

QIDP Professional TRAINING



Module 1: Introduction to the World of the QIDP

Module 2: Leadership and Communication

Module 3: Behavioral Supports

Module 4: Person Centered Planning

Module 5: Record Keeping

Module 6: Advocacy, Rights, and Resources

Module 7: Environmental and Safety Supports

Module 8: Medical Supports

Module 9: Rules and Regulations

Module Overview

MEDICAL SUPPORTS	2
COMPONENTS OF A BASIC PHYSICAL ASSESSMENT	5
THE FATAL FOUR	9
MEDICATION PRINCIPLES	17
RULES TO REMEMBER.....	18
MEDICATION SIDE EFFECTS	21
NUTRITION	23
UNEXPLAINED WEIGHT LOSS.....	24
CHOKING	25
SPECIAL DIETS	28
CHOPPED TEXTURE DIET	29
GROUND TEXTURE DIET	30
PUREED TEXTURE DIET.....	31
PICA	33
PROTOCOL.....	35
AGING	37
AGING AND SYSTEMS.....	40
BOWEL TRACKING	42
BRISTOL STOOL CHART.....	43
URINARY ISSUES	45
URINARY TRACT INFECTIONS	46
OVERVIEW OF SELF-INJURIOUS BEHAVIOR	47
INFECTION CONTROL	48
EMERGENCY PROTOCOLS.....	49
RECOMMENDED READING & RESOURCES	50

Module 8 Introduction

Why is this information important to you, as a QIDP?

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. When necessary, you will need to develop supports to fill gaps for an individual who cannot manage each of these independently.

Objectives

Participants will be able to:

- Identify and explain the components of a basic physical assessment.
- Recognize a potential emergency situation based upon an individual's characteristics and vital signs.
- Outline dietary restrictions and related diet plans that are common.
- Describe the dangers of PICA and suggest protocol for dealing with the disorder.
- Explain risk factors for the major health issues, including aspiration, dehydration, constipation, and epileptic seizures, commonly known as the Fatal Four.
- Demonstrate an understanding of the intervention strategies for the Fatal Four.
- Recognize bowel and urinary issue risk factors and treatment options.
- Classify the types and typical side effects of the medications usually prescribed to individuals with disabilities.

MEDICAL SUPPORTS

“The human body experiences a powerful gravitational pull in the direction of hope. That is why the patient’s hopes are the physician’s secret weapon. They are the hidden ingredients in any prescription.”

–Norman Cousins

When evaluating health services, it is imperative that you 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 that may require interventions. Make sure the information is passed on to those that have a need to know such as staff, family and administrators.

For certain medical or behavioral situations, the team may recommend that a consultation by an expert is necessary. Be sure to know your agency policy on consultations. Any recommendation from a consultant that involves active treatment, therapy or a change in diet texture/order will usually require a physician’s order before it is implemented.

Preparing For a Medical Appointment

Primary care physicians do not necessarily have education or experience working with people with intellectual and developmental disabilities. As a QIDP, there are many considerations for maximizing the time and benefit of physicians and other medical practitioners.

1. The decision regarding who should accompany the person should be based upon knowledge of the person, knowledge of the medical concern, comfort level of person, ability to articulate the concern and communicate with the physician.
2. Prior to the visit, talk with those involved in the individual's health care to identify any health concerns.
3. Tell the physician about all medications the person is taking. *It may be helpful to bring a list.*
4. Bring a written list of any concerns and questions you and/or the individual may have.
5. Make sure you understand what the physician is saying and don't be afraid to ask for clarification.
6. When the physician writes a prescription, ask any questions you may have about the medication.
7. Encourage the individual to ask questions and express concerns.
8. Ask for clear directions for follow up.



Nursing support varies from agency to agency and program to program. Review relevant material related to nursing supports and protocols for your agency.

Podiatrist

Diabetes can cause poor blood flow to extremities including the feet. Even the most minor cuts, abrasions and sores on a diabetic's foot can result in serious health complications. Given this, it is often best for people with diabetes to see a podiatrist.

Dentist

Poor dental care can be related to many health issues such as earaches, headaches, heart disease and poor nutrition.

Orthotist

Orthotists are concerned with managing body function with the use of splints, braces, orthotics and wheelchairs as directed by a health care specialist. They will also modify equipment to ensure a therapeutic and comfortable fit. Orthotists may come to the home to see individuals in their own setting or they may evaluate them in a clinic or hospital.

Splints, braces, wheelchairs, etc. are called "durable medical equipment" (DME) and are usually paid for by insurance plans. The need for DME should be assessed by occupational or physical therapists and constructed or modified according to the therapists' specifications.

Physical and Occupational Therapists

The physical therapist's duties may include:

- Assessing body movement and posture.
- Providing direct therapy.
- Determining the need for adaptive and protective equipment (They may also assist in the design and repair of such equipment)
- Assisting in training the individual and others in:
 - Proper positioning
 - Range of motion
 - Body mechanics to maximize mobility and flexibility

The occupational therapist's duties may include:

- Assessing motor skills needed to carry out activities of daily living.
- Assessing hand-to-mouth and grasp/release patterns necessary for eating.
- Determining adaptive equipment needs and functional arm positioning to facilitate eating and other fine motor skills.

Speech-Language Pathologist/Specialist

Persons who have intellectual and developmental disabilities often have swallowing difficulties that worsen as they age. Recognizing subtle changes that put them at risk for aspiration is

essential in keeping them safe. Speech-Language pathologists are often the specialists who assess speech, language development, and swallowing skills.

Speech-Language Therapist/Specialist duties include:

- Oral-Motor Function:
 - Assessing oral-motor function and swallowing status
 - Recommending, assisting and interpreting results of video fluoroscopy studies
 - Developing and managing exercises for swallowing
 - Recommending aspiration precautions, diet consistency and the degree of supervision required when eating. A physician's order is needed to permanently change food textures
 - Assisting the individual and training caregivers in safe swallowing techniques

- Language and Communication
 - Evaluating language and communication skills
 - Assessing language comprehension and overall responsiveness
 - Developing and teaching exercises for speech and communication
 - Recommending, developing, implementing and maintaining alternative communication devices, such as visual communication systems

Components of a Basic Physical Assessment

Temperature, Pulse, Respiration, Blood Pressure

There are four major components to the basic physical assessment: temperature, pulse, respiration, and blood pressure. It is important that each component is taken occasionally when an individual is in his/her usual state of health. This data will assist in establishing a baseline. Otherwise, there is no data for comparison when the person is ill.

Temperature

Temperatures varying from 97°F to 99°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 increase 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 the 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

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 (most common)
- Temporal artery - just above and to the outer side of eye orbit
- Carotid artery - on the neck on either side of the windpipe
- 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 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 the process of a substance combining with oxygen. Respiration is the exchange of gases between an organism and its environment. These are common characteristics of all living things. It is essential for chemical changes of metabolism which must take place if life is to be maintained.

Mechanics of Respiration:

- Each cell in body requires oxygen and food for maintenance of life and normal functioning.
- Chemical processes of metabolism take place within cells so food and oxygen must be supplied to all body cells. The 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 humans 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
- Digestion - due to muscular and metabolic activity
- Disease conditions - depends on disease
- Drugs - depressant drugs, e.g., 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, e.g. 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).

Factors Causing Variation in Blood Pressure:

- Age- Blood pressure is lower in children than in adults; e.g., 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.
- Medication side effects

The Fatal Four

Aspiration, Dehydration, Constipation, Seizures

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 sickness and even death. They are frequently referred to as the “fatal four” risks: aspiration, dehydration, constipation and epileptic seizures.

Aspiration, dehydration and constipation may be conditions that often go unrecognized because 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.

If a person has epileptic seizures, it is the suddenness and the unpredictability of this disorder that places the person most at risk. Injury, aspiration, drowning accidents and seizures that continue without stopping may cause hospitalizations and/or even death.

For all of the “fatal four” risks, alertness of the caregivers and careful monitoring can greatly minimize these hazards and ensure timely interventions should they occur.

Aspiration

Aspiration is defined as the inhalation of food, fluid, saliva, medication or other foreign material into the trachea and lungs. Any material can be aspirated on the way to the stomach or as stomach contents are refluxed back into the throat. In some cases, aspiration can lead to pneumonia and even death. The following information will help identify risk factors and interventions that may be unique to persons with intellectual and developmental disabilities.

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), 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 relaxed muscles may cause 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

Review the health history for aspiration risks:

- A diagnosis of risk for aspiration or past episodes of aspiration
- A diagnosis, such as cerebral palsy, muscular dystrophy, epilepsy
- GERD, dysphasia (difficulty in swallowing) or hiatal hernia
- History of aspiration pneumonia
- Needing to be fed by others
- History of choking, coughing, gagging while eating
- Needs modified food texture and fluid consistency
- Eating/swallowing evaluations and laboratory tests (barium swallow, pH study, etc.) that indicates dysphasia
 - Has unexplained weight loss or chronic dehydration
 - Takes medications that may decrease voluntary muscle coordination or cause drowsiness
- Has unsafe eating and drinking practices, such as eating/drinking rapidly and food stuffing
- Has chronic chest congestion, frequent pneumonia, moist respirations, persistent cough or chronically uses cough/asthma medications

Mealtime behaviors that may indicate aspiration:

- Eating slowly
- Fear or reluctance to eat
- Coughing or choking during meals
- Refusing food 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
- Swallowing large amounts of food rapidly
- Refusing to eat except for "favorite caregiver"

Signs and symptoms that may indicate aspiration risks:

- 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

Aspiration interventions:

- Call 911 if the person stops breathing and start CPR
- Stop feeding/eating immediately (may restart meal if feeding/dining instructions, supervisor or health care professional give permission)

- Keep person in an upright position and encourage coughing
- If in doubt on what to do, call the health care professional or 911

Guidelines on how to prevent or minimize the risk of aspiration:

- Obtain a consultation by a swallowing specialist if symptoms occur
- Change diet consistency, texture or temperature (need a physician's order)
- Slow pace of eating and decrease size of bites
- Position to enhance swallowing during meal times
- Keep in an upright position after meals for 45 minutes or as ordered
- Elevate the head of the bed 30 to 45 degrees
- Avoid food/fluid 2-3 hours before bedtime
- Consider the use of medications to promote stomach emptying, reduce reflux and acidity
- Write an aspiration protocol and written instructions on how the person is to eat or be fed and provide caregiver training.
- The aspiration protocol should cover the following:
 - The assistance level needed
 - Correct positioning for all oral intake and tooth brushing
 - Eating/feeding equipment needed
 - Physical and verbal cueing needed
 - Location of meals (Some individuals may need to eat alone as they become distracted when eating with their peers)
 - Recognition of aspiration symptoms, what to do if noted and who to notify

Aspiration risks and feeding tubes:

Many individuals with intellectual and developmental disabilities that have swallowing difficulties have permanent feeding tubes surgically inserted. Having a feeding tube does not eliminate the risk of aspiration. Stomach contents can still enter the airway via regurgitation or oral secretions can be aspirated if the person has dysphagia. Occasionally anti reflux surgery will be performed to tighten the lower esophageal sphincter. Having this surgery will not conclusively eliminate the risk of aspiration, but should lessen the risk. Some standard aspiration precautions are:

- Administering tube feedings in an upright sitting position and keep upright for at least 45 minutes after.
- If the person must be fed in bed, keep the head of bed at a 45 degree angle while feeding and for 45 minutes to an hour after.
- Don't overfill the stomach.
- Nutrition given at room temperature is better tolerated.
- Don't feed too rapidly; feedings should be administered over at least 30 minutes or as ordered.

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 are soft, normal sized and are 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

Review of health history for risk of constipation:

- Has a current or previous diagnosis of constipation.
- Has a routine order for bowel medications and/or treatments.
- Uses PRN bowel medications.
- Hospitalizations or outpatient treatments for constipation (bowel impaction, obstruction).
- Takes medications that affect the body's hydration status or have constipating side effects.
- Diet orders to increase dietary fiber (prunes, bran, psyllium, etc.) without adequate fluid intake.
- Individual has a constipation protocol.
- Caregiver's documentation indicates that the individual complains of stomach discomfort, strains with elimination, has abdominal distention, makes frequent trips to the bathroom or engages in rectal digging.
- Bowel record shows that the individual is passing hard feces or bowel movements more than 2 – 3 days apart.
- Recent decrease or stopping of routine bowel medications.

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

Constipation Interventions:

- 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
 - Fluid requirements
 - When to give PRN bowel medications and how to document the results
 - When to assist with bathroom use
 - How and where to document bowel movements
 - To report observations and/or data to the health care professional routinely and as needed

Guidelines on how to prevent or minimize constipation

- Encourage physical activity to increase muscle strength and tone.
- A positioning schedule for non-mobile individuals with time in an upright position
- Review of medications for side effects of constipation
- Establish toileting routines and schedule. For example: Drinking a warm beverage first thing in the morning.
- Teach the person to take slow, deep breaths to increase abdominal pressure during toileting.
- Teach the person to respond to the natural urge to defecate.
- Placing feet on a small step stool while sitting on toilet
- Providing enough time and privacy for toileting

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 fluid, such as drooling, diarrhea, sweating and vomiting
- Taking medications that affect body fluid balance, such as diuretics
- Being in a hot environment without sufficient fluid intake

Review of health history for risk of dehydration:

- Physician has written a diagnosis of dehydration
- Physician has written an order for a minimum amount of fluid each day
- Has required intravenous fluids for dehydration either as an outpatient treatment or when in the hospital
- Takes a medication that affects body fluid balance, such as a diuretic
- Has a history of difficulty with drinking fluids, such as refusal or spillage
- Cannot independently access fluids or communicate thirst
- Has a protocol for dehydration
- Weight record reflects rapid weight loss
- History of frequent vomiting/diarrhea

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

Dehydration interventions

- 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

Guidelines for dehydration prevention:

- Individuals should be encouraged to drink 8 – 10 glasses of fluid/day (64 – 84 ounces/day or 2000 – 2400 cc/day).
- Persons who weigh more must drink more; persons who weigh less need less.
- If a person is reluctant to drink fluids, offer foods high in fluid content, such as gelatin, watermelon, puddings, yogurt or ice cream.
- Persons who are very active, work hard, have a fever or perspire heavily need more fluids.
- Persons who have cardiac or kidney disease may need less fluid.
- A person with dysphagia needs a swallowing evaluation by a health care professional.
- Implement a dehydration protocol and provide caregiver training:
 - Have clear instructions regarding fluid requirements
 - List acceptable minimal amount of fluid intake/day
 - Consider the need for monitoring of intake and output
 - List signs and symptoms of dehydration, what to do if seen and who to notify

Seizure Disorder (Epilepsy)

Epilepsy is a disorder of the brain that is characterized by chaotic brain activity which often results in seizures. Individuals with intellectual and 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.

If there has been a seizure in the past 12 months or antiepileptic medications have been changed within the last 6 months, then water safety precautions (such as 1:1 continual observation in pool/tub, wearing a lifejacket, using shower only or no tub baths) must be considered.

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, aneurysms
- Traumatic brain injuries
- Review of health history for risk of epilepsy
- Has a diagnosis of seizures, seizure disorder or epilepsy

- Has a history of a seizure(s) within the last five years
- Has an epilepsy protocol
- Takes antiepileptic medications for epilepsy or has had other treatments, such as a vagal nerve stimulator or ketogenic diet

Guidelines for seizure prevention:

- Give antiepileptic medications on time as prescribed (be sure a protocol for missed medication is in place)
- Promote good relationships with health care professionals/specialists
 - Provide accurate documentation and record keeping
 - Keep appointments and be on time

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
- Cushion the person's head, arms and legs
- Keep track of how long the seizure lasts

After the seizure:

- Turn the individual on their side when relaxed
- 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

Medication Principles

Approximately 35% to 50% of people with DD receive psychotropic medication. 65% of psychotropic medications prescribed are antipsychotics (Indiana Institute on Disability, 2011). The most common types of medications prescribed for people with intellectual and developmental disabilities include: antipsychotic, anti-anxiety, antidepressant, stimulant, and antiepileptic drugs.

Antipsychotic and Anti-anxiety Drugs

Antipsychotic and anti-anxiety drugs are medications most frequently prescribed for people with intellectual and developmental disabilities. They may be prescribed for conditions associated with aggressive, destructive and/or self-abusive behaviors. Antipsychotic drugs are generally strong or major tranquilizers. Anti-anxiety drugs refer generally to minor tranquilizers. Antipsychotic drugs are generally prescribed more often than anti-anxiety drugs.

Antidepressant Drugs

Antidepressant drugs are frequently prescribed for the treatment of depression in adults. This is especially true when the symptoms include psychomotor disabilities, sleep disorders, loss of appetite, weight loss, and constipation. They may be prescribed for conditions associated with behavioral problems such as hyperactivity and aggression.

Stimulant Medications

These are generally prescribed to treat minimal brain dysfunction, hyperactivity and attention deficit disorders. The intended outcome is to improve the attention span of the individual. They may be prescribed for individuals who demonstrate short attention spans, aggression toward others, impulsiveness, and restlessness.

Antiepileptic Drugs

Antiepileptic drugs are used in the treatment of seizure disorders. People with intellectual and developmental disabilities have an increased incidence of epilepsy. The percentage of individuals with intellectual and developmental disabilities who also have epilepsy increases with the severity of disability. Antiepileptic drugs can be successful in the treatment of epilepsy; however, only 50% of people can achieve complete seizure control through use of these medications. The nature and unpredictability of the side effects associated with the drugs also require that they be closely monitored.

Taking any medication poses some potential risk. These risks are referred to as *side effects*. Two major classifications of drugs are prescription and non-prescription. When taken with a prescribed medication, non-prescription drugs may alter the effect of the prescribed medication. For this reason, it is critical that you consult the physician or pharmacist when using non-prescription drugs if a prescription drug is already being used.

Medication Rules to Remember

1. Medications may not always work as intended.
2. Medications may produce an effect that is different from the effect that was desired.
3. Medications may produce no effect.
4. Medications may produce an opposite effect than the desired effect.
5. Medications may make a problem worse. These are called adverse effects (life threatening) or side effects (undesirable).
6. Some medications can have good or bad reactions with other medications already being taken.
7. Many medications taken for mood and behavior may take time to work (such as antidepressants).
8. Be patient when new medications are started. They may take 3-4 weeks to work and side effects may begin at once.
9. Give medications on time and as prescribed.
10. 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

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 by the nurse, 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 person's support team.

If the individual is assessed to be not 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 ordering and picking up their own prescriptions.

Refusal of Medications- The Right to Refuse

People always have the right to refuse to take medications. It is your responsibility to work with and support individuals in taking medication; however, if someone refuses to take a medication, you should always try to determine the reason why the person is refusing.

Common reasons for refusing medication:

- Unpleasant side effects such as drowsiness
- Unpleasant taste
- Doesn't understand what the medication is for
- In denial that the medication is needed



Agency specific protocols for handling refusal of medication should be reviewed.

It is NEVER okay to crush or hide the medication in food or drinks to get a person to take his/her medication. The only time it is permissible to crush or alter any medication is if the medical professional gives permission for you to do so. If you think crushing the medication, or mixing it with food will make it easier for the individual to swallow, then you must first discuss this with the physician.

Unpleasant Taste

Please be aware that many medications cannot be crushed. If you crush some pills that are designed to be released slowly, you will get all of the medication at once. Other formulations also require that you don't crush or split. Some medications shouldn't be taken with milk. Others shouldn't be taken with juice.

Please talk to the pharmacist before trying any of the following:

- Taking a taste of honey after swallowing the pill
- Using ice chips to suck on before taking the pill
- Filling your mouth with a beverage before taking the pill

Drowsiness

If the individual refuses to take their medication because of drowsiness, you should discuss it with the prescribing physician. The doctor may suggest that the medication be taken at a different time of day (such as before bedtime), or an alternative medication may be available which does not cause drowsiness.

Lack of Understanding

If you are providing assistance to someone with intellectual and developmental disabilities and they refuse to take a medication, it may be because they do not understand what the medication is for. Sometimes simply talking with the person about the reason for the medication can help them be more willing to take it.

Denial of Need for Medication

Sometimes people may deny that they even need the medication. You should explain the need to them in language they understand, but don't argue with the person. Sometimes a simple statement from the physician to the individual to remind them to take the medication every day can help.

Even when you are armed with the best strategies, people you help support may still refuse to take medications. If you are assisting someone with intellectual and developmental disabilities who refuses his/her medication, you should respect the individual's right to choose not to take it. However, be sure to document the time, date, and medication missed in the person's clinical record and MAR and bring it to the attention of the medical health professional. Complete a Medication Error report and be sure to follow your agency's policy and procedure.

Medication Side Effects

Tardive Dyskinesia

Tardive dyskinesia (TD) is generally defined as a variable combination of abnormal voluntary movements associated with the long term use of older generation antipsychotic or 'neuroleptic' medication such as Mellaril and Haldol. These medications are used to treat such things as schizophrenia, bipolar disorder and Tourette's Syndrome. Medications such as Risperdal (Risperidone) and Abilify (Aripiprazole) are also approved to treat irritability in a person with Autism. The abnormal movements of TD may affect the face, eyes, mouth, tongue, trunk and upper and lower limbs. Some movements include grimaces, bursts of blinking, thrusting, twisting or jerking movements of the arms, hands, feet, or toes. The muscles of respiration and speech can be impaired by TD too. In the worst cases, a person with TD will thrash about continually.

TD severity may be related to greater antipsychotic medication dose or greater cumulative dose over time and organic factors. Elderly patients are thought to be at greater risk for severe TD than younger people. Also, gradual antipsychotic reductions may be associated with less severe forms of TD than abrupt reductions.

Unfortunately at this time, there is no cure for TD. Most doctors treat TD by discontinuing or lowering the dosage of the medication believed to be causing the TD. Some drugs, such as Tetrabenzine, Miraplex, and Clozapine, show promise in treating the condition.

Some of the older generation of neuroleptics which may cause TD include (Generic name of medication is listed first)

- Chlorpromazine (Thorazine)
- Fluphenazine (Prolixin)
- Halperidol (Haldol)
- Thioridazine (Mellaril)

Newer generation neuroleptics include:

- aripipizol (Abilify)
- olanzapine (Zyprexa)
- quetiapine (Seroquel)
- resperidone (Risperdal)
- ziprasidone (Geodon)

The newer atypical antipsychotics are safer than the older generation when it comes to TD.

Medications used for treatment of digestive conditions include:

- metoclopramide (Reglan) used to treat GERD/heartburn
- prochlorperazine (Compazine) used to treat frequent nausea and vomiting

There are a number of neurological, systemic and behavioral conditions which may be confused with TD because of abnormal movements that may be associated. Some conditions which can affect a person's movements and may be detected when doing a TD assessment are:

- Age
- Cerebral Palsy
- Contact lenses
- Down Syndrome
- Drug Intoxication
- Heavy Metals
- Huntington's Chorea
- Hyperthyroidism
- Parkinson's Disease
- Tourette's Syndrome

TD Assessment Scales

First, it is important to understand that assessment instruments, or TD scales, are not diagnostic instruments. They give an idea of what movements are occurring in a "snap shot" of time; however, they are not diagnostic tests and do not explain what may be causing the movements observed.

Two of the most widely used scales are:

- Dyskinesia Identification System: Condensed User Scale (DISCUS)
- Abnormal Involuntary Movement Scales (AIMS)

Neuroleptic Malignant Syndrome

Neuroleptic malignant syndrome is a life-threatening, neurological disorder most often caused by an adverse reaction to neuroleptic or antipsychotic drugs. Symptoms include high fever, sweating, unstable blood pressure, stupor, muscular rigidity, and autonomic dysfunction. In most cases, the disorder develops within the first 2 weeks of treatment with the drug; however, the disorder may develop any time during the therapy period. The syndrome can also occur in people taking medications for Parkinson's known as dopaminergics if those drugs are discontinued abruptly.

If this condition occurs, generally, intensive care is needed. The neuroleptic or antipsychotic drug is discontinued, and the fever is treated aggressively. A muscle relaxant may be prescribed. Dopaminergic drugs, such as a dopamine agonist, have been reported to be useful.

Early identification of and treatment for individuals with neuroleptic malignant syndrome improves the outcome. If clinically indicated, a low potency neuroleptic can be reintroduced very slowly when the individual recovers, although there is a risk that the syndrome might recur. Another alternative is to substitute another class of drugs for the neuroleptic. Anesthesia may be a risk to individuals who have experienced neuroleptic malignant syndrome.

Nutrition

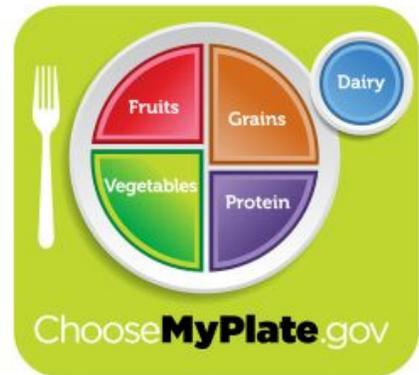
Nutrition is an important factor affecting health. A balanced diet of healthy foods, along with healthy exercise, is the best way to maintain good health.

Obesity is epidemic in America. 2/3 of American adults and 1/3 of American children are obese. Contributing factors to this condition include over-consumption of foods with low nutritional value, portion sizes that are too large, eating an unbalanced diet and not enough physical activity.

Dietary guidelines, developed by the federal government and updated in 2010, are easy to understand with the My Plate model. Even so, one size doesn't fit all.

Special dietary needs or restrictions must be considered. Factors influencing special dietary considerations relevant to people with intellectual and developmental disabilities include:

- Obesity
- Diabetes
- Choking/swallowing dysfunction
- Pica
- Food intolerance/allergies
- Need for special nutrients



In order to complete the checklist below, it is necessary to know the person's dietary needs and restrictions, observe food supplies in the home, observe the person at mealtimes and speak to the cooking staff about requirements.

Considerations for proper nutrition:

- € 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.

Support Strategies for Unexplained Weight Loss

Determine if the service plan continues to be appropriate and revise the plan if necessary.

Determine if the person has experienced an emotional trauma, loss or any other significant life change.

You may want to make observations during meals and determine if services are being provided 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). Observe at least two meals. For each person being observed, identify any special needs and the interventions planned to meet their needs.

For example:

- Individual'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?
- Were diet orders, portion sizes, preferences, and condiment requests being honored?

Choking

Factors that Increase the Risk of Choking

Individuals with intellectual and developmental disabilities may have a number of factors that increase the risk of choking, including but not limited to:

- Neurological and muscular disorders such as cerebral palsy and seizure disorders
- Dysphagia (difficulty swallowing)
- Side effects from medications
- Gastroesophageal reflux disease (GERD)
- Difficulty swallowing
- Few or no teeth
- Dentures
 - Can make it difficult to sense whether food is fully chewed before it is swallowed
 - If dentures fit poorly or hurt, individuals might not want to chew their food or may not wear them and be unable to chew their food
- Placing too much food or medication in one's mouth
- Not chewing food well enough prior to swallowing
- Eating or drinking too fast
- Inattention while eating
 - Talking, laughing, walking, running or playing
 - Distracted by other persons or activities
- Poor posture while eating
- Swallowing non-edible objects (Pica)
- Food stealing - resulting in eating quickly
- Incorrect diet texture - liquids or food items not prepared correctly
- Eating something with two or more diet textures, especially anything with a thin liquid and a solid component such as cereal and milk

Common Foods Identified as "High Risk" for Choking

- Hotdogs
- Chicken on the bone
- Grapes
- Peanut butter
- Peanut butter sandwiches on soft bread
- Thick chewy bread, e.g. white bread, bagels, pizza, etc.
- Marshmallows
- Dry, crumbly foods such as cornbread or rice served without butter, jelly, sauce, etc.
- Dry meats such as ground beef served without sauce, gravy
- Whole, raw vegetables served in large bite-sized pieces
- Whole hard fruits like apples or pears

- Candy with large nuts
- Hard nuts
- Hard candy

Awareness is the First Step of Prevention

Because of the risk factors associated with choking, it is critical to provide adequate supervision of persons served, and be trained and familiar with individuals' needs:

- Prescribed diets
- Meal time or Pica precautions
- History of previous choking incidents or difficulty swallowing
- Properly assisted eating techniques
- Positioning during and after meal time
- Required supervision during meals

Important Safety Tip

It is common for people who are choking to either leave the table or move around very quickly. Be alert for those who leave without warning or who get up, move quickly and appear to be agitated.

Emergency Response to Choking

- Immediately call 911. If another person is present, instruct them to call 911.
- Follow your agency's training for responding to a choking victim.
- Immediately provide repeated abdominal thrusts, known to some as the Heimlich maneuver, until the object causing the choking is dislodged and the individual can cough forcefully, speak or breathe, or until the individual becomes unconscious.
- If the individual is unconscious, remove any visible obstructions from the mouth and begin administering CPR. Check periodically to see if the obstruction becomes dislodged.

Indicators of PARTIAL Airway Obstruction

- Able to speak, cry, and respond to you
- Breathing is noisy, labored, or gasping. Some air will come from the mouth
- Coughing, or making "crowing" noises
- Very agitated or anxious
- Skin becomes paler, may have bluish tint

Emergency Response to Partial Obstruction of Airway

- a. Reassure the individual.
- b. Encourage the individual to cough.
- c. Avoid giving the individual anything to eat or drink.
- d. Keep monitoring the situation.
- e. Call an ambulance if the obstruction is not removed, or you can hear wheezing or noisy breathing.
- f. If the obstruction is cleared, always have medical/nursing personnel determine if there is a need for additional clinical follow up.

Special Diets

The act of swallowing involves chewing food and moving it into the back of the mouth to transport it down the esophagus, the tube that moves food to the stomach. Difficulty with swallowing is the feeling that food or liquid is stuck in the throat or at any point before the food enters the stomach. This problem is also called dysphagia. Any symptoms of difficulty swallowing must be investigated. After a visit to the individual's healthcare provider, a swallow study may be needed.

Swallowing is a complex act. Many nerves work in a fine balance to control how the muscles of the mouth, throat, and esophagus work together. Much of swallowing occurs without you being aware of what you are doing. The people that we help support may have a variety of disorders which make swallowing difficult.

A brain or nerve disorder can alter the fine balance in the muscles of the mouth and throat. An individual may first notice having problems only with certain types of foods or liquids. Difficulty eating very hot or cold foods, dry crackers or bread, meat, or chicken may be an early sign of swallowing problems.

If a special diet is ordered for someone that you help support, it is critical that the diet is followed at all times. **All** staff that provide support to the individual who is on a special diet must be trained in how to prepare the diet and in any mealtime assistance that an individual requires. This training should be thoroughly documented.

The table of food items for each type of diet is meant for example only. You should follow diet that is prescribed for the individual by the health care provider.

Chopped Texture

Purpose: This diet is for persons who have difficulty chewing some regular foods or have difficulty cutting up foods.

Diet Principles: Some foods are modified by dicing, chopping or cutting into bite-sized pieces as tolerated. Most meats are cubed and raw vegetables and hard fruits are finely diced. This diet texture can be applied to any portion size or therapeutic diet.

FOODS FOR THE DAY	EXAMPLES OF FOODS ALLOWED	EXAMPLES OF FOODS TO AVOID
MILK & MILK PRODUCTS	Milk, cottage cheese, sliced cheese	None
MEAT OR SUBSTITUTE	Cubed meat and poultry, whole fish, tender sliced lunchmeat and cheese, eggs, cooked dried beans and peas	All others
BREADS, CEREALS, PASTA & RICE	Whole grain, enriched bread, cereals, crackers, pasta, or rice	None
VEGETABLES	Cubed cooked vegetables, shredded lettuce, vegetable juice, finely diced raw carrots and celery. White or sweet potato	Whole raw vegetable salads, whole raw carrots and celery
FRUITS	May be fresh, canned, or frozen, served whole (except apples), diced, or as juice. Soft fresh fruit as tolerated	Whole fresh apples, Whole hard fresh fruit
FATS	Margarine, butter, salad oil, mayonnaise	None
DISCRETIONARY CALORIES	Puddings, ice cream, sherbet, cakes, cookies, gelatin, pastries, pie, sugar, jelly, salt, herbs and spices, flavorings, pepper	None

Ground Texture

Purpose: This diet is for persons who have difficulty chewing and/or swallowing. It is intended to minimize the need for chewing and to ease swallowing.

Diet Principles: Foods are finely minced or ground, and moistened. Foods that are fork-mashable are included. This diet texture can be applied to any portion size or therapeutic diet.

FOODS FOR THE DAY	EXAMPLES OF FOOD ALLOWED	EXAMPLES OF FOODS TO AVOID
MILK & MILK PRODUCTS	Yogurt, cottage cheese, custard, cheese spread (ground)	String cheese or other cheese larger than diced
MEAT OR SUBSTITUTE	Moistened ground meats, ground dried beans, meat salads made with ground meat and vegetables, scrambled eggs, soft tofu	Unmoistened meats, whole hamburger patty, cold cuts, whole hard cooked egg
BREADS, CEREALS, PASTA, & RICE	Soft, moist bread products such as moistened breadcrumbs or bread pudding, cooked cereals (oatmeal, farina, malt-o-meal), moistened rice and small chopped pasta	Bread with: seeds, nuts, dry fruits, unsoaked crackers, gold fish crackers, teddy grahams, dry cereal, coarse whole grain cereals not softened by soaking
VEGETABLES	Minced or ground tomatoes, peas, beets, lima beans, creamed or pureed corn, kidney beans, spinach, gelled vegetable salads, mashed potatoes, ground tater tots, minced potato salad, tender steamed potatoes that can be mashed with a fork	Raw crunchy vegetables without sauce or dressing, potato chips, whole French fries
FRUITS	Ground or minced baked apples, ripe banana, peaches, crushed pineapple, canned/cooked fruit, applesauce, pureed raisins, fruit cocktail, blueberries, strawberries, pineapple sauce and pureed bananas can be used if crushed pineapple and minced bananas are not tolerated	Raw and crunchy fruit, fruit roll-ups, dried fruit, coconut
FATS	Margarine, butter, salad oil, mayonnaise	None
DISCRETIONARY CALORIES	Moistened soft cookies, cubed cake	Seeds, unmoistened cookies, plain peanut butter

Pureed Texture

Purpose: This diet is for persons who have chewing or swallowing problems and may not safely handle a ground texture.

Diet Principles: Foods are pureed to smooth consistency unless already in a comparatively smooth form such as mashed potatoes. This texture can be applied to any diet portion size or therapeutic diet.

FOODS FOR THE DAY	EXAMPLES OF FOOD ALLOWED	EXAMPLES OF FOODS TO AVOID
MILK & MILK PRODUCTS	Yogurt, pureed cottage cheese, custard, ice cream	Hard and semi-hard cheeses used alone
MEAT OR SUBSTITUTE	Pureed meat, poultry, fish, eggs, cooked dried beans, soft tofu	All others
BREADS, CEREAL, PASTA, & RICE	Moistened bread crumbs or pureed baked bread pudding, cooked cereals (pureed oatmeal, farina, malt-o-meal), moistened pureed rice or rice cereal, pureed pasta	All others, dry cereal, coarse whole grain cereals not softened by soaking
VEGETABLES	Pureed: tomatoes, peas, beets, lima beans, pureed creamed corn, kidney beans, spinach, pureed gelled vegetable salads, mashed potatoes, pureed tater tots, and pureed potato salads	Whole creamed corn, all other potato products
FRUITS	Pureed: baked apples, banana, peaches, pineapple sauce, canned/cooked fruit, raisins, fruit cocktail, blueberries, strawberries and applesauce	Raw and crunchy fruit, fruit roll-ups, dried fruit, coconut
FATS	Margarine, butter, salad oil, mayonnaise	None
DISCRETIONARY CALORIES	Pureed soft cookies or cake, ice cream, pudding	Seeds, unmoistened cookies, peanut butter (by itself)

Thickened Liquids

Thickened liquids are prescribed for some individuals with swallowing problems. Thickeners slow the flow of liquids and make them easier to swallow. The degree of thickness that the individual may need to swallow safely is prescribed by the health professional after a swallow study is performed.

Nectar Thick Liquids: This is slightly thickened.

- Fork test: Liquid coats the fork and quickly sinks through the prongs.
- Spoon test: Liquid leaves spoon in a fine “ribbon” or “trail” when poured or stirred, similar to heavy syrup found in canned fruit, or to maple syrup.

Honey Thick Liquids: This is thicker than nectar, closer to honey.

- Fork test: Liquid coats the fork and flows slowly through the prongs.
- Spoon test: Liquid flows slowly from spoon but still pours, somewhat like a milkshake.

Pudding Thick Liquids: This is the thickest. It does not pour, but drops from the spoon.

- Fork test: Liquid remains on fork.
- Spoon test: Liquid does not pour from spoon. The spoon stands up in product and liquid requires a spoon for eating.

Preparation

Follow manufacturer’s recommendations EXACTLY for measurements of both the commercial thickener and the liquid. Follow recommendations for waiting time for the thickener to work. USE NO MORE THICKENER THAN NECESSARY to avoid excess calories and over-thickening.

Pica

Pica presents a serious risk to a person's health and should not be disregarded or taken lightly. It can result in serious illness, surgery and even death. It is important to understand the condition and its specific manifestation in an individual. A well developed safety plan will give caregivers the information that they need to assist individuals to live safe, happy and healthy lives.

Pica is defined as the compulsive eating of non-food items. There are many theories about the cause of pica; however, within the field of intellectual and developmental disabilities the cause often remains unknown. Some *possible* causes of pica behavior include:

- Medical problems
- Psychiatric illnesses
- Behavioral functions

Individuals who have pica may seek out a wide variety of items to ingest. The behavior is very individualized. Some may seek out specific items to ingest while others may ingest any small item in their environment. Therefore a plan/protocol for safety must be developed specifically for the person, their pica behavior and health risks.

Prader-Willi, a syndrome characterized by chronic feelings of insatiable hunger, can lead to excessive eating and life-threatening obesity. Like those with Pica, individuals with Prader-Willi may require consistent and unique care to avoid a health crisis.

At times it may be necessary to restrict a person's access to food. When considering such restrictions, proper protocol must be followed.



Discuss your agency's Human Rights Committee and related policies and procedures.

Risks associated with putting non-food items into the mouth and/or swallowing:

Bowel blockage – items that are swallowed may clump or stick together and eventually block the bowel. These items may include:

- String, thread or fuzz
- Paper
- Disposable gloves (latex, plastic)

Ulceration and perforation

Any object that stays in contact with one spot in the bowel can cause ulceration and eventually perforation. Coins are particularly dangerous. Any sharp object, such as a safety pin or screw can puncture the esophagus, stomach or intestines.

Poisoning/Toxicity/Parasitic Infection

- Furniture polish – damages the lungs
- Cleaning solvent
- Antifreeze – damages the kidneys
- Batteries
- Paint chips from lead based paints
- Cigarettes and butts
- Dirt from areas frequented by pets/animals
- Pet feces

Choking/Aspiration

- Non-food items large enough to block the airway

Dental and Mouth Injuries

- Items too hard to chew (rocks, buttons, etc.)

Nutritional Deprivation

- Eating enough non-food items to displace legitimate caloric intake

Pica Prevention

Techniques for coping with Pica behaviors fall into these categories:

- Sweeping
- Adapting
- Avoiding
- Interfering

Sweeping

Sweeping is a simple way to identify potential hazards in the area.

A sweep has five steps:

- *Stop* – Keep the person from entering a new area before the sweep is done.
- *Look* - Spot any possible hazards in the area.
- *Investigate* – Decide on the risk from each of the possible hazards.
- *Document* – Keep track of the hazards that are found.
- *Eliminate* – Get rid of any likely hazards when feasible.

Adapting

Adapting the person's daily tasks is usually required. An adaptation task has these steps:

- *Assess* – Look at each new task.

- *Identify* – Spot the likely hazards for the person in each task.
- *Modify* – Adapt the new task to remove the item.

Avoiding

Avoiding some places at the times when Pica is most likely to happen is a good way to prevent it. Avoiding pica behavior has these steps:

- *Locate* the places the behavior is most likely to happen.
- *Identify* – Spot the likely hazards for the person in each location.
- *Plan* – Schedule to avoid the places at times that the Pica behavior could happen.

Interfering

Interfering with Pica behavior by giving the person other things to do can help to prevent the behavior.

- *Find* – Design tasks that get in the way of the behavior.
- *Be* sure that the tasks are safe for the person to do.
- *Assure* that the task is one the person can do.

Other tips to help prevent Pica from occurring include:

- Limit access to environments that are not rigorously monitored for small indigestible items.
- Ensure close supervision of the individual and that all caregivers understand the individual’s risk of Pica.
- Develop a protocol specific to the individual and their support needs; provide caregiver training in all locations where the person spends time.
- Consider the need for routine surveillance (Pica sweeps) of the areas frequented by the individual to find and remove targeted Pica items.
- Avoid clothing with buttons/bows that can be pulled off.
- Avoid toys/gifts with small pieces that can be chewed or broken off and swallowed.

Discuss the following:



Is anyone here currently serving or has anyone previously served an individual with Pica?

What measures have you used to interfere with the disorder? Have you had any success?

How does Pica differ from Prader-Willi?

Protocol/Safety Plan

A protocol/safety plan should be developed with input from the people who know the individual and their environment best.

Five Steps of a Safety Plan include:

1. A list of the things that the person might either swallow or attempt to swallow
2. A system for keeping track of both ATTEMPTED, as well as, COMPLETED ingestion

3. Strategies for preventing any attempt
4. A plan for training staff
5. Criteria for revising the safety plan

The plan should also give guidance for:

- When to call 911
- When to call poison control (the phone number of poison control should be posted by every phone)
- List times/locations where pursuit of items is most likely, if known
- Steps in prevention, such as Pica sweeps, no buttons on shirt, etc.
- Signs and symptoms that the individual may display if a non-food item is swallowed

Verbal encouragement can be used to coerce an individual into spitting out non-food items. Staff should be trained not to put their hands, fingers, etc. into an individual's mouth in an attempt to remove objects. If a non-food item is suspected of having been ingested, the individual must be monitored for symptoms of obstruction, infection, poisoning or other adverse effect.

The following symptoms may indicate a need to notify the physician:

- Refusal of food or fluids or decreased intake
- Lack of bowel movements or small watery stools
- Abdominal pain and discomfort
- Vomiting
- Fever
- Hard or protruding abdomen
- Walking stooped or bent over as if in pain (if not usual for the individual)
- Complaining of not feeling well or not wanting to get out of bed, go to work or participate in favorite activities

If an individual displays Pica behavior for the first time, it is essential to ensure that the physician is informed of the following facts:

- A clear description of the behavior, clarifying that it is new to the person
- Any data collected on frequency
- Specific items that the person is seeking out

Aging

Older people can expect some decline in their five senses. While the sense of smell, taste and touch all change with age, often the most noticeable changes affect our vision and hearing. As senses change, older people may find it more difficult to socialize and participate in activities. Changes to our senses may also increase the need for assistance with personal care.

Hearing

Starting around age 30, we begin to experience hearing loss. By age 40 or 50, it can be hard for many people to distinguish between sounds that are coming from nearby or farther away. Higher tones such as the voices of women and children can be more difficult to hear as we age. These higher tones also help us to *understand* speech. Frequently, people with a hearing loss in the higher tones complain that they can hear speech, but are unable to understand what is being said.

Older people may find it hard to engage in or follow a conversation. It can be challenging to talk on the telephone, hear music or hear the television. People with hearing loss often use hearing aids or hearing devices, sometimes called “Assistive Listening Devices”. Others may choose to avoid social situations where their impairment may be noticeable or they may feel conspicuous or uncomfortable.

Possible signs of hearing loss:

- The radio or TV volume is on very loud.
- The individual may ask you to repeat things.
- You notice the person watching your mouth very closely.
- If you turn your back to the person, he/she does not hear or understand you.
- The individual talks unusually loud, yet doesn't realize it.
- The individual doesn't hear the door bell or a knock at the door.

Support Strategies:

- Schedule regular exams with an Audiologist to check for wax, disease and gradual hearing loss
- Obtain amplification (hearing aid or assistive listening device) if indicated
- Speak slower
- Reduce background noise
- When speaking, face the person with light on your face (not behind you)

To participate in a hearing loss simulation, listen to the computer generated samples at <http://www.cdc.gov/niosh/mining/content/hlsoundslike.html>

Smell

Aging may gradually reduce the ability to detect and identify odors. Other factors which affect smell include smoking and medications.

Older people may be less aware of body odor or excessive use of perfume, and may lose their natural ability to detect spoiled food or smoke. Regularly replace smoke detector batteries; a good rule of thumb is to change the batteries when the time changes. If a person has body odor, it is important to respectfully bring it to his or her attention to help maintain their dignity. A person may not notice odors or detect unsafe smells. Offer support and kind words to help avoid potentially embarrassing or dangerous situations.

Watch carefully what the person eats.

- Be aware of exposure to chemicals such as ammonia, bleach, smoke or gas, which may cause harm. Remove the individual from such situations.
- Eating spoiled food or not reacting to bad smells might indicate that an individual is losing their sense of smell.

Support Strategies:

- Be sure to use smoke detectors
- Use care if using propane stoves or water heaters
- Discard food after recommended time, check for spoilage
- Assist with awareness of body odor or over-use of fragrances

Taste

The intensity of taste and the ability to identify different tastes diminishes as we age. Older people tend to maintain the ability to detect sweet taste, but have more difficulty detecting sour, salty and bitter tastes. Other factors that affect taste include dentures, medications and smoking.

Concern – If older people find eating to be less enjoyable or satisfying, they may eat less often or eat only those foods with a distinctive or strong flavor. It is important for people of all ages to eat a healthy and balanced diet, not just the foods that taste good.

Touch /Sensitivity

With age, the sense of touch often declines due to skin changes and reduced circulation. Skin is less sensitive to temperatures such as hot and cold water. Small motor skills such as opening a jar or handling silverware may also become more challenging. People with arthritis, diabetes or vascular disease may face additional challenges and limitations.

Concern – Many older people may not be aware of their diminished sense of touch and as a result could unintentionally injure themselves. People leading a more inactive or sedentary lifestyle are often less sensitive and may not notice potential dangers. No reaction (or a slow one) to a change in temperature or pain may be a sign that a person is losing his sense of touch. If a person loses their sense of touch, he may be at risk of hypothermia or hyperthermia, heat

stroke, burns, or frostbite. Watch the person closely as he may not react to water temperatures that may cause burns.

Protecting the skin:

- Minimize use of soap and rinse well
- Dry well and use moisturizers
- Reposition frequently if mobility is limited
- Check skin frequently for sores, dryness or other abnormalities
- Label hot and cold water and monitor water temperatures
- Use sun protection. The individual may stay longer in the sun than usual and cause sunburn. Be sure people wear 15+ sunblock when outside.

Vision

Aging may cause noticeable vision changes. The pupil of the eye becomes less responsive to changes in lighting making it difficult to see in the dark. The lens of the eye gradually thickens and yellows. There is a loss in visual acuity, which is the ability to notice detail. An older adult may openly share concerns about his/her vision. But sometimes the change occurs so gradually that the individual adapts and is not aware of the changes. Of the many eye diseases that affect older people, the most common are cataracts, diabetic retinopathy, glaucoma and macular degeneration.

- Cataracts are a gradual clouding of the lens of the eye, making images less clear and sharp.
- Diabetic retinopathy is caused by a lack of circulation to the retina where the arteries in the retina become weakened and leak, forming small spots that cloud a person's vision.
- Glaucoma is a buildup of pressure inside the eye that ultimately can destroy the optic nerve and lead to blindness.
- Macular degeneration causes deterioration of the retina, responsible for focusing central vision in the eye. It becomes difficult to read and recognize detail, and over time can cause blindness.

Concern -It can become difficult for older people to see in dimly lit places such as a restaurant or theatre. Night driving and driving in rainy conditions can be dangerous due to an inability to see road signs, judge distance or recover from the sudden glare of oncoming traffic. As we age, many people will rely on reading glasses, bifocals or trifocals to help maintain their eyesight. Medical treatment or surgery may be an option for many conditions.

To gain an understanding of how different eye diseases can affect vision, visit the following website: <http://www.nei.nih.gov/health/examples/index.asp>

Symptoms of the problem:

- Rubbing eyes
- Squinting
- Shutting or covering one eye

- Tilting or thrusting head forward or to one side
- Redness of eye or area around eyes

Changes in Function:

- Stumbling
- Hesitancy on a step or curb
- Holding objects/books closer to eyes
- Sitting closer to TV

Some clues to look for:

- Wearing spotted, soiled or mismatched clothing
- Using non-visual methods such as searching with their hands for an object, or searching for the edge of a chair to walk around it
- Needing more lighting for activities
- Falling or bumping into furniture or doorways
- Not aware of a decline in cleanliness of living area

Support Strategies:

- Use bright contrasting colors around doors and steps.
- Avoid highly polished surfaces. This will allow for good light, yet limit the glare.
- Use bright light. This will help the person know the difference between detail and colors.
- Limit the time of “close work” (for example, knitting or reading).
- Provide support in a new environment until the person has become accustomed to it and can easily find his way around.
- Provide support when walking if needed.
- Use adaptive aids such as telephones with larger numerals, large print books, and magnifying glasses.
- Provide adequate handrails in stairwells and other areas where the person may need support.

Aging and the Gastrointestinal System

In older adults, the stomach produces less gastric juice which may lead to more frequent indigestion and ulcers. A decrease in saliva production may lead to gum disease. Aging causes decreased smooth muscle tone which means slower digestion and emptying of the stomach bowel. There is also less absorption of nutrients from food.

Support Strategies:

- Promote elimination through increased fluids, fiber and physical activity
- Observe for constipation
- Encourage slower eating with smaller, more frequent meals
- Avoid empty calories

Aging and the Genitourinary (Urinary/Reproductive) System

With age, bladder capacity and muscle tone decreases. The kidneys become less efficient and enlargement of the prostate is common.

Support Strategies:

- Observe for voiding patterns – increased or decreased frequency or changes in continence
- Observe for signs of infection – frequency urgency, accidents, discomfort, unusual odor or bleeding
- Encourage good hygiene practices

Aging and the Pulmonary System (Lungs)

Aging may cause lungs to become less elastic and therefore less able to take in oxygen. Breathing becomes less efficient and tolerance for exercise decreases. The lungs are less able to eliminate mucous because of changes in the respiratory tract and there may be a decreased cough reflex.

Protecting the Lungs

- Avoid smoking and second-hand smoke
- Encourage deep breathing, physical activity
- Help alleviate stress
- Encourage proper diet and enough fluids
- Watch for signs of infection (increased coughing, shortness of breath, colored sputum, increased confusion)

Aging and the Musculoskeletal System

Aging may cause a decrease in muscle mass, strength and tone. Joints show decreased mobility and bones become more porous and fragile. There is also an increased likelihood of developing arthritis.

Protecting the Musculo-Skeletal System

- Encourage independent movement and self-care
- Promote regular exercise
- Implement safeguards to prevent falls
- Promote safe use of mobility aids
- Provide seating that is comfortable, firm, and not too deep
- Ask health care provider about calcium and vitamin D supplements

Bowel Tracking

Agencies should have a bowel tracking system for all individuals who receive bowel related treatments so that agency staff and nurses can recognize when problems are arising. A bowel tracking system should include day/time of bowel movement, quantity of stool, and character of the stool.

Roles and Responsibilities

QIDP

- Recognize relevant risk factors or trends that may indicate a need for medical evaluation and changes in the treatment plan.
- Ensure the healthcare provider is presented this information when the individual is assessed.
- Ensure individuals who are being treated for constipation have a bowel tracking system in place and that all staff are trained in this tracking.
- Consider periodic bowel tracking for all individuals so the diagnosis of constipation is not overlooked.
- Must ensure that individuals who are able to be physically active have adequate opportunity to stay physically active.
- Ensure a meal program that provides good sources of dietary fiber.
- Every individual should have an area that addresses bowel elimination in the annual nursing assessment, and be included in the ISP as appropriate.
- For individuals treated with any medication for constipation, the ISP should reflect information from bowel tracking forms as well as how often a “PRN” medication (i.e. a suppository or enema) is used to treat the individual.

Bristol Stool Chart

There are seven types of stools (feces) according to the Bristol Stool Chart. The Bristol Stool Chart or Bristol Stool Scale is a medical aid designed to classify feces into seven groups.

The type of stool or feces depends on the time it spends in the colon. After feces is passed, what is seen the toilet bowl is basically the result of the persons diet, fluids, medications and lifestyle. The Bristol Stool Chart can be used to evaluate stools.

The Bristol Stool Chart shows seven categories of stool. Every person will have different bowel habits, but the important thing is that stools are soft and easy to pass – like types 3 and 4 on the following page.

Types 1–2 indicate constipation

Types 3–4 are ideal stools as they are easier to pass

Types 5–7 may indicate diarrhea and urgency.

The Bristol Stool Chart was developed by K. W. Heaton and S. J. Lewis at the University of Bristol and first published in the Scandinavian Journal of Gastroenterology in 1997.

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Choking From Bulk Forming Laxatives

Psyllium and polycarbophil are bulk forming laxatives and are known by trade names such as Metamucil, Perdiem, Genfiber, Fibercon, Equilactin and others. This type of laxative can cause choking and obstruction of the airway if they are not mixed according to the manufacturer's instructions. These products can quickly harden and may create a solid mass that can block the person's airway- creating a medical emergency that could result in death.

These laxatives must be mixed or taken with at least 8 ounces of water or juice. Powdered bulk forming laxatives should NEVER be mixed with food. Bulk forming fiber laxatives work by absorbing liquid in the intestines and swelling to create a softer, bulky stool that is easier to pass. Bulk forming laxatives come in powders, capsules or wafers.

Care must be taken to administer these medications properly. Powder laxatives must be mixed with at least 8 ounces of water or juice. If the mixture is too thick, add more liquid. After drinking the entire mixture, add a little more liquid to the same glass, swirl gently and drink right away to make sure you get the entire dose. If capsules are not taken with enough water, they may become stuck in the throat, swell and obstruct the airway. Wafers must be thoroughly chewed and taken with adequate water.

Urinary Issues

Some people may experience the frustration and embarrassment of urinary incontinence, the inability to hold urine. It is a common problem. It can affect young and old, men and women. The extent can range from an occasional leakage of urine, to a complete inability to hold any urine. When this happens, clothing gets wet, odors develop, and the person becomes uncomfortable. Being incontinent is beyond the person's control and dealing with it as a professional requires understanding, kindness and patience.

Common Types of Incontinence

- **Urge incontinence** is a sudden overwhelming need to urinate and the person is unable to control or stop the urine. Some common triggers are running water, hand washing and going out in the cold. When this happens, the person might lose urine very quickly or may leak slowly on the way to the toilet. Some people with urge incontinence also need to use the toilet frequently during the day and sometimes during the night.
- **Stress incontinence** occurs when you cough, laugh, sneeze or exercise.
- **Overflow incontinence** is when the bladder becomes full and starts to overflow.
- **Functional incontinence** occurs when a person is unable to get to the toilet, sometimes because of a physical disability such as arthritis. There is nothing wrong with their bladder. It is simply a matter of circumstances preventing the person from getting to the toilet.

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 include:

- Urinary tract infection, bladder infection or kidney infection
- Obesity or being overweight
- Caffeine or alcohol
- Enlarged prostate
- Constipation or stool impaction
- Stool impaction from severe constipation which causes pressure on the bladder
- Side effects of medications

Interventions that May Help with Incontinence include:

- Encourage people to use the toilet prior to sleep at night
- Make sure there is a lighted passageway to the toilet at night

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

Urinary Tract Infections

A urinary tract infection (UTI) is an infection anywhere in the urinary tract, 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. E. coli bacteria in human intestines is the bacteria that causes many UTIs. Usually the person's body removes the bacteria during urination and people have no symptoms.

Risk factors for Urinary Tract Infections

- Use of a catheter
- Problems with the pelvic muscles and nerves as in Cerebral Palsy, spinal cord injury, or other neuro-muscular conditions
- Diabetes, HIV/AIDS, and Cancer
- Obesity
- Menopause
- Poor hygiene, such as inability to clean/wipe properly after bathroom use

Symptoms of UTI

- Urine is dark, cloudy, or smells
- Dull pain in the back or sides (above the hip)
- Burning and pain with urination
- Feeling the urge to urinate often
- Bloody or pink-tinged urine
- Pain in the lower area of the belly
- Incontinence
- Nausea/Vomiting
- Confusion and Disorientation
- Fatigue and Drowsiness

Interventions/Prevention for UTI

- Hand washing before **and** after bathroom use
- Cleansing genital area front to back during baths/showers
- Wiping from front to back (especially in females) after bathroom use
- Keep well hydrated to prevent concentrated urine in the bladder which can grow bacteria

Overview of Self-Injurious Behavior

One of the most difficult health issues to manage is injury prevention from self-injurious behavior (SIB). The severity of injuries can vary from mild skin abrasions to life threatening head injuries. In persons with intellectual and developmental disabilities, the behavior may occur frequently and be directed at one part of the body, such as striking one ear with a fist or biting one hand. Suicide is uncommon in persons with intellectual and developmental disabilities and SIB.

Theories of causation are:

- An attempt to reduce stress and maintain homeostasis by using SIB as a diversion from stressful internal feelings or external situations. (Some experts view SIB as an extreme form of self-stimulating behavior)
- A way of blocking or controlling physical discomfort
- An attention seeking behavior that elicits response from others
- Results from boredom and the need for stimulation
- A disruption or chemical deficiency in the brain's neurotransmitter system
- A response to feelings of shame and worthlessness due to a history of trauma

Injuries that occur can range from mild calluses on one hand or wrist from biting to skull fractures and retinal detachments from repeated head banging. The more at risk the person is from tissue and organ damage, the more aggressive the intervention must be to stop or minimize the behavior.

Possible Interventions:

- Medical evaluation to determine if there is any physical cause (e.g., headache, earache, toothache, etc.)
- Therapy to address a history of trauma
- Distraction and diversion
- Psychoactive medications alone or in combination; no one specific medication class lessens or eliminates SIB in all persons
- Removal of rewards contingent on SIB
- Physical restraints when the behavior is intense. In some individuals, SIB occurs infrequently but is very intense when it occurs. Physical restraints such as mittens, wrist protectors and helmets can be worn during periods when SIB is intense to prevent injury.
- Combination of any or all of these methods.

Because of the complexity of SIB behavior, a behavior specialist is usually needed to help caregivers with interventions that may stop or minimize the behavior. If interventions are restrictive, the plan must be approved by the team. If any type of restrictive intervention is used, it must be approved by the agency's Human Rights Committee.



Discuss your agency's policies and procedures for addressing SIB

Infection Control

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 frequent and effective 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.

Current Regulations

All staff who directly support people with intellectual and developmental disabilities must complete blood-borne pathogen training annually. 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

Emergency Protocols



Review your agency specific protocols

- Agency on-call system
- Activating 911 services

After contacting 911,

- **STAY CALM**, so that you can reassure the person and not add to fear and concern.
- **STAY WITH THE PERSON** until the emergency professionals arrive.
- **MAINTAIN AIRWAY**, if necessary by tilting the head back.
- **CONTROL BLEEDING** by application of pressure, or use of a tourniquet if necessary.
- **TREAT FOR SHOCK** by having the person lie down, loosen clothing, cover with a blanket, and seek medical attention.

Recommended Reading & Resources

Although we will try to cover a great deal of material with you today in class, the topic of medical supports is a broad one that requires continued study and attention throughout your career. We recommend the following resources as good places to start with regard to furthering your knowledge and understanding of this important topic.

- DHS Developmental Disabilities Nursing Manual
http://www.oregon.gov/dhs/spd/provtools/nursing/ddmanual/all_sections.pdf
- DHS Developmental Disabilities Nursing Manual
http://www.oregon.gov/dhs/spd/provtools/nursing/ddmanual/all_sections.pdf
- Medical Issues for Adults with Mental Retardation/Developmental Disabilities by *Carl V. Tyler, M.D.*
- PICA Behavior: A Short Overview by *Casey S. Nelson*