KEYNOTE: Compassion Fatigue - Mike Boniello, LCSW. A secondary trauma which occurs typically among helping professionals and caregivers. This session will provide an in-depth overview of the signs of compassion fatigue, why it happens and how to create a life/work balance.

ATTENDANCE ENCOURAGED. REGISTRATION REQUIRED.
BIOGRAPHICAL SKETCH

MICHAEL BONIELLO, LSCSW LCSW

Michael Boniello is a licensed clinical social worker in both Kansas and Missouri. He has been in private practice for the past 28 years in Prairie Village, KS where he has specialized in trauma recovery, addictions (including sexual compulsivity) and the treatment of sex offenders. Prior to establishing his own practice, he served as program manager of adolescent sex offenders at the Wyandot Center and as a staff clinician on the adult sex offender unit. In addition to his clinical practice, he has consulted with a number of agencies including the Division of Family Services (DFS), the Division of Children and Families (DCF) and Lansing Correctional Facility. He has also presented at numerous conferences on the state, national and international levels on topics as varied as Assessing Sexually Addictive Behavior, The Treatment of the Sexually Abused Child, Managing Compassion Fatigue and the Treatment of Clergy Who Offend. Lastly, he was a faculty member at the University of Kansas from 1995–2015 where he taught Clinical Social Work Practice, Mental Health and Psychopathology, Clinical Social Work Supervision, Solution Focused Therapy and Social Work with Traumatized Populations.
UNDERSTANDING COMPASSION FATIGUE IN THE WORKPLACE

MICHAEL BONIELLO
LSCSW LCSW

DEFINING COMPASSION FATIGUE

COMPASSION FATIGUE IS A TYPE OF SECONDARY TRAUMA WHICH OCCURS TYPICALLY AMONG HELPING PROFESSIONALS,
› PROFESSIONAL CAREGIVERS AND NONPROFESSIONAL CAREGIVERS.
› IT OCCURS AS A RESULT OF PROLONGED EXPOSURE TO OTHERS WHO HAVE EXPERIENCED TRAUMA, WHO ARE IN NEED OF SERVICE AND/OR REQUIRE THE RESOURCES OF OTHERS TO SURVIVE EMOTIONALLY, PHYSICALLY, OCCUPATIONALLY AND/OR FINANCIALLY.

DEFINING COMPASSION FATIGUE

› COMPASSION FATIGUE HAPPENS MOST OFTEN WHEN THERE IS A COMBINATION OF:
› HIGH DEMAND FOR PROFESSIONAL AND PERSONAL RESOURCES IN ORDER TO PROVIDE SERVICES (CATALYST FOR CHANGE)
› LITTLE RETURN IN TERMS OF SALARY, BENEFITS, SUPPORT AND/OR DIRECTION (SUPERVISION)
› SELF-MEDICATION IN ORDER TO RESOLVE THE DISCREPANCY BETWEEN ENERGY DEMAND AND COMPENSATION
REASONS FOR COMPASSION FATIGUE
» LOW SALARY/FINANCIAL STRESS
» LACK OF BENEFITS
» LACK OF ADEQUATE SUPERVISION
» LACK OF SUPPORT
» CRITICAL JUDGMENT OF SERVICE
» LACK OF RESPECT FOR WORK BY OTHERS
» UNDERAPPRECIATION OF SERVICE BY CLIENTELE
» UNRESOLVED TRAUMA IN PERSONAL LIFE
» STRESS RELATED TO MULTI-TASKING
» GOSSIP IN "THE WORKPLACE"

TOP MEANS OF SELF MEDICATING
» High carbohydrate, high fat "comfort" food
» Caffeine
» Nicotine
» Over-the-Counter medications

» There is a dramatic rise in sexual addiction, gambling and spending compulsion as in the rest of society. Although present, alcohol and/or drugs are not readily used recreationally or in excess by helping professionals.

RAMIFICATIONS OF SECONDARY TRAUMA
» PHYSIOLOGICAL/BIOCHEMICAL
» IMMUNE SYSTEM DISTURBANCE(S)
» ARousAL SYSTEM DISTURBANCE(S) RESULTING IN POSSIBLE SLEEP DISORDERS, SEXUAL DISORDERS, EATING DISORDERS, DISORDERS OF DIGESTION AND ELIMINATION, HYPERAROUSAL, ANXIETY AND DEPRESSION
» SOMATIC DISORDERS
» HYPERSENSITIVITY TO ENVIRONMENTAL STIMULI PARTICULARLY WITH REGARDS TO RAPID CHANGES AND TRANSITIONS
» PROPENSITY TO SELF MEDICATION AND ADDICTION
RAMIFICATIONS (CONT’D)

» EMOTIONAL
  RAPID MOOD SHIFTS COINCIDING WITH CHANGES IN INTERNAL AND/OR EXTERNAL ENVIRONMENTS
  UNRESOLVED GRIEF RESPONSE
  FEELINGS OF POWERLESSNESS AND HOPELESSNESS
  EMOTIONAL BLUNTING AND FEELINGS OF DETACHMENT
  EMOTION DYSREGULATION

RAMIFICATIONS OF SECONDARY TRAUMA

» EMOTIONAL CONT’D
  ANXIETY/PANIC DISORDERS
  DEPRESSION (MOST OFTEN DYSTHYMIC DISORDER)
  LACK OF EMOTIONAL-COGNITIVE-BEHAVIORAL CONGRUENCE
  LONGER THAN NORMAL RECOVERY PERIOD AFTER EMOTIONAL DISTURBANCE OCCURS

RAMIFICATIONS (CONT’D)

» COGNITIVE
  DISTURBANCE IN PERCEPTION (RE: SELF, BODY IMAGE, INTENTIONS OF OTHERS, INCREASED PARANOIDIA, ETC.)
  DISTURBED PHYSICAL, EMOTIONAL AND SOCIAL BOUNDARIES
  LACK OF TRUST IN THE SOCIAL ENVIRONMENT
  PHOBIAS
  MEMORY DISTURBANCE (SHORT TERM IN PARTICULAR)
  LEARNING DISORDERS
  RUMINATIVE THOUGHT PATTERNS
RAMIFICATIONS OF SECONDARY TRAUMA

Cognitive

- Disturbed Personality Development (Protection vs. Adequacy)
- Depersonalization of Self and Others
- Self Harm Ideation

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RAMIFICATIONS (CONT'D)

Behavioral

- Poor Impulse Control
- Ineffective Coping (Regression, Denial and Projection)
- Ineffective Judgment and Decision Making
- Ineffective Selection Process
- ADHD Like Symptoms
- Sexualized Behavior
- Dependency/Codependency
- Adrenaline Dependency

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RAMIFICATIONS OF SECONDARY TRAUMA

Behavioral (Cont’d)

- Controlling Behaviors
- Obsessive–Compulsive Patterns of Behavior
- Repetition Compulsion
- Antisocial Behaviors
- Self Defeating Behaviors
- Self Harming Behaviors (E.g. Self-Medication)
RAMIFICATIONS (CONT’D)

> SPIRITUAL
>
> LACK OF BLUEPRINT OR LIFE PLAN LEADING TO CHRONIC DEPRESSION AND ANXIETY
> AMORALITY
> EXISTENTIAL LONELINESS
> ETHICAL DIFFICULTIES IN PRACTICE

SYMPTOMS OF COMPASSION FATIGUE

JOB TASKS

Decrease in quality of work
Decrease in quantity of work
Low Motivation
Avoidance of job tasks
Procrastination
Perfectionism (obsessive thoughts/behavior)

SYMPTOMS OF COMPASSION FATIGUE

> MORALE
>
> Decrease in confidence
> Loss of interest in work/profession
> Negativity
> Apathy
> Demoralization
> Lack of appreciation
> Detachment
> Feelings of inadequacy
SYMPTOMS OF COMPASSION FATIGUE

INTERPERSONAL
- Withdrawal from colleagues
- Impatience/increased irritability
- Decrease of communication
- Increase in codependency
- Staff conflicts
- Shift in ability to maintain professional boundaries

SYMPTOMS OF COMPASSION FATIGUE

BEHAVIORAL
- Increase in absenteeism
- Exhaustion
- Physical illness (arousal system, immune system)
- Impaired judgment
- Increase in tardiness
- Overwork
- Frequent job changes (especially in the same agency)

INTERVENTIONS TO MANAGE COMPASSION FATIGUE

Michael Boniello
LSCSW, LCSW
ENHANCE RESILIENCY

- THROUGH EMOTION REGULATION
- BEHAVIORAL MODIFICATION

TWELVE INTERVENTIONS

1. EATING
   Nutritionists have known lowered carbohydrate and fat intake will promote health & help us become resilient both physically and emotionally.
   - 6 smaller meals containing combination of carbohydrate and protein to enhance energy and brain power for longer periods of time

TWELVE INTERVENTIONS

2. EXERCISE
   - For healthy metabolism — Trainers suggest 30 minutes of low impact exercise three times a week
   - For stress and/or compassion fatigue management — 45 minutes four times a week
TWELVE INTERVENTIONS

3. ELIMINATION
   - 6-8 cups of water per day
   - 4-6 cups of water per day if in combination with a high fruit and/or vegetable diet
   - Other beverages may be consumed but should not take the place of water intake
   - At least 2 meals/day containing high fiber

4. SLEEP
   - 7-9 hours / per night
   - Power naps although suggested should not take the place of nightly sleep

3. EMOTIONAL REGULATION
   - Know your emotional triggers
   - Find healthier coping strategies (problem solving)
   - Don't sweat the small stuff – remain "Mindful"
   - "Balance the Brain" by grounding
TWELVE INTERVENTIONS

6. SELF SOOTHING

7. RELAXATION
   - 25 minutes 3/week

8. RECREATION

9. SET HEALTHY BOUNDARIES

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TWELVE INTERVENTIONS

10. SUPPORT
   - Support of "like people"
   - Support of "unlike people"

11. PSYCHOPHARMOCOLOGY &
     PSYCHOTHERAPY

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TWELVE INTERVENTIONS

12. ADMINISTRATIVE SUPPORT

\[SUPervisors\ AND\ Administrators\ SHOULD: \]
   - Promote a healthy work environment
   - Promote a safe work environment
   - Support a work environment that supports
     healthy living
   - Provide adequate supervision and direction
   - Promote educational advancement
   - Support increased benefits/salary packages
     (when able)
HELPFUL REMINDERS

- Remain mindful
- Reduce intake of carbohydrates and fats in your diet
- Reduce intake of nicotine, caffeine and alcohol
- Reduce intake of carbonated beverages especially the high caloric, caffeinated types
- Form a social network of supportive people
- Set healthy limits around giving
- "Don’t sweat the small stuff"
- Self-soothe whenever possible
Section Objectives

Participants will be able to:

• Understand the prevalence of dementia in the IDD population and the diagnostic process

• Understand the importance of utilizing early and ongoing assessments

• Know how to more effectively communicate to those with dementia

• Share knowledge, challenges, and concerns with others in this session
Most adults with ID are typically at no more risk than the general population.
  - However, adults with Down syndrome are at increased risk.

In the USA, an estimated 9,000+ adults with ID may be affected.
  - This number is expected to at least triple in the next 20 years.
Higher Prevalence of Alzheimer's in People with Down Syndrome

Studies suggest that more than 75 percent of those with Down syndrome aged 65 and older have Alzheimer's disease, nearly 6 times the percentage of people in this age group who do not have Down syndrome.

www.alz.org/dementia/down-syndrome-alzheimers-symptoms.asp
Symptoms of Dementia in Individuals with Down syndrome

• In people with Down syndrome, changes in overall function, personality and behavior may be more common early signs of Alzheimer's than memory loss and forgetfulness.

• Memory loss also may occur.

• Look for signs and symptoms in adults when they are in their late 40s or early 50s.
Atypical Presentation of Alzheimer’s in DS

- Earlier onset than general population (> 40).
- Management similar to general population.
- No strong evidence that Alzheimer’s drugs benefit.
- Depression and thyroid disease common in DS and can mimic dementia.
- Normal age-associated deficits are common.
- Often present with behavioral symptoms instead of memory loss.
- Seizures, myoclonus (sudden, involuntary muscle contractions or relaxation)
Symptoms of Dementia in Individuals with Down syndrome

**Early symptoms may include:**

- Reduced interest in being sociable, conversing, or expressing thoughts
- Decreased enthusiasm for usual activities
- Decline in ability to pay attention
- Sadness, fearfulness, or anxiety
- Irritability, uncooperativeness, or aggression
- Restlessness or sleep disturbances
- Seizures that begin in adulthood
- Changes in coordination and walking
- Increased noisiness or excitability
Why is Diagnosis More Difficult in Adults with ID?

**Inability to report** - Individuals with ID may not be able to report signs and symptoms.

**Habituation** - Subtle changes may not be noticed.

**Assessment tools lacking** - Most generally used dementia assessment tools are not relevant for people with ID as the measures often test for skills or knowledge not often possessed by adults with ID.

**Measuring change** - Difficulty of measuring change from previous level of functioning.

**Mistaken identity** - Conditions associated with ID, such as lifelong cognitive impairment, may be mistaken for signs of dementia.
# NTG-EDSD

The NTG Early Detection Screener for Dementia, derived from the DSMS, can be used for early detection of those with an intellectual disability who are suspected of having dementia or any other signs of mild cognitive impairment. It is a five-question self-administered instrument that is expected to be understood by those with intellectual disabilities, independence, and basic reading comprehension level. It is self-administered and subject to recall and can identify individuals at high risk for further assessment. An increased score may suggest non-dementia cognitive impairment, and further assessment may be needed. The instrument is designed for use by persons with mild to moderate intellectual disabilities. It is a screening tool to help identify persons who may be at risk for dementia.

**Instructions:** For each question block, check the item that best applies to the individual or situation.

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## 1. Date:

- First: 
- Last: 

## 2. Date of birth:

- First: 
- Last: 

## 3. Sex:

- Female
- Male

## 4. Best description of level of intellectual disability:

<table>
<thead>
<tr>
<th>Level of Intellectual Disability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No discernible intellectual disability</td>
<td></td>
</tr>
<tr>
<td>Mild (IQ 55-69)</td>
<td></td>
</tr>
<tr>
<td>Moderate (IQ 40-54)</td>
<td></td>
</tr>
<tr>
<td>Severe (IQ 25-39)</td>
<td></td>
</tr>
<tr>
<td>Profound (IQ 24 and below)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

## 5. Diagnosed condition (check all that apply):

- Autism
- Cerebral palsy
- Down syndrome
- Fragile X syndrome
- Intellectual disability
- Prader-Willi syndrome
- Other

## Current living arrangement of person:

- Lives alone
- Lives with spouse or friend
- Lives with parents or other family members
- Lives with paid caregiver
- Lives in community group home, apartment, supervised housing, etc.
- Lives in senior housing
- Lives in congregate residential setting
- Lives in long term care facility
- Lives in other
Family Questionnaire

In order to have a better understanding of your loved one and how to work best with him/her, we ask that you assist us in gathering information regarding their past. This will include information such as where they were born, where they grew up, early family life, siblings, hobbies and interests, current family life, past work history and personality characteristics that make them unique. This information will help us to discover meaningful activities for each individual, track any unusual behaviors, and assist with our memory retention exercises.

Individual’s Name: ___________________________ Date: __________________
Source (s) of information: _____________________ Relation: _________________
Current Living Conditions: ______________________________________________

All questions below pertain to the individual being evaluated:

Personal History

Full Name: ___________________________ Nickname: ___________________________
Maiden Name: ___________________________ Religion: ___________________________
Ethnicity: ___________________________ Birth date: ___________________________
Past Education: ___________________________ Past Occupation: ___________________________

1) What age do you think your loved one is living in their mind?
   Do they look for their mom or dad?
   Do they perceive them self as younger?

If yes, please describe:
The Importance of Differential Diagnosis

1. Rule out treatable conditions.
2. Receive appropriate treatment and support services.
3. Maintain the highest possible quality of life and functioning.
Essentials of a Diagnostic Workup

• **History and physical** (including psychiatric, personal, past medical and family histories and mental state assessment)

• **Lab tests**
  
  Evidence supports the following tests:
  
  • Complete blood cell count
  • Serum electrolytes
  • Glucose
  • BUN/creatinine
  • Serum B12 levels
  • Thyroid function tests
  • Liver function tests
  • Celiac screening if DS

• **MRI and/or CT scan to detect lesions that could result in cognitive impairment.**
Psychotropic Medications

• Although the Food and Drug Administration has not approved pharmacotherapy for *neuropsychiatric symptoms* (such as aggression, agitation, depression, anxiety, delusions, hallucinations, apathy, disinhibition), psychotropic medications are frequently used to manage these symptoms.

• There are a few cases of proven pharmacological efficacy, however, significant risk of adverse effects may offset benefits.

• Non-pharmacologic approaches to difficult behaviors should always be tried first with pharmacotherapy a last resort.
1. Difficult behaviors cannot be changed with words

- Technique: Change your:
  - approach to the person
  - reaction to the behavior
  - the environment
- Individuals with dementia have impairments in short term memory as well as an inability to learn new information.
- A person with dementia cannot be told to do, or not do, something and be expected to remember.

Credit is given to Paul Raia for these original ideas.
Communication Strategies (#2)

2. Don’t say “No” and NEVER ARGUE!

- You cannot reason with a person who has lost the intellectual ability to process thoughts in a logical and rational manner.
- Arguing will encourage frustration, fear, and anger.
- The goal is not to be correct!
- Remember – the person is experiencing a decline in their reasoning skills at the same time they are experiencing an increase in their emotional reactions.
- Feelings are more important than facts.

Example: Donna tells you she is a movie star. Agree with her. It hurts no one to let her live in a reality that may be more reflective of her dreams than the life she actually lived.
Communication Strategies (#3)

3. It’s their reality and you must enter it

• **Technique: Validation**
  • Builds empathy and creates a sense of trust and security that reduces anxiety.
  • Enter their reality and reminisce with them.
  • Match their emotions.

Example: Tom tells you that his mother was here today (but you know his mother died last year). You say, “That’s wonderful. You must love your mother very much.”
Communication Strategies (#4)

4. Reduce fear and acknowledge underlying emotions

- As the disease progresses the person loses the ability to express and cope with their fears.
- Persons with dementia cannot “self soothe” if their fears become overwhelming.
- Reassure the person and respond to their emotion.
Is it something I did??

For example:

• Did I argue? Tell the person “no.”
• Was I rushing the person?
• What language was my body language sending?
• Was I overestimating what the person was capable of doing? (i.e. too many steps to the task)
Trigger: Pain/Discomfort

• Does this person have any known medical conditions that may produce pain:
  • Ex. Arthritis, migraines, osteoporosis, stomach problems

• Has there been a recent change in medications?
  • Ex. New medication or increased dosage – side effects?

• Could there be the onset of a new acute illness?
  • Urinary tract infection, impaction, pneumonia can cause delirium and produce a sudden change in mental status. Delirium is a medical emergency.

• Is the person too hot, too cold, clothes uncomfortable, need to change their position, etc.

• Are they in emotional pain?
  • Ex. Frustrated at being expected to do a task that is beyond their ability, scared, feeling threatened, depressed, anxious?
Trigger: Environmental

- New or unfamiliar setting, change in routine
- Change in staff
- Noise
  - TV, radio, overhead paging system, people talking
- Lighting
  - People with dementia need 30% more light than we do.
  - Glare, shadows
- Large number of people
  - Over stimulating
- No orienting cues for way finding.
  - Bedroom, bathroom
IDD Dementia Coalition
• Questions?
• Comments?
Common Health Problems for Individuals with I/DD and How They Can Be Prevented:

The Fatal Five

Julie Cooper, BSN, RN MA
Five Common Health Issues in the IDD population, with the potential to be life threatening:

- Dysphagia/Aspiration
- Dehydration
- Constipation
- Epileptic Seizures
- Sepsis
Dysphagia/Aspiration

- Dysphagia - Difficulty in swallowing
- Aspiration - Occurs when bits of food, fluid and saliva or other materials are inhaled into lungs.
Who is at Risk?

- People assisted in eating by other people.
- Those with weak or absent coughing/gagging reflexes; this is seen commonly in persons who have Cerebral Palsy or Muscular Dystrophy.
- Persons with poor chewing or swallowing skills
- Food stuffing behavior, rapid eating/drinking and pooling of food in mouth.
Who is at Risk? (Cont.)

- Medication side effects that can cause drowsiness and/or relaxed muscles causing delayed swallowing and suppression of gag reflex
- Impaired mobility that leaves a person unable to sit upright while eating
- Seizure activity while eating or drinking, or failure to place someone on their side after a seizure, which would allow oral secretions to enter the airway.
Behaviors/Actions that may Indicate Aspiration:

• Fear or reluctance to eat
• Coughing or choking during meals
• Refusing fluids and/or food
• Eating extremely slowly
• Fluid and food falling out of person’s mouth
• Eating in an unusual position
• Only wanting to eat when being assisted by a “favorite caregiver”
Signs and Symptoms that may Indicate Aspiration:

Many of the same behaviors listed in the previous slide, but with the addition of:

- Irregular breathing
- Moist sounding respirations
- Wheezing or rapid respirations
- Turning blue while eating
- Intermittent fevers
- Chronic dehydration
Signs and Symptoms that may Indicate Aspiration: (cont.)

- Regurgitation
- Emesis (vomiting)
- Rumination - chewing food and holding food in mouth for a long time, until soft enough to swallow, and/or regurgitating small amount of food into mouth.
Interventions for Aspiration:

• Use the chin-down position while assisting at-risk person with eating or drinking; encourage this position with those who can eat/drink without assistance.
• Nectar-thickened liquids (Need Physicians order)
• Honey-thickened liquids (Need Physicians order)
• Dental soft diet
• Pureed diet (Need Physicians order)
Constipation:
When _____ Doesn’t happen…

• Constipation is when an individual has a difficult time:
  Passing stool
  Passing hard, dry stools
  Passing stools that are small and marble like

• Bowel movement frequency varies from person to person

• Normal bowel movements are defined as:
  Soft, normal sized feces that are passed easily out of the bowel
Risk Factors for Constipation:

- Neuromuscular degenerative disorders
- Spinal cord injuries or birth defects
- Persons with muscle weakness, who lack tone and strength needed for adequate bowel function
- Diets lacking in adequate fiber and fluids
- Aspiration risk with poor swallowing skills
- Inconvenient / inadequate access to the bathroom
Risk Factors for Constipation: (cont.)

• Immobility and poor body alignment
• Medications that slow down gastric motility
• Hemorrhoids or conditions that make bowel elimination painful
• History of frequent bowel stimulation use, which can cause decreased bowel reactivity
• Psychiatric issues that manifest as the repression of the urge to defecate
Constipation signs and symptoms:

- Spending a lot of time sitting on the toilet
- Grunting and/or straining while passing stool
- Refusal to eat or drink
- Small, hard dry feces
- Bloating and complaints of stomach discomfort
- Protruding hard abdomen (can be a medical emergency)
- Emesis (vomiting) that smells like feces (is an emergent issue)
Interventions/Prevention:

- Consultation with Primary Care Physician or Dietitian
- Implement an individual constipation protocol
- Exercise, increase activity level
- Review medication regimen
- Treat reasons for painful bowel movements, i.e. hemorrhoids
- Review bathroom access
- Lastly medication interventions to address severe constipation concerns
Observations that prompt concern:

- No bowel movement for more than three days
- Last two bowel movements were hard
- In last three days, only small bowel movements reported
Dehydration:

Occurs when an individual does not drink enough or does not have the opportunity to drink enough fluids.

Dehydration occurs when more fluids are lost than are replaced.
Dehydration risks factors:

- Persons unable to access fluids without assistance
- Trouble swallowing with coughing and choking during meals
- Fluid, food and saliva falling out of an individual's mouth
- Refusing fluids and food
- Inability to effectively communicate thirst to caregivers
- Medical conditions that can affect fluid levels
- Conditions where the body fluids are lost
- Medications that can affect fluid balance in the body
Signs and Symptoms of Dehydration:

• Dry skin with poor elasticity
• Extreme thirst
• Sticky, dry mucus
• Lethargy and decreased alertness
• Fever
• **Increased heart rate, decreased blood pressure**
• Concentrated urine that is dark colored and has a strong smell, decreased urination
Interventions for Dehydration:

• Offer fluids if the person can drink safely, and is alert

• If not able to safely take fluids, call health professional for administration of Intravenous fluids (IV fluids)
Seizure Disorder:

Epilepsy is a brain disorder that is characterized by recurring seizures.
Factors that place individuals at Risk for Epilepsy:

- Pre-natal and Post-natal brain injury, such as:
  - Trauma
  - Anoxia
  - Infection
- Congenital brain malformations
- Aneurysms, hemorrhage, clots, and brain tumors
- Traumatic brain injuries
Immediate interventions for Seizure activity:

- Guide the person away gently from or prevent access to dangerous areas, stay with the person
- **DO NOT PLACE ANYTHING IN THE PERSONS MOUTH**
- Prevent injury by moving objects that could cause injury away from the person
- Only move the person is unsafe area
- If in water, keep persons head above water
- Do not restrain the person
- Protective pad under person head, arms and legs
- Track how long the seizure lasts
After the seizure:

• Loosen clothing
• Check for injuries and treat as needed
• Document seizure on a seizure calendar or record
• Sufficient time to recover needs to be given, before resuming activity
JC2  

person recovering from a seizure

Julie Cooper, 7/16/2014
General Interventions:

- Track on seizures in a consistent manner
- Monitor for side effects to seizure medications
- Maintain a safe environment
- Train all caregivers on individual seizure protocols
SERIOUS BUSINESS
Septicemia and sepsis are serious bloodstream infections that can rapidly become life-threatening. They arise from various infections, including:

- skin
- lungs
- abdomen
- urinary tract
What you need to know

- Hospitalization rates for septicemia or sepsis more than doubled from 2000 through 2008
- Patients hospitalized for septicemia or sepsis were more than eight times as likely to die during their hospitalization
What should I do?
Any two of the signs below that are new **AND** a known or suspected source of infection.

- fever
- low blood pressure
- rapid respirations
- high blood sugar
- low body temp
- chills
- altered mental status
Signs of Sepsis cont.

- Temperature greater than 100.9°F, or less than 96.8°F
- Heart rate greater than 90 beats per minute
- Breathing greater than 20 breaths per minute
- Low blood pressure
- Altered mental status
- Blood sugar greater than 120 in the absence of diabetes.

Fact: Every hour that passes without treatment raises the risk of death by 10%
Advocate!

Be prepared to make your case when going to the Emergency Department:

• Ask for a blood culture.
• Explain what current infectious process may be occurring and what 2 vital signs are out of parameter for the individual.
• Early diagnosis can save the life of someone you support, or your own.
The Fatal Five

- The previous slides discussed major health issues that are very common in the I/DD population
- These health issues can lead to severe morbidity and death
- With increased monitoring we can help prevent these conditions and increase quality of life
References

• Agency for Healthcare Research and Quality.
• Health Risk Screening Tool, developed by Karen Green McGowan, RN, CCDN.
• MedlinePlus Medical Encyclopedia. Septicemia. U.S. National Library of Medicine National Institutes of Health
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• National Institutes of Health
• Illinois Department of Human Services
• “Mosby’s Textbook for the Home Care Aide”
• Bowel and Bladder Foundation