



Principles of Caregiving

AGING AND PHYSICAL DISABILITIES

A training program
for caregivers, personal
attendants and direct
support professionals.

THE ARIZONA DIRECT CARE CURRICULUM PROJECT.

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For more information about the curriculum project, please visit the Arizona Direct Care Initiative website at www.azdirectcare.org.

PREFACE TO THE PRINCIPLES OF CAREGIVING

The Development of Standardized Direct Care Professional Training in Arizona

The need for home and community-based caregiving is one of the most compelling issues of our time. It will affect nearly every family in America. In order to be ready to meet the increasing demand for home and community-based services, Arizona must develop a capable and compassionate workforce of caregivers. We are better prepared to meet these challenges through the *Principles of Caregiving* training for caregivers, personal attendants, and direct support professionals.

In 2004, Governor Janet Napolitano appointed the Citizens Work Group on the Long Term Care Workforce (CWG) to further develop and provide recommendations for improving the quality of the long-term care workforce. In 2005, the CWG laid out ten recommendations. One called for the implementation of a standardized, uniform, and universal training curriculum for the direct care workforce.

The Direct Care Curriculum Project is a partnership between the Arizona Department of Economic Security, the Arizona Health Care Cost Containment System, the Developmental Disabilities Planning Council (formerly the Governor's Council on Developmental Disabilities), the Arizona Department of Health Services, and the Direct Care Workforce Committee. The *Principles of Caregiving* training manuals were created to help establish a high-quality training program for direct care and direct support professionals in Arizona. Many individuals and agencies were involved, representing home care providers, community colleges, advocacy organizations, and state agencies. Refer to the Appendix for a list of acknowledgments.

NOTES TO THE STUDENTS

Principles of Caregiving: Aging and Physical Disabilities is Level 2 module of the *Principles of Caregiving* series. It builds on the Fundamentals module, and contains advanced material for DCWs working with older adults or persons with physical disabilities. The Fundamentals module should be completed first. Some review may be necessary before completing this module.

This module is independent of the other Level 2 modules in the series. You can complete this portion of the training without studying the other modules.

Depending on the needs of your employer and the clients served, you may not need all the knowledge and skills presented in Aging and Physical Disabilities, but you are encouraged to study the whole program. The *Principles of Caregiving* curriculum is designed to provide a well-rounded introduction to caregiving and direct supports, and you will be prepared to work for a variety of clients and employers.

Principles of Caregiving includes the following modules:

- Level 1: Fundamentals
- Level 2: Aging and Physical Disabilities
- Level 2: Developmental Disabilities
- Level 2: Alzheimer’s Disease and Other Dementias

Competencies for Arizona Direct Care Workers

The competencies are the basis for the training and testing of any staff providing housekeeping or homemaker services, personal care, or attendant care services for a state-funded program in Arizona. The *Principles of Caregiving* books address all of the competencies and help you prepare for the Arizona DCW tests. For a list of competencies, see the Appendix of this module, or refer to the Arizona Direct Care Initiative website at www.azdirectcare.org, click on Competencies.

Learning Objectives

Each chapter of the Aging and Physical Disabilities module begins with an introductory page that lists the learning objectives and the key terms for that particular chapter. Some sections also list skills; these are procedures that you should practice and demonstrate to your instructor. The following symbols are used to identify certain components:



Exercises and activities.



Procedures that you need to practice and demonstrate.

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

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PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 1 – BODY SYSTEMS: FUNCTION, CHANGES WITH AGING, CARE IMPLICATIONS AND CONDITIONS

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- A. Definitions
- B. Heart, Circulatory System and Lungs
- C. Brain and Nervous System
- D. Skin, Hair, and Nails
- E. Bones, Joints and Muscles
- F. Stomach, Intestines and Liver
- G. Kidneys and Bladder
- H. Immune System
- I. Vision, Hearing, Taste and Smell
- J. Diabetes

OBJECTIVES

1. Explain the difference between acute and chronic illness.
2. Identify major body systems and their functions.
3. Describe the effect of aging on the body.
4. Identify and describe the major chronic conditions and therapeutic interventions used.
5. Describe the significance of diabetes and implications for caregiving.

KEY TERMS

Acute	Diastolic (blood pressure)
Aging	Disability
Amputation	Hyperglycemia
Arthritis	Hypoglycemia
Asthma	Incontinence
Blood Pressure (BP)	Osteoporosis
Chronic	Paralysis
Chronic Obstructive Pulmonary Disease (COPD)	Seizure
Constipation	Stroke
Contracture	Systolic (blood pressure)
Dementia	Therapeutic Interventions
Diabetes	Urinary Tract Infection (UTI)

A. DEFINITIONS

- **Aging:** Aging is the process of becoming older. It affects an individual's body and mind. Factors involved with the aging process are genetically determined and affected by the individual's medical conditions and lifestyle.
- **Disability:** A condition which limits a person's ability to function in one or more major life activities. This can include communication, walking, and self-care (such as feeding and dressing oneself). Disability is most likely a lifelong condition, resulting in the need for assistance.
- **Therapeutic interventions:** Therapeutic interventions are care strategies and treatments. They are given based on individual diagnosis and needs and are addressed in the care/support plan.
- **Acute illness:** Acute illnesses progress rapidly, last a certain length of time, and then the person recovers.
- **Chronic illness:** Long-term conditions requiring long-term care. According to the U.S. National Center for Health Statistics, a chronic illness lasts three months or more.

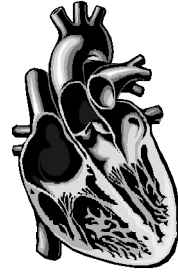
The importance of reporting a change in condition

It is essential that caregivers recognize and report a change of condition in their clients, especially a sudden one. A change of condition means that there is something going on that is not usual for the person. Often these changes of condition, if not noticed and quickly acted upon, result in serious outcomes, possibly hospitalization or even death. Caregivers should be aware of their agency's policies on reporting. In general, call the supervisor or 911 when changes occur. They will assist in determining the next course of action to follow.

B. HEART, CIRCULATORY SYSTEM AND LUNGS

Function

The *heart* is the key organ in the circulatory system (also called the cardiovascular system). The heart is a hollow, muscular pump. Its main function is to force blood throughout the body.



The *circulatory system* consists of blood vessels (arteries and veins) which carry blood to and from the heart. The blood brings oxygen and nutrients to all of the body's cells and vital organs and takes waste products away.

The *lungs* are among the largest organs in the body. They allow you to take in fresh air, get rid of stale air, and even talk. As you breathe in, air goes into your lungs through the windpipe. Your diaphragm tightens and flattens out, creating a suction that brings air into the lungs. The lungs are part of the *respiratory system*. When you breathe in (inhale), the air brings oxygen into the lungs. When you breathe out (exhale), the body gets rid of carbon dioxide (waste).

Changes as we age

- Heart does not pump as efficiently (pump begins to tire out).
- Decreased blood flow to all parts of the body.
- Lungs do not exchange oxygen and carbon dioxide as efficiently.
- Not as much oxygen delivered to all parts of the body.
- Leads to decreased efficiency of all organs of the body.

Implications for care

- When helping a person from a lying or sitting position to walking, allow the person to rest for a minute before walking. This will give time for the blood to reach the brain, decrease dizziness, and prevent falls.
- Allow more time for *activities of daily living* (ADLs), including walking, bathing, and dressing. Don't rush the client.

Conditions involving the heart, circulatory system and lungs

- **High blood pressure (hypertension - HBP, HTN)**
High blood pressure affects almost 30% of adults in the U.S., yet most have no symptoms. Uncontrolled high blood pressure can lead to stroke, heart attack, heart failure or kidney failure. The only way to tell if a person's blood pressure is within the normal range is to have it checked regularly.



Blood pressure guidelines

- The target BP should be less than 140/90.
- If the person has diabetes or kidney problems the target BP should be less than 130/80.

If your client's blood pressure is consistently outside these guidelines, encourage him/her to notify the physician.

- **Cardiovascular disease**

This disease involves the heart and/or blood vessels (arteries and veins), specifically the coronary arteries. Fatty deposits (plaques) stick to the internal walls of the vessels, causing a condition called *atherosclerosis*. The plaques can totally block the passage of blood. This can cause pain (*angina*) and death of the affected heart muscle (*myocardial infarction*).

- **Angina**

Angina is chest pain due to the lack of blood and oxygen to the heart muscle. This is generally due to plaque blocking a coronary artery. Some individuals can get bypass surgery. Others are not good candidates for surgery. Their doctor may prescribe medications to expand blood vessels.

Nitroglycerin (NTG) is a medication used to treat angina. When the person feels chest pain (it can also be pain radiating down the arm or jaw) he or she should rest and take NTG if prescribed. The usual dosage is one pill under the tongue and wait 5 minutes. If the pain continues, the person can repeat the sequence up to two more times.

Note: If you assist someone in taking a NTG pill, always put the pill in the bottle cap. Don't put it in the palm of your hand. The pill can dissolve in the sweat on your hand, possibly giving you the dosage and the side effects of the pill (severe, pounding headache). Also, the person should get a fresh supply of NTG tablets at least yearly, because the pills are destroyed by light. Store the medicine in a cool, dark place. Don't place it on a windowsill or in direct sunlight.

- **Heart attack (myocardial infarction, MI)**

The heart muscle dies if it does not get needed blood and oxygen. The amount of damage to the muscle determines the long term effects and recovery level after the heart attack. Proper diet, exercise and lifestyle changes can help the person regain strength and learn how to avoid future attacks.

- **Chronic obstructive pulmonary disease (COPD)**

Chronic obstructive pulmonary disease is a chronic, progressive decline in lung function. It becomes more difficult to breathe. The lungs become damaged and air flow is blocked. Included in the diagnosis of COPD are chronic bronchitis, asthma, and emphysema. Emphysema is the most common type of COPD.

Emphysema

- Most common cause is smoking.
- Breathing is difficult due to swollen, inflamed air passages, damaged air sacs (*alveoli*) in the lungs, excess mucous, and anxiety.
- Treatment includes medications, quitting smoking, staying as active as possible, and oxygen therapy.

Asthma

The individual may have allergies and infections and be very sensitive to certain things such as cold air, exercise, dust, smoke, etc. When exposed to one of these things the person's air passages become swollen and air movement is difficult. This is referred to as a flare-up or *asthma attack*. Immediate medical attention/medications (including the use of inhalers) are indicated as the client may stop breathing and may even die.

Oxygen equipment

Patients with advanced COPD may use supplemental oxygen. Some precautions when using oxygen equipment include:

- Keep tubing away from any heat source including cigarettes and space heaters.
- Store oxygen tanks upright but secure so they cannot be bumped into or fall over.
- When traveling make sure the oxygen tanks are secured in the car (use a bungee cord and strap the tank to the back of the passenger seat).

C. BRAIN AND NERVOUS SYSTEM

Function

The *brain* sends electrical signals throughout the body. The brain is divided into sections and each section controls different parts or functions of the body. The brain controls:



- What you think and feel.
- How you learn and remember.
- The way you move your body.
- All organ functions.
- Things you might be less aware of, like the beating of your heart, breathing, digestion of food, etc.

The *nervous system* is the network that sends messages back and forth from the brain to different parts of the body. Imagine the nerves as wires that the signals travel through, the path between the brain and the other organs.

Changes as we age

- Loss of brain cells.
- Learning takes longer.
- It takes longer for brain to “search and retrieve” information.
- Sleep pattern changes, increased waking during the night.
- Nerves react more slowly, less sensitive to temperature extremes.
- Decreased sensitivity to pain, injuries may go undetected.

Note: Intellect, judgment, comprehension, and retention usually do not change with age.

Implications for care

- Reduce stress of learning new things, keep environment calm and routine.
- Present new things visually and verbally.
- Notify supervisor if client has sudden change in memory.
- Encourage quiet mental activities or light snack during wakeful periods at night.
- Check feet and between toes for cuts, bruises, burns or lesions that may have gone unnoticed because of decreased pain sensation.

Conditions involving the brain and nervous system

For conditions involving the brain and nervous system see Chapter 2, Physical Disabilities and Conditions: The Brain and Nervous System, in this course manual.

D. SKIN, HAIR AND NAILS

Function

The *skin* is the largest organ of the body. It provides protection, regulation of body temperature and sensation for underlying tissues and other body parts.



Protection

Our skin is a shield that protects us from:

- mechanical impact such as pressure.
- temperature impact such as heat or cold.
- environmental impact such as chemicals, the sun's UV-radiation, bacteria, and water loss.

Regulation

The skin controls and adjusts our body temperature. The production of sweat, which evaporates on the skin's surface, helps cool us down.

Sensing Touch

Feeling touch is one of our body's most important senses. Without it, we would not be able to feel the gentle touch of a loved one, the warmth of a hot cup of tea, or the wind blowing in our faces. This sense is made possible by cells and nerve endings in the skin, which send signals to the brain.

Hair serves as insulation from the cold and heat. It extends the sensory ability of the skin and is a natural protection against the sun's harmful ultra-violet rays.

Nails (fingernails and toenails) protect the ends of the fingers and toes. They are also an extension of the fingers, providing a precision grip in picking up small items.

Changes as we age

- Skin is drier, less elastic, and more fragile. It bruises and tears more easily.
- Fatty layer decreases (decreased natural padding).
- Hair grays, and there is more facial hair in women (may need trimming).
- Nails thicken and become more brittle.

Implications for care

- **The goal is to keep skin healthy and free of any breakdown.**
- Use lanolin based soaps instead of antibacterial or deodorant soaps or alcohol-based products.
- Inspect the person's skin for signs of skin breakdown frequently.
- Use lotion to help keep the person's skin supple and relieve dry, scaly skin.

- Change the person’s position in bed or chair at least every two hours to relieve pressure.
- File nails, **do not clip**.

Tip: To relieve extreme dryness of the hands and/or feet, apply petroleum jelly to the area and cover with cotton gloves or socks before going to bed.

For more information on skin care refer to Chapter 4, Personal Care, in this course manual.

Conditions Involving the skin, hair and nails

- **Edema**

Excessive accumulation of fluid in a body part, usually the legs, results in swelling. In extreme cases this fluid can leak out of a client’s pores and lead to skin breakdown. This can be caused by heart and circulation problems. If the swelling gets worse, the person may need medical care. Care includes a diet low in salt and elevating the affected body part if possible.

- **Sun damage**

In Arizona, the sun is a huge factor in skin safety and health. Sun damage can be extreme and may lead to skin cancer, extreme sun burns and skin damage. Nothing can undo sun damage, but the skin can occasionally repair itself. The client may have an increased risk to sun issues that include sun stroke, dehydration and severe skin damage. Here are some tips for the client to help keep the skin healthy:



- Use sunscreen when outdoors. Sunscreen with an SPF of 15 or more provides the most protection.
- Wear a hat and long sleeves when outdoors and sunglasses that block UV rays.
- Examine the skin regularly for moles that suddenly begin growing or change color, and new growths.
- Drink plenty of fluids to keep hydrated.
- Sit or walk in the shade when possible, and avoid long periods of outside activities.

- **Pressure ulcers**

Pressure ulcers, also called bed sores, are breaks in the skin from prolonged pressure in one spot, for example sitting or lying in one position for a long time. Refer to Chapter 4, Personal Care in this course manual for more information on pressure ulcers.

E. BONES, JOINTS AND MUSCLES

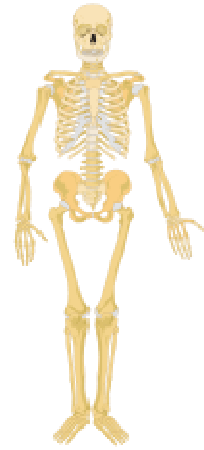
Function

Bones provide support for our bodies and help form our shape. They are the protective frame around our organs; the ribs protect the heart and lungs, the skull protects the brain, etc. Although they are very light, bones are strong enough to support our entire weight.

Joints occur where two bones meet. They make the skeleton moveable—without them, the body would be stiff and rigid.

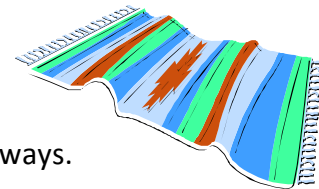
Muscles are also necessary for movement. They are the tough, elastic tissue that pull and push our bones when we move.

Together, our bones, muscles, and joints form our *musculoskeletal* system. They enable us to do everyday physical activities by allowing us to move freely.



Changes as we age

- Loss of muscle tone; joints become less flexible.
- Bones become more porous, more brittle with increased risk of fractures.
- Cartilage between vertebrae (spinal disks) shrinks. This makes the person shorter with stooped posture.
- Slower reflexes and coordination increase risks for falls.



Implications for care

- Prevent falls by removing barriers and scatter rugs; clear pathways.
- Avoid rushing the elderly person when walking.
- Encourage use of hand rails and/or assistive devices for support.
- Ensure adequate lighting, especially at night.

Conditions involving the bones, joints and muscles

• Arthritis

Arthritis causes inflammation and deterioration of the joints. There are two main types. Osteoarthritis and rheumatoid arthritis.

Osteoarthritis

- Degeneration of the joints causing pain and stiffness.
- The most common form of arthritis—90% of people over 50 have some osteoarthritis.
- Symptomatic treatment with aspirin or non-steroidal anti-inflammatory drugs (NSAIDs), such as Ibuprofen or Naproxen.

Note: Non-verbal elders with certain conditions (for example, dementia) may have problem behaviors due to unrelieved arthritis pain.

Rheumatoid arthritis (RA)

- More severe form of arthritis but less common.
- Causes joint deformities.
- More difficult to treat since it is considered an auto-immune disease (immune system kills its own body tissue).
- Can also affect internal organs such as heart, lungs, and muscles.

- **Osteoporosis**

The loss of calcium in the bones makes them porous and brittle. This causes an increased risk of fracture.

- Risk factors: hereditary factors, decreased calcium intake, lack of exercise.
- Treatments include medications to increase calcium uptake and weight training (exercising with weights helps calcium re-absorption).
- Causes decrease in height as the vertebrae collapse and the spine curves. This leads to decreased range of motion and painful mobility.
- Causes compression fractures of the spine.
- Fractures increase risk of joint replacement surgery.
 - Major surgery can cause complications in older adults.
 - The majority of elders who have hip replacement surgery never return to prior level of functioning.

- **Contractures**

Contractures are shortening and tightening of muscles, skin, tendons and ligaments, preventing normal movements. The most common causes are prolonged bed rest, scarring from injury (usually burns) or lack of use (immobilization).

The DCW may be asked to assist with range of motion exercises and repositioning. This helps keep the joints and muscles flexible and circulation flowing. This is another reason why repositioning every two hours is important.

- **Amputation**

The removal of a limb or body part, generally through surgery. Amputations can be performed for the following reasons:

- To remove tissue that does not have an adequate blood supply.
- To remove a body part due to severe injury.
- To remove tumors.

Complications from uncontrolled diabetes may result in an amputation. Decreased blood flow to the hands and feet can cause tissue and muscle damage.

- **Muscular dystrophy (MD)**

Muscular dystrophy is an inherited disease. It is caused by a genetic defect that causes healthy skeletal muscles to become weaker. Symptoms gradually get more severe as muscles get weaker. There is no cure and no way to stop the disease process. MD is not contagious. There are many different types of MD, but these are the most common:

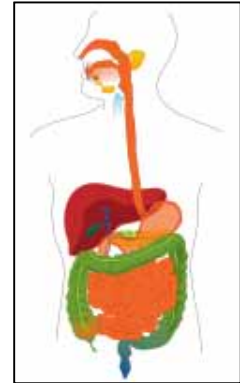
- *Duchenne*: Develops early, between 2 and 6 years of age. Symptoms include waddling or walking on toes, difficulty in running, protruding abdomen. More likely to occur in males.
- *Facioscapulohumeral*: Usually becomes evident in teens. Facial weakness is always present (difficulty closing eyes and whistling). Other symptoms include difficulty raising arms, lifting objects, prominent shoulder blades.
- *Myotonic*: Appears in early adulthood, less often in adolescence. Symptoms include stiffness in hands and feet, especially after chill, difficulty relaxing grip, and facial weakness.

F. STOMACH, INTESTINES AND LIVER

Function

The stomach and intestines are responsible for the digestion of what we eat and drink. Digestion includes absorption of all the nutrients, including vitamins and minerals. The liver is an organ that functions across many systems.

The *stomach* is the organ where food begins the digestion process. The stomach is a muscular, elastic, pear-shaped bag in the abdomen. After food is chewed and swallowed, it goes into the stomach through the *esophagus*. Once the food enters the stomach, acids break down the food into tiny, usable pieces. The food then passes into the intestines.



The *intestines* (also called bowels or colon) are the main part of food digestion and waste elimination. The intestines are divided into two major sections, the *small intestine* and the *large intestine*. The small intestine is where most of the digestion occurs. Most nutrients are absorbed through the walls of the small intestine and distributed throughout the body to fuel the body's functions. The large intestine continues the process by absorbing any leftover nutrients and water. It also pushes the waste along.

The *liver* aids in digestion and removes impurities in the blood. The liver also produces chemicals that regulate many of the functions of the body.

Changes as we age

- Decreased stomach acid and saliva enzyme production make digestion difficult.
- Slowed bowel action can lead to indigestion and constipation.
- Loss of teeth affects ability to chew and digest food.

Implications for care

- Avoid foods that are difficult to digest or chew.
- For constipation, increase fluid intake (eight 8-oz. glasses per day is recommended). Add fresh fruit, veggies, whole grains/fiber, prunes to diet, and exercise.

Conditions involving the stomach and intestines

• Ulcers

Ulcers are sores in the stomach or intestinal lining.

- Can be in stomach or in parts of the intestine.
- May cause heartburn.
- Bleeding ulcers are sores that bleed into the stomach or intestines. Once thought to be caused by increase in stomach acid, ulcers are now known to be created by certain bacteria in the stomach. Persons should not take aspirin or NSAIDS (e.g., Ibuprofen) if they have a history of bleeding ulcers.
- Medication may be prescribed.

- **Constipation/impaction/obstruction**

The longer the stool stays in the colon the more water is absorbed and the harder the stool becomes.

Constipation

- Constipation is a hard stool that is difficult to pass. This is not related to frequency.
- Causes include low fiber diet, ignoring urge to pass a stool, decreased fluid intake, inactivity, certain drugs, aging, and certain medical conditions.
- Discourage use of routine laxatives. The body can become dependent on them and valuable nutrients are lost with their use. Glycerin suppositories and/or stool softeners are preferred.

Impaction/obstruction

- Hard, dried feces that are packed into lower intestines (constipation that has gotten worse).
- Symptoms are loss of appetite, abdominal cramping, leaking diarrhea, change in behavior.
- Impaction can lead to complete bowel obstruction.
- The person needs medical attention, usually for oil retention enema, possible manual extraction, and even surgery with severe cases of obstruction.

- **Diarrhea**

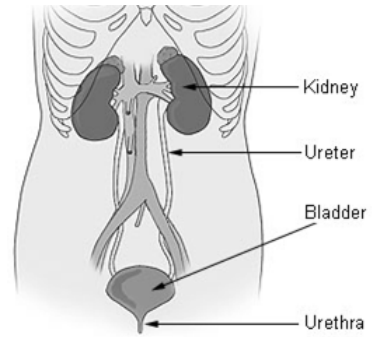
- Loose, watery stool.
- Causes include infections, irritating foods, parasites, etc.
- Need to replace fluids to prevent dehydration.
- Notify supervisor if client has more than two diarrhea episodes in a day.

G. KIDNEYS AND BLADDER

Function

The kidneys and bladder filter blood and produce urine. They aid in the removal of wastes and excess fluids from the body. The kidneys also play a major role in producing chemicals needed for other body functions.

The *kidneys* remove waste and excess fluid that naturally build up in your blood after your body breaks down food. The kidneys collect the waste and send it on to the bladder as urine. They also make hormones and red blood cells that keep your bones strong and your blood healthy.



The main function of the *bladder* is to store and release urine. The bladder is a hollow, muscular, balloon shaped organ that collects urine from the kidneys and stores it until it is full enough to empty. The bladder sends a signal to your brain to let you know it is full and that you need to go to the bathroom.

Changes as we age

- Decreased function of the kidneys, not as able to filter medication by-products.
- Decreased bladder capacity (can hold 2 cups at age 25, 1 cup for an older person).
- Decreased signal time for urge to urinate. The person may urinate as soon as the urge signal is received. This can lead to incontinence.
- Increase of stress incontinence (dribbling, especially for women, after coughing, sneezing, laughing or strenuous activity).
- Incomplete emptying of bladder can lead to increased bladder/kidney infections.
- Prostate gland in men increases in size. This can make urination difficult.

Implications for care

- Monitor for toxic medication reactions.
- Prevent incontinence with routine toileting every two hours. Use easy to remove clothing, and use a bedside commode as indicated.
- Monitor for signs of bladder/kidney infections (change in behavior, increased temperature, change in odor/color of urine, burning/painful urination, back or abdominal pain, etc.).
- Monitor for signs of skin breakdown.

Conditions involving the kidneys and bladder

- **Kidney Failure**

If the kidneys are damaged, they can't properly filter harmful wastes that build up in the body. Blood pressure may rise. The body may retain excess fluid and not make enough red blood cells. This is called kidney failure.

Symptoms of kidney failure include:

- decreased urine production
- body swelling (edema)
- problems concentrating
- fatigue
- confusion
- diarrhea
- extremely tired, sluggish
- nausea and vomiting
- abdominal pain

- **Urinary tract infections**

A *urinary tract infection* (UTI) usually refers to a bladder infection, but can affect other parts of the urinary tract.

Symptoms may include:

- Increased sleepiness or confusion (more common symptom in the elderly).
- Urine cloudy, foul smelling, with floating objects or bloody.
- Low grade fever.
- Burning sensation during urination.
- Feeling like you have to urinate often, maybe with only little amounts.

Tip: Prevent UTIs with increased fluid intake.

- **Urinary incontinence**

Incontinence is the loss of bladder control or the involuntary passage of urine.

This is most often due to loss of muscle strength with age, illness or injury. Treatments range from simple exercises to surgery. Women are affected more often than men. If individuals go to the toilet before they get the urge to void (every 2-3 hours), they can reduce the episodes of incontinence.

- **Benign prostatic hyperplasia**

Benign prostatic hyperplasia (BPH) is an enlarged prostate gland. The prostate enlarges as a man ages. Most of the time this enlargement is benign (non-cancerous), but it can become cancerous. Cancer of the prostate is the second leading cause of cancer related deaths in men (lung cancer is first). Men over 50 should have a prostate exam, especially if these symptoms are noted:

- Difficulty starting and keeping urine flowing.
- Dribbling of urine.
- Needing to urinate frequently, more bothersome at night.

- History of UTIs due to retained urine.

Treatment for an enlarged prostate gland may include a surgery in which pieces of the prostate are removed. Post-op care will include increased fluid intake and monitoring for increased bleeding into the urine.

H. IMMUNE SYSTEM

Function

The *immune system* is responsible for fighting diseases and foreign bodies. An immune system deficiency can leave the body open to infection. Causes include:

- Immune system's efficiency decreasing due to normal aging.
- Chemotherapy.
- Steroid treatments (for example, prednisone).
- Recent transplant surgery (medications are prescribed to reduce resistance to foreign bodies).
- HIV/AIDS.

The number of older people with HIV/AIDS is on the rise. About 75,000 Americans age 50 and older are diagnosed with AIDS. This is about 10% of all people diagnosed with AIDS in the United States.

Changes as we age

- Immune system does not work as efficiently.
- Decreased ability to fight infections.

Implications for care

- Watch for signs of infection: **change in behavior**, fever, decreased appetite, poor color.
- Encourage immunizations such as the yearly flu vaccine.
- The elderly should limit contact with people who are ill (including the DCW), as this may lead to an infection the person cannot fight.

I. VISION, HEARING, TASTE AND SMELL

Function

Vision, hearing, taste and smell are four of the five body senses (touch is covered in Section D of this chapter). Sensory cells produce signals and send them via the nervous system to and from the brain. Senses can alert a person to danger and allow individuals to enjoy and interact with their environment.

Changes as we age

- Decreased vision. It becomes difficult to read and judge distance.
- Increased sensitivity to glare.
- Decreased hearing.
 - High frequency sounds are distorted.
 - Difficulty with hearing if the person cannot see the speaker.
 - Person may withdraw or get depressed if not able to join in conversations.
 - Increased earwax buildup.
- Decreased sense of taste and smell. Food may not taste the same.

Implications for care

- Provide adequate lighting day and night.
- Reduce glare (mirrors, high gloss furniture, etc.).
- Use contrasting colors for floors, walls, steps.
- The person should use eyeglasses and keep them clean.
- The person should have annual eye exams and have ears checked for wax buildup.
- For someone who is hard of hearing:
 - Speak clearly but don't shout; reduce background noise (turn off TV and radio, etc.).
 - Face person when talking, remove anything from mouth (gum, food).
 - Encourage use of hearing aids or amplifiers (clean aids with soft brush; have extra batteries).
- Appetite may decrease. To encourage eating, add appropriate seasonings and have pleasant eating environment.
- Important to keep record of person's weight and appetite.

Conditions involving vision



- **Cataracts**
 - Cloudiness of the lens of the eye. This leads to decreased night vision, glare, and blurry vision.
 - Current treatment includes out-patient laser surgery.
 - Post-op care includes several eye medications and limits on lifting and bending over.
- **Glaucoma**
 - Fluid pressure builds up inside the eyeball. This causes pressure on the optic nerve, leading to blindness. Damage is irreversible.
 - Usually the person does not feel any pressure, so it can only be diagnosed with an eye exam.
 - Treatment includes eye drops and sometimes surgery.
 - People over age 40 should have annual eye exams.
- **Macular degeneration**
 - Leading cause of blindness in people over age 50.
 - The macula (an area of the retina) begins to deteriorate causing blurry or spotty central vision.
 - Certain vitamins with minerals may help.
 - Low vision aids will help. This includes well-lit rooms (but reduce glare), use of high contrasting colors, and use of large print books.

J. DIABETES

Diabetes is an imbalance of glucose and insulin in the blood. Insulin is produced by the pancreas and is responsible for transporting glucose molecules in the blood into the cells.

Normal range for fasting blood glucose is 90 to 110. There are two main types of diabetes:

Type I (Early onset/Insulin dependent)

- Pancreas no longer produces insulin (possibly caused by the body attacking itself).
- Individual must have insulin injections.

Type II (Late onset/diet controlled)

- Due to:
 - Deficiency in insulin production (not enough to meet needs).
 - Cells becoming resistant to insulin.
- Previously seen as affecting older adults, now being seen in children.
- Possible causes: heredity and diet high in fat and sugar.



Diabetic complications (control blood sugars to decrease risk)

- Blindness
- Increased risk for heart attacks, strokes, and circulatory problems
- Wounds, skin lesions, incisions, etc. heal slowly
- Amputations
- Kidney damage and failure
- Nerve damage in extremities (diabetic neuropathy)
- Impotency in men

Treatment

- **Diet** can also control borderline diabetes (when blood sugars are just slightly elevated). Currently, diet focuses more on amount of carbohydrates consumed at each meal rather than limiting concentrated sweets. This allows for more food choices.
- **Exercise** reduces blood sugar, so diabetics are encouraged to be as active as possible.
- **Oral medications** are aimed at increasing insulin production or decreasing the cell's resistance to insulin.
- **Insulin** administered by injection at least once per day. There are different types and lengths of action.

Diabetic foot care

Proper foot care is very important because the feet are areas most affected by decreased blood flow. Since people with diabetes are at risk for poor circulation, their feet need to be inspected regularly for cuts, sores and black spots (a sign of lack of blood supply). Untreated skin problems can lead to serious health risks, including amputation of the foot or leg. If you notice a change in the skin on the feet or anywhere else, you should notify your supervisor.

Refer to the Foot Care section in Chapter 4, Personal Care, in this course manual for more information.

Diabetic emergencies

Remember: Normal blood sugar levels are about 90 to 110 on a test.

- **High blood sugar** (*hyperglycemia*) – Range is anything above 125 to 500+. High blood sugar has a wide range of variance before a person's functions are impaired.
- **Low blood sugar** (*hypoglycemia*) – Symptoms occur with most people at about 70 (see symptoms list on following pages). This means the sugar level just needs to drop a little for the person to start having symptoms. The brain is more sensitive to a drop in blood sugar. It will not function correctly if the sugar level is too low.

Low blood sugar is much more of a danger than high blood sugar. If the person starts to show symptoms of low blood sugar, give the person ½ glass of orange juice or regular soda, followed by a high protein snack such as milk and crackers or half a meat sandwich. **If you think the person may not be able to swallow, DO NOT GIVE FLUIDS!** Instead put a concentrated sweet such as sugar or frosting (not hard candy) inside the mouth.

If you give sugar and the person's symptoms do not go away, you know that something else (such as a stroke) could be causing the symptoms. It will **not hurt** the person to be given the extra sugar if low blood sugar is not the cause of the symptoms. Extra sugar is fine since high blood sugar has a wider range of levels.

Also, **INSULIN AND FOOD MUST GO TOGETHER.** If the person has an insulin shot and no food, a diabetic emergency may happen!

See the following pages for information about hypoglycemia and hyperglycemia.



Hypoglycemia (Low Blood Glucose)

Some Symptoms:

Causes: Too little food or skipping a meal; too much insulin or diabetes pills; more active than usual.

Onset: Often sudden.



IF LOW BLOOD GLUCOSE IS LEFT UNTREATED, YOU MAY PASS OUT AND NEED MEDICAL HELP.

What Can You Do?



CHECK your blood glucose, right away. If you can't check, treat anyway.



TREAT by eating 3 to 4 glucose tablets or 3 to 5 hard candies you can chew quickly (such as peppermints), or by drinking 4-ounces of fruit juice, or 1/2 can of regular soda pop.



CHECK your blood glucose again after 15 minutes. If it is still low, treat again. If symptoms don't stop, call your healthcare provider.

For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

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Concept developed by Rhonda Rogers, RN, BSN, CDE

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Hyperglycemia (High Blood Glucose)

Causes: Too much food, too little insulin or diabetes pills, illness, or stress.

Onset: Often starts slowly.

Some Symptoms:



EXTREME THIRST



NEED TO URINATE OFTEN



DRY SKIN



HUNGRY



BLURRY VISION



DROWSY



SLOW HEALING WOUNDS

HIGH BLOOD GLUCOSE MAY LEAD TO A MEDICAL EMERGENCY IF NOT TREATED.

What Can You Do?



CHECK BLOOD GLUCOSE

If your blood glucose levels are higher than your goal for three days and you don't know why,

CALL YOUR HEALTHCARE PROVIDER



For more information, call the Novo Nordisk Tip Line at 1-800-260-3730 or visit us online at ChangingDiabetes-us.com.

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PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 2 – PHYSICAL DISABILITIES AND CONDITIONS: THE BRAIN AND NERVOUS SYSTEM

CONTENTS

- A. Basic Principles
- B. Physical Disabilities and Conditions
 - 1. Spinal Cord Injuries (SCI)
 - 2. Traumatic Brain Injuries (TBI)
 - 3. Strokes
 - 4. Multiple Sclerosis (MS)
 - 5. Amyotrophic Lateral Sclerosis (ALS)
 - 6. Parkinson’s Disease
 - 7. Seizures

OBJECTIVES

1. Identify the basic principles of care for a person with a disability.
2. Identify common physical disabilities and conditions involving the brain and nervous system and the therapeutic interventions used.
3. Explain effective techniques that can be used in providing care for these conditions.

KEY TERMS

Aphasia

Plegia

Autonomic dysreflexia

Seizure

Exacerbation

Spinal cord injury (SCI)

Paralysis

Traumatic brain injury (TBI)

A. BASIC PRINCIPLES

Individuals have individual needs

As with any condition, an individual with a disability is unique with unique strengths and challenges. People with the same disability will have different needs. For example, a person with multiple sclerosis may or may not be incontinent. You must check the service plan or ask the supervisor to determine the interventions that are to be used with each person.



Therapeutic interventions

Therapeutic interventions for persons with physical disabilities will be unique to each individual. Therapeutic interventions can include range of motion (ROM) exercises, durable medical equipment (DME), physical therapy (PT), occupational therapy (OT), speech therapy (ST), proper diet, etc. These interventions can be crucial to maintaining or improving the health and welfare of a person with a physical disability.

Paralysis

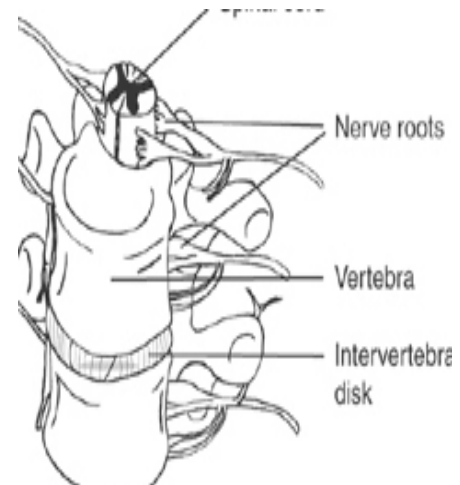
Paralysis is the inability to move a body part or even the whole body. There is loss of feeling, usually as a result of injury to the nervous system or spinal cord. Conditions involving the brain and nervous system may or may not cause paralysis.

B. PHYSICAL DISABILITIES AND CONDITIONS

1. Spinal Cord Injuries (SCI)

The spinal cord is a long, rope-like cord about the width of your little finger that extends from the brain to the lower back, where it fans out like a horse's tail. It is protected by bones called vertebrae. Between the vertebrae are disks which act as cushions. The spinal cord is the second most protected organ in your body, next to the brain.

The spinal cord can be damaged easily. Some spinal cord injuries (SCI) are the result of something going into the spine, for example, a gunshot wound. Another type of injury can be something that causes pressure within the spinal column. An example would be a tumor inside the spinal column. Another type of injury can occur from actually breaking the vertebra, which can then cut the cord.



Types of injuries

Complete: All the nerves at the level of injury are damaged. There will be no voluntary movement or sensation below the level of injury.

Incomplete: Partial damage to the nerves at the level of injury. There may be some movement and/or sensation.

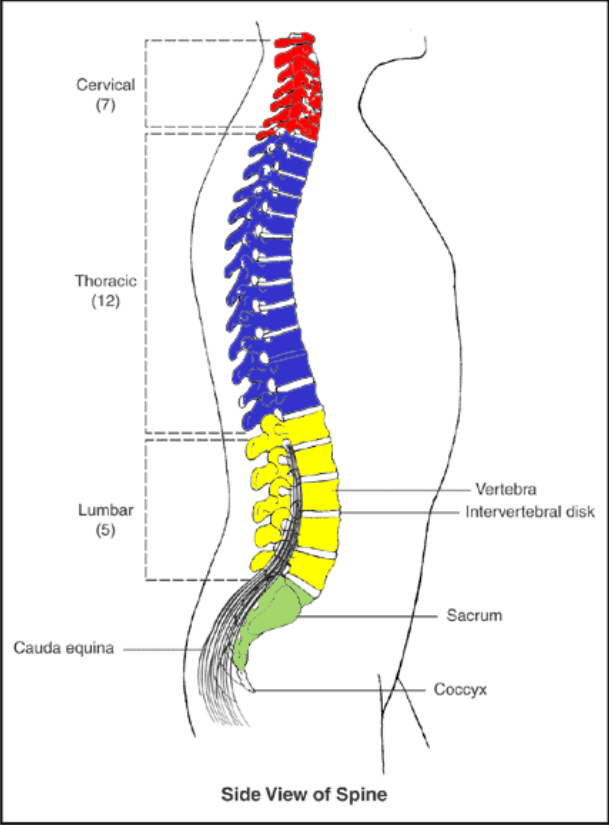
**The Spinal Column and the Body Parts/
Muscles Involved at These Levels of Injury**

■ CERVICAL (Quadriplegia)
C4 - Diaphragm (Breathing)
C5 - Shoulders
C6 - Wrist
C8 - Hand

**■ THORACIC (Paraplegia
with Varying Upper Body
Strength)**
T2 to T7 - Chest Muscles
T9 to T12 - Abdominal
Muscles

■ LUMBAR (Paraplegia)
L1 to L5 - Leg Muscles

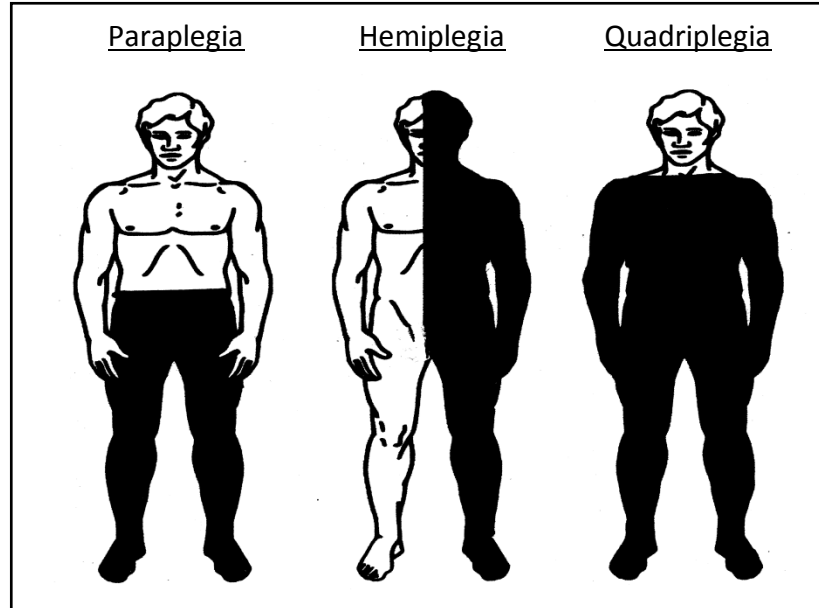
**■ SACRAL (Tailbone) -
Elimination**
S2 and below - Bowel and
Bladder



Side View of Spine

Types of plegias or paralysis

This diagram illustrates the types of paralysis (*plegias*). Different areas of the human body are paralyzed in each specific category of plegia. Hemiplegia is most often associated with a stroke.



Autonomic dysreflexia (hyperreflexia)

Autonomic dysreflexia (AD) is an emergency medical condition. It causes extremely high blood pressure as a result of a stimulus below the level of injury. **This can lead to a stroke!** It generally occurs in individuals who have an injury at T-6 or above.

Why this happens

When a stimulus occurs in the non-injured body, blood vessels dilate and the blood pressure rises. Messages are sent from the brain to lower the blood pressure to keep the body in balance. In a person with an SCI, those messages cannot pass through the level of injury. The blood pressure then rises uncontrollably. This rise in blood pressure will cause signs and symptoms that something is wrong.

Symptoms

- Pounding headache.
- Profuse sweating (above the level of injury).
- Nasal congestion and pupil constriction.
- Goose bumps/chills.
- Slow heart rate (brain's response to high BP).
- Vision changes (seeing spots, blurry vision).
- Anxiety, apprehension.
- Flushing of skin (above level of injury).

Causes

The causes of AD are varied. Basically it is any stimulus below the level of injury. Although this is not a complete list, following are some of the causes:

- Full, distended or infected bladder (check the catheter tubing for blockage).
- Blocked bowels (constipation).
- Pressure ulcers.
- Broken bones, severe cuts.
- Labor pains, menstrual cramps.
- Extreme temperatures, sunburns.
- Tight clothes.
- Stress.
- Ingrown toenail.

What to do

- Have the person immediately sit up or raise head to 90 degrees. This will reduce the blood pressure.
- Determine the cause.
- If you can't determine the cause, GET HELP!! Call or go to the hospital. Be aware that not all health providers will be familiar with AD. It is a good idea to carry an ID card, which explains it.

Persons who are paralyzed can CARRY A CARD! It may save a life!

Below is an example of a card a person can cut out and carry in a wallet. Put the person's name in the space below "FOR AUTONOMIC DYSREFLEXIA." Let health care team members and contact people know this person has this card. Use it with medical staff for instructions in emergency care.

<p>MEDICAL ALERT FOR AUTONOMIC DYSREFLEXIA</p> <p>Name: _____</p> <p>is subject to the above syndrome. This is a serious medical problem that can occur in people with a spinal cord injury above the 6th thoracic level. The symptom of autonomic dysreflexia (AD) can be caused by many types of stimuli below the level of the spinal cord injury, but the most common emergency causes are: (1) full or spastic bladder or (2) bowel distention (usually from stool in the rectum). Severe AD is a medical emergency which if not properly treated can result in cerebral vascular hemorrhage (stroke).</p> <p>Symptoms:</p> <ul style="list-style-type: none"> • Pounding headache • Flushing of skin and sweating above the level of injury • Increased blood pressure (as high as 250/150), slow pulse • Apprehension/anxiety • Vision changes, blurring, spots before the eyes • “Goose bumps” 	<p>Medical Treatment:</p> <ol style="list-style-type: none"> 1. If the AD episode is not resolving after the above measures, medical treatment is necessary. Ask the patient if he has his own supply of any of the AD medications. If not, transport patient to an emergency room as soon as possible. 2. If the AD episode is not resolving and/or the blood pressure reaches 160 systolic, give the patient Nifedipine 10 mg sublingual. Instruct patient to bite through the capsule and hold it beneath his tongue. May repeat Nifedipine dosage after 15 minutes if blood pressure has not responded. 3. Continue to look for causes of AD by checking the patient’s entire body. Other causes include fractures, sores and tight clothing. 4. Alternative treatments (if Nifedipine is not available or does not work): <ol style="list-style-type: none"> a. Nitroglycerine ointment: 1 inch to upper chest or back. If no resolution in 15 minutes add additional 1 inch. b. Markedly elevated blood pressure not responding to the above measures should be treated with IV Apresoline (20 mg/1cc). Inject 0.5cc SLOWLY. May repeat dosage after 15 seconds of no response. 5. Blood pressure may be safely lowered to 90/60, which is typical of quadriplegics in the sitting position. 6. After an episode of AD, it is not uncommon for a second episode or rebound to occur, so blood pressure should be checked every 30-60 minutes for the next 4-5 hours.
<p>What To Do: (First Aid) (Most of these measures are for emergency personnel)</p> <ol style="list-style-type: none"> 1. Place patient in a sitting position 2. Drain the bladder. <ol style="list-style-type: none"> a. If catheter is in place, check for kinking. If catheter is plugged, do not try to irrigate. Change foley using Lidocaine jelly for lubrication. b. If no catheter is present, insert a catheter using Lidocaine jelly for lubrication. Do not crede (push on) the bladder. 3. If emptying the bladder has not decreased the blood pressure and there is stool in the rectum, apply Lidocaine jelly to the anal sphincter and wait three minutes. Then, using a Lidocaine-lubricated gloved finger, gently remove stool from the rectum. 	



Living With a Spinal Cord Injury

My name is Gregg and back in 1993 I became a quadriplegic from a car accident. After ten months in the hospital, I went to an independent living center in Minneapolis. There I learned how to live as independently as I could before moving back into the mainstream of life. The rehab program involved physical therapy to build up my strength, and occupational therapy to find adaptive devices for me to do routine tasks such as, writing, typing, shaving, cooking, unlocking doors, and other activities of daily living. After seven months of rehab I moved into an apartment where I had a live-in aide, but a couple years later I started living on my own and have ever since. I graduated from college, and then moved to Arizona in 2002. I currently receive my attendant care under Arizona Long Term Care System.

I try to maintain my independence as much as possible, but there are things someone has to help me do or do for me. A typical day starts out with my attendant arriving to get me out of bed. She comes into my apartment and opens the curtains, and after giving me a minute or two to clear the gunk out of my eyes, we begin the processes: range of motion on my legs / replace and clean a night bag with a daytime leg bag / transfer to shower chair and move into bathroom / bowel care program / shower / transfer back to bed / dress / transfer back to wheelchair / breakfast and food prep / laundry some days. My bowel care program is every other day, so on the other days I get dressed right away and transfer to my wheelchair not having to shower. During my bowel care program (approximately 50 minutes), my attendant does household chores: vacuuming, dusting, emptying the dishwasher, making the bed/changing sheets, and other tasks as needed. I do my own shaving and brushing teeth, but my attendant sets the items up for me, and then cleans and puts them away when I am finished. Now it is time to plan/prepare food and water for the day. I have three jugs of water filled for my easy access. I like to cook, but slicing, dicing, and chopping isn't easy for me, so my attendant preps whatever items I need. If I wanted to cook a hamburger in my George Foreman grill, for instance, my attendant slices tomato, onion, and lettuce, placing them in a container in the fridge, along with a hamburger patty. All I have to do fry the hamburger, and put together a complete sandwich. And let us not forget that somewhere in amongst doing all this, some days I have to have my laundry washed and dried.

At night someone has to put me to bed. My attendant transfers me to bed, undresses me, connects the night drain bag and cleans the day leg bag, does range of motion on my legs, tucks me in, and if I'm lucky maybe a goodnight song/story.

My attendant is a VERY IMPORTANT person. I rely 100% that he or she will be here to get me out of bed in the morning. If no one shows up or is late, then I am stuck in bed, waiting. So, I have to trust my attendant WILL be here when I expect them to be. It's the same thing at night when I go to bed. If no one shows up or is late, then I am stuck sitting up in my wheelchair.

Gregg, a Person with Quadriplegia



Psychological adjustment

A person with an SCI will go through a physical adjustment and a psychological adjustment. There is no set length for this process; nor is there a specific pattern as to how the person will handle it. Often you will see the individual experience the phases of the grieving process. Your role as the assistant is a vital one. Be as supportive as possible. Be honest with the person. It is good for the individual to look into the future, but remind them to focus on where they are now, both physically and emotionally.

Remember, an individual with an SCI still has talents and abilities to offer. Using adaptive equipment, modifying the environment, etc., will assist individuals with SCIs to utilize the abilities they have. To have your body's physical ability change often creates the idea that you no longer have anything to offer. It's all a process of the individual learning how to express him/herself again.

Bowel care and bladder management

The goal for a bowel care program is to establish emptying the bowel at regular times, and prevent embarrassing accidental bowel movements. A bowel care program usually consists of inserting a suppository followed by a digital stimulation routine. A bowel care program is usually established three times a week, but does vary from client to client.

Note: Most agencies do not allow DCWs to insert a suppository or perform digital stimulation. Check with your supervisor to determine your job responsibilities. DCWs can perform the clean-up after a qualified person does the suppository and stimulation.

a. Bladder control and care

Intermittent catheter: Catheter inserted every 2-4 hours directly into the bladder through the urethra allowing the bladder to drain.

Indwelling catheter: Catheter inserted into the bladder through the urethra and remains inside the bladder.

Supra-pubic catheter: Catheter is inserted through the lower abdomen into the bladder.

External catheter: Also known as a condom, Texas, or buffalo catheter.

- Change every day (easier to change if penis is somewhat erect).
- Wash skin well to remove glue and old urine.
- Dry skin thoroughly.
- Clip hair that may get caught in the adhesive on catheter.



2. Traumatic Brain Injuries (TBI)

A traumatic brain injury may occur when a force severely impacts the brain. Brain trauma can be caused not only by the force of the injury, but also by increased pressure in the brain from swelling that happens after an injury. TBI is a major cause of death and disability worldwide, especially in children and young adults. Causes include falls, vehicle accidents and violence. Preventative measures include use of such things as seat belts and sports or motorcycle helmets. Programs to reduce the number of accidents such as safety education programs and enforcement of traffic laws also promote prevention.

TBI can cause multiple physical and mental problems. The severity and type depends on location of the injury and the amount of brain involvement. The outcomes can range from complete recovery to permanent disability or death. A brain injury can affect not only the movement of the body but also all the functions that the brain controls, such as judgment and speech.

3. Strokes

Strokes, also known as cerebrovascular accidents (CVA) or brain attacks, can be caused by blocked arteries or bleeding within the brain. Brain damage occurs when blood flow to or within the brain is interrupted. Without oxygen, the brain cells die. The location of these damaged cells will determine the symptoms and severity of the stroke.

Signs and symptoms of a stroke include drooping of one side of the face, slurred speech, visual disturbances, lack of coordination or paralysis of extremities.



There are two types of strokes:

- Blood vessels can leak blood into the surrounding tissue. This can be caused by a weakened artery wall (aneurysm) or by trauma
- There is a blockage of blood flow due to a clot or plaque formation

If the cause is due to a blockage, a medication can be given within the first three hours (per American Heart Association guidelines) that will greatly reduce the effects of the stroke. If the cause is due to blood leaking, that same medication can cause further bleeding and possibly death.

It is very important the individual be taken to the emergency room for treatment within two hours of the beginning of symptoms. It has been proven that severe damage can be lessened or even reversed if treatment is received within the 2-hour window.

Possible effects of a stroke

- Paralysis.
- Memory loss.
- Impaired judgment.
- Aphasia (difficulty expressing oneself).
- Depression.
- Emotional instability.
- Seizures.

Following a stroke, it is important that the individual get rehabilitative therapy **as soon as possible** to lessen the effects of the impairment, and to learn how to manage ADLs with the impairment. The caregiver can assist in making sure therapy arrangements are being made and followed.

The caregiver can also help by allowing the person to be as independent as possible, and to allow plenty of time for independent function. This will help decrease depression.

4. Multiple Sclerosis (MS)

Multiple sclerosis is the most common central nervous system disease among young adults in the United States. The central nervous system acts like a switchboard, sending electrical messages along the nerves to various parts of the body. These messages control all our conscious and unconscious movements. Most healthy nerve fibers are insulated by a *myelin sheath*, a fatty substance that aids the flow of messages. In MS, the myelin breaks down and is replaced by sclera, or scar tissue (*sclerosis*). This distorts or even blocks the flow of messages for vision, walking, talking, etc. Multiple sclerosis is not a mental illness, contagious, preventable or curable. The disease is progressive, although damage to the central nervous system occurs at different rates in different people.

Symptoms

- Seeing double or uncontrolled eye movements.
- Partial or complete paralysis in any part of the body.
- Shaking of the hands.
- Loss of bladder or bowel control.
- Staggering or loss of balance.
- Speech problems such as slurring.
- Weakness or unusual tiredness.
- Loss of coordination.
- Numbness or prickly sensations.
- Obvious dragging of feet.

Causes

- *Virus attack*: MS might be caused by some slow-acting viruses or it might be a delayed reaction to a common virus.
- *Immune reaction*: MS might involve an auto-immune reaction in which the body attacks its own tissues by mistake.
- *Combination*: When viruses invade the body, they take over body cells. The body's defense system might become confused because some viruses take over parts of cells and it might attack both body cells and virus cells.

There is much not known about MS, and the possibility of developing the disease cannot be predicted. However, there is a pattern in who is more likely to develop it:

- *Young adults*: Symptoms usually appear between ages 20 and 40.
- *Women*: Slightly more women than men develop MS.
- *People in areas with high standards of sanitation*: Perhaps children in these areas are not exposed to some factor that would help build immunity to MS.

Exacerbation (flare-up)

This term is often associated with MS, meaning the client is having a flare-up. *Relapsing-remitting multiple sclerosis* is a form of MS in which symptoms randomly flare up (relapse) and then improve or fade. This relapsing-remitting pattern emerges with the onset of the disease and may last for many years.

For more information contact: National Multiple Sclerosis Society, Arizona Chapter: (480) 968-2488.

5. Amyotrophic lateral sclerosis (ALS)

Also known as *Lou Gehrig's disease*, ALS is a progressive wasting away of certain nerve cells of the brain and spinal column called *motor neurons*. The motor neurons control the voluntary muscles, which are the muscles that allow movement. The cause for ALS is unknown. Symptoms of ALS in the beginning are weakness of one leg, one hand, the face, or the tongue.

ALS is a progressive, disabling disease. ALS affects walking, speaking, eating, swallowing, breathing, and other basic functions. These problems can lead to injury, illness (for example, pneumonia) and other complications. A person diagnosed with ALS will need to make decisions on treatment or lack of treatment as the disease progresses. Treatment in the early stages can include the use of a cane, shower chair, physical therapy, occupational therapy, speech therapy, and medication. As the disease progresses, breathing assistance with a ventilator and tube feeding will be necessary.

6. Parkinson's disease

Parkinson's disease is related to a chemical imbalance in the brain. Cells that make a brain chemical called dopamine, which helps control muscle movements, are slowly

destroyed. Symptoms may include rigid movements (freezing), tremors, loss of balance and coordination, and loss of facial control (blank affect). Medications may help control the symptoms, but the disease gets worse over time.

- The individual may have problems chewing, swallowing, or speaking.
- Can lead to dementia.
- Do not mistake blank affect for lack of comprehension.

7. Seizures

Seizures are caused by sudden, abnormal electrical signals in the brain. Most people think of seizures as uncontrollable shaking of the body, with the person not knowing what is happening. After a seizure, the person is generally confused, tired and sometimes has muscle soreness from the spasms. There may have been some injuries due to falling, hitting objects or biting the tongue or cheeks.

There are two types of seizures:

- *Focal*: A seizure in one side of the brain, causing mild spasms of the brain. The client may seem to stare into space, not respond when spoken to or touched, or eyes may seem to not focus or may close.
- *Generalized*: Abnormal signals affect both sides of the brain. Usually, with this type of seizure the person will become rigid with jerking movements, then become relaxed but unresponsive. The person will gradually become more responsive but will need reassurance as to what happened. The person may also lose bladder control.

Both types of seizures usually last between 30 seconds and 1 minute. Clients experiencing seizures should be allowed free movement. Do not attempt to hold or restrain them in any way, or put anything in their mouths. The caregiver should protect the person's head from banging on a hard floor and move objects away from the person's body that may cause harm.

Seizures lasting more than five minutes, multiple seizures (several episodes in a row) or clients that do not awake afterwards are cause for immediate medical attention.



Providing Care for My Son, Corey, who has a Traumatic Brain Injury

When a personal attendant has the opportunity to work for a consumer who has intense care needs, it may be helpful to know several things in advance.

Our son, Corey, is one of those consumers with intense needs. Corey was in a car accident that left him with a severe traumatic brain injury (TBI). Corey is completely dependent for all of his needs. Corey cannot talk, but he can blink his eyelids for “yes” and “no”. Corey understands everything going on around him. Corey has a wheelchair and relies on the attendant to reposition and move him.

Taking care of someone like Corey who understands everything, cannot verbally communicate, and who is completely dependent on someone else can not only be very physically, mentally, and emotionally draining on the attendant, it can be challenging. It is wise for an attendant to care for someone like Corey part time and have a verbal consumer for the rest of the week. A good example is having a consumer who is verbally interactive in the mornings and having an intense care consumer, like Corey in the afternoon, (or vice versa). This way the attendant does not get “burned out”, nor mentally and emotionally exhausted, nor feel “isolated”. This arrangement is also good for the consumer who is in Corey’s situation, because these intense care consumers need stimulation and variety in their lives since they are less likely to get out among lots of people and tend to feel isolated themselves.

There are several things to consider about the household/families in which these intense care consumers live. One, there is probably a lot of stress because of the high needs of the consumer. The family will be sleep deprived because of getting up all night long to care for their loved one. There may be moodiness and emotional times for the family because of what has happened to their loved one and how now they have to manage their loved one’s care (medical needs, etc.). Another source of stress for the family is that they may have some loss of income now that they must stay home with the loved one. Also, now the family has to have extra non-family members in their home. The attendant should never take any of the moodiness personal. Those things are the result of what the family experiences.

The attendant needs to be aware that if the family is busy, whether working or tending to household tasks, they are not ignoring their loved one. While the attendant is there, that is the only time the family can work, and do everything that needs to be done, because when the attendant is gone the family is back on full time care with the consumer, their loved one.

Further, the attendant should try not to interrupt the family members (with chit chat or their own personal goings on), unless the consumer needs something that can’t wait or it’s time for family to administer medical needs, tube feeding, etc.

The attendant needs to have the ability to talk to the consumer all the time despite the fact that the consumer cannot respond verbally. As the attendant and consumer get to know each other, the attendant will understand other forms of communication the consumer uses, but still needs to talk all the time. I would suggest that an attendant ask their self, “Can I handle this consumer situation? Can I handle not hearing my consumer speak to me?” If the attendant can’t, don’t take the job. Training new attendants is very time consuming for the family and emotionally hard on the consumer because the consumer becomes very attached to the attendant.

It takes a special person to do this job. Those that take this type of intensely emotional job are a blessing to these consumers and their families. We pray every day that the attendants are blessed.

Theresa Buhr, mother of Corey



PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 3 – PSYCHOLOGICAL/EMOTIONAL CONDITIONS

CONTENTS

- A. Emotional Impact of Chronic Disease or Disability
- B. Emotional Impact of Aging
- C. Anxiety
- D. Depression
- E. Addictions and Older Adults
- F. Resources

OBJECTIVES

1. Identify common psychological and cognitive conditions.
2. Describe behavioral, communication, and safety issues associated with these conditions.
3. Explain effective techniques for addressing these conditions.

KEY TERMS

Adjustment	Obsessive-compulsive disorder (OCD)
Anxiety disorder	Panic disorder
Comfort zones	Phobia
Depression	Psychological
Holistic view	Suicide

A. EMOTIONAL IMPACT OF CHRONIC DISEASE OR PHYSICAL DISABILITY

So much of the emotional impact of a chronic illness or physical disability revolves around the adjustment. Adjustments to not feeling well, to decreased activity and capability, and changes in priorities, finances, self-image, and relationships can all surface at the same time. Adjustment isn't just for the beginning stages of an illness. There is a continued need for emotional and mental change as the physical changes become more evident.

Chronic illness or disability often produces feelings of helplessness, frustration, hopelessness, or great sadness. It is common to experience resentment at being ill or needing others' help and grief at loss, at the multiple aspects of loss. Regardless of the illness, there is a powerful emotional component which contributes to a need for physical *and* emotional support and care.

The emotional wellness of an ill and/or aging person has a major and marked impact on the physical symptoms under stress. Exactly how emotions, mind and the physical body relate is, of course, a complex question. Improvement of emotional wellness may help control certain physical symptoms in some types of chronic or serious illnesses.

Pre-existing attitudes about illness can also affect adjustment. As thoughts and emotions change, physical symptoms often shift. Even when the physical symptoms remain the same, however, the client's attitude about them can help or hinder their disease process. For example, the individuals might see their illnesses in a new, more accepting light. The less people think their illnesses will impact their lives, the greater their overall quality of life may be, even if their symptoms don't improve.



The DCW should remember to address the emotional as well as the physical needs of the client in his/her care.

Providing holistic care and support

There is a definite connection between mind and body—one affects the other. Healthcare professionals have an increased interest in a *holistic* view of the client's emotional, physical and spiritual needs in providing care. Holistic means concerned with the whole system, rather than as separate parts. Holistic medicine is concerned with the body and mind and the influence one has on the other.

Clients need to feel that their circumstances and feelings are appreciated and understood by the DCW and health care team without criticism or judgment. If clients feel the attention and service they receive is genuinely caring and tailored to their needs, it is far more likely that they will develop trust and confidence in the caregiver and the agency as a whole.

Poor psychological and emotional health damages physical health outcomes. Studies have proven a connection with high emotional stress and coronary artery disease. Depression,

stress, anger and negative emotions in general are strongly associated with increased physical problems. It is important for the DCW to have a holistic view of the client, to try to meet the emotional, physical and spiritual needs when providing care. For example, it is not just bathing a client, but also understanding the client may feel embarrassed or ashamed by the task. The DCW must have a caring, non-judgmental approach to meet the physical as well as the emotional needs of the client when providing that bath.

B. EMOTIONAL IMPACT OF AGING

As the body ages, there are a number of changes that occur. How a person manages those changes can affect their entire outlook in their “golden years.”

People age differently, and they think and feel differently about aging. Even though there are many challenges of aging, these can often be addressed through simple steps that improve communication and make the environment safer and easier for the older person to navigate. The existence of an efficient, effective caregiver may help to make it easier for the older individuals to live independently in their homes for as long as possible.

Physical Impact	Emotional Impact
<ul style="list-style-type: none"> • Energy level slows, less active, may gain weight. • Body systems deteriorating. • Sensory loss (hearing and vision) decreases safe movement and communication. • External changes: skin wrinkles and becomes fragile, gray hair. • Changes in bone mass and strength, falls often result in serious injury. • Sensitivity to scents, light changes, and medication caused by changing body systems. 	<ul style="list-style-type: none"> • Interests in hobbies/events may lessen. • Fear of death/religious needs increase. • Social engagements may be refused, isolation leads to loneliness. • Physical effects of aging may have high mental impact, may seek out plastic surgery, etc. • Vulnerability may affect comfort, anxiety, trust of strangers. • Grief over losses; independence, loved ones, pets, job, etc. may create severe depression. • Embarrassment and shame at conditions (incontinence, dependence, illness seen as weakness, etc.).

C. ANXIETY

Anxiety disorders include:

- Panic disorder.
- Post traumatic stress disorder (PTSD).
- Specific phobias.
- Obsessive-compulsive disorder (OCD).
- Social phobia (or social anxiety disorder).
- Generalized anxiety disorder (GAD).

Signs and symptoms

Each anxiety disorder has different symptoms, but all the symptoms involve excessive, irrational fear and dread.

Behavioral issues

People with anxiety disorders may not be able to cope with the stresses of everyday life and have difficulty functioning. For example, they may not want to venture outside of their homes, or they may be afraid of germs to the point of having to wash their hands many times a day. **Some people with anxiety disorders can become agitated and aggressive if taken out of their comfort zones.** This is especially true for a person with dementia who has an anxiety disorder.

Communication techniques

Along with other communication techniques you need to use a calm, reassuring approach. (for example, “*I understand you are upset but you will be safe here.*”). Listen with concern and understanding.

Treatment/management

Treatment is aimed at the cause. If the person has a phobia, treatment may be focused on exposing the person to the thing that causes the phobia gradually (desensitization). Counseling may also help the person cope with stressors to reduce anxiety. Medications, including anti-anxiety agents, may also help. However, anti-anxiety medications can be addictive and may have undesirable side effects, especially in the elderly. Medications should only be used under the direction of a healthcare professional.



“I couldn’t do anything without rituals. They invaded every aspect of my life. Counting really bogged me down. I would wash my hair three times as opposed to once because three was a good luck number and one wasn’t. It took me longer to read because I’d count the lines in a paragraph. When I set my alarm at night, I had to set it to a number that wouldn’t add up to a ‘bad’ number.”

A person with OCD, from “Anxiety Disorders,” National Institute of Mental Health, 2009



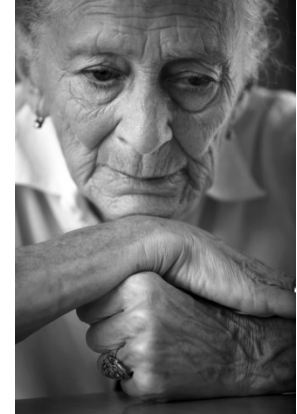
D. DEPRESSION

Major depression is the leading cause of disability in the U.S. and worldwide. Older Americans are disproportionately likely to die by suicide. Among the highest rates (when categorized by gender and race) are white men age 85 and older, with 59 deaths per 100,000 persons in 2000, more than five times the national rate of 10.6 per 100,000.

Signs and symptoms

- Persistent sad, anxious, or empty mood.
- Feelings of guilt, hopelessness, worthlessness, pessimism (for example, *"I don't know if I can go on."*)
- Loss of interest or pleasure in hobbies and activities that were once enjoyed.

Some symptoms may be side effects of medication the older person is taking for a physical problem. They may also be caused by another condition or illness the person has such as heart disease, stroke, diabetes, cancer, and Parkinson's disease.



Depression is NOT a normal part of aging

Behavioral symptoms

- Statements about death and suicide threats.
- Reading material about death and suicide.
- Increased alcohol or prescription drug use.
- Failure to take care of self or follow medical orders.
- Stockpiling medications.
- Sudden interest in firearms.
- Social withdrawal or elaborate good-byes.
- Rush to complete or revise a will.
- Overt suicide.

Communication techniques

- **Be supportive.** It is important to let the person know that you are there to listen and spend time together doing things you both enjoy.
- **Be concrete and direct,** though kind. For example, you could say, *"You don't seem to be yourself these days. I've noticed that you have been sleeping more and not reading the paper like you used to enjoy doing. Are you OK?"* You may find that the person will become defensive, tearful, or angry. However, it is important to keep in mind that your concern could be very helpful, even if it takes the person some time to come around. If you get a reaction like this, follow up at a later time. You might say, *"I'm sorry you found*

what I asked you to be upsetting. I just wanted to help. Please let me know if I can help in any way."

- **Avoid being overly light-hearted or confrontational.** Many people make the mistake of trying to get a depressed person to "snap out of it." Some do this by cracking lots of jokes and making light of the person's feelings. Other people will try to get tough with the depressed person, saying things like, "*You don't have anything to be upset about,*" or "*Think of all the people who are worse off than you.*" Such approaches are rarely helpful and may even backfire. The depressed person is likely to feel worse and may even become angry.
- **Ask questions.** Depressed people often feel very alone and isolated. You might say, "*I hope you won't find my questions rude,*" or "*Please let me know if I am asking something too personal,*" then ask! Providing the opportunity to talk can be a valuable gesture in helping a depressed person.
- **Ask about suicidal thoughts.** Asking someone if he or she has thought about suicide will NOT increase the likelihood of the person doing so. In fact, people are often relieved to be able to talk about such scary thoughts. One way to do this is to restate something the person has just said, followed by a question about suicide. For example, you could say something like, "*When you say that you feel like giving up on life, do you mean that you have been considering suicide?*"
- **Try to get some help. Call your supervisor and report the situation** so that an appropriate referral can be made. If the person is having suicidal thoughts, DO NOT LEAVE THE PERSON ALONE.

Treatment/management

Research has shown that certain types of short-term psychotherapy are effective treatments for late-life depression. Combining psychotherapy with antidepressant medication, however, appears to provide maximum benefit. In one study, approximately 80 percent of older adults with depression recovered with combination treatment. The combination treatment was also found to be more effective than either treatment alone in reducing recurrences of depression.

Information adapted from the National Institute of Mental Health website: <http://www.nimh.nih.gov/>

E. ADDICTIONS AND OLDER ADULTS

Addiction is a chronic, relapsing brain disease. An individual who has an addiction to a substance has become dependent upon the substance. When substance use ceases, withdrawal can provoke serious effects. Some physical symptoms of withdrawal include headaches, diarrhea, sweating, physical pain, vomiting, and tremors.

Alcohol

The largest problem with substance abuse comes from alcohol consumption. Taking medications together with alcohol can cause additional problems.

Some indicators that an older adult may have a problem with alcohol:

- Cognitive decline or self-care deficits.
- Non-adherence with medical appointments and treatment.
- Unstable or poorly controlled hypertension.
- Recurrent accidents, injuries or falls.
- Frequent visits to the emergency room.
- Gastrointestinal problems.
- Unexpected delirium during hospitalization.
- Estrangement from family.

A number of the symptoms for alcoholism in older adults resemble other geriatric disorders. Diagnosing alcoholism should be done only by a licensed professional trained in substance abuse and treatment.

Prescription and over-the counter medication

Most older adults who misuse their medications do so *unintentionally*. Older individuals often take several medications. They may not read the labels correctly or they may misunderstand the dosage directions. For any of these reasons, overdose, additive effects, and adverse reactions from combining drugs can occur.

Intentional misuse of prescription medications happens for a variety of reasons. Sometimes, it's because a tolerance has developed from prolonged use of a drug, or because the side effects are pleasurable or an added escape from boredom or pain. Unintentional misuse can progress into abuse.

The DCW should report all observations and concerns regarding medications or alcohol to the supervisor.

F. RESOURCES

- National Institute of Mental Health, <http://www.nimh.nih.gov/>
 - Depression: <http://www.nimh.nih.gov/health/topics/depression/index.shtml>
 - Substance abuse: <http://www.nlm.nih.gov/medlineplus/drugabuse.html#cat23>
- “Aging and Addiction, Helping Older Adults Overcome Alcohol or Medication Dependence” Carol Colleran and Debra Jay. Hazelden, 2002.
<http://www.agingandaddiction.net/alcohol.html>

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 4 – PERSONAL CARE

CONTENTS

- A. Basic Principles
 - 1. Following Service Plans
 - 2. Activities of Daily Living (ADLs)
 - 3. Client Dignity and Rights
 - 4. Cultural and Religious Issues
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- B. Skin Care
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Chapter 4 – Personal Care

E. Assistive Devices for Bathing

F. Meal Assistance

1. Assistance with Setting Up a Meal
2. Assistance with Eating
3. Feeding an Individual who has Difficulty Swallowing
4. Feeding an Individual with a Cognitive Disability
5. Encouraging Appetite
6. Assistive Devices for Eating

OBJECTIVES

1. Identify and describe activities of daily living and instrumental activities of daily living.
2. Explain the importance of observing client rights, dignity, and cultural preferences.
3. Describe techniques for preventing skin damage and pressure ulcers.
4. Identify 3 or 4 characteristics of people who might be at risk for skin-integrity concerns.
5. List the most common causes of skin breakdown.
6. Identify and explain basic principles of personal care and demonstrate selected personal care skills.
7. Describe how to promote independent functioning and respect a person's privacy while providing personal care.

SKILLS

- Bed bath
- Assisting with dressing
- Assisting with oral care
- Emptying a catheter drainage bag
- Positioning on the bedpan
- Assisting with eating

KEY TERMS

Activities of daily living (ADLs)	Grab bar
Ambulation	Incontinence
Aspiration	Instrumental activities of daily living (IADLs)
Catheter	Mobility
Circulation	Perineal care
Friction	Pressure ulcer

A. BASIC PRINCIPLES

1. Following Service Plans

Individuals, and their caregivers and health care providers will develop a *service plan*, also called a *care plan* or *support plan*. This is part of an assessment process for direct care assistance. It is based on the needs and the functional ability of the individual to perform activities. These are divided into *activities of daily living* (ADLs) and *instrumental activities of daily living* (IADLs).

Direct care workers must follow the agreed-upon service plan. If the client wants you to do something that is not in the service plan, you may be opening yourself and the agency to disciplinary and/or liability issues. Contact your supervisor if such a situation arises. Refer to the explanation of care and support plans in the Chapter 6 of the *Principles of Caregiving: Fundamentals* course manual.

When beginning care for *any* individual, regardless of condition; whether a family member or regular client, remember to allow the client as much independence as possible. Clients should be encouraged to continue to do as much as they can for themselves. The DCW should:

- Resist the urge to do everything for them. This is not healthy for the client or the direct care worker.
- Ask the client/family to determine what they can do. Assist but don't take over the task.
- Do provide physical and emotional supportive. Be available to listen, and be sympathetic yet genuine.
- Review the service plan for instructions. Check to see if the person is independent, or at minimum or total assistance for tasks.
- Continue to communicate with the client and family. Needs and abilities may change, sometimes daily.

2. Activities of Daily Living (ADLs)

Activities of daily living are considered a person's basic self-care tasks. They include the ability to:

- Dress.
- Eat.
- Ambulate (walk).
- Toilet.
- Take care of hygiene needs (e.g., bathing, grooming).

There are also *instrumental activities of daily living* (IADLs). These activities are important for functioning in the community and include the ability to:

- Shop.
- Keep house.
- Manage personal finances.
- Prepare food.
- Transport (drive, ride the bus, etc.).

The DCW's assistance with ADLs and IADLs helps fill the gap between what the person can do independently and what he/she needs help with. But for each activity that the DCW does, the client has a little less control and may lose out on being able to exercise the muscles and joints involved in the activity.

This section focuses on the personal care needs—the ADLs—and how to provide assistance to meet those needs. Assistance with some IADLs (housekeeping, food preparation) is addressed in the *Fundamentals* course manual.

3. Client Dignity and Rights

The DCW's responsibility is to help an individual maintain normal function, or to compensate for or regain lost function. The DCW must do so in a professional manner. This preserves the person's dignity. An example is not exposing more of a person than is absolutely necessary during bathing. Offering choices is an important way to preserve dignity.

Individualized person-centered services promote the principles of choice and respect. For example, individuals should be allowed to bathe at the time they desire and the way they prefer. Each person should choose what clothes to wear. One goal of personal care service is to provide assistance with an ADL, but it is also intended to maintain independence, renew and uplift the person's spirit.



Client rights emphasize dignity, respect, choice, and empowerment (controlling what they can control).

4. Cultural and Religious Issues

DCWs must appreciate the cultural differences between their own culture and the client's culture. Respect the person's culture and demonstrate that appreciation and respect while providing services. For instance, for some in the Hindu religion, personal hygiene is very important. Bathing is required every day, but bathing after a meal may be viewed as causing injury. However, not all people who are Hindu hold the same beliefs, just as people with a Hispanic last name may not like Mexican food. For input on

individual cultural and religious issues **ask the client, other caregivers, and your supervisor.**

Direct care workers should have warmth, empathy and genuineness. As discussed in Chapter 4, Cultural Competency, in the *Fundamentals* course manual, DCWs must also have a sense of compassion and respect for people who are culturally different. Just learning the behavior is not enough. When a person has an appreciation and respect for others they can display warmth, empathy and genuineness.

5. Observing and Reporting

Proper documentation and reporting of personal care tasks is critical. Refer to Chapter 6, Observing, Reporting and Documenting, in the *Fundamentals* course manual for more details.



While providing care such as bathing a client or applying lotion to a person's feet, be **very observant** of any changes in skin condition. If any changes are noted, they must be reported and documented immediately. **Document to whom the report was given, what action was recommended, and the outcome of that action.**

A paid provider of care and support is expected to contact a supervisor, who will contact the appropriate parties to get the necessary assistance.

Failing to contact anyone is viewed as *negligence* and can be grounds for an abuse investigation. Protect yourself against any liability or disciplinary action.

! Document and report your observations.

B. SKIN CARE

Older adults and people with disabilities are susceptible to skin problems because of changes that happen as a person ages. Skin health can also be affected by medical conditions, pain, depression, confusion and/or injury. It is critical for a DCW to routinely check a client's skin for any changes and report changes to the supervisor. Early intervention is of utmost importance in maintaining a client's health and decreasing liability for the DCW and the agency.



Contact your supervisor before proceeding with any action related to skin problems.

1. Bruises and Cuts

A *bruise* is a common skin injury that results in a discoloration of the skin. Blood from damaged blood vessels deep beneath the skin collects near the surface of the skin resulting in what we see as a black and blue mark.

- Unexplained bruises that occur easily or for no apparent reason may indicate a bleeding disorder, especially if the bruising is accompanied by frequent nosebleeds or bleeding gums. **Notify your supervisor.**
- Bruises in older adults frequently occur because the skin has become thinner with age. The tissues that support the underlying blood vessels have become more fragile.

A cut, or *laceration*, refers to a skin wound. You can usually stop the bleeding by applying direct pressure over the wound with a clean cloth (or dressing). If the cut is on an extremity such as an arm or a leg, you can elevate the extremity. Washing the area with soap and water will help reduce the risk of infection. Cover the cut with an adhesive bandage. Depending on your agency's policies, you may need to report this to your supervisor.



Remember to wear gloves with ANY and ALL blood exposures!

2. Pressure Ulcers

Pressure ulcers, also called pressure sores, bed sores or decubitus ulcers, are lesions caused by unrelieved pressure resulting in damage to underlying tissue. Pressure compresses the tissue, causing decreased circulation. This can lead to decreased oxygen and nutrients and ultimately the death of the tissue. Common problem sites are bony areas (e.g., tailbone, heels, and elbows). The most common sources of pressure that result in ulcers are:

- Sitting or lying in one position too long.
- Rubbing casts, braces or crutches.
- Wrinkled bed linens and poorly fitting clothes.

Stages of skin damage

- **Stage I:** Mostly on the skin surface, indicated by reddened area that does not return to normal skin color 20-30 minutes after pressure is relieved. The skin remains intact. In individuals with darker skin, discoloration of the skin, warmth, edema (swelling from fluid accumulation), or a hardened area may be indicators.
- **Stage II:** There is partial thickness skin damage, affecting the outermost skin layer (epidermis) and the layer directly below it (dermis), or both. The ulcer looks like an abrasion or blister.
- **Stage III:** This involves the full thickness of the skin, extending into the underlying tissues. This deeper layer of skin tissue may have a relatively poor blood supply and can be difficult to heal. The ulcer is a deep crater with or without undermining (tunneling) of surrounding tissue.
- **Stage IV:** There is full thickness skin loss with extensive destruction, tissue dying (necrosis), or damage to muscle, bone, or supporting structures.

For more information and photos on stages of pressure ulcers refer to http://www.in.gov/isdh/files/Pressure_Ulcer_Classifications_-_Color_Version.pdf

Prevention

- **Avoid prolonged exposure.** Remind or help the individual to change position at least every 2 hours. If an area stays reddened for more than 20-30 minutes, reduce time for changing position by 30 minutes.
 - Assist or remind wheelchair users to relieve pressure on the tailbone every 20-30 minutes by pushing up on the armrests, shifting from side to side, or leaning forward, feet on the floor, making sure not to fall. Also encourage the use of pressure relieving cushions made specifically for wheelchairs (no pillows or plastic donuts).
 - Encourage mild exercise and activities that do not involve sitting for long periods of time.

- Be sure bedding and clothing under pressure areas such as the tailbone, elbows, or heels, etc. are clean, dry and free of wrinkles and any objects.

It is the **DCWs responsibility** to change the person's position at least every 2 hours if the person is unable to do so on his/her own (for example, an individual who has quadriplegia).

- **Avoid skin scrapes from friction.** To prevent these scrapes:
 - Follow safe transfer procedures. Do not drag or slide a person across surfaces. Get help or use a lift sheet to turn and move a person in bed.
 - Do not elevate the head of the bed more than 30 degrees. This will reduce pressure on the tailbone. If the person needs to be sitting upright after eating, lower the head of the bed to 30 degrees after an hour.
 - Prevent the client from sliding down in the wheelchair.
- **Protect skin over bony areas and where two skin surfaces rub together.** Protect the skin with clothing and special pads for elbows and heels. Cushions are good but do not replace frequent positions changes.
- **Protect fragile skin from being scratched.** Keep fingernails (yours and the client's) and toenails short. Long toenails can scratch a person's legs.
- **Protect skin from moisture.** Keep skin dry. Be aware of moisture sources, including baths, rain, perspiration, and spilled foods and fluids. Damp skin can become swollen, soft and irritated, leading to sores, rashes, and fungal infections.
- **Check contact points.** Observe skin that comes in contact with splints, braces, or other orthotic appliances for any signs of breakdown.
- **Watch for allergic reactions (rashes) from health and personal care products.** For example, some persons are allergic to incontinence pads.
- **If you see an area is reddened,** provide a light massage *around*, **not on**, the reddened area, to increase circulation to the area.



Remember to contact your supervisor if you notice any changes in the person's skin.

Other contributing factors

- **Dehydration and poor diet.** Adequate fluid intake is essential to maintaining healthy skin. Water and foods rich in protein and vitamins (especially vitamin C and zinc) help the body resist trauma, fight infection and promote healing.
- **Body weight.** Being particularly overweight or underweight increases the risk of skin problems.
- **Illness.** Diabetes, heart disease and poor circulation increase the risk of pressure sores.
- **Limited mobility and awareness.** Willingness and ability to engage in activities may be reduced by pain, sedation, low energy, or motor or mental deficits.
- **Irritants.** Chemicals (including urine) and other substances (for example, anti-bacterial soaps or detergent residues in linens) can irritate and inflame the skin.
- **Injury.** The risk of skin breakdown increases at the site of an injury. A burn from a heating pad, a scratch, bruise or scrape can develop into an ulcer if not properly treated.
- **Smoking.** Persons who smoke have decreased circulation and heal more slowly.

C. BATHING, DRESSING AND GROOMING

1. Skin Care

In general, skin care involves keeping the skin clean and dry, preventing prolonged pressure, good nutrition and exercise. It is important to regularly inspect the client's skin for signs of infection or breakdown. Refer to Section B in this chapter for more details on preventing skin damage.



**Prevention is better than treatment.
Be observant to reduce the risk of problems.**

Skin care tips

- **Aloe Vera gel** (the green gel in the first aid aisle—not the lotion) is very good for use on minor skin irritation such as chafing between the legs, groin folds, or under the breasts. Use as directed. Make sure aloe is listed as the first ingredient. Cheaper products will list water as the first ingredient.

Do not use gels or lotions on open skin areas without getting supervisor approval.

- If a woman does not wear a bra and has large breasts, use a clean piece of 100% cotton material such as a man's hankie or piece of undershirt and place under the breasts after her shower. It will help to keep the skin dry.
- Medicated powder may also work well on minor skin irritation.
- Use lanolin based soap instead of antibacterial or heavily scented soaps. A rinseless soap also works well.

2. Bathing

Bathing provides many benefits:

- Cleansing and removing wastes from the skin.
- Stimulating circulation.
- Providing passive and active exercise.
- Helping a person feel better about him/herself and his/her appearance.
- Providing an opportunity to observe the skin and an opportunity to connect with the person.

Some individuals may be able to bathe without help. Some may need assistance occasionally, and others may need help all of the time. **Encourage as much independence as possible.**

How often a client bathes will probably be between you and the client, although a minimum of once a week is recommended. When considering the frequency of bathing, remember that each time an individual bathes, it washes off natural oils making the skin drier. The client's bathing patterns, incontinence issues, skin type, recent activities, and physical condition will all be factors in how often the client bathes.

Tub baths are not recommended for people with disabilities or elderly persons because it increases the risk of falls or of not being able to get out of the tub.

A rule of thumb: If an individual cannot get in and out of a tub without assistance, then a shower should be done using a shower seat. This is safer for the client and the DCW. Notify your supervisor if this is an issue.

TIP: A visual that works well in discussing the safety of a tub bath is to ask the person if he or she could sit on the floor and expect to get up without help. That is essentially what he/she would be doing with a tub bath.



Procedure: The Bed Bath

Bathing is an ADL that cleans skin, improves circulation, and provides an opportunity for range of motion and socialization. It is preferable to transfer the client to a chair to provide a partial bath or to a shower bench. When this is not possible due to client weakness, decreased endurance (person cannot sit upright for an extended time), or respiratory problems that make transfers too taxing, then a bed bath should be provided.

Supplies

- Wash basin and lanolin based soap (rinseless soap works best).
- At least four soft, absorbent towels and two soft washcloths.
- Disposable gloves.
- Moisturizing body lotion.

Description of procedure

1. Ask the client his/her preferences. Based on the response, gather supplies and plan how to proceed.
2. Explain procedure and continue to talk the client through each step of the bath.
3. Assist the client with removing clothing, eyeglasses, and jewelry.
4. Wash your hands and put on disposable gloves.
5. Place two large towels, one covering the shoulders to waist and the other from the waist to the toes on top of the client's top sheets. Then carefully remove the top sheets underneath leaving the towels in place. This keeps the client covered.
6. Use one washcloth for cleansing, another for rinsing (unless rinseless soap is used).
7. Have the client wash his/her face if able, or wash the client's face making sure the areas behind the ears get washed and dried.
8. Place towel lengthwise under the client's arm. Wash, rinse and pat dry the arm, armpit, and hand (place the hands in the wash basin if possible). Repeat with other arm, armpit, and hand.
9. Lift up the chest towel just enough to expose the chest and wash, rinse and pat dry. Re-cover the chest.
10. Lift up the towel covering the abdomen and wash the area to the groin. Rinse and pat dry. Replace the towel.
11. Remember to change the water as soon as it gets cold.



12. Place towel lengthwise under the client's leg. Wash, rinse and pat dry the leg and foot. Place the foot into the wash basin if possible. Make sure area between the toes is dried. Check the heels for any signs of skin problems.
13. Repeat the same process on the other side of the body.
14. Turn the client on the side away from you. Exposing just the back, place a towel lengthwise close to back.
15. Beginning at shoulders and working down toward buttocks, wash, rinse and pat dry the back. Examine tailbone area for skin problems (this is a common problem site).
16. Turn the client on back. If person cannot wash the genital area, do it for him/ her, always wiping from genital to anal area (front to back). See *Perineal care* below.
17. Turn client on side. Wash the rectal area, front to back, rinse and pat dry.
18. Apply moisturizer while the skin is still moist.
19. Assist the client in dressing.
20. Put away supplies, remove gloves and wash hands.



Perineal care

Perineal care is the term for cleansing the genital area. Be sure to provide for privacy and comfort. Use a towel or bath sheet to keep the client covered while you do perineal care.

- **Female:** Have the woman lie on her back (with or without her knees bent depending on her ability). Visualize the area and separate the labia. With a washcloth make one swipe from front to back. Turn over the cloth and make another swipe from front to back. Continue until the area is cleansed. Rinse with water using the same procedure and pat dry.
- **Male:** Have the man lie on his back. If the individual is uncircumcised retract the foreskin. Grasp the penis shaft and with a circular motion cleanse from the tip of the penis down the shaft. Turn over the cloth and repeat from the head of the penis to the shaft. Wash the scrotum. Rinse with water and pat dry. **For the uncircumcised male put the foreskin back into the original position.**
- **For rectal area:** Have the person lie on the side away from you. If necessary separate the buttocks to visualize the anal area. Wipe from the front to the back, turning to a new area of the washcloth after each swipe until the area is clean. Rinse with water and pat dry.



Practical tips

- Throughout the procedure the client should be encouraged to perform as much of the bathing routine as possible. Ask specifically if the person can wash his/her own face or genital area.
- The DCW should **ensure privacy and dignity by only exposing the areas necessary** during bathing. Close the door and pull the window shade, if necessary.
- Make sure the room is warm and draft free.
- Be careful not to overtire a client. If a person becomes too tired, finish up with the most important areas (face, hands, arm pits, and genitals) and leave the rest for another day.
- When washing the eyes, wipe one eye, turn the cloth and wipe the other so as not to contaminate the other eye. Repeat as necessary.
- When applying moisturizer, gently massage bony prominences (e.g., hips, tailbone, elbows) using a light circular motion. Be observant for any skin changes. Do not massage legs. Poor circulation often causes clots to form, which can be dislodged by massage.

Don't forget!

- Wash areas from clean to dirty, that is, from head to rectum.
- Communication is very important before and during the procedure. This includes non-verbal communication during perineal care. If you feel uncomfortable or hesitant, your client will probably feel the same. Even if the client is non-verbal, continue to talk to the client as if he/she could communicate.
- Keep water warm to aid in comfort. Cool water can cause the client to chill.



My First Bed Bath

I knew when I started to work for my client who was quadriplegic, I would sooner or later that first day have to give my first bed bath. I got to say I was a little nervous - no, a lot nervous. Role playing was fun in class, but now this was the real deal. Just me and the client. I started out first to wash her hair very gently and I could see she was relaxed. Then she started to have a conversation with me. 'This is not that bad', I thought as I was half way through the bed bath. I continued washing her and when I got to her private parts I was very confident and relaxed. It was not bad at all. I was surprised at how light she was when I turned her to her backside. By then we were both having such a great time accomplishing the bed bath that I didn't realize I had finished with the bed bath until I was done. I have given many bed baths since then, but my first one will always be the one I remember.

Mirtha Castaneda



3. Hair Care

Routine hair care involves washing, combing, drying and styling. It can be a very tiring task, even for clients who are independent in most areas. A client may enjoy going to a hair salon or barbershop. Some hairdressers will make house calls, too.

Washing, drying and styling a person's hair can take 30 to 60 minutes. Consider scheduling a shampoo on non-bath days to conserve the individual's energy. A shampoo once a week or every two weeks is appropriate for an older person.

A shampoo can be given in the tub or shower, at the sink, or in bed. Where the hair is washed will depend on what is appropriate for, and desired by, the individual. The client's health, mobility, energy level and personal preference should be considered. Always consider the client's wishes when determining a style. It should be easy to care for and appropriate for the person. The person's own styling equipment (e.g., styling brush, curlers, and hairpins) should be used.

Note: If you need to give a person a shampoo in bed there are plastic shampoo trays that work very well. If you do not have a tray, you can use a rolled up towel covered with a plastic trash can liner.



Caution: If the person has an eye disorder or has had recent eye surgery, consult a health care professional before proceeding with a shampoo. You may need to avoid moving the head into various positions that might cause increased pressure on the eye.

4. Dressing

Providing assistance with dressing, or dressing a client with or without an extremity weakness, is a skill that many DCWs will use daily. The key to assisting with dressing, as with any of the personal hygiene and grooming tasks, is for a DCW to **allow a client to be as independent as possible**, even if the person dresses slowly.



Procedure: Assisting with Dressing

Supplies

Articles of clothing client wishes to wear.

Description of procedure

1. Communicate with client the assistance procedure and expectations.
2. Provide for client's comfort and privacy.
3. Discuss client's preference of clothing. Offer the client a choice of what they want to wear that day.
4. Retrieve the clothing, and lay it out in an orderly fashion.

5. Dress weak side first (if applicable). Put the clothes on the weaker arm and shoulder side first, then slide the garment onto the stronger side. When undressing, undress the strong side first.
6. As much as possible, dress the client while seated. Put on underwear and slacks only up to the client's thighs. To finish, ask him/her to stand, or assist to stand, and then pull up the underwear and slacks.
7. Continue to communicate each step in the process as you go along.

Practical tips

- Always discuss with clients what their preferences are and how they are most comfortable.
- Don't assume a client wants to wear items of clothing that someone else may have chosen for them.
- Be aware of how the client may be feeling about needing assistance.
- Be aware of any issues that could cause the client to get tired or frustrated easily.
- Be pleasant while completing this task, engage the client in conversation.
- Encourage the client to wear clothes with elastic waistbands and Velcro closures.

Don't forget!

- Encourage the client to be as independent as possible.
- Only provide the assistance needed – don't do everything for the client just because it is faster for you.
- If the person has a stronger and a weaker side, put the clothes on the weaker arm and shoulder side first, then slide the garments onto the stronger side. When undressing, undress the strong side first.

5. Shaving

For most men shaving is a lifelong ritual, one they are able to perform in later life despite impairments. The act of shaving, as well as the result, usually boosts morale. A male client should be allowed to shave himself unless it is unsafe for him to do so. A female client may desire to have leg, armpit or facial hair shaved.



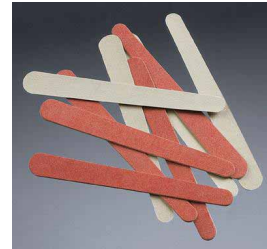
An electric razor is easiest and safest to use. Clients who have diabetes or who take anticoagulants should use an electric shaver. After shaving with the electric shaver, rinse the face with warm water or place a warm wet washcloth over the face and pat dry. If the individual desires, apply after-shave lotion.

6. Nail Care

Nail care for fingers and toes prevents infection, injury, and odors. Hangnails, ingrown nails, and nails torn away from the skin cause skin breaks. Long or broken nails can scratch the skin or snag clothing. Nails are easier to trim and clean right after soaking or bathing. **Some agencies do not allow their staff to clip nails** because using clippers can cause damage to surrounding tissue.

Supplies

- Wash basin with warm water.
- Nail clippers (not scissors).
- Orange stick, emery board or nail file.
- Lotion or petroleum jelly.
- Paper towels.



Procedure

1. Arrange items next to the client. Allow the person to soak nails for 10-20 minutes or do the procedure after a bath. Clean under the nails with an orange stick.
2. Clip nails **STRAIGHT ACROSS** with the nail clippers **if allowed to do so**. Shape fingernails with an emery board or nail file.
3. Apply lotion or petroleum jelly to hands and feet.
4. Clean and return equipment and supplies to their proper place. Discard disposable items.



**Contact your supervisor before clipping nails,
because this is a liability risk.**

Do not trim (cut or clip) nails if a person:

- Has diabetes.
- Has decreased circulation to the legs and feet.
- Takes drugs that affect how the blood clots.
- Has very thick nails or ingrown toenails.

In these cases, nails should be **filed only** to prevent possible cutting of the skin. If more care is required, a podiatrist should be consulted. This is usually covered by insurance for the cases listed above.

7. Foot Care

Soaking the feet can help a person in three ways: it promotes relaxation, provides exercise, and allows an opportunity to examine the feet for problems. **Soaking is not advisable for all clients.** Those with *diabetes* should not soak their feet. Consult your supervisor to be sure this procedure is recommended. General guidelines for soaking and caring for feet are:

- Schedule soaks on non-bath days. The client can soak feet while sitting and doing grooming tasks or while watching TV. The foot soak should not last more than 20 minutes.
- Provide a basin of warm water and mild soap.
- Remind the client to exercise feet while soaking. Give step-by-step instructions: Wiggle the toes, stretch the feet, rotate the ankles clockwise, then counter-clockwise, flex and extend the toes and ankles.
- Pat feet dry. Dry thoroughly between the toes.
- **Examine the feet. Look carefully, especially if the individual limps, resists walking or paces. Increased friction may cause blisters or pressure sores.** If any lesions are noted, contact your supervisor for further instructions.
- Apply lotion to dry, cracking skin. Use a lotion containing lanolin or mineral oil.
- Clean and return equipment and supplies to their proper places. Discard disposable items.

Foot care for people with diabetes

There is an important connection between diabetes and foot care. A person with diabetes is more vulnerable to foot problems because diabetes can damage the nerves and reduce blood flow to the feet. The American Diabetes Association estimates that one in five people with diabetes who seek hospital care do so for foot problems. By taking proper care of the feet, most serious health problems associated with diabetes can be prevented.

The following foot care strategies are for people with diabetes. **However, all people will benefit from healthy foot care strategies.**



Foot Care for People with Diabetes

People with diabetes have to take special care of their feet.

- 

1 Wash your feet daily with lukewarm water and soap.
- 

2 Dry your feet well, especially between the toes.
- 

3 Keep the skin soft with a moisturizing lotion, but do not apply it between the toes.
- 

4 Check your feet for blisters, cuts or sores, redness or swelling. Tell your doctor right away if you find something wrong.
- 

5 Use an emery board to gently shape your toenails straight across. Do not use scissors or nail clippers.
- 

6 Wear clean, soft socks that fit you.
- 

7 Keep your feet warm and dry. If you can, wear special padded socks and always wear shoes that fit well.
- 

8 Never walk barefoot indoors or outdoors.
- 

9 Examine your shoes every day for cracks, pebbles, nails or anything that could hurt your feet.

**Take good care of your feet - and use them.
A brisk walk every day is good for your feet.**

For more information, call the *Keeping Well With Diabetes* Tip Line at 1-800-260-3730 or visit us online at kwwd.com.

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8. Oral Care

Soft tissues of the teeth tend to harden with the aging process. Pain perception is reduced (painful toothaches are uncommon). Gum tissues recede from around the teeth. Aging tooth enamel, tobacco smoke, food pigments and saliva salts cause discoloration of teeth, ranging from yellow to brown, that cannot be removed by surface cleansing.



Good oral hygiene prevents sores and bad breath and keeps mucous membranes from becoming dry and cracked. Poor oral hygiene can contribute to poor appetite and the bacteria in the mouth can cause pneumonia. Inflamed gums also set up an inflammatory process that puts a strain on the heart and decreases resistance to infections. Encourage clients to brush their teeth daily, especially at bedtime. Electric tooth brushes or brushes with larger or longer handles promote self-care.

Providing proper oral hygiene for an individual that is unable to care for his or her own teeth is an important role for a DCW. Proper tooth brushing techniques help prevent conditions such as gingivitis, tooth decay and tooth abrasions, a condition in which the tooth is worn away. If you assist a client with oral hygiene, examine the mouth on a regular basis for signs of redness, swelling, or bleeding. A dentist should check any red or white spots or sores that bleed and do not go away within two weeks.



Procedure: Assisting with Oral Care

Supplies

- An extra soft or soft bristled manual toothbrush and toothpaste.
- Emesis basin.
- Disposable cup.
- Water or mouth rinse.
- Protective covering for clothing.
- Protective gloves.

Description of procedure

1. Gather all needed materials.
2. Provide an explanation of what will occur prior to starting the process and continue throughout.
3. Place the person in a seated (minimum of 60 degrees) or standing position prior to beginning.
4. Place a protective covering over the persons clothing.
5. Wash hands and apply gloves before brushing the person's teeth.

6. Apply water and a small amount of toothpaste to the toothbrush.
7. Brush all surfaces of the teeth and gum line before brushing the inside of the teeth. It is a natural reaction to bite down on whatever is placed in the mouth. To help avoid the bite reflex, do not insert the toothbrush to the inside of the mouth until later in the process.
8. Offer the person the opportunity to rinse and spit into an emesis basin as needed. If the person cannot independently rinse, turn the person to one side to allow the liquid to run from the person's mouth into a folded cloth.
9. Rinse the toothbrush periodically and apply another small amount of tooth paste as needed.
10. Clean the inside and outside teeth.
11. Upon completion, clean and dry the area around the person's mouth and remove protective covering. Dispose of soiled linen and trash.
12. Remove and dispose of gloves. Wash your hands.

Practical tips

- Try standing behind the person so you are looking down on his/her mouth. This will allow easier access and a better view of the person's mouth.
- Don't use too much toothpaste.
- Brush all three areas of the teeth (outside, inside and top).
- Allow the client an opportunity to rinse as often as needed.
- If the client is not able to spit out water, use an oral swab instead of a toothbrush.

Don't forget!

- Thoroughly clean the toothbrush after each use.
- Start with the outside of the teeth.
- Utilize universal precautions and infection control measures through the process.

Denture care

Dentures need to be cleaned at least once a day to prevent staining, bad breath and gum irritation. Partial dentures require the same care as full dentures. If you perform this task for the client, follow this recommended procedure:

- Wash your hands before and after handling dentures, and wear disposable gloves.
- Use a tissue or clean washcloth to lift one end, break the suction, and remove the dentures from the person's mouth.
- Observe the mouth for loose, broken teeth, sores, swelling, redness or bleeding. Any of these could indicate improper fitting dentures or a more severe mouth problem.
- Place dentures in a container filled with cool water.
- Clean dentures over a basin filled with water or lined with a washcloth, to prevent breakage should dentures be dropped accidentally.
- Cup dentures in hand. Brush the upper inside first, then the tooth and palate area. Rinse thoroughly.
- Have the individual rinse before replacing dentures. Provide a mouth rinse such as a saltwater (saline) solution. A warm saline rinse in the morning, after meals and at bedtime is recommended.
- Per the individual's preference, apply denture cream or adhesive to dentures before replacing.
- Store dentures in water when not in the person's mouth. This keeps them from warping. Dentures should soak in water for 6 to 8 hours each day (usually overnight).

For more information, refer to <http://www.oda.org/upload/SmilesForSeniors.pdf>

Use of oral swabs or “toothettes”

Oral swabs are designed with soft, secure foam heads with distinct ridges to gently lift and remove debris and mucous from the oral cavity. These can be used for individuals



who have difficulty with a hard toothbrush in their mouths. It is also useful in moistening the mucous membranes of the mouth, especially for people in terminal conditions or who are comatose. Dip swab in a dilute mouthwash or saline solution and swab the oral cavity and gums. Dispose of the swab after use.

D. TOILETING

The DCW's responsibility is to help clients maintain normal function or to compensate for lost function. This must be done in a professional manner that preserves the person's dignity. Ensure privacy and comfort, and do not rush the individual.

Problems with elimination may occur due to a variety of reasons. Age-related changes, emotional stresses, and chronic diseases that disturb mental health, affect nutrition and limit activity are all possible causes. Bowel and urinary problems may come and go or may be constant, depending on the cause. The physical and emotional burden of bowel and bladder control problems can include:

- Increased risk of skin breakdown and infections.
- Feelings of anxiety, shame, embarrassment, and frustration.
- Decreased sense of control, dignity, and self-esteem.
- Concern about the future.
- Decreased self-image.
- Loss of privacy to perform private functions.
- Social isolation.



1. Urinary Incontinence

Urinary incontinence is the involuntary leakage of urine, regardless of the amount. Common bladder problems can be caused by reduced bladder capacity, a weakened bladder sphincter muscle, and decreased bladder muscle tone are all common. Other bladder control causes can be:

- **Neurological changes.** Nerve signals to the brain that the bladder is full are slowed, giving the person less time to reach the bathroom.
- **Mental impairment.** For example, memory loss can affect a person's ability to find the toilet and remember proper toileting procedures.
- **Psychological changes.** Depression, stress and fatigue can reduce the individual's motivation and ability to remain continent.
- **Infection.** Bladder infections are common among women.
- **Medications.** Diuretics increase urine output. Sedatives reduce awareness of the need to urinate.
- **Alcohol.** Alcohol increases urine output and reduces awareness of a full bladder.

Types of incontinence

The four major types of urinary incontinence are:

- **Stress incontinence.** Leakage of urine during exercise, coughing, sneezing or laughing.
- **Urge incontinence.** Involuntary bladder contractions or the bladder sphincter opens with a sudden urge to urinate. The time between the brain sending the urge signal

and the bladder sphincter opening is shortened leading to less time to make it to the bathroom.

- **Overflow incontinence.** Leakage of small amounts of urine from a constantly full bladder. This commonly occurs in men who have enlarged prostate glands and people who have diabetes.
- **Functional incontinence.** Occurs when individuals do not have the physical and functional ability to get to the bathroom in time. Otherwise, they would have normal control. It commonly occurs with conditions such as severe arthritis, Parkinson's disease and memory loss.

Control of incontinence

- **Establish toileting schedule every two hours.** Schedule trips to bathroom 10-15 minutes before the typical time incontinence usually has occurred in the recent past. Emptying the bladder before getting the urge allows more time for the client to get to the bathroom.
- **Identify care you need to provide.** If access to the bathroom is a contributing factor, list steps you need to take to correct the situation (for example, provide the client with a urinal or commode in the room or label the bathroom door so that a confused person can identify it). The following practices are safe in most situations.
- **Encourage the use of a toilet or commode** instead of a bedpan. This allows for a more normal position and assists the body in emptying the bladder and bowel.
- **Encourage the client to wear clothing designed for easy removal.**
- **Remind in an appropriate manner.** Use words in the client's vocabulary. A memory-impaired person may remember childhood terms such as "potty." If such terms are used, be sure everyone understands this is not meant to demean the client, but rather to help.
- **Provide plenty of fluids,** unless doctor's orders say otherwise. A full bladder sends stronger messages to the brain. Also, adequate fluids dilute urine, making it less irritating to the bladder wall. Offer a glass of prune juice at bedtime if constipation is a problem.
- **Encourage complete emptying of bladder** before bedtime and immediately after getting up in the morning.

2. Incontinence Pads

Incontinence pads and briefs help manage bladder and bowel incontinence. They are very absorbent and protect clothing. There are many different types of pads and briefs on the market. If the client is unhappy with a certain type, try others before giving up. Please *do not* use the term *diaper* with adults.

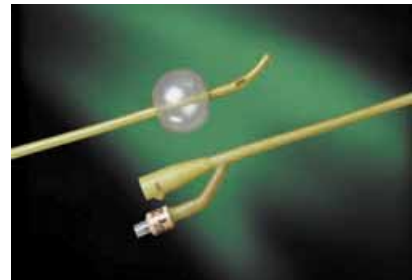


When assisting with changing a pad or brief, gather supplies (new pad, plastic bag, and cloth or disposable wipes for cleansing the skin). The DCW should put on gloves and assist in removing the old pad as necessary. Put the soiled pad into the plastic bag. Assist the person in cleansing the peri area (the skin needs to be cleansed of urinary and stool enzymes that will break down skin). Place any soiled disposable wipes in the plastic bag. Assist in applying a new pad. Peel off gloves and toss into plastic bag. Tie bag and take to outside trash. Wash hands.

3. Catheter Care

a. Indwelling catheter

An indwelling catheter, also called a *Foley catheter*, is a long tube inserted into the bladder to drain the urine. It is inserted through the urethra, the normal opening to the bladder, and remains in place with a small, inflated balloon at the tip of the catheter. It is important to reduce the risk of urinary tract infections. This is achieved by using clean techniques and correct positioning of the catheter, tubing, and drainage bags. **Routine catheter changes are done by a nurse, but it is the responsibility of the DCW to notify a supervisor/nurse of any changes in the urine or complaints of pain.**



Catheter care guidelines

- Make sure urine is allowed to flow freely. Tubing should not have kinks or have anything blocking the flow.
- **Keep the drainage bag below the level of the bladder AT ALL TIMES** including while in bed or using a walker/wheelchair. Do not attach the drainage bag to a bed rail.
- Do not set the drainage bag on the floor as this can contaminate the system.
- Coil the tubing on the bed. Keep the tubing above the drainage bag.
- Secure the catheter to the inner thigh with tape or catheter strap to reduce the friction and movement of the catheter at the insertion site.
- Check for leakage of urine and report findings to your supervisor.

- Cleanse the catheter insertion site when giving daily peri care and if needed, after bowel movements and vaginal drainage using the procedure outlined below.
- Drain the drainage bag in the morning and before bedtime and as needed (See *Emptying the catheter drainage bag* procedure on next page).
- Report any complaints of pain, burning, irritation, the feeling of a need to urinate, or any changes in urine characteristics such as color, clarity, and odor, to your supervisor.

Cleansing catheter at insertion site

- Put on gloves.
- Separate the labia (female) or retract the foreskin (male).
- Check the catheter insertion site for abnormal drainage. Holding the catheter in place with your fingers, cleanse the catheter from the urethral opening down the catheter about four inches. Use soap and water.
- Avoid tugging on the catheter as this may cause the catheter balloon to dislodge and cause pain.
- Make sure the catheter is secured properly and continue with any further peri care.
- Replace the foreskin on a male to the original position.



Never tug or pull on a catheter. Never try to insert a catheter. During a transfer, move the catheter bag first, keeping the bag below level of the person's bladder.

b. Suprapubic Catheter

An indwelling catheter is inserted through a permanent, surgical opening in the lower abdomen to the bladder to drain the urine. The catheter is then attached to a urinary drainage bag or a leg bag. The care guidelines are the same as for the care for an indwelling catheter listed above.

c. External Catheter

An external catheter, also referred to as a *buffalo, Texas, or condom catheter* is applied like a condom to the penis and then attached to a urinary drainage bag or leg bag. The tip of the penis should not rub on the interior of the catheter. The catheter needs to be changed every 24 hours and the penis washed and pat dried before applying a new catheter.



Procedure: Emptying the Catheter Drainage Bag

A person with an indwelling urinary catheter will have some type of a urinary collection device often referred to as a catheter bag. This catheter bag will have to be emptied by the client or DCW on a regular basis, with special attention to infection control practices.



Supplies

- Catheter bag (large bag that can hold 2000 cc of urine, sometimes referred to as nighttime drainage bag).
- Disposable gloves.
- Collection container (can be urinal, small pitcher or comparable device).
- Optional: Leg bag (holds 600-900cc and usually used during the day for more mobile clients).

Description of procedure

1. Explain to the person what you are going to do.
2. Wash hands, put on gloves.
3. Place the drainage container below the level of the client's bladder.
4. Unhook the tube and open the clamp **over the container** (be careful not to touch the tube on the side of the container).
5. Drain the urine into the container, close the clamp, and refasten the tube to the urine bag. Empty the contents of the container into the toilet.
6. Rinse the container and pour the rinse water into the toilet and flush.
7. Disinfect container, dry with paper towels and put away for storage.
8. Remove gloves and wash hands following proper procedure.

4. Ostomy Care

An *ostomy* is a surgical opening in the abdomen through which waste material discharges when the normal function of the bowel or bladder is lost. A *colostomy* is an opening from the large intestine (colon) to eliminate bowel movements. A *urostomy* is an opening to bypass the bladder and drains urine.

The care and management of the ostomy depends on what type it is. Typically, the person wears a plastic collection pouch. It is attached to the abdomen at all times to protect the skin and collect the output. When a new pouch is needed, the skin is cleansed with soap and water, a protective skin barrier may be applied, and a new pouch is applied. It may have to be precut to fit the *stoma* (opening). The pouch is emptied at the person's convenience. Again, how the pouch is emptied will depend on

the type of ostomy and the supplies used. Some colostomies can be controlled by irrigation (enema) and only require a small gauze pad or plastic stick-on pouch to cover the stoma between irrigations.

There are different types of ostomy supplies on the market and each individual will have individualized needs for depending on the type of ostomy, the size of the stoma and personal preference. Notify your supervisor if ostomy care is needed.

More detailed information can be found in *Colostomy Guide*, a publication of the United Ostomy Associations of America. Contact UOAA at 1-800-826-0826, or visit the website at http://www.uoaa.org/ostomy_info/pubs/uoaa_colostomy_en.pdf



Remember to wear gloves during catheter and ostomy care. Wash hands before and after removal of the gloves.

5. Use of a Bedpan

Regular, periodic elimination of body wastes is essential for maintaining good health. Clients who are confined to bed or who have limited ambulation may rely on the DCW to help them with this task. This often includes assisting the client with the proper positioning and use of a bedpan. The DCW must be aware of the emotional concerns of the client, preserving their privacy and dignity in the accomplishment of this task while maintaining good personal hygiene.



Procedure: Positioning on the Bed Pan

Supplies

- Bedpan and cover (if available).
- Basin of warm water/soap.
- Washcloth/towel.
- Paper towels/protective pad.
- Toilet tissue.
- Disposable gloves.
- Baby powder or corn starch (if available).

Description of procedure

1. Explain procedure/expectations to client.
2. Provide for client's privacy.
3. Assemble supplies, place all but protective pad on nightstand.
4. Wash hands, apply gloves.

5. Raise bed to comfortable position, lower head if elevated (if mechanical bed is used).
6. Place protective pad on bed or bedside chair.
7. Ask the individual what they need help with in removing clothing and assist as needed.
8. Fold bedcovers back, raise the client's gown, or assist with lowering pajama bottoms.
9. Sprinkle bedpan with baby powder or cornstarch for ease in sliding on and off the bedpan (prevents skin tears). Placing a paper towel in the bottom aides in emptying solid waste and cleaning the bedpan later.
10. If the client can assist:
 - Ask client to flex the knees, place the feet flat on the bed mattress.
 - Ask client to lift buttocks. The DCW may assist by putting a hand on the small of the back and lifting gently and slowly with one hand.
 - Place the protective pad on the mattress. Push bedpan downward into the pad and slide under client's buttocks.
11. If the client cannot assist
 - Roll client onto side, away from DCW.
 - Place the protective pad on the mattress. Push bedpan downward into the pad and roll the client onto the bedpan.
12. For all clients
 - Replace bedcovers and raise the head of the bed (if applicable).
 - Place toilet tissue within reach.
 - Allow person privacy. Step away from the bed and ask to be notified when through.
 - Bring tub of warm water and perineal care supplies back to bedside.
 - Lower the head of the bed and remove bedpan. Unfold bedcovers, roll client to side, pushing bedpan into the mattress and pad and holding onto the pan carefully so as not to tip or spill contents.
 - Cover the bedpan and set aside.
 - Assist with perineal care (cleaning) as needed if client is unable to do so.



- Assist client with hand washing or antiseptic cleanser, if needed.
- Replace clothing and bedcovers. Provide for safety and comfort.
- Take bedpan to bathroom. Empty contents into toilet, being careful not to splash.
- Rinse, disinfect, dry and store bedpan using proper infection control procedures.
- Remove gloves and wash hands.
- Communicate with client as to comfort, and position as needed.

Practical tips

- Narrow end of the bedpan should face the foot of the bed. Client’s buttocks should rest on the rounded shelf of the bedpan.
- Check for proper positioning to avoid spills, glance at bedpan from the top, between client’s thighs.
- Always discuss preferences with the client and how they are most comfortable.
- Remember to collect supplies in advance.
- Always maintain safety and privacy in the procedure (raise/ lower bed, put up rails).
- This is a good time to make skin assessments, looking for “hot spots.”
- Encourage the client to help as much as he/she possibly can. This helps maintain independence.
- Stay close to hear when the client is done; don’t leave him/her on the bedpan too long.
- Don’t put soiled bedpan on the night stand.
- Casual conversation makes task more pleasant for both the client and you.

Don’t forget!

- Discuss the procedure with the client. Don’t just jump in and mechanically perform.
- Don’t forget your gloves!
- Be sure to keep client covered and maintain dignity throughout procedure.
- Use good body mechanics when turning and rolling – protect your back.
- Don’t forget to help the client with personal hygiene, such as washing the client’s hands.

6. Skin Care After Toileting

Skin care after toileting assistance is extremely important. The enzymes contained in urine and fecal matter can cause skin irritation and rashes. These are similar to diaper rashes in infants. For individuals who are incontinent, a daily shower is advisable.

If the person wears incontinence pads (do not use the term *diapers* unless it is an infant), it may be necessary to apply some type of skin protectant to the buttocks and peri area.

E. ASSISTIVE DEVICES FOR BATHING

Falls in the bathroom are some of the most common household accidents. Wet, soapy tile, marble, or porcelain surfaces in your bathroom can be very slippery. A seat designed for the bath or shower and grab bars allow a person to enjoy safely bathing in comfort. Seats come in different sizes and styles. In any case, look for one that is strong, stable, and has rubber caps on the legs to prevent slipping. If a bath stool or chair is used, they should be used with a secure grab bar to allow for safe entry and exit from the tub or shower.

Bath stool

Economical and lightweight, the bath stool is suitable for a person of slight to medium build. The rubber-capped legs prevent slippage and, with no backrest, allow for easy access to a person's back. The bath stool is ideal for narrow tubs and can easily be stored when not in use. However, its small base is unstable.



Bath chair

The bath chair is good for a person with poor back strength and a bigger build (some seats can support up to 400 pounds). While stability is better with rubber-tipped legs and a wide base, the bath chair may not fit inside a narrow tub.



Transfer bench

A bench is the preferred device for getting in and out of a tub safely. As a person ages the muscles in legs get weaker so lifting the legs over and into the tub is more hazardous. With a bench the long seat remains partly inside and outside the tub. A person sits down outside the tub and then moves inside by sliding the body across the seat. The suction cups on the height adjustable legs prevent slippage. A towel placed on the bench before sitting down will aid in sliding over on the bench.

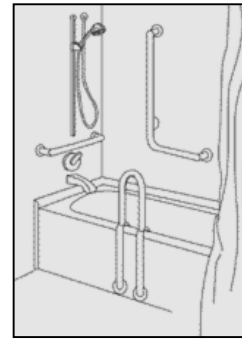


Hand-held shower heads

Standard shower heads can be replaced with a hand-held model. This shower head allows an individual to hold the water at the level needed in the shower. Look for longer hose lengths for a seated person.

Grab bars

Installing grab bars in the tub and shower can help a person get in and out more easily and reduce risk of falling. A grab bar near the toilet can give support when sitting down and standing up. If more support is needed, there are a variety of railings that can be added to the toilet itself.



For grab bars, be mindful of these points:

- The diameter of grab bars should be 1-1/4" to 1-1/2". Textured surfaces provide easy gripping.
- The space between the wall and the grab bar should be 1-1/2" to prevent the hand from being wedged between the wall and the bar.
- For proper support, grab bars must be mounted securely into wall studs or use secure anchoring devices.

Raised or elevated toilet seats



A



B



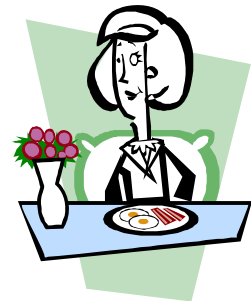
C

Raised toilet seats assist people who have difficulty getting up from the toilet. The higher the seat, the less distance you have to raise yourself. There are different types. The ones with armrests will help the person push up when standing. Some are freestanding (image B above), and some attach to the toilet (A and C). The style in image A can be tippy and requires the use of grab bars, while the other two types are more stable but can get in the way during transfers. If this is a problem, look for swing away armrests or grab bars.

When ordering a raised toilet seat, the person's body build and weight need to be carefully considered. **The person must be able to have both feet flat on the floor when sitting on the seat or it is too high.** Installing a "high boy" or "comfort height" toilet may also be another option. These toilets have a higher seat level.

F. MEAL ASSISTANCE

Direct care workers may help clients at mealtimes. Whenever possible, the person should eat with a minimum of assistance. If needed, adaptive equipment should be available to encourage self-feeding. Feed a person only if he/she is unable to do so.



1. Assisting with Setting Up a Meal

- The individual should be sitting with his/her head elevated to prevent choking.
- Cut meat, open cartons, butter bread if assistance is needed.
- Use clock description for a person with a vision impairment (e.g., meat is at 12:00; salad is at 4:00, etc.).

2. Assistance with Eating

Providing assistance with eating and/or feeding a client is a skill that many direct care workers will use on a daily basis. The purpose of this skill is to ensure that the DCW knows the correct technique for assisting with and/or feeding another individual.



Procedure: Assisting with Eating

Supplies

- Spoon and/or fork, napkin, bowl or plate, clothing protector, cup.
- Food items.

Description of procedure

1. Maintain dignity and safety of client at all times.
2. Check care plan or with supervisor to determine if choking hazard exists.
3. Ensure that you cut up meat, open cartons, butter bread, etc. *if* that type of assistance is needed.
4. Sit next to the individual at eye level.
5. Ensure that the individual is sitting with his/her head elevated to prevent choking.
6. Provide **ONLY** the amount of assistance that is necessary (graduated guidance, hand over hand, etc). **Encourage the client to be as independent as possible.**
7. Check the temperature of food before you begin. Feel the container, observe for steam, to ensure the food is at an acceptable temperature.
8. Explain what foods are on the plate. For someone with a visual impairment, use the clock description method (e.g., “Your meat is at 12:00, vegetables are at 3:00”, etc.).

9. Ask the individual what he/she wants to eat first.
10. Watch the individual to make sure the food is swallowed before giving more food or fluids. Remind the individual to chew and swallow as necessary.
11. Offer liquids at regular intervals.
12. Engage the client in pleasant conversation while completing this task, but don't ask questions that take too long to answer.
13. Do not rush the individual.
14. Once the meal is complete, ensure that you help the individual in wiping his/her face and washing hands as necessary.

Practical tips

- Be aware of how the individual may be feeling in regards to needing assistance. Ensure dignity and respect by allowing clients to make their own food choices, giving options and respecting preferences.
- Be aware of any issues causing the individual to tire or get frustrated easily.
- Pay special attention to individuals who may present a choking hazard.
- Ensure that you are communicating with the individual about the pace in which you are feeding or assisting him/her with eating.

Don't forget!

- Don't do everything for the client just because it is faster for you. Only provide the assistance that is truly needed.
- Don't assume the individual likes every item that has been served.
- Don't treat the client like a child. For example, do not wipe client's mouth with the spoon.
- Serve food in proper consistency to avoid choking.

3. Feeding an Individual who has Difficulty Swallowing

- Position the person upright in a chair to prevent choking or aspiration (inhaling liquids).
- Keep the client oriented and focused on eating.
- Help him/her control chewing and swallowing by choosing the right foods (a diet containing foods with thick consistency, which are easier to swallow) such as:
 - Soft-cooked eggs, mashed potatoes and creamed cereals.
 - Thickened liquids are often used.

- Offer a variety of textures and temperatures of foods as this stimulates swallowing.
- Difficulty swallowing may only be temporary and will improve after recovery from illness.

4. Feeding an Individual with a Cognitive Disability

- Avoid changes. Seat the person at the same place for all meals.
- Avoid excessive stimulation. Too much activity and noise often adds to confusion and anxiety. Remove distractions, if possible, and gently refocus the person.
- Meals should be ready to eat when the person is seated (e.g., meat is cut, bread is buttered, etc.).
- Avoid isolating the person. Isolation leads to more confusion.
- Call a client by a name he/she prefers. Achieve and maintain eye contact.
- Use a calm voice, speak softly, slowly, clearly and face the person.
- Keep communication simple. Use simple, short instructions such as “pick up your fork,” “put food on your fork,” “put the fork in your mouth.”
- Use objects or hand movements to help with cueing.

5. Encouraging Appetite: Appeal to All the Senses

- Pay attention to the presentation of food. Try to not let foods on the plate run together.
- Set the table with a tablecloth and/or placemats. Use nice plates, flatware and possibly flowers.



Right Way



Wrong Way

- Play soft music.
- Have a meal with a theme such as South of the Border or Italian, with the appropriate food and music.

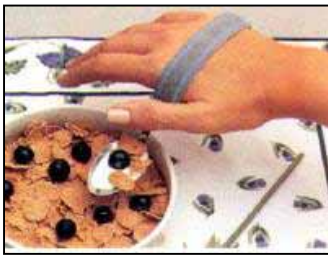
- Keep the table conversation positive and pleasant. Never say such things as, “If you don’t eat, you won’t get dessert!”
- Make sure eyeglasses are on and clean (increases visual appeal).
- May need to increase spices to make food more appetizing.

6. Assistive Devices for Eating

Encouraging a person to eat as independently as possible encourages a person’s self sufficiency, self-esteem and can save time. Sometimes, a client may need to be fed or guided through a meal. The following are general considerations:

- Provide adaptive devices, such as a rocker knife which allows one-handed cutting.
- Provide foods that do not require use of utensils (e.g., finger foods, soup in a cup).
- Build up handles on utensils to make them easier to grasp.
- Use contrasting colors in place setting.
- Be consistent in placing food on a plate and on the table in specific order (for example, potatoes are at the 3:00 position, meat is at 9:00 for visually impaired persons).

Examples of Assistive Devices for Eating



Eating utensil with elastic strap – For limited gripping ability



Offset spoon and rocker knife - For limited hand grasp and one-handed cutting



Scoop dish – Higher and curved side keeps food from falling off the edge of the plate

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 5 – TRANSFERS AND POSITIONING

CONTENTS

- A. Principles of Body Mechanics for Back Safety
- B. Transferring
 - 1. Basic Principles
 - 2. Gait Belt
 - 3. Transferring Out of Bed to a Standing Position
 - 4. Transfer from Wheelchair to Chair
 - 5. Mechanical Lift
 - 6. Transfer or Slide Board
- C. Ambulation (Walking)
- D. Turning and Positioning
 - 1. Preventing Pressure Sores
 - 2. Preventing Contractures
 - 3. Positioning in Bed
 - 4. Positioning in Wheelchair or Chair
 - 5. Range of Motion (ROM) Exercises
- E. Assistive Devices
 - 1. Canes
 - 2. Walkers
 - 3. Wheelchairs

OBJECTIVES

1. Identify and demonstrate good body mechanics related to transferring and walking with an individual.
2. Explain the importance of repositioning and list techniques for preventing skin damage and pressure ulcers.
3. Describe common assistive devices and techniques for using them safely.
4. Demonstrate the safe use of selected assistive devices.

SKILLS

- Assistance with ambulation
- Application and use of gait belt
- Technique for positioning a person in bed
- Technique for positioning a person in a wheelchair
- Transfer from chair to wheelchair
- Transfer out of bed

KEY TERMS

Ambulation	Mechanical Lift
Body mechanics	Range of motion (ROM) exercises
Center of gravity	Transfer
Contractures	Transfer board
Gait belt (transfer belt)	Walker
Leverage	Wheelchair



REMEMBER! Safe transfers and following proper procedures will protect your health and safety and the people you care for. Assistive devices and equipment can help with ADLs but they need to be used correctly. If you do not use equipment correctly, you and the person you care for may be at risk. This chapter covers proper procedures for transfers and positioning and use of assistive devices and equipment. However, there are many different types of equipment being used by our clients.

A. PRINCIPLES OF BODY MECHANICS FOR BACK SAFETY

Using correct body mechanics is an important part of a DCW's job because:

- The individual with a disability depends on the DCW for hands-on assistance. If the DCW does not take care of his/her back with correct body mechanics, the DCW will not be able to provide that assistance.
- Not using correct body mechanics puts the safety of the client and DCW at risk.
- Some injuries cause permanent disabilities.

Just as lifting, pushing, and pulling loads can damage your back, so can bending or reaching while working in an individual's home. As a DCW, you may have witnessed firsthand the pain and misery a back injury can cause. The good news is that you can learn some simple ways to reduce the risk of injury.

Body mechanics principles

- **Proper footwear:** DCWs should always wear proper footwear. Wear closed, non-slip shoes.
- **Center of gravity over base of support:** Be aware of center of gravity over base of support in working with a client. Usually a person's center of gravity is right behind a person's navel (belly button). A good base of support is being in a standing position where the feet are slightly apart and knees slightly bent.
- **Principles of body leverage:** Using leg and arm muscles is important, as is applying body leverage. Mirror posture of the client. Use body as a whole and not just one part.



Call your supervisor to get more training or clarification on any transfer skill or use of equipment.

B. TRANSFERRING

1. Basic Principles

A move as basic as getting in and out of a chair can be difficult for an individual with a disability, depending on his/her age, flexibility, and strength. Techniques for assisting an individual with transfers can vary. Some persons require a high level of assistance (maximum assist). The DCW will have to use assistive devices, such as a gait belt or a mechanical lift. Other persons will need less assistance (minimum assist), making the devices optional. The height and stability of the chair or other sitting surface also plays a role in the successful transfer. A slightly raised seat is preferable to one that is low or deep. A chair that has armrests is also preferable.

Levels of assistance in transfers

- **Maximum assist**
 - Mechanical lift.
 - Gait belt with person who is 50% or less weight bearing.
- **Moderate assist**
 - Gait belt with person who is 50% or more weight bearing.
 - Verbal cues with moderate physical assist.
- **Minimum assist**
 - Gait belt optional.
 - Hands on with person who is 85 - 90% weight bearing.
 - Verbally and physically guiding the client.
 - Stand by assist (this is to ensure safety).

General guidelines for assistance with transfers

While procedures can vary for certain kinds of transfers, there are general guidelines that apply when assisting with any transfer:

- Explain each step of the transfer and allow the person to complete it slowly.
- Verbally instruct the client on the sequence of the transfer (“Move to the front of the chair,” etc.).
- When assisting in the transfer of a person **do not** grab, pull or lift by the person’s arm joints (elbows, shoulders, wrists) as this can cause a joint injury.
- **Know your limits!** Don’t transfer anyone heavier than what you can handle.
- If the person is unable to stand or is too weak to stand, the DCW should use a mechanical lift for transfers. If this is not in the service plan or you do not know how to use a mechanical lift, ask your supervisor for instructions on what to do.

! At no time should the client put her or his hands around the DCW's neck during a transfer.

2. Gait Belt

A *gait belt*, sometimes called transfer belt, provides the DCW with secure points to hold onto while assisting clients in walking and transfer activities.

Before using, ensure the client can safely wear a gait belt. You may not be able to use one if the person:

- Has had recent surgery or incisions (within the last 6-8 weeks) in the abdominal and back areas.
- Has an ostomy (for example, a colostomy), G-tube, hernias, severe COPD, post-surgical incisions, monitoring equipment, tubes or lines that could be interfered with by the pressure.
- Is pregnant. Applying a gait belt to a pregnant woman could cause injury to the unborn child.

If it is determined the client cannot safely use a gait belt, the DCW should contact the supervisor for instruction on agency specific policy and procedures.



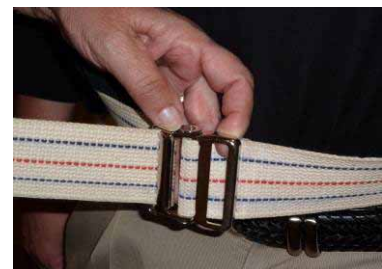
Procedure: Use of Gait Belt

Supplies

Gait belt (with metal teeth or quick release buckle)

Description of procedure

1. Tell the person what you are going to do.
2. Position the person to make application of the belt easier. The person needs to move forward and sit on the edge of the chair.
3. Place the gait belt around the client's waist, above the pelvic bone and below the rib cage. Always place the gait belt on top of clothing, and for females make sure breast tissue is above the belt.
4. Pass the metal tip of the belt end through the teeth of the buckle first and then through the other side of the buckle.
5. Adjust it so it is snug, but not uncomfortable for the client. You should be able to slip your open flat hand between the belt and the client.



6. Tuck the excess end of the belt through the waist band.
7. The strap should lay flat across the buckle.
8. ALWAYS verify proper closure before use.
9. ALWAYS grasp the transfer belt from underneath.
10. Remove the gait belt when not in use, or loosen it.



Practical tips

- It is important that you ask permission before applying a gait belt because you are about to invade the client's personal space. Maintain client's rights by informing him/her of all procedures prior to actions.
- Gait belts come in various lengths. Use an appropriate size for the client.
- Belts with padded handles are easier to grip and increase security and control.
- Use a rocking and pulling motion rather than lifting when using a belt.
- DCW should walk slightly behind the client with a hand under the bottom of the belt.
- On some gait belts, the seam and label will be on the outside, on other belts it is on the inside. Don't assume that the manufacturer's label is on the inside. Start by putting the end of the belt through the teeth first.

Don't forget!

- Apply gait belt over clothing, NEVER apply to bare skin.
- Check female clients to make sure no breast tissue is caught in belt.
- Use good body mechanics when transferring a client with a gait belt.



3. Procedure: Transferring Out of Bed to Standing Position

Supplies

Non-slip shoes/socks.

Description of procedure

- a. Tell the client what you are planning to do.
- b. If the person is in an hospital bed:
 - Raise the head of the bed.
 - Assist in having the person extend his/her legs over the edge of the bed.
 - Support the person's back and shoulders (not the neck) if needed, and help him/her to a sitting position.
- c. If the person is in a standard bed:
 - Have the client roll onto his/her side, facing you, elbows bent, knees flexed.
 - Assist in having the person extend his/her legs over the edge of the bed.
 - Instruct client to use his/her forearm to raise up and the opposite hand to push up to a sitting position while you support the back and shoulders (**not the neck**), if needed.
 - You may also need to place your arm under the person's knees and help him/her to a sitting position.
- d. Allow client to sit on the edge of the bed for a minute or two, to regain sense of balance. Make sure the person does not slip off the edge of the bed.
- e. Assist with putting on non-skid footwear (sneakers, slippers, tread socks are good choices).
- f. If bed was raised or lowered, make sure to adjust to a height in which the client's feet can touch the floor comfortably.
- g. Instruct client to place feet flat on the floor.
- h. Ensure the client is oriented and stable before assisting to stand.
- i. Keep one hand on the client's elbow and the other behind the client's back when standing.



Practical tips

- Be sure to have supplies ready. Do not leave client on the edge of the bed while you go find slippers or a robe.
- Remember to support limbs and back during procedure.

- **BE OBSERVANT!** It is common for the blood pressure to drop when going from a prone to a sitting position, causing light-headedness or dizziness. Watch the client for changes in condition, such as color changes, respiratory changes, and other signs of distress.
- Use good body mechanics when turning a rolling, moving, and standing. Protect your back.
- Encourage the client to help as much as he/she possibly can. This helps maintain independence.

Don't forget!

- Don't forget to lower the bed if a mechanical bed is being used.
- Do not pull client by arms, hands, wrists, etc. Support back and knees to prevent injury.
- Do not let the client place his hands or arms around your neck while you assist.



4. Procedure: Transfer from Wheelchair to Chair

A move as basic as getting in and out of a chair can be difficult for an individual with a disability. Techniques for assisting an individual with transfers can vary from minimum assist to maximum assist. While procedures can vary for certain kinds of transfers, there are general guidelines that apply when assisting with any transfer.

Supplies

- Wheelchair, chair.
- Gait belt.

Description of procedure

Person is 50% or more weight bearing (moderate assist).

1. Ensure the client can safely wear a gait belt (refer to Section B.2, Gait Belt).
2. Explain the gait belt procedure to the client.
3. Ask the client's permission to use the gait belt. Explain that the belt is a safety device and will be removed as soon as the transfer is complete.
4. Tell the client what you are going to do.
5. Lock the wheels of wheelchair.
6. Put the footrest in the up position and swing the footrest to the side or remove.
7. Take off the armrest closest to the chair (or drop armrest, if possible).
8. Place chair at a 45-degree angle to the wheelchair.

9. Have the client move to the front of wheelchair seat.
10. Use gait belt secured around client's waist to assist him/her out of the wheelchair
11. Foot placement (depending on the client's disability or preference):
 - Place both of your feet in front of the client's feet with your toes pointed outward.
 - Place one foot slightly in front of the other one. The foot in front will be placed between the client's feet.



12. Have the client either hold onto your shoulders or waist, **not around your neck!**
13. Grasp the gait belt on both sides with fingers under belt.
14. Bend at knees and hips. Using body leverage lift with legs, not back.
15. Assist the client to a standing position, mirroring posture of person.
16. Have the client stand for a minute, shifting weight from one foot to other.
17. Pick up your feet and move them facing the chair as the client takes baby steps to a standing position in front of chair.
18. Ask the client if he/she feels the chair seat on the back of his/her legs.
19. Have the client put his/her hands on the armrests.
20. Assist the client to a seated position, mirroring the client's posture.

Practical tips

- The DCW should always wear the proper footwear (closed, non-slip, flat shoe).
- Use smooth fluid motions.
- Don't rush the transfer procedure.

- Don't transfer a person who is too heavy for this type of body transfer. Ask your supervisor for further training.

Don't forget!

- Keep body in proper alignment and use proper body mechanics.
- Move feet with the pivot, do not twist.
- Be sure to use the gait belt properly.



At no time should the client put her or his hands around the DCW's neck during a transfer.

5. Mechanical Lift

A *mechanical lift* is used to transfer a person from a bed to a wheelchair, a wheelchair to a couch, etc., and **not** to transport from one room to another. There are different models. You will probably learn to operate one type of lift in this class. When you work with a client who uses a mechanical lift, be sure to practice using it. If it is a different model, ask for instructions. **Never** operate any device that you have not been trained to use.

Parts of the mechanical lift

- Spreader bars.
- Steering handles.
- Caster wheels.
- Hydraulic sleeve.
- Boom.
- Cradle.
- Valve or Pin stop.
- Sling types:
 - Canvas/mesh.
 - One piece.
 - Commode cut out.
 - Split or U shape.



There are many different lifts and slings. Be sure to get instructions before using *any* lift.



Procedure: Use of Mechanical Lift

- a. Examine the mechanical lift to make sure the lift is in proper working condition.
- b. Tell the person step-by-step what is going to be done.
- c. Have the bed flat when transferring a person.
- d. Roll the person onto his/her side, away from you, and place the smooth side of the sling touching the person. Then roll the person back toward you onto his/her back. The sling is now under the person. Be sure to use correct body mechanics when rolling the person.
- e. Move the lift into position. Use the spreader bar handle to open the spreader bars to give a wider base of support when rolling the lift with the person in the sling.
- f. If using a sling with chains, insert chain hooks from inside the sling to outside so the hooks will not scratch the person.
- g. If using a sling with color coded straps, attach to cradle so that strap color used is the same on each side of the cradle, e.g., purple on each side.
- h. Secure the person's arms inside the sling. If the person cannot do this alone, this can be done by rolling the bottom of the person's T-shirt over the person's arm or using a hand towel wrapped around the person's arm like a muff.
- i. Pump the handle until person is raised just free of the bed. Rotate the client to face the hydraulic sleeve with feet straddling the sleeve.
- j. Use the steering handle to pull the lift from the bed and maneuver to a chair or wheelchair. Slowly release the valve and lower the person while putting your hand on the person's knee and gently move the person so the person is touching the back of the chair. This step will help the client to have correct placement in the chair.
- k. Check to see if the person is positioned correctly in the chair. Unhook the chains or straps and move the lift out of the way. Leave the sling under the person unless directed differently.



Transition from Body Transfer to Hoyer Lift

I have been providing care to my Mom for the last twelve years. I love my Mom and I want to be there for her as she was always there for me. Mom is in her mid eighties and she is still spry and takes a lot of pride to be independent. Mom at first only needed some assistance in getting up. Then, she needed to use a walker. She was able to maneuver around pretty good. As time went by, Mom needed to use a wheel chair. I never really noticed the additional hands-on I was doing. As time went on, my body started to feel the aches and pains from the transfers. I talked to my supervisor and she set up a home visit. We both agreed that having a Hoyer Lift would keep me from further stress on my body and also keep my Mom safe in doing transfers. I have to say the first time I thought about using a Hoyer Lift, I felt it was quite intimidating. Both my Mom and I experienced some grieving going on because it was another challenge we needed to face. My Mom's physical independence was slowly being taken away. Both Mom and I talked about our feelings on this transition. I am blessed that my Mom understands the importance of me taking care of myself. She understood what would happen to us if I injured myself. We are a team, and a team we will continue to be.



6. Transfer or Slide Board

A *transfer board*, or slide board, is made out of plastic or wood and can be used to transfer from surfaces equal in height such as from a wheelchair to a commode or a car seat. It is particularly useful for individuals who are unable to stand but have upper extremity strength. There are many types of transfer boards. The one to use will depend on the person's weight and functional ability.



To use, the person will shift his/her weight to one side and the person or the DCW will place one end of the board under the person's hip and thigh. The other end is placed on the surface being transferred to. The person will pull himself/herself over the board until situated on the other surface. Then the person shifts his/her weight again and the board can be pulled out.

C. AMBULATION (WALKING)

Ambulation simply means to walk or move from one place to another. Every client will be different in his or her level of need for assistance, and it will differ in how you help each one. We have heard the old saying that there are no two people alike. There are also no two disabilities that are alike. The question becomes how do we do this when the individual we are assisting cannot do it on his/her own?

There are several benefits to ambulation, some of which include:

- Relieves stress and anxiety.
- Improves and/or maintains muscle strength.
- Improves circulation.
- Decreases problems with digestion and elimination.
- Improves appetite.



Procedure: Assistance with Ambulation

Supplies

- Gait belt and/or other walking aids, like a cane or a walker.
- Non-slip, properly fitting footwear.

Description of procedure

1. Before you begin, familiarize yourself with the expectations and requirements of the service plan. Contact your supervisor if you need clarification.
2. Ensure the client can safely wear a gait belt. See Section B.2, Gait Belt for procedure and contraindications.
3. Communicate procedure to client before you begin.
4. Apply non-skid, properly fitting footwear.
5. Have the client's walking aid available, if required.
6. Apply gait belt (see Section B.2, Gait Belt).
7. Make sure that the client has his/her feet firmly on the floor.
8. Use an underhand grasp on the gait belt for greater safety.
9. Assist client to a standing position as described in previous skills.



10. Walk behind and to one side of the client during ambulation. Hold on to the belt from directly behind him. Be aware to support weaker side, if applicable.
 - Right side: Stand between the 4 and 5 o'clock positions.
 - Left side: Stand between the 7 and 8 o'clock positions.
11. Let the client set the pace. Walk in step with the client, maintaining a firm grasp on gait belt.
12. Watch for signs of fatigue.



Ambulation with a cane

The handle of the cane should be at a height that would be equivalent to where the client's wrist of his strong hand would fall if his/her hand was placed at his/her side when standing in an upright position. The client should be using the cane on his/her strong side, and the DCW should be walking on the client's weak side for assistance.

Ambulation with a walker

The correct walker height is determined the same way as was listed for a cane. When assisting a client with ambulation when using a walker, it is important that the client stay inside the frame of the walker. Make sure it has been properly fitted for the individual. The DCW should always walk on the client's weak side to provide additional support as needed.



Note: In the instance a client does collapse or loses his/her footing, it is acceptable to ease the person gently to the floor. The DCW should not try to carry the person, hold him up or catch him if he starts to fall.

Practical tips

- Communicate expectations with the client at all times.
- Encourage the client to assist as much as possible.
- Be aware of, and remove, tripping hazards: electrical cords, throw rugs, clutter, etc.
- Make sure that you are standing on the person's weak side, if applicable.
- Be observant. The client may tire easily and can only handle short walks.
- Ensure assistive devices fit properly. Notify your supervisor with concerns.
- The tips on the canes wear out over time and it may be necessary to replace them periodically.
- Don't rush the client to meet your schedule.

Don't forget!

- Keep a firm grasp on gait belt **at all times**.
- Don't assume that once the client is up and moving, he/she will continue to be stable. Always be prepared for a fall.

D. TURNING AND POSITIONING

Some individuals spend many hours in bed or in a chair or wheelchair. Some people can shift or turn on their own, but others will need assistance. The DCW is responsible for reminding the individual to change position regularly and to provide assistance when needed. This will help prevent skin breakdown and muscle stiffness. Some people may need assistance with repositioning or exercises to prevent contractures. After turning or after a transfer, it is important to ensure proper positioning for the individual.

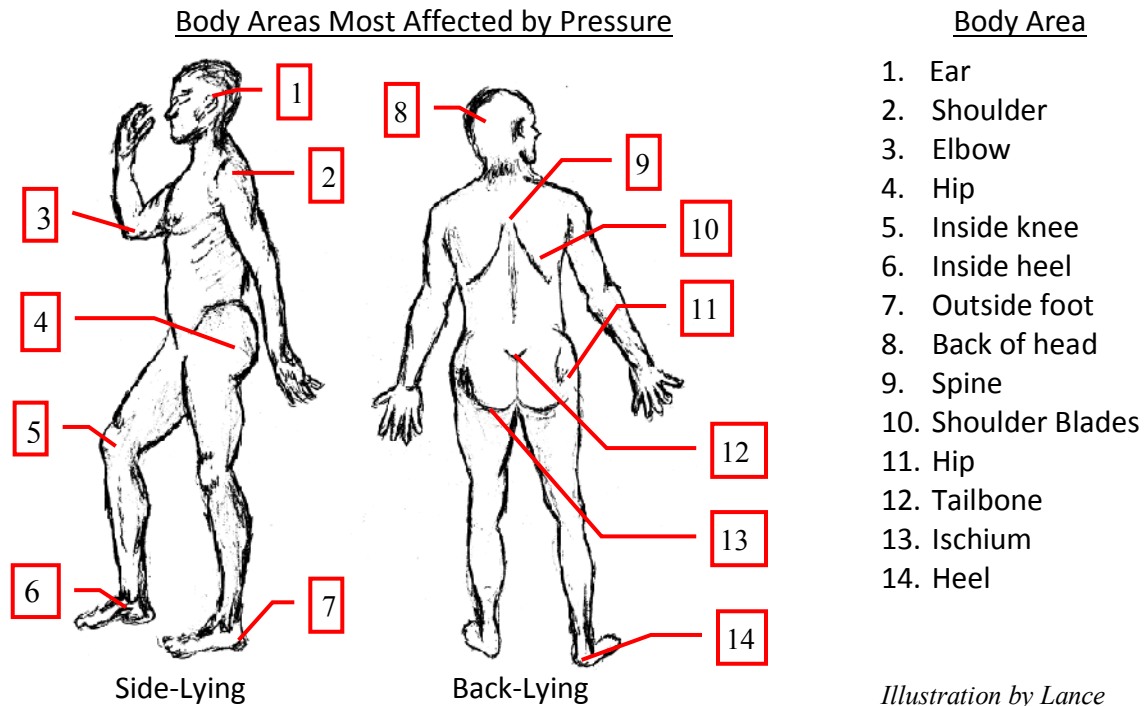
1. Preventing Pressure Ulcers

A person sitting a long time may slide down in the chair. The DCW needs to assist the individual with repositioning. If the person is sitting in a wheelchair, make sure the wheels are locked before repositioning the individual. Even with a good sitting position, the person should be encouraged to shift weight frequently. This will help prevent soreness and pressure ulcers on the skin. Also encourage the use of pressure relieving cushions made specifically for wheelchairs (no pillows or plastic donuts).

When a person remains in bed for a long time, it is also important to turn and shift weight. Some individuals just need to be reminded; others need assistance. The person can alternate positions from being on the back (supine) to the side (lateral) or face down (prone).

A client who cannot change positions on his/her own must have the **DCW change his/her position** in bed **at least every two hours**.

For further information, see Section B, Skin Care, under Chapter 4, Personal Care in this course training manual.



2. Preventing Contractures

A contracture is a stiffening of a muscle due to immobilization. Following a stroke or other injury, muscles can remain inactive for long periods of time. During this period of time, the muscle atrophies (gets smaller and shorter), sometimes to the point that it can no longer be used. Contractures can form in the hands, fingers, arms, hips, knees and calves, as well as other areas of the body.

When a person with a disability is sitting, make sure he/she is sitting upright to prevent contractures from forming in the chest muscles and the front of the shoulders. Make sure that both feet are flat on the floor, and encourage the person to keep palms open and down in a relaxed manner, possibly against a table or armrest. This will prevent contractures from developing in the hand. For example, after a brain injury putting a rolled washcloth in the person's hand may help prevent hand contractures, and will also help with hygiene tasks.

Once a contracture has developed, it can be difficult and painful to treat. It severely restricts a person's movement and independence. DCWs can help prevent contractures through proper positioning, exercise and equipment.

3. Positioning In Bed

Proper alignment of a client while in bed can be essential to the client's comfort and proper rest. The DCW must conscientiously assist in maintaining good body alignment, proactively address pressure points, and be alert to supporting the natural curves of

the body. These curves need to be supported to prevent undesired pressure that may lead to uncomfortable areas or pressure ulcers.

Proper positioning:

- Helps the client feel more comfortable.
- Relieves strain.
- Helps the body function more efficiently.
- Prevents complications with skin breakdown and pressure ulcers.



Procedure: Positioning in Bed

Supplies

Blankets, pillows of assorted sizes.

Description of procedure

1. Provide for client's privacy.
2. Communicate expectation/procedure to client (how is the client most comfortable, are there any pressure concerns, ask about personal preferences).
3. Raise bed to comfortable position, lower side rail (if mechanical bed is available).
4. Roll client to a new preferred comfortable position (support upper torso and head).
 - Supine: flat on the back.
 - Fowler's: on the back with head raised slightly.
 - Lateral: on either side (but not resting directly on hip).
 - Prone: on the stomach.
5. Place pillows or soft rolled towels under such areas as:
 - The client's head, shoulders, the small of the back.
 - The arms and elbows.
 - The client's thighs (tucked under to prevent external hip rotation).
 - The ankles, calves and knees, to raise the heels off the bed. Do not just raise the ankles without supporting the knees and calves.
6. The knees may be flexed and supported with a small pillow or blanket roll.
7. A small pillow or roll may be added at the feet to prevent foot drop.

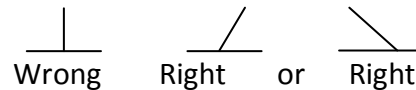
Positioning in Bed



Supine Position, on the back, with pillows used for support; heels off the bed. Note pillow under head is placed under shoulders, and under ankles, calves and knees.



Lateral Position, on the side, with pillows used for support-- person should not be placed at 90 degree angle (hip to bed) but rather slightly side lying either to front or to back



4. Positioning in Wheelchair or Chair

When a person with a disability is sitting in a wheelchair or chair, make sure she/he is sitting upright to prevent the risk of contractures and pressure ulcers. A proper sitting position places the person in good, comfortable alignment. Good alignment involves head, shoulders, and hips squarely over the axle of the wheel.

Try this before doing the procedure: Slouch in a chair. Then try to reposition to the back of the chair without using hands. You will find yourself automatically rolling back and forth, shifting one leg, then the other. This motion of backing up in a chair (first one side, then the other) is used in this technique of repositioning.



Procedure: Positioning in Wheelchair/Chair

Description of procedure

1. Explain to the client what steps you are going to do to reposition him/her.
2. Have wheelchair locked with caster wheels in forward position This can be accomplished by moving the wheelchair backwards. The front caster wheels swivel forward, which gives the wheelchair a better base of support.
3. Swing foot rest to side, or remove if possible.



Incorrect *Correct*
Position for Front Wheels

4. Stand in front of the person with the left leg of the person between your legs.
5. Have the client lean forward with the person putting his/her head above *your* left hip. This places most of the person's weight on his/her right buttock side. Your left arm should come across the person's back to provide stability.
6. Place your right arm under the thigh of the person's left leg while placing slight pressure against the person's left knee with your knee. It is best to use the wide area above your knee to press against the client's knee.
7. With a fluid motion, use your entire body to gently push the person toward the back part of the wheelchair.
8. Let the client sit up and then repeat the same procedure for the person's other side.
9. You might need to do this several times (both left side and right side) for the correct alignment of the client in the wheelchair.



Practical tips

- Always explain to the person what is being done.
- Make sure wheels are locked.
- Make sure the person's weight is on the side *opposite* the side that is to be re-positioned.
- Use your entire body when positioning.

Don't forget!

- Always use proper body mechanics. Poor body mechanics can injure both you and the client.
- Do not rush the procedure. You may need to do this procedure a couple of times to get the client all the way back in the chair.
- DO NOT lift client over the back of the handles of the wheelchair.

Note: If doing this procedure with someone in a chair, make sure the back of the chair is secured so that the chair does not move when repositioning the client. Then follow steps 4 through 8 above.

5. Range of Motion (ROM) Exercises

Range of motion exercises are the best defense against the formation of contractures. A physical therapist, home health nurse or other health care professional should recommend helpful ROM exercises for an individual with disabilities to do at home. These exercises will concentrate on the joints. Each motion should be repeated, slowly and gently, and never beyond the point of pain. **Never exercise a joint that is swollen or red.**

Some individuals will be able to do ROM exercises independently with nothing more than encouragement and direction. Some will need assistance, possibly helping them to lift, stretch and move limbs and joints, or being physically cued on how to perform the exercise. Others who are very limited physically may be dependent on the DCW to actually move them through the exercises. Regardless of how much assistance is required, the person will benefit from the movement by allowing them to maintain more range of motion.

- *Active* ROM exercises are done by the person.
- *Passive* ROM exercises are done by the caregiver.



Refer to the service plan or ask your supervisor for instructions before assisting with any exercises.

This website from the University of Washington School of Medicine has additional information about range of motion exercises:

http://www.orthop.washington.edu/uw/livingwith/tabID_3376/ItemID_83/PageID_87/Articles/Default.aspx

E. ASSISTIVE DEVICES

1. Canes

As people grow older, important daily activities like walking, dressing, bathing, and eating may become increasingly difficult to manage. Many older people depend on assistive devices to help carry out these activities.

In choosing a cane, metal is preferred over a wooden cane since wood can splinter or crack. The handle of the cane should be as high as the wrist of the hand opposite the person's weak side. While standing and holding the handle of the cane, the elbow should be at a 20 to 30 degree angle. The quad cane, so named because it has four feet, adds more stability to a cane to help the user maintain balance and equilibrium while walking. Tips on the end of cane legs provide traction and absorb shock, thereby cushioning the hand. A convenient option is a wrist strap attached to the handle of a cane allowing the hand to be free without having to set down the cane. It also prevents a person from dropping the cane.

Important considerations for effective cane use

- A person should not use a cane on stairs without using a handrail or the support of another person on the opposite side. Most quad canes and other wide base canes are not safe for use on stairs.
- Because they slip easily, a person should not, in general, use canes on snowy or icy surfaces. However, metal or rubber tips that grip the ice may give more protection against slipping and falling.
- Make sure the cane tips are not worn down. Replacement cane tips are readily available in larger drug stores.

2. Walkers

Walkers rank second behind canes in amount of users, numbering almost two million people in the U.S. Since their introduction over two hundred years ago, walkers have changed greatly. Able to support up to 50% of a person's weight, walkers are more stable than canes. Walkers are helpful for people with arthritis, weak knees or ankles, or balance problems.

The most basic walker design, the standard walker, is the type most often used in therapy. To operate, a person lifts the walker, moves it forward, and puts it back down with each step. Because they require lifting, extended use may cause strain on the wrists, shoulders, and arms.

Important considerations for effective walker use

- A professional, such as a physician or physical therapist, should help choose or prescribe a walker, and then demonstrate how to walk correctly with it.

- Walker height is best when the arm bends at the elbow in a 20 to 30 degree angle. This is achieved by having the top of the handle of the walker at the same height as the bend of the person's wrist.
- To prevent tripping or falling, the person should:
 - Always look ahead, not at the feet.
 - Walk inside the walker. Avoid pushing the walker too far ahead, as if it were a shopping cart.
 - Use walkers only in well-lit areas. Cluttered and crowded areas, throw rugs, and wires running across the floor should be avoided.
 - Wear appropriate footwear. Properly fitting shoes with rubber soles are best. Loose fitting footwear such as slippers, or slippery-soled shoes should be avoided.
 - Avoid using the walker on stairs.

Small rooms, such as bathrooms, may prevent safe walker use. One solution is to install grab bars. If using a wheeled walker, a person may also reverse the wheels so that the wheels are on the inside of the walker, thereby saving 2-3 inches of space. If getting through a narrow doorway is an issue, the person might install swing-away or expandable door hinges that swing the bathroom door out of the doorway.

Types of Walkers



A. Standard



B. Wheeled



C. Rolling

Unlike the standard walker (image A above), the user merely pushes the two-wheeled walker (B) forward. No lifting is necessary, so the walking style is more natural. Some have auto-glide features that allow the rear legs to skim the surface. Another option may be to insert tennis balls on the bottom of the legs to allow them to glide easier.

Three or four-wheeled rolling walkers (C) require less energy and strength to use. Gliding over carpets and thresholds is easier, and they may provide better performance in turning. Three and four-wheeled walkers often have hand brakes. Wheel size and walker weight vary greatly in different models of wheeled walkers. All are heavier than standard walkers. Because many wheeled walkers do not fold, they may be more difficult to transport. They move easily in all directions, so caution must be used to not let the walker inadvertently roll away while trying to sit on the bench seat. Make sure the person is instructed to set the hand brake before sitting down.

3. Wheelchairs

Today, more older Americans use wheelchairs than any other age group. Unfortunately, many people are not aware of the wide variety of wheelchairs to fit different needs and only know about the standard, heavy-duty wheelchair. Many people pick up wheelchairs from garage sales, or receive them as gifts from well-meaning friends. This may result in a poor fit between the user and the wheelchair, which can cause skin problems. It is important to consult with an expert before selecting a wheelchair. People often use wheelchairs for extended periods a day, so it is important that the wheelchair be comfortable.



The most frequently prescribed wheelchair is the standard wheelchair. Standard chairs are heavy, usually weighing over forty pounds. People who need to transport or store their wheelchairs might prefer lightweight wheelchairs. These lightweight chairs are much lighter than the typical standard chair and require less strength and energy to move.

Power or electric wheelchairs are powered by batteries and require much less physical strength to move than standard (manual) chairs. They provide independence for people who are unable to propel themselves in manual chairs. Since these wheelchairs have to carry heavy batteries and power systems, the frames are generally sturdier than manual chair frames. Because of the extra equipment, power chairs may be a bit wider, are very heavy and do not fold. Most power chairs will require a van with a special lift for transportation. The wheelchair supplier should explain how and when to charge the batteries. With regular use, a battery should last a minimum of one year before replacement may be necessary. Wheelchair batteries differ from car batteries, and should be bought only from a wheelchair supplier.

Scooters are also powered by batteries and resemble a horizontal platform with three wheels and a chair. Scooters are useful for people who can walk short distances but need help for long distances. Some scooters can be taken apart easily for transportation in the trunk of a vehicle.

Wheelchair accessories

Check with companies that sell wheelchairs for these and other accessories.

- Safety flags are available to make the person and the person's wheelchair more visible to drivers, should it be used while crossing streets.
- Lights can also be added for extra safety, especially for night use.
- Bumpers, footrest pads, and sun canopies are also available.

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 6 – SEXUALITY AND DISABILITY

CONTENTS

- A. Basic Principles
- B. Sexuality and Aging
- C. Sexuality and Disabilities

OBJECTIVES

1. Describe sexuality issues related to aging and physical disabilities.

KEY TERMS

Commitment

Sexuality

Erectile dysfunction

Social policy

Impotence

Value-laden

A. BASIC PRINCIPLES

A person's sexuality involves the total sense of self as male or female, man or woman, as well as perceptions of what it is for others to be female or male. It includes attitudes about one's body and others' bodies. Sexuality is emotional, physical, cognitive, value-laden, and spiritual.



A distinction should be made at the outset between sex and sexuality. Sex refers to the physical act of making love, to genital expression. Sex is, in fact, only a small part of sexuality. Sexuality is an integrated, individualized, unique expression of self.

- **Sexuality is emotional.** With the coming of puberty, boys and girls experience new awareness of their bodies, other persons, and related emotions. Throughout life, sexuality deals with one's feeling about self and others, pain and pleasure, love and hate, physical touching or restraint.
- **Sexuality is physical.** It involves touching, physical closeness, and sexual expression. All five senses are involved, touch, smell, taste, visual and hearing.
- **Sexuality is cognitive.** Mental attitudes, self-understanding, and relationships help express who and what persons are as sexual beings. Language is a key part of our sexuality both in naming parts, physical acts and our own experiences in communication with other people.
- **Sexuality is value-laden.** Words and concepts such as justice, love, norm, should and should not, are ethical in character and are important to the full understanding of sexuality. One's values determine honesty, fidelity, promise-keeping, truth-telling, and the purposes of sexual expression.
- **Sexuality is spiritual.** The sexual act involves mutual giving. There is a voluntary surrender of self to another through which a larger unity is achieved. Elements of commitment, being in touch with another and with oneself are involved in one's sexuality and relationships to others as sexual beings.
- **Sexuality is personal.** Each person is a sexual being on her or his own terms. In that sense, one's sexuality is unique, one of a kind. It is communication that is fun and playful, serious and passionate.
- **Sexuality is social.** This relates to social policy questions such as rape laws, equality of women and men in matters of employment, guidelines for genetic research, and abortion. It affects cultural understandings of socialization as male and female, the role of pornography, and the meanings of marriage and community.

Excerpted from: *Human Sexuality, A Preliminary Study*, The United Church of Christ

B. SEXUALITY AND AGING

Aging can have an impact on sexuality and sexual functioning. As with other organs, the reproductive and sexual organs lose efficiency. Women usually begin to have vaginal dryness, and often males have difficulty with erectile dysfunction. We don't discuss sexuality enough when considering the lives of older adults. It's easy to assume that aging brings dramatic changes and that sexuality is not a topic that concerns older adults to any great degree. Sometimes, however, events bring about a dramatic shift in awareness and understanding. The boom in Viagra prescriptions is an example of such an event.



There is much information on the Internet regarding sexuality and aging, sexuality and dementia, sexuality and Alzheimer's disease, etc. Many articles about aging and human sexuality can be found on the American Psychology Association's web site, at www.apa.org.

C. SEXUALITY AND DISABILITIES

Disability can have an impact on sexuality and sexual functioning. Major types of disabilities and typical sexuality issues for those disabilities are described below. For detailed information about how a disability may affect sexual functioning consult a physician or other resource professionals.

Amputation

Amputation does not affect sexual organ function unless the amputation involves the bowel or bladder. Amputations do not affect or lower the desire of sexual activity. Loss of a limb may cause depression or lower self-esteem. Talking to a counselor, friend, or other professional can help eliminate these problems. Amputation will limit some of the physical activities that may give your partner pleasure. Open communication with your partner is the key to removing any stigma surrounding your amputation.

Arthritis

Arthritis does not affect sexual organ function but can impose limitations on physical activity. Pain and stiffness are the biggest factors that can interfere with an active sex life. Pain can dull the desire for sexual activity and limit the positions you can use in sexual acts. Fatigue from dealing with activities of daily living may also decrease your sexual desire. Stiffness can restrict movement and affect use of limbs. Experimentation with positions, the timing of medication and the timing of sexual activity can be worked out so that sexual activity is possible and pleasurable. In addition, the use of heat and warm-up exercises can be helpful.

Like amputation, arthritis can cause depression and lower self-esteem. Medications can affect sexual desire. Other disabilities associated with arthritis may also be an issue for the person who wants to be active.

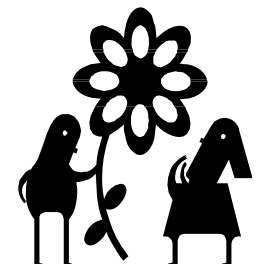
Counseling may also be appropriate. A positive note on arthritis and sexuality is that many people with arthritis report sexual activity actually relieves pain up to eight hours after intercourse.

Blindness

Blindness does not create any problems with sexual functioning. Some of the disabilities which lead to blindness can cause other problems related to sexual functioning. For example, diabetes can cause blindness and also is known to cause impotence in some men. Congenital blindness will cause a woman to start her cycle earlier and she may have more irregularities. This happens because the pineal gland located in the brain regulates a woman's period and is affected by lack of light.

Cerebral palsy

Cerebral palsy does not cause loss of sexual functioning or loss of desire for sexual activity. Physical problems such as sensory loss and limited movements due to spasticity can be a problem. Medication may be helpful. Communication between partners is important when dealing with physical barriers. In many cases, people with cerebral palsy are socialized together and may develop relationships with each other. If this happens, education and counseling of all persons concerned (guardians need to be included if the partners have legal guardians) can be helpful to the two people desiring a sexual relationship. The biggest obstacle to sexuality with a non-disabled person is the attitudes imposed by society. These act as barriers to socially isolate the person who has cerebral palsy, making communication and sexual activity more difficult.



Deafness

Deafness creates no problem with sexual functioning. However, since the act of giving and receiving pleasure involves communication, the couple will need to work out a system for expressing needs and desires. One might also consider leaving a light on or using candles to enhance visual communication and to fully appreciate your partner's response.

Diabetes

It is not always thought of as a disability, yet diabetes is currently the leading cause of permanent physical impairments in the United States today. Between 25 to 49 percent of males with diabetes develop impotence. There has been no correlation between diet, duration of diabetes or types of medication to control diabetes and the increase of impotence.

There also has been no demonstrated loss of interest in sexual activity among the diabetic population. Regardless of the reasons for the possible impotence, the person with diabetes may want to consider a penile prosthetic to increase sexual activity.

Epilepsy

Epilepsy is a disorder occurring within the brain that causes some type of altered consciousness, which may be accompanied by uncontrollable physical movements or seizures. Men with temporal lobe epilepsy have experienced impotence and loss of sexual desire but not necessarily at the same time. Some medications used to control epileptic seizures may cause depression or drowsiness, which may lower sexual desire, but these drugs do not cause loss of sexual functioning.

Sexual activity does not cause seizures. Activities sometimes associated with sexual activity such as excessive drinking, emotional tension, fatigue or lack of sleep and food may contribute to setting off seizure activity. Careful monitoring of activity, diet and rest may help keep epilepsy under control.

Like cerebral palsy, epilepsy carries a negative social stigma, which is sometimes the biggest obstacle to enjoying sexual activity. Although major educational campaigns are underway, the person with epilepsy still must take the lead to make potential sexual partners understand that epilepsy does not interfere with sexual functioning, love, or marriage.

Developmental disabilities

Developmental disabilities do not affect sexual functioning or desires. Most of the problems experienced by people who are developmentally disabled relate to the attitudes of non-disabled members of the general public. In the case of legal guardianship, all persons involved may find it helpful to meet with counselors or other professionals. Education about human sexuality is important for mentally disabled persons and all others concerned with them. Education and communication will be necessary to work things out for both partners.

Head injury

Head injuries can cause a variety of physical and emotional problems. These problems may be significant depending upon how much and what parts of the brain were damaged. No two head injuries are alike. Physically, there is no impairment in the sexual organs. The problems with sexual function stem from other physical issues such as loss of spatial awareness (where the body is in space), loss of sense of rhythm and timing, loss of movement on one side of the body, or loss of sensation, which can limit sexual pleasure. Communication between partners is the key to working out these physical issues.

If a person who has a head injury also experiences emotional disorders, his or her ability to process information may be limited depending upon the severity of these disorders. The person may show poor judgment, irrational thinking and be very impulsive. The limbic system located in the brain stem is thought to control emotions and sexual urges. If the head injury includes damage to the limbic system, emotional problems and uncontrollable sexual urges may result. Education about the disorder can help, but frequently behavior modification programs and counseling are necessary.

Spinal cord injury

A spinal cord injury (SCI) does affect sexual functioning or desires. An SCI can affect virtually every system of the human body. Many people who sustain an SCI have concerns about how their injuries have affected their ability to participate in and enjoy a sexual relationship. Sexual function is controlled by parts of the central nervous system (CNS), particularly the brain and spinal cord. Interruptions to the CNS through injury to the spinal cord will therefore have some effect on sexual function. The extent of sexual function impairment depends on a variety of factors including the level of injury, the severity of damage to the spinal cord, and whether the individual is male or female.

- **Female sexual function after an SCI:** A female’s ability to engage in sexual activity is less likely to be affected by an SCI because of the way the female body is constructed. A woman is often able to have intercourse as easily after the SCI as before, although additional lubrication may be needed to avoid chafing and to make the act of intercourse easier to initiate. Alternative positioning of one’s body may have to be considered as well.
- **Male sexual function after an SCI:** For males, the situation of sexual functioning is a little more complicated. Some men are able to achieve erections quite easily, while others can achieve erections occasionally and some are unable to achieve erections at all after an SCI.
- **Sexual sensation after an SCI:** As with other basic physiological functions after an SCI, sexual sensations can also be altered. Some of the nerves that once provided pleasurable feelings in sexual organs and other erotic areas of the body may no longer be working as they did before injury. Some people retain specific sexual sensations in the genital areas, while others notice they are diminished or absent. Many have reported heightened sensations in different parts of the body—the neck, earlobes, arms or other areas of skin.

Many people who have sustained an SCI have indicated that their total enjoyment of the sexual experience after the SCI is as good as, if not better than, their pre-injury sexual experiences. Necessity in many cases encourages them to concentrate on holistic sexual experiences rather than on genital-specific sex. Many individuals report that they can still achieve climax but not in the same way as before their injury. Again, the best way to discover personal likes, dislikes, and needs is exploring openly with a willing and loving partner.

SCI and Sexuality was adapted from: SCI Network Fact Sheet 4, “Sexuality After SCI”
<http://spinalcordinjury.net/docs/scifact4.html>

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 7 – ACTIVITY PLANNING

CONTENTS

- A. Principles of Activity Planning
- B. Cultural and Religious Issues
- C. Activities Specific to Various Disabilities and Functional Abilities
- D. Activity Planning Exercise
- E. Resources

OBJECTIVES

1. Identify and explain the basic principles and purpose of activities for clients.
2. Describe the importance of client rights and cultural or religious issues in regard to activity planning.
3. Identify examples of activities suitable for clients with specific disabilities.

KEY TERMS

Aromatherapy lotions

Reminisce

Exercise

Sensory stimulation

Functionally specific

Socialization

A. PRINCIPLES OF ACTIVITY PLANNING

Activities should be functionally specific (designed for the abilities of each individual) to:

- Reduce depression, stress and anxiety.
- Help the individual recover basic body movements and reasoning abilities.
- Build self-confidence.
- Promote socialization and interaction.
- Relieve boredom.

Before beginning any exercise program the client should consult with a health care provider for an individualized plan.

Find activities that interest the client, not just those that interest you. Remember the importance of *client rights*. Clients have the right to refuse activities.

- Rather than thinking of activities as doing something with the client at a specific time the DCW should incorporate strengthening or sensory stimulation activities into regular personal care activities. For example, assisting with bathing is an *activity*. The DCW could play music and sing to/with the individual during bathing. Not only is it a great distracter but it is also an opportunity to connect with the client. Another example is foot massages with aromatherapy lotions. It accomplishes a sensory stimulating activity, and allows the DCW to examine the client's feet for any skin changes.
- Play music according to the client's preferences (brush up on your "oldies but goodies" such as "Daisy" and "How Much is that Doggy in the Window?"). Some clients prefer some of the old gospel classics like "Rock of Ages" or "This Little Light of Mine." The client will not mind if you do not have a perfect voice, and the two of you can laugh at forgotten words or have the client fill in some of the words for you.
- Consider activities such as walking, water workouts or wheelchair exercises. Exercising with even minimal weights can increase bone strength. Such activities reduce the risk of falls by improving muscle strength, balance, coordination and flexibility. Avoiding exercise because of fear of falling actually increases the risk of falls.



B. CULTURAL AND RELIGIOUS ISSUES

Look to the client’s cultural and ethnic background for possible activities. Ask the family what the client has enjoyed or been involved with in the past. Music is an important part of most cultures. Ask the client and family about what kinds of music the client prefers.

Religious and spirituality activities play a significant role in providing meaning and shaping the purpose in life for many people. The DCW must be very sensitive to the religious beliefs of the client and not try to convert the client to the DCWs viewpoints. Religious music may play an important part of the client’s life.

C. ACTIVITIES SPECIFIC TO VARIOUS DISABILITIES AND FUNCTIONAL ABILITIES

General Activities	Dementia, Stroke, Brain injury	Wheelchair Users with Arm Mobility	COPD, Breathing Problems
Try to appeal to hobbies and interests	Appeal to senses—color, shape, texture, scents	Exercises aimed at increasing upper arm strength	Start slowly and gradually—take breaks as needed
Playing checkers or other board games	Read a story or newspaper	Bicep curls	Short walks
Play cards	Review family snapshots	Seated push-ups	Yoga
Write a personal history	Go for a walk	Weight lifting	Dancing
Go for a walk	Listen to music	Play a tape of yoga/ Tai Chi	Stationary bike
Write a letter	Sing Christmas or spiritual songs	Exercise lower extremities using stretchy bands	Exercise upper and lower extremities using stretchy bands
Make a craft/ holiday decoration	Give a manicure/ pedicure		
Swim	Massage with aromatherapy lotion		
Watch/discuss a movie	Reminisce (recall from past)		
Plan meal, make grocery list, clip coupons	Make a grocery list and discuss prices then and now		
Cooking	Fold towels		



D. ACTIVITY PLANNING EXERCISE

Implementing an exercise plan

Scenario: You are assigned to a female client who has a severe form of arthritis. The physical therapist has developed a service plan for the client. However, when you ask her about it, she tells you, “It hurts too much to exercise.” What three steps could you take to ensure that the client completes the exercise plan?

Answers could include:

- Talk to the therapist to see if the exercises could be broken into more manageable parts. Start slow and take breaks.
- See if there are activities that the client enjoys doing that can be used as part of the plan. Check with the therapist to see if the activities can be used. Make it fun.
- See if the client has pain medication that she can take before the exercises. Non-narcotics such as ibuprofen or acetaminophen are preferred.

Activity planning for clients

- Divide participants in the class into groups.
- Each group decides on one or two clients with a certain disability or condition. Examples are listed below. The instructor may provide additional examples.
- Each group should decide on an appropriate activity and the supplies needed for each client based the client’s needs, functional status, and cultural/ethnic background.
- Each group can share the activities chosen with the whole class discussing what other activities might be good and what activities might not work as well.

Examples of possible clients:

- An individual with advanced Alzheimer’s disease who is Jewish.
- A young adult who is a wheelchair user who used to run marathons.
- A person who has had a recent stroke and is having difficulty talking.
- A child with cerebral palsy.



The Job I Almost Didn't Take

My name is Anthony, and I have been a caregiver for five years. I want to share one rewarding experience I had with one consumer or almost did not have. At the time of the interview with my consumer and family, I almost decided not to take the position because when I walked into the home, the home was extremely cluttered; I could not even see the counter or the stovetop in the kitchen. I continued with the interview and tried to focus on the consumer and his needs. The more I talked with the consumer and his wife the more connected I started to feel. I got to the point where now the emphasis was on Travis, the consumer, and not on the house conditions. Travis's wife stated he had an aneurysm and a stroke and was also dealing with the challenges of Parkinson's disease. Later, I found out that Travis at one time was a well-known folk musician who played the guitar and sang, but now the loss of being able to express himself through the talent of his music was overwhelming. In the beginning when I started to provide care for Travis, he appeared to be in an extreme depressed state. Part of my responsibility from the service plan was to encourage Travis to do his breathing exercises. I have to say it was a boring exercise. Travis often struggled to do his repetitions on this breathing device. I remember reading an article about another consumer using a harmonica which aids to the strengthening of the lungs. Well, I talked to Travis about this idea of using the harmonica and he agreed. I was amazed on what doors opened from that suggestion. Travis' breathing increased from where he could only use the harmonica in the beginning for a couple of seconds to now playing duets for minutes at a time. His passion for music had been aroused again. In fact, we even played at an awards banquet. I have been providing care for Travis for six months. I am glad that day when I interviewed Travis I saw past all the clutter. Has the clutter changed? No! I continue to have discussions regarding me being able to provide the appropriate efficient care for Travis in the time allocated and not have to always go on a hunting trip trying to locate the required supplies to meet his needs. At times I struggle with the life style, but I do some internal talking to myself. As caregivers, we are often faced with life styles different from our own, but we need to focus on the real task at hand, the consumer's needs. Communication with the consumer and family is a win/win situation.

Anthony Lelli, caregiver



E. RESOURCES

Web sites

- The Therapeutic Recreation Directory, www.recreationtherapy.com/tractv.htm
- *Activities for Caregivers: 101 Things to Do*, Alzheimer's Association website, www.alz.org/alzwa/documents/alzwa_Resource_CTP_101_Things_To_Do.pdf

Agencies

- Local parks and recreation sponsored senior centers and subsidized lunch sites.
- The Alzheimer's Association, www.alz.org.

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 8 – DEMENTIA SPECIFIC CARE

CONTENTS

- A. Dementia Overview
- B. Alzheimer’s Disease
- C. Communication Strategies
- D. Challenging Behaviors
- E. Dementia and Sexuality
- F. Assisting with ADLs
- G. Activities
- H. Pain Management Techniques
- I. Safety Concerns

OBJECTIVES

1. Identify and describe dementia-specific care related to:
 - a. the types and stages of dementia,
 - b. communication,
 - c. importance of activities,
 - d. managing difficult behaviors, and
 - e. safety issues.
2. Identify and describe the activities of daily living issues related to dementia-specific care.
3. Demonstrate selected personal care skills as they relate to dementia-specific care.

KEY TERMS

Alzheimer's disease	Pharmacological
Dementia	Reversible dementia
Irreversible dementia	Sundowning
Life Story	Wandering
Non-pharmacological	

This part of the training is intended to introduce the student to dementia-specific care. It is intended to be an overview of the topic.

The Alzheimer’s Association, Desert Southwest Chapter, has developed a module by a committee of professionals in the field of dementia-related care that provides in-depth training on care and treatment options.

Anyone who provides care for individuals with cognitive impairments and dementia is encouraged to attend the *Principles of Caregiving: Alzheimer’s Disease and Other Dementias* module training.

A. DEMENTIA OVERVIEW

Dementia is a progressive cognitive (thinking, reasoning, remembering) decline that impairs daily functioning. Often a group of symptoms may be present with certain diseases or conditions.

Normal, age-related forgetfulness or dementia?

As a person ages, it is common to walk into a room and think, “What did I come in here for?” Individuals may experience these momentary memory lapses, which include forgetting where they put their keys or where they parked the car at the mall. These are a normal part of aging. Even finding it difficult to remember phone numbers or the names of a recently introduced person are normal, age-related forgetfulness.

With dementia, the individual may forget family members’ names, or the person may not only misplace the keys, she may actually put them in the refrigerator. With dementia, it is not just memory that is affected, but reasoning and judgment as well.

With normal forgetfulness a person may forget the details of an event. A person with dementia may forget the entire event, insisting that it never happened. Normally, a person will be bothered by a memory lapse. A person with dementia seems to not be bothered by memory lapses.



Symptoms

Symptoms of dementia may include:

- Decline in memory, thinking, and reasoning.
- Changes in personality, mood, and behavior.
- Difficulties in language, visual recognition, and executing activities.

Types of dementia

Dementias may be reversible or irreversible. Some dementias may be resolved with appropriate medical care. Others, often caused by disease, are incurable.

Reversible

- Medical conditions such as dehydration and infections.
- Chronic medical condition being out of control (e.g., thyroid problems).
- Reaction to medication.
- Overmedication, mismanagement, withdrawal.
- Psychiatric causes such as depression, lack of sleep, stress, etc.

Irreversible

- Alzheimer's disease, the most common form of dementia.
- Vascular (multi-infarct) dementia, caused by strokes.
- Lewy body dementia, in which the person may have fluctuations in memory, hallucinations (anti-psychotics may make condition worse), rigidity in movements.
- Parkinson's disease.
- Pick's disease, a dementia involving the frontal lobes of the brain, causing behavior changes and aggressiveness.
- Huntington's disease, an inherited illness defined by uncontrolled movements and decreased physical and mental functioning.
- AIDS.
- Other rare forms such as Creutzfeldt-Jakob disease.

Depression and dementia

Depression is a chemical imbalance in the brain that can cause symptoms such as memory impairment, inability to think clearly, lack of motivation and loss of interest in activities that were once pleasurable. These same symptoms can be found with someone who has dementia. Some of the ways you can determine the difference is that individuals who are depressed usually can score very well on mental status exams and other tests that evaluate cognitive function. They may also complain about their memory loss. However, individuals with dementia score poorly on cognitive function tests and often deny any memory problems.

People who have dementia are also at a higher risk for the chemical imbalances that cause depression so individuals may have dementia and depression. If the person just has depression and responds well to treatment, the symptoms should go away. If the person is depressed and has dementia, proper treatment may make the symptoms better but they will not completely disappear.

In order to obtain the proper diagnosis and treatment, individuals exhibiting signs of depression or dementia need to be evaluated by a physician.

B. ALZHEIMER'S DISEASE

Alzheimer's disease (AD) is a progressive, degenerative disease affecting the brain. The symptoms gradually worsen over a number of years. In its early stages, memory loss is mild, but with late-stage Alzheimer's, individuals lose the ability to carry on a conversation and respond to their environment.

Although the exact cause or causes of Alzheimer's disease are not known, most experts agree that Alzheimer's, like other common chronic conditions, probably develops as a result of multiple factors rather than a single cause. The greatest risk factor for Alzheimer's disease is advancing age, but Alzheimer's is not a normal part of aging. Most Americans with Alzheimer's disease are aged 65 or older, although individuals younger than age 65 can also develop the disease. Heredity is believed to play some role.

- Sticky protein patches (amyloid plaques) form in the brain and nerve cells die.
- Nerve fibers twist into a tangle, not allowing conduction of impulses.
- Alzheimer's affects more women than men. The longer a person lives the more likely he or she is to develop the disease.
- Average life expectancy after diagnosis is 3-20 years.
- 7 out of 10 persons with dementia live at home, with much of their care falling to family members.
- **Caregiver stress is a major reason why service is requested.** 80% of caregivers report higher levels of stress, and 50% suffer from depression.

Currently, among Alzheimer's disease professionals, there is a greater urgency to educate people to get early screening and treatment. With early detection, a person:

- May get the maximum benefit from medications.
- Have more time to plan for the future.
- Get more care and support for the person and their family members.

Stages of Alzheimer's disease

People with AD usually do not fall neatly into one stage. They may even have some variable symptoms (good days and bad days).

Early stage

- Short term memory loss.
- Difficulty handling checkbook, finances, organization.
- Poor judgment and personality changes.

Mid stage

- Memory worsens.
- Increased difficulty expressing oneself.
- Difficulty using objects correctly (toothbrush, silverware).
- Disorientation to time and place.
- Restlessness or pacing.
- Behavior changes, loss of impulse control.
- Self-care abilities more impaired.

Late stage

- Limited or nonsense verbalization, or no speech.
- Oriented only to self.
- Incontinent bladder and bowel.
- Needs maximum assistance walking, unable to walk, or bedridden.
- Requires total assistance for all ADLs.

Terminal stage

- Late stage criteria *plus*:
- Difficulty chewing/swallowing.
- Infection/recurrent fever in past 12 months.
- Pressure ulcers.
- Weight loss.

C. COMMUNICATION STRATEGIES

The use of appropriate verbal and non-verbal strategies is extremely important when providing care for a person with dementia. The two most important factors are your actions and reactions (both verbal and non-verbal) to the individual and his/her behavior.

The following tips also work well in dealing with clients who do not have dementia but have some other behavioral problem. Also, refer to Chapter 3, Communication in the *Principles of Caregiving: Fundamentals* course manual for more information.

The Life Story

The life story lists some of the unique aspects of that person's life. It can give caregivers valuable cues for:

- What to talk about when trying to use distraction.
- Activities that engage the client.
- Music that the person would enjoy.

The person may help you create a life story as part of reminiscing, or you might ask the family to assist in completing a life story.



My Mom has Alzheimer's

My Mom lived with me for a couple of years after my Dad passed away. Mom loves people. She made the choice to move to a retirement home because she wanted to be around people all the time and pretty soon she knew she would have to give up driving. In a time of only six years I saw Mom go from the retirement center, to the assisted living center, and now she is in the memory unit. It is a roller coaster of a ride with emotions. This is the Mom I used to talk to about problems and we would come up with solutions to solve the world. Now our conversations are about when Dad is coming home. This conversation usually happened around 6 p.m. I remember someone telling me about "sundowners." This is the time when people who have been diagnosed with dementia or Alzheimer's would get upset or confused. One time, Mom was really upset and she would not eat because she said she had dinner all ready and was waiting for Dad to come home. Mom was truly upset, nervous, and wondering where he was. At first, my heart broke to hear her ask me this question, since Dad died many years ago. But I learned to be creative about answering her. "Mom, remember how Dad has to travel with his job? Well he was in a snow storm and he won't make it home tonight." My Mom looked at me with a great sigh of relief and kept saying, "Well, thank God he is alright. Thank God he is alright!" She then asked me what she should do with the dinner she made. I told her I would put everything away. I was amazed how she just smiled and relaxed, and then she went to eat her dinner. When I left that day, I thought to myself is it really sad to be in a place where Mom is so happy? Now I almost feel comfortable being where Mom is on those days when she is living in the past. When Mom is living in the past I tell her how much Dad loves her and I love to see her smile. I remember someone saying to me that I needed to go to my Mom's world and not try to make her be in my world. Now I understand.

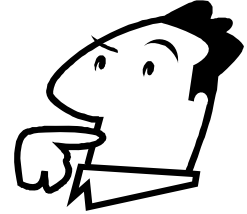
–Daughter of a Person with Alzheimer's disease



D. CHALLENGING BEHAVIORS

Persons with dementia may present challenging or difficult behaviors for the caregiver. Causes may be the effects of Alzheimer's disease on the brain, confusion, fatigue, pain, understimulation or boredom, or a lack of routine. Over-stimulation may also be a factor in difficult behavior.

The caregiver's approach and reaction to the behavior can either aggravate or defuse a challenging encounter.



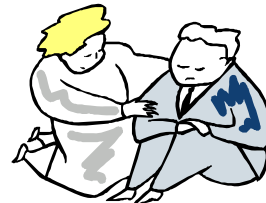
Types of behaviors

- Combativeness and aggression.
- Wandering and rummaging.
- Physical restlessness (pacing).
- Sundowning, becoming more confused/agitated in the late afternoon and evening.
- Inappropriate sexual behavior.

Tips for managing challenging behaviors

The approach used by a caregiver can significantly impact problem behaviors in a person with dementia. The caregiver can escalate a problem, or can calm the person by using the correct approach.

- Introduce yourself at each encounter.
- Use touch as appropriate.
- Try to determine the cause of the behavior (boredom, pain, anxiety, etc.) and then try to reduce or eliminate it. Causes may be:
 - Boredom. Try a functionally appropriate activity.
 - Pain. Try the appropriate non-pharmacological treatment first (see Section H in this chapter).
 - Anxiety. Try reassurance and diversion.
- Use a soft approach:
 - Smile, use a warm demeanor.
 - Use pleasant voice tones.
 - Go slow.
 - Talk in short, simple sentences.
 - Avoid correcting or confrontation.
 - Appeal to the emotion and let the person know you will keep him/her safe.
 - Be flexible in getting tasks accomplished.



Tips for Working with Difficult Behaviors Associated with Dementia

1. **Keep calm.** If the person is excited and you become excited, the situation will only get worse. Instead, maintain a calm voice and stature.
2. **Take the person away from the present environment or try to focus on something else (*diversion or redirection*).** Changing the subject or the environment can often be helpful. Try a different scene, such as a backyard patio, to see if the agitation decreases. Talk soothingly about something you know the person enjoys, such as their family, or involve the person in an activity he/she likes to do, such as drawing.
3. **Talk and move slowly so that the person does not feel threatened.** If the person is already feeling insecure or frightened, it will not help if someone else rushes in or speaks in a loud voice. Instead, stay relaxed and try not to upset the person further.
4. **Try soothing touch.** For some people, a gentle arm around the shoulders, holding hands, or a gentle back scratch can be reassuring and soothing. Be sure this is appropriate for your client, or it may have disastrous results.
5. **Do not try to correct the person.** Because of the brain damage, it will not help to correct a person with dementia about reality. Instead, try to "go with the flow" and let the person say whatever she/he wants to, even if you know it is not true.
6. **Respond to the emotions of the person.** Regardless of what caused the agitation, the person is upset. Try to focus on what the person is feeling or what emotions he or she is displaying, instead of the actual words being used.
7. **Always treat individuals with respect and dignity.** Never forget that the person is an adult, despite their behavior. **Don't punish them or talk to them like a child.**

Adapted from "Alzheimer's Disease: Pieces of the Puzzle" produced by Arizona Long Term Care Gerontology Center (now the Arizona Center on Aging) at the University of Arizona.

E. DEMENTIA AND SEXUALITY

Changes in sexual behavior in a person with dementia can be very upsetting for family members and the DCW. Some behaviors that might be exhibited:

- Flirtatious behavior. The person may forget marital status and begin to flirt with others, including the DCW.
- Unreasonable jealousy or paranoia.
- Exposing or fondling self inappropriately.
- Misinterpretations, making sexual advances to another person, including the DCW, because he/she believes the person is the spouse.

Try to determine if there is a cause for the behavior. If the person is fondling him/herself, the person may need to use the bathroom. If the cause cannot be corrected, gentle diversion usually works. However, DCWs who feel threatened or need advice should call their supervisors.

F. ASSISTANCE WITH ACTIVITIES OF DAILY LIVING

As dementia progresses, there will be a decline in the ability to do activities of daily living (ADLs) independently. Unfortunately, this trend cannot be reversed, but you can improve a person's quality of life by making the person feel as productive and independent as possible. The following are some guidelines to follow when providing assistance with ADLs for a person with Alzheimer's disease. As always, clients need to be offered choices and preferences. DCWs will meet less resistance if the person retains a sense of control.

- **Establish and maintain a routine.** Establishing and maintaining a routine is very important when assisting with ADLs. A routine does not rely as much on memory, especially if it has been done throughout the person's adult life. Ask the person or family for input. Try to do the various ADLs such as bathing at the same time and in the same manner each time.
- **Have the person help.** Losing the feeling of being productive can be troubling to some people. Allow the person to help with such things as washing dishes (even if you have to re-wash them later) or folding towels. A man could water plants outdoors. Other things that the person could help with are clipping coupons, sorting laundry, setting the table, etc. Ask the person or family what the person likes to do, and arrange activities where he or she can help.
- **Specialized clothing.** Shoes with Velcro fasteners, tube socks, pull-on shirts and pants all make it easier to dress and undress (and also help when trying to get to the bathroom on time). In the mid to late stages of the disease you may need to use clothing that is harder for the person to remove, if inappropriate undressing becomes a problem.

Bathing strategies

Behaviors that may occur

- Fighting/resisting the caregiver.
- Yelling/swearing/biting.
- Crying/moaning.



Why behaviors occur

- Person may be frustrated.
- Person may be experiencing discomfort and/or loss of dignity.
- The person is trying to say “NO!”

Caregivers need to re-think the bathing situation, and see these behaviors as self-protective, rather than combative or resistant.

Steps to successful bathing

Re-think the bathing experience

- Ask the family about the person’s bathing preferences prior to dementia such as shower or bath, how often and what time of day is preferred.
- Use bathing preferences and rituals that have been pre-established.
- Keep in mind the goal is to create a comfortable and pleasurable experience for the person with dementia.

Approach Strategies

- Always use the soft approach and try a variety of techniques.
- Don’t ask the person if she wants a bath or shower if you are not willing to accept no for an answer!
- If the person refuses you, leave and come back again in a few minutes.
- Change the term bath or shower to “getting freshened up.”
- Focus on a reason for the person to get clean (for example, going to an appointment or going to see a relative).

Be Organized!

- Have the room ready to go! Bathing area should be warm, well lit, with all the supplies ready.
- Position the person comfortably.
- Have enough bath blankets/towels to keep the person covered at all times.

Helpful Tips

- Remember to keep the person covered at all times.
- Lift the blanket or towel as you bathe the person and then replace (some of the resistance may come from being uncovered).

- Begin bathing the least disturbing area first, the feet, and move up from there, saving the genital area and face until last.
- Utilize distraction techniques. Play music or sing, if the person has a preference. Use the person's life story to stimulate a conversation.
- Give the person something to hold or to eat or drink (something sweet?).

Shampooing

Save washing the hair until last, *or* separate it from the bath completely. Try shampooing hair in a chair using washcloths and rinseless soap. If it remains a problem, consider making arrangements for a beauty shop/barber instead of trying to do it at home. This is especially good for people who enjoyed regular beauty shop/barber appointments when they were younger. Make it a special outing with a stop at a favorite diner.

G. PLANNING ACTIVITIES

Activities provide opportunities for social interaction, encourage creative self-expression, increase feelings of achievement and enjoyment, and decrease agitation, boredom, and isolation.

Gear activities to the *functional abilities* of the person. If the activity is too difficult, the person may become overwhelmed. If it is too easy, the person may become bored. Both can lead to problem behaviors.

Possible Activities

- Give the person something meaningful to do, like folding towels.
- Look at picture books and magazines and make a card or cut out pictures.
- Play music of the person's preference or try singing old favorites.
- Watch TV programs only if the person shows interest (for example, nature programs, musicals and Lawrence Welk, old comedies like I Love Lucy).
- Offer frequent snacks and fluids.
- Use lotion to give a 1 to 2 minute hand or foot massage. Consider adding an essential oil for aromatherapy.
- Read a poem, prayer, or scripture verse.
- Exercise
 - Accompany the restless person on a walk, just to look at flowers on the patio.
 - Designate a safe area where the person can walk.
 - Take a person who uses a wheelchair for a walk.



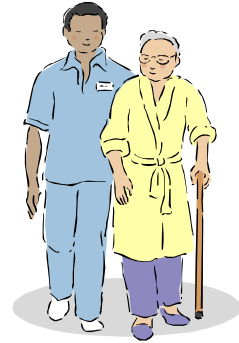
H. PAIN MANAGEMENT TECHNIQUES

A person with dementia may not be able to tell a caregiver that he/she is in pain. It is very important that the caregiver be alert to changes in the person's behavior that might signal the person is in pain. Try to provide one of the non-pharmacological approaches first.

Non-pharmacological

Non-pharmacological means not using medication. Caregivers can do these measures without a physician's order:

- Try a change of position or a walk.
- Offer to take the person to the toilet.
- Offer snacks/fluids.
- Give a lotion massage.
- Reduce stimulation in environment and allow for quiet time.
- Listen to music.
- Adjust body temperature. The person may be too hot or too cold, you may need to adjust clothing or thermostat.



Pharmacological

Pharmacological remedies involve the use of medications. If the non-pharmacological strategies do not work, report this to the family and your supervisor. The person's physician may prescribe a medication that will relieve pain. Helpful points to remember:

- A non-aspirin pain reliever such as Tylenol usually works well.
- Narcotics are usually not tolerated well in elderly individuals.
- Anxiety in an elderly person with dementia is not always well-managed by anti-anxiety agents.
- Pills don't always work and some may have serious side effects.

Adapted from: Palliative Care for Advanced Dementia, Train the Trainer Program, Alzheimer's Association, Desert Southwest Chapter.

I. SAFETY CONCERNS

Safety is the primary responsibility when caring for a person with dementia. Make sure that basic fall-prevention measures are used (for example, clear pathways, no scatter rugs, etc.). Refer to the Section C, Falls, in Chapter 9 of the *Principles of Caregiving: Fundamentals* course manual.

Wandering

It is estimated that 50% to 60% of people with Alzheimer’s disease will wander. This means that the person may try to leave the building alone. The danger is that the person may get lost. A person with dementia may not be able to ask for help or even remember his/her address. The Alzheimer’s Association website contains more information on wandering. Go to www.alz.org/living_with_alzheimers_wandering_behaviors.asp

Safe Return® program

The MedicAlert + Alzheimer’s Association Safe Return® program is a nationwide emergency response system offered through local Alzheimer’s Association chapters. A person at risk for wandering can be enrolled and receive a bracelet with information engraved. Anyone finding a person who is lost can call the phone number on the bracelet to get help. For more information, visit www.alz.org/safereturn.

PRINCIPLES OF CAREGIVING: AGING AND PHYSICAL DISABILITIES

CHAPTER 9 – GRIEF AND END-OF-LIFE ISSUES

CONTENTS

- A. Grief and the Separation Process
- B. The Dying Process
- C. Emotional Issues
- D. Coping Strategies
- E. Cultural and Religious Issues
- F. Advance Directives
- G. Hospice
- H. Grief Activity
- I. Resources

OBJECTIVES

1. Describe the grieving process.
2. Describe the dying process.
3. Identify and explain emotional issues and coping strategies.
4. Explain the impact of culture and religion on end-of-life issues.
5. Describe advance directives and the significance of the “orange form.”

KEY TERMS

Advance directives	Grief
Do not resuscitate	Hospice
Durable power of attorney	Living will
Dying process	Orange form



A Family-Centered Death at Home

Donna Olsen, at age 15 was diagnosed with Osteogenic Sarcoma, a cancer that was present in a bone in her leg. From the age of 15 to 17, Donna went through several types of chemotherapy, above the knee amputation, radiation, and three lung surgeries. When the cancer spread to Donna's heart lining, Donna knew she was going to die.

Donna wanted to exert as much control over the course of her death as she had over her challenge of cancer. Donna made a choice to die at home. With the help and support of her family she was able to do just that. Donna had her hospital bed and oxygen tank set up in the family room. She wanted to be where the action was. Donna's mom, Diane stated: "Donna was not afraid of dying. In fact, one time while she was playing cards (for money) with her grandma, Donna said: 'you know Grandma, I'm not afraid of dying' then she collected her 3 dimes." Donna had a multitude of family and friends come through to visit – friends from school, from her church, from the hospital, but her world did start to get smaller as the cancer started to ravage her body. For two months before Donna died, the house continued to be filled with laughter, talking, TV, and music. Donna even went into a coma for one week. Diane asked the visiting nurse, "Should Donna be given some kind of nutrition?" The nurse responded: "Feed the body, feed the cancer." Donna came out of her coma two weeks before she died. Diane stated: "Donna was starting to stir for a couple of hours and then she 'woke up' and said she was thirsty and wanted a Coke. I remember Donna telling me she remembers hearing people talk while she was 'sleeping.'" Donna died at home just as she wished. Prior to Donna's death, arrangements were made with the doctor and mortuary, so 911 would not be called. Donna's mother states her biggest accomplishment in life is "We did cancer, we did it well, and we had fun, not to say there wasn't any pain."

When I look back at the time I had with Donna and think of the emotions I experienced, I realized I had acceptance in the beginning. How could I not have acceptance, I had Donna looking at me for strength and our strength always bounced off each other. Did I ever have anger? I remember the time I felt anger distinctly. After Donna died I decided to go back to school and be a social worker. I remember my first class: "New Horizons for Women." I went to class and my teacher shared with us how she was diagnosed with cancer and had her leg amputated. I looked at the teacher and there she stood the same size as Donna, the same hair color, and the same leg that was amputated. When we talked after the class she had the same cancer Donna had. I went to my car and I just sat there and I was angry, I mean really angry. I allowed every cell in my body to be angry. Why was I angry? I then realized I will never experience Donna as an adult, as a wife, as a mother. After allowing myself to experience the deep anger, I was then able to process the anger and let it go. I will remember my husband telling me: "It is okay to be angry but to stay angry becomes a choice. Our feelings are real, but what we do with our feelings is our choice." I continue to thank God for the treasure he gave me to have Donna as my daughter. I had her for 17 years. What a blessing! BUT.... I still do miss her!

By Diane Patton, Mother of Donna Olsen



A. GRIEF AND THE SEPARATION PROCESS

Grief is an emotional reaction to a major loss. The words sorrow, heartache and depression are often used to describe feelings of grief. Whether you lose a loved one, animal, place, or object, or a valued way of life such as your job, marriage, or good health, some level of grief will naturally follow. We are most familiar with grieving as a response to the loss of life, usually tied to losing a close friend or family member.

Years ago, multiple generations lived together and cared for each other all the way through illness and death. Then it became the norm for people who were seriously ill to go to the hospital, and they eventually would die there. Families are returning to the practice of caring for their loved ones through an illness or aging, and many are choosing to spend their last days at home or in the surroundings they choose rather than in a hospital. Laws have been written to allow families to make their own choices about who will care for them, and how and where they will experience the natural process of death.

Scientists have studied people with grief and loss and that has led to theories about grieving that are widely accepted as true. There are stages of grief that many people go through. Although people do experience grief in many of the same ways, remember that everyone will react differently. There is no set time from one stage to the next, people will grieve at their own pace. It is not uncommon for someone to still be grieving 1 or 2 years after a tragic loss.

Stages of Grief

Individuals do not necessarily go through all these stages in order, and they may repeat stages. The grief process is unique to the individual.

- **Shock:** People don't really understand what has happened. They may not remember even being told of the event. This is a protection of the mind to take care of itself, to avoid the hurt. There may be no tears and little or no display of emotion.
- **Denial:** Denial is a temporary reaction after unhappy news. The person refuses to accept what has happened. Some people deny the death of a loved one so much that they won't let anyone refer to them as 'gone.' They may still talk to the person. Some may insist on setting their place at the table, etc.
- **Anger:** Anger is a common feeling after a loss. Some people don't really know who they are mad at, they are just mad that this bad thing happened to them. Some may be mad at the people they feel are responsible for the loss, the person who died and left them alone, the doctor/hospital, or even God or another deity. Anger is hard for families because there is the feeling of blame.
- **Bargaining:** The "let's make a deal" phase. The person attempts to correct the loss by making deals with other people, sometimes with God or another deity. Statements like, "Dear Lord, I promise to start going to church," or "Please let the test on my cancer be

wrong. I promise if the test is wrong I will change my life and join the Peace Corps" are the bargaining part of grief and it is normal.

- **Depression:** This is the most dangerous stage of grief. Everyone goes through depression before they can heal from a major loss. They may not be interested in much of life, eating, sleeping or being with people. Some just want to give up and may not get out of bed. If thoughts or discussion of suicide are present, professional assistance may be needed.
- **Guilt:** Guilt is marked by statements of "If only I had done or been..." It usually comes from things one cannot change. Individuals tend to blame themselves in an effort to make sense of the loss. "This is my fault, I caused this by..."
- **Acceptance:** Living in the present is possible. It's a decision to be at peace with the way things are. To know that no amount of denial, bargaining, anger or depression is going to bring the person back or reverse the situation. Acceptance and hope mean that the person understands that life will never be the same, but that life goes on and the pain lessens over time.

B. THE DYING PROCESS

Death comes in its own time and in its own way, and death is unique to each individual. You may notice these changes in a person nearing the end of life.

One to three months prior to death

- **Withdrawal:** This is the beginning of withdrawing from the outside world and focusing inward. The person's world becomes smaller, possibly involving only closest friends and immediate family. You will see the person possibly taking more naps, staying in bed all day; sleeping more becomes the norm. Verbal communication decreases, as touch and not speaking take on more meaning.
- **Food:** We eat to live. When a body is preparing to die, it is perfectly natural that eating should stop. This is one of the hardest concepts for a family to accept. **It's okay to not eat.**

The person dying will notice a decrease in eating. Liquids are preferred to solids. Meats are the first to go followed by vegetables and other hard-to-digest foods. Cravings will come and go.

One to two weeks prior to death

- **Disorientation:** The person is sleeping most of the time now and cannot seem to keep his or her eyes open but can be awakened from the sleep. Confusion can take place when you talk to the person. The person may start talking about previous events and people who have already died. The focus is transition from this world to the next.
- **Physical changes**
 - Blood pressure often lowers.
 - Pulse beat becomes erratic, either increasing or decreasing.
 - Skin color changes.
 - Breathing changes. It has an erratic rhythm, either increasing or decreasing.

One to two days, to hours prior to death

- **Physical changes**
 - A burst of energy may be present.
 - Breathing patterns become slower and irregular, sometimes stopping for 10 to 45 seconds.
 - Congestion may be audible.
 - Eyes may be open or semi-open and have a glassy haze.
 - Hands and feet become purplish and parts of the body become blotchy.
 - The person may be non-responsive.

C. EMOTIONAL ISSUES

Client and family

Individuals are unique in their display of emotions. The fact that some people do not display what others think is normal does not mean that they are not grieving.

Some differences in grieving:

- Some people are quite vocal; some are quiet.
- Some are accepting; some are in denial or shock.
- Some people weep; some are very stoic (emotionless).
- Some people are angry; some may appear happy.

Direct care workers

It is natural that the DCW and the person being cared for have a connection. When that person dies, the DCW may grieve as though the person were a family member. Some coping strategies are described Section D below.



Exercise

This exercise will help you understand the dynamics of a family dealing with a loss, whether it is through death of a loved one, disability, or any other major change.

- Envision a child's mobile. Imagine on the mobile are five family figures: mom, dad, sister, brother, and grandmother. The family is in balance until a family member's diagnosis takes place.
- Let's say the brother has just been in an accident and has sustained a spinal cord injury. Remove the brother from the imaginary mobile and what happens? The mobile becomes out of balance. For the family mobile to get in balance again, everyone needs to re-negotiate their position in the family
- Other family members may have their own difficulties. Their position in the mobile changes. For example, the sister is going through her own crisis from just being a teenager. Dad might not be able to deal with the added changes and starts drinking. Grandma is in her own world. Sometimes, the whole family mobile is trying to be balanced by one person. In this case. Mom.

D. COPING STRATEGIES

Part of *healthy grieving* is allowing yourself to grieve. Not doing so can cause emotional and/or physical problems later. Take care of yourself by:

- **Talking:** Use your social support system, or talk to a clergyperson or a counselor.
- **Writing:** Take up journaling, even writing letters to the deceased person about things you wished you would have said.
- **Reminiscing:** Remember the good times. Plant a garden in the person's honor, or support causes the person was involved in.
- **Getting enough sleep, exercising, and eating healthy:** Keep your body healthy. Do not turn to alcohol or drugs to numb the pain. This usually makes the situation worse.
- **Planning ahead:** Realize that anniversaries, holidays and special days will be difficult at first. Plan to spend time with a valued social support.
- **Don't be reluctant to ask for help:** Help is out there, just ask. (See Section I, Resources, later in this chapter.)

Client and family

DCWs must be aware of the needs of the people they are assisting. If you think a client is not grieving in a healthy way, talk to your supervisor. He or she may be able to arrange agency or community resources.

Direct care workers

People grieve differently. Allow yourself to grieve in your own way. You may need to talk to a valued social support. You may need to have some relaxation time. Try to be good to yourself and seek out the help that you need. Your supervisor may be very helpful in arranging agency or community resources to assist you.

E. CULTURAL AND RELIGIOUS ISSUES

Cultural and family differences will influence the death and dying process. DCWs should be aware of the various beliefs and practices of the people for whom they are providing care. Cultural differences vary, and it may be difficult to become culturally competent in all areas. Ask your supervisor for direction on how to handle an individual's needs.

Some religions or cultures:

- Discourage or forbid embalming and autopsy.
- Will not allow non-family to touch the body.
- Do not want the body to be touched shortly after death.
- Cover the mirrors in the home after a family member dies.
- Remove water from the room after family member dies.

F. ADVANCE DIRECTIVES

Advance directives are documents that specify the type of treatment individuals want or do not want under serious medical conditions in which they may be unable to communicate their wishes. Generally two forms are involved with advance directives:

- **Living will:** Outlines the medical care an individual wants or does not want if he or she becomes unable to communicate their wishes or make decisions.
- **Durable medical power of attorney:** Lists another person to act as an agent or a surrogate in making medical decisions, if the individual becomes unable to do so.

Advance directives can be done by an individual and do not require an attorney. The advance directive must be completed while the person is still competent. In Arizona, the forms do not have to be notarized. If the individual moves to another state that requires notarization, the Arizona forms would not be valid.

More information on advance directives can be found in Chapter 2, Ethical and Legal Issues in the *Principles of Caregiving: Fundamentals* course manual.

Pre-hospital medical care directive

The *pre-hospital medical care directive*, also known as a *do not resuscitate (DNR) order* or the *orange form*, is a special type of advance directive. This form states that if the heart stops beating or breathing stops, the individual does not want to receive cardiopulmonary resuscitation (CPR) under any circumstances. This special form, which is printed on bright orange paper, notifies the paramedics and emergency medical response team that this choice has been made.

The orange form should be displayed on the refrigerator or behind the living room door where the paramedics can see it, should the individual have cardiac and/or respiratory arrest.



If the client has an orange form, the DCW should contact the supervisor for guidance on the agency's policies and procedures relating to CPR for the client.

The orange form only covers cardiac and respiratory arrest. If the client has another type of medical emergency, the DCW should provide first aid measures, including calling 911 as indicated.

More information on advance directives for individuals residing in Arizona can be obtained from:

- Health Care Decisions, www.hcdecisions.org/
- Arizona Attorney General's website, www.azag.gov/life_care/index.html

G. HOSPICE

Hospice is a program of care and support for someone who is terminally ill. A physician has to certify that the person has less than six months to live. The person's diagnosis can be cancer, kidney failure, emphysema, Alzheimer's disease or any other condition that may be terminal. A specially trained team cares for the whole person. This includes his or her physical, emotional, social, and spiritual needs. Hospice also provides support to family members of the terminally ill person. Services are generally given in the home, but they may also be given at an in-patient facility. Hospice focuses on comfort measures, not on curing an illness. A DCW may provide housekeeping and other supportive services.



H. GRIEF ACTIVITY

The purpose of this exercise is to experience letting go of friends, family, and activities you dearly love. This exercise relates to some of the grieving indicators that your clients may experience.

Supplies

- 15 pieces of paper approximately (1" x 2") for each person.
- Pens.
- Garbage can.

Activity

Think of 5 family members, 5 friends or acquaintances, and 5 activities you like to do (example: reading, watching TV, tennis, bowling, sewing, running, etc.). Write the name of a family member, friend, or activity on each piece of paper. Then arrange the pieces of paper so you can see each one. Take some quiet time (approximately 2 to 5 minutes) and think of *each* person and *each* activity you chose.

- **Scenario 1:** Imagine you were just in a car accident and you have sustained a spinal cord injury. What activities, that now as a wheelchair user, are you prevented from doing? Tear up those activities and discard them. Are there any people you directly do these activities with? Tear up their names and discard them.
- **Scenario 2:** Imagine you have a persistent cough, so you go to the doctor. You find out you have cancer and you will need to undergo chemo therapy. It is suggested that you may need to take a one year leave of absence from work. Did you write down the names of any people you see at work? Tear up those names and discard them.
- **Scenario #3:** Imagine you have just found out you have been diagnosed with inoperable blindness. How will this affect the activities you have chosen? Tear up and discard those activities you will not be able to do because you are blind.
- **Scenario #4:** Now take two people you have chosen and just put them aside. How would you feel if they were not involved in your life anymore?

How did you feel when you had to actually tear up and discard any activities or people?
How did you feel when you removed and put two loved ones aside?

I. RESOURCES

- Area Agency on Aging Senior Help Line, (602) 264-2255
- Community Information and Referral, (602) 263-8856
- If the deceased person was open to hospice services, contact the social worker for that hospice agency.
- Advance directive information for individuals residing in Arizona can be obtained from:
 - Health Care Decisions, www.hcdecisions.org/
 - Arizona Attorney General's website, www.azag.gov/life_care/index.html

APPENDIX

Arizona Education Requirements for Direct Care Workers

Direct care workers (DCWs) must meet training and testing requirements if they work for agencies that provide services for publicly funded programs in Arizona.

This training requirement applies to these services provided in a person's home:

- Attendant care
- Personal care
- Housekeeping / homemaker

It applies to programs offered by these agencies:

- Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care Services (ALTCSS)
- Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD)
- Arizona Department of Economic Security (DES), Division of Aging and Adult Services (DAAS), and its programs offered by the Area Agencies on Aging (AAA).

Note: There are different training requirements for caregivers in assisted living facilities. Please contact the Arizona Department of Health Services for more information.

Education standards and requirements include:

- Obtain certification in cardio-pulmonary resuscitation (CPR) and first aid.
- Demonstrate skills, knowledge and ability *prior* to providing care as a paid caregiver:
 - Pass required knowledge tests.
 - Demonstrate skills.
- Training and testing is based on the Arizona Direct Care Worker Competencies.
- A DCW may be exempted from the initial training and testing process if the DCW meets one of the following:
 - A DCW with an initial hire date prior to January 1, 2011 is deemed to meet the training and testing requirements with the DCW agency where they are currently employed. If the DCW becomes employed with another agency on or after January 1, 2011, he or she will have to complete the competency testing.

Appendix

- A caregiver who is a registered nurse (RN), licensed practical nurse (LPN), or certified nursing assistant (CNA) is exempt from the DCW training and testing requirements. This exemption allows the DCW agency the discretion to test and train their employees as desired.
- A DCW who has not worked as a DCW or has not had work experiences similar to that performed by DCWs in the last two years will be required to demonstrate competency by passing both a knowledge and skills test prior to providing services.
- DCWs with prior experience may take a *challenge exam*. If they pass, no additional training is required at that level. The challenge exam may be taken only one time.
- In order to offer the Arizona Standardized DCW Test, an organization must be an *approved training program*. This can include agencies that hire DCWs and provide services, community colleges, and private vocational programs.

ARIZONA DIRECT CARE WORKER COMPETENCIES (KNOWLEDGE AND SKILLS)

Aging and Physical Disabilities (Level 2)

Topic Areas

- A. Roles and Responsibilities within the Agency and/or Community
- B. Chronic Diseases and Physical Disabilities
- C. Physical and Emotional Needs of an Individual
- D. Transfers and Positioning
- E. Personal Care
- F. Activities and Activity Planning
- G. Dementia-Specific Care
- H. Grief and End-of-Life Issues

Skills

Skills will be tested through description, role-play or simulation. The instructor will provide details about the scenario, adapting the scenario to the needs of the person receiving assistance. Instructors may ask for a description of the steps involved in performing skills, a simulation (role-playing) in a classroom setting, or demonstration in a home-setting where appropriate. With each skill, ancillary skills are to be demonstrated, including communication and enhancing dignity and independence.

1. Assistance with activities of daily living:
 - a. Dressing.
 - b. Grooming, including nail care, oral care, hair care and shaving.
 - c. Bathing (tub bath, shower, sponge bath / bed bath).
 - d. Toileting needs (emptying catheter bag; use of bedpan).
 - e. Eating (total assistance/feeding, prompting/hand-over-hand assistance).
2. Techniques for positioning and transferring a person:
 - a. Assistance with ambulation.
 - b. Application and use of gait belt.
 - c. Techniques for positioning a person (bed / wheelchair).
 - d. Transfer in and out of a wheelchair.

- e. Transfer out of bed.
3. Redirect a person with dementia.

Chronic Diseases and Physical Disabilities

1. Explain the terms aging, chronic illness and disability.
2. Describe the following body systems and their main function:
 - a. Heart and circulation.
 - b. Lungs.
 - c. Brain and nervous system.
 - d. Skin, muscles and bones.
 - e. Stomach, bowels and bladder.
3. Explain the effect of aging on the body.
4. Identify common conditions affecting each body system, and explain how these would affect a person's care.
5. Describe signs and symptoms of anxiety and depression.
6. Explain the terms paralysis and amputation.

Physical and Emotional Needs of an Individual

1. Describe the impact of aging on the physical and emotional needs of an individual.
2. Describe the physical and emotional needs of a person with a psychological or cognitive condition.
3. Give examples of how to determine a person's abilities, needs, and wishes when providing services.
4. Discuss the possible emotional impact of a physical disability or chronic disease.
5. Describe how age, illness and disability affect sexuality.

Transfers and Positioning

1. Identify and describe common assistive devices, including gait belt, walkers and wheelchairs.
2. Explain the importance of proper transfer skills and the safe use of assistive devices.
3. Explain the importance of repositioning and list techniques for preventing skin damage and pressure ulcers.
4. Describe the purpose of a mechanical lift and/or slide board.

5. Describe and role-play techniques for positioning and transferring a person.
 - a. Assistance with ambulation.
 - b. Application and use of gait belt.
 - c. Techniques for positioning a person (bed / wheelchair).
 - d. Transfer in and out of a wheelchair.
 - e. Transfer out of bed.

Personal Care

1. Identify and explain the relationship between a person's service plan and the DCW role when providing assistance with activities of daily living (ADLs).
2. Give examples of techniques that can be used to preserve dignity and privacy while providing personal care.
3. Give examples of techniques that can be used to promote independent functioning and respect a person's preferences while providing personal care.
4. Identify 3-4 characteristics of people who might be at risk for skin-integrity concerns.
5. List the most common causes of skin breakdown.
6. Simulate/role-play or describe assistance with ADLs:
 - a. Dressing.
 - b. Grooming, including nail care, oral care, hair care and shaving.
 - c. Bathing (tub bath, shower, sponge bath / bed bath).
 - d. Toileting needs, including the use of incontinence products and colostomy devices; emptying catheter bag; positioning of bedpan.
 - e. Meals (total assistance/feeding; prompting/hand-over-hand assistance).

Activities and Activity Planning

1. Identify basic principles and purposes of activities and give examples.
2. Describe how a person's functional status affects activities.
3. Give examples of activities suitable for consumers with specific disabilities.
4. Describe the individual's right to choose or refuse activities.
5. Give an example of choosing an activity appropriate to a person's cultural or religious background.

Dementia-Specific Care

1. Define different types of dementia.
2. Describe the stages of dementia.
3. Understand changes in cognitive abilities, and describe the difference between normal forgetfulness and forgetfulness associated with dementia.
4. Identify dementia-related symptoms of depression and withdrawal from normal life activities.
5. Understand changes in behavior and emotions.
6. Identify and describe dementia-specific care related to:
 - a. Communication issues and the use of a life story.
 - b. ADLs.
 - c. Managing difficult behaviors.
 - d. Planning activities.
 - e. Pain management.
 - f. Safety issues.
7. Role-play or describe how to redirect a person with dementia.

Grief and End-of-Life Issues

1. Identify the stages of grief.
2. Give examples of behaviors at different stages of grief.
3. Understand that death is unique to each individual.
4. Describe physical (and emotional) aspects of the dying process.
5. Give examples of how cultural and family differences influence the death and dying process.
6. Explain how a death can affect a DCW.
7. Identify and explain coping strategies relevant to grieving and/or dying.
8. Describe resources the community has to offer.

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