resistant, spill proof container. Containers shall be in all areas where needles are commonly used to ensure easy employee access. Needles shall not be recapped.

Containers used for blood or body fluids must be designed for safe transportation and disposal. The container must be leak proof, and must be designed for adequate decontamination if reusable. Wastes must be removed as often as necessary to maintain a sanitary condition.



All bags of waste contaminated with blood or other potentially infectious body fluid must be carefully handled and double bagged if outside contamination or puncture is likely.

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9790

29 CFR 1910.145(f) – Accident Prevention Tags

Every bag of material contaminated with blood or potentially infectious body fluid must be securely marked with tags or other forms of warning. If tags are used, they shall have a signal work or symbol for “Biohazard”, and a major message legible at five feet. The message shall state the specific hazard or hazards, and may be written, pictographic, or both. Employees must receive training about the tags.



http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9794

INFECTION CONTROL PROGRAM

Universal Precautions for blood borne pathogens are part and parcel of Standard Precautions. It treats all blood and other potentially infectious materials as if they were known to be infected with bloodborne diseases. Blood and other materials that can carry pathogens that causes serious diseases. Materials include human body fluids, unfixed tissue or organs, and HIV/HBV-containing cell or tissue cultures. **The intent of Universal Precautions is to protect the healthcare worker from bloodborne diseases.**

The United States Department of Labor and Occupational Health and Safety Administration Standards for dealing with bloodborne pathogens can be found at:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

The CDC guidelines stress that each health care work site needs an effective infection control program. The program can either provide written or oral instruction and must include the following:

- Identification of employees at substantial risk from direct patient care and housekeeping chores involving direct cleanup of blood and body fluid.
- Proper use of protective gear.
- Proper use of warning signs and tags
- Decontamination of instruments and areas, and safe disposal of used instruments and potentially infectious waste.
- Employee training and education.
- HBV vaccination program.



Handwashing

Handwashing remains the single most effective means of removing organisms acquired from infected patients. Handwashing consists of a soap and water wash for longer than 10 seconds using a rubbing action that creates a lather over the entire hand surface and is then fully rinsed for 20 – 30 seconds with running water. Hands should be dried with disposable or single-use towels or an air dryer.

Hand Disinfection

- Plain soaps – (Dispenser soap, bar soap)
 - Removes most transient organisms
- Antiseptic Hand Soaps – (chlorhexidine)
 - Removes transient flora
 - Decreases resident flora
 - Residual effect up to 6 hours

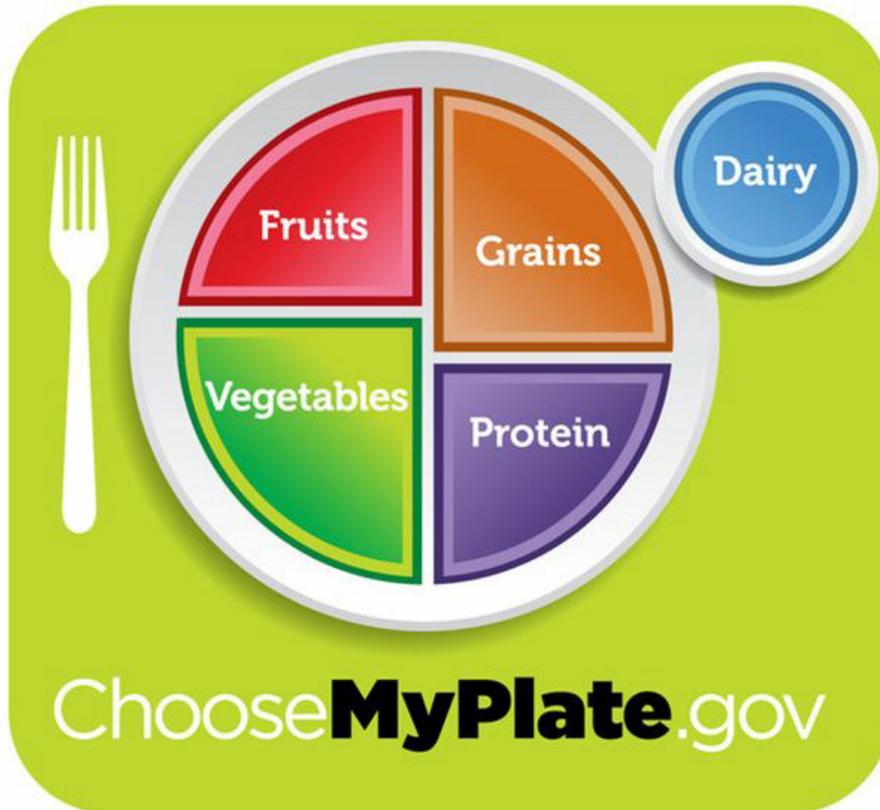
Antiseptic Waterless Products (Alcohol Hand Disinfectants)

- Hands not visibly soiled
- Rapid, effective activity
- Remove transient flora
- No residual activity

Hand Lotions

- Skin irritation increases the number of organisms
- Hand lotions maintain skin integrity
- Only lotions that do not inhibit the residual activity of chlorhexidine
- Petroleum based hand lotions interfere with the integrity of latex gloves
- Bottles with pump dispensers to avoid cross contamination

NUTRITION



One size doesn't fit all. MyPlate offers personalized eating plans and interactive tools to help you plan/ assess your food choices based on the Dietary Guidelines for Americans.

There are many special diets that may be prescribed to the individuals at your agency. It is your responsibility to ensure that these diets are followed. In order to understand the importance of these diets, it may be helpful to understand why they may be needed (i.e., food intolerance, diabetic, special nutrients; thickened liquids, etc.)

Visit: www.ChooseMyPlate.gov for all the latest on the food pyramid.

In order to complete the checklist below, you will need to know people’s dietary needs and restrictions, look through the food supplies in the pantry and refrigerator/freezer, observe at mealtime and speak to the cooking staff.

Fundamentals of Diet & Nutrition

Required Condition	Action to take if condition
Meals are planned based on individual's nutritional needs and preferences.	
Meals are prepared according to plan.	
Where necessary, a monitoring mechanism is in place for determining if the individual is consuming food according to the plan.	
Nutritional snacks are available.	
The diet is varied.	
Food is prepared and stored in sanitary manner.	
Adaptive devices are provided to maximize independence in eating and preparing food.	
The meal planner is aware of drug/food interactions and other dietary restrictions/requirements.	
The individual is being provided diet and preparation education.	
Food choices and preferences are valued.	
Food substitutions are available.	

The Experience of Loss

All people experience losses in their lives. The individuals we support are no different.

Directions: List below as many types of loss that you or others might experience.

- Death of family, friends, staff
- Loss of ability due to illness
- Loss of employment
- Loss of home
-
-
-
-



The Grief Process

The response to loss is known as the grief process. These were made known by Elizabeth Kubler-Ross. While not all people will follow or experience all of these steps, there is a general consensus that they are fairly predictable in type and sequence.

Following is a summary of the grief process as presented by Elizabeth Kubler-Ross.

Denial: People confronted by their own or someone else's impending death may deny the fact. There are many forms of denial:

- ❑ Denying that the person is ill at all.
- ❑ Denying the specific diagnosis.
- ❑ Denying that the diagnosed condition is fatal.
- ❑ Minimizing the threat of the illness.
- ❑ Acting in ways that ignore the fact of impending death. (E.g., Making plans far into the future or making unwarranted and overly optimistic comments about the treatment.)



Anger: This the *Why me?* stage. The person becomes bitter, irritable and angry. The anger can take several forms:

- ❖ Directed at the fact that the person is dying.
- ❖ The anger is often expressed toward God, even by devoutly religious people.
- ❖ Directed at other things and people. Sometimes staff members can become the object of this displaced anger.
- ❖ The person may not complain about anything in particular, but just act gruff and hostile.



Bargaining: In this stage, there is a partial acceptance.

The person acknowledges the situation but still sees a chance to change things or at least to postpone death. Some versions of bargaining are:

- ❖ To pray for time.
- ❖ To make a deal ("If I get better, I'll...")
- ❖ To target some event to reach before dying (a birthday, wedding, etc.)
- ❖ To seek time to undo wrong.



Depression: In this stage, the person recognizes the inevitability of death and the full impact of what he or she is going to lose, coupled with the realization of increased deterioration and perhaps increased pain. The result is depression.

Acceptance: In this stage, the person becomes serenely calm, even as weakness, pain, and deterioration increases. The person *comes to terms* with his or her death. We also know that:

- ❖ Not everyone experiences each stage.
- ❖ Stages co-exist.
- ❖ None of the stages are necessarily a bad thing. They are all ways of dealing with the overwhelming fear, loss, and upsetting thoughts brought on by an acknowledgment of one's death. A given stage only becomes problematic when it distorts the person's perceptions and communication to the point where his or her relationships suffer or where self-destructive behaviors appear.
- ❖ A given stage can end and then reappear.
- ❖ People experiencing loss or grief, often go through these same stages.



Individuals with intellectual disabilities may express their grief through their behavior. This can include acts of aggression, rage, crying, withdrawal, etc. As a QIDP, you need to be supportive and alert since they may have difficulty expressing their thoughts.

Assistive/Corrective Devices & Prosthesis

Assistive devices and prosthesis improve the quality of life for individuals. They provide the means to greater independence by maximizing the functional abilities an individual has. Included are:

- ❖ Adapted glasses, cups, plates
- ❖ Switches
- ❖ Adapted eating utensils
- ❖ Artificial limbs
- ❖ Wheelchairs, crutches, walkers
- ❖ Telecommunication Device for the Deaf (TDD)
- ❖ Video Relay Service (VRS)
- ❖ Communication devices – language boards, computers, picture schedules
- ❖ Photo/Picture telephone
- ❖ Hearing aids
- ❖ Eye glasses
- ❖ Dentures
- ❖ Splints
- ❖ Ankle foot orthotics (AFOs)
- ❖ Teletypewriter (TTY)
- ❖ Voice Activated Software

Many of these devices are commercially available. Others are homemade devices. This is an area where it is especially important to know the individual. You must study the person to see what they can control. The Illinois Assistive Technology Project can use this information to come up with a way of providing greater independence. In many cases, this requires *thinking outside the box*.

<http://www.iltech.org/>



Positioning and Transferring

To learn about the anatomy of lifting; lifting patients from beds and wheelchairs; lifting patients with needs; using assistive devices; risk management; body mechanics; and lifting and moving safely, visit:

www.cdc.gov/niosh

Before attempting any transfer:

- ❖ Always thoroughly explain the procedure to the person.
- ❖ Ask permission before touching the person.
- ❖ Be sure to use good body mechanics to prevent injury.
- ❖ General Rule -- be sure to reposition persons at least every two hours to prevent sores, contractures, circulation problems, breathing problems, constipation.
- ❖ Basic positions are supine, prone, side lying, sitting.
- ❖ Maintain good body alignment when positioning the person.
- ❖ Use positioning aids as appropriate (pillows, bolsters, handrails, etc).
- ❖ If working with people who are immobile, it is recommended further training be obtained from a nurse or a physical therapist or positioning and moving specific individuals, passive range of motion (P.R.O.M.), etc.



2. Transfer between a bed and a wheelchair

Common Causes of Back Injuries

Not all back injuries are a result of sudden trauma but rather the cumulative damage suffered over a long period of time. There are certain actions, movements and motions that may be more likely to cause and contribute to back injuries than others. They include:

- Repetitive motions—When you use repetitive motions, such as stacking items, remember your back is always working.
- Twisting at the waist—This frequently happens when using a shovel or transferring someone.
- Reaching and stretching—When you reach and stretch for items, especially in high places, you are at risk for injury.
- Lifting or carrying—Lifting or carrying objects with awkward or odd shapes.
- Working in an awkward or uncomfortable position—This includes kneeling, or tasks that require bending over for long periods of time.
- Slipping—Slipping on a wet floor, ice or steps.
- Standing or sitting—Standing or sitting too long in one position.
- Pushing or pulling—Pushing or pulling large objects such as trash bins can be as hard on your back as heavy lifting.

Safe Lifting

Because most back injuries are a result of improper lifting, you need to learn to lift properly. The following are the six steps to proper body mechanics. You and the people you support should follow these six steps every time you lift:

- 1) Maintain a wide base of support—Position your feet about shoulder width apart, with one foot slightly in front of the other.
- 2) Bend at your knees—Bend at your knees and squat down, keeping your back straight.
- 3) Turn, don't twist—Move your body as a single unit. Don't twist while lifting or lift while twisted. Make turns with your feet, not your waist.
- 4) Lift with your legs—Let your powerful leg muscles do the work of lifting, not your weaker back muscles. Maintain your three natural curves.
- 5) Keep the load close—Do not hold the load away from your body. The closer it is to your spine, the less force it exerts on your back.
- 6) Keep your back straight—Whether you are lifting or setting down the load, do not add the weight of your body to the load.

Scenario Seven

Over the past 3 months, staff has noticed a decrease in Rachel's activity level and social interaction. She has become progressively less talkative and spends excessive time lying in bed. She has become disinterested in her DT programming and frequently refuses to get up even for breakfast. She has completely refused workshop for the past week and a half. She complains of non-specific aches and pains. When attempts are made to motivate Rachel to work or even participate in leisure activities, she becomes irritable and at times will scream or cry excessively.

Yesterday, Rachel was noted walking aimlessly outdoors. A staff member had to stop her car abruptly in the parking lot as Rachel walked in front of it acting as if she did not notice it. Rachel is normally very careful when crossing streets or walking in the parking lot. She responded to the staff member's concern by yelling and returning to her bed.

In addition to these behavior changes, Rachel has become apathetic towards food. This is noticeably abnormal behavior for her. Even her parents are concerned as she no longer seems to enjoy her trips to her favorite restaurant and picks at her favorite foods. Despite the decreased appetite, Rachel has gained 9 lbs. over the last 3 months.

Since Rachel has also missed her last 2 periods, a pregnancy test was done. Results were negative.

Some staff suspects that Rachel is acting out in opposition to the recent addition of time-out in her behavior program. Some believe that Rachel is upset due to the resignation of her favorite staff member.



Discussion and Questions

1. What are some of the possible reasons for the changes in Rachel's behavior that should be considered? What other information might you need to assess this situation?
2. A pregnancy test was done. Should other medical possibilities be explored? Why or why not?
3. What should the Q do to insure that medical considerations are addressed?
4. Should psychiatric possibilities be explored even though there is not previous history of mental illness? Why or why not?

Scenario Eight

Rachel was recently diagnosed with an eye infection. This is the third occurrence in the last 6 months. The drainage from Rachel's eyes is contagious. Drainage can be carried by hand to hand contact. Infection occurs when the contaminated hand comes in contact with one's eye.



Rachel is very affectionate and enjoys physical contact with staff. She also lacks good hand washing skills and is reluctant to wash her hands at the times she should. She complains of itchy eyes and rubs her eyes frequently even when infections are not present.

Discussion and Questions

1. What are the infection control concerns for Rachel, staff, and other individuals?
2. What medical concerns should be evaluated? Examples: Cause of infection, cause of itchy eyes, etc.
3. What types of training are necessary for staff and for Rachel?
4. How could more frequent hand washing and improved hand washing skills benefit Rachel, staff and other individuals?

SAMPLE LETTER TO HEALTH CARE PROVIDER ON BEHALF OF A PERSON WITH DEVELOPMENTAL DISABILITIES

Note: This is a great suggestion. We recommend it highly.

-- Rice Brooks, Health Promotion Project.

Robin Jones, MD
555 Center Street
Madison, WS 53700

Dear Dr. Jones:

I am writing to tell you about myself so that we can better work together to keep me healthy.

Mary Sawyer, who has known me very well for several years, helped me write this letter. I live with her and her high school age children in an Adult Family Home. Another person who knows me well is my case manager from Dane County Adult Community Services; his name is Brad Fields. Brad told me about you and suggested that you would be a good choice for a doctor to meet my needs.

Although I only use a few words, I understand a great deal and pay attention very well--especially in a new place or with unfamiliar people. I am 38 years old and usually in good health. I have always had checkups with my doctor and dentist at least once a year. Since I have seizures and they are not completely controlled, I also tend to need stitches (because of falls) or medication reviews from time to time.

Mary and I work together at home on health concerns. We have a file folder with my records and write important things on a calendar that we keep from year to year. Since my medication schedule is fairly complicated, Mary helps me remember to take the right medicines on time and we record each dose when I take it. I always remember to bring my folder to each appointment.

Mary accompanies me for appointments, but remains in the waiting area until the exam is over unless there is a specific reason for her to participate in some way.

Here are some things that are helpful for me during exams:

- ❖ Please tell me what you will do each step of the physical exam. When I see and understand what is next, I will be able to be more relaxed.
- ❖ I am very ticklish and will bring my legs up fast when you check my abdomen unless you first have me put my hands where you will begin. Place your hands over mine and then tell me I can take mine away. Use firm touch and a calm, quiet voice.

If I need to have an examination or procedure that might be uncomfortable, here is what helps me best:

- ❖ Tell me why the procedure or treatment is important.
- ❖ Show me the equipment you will use and tell me in a simple way what you will do.
- ❖ Ask me if you would like Mary to come into the room and give me support. Wait for her to join us before you proceed.
- ❖ Then ask me to let you know when I am ready. Say, "Are you ready now, Joe?" Watch my face, because I will nod when I am ready.
- ❖ If you would usually offer someone a local anesthetic (for example for a few stitches or filling a tooth), show me the syringe and ask me if I want it. I usually prefer to do without it. I will take your arm and bring it towards me as a sign I want you to go ahead without anesthesia. Sometimes I do this quickly, so you should not be startled. You can ask me how I am doing as you go ahead. I almost always do fine without it. I can hold still best when you keep talking to me and telling me how things are going.

At the end of every appointment, it is important for Mary to join us to talk thing over. Since she knows me so well, she might be able to ask questions or get clarification about something that could be of concern to me. Also, since we work together on my health, she needs to be informed about changes in my treatment so we can follow up appropriately.

My parents are my guardians. They live in town and we get together 1-2 times a month for brief visits. They will be happy to talk with you by phone about my health and sign documents as needed. Mary keeps them informed of any changes or problems, so they know how I am doing.

Thank you for reviewing this information. I will see you next month for my annual checkup.

Sincerely,

Joseph Smathers
1234 Lake Street
Madison, WS 53700
Telephone: 211-1234

Additional information on Health and Disability can be found at:

<http://www.aahd.us/page.php>