



# Durham Region PRC Bulletin

Compiled by the Psychogeriatric Resource Consultants  
of Durham Region

24<sup>th</sup> Edition  
July 2008

The role of the **Psychogeriatric Resource Consultants (PRC) of Durham Region** is to enhance and co-ordinate supports for long term care homes and community agencies. The aim is the development of expertise in the care and support of older clients with complex and serious mental health needs and their associated responsive behaviours.

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## A Day in the Life of...Sharing a Patient's Story

Transferring care of a patient from one facility to another is a significant process to ensure the optimal well-being and success of that individual in their new setting. When we consider an elderly individual with a mental health challenge or memory disorder, this process of communication between caregivers upon discharge becomes a crucial one. The intricacies of an individualized plan of care are the keys to success for these patients and when disrupted, can pose challenges and often relapse. The nursing staff in the Seniors Mental Health Program at Whitby Mental Health Centre have developed a unique approach to conveying the patient's daily routine and plan of care to receiving caregivers. In consultation with the health care team and patient/family when possible, the primary or associate nurse facilitates the creation of 'A Day in the Life of...' in preparation for discharge. The patient's story, written in first person, walks the new caregiver through a typical day from beginning to end, focusing on precise preferences, approaches and strategies for success.

In May 2008, staff from Whitby Mental Health Centre (WMHC) had the pleasure of presenting this innovative discharge tool at the Ontario Gerontology Association Annual Conference in Toronto. Dr. Jean Byers, Julie Salkeld RN, Helen Hadwin RPN and Sandra Mairs RN highlighted the history of the tool, how it is developed, stakeholder feedback and shared samples with the audience.

The original idea for "A Day In The Life Of..." began years ago as a solution to a problem part-time staff were experiencing on the Seniors Memory Disorders Unit. They felt a disconnect and believed there was a lack of information sharing in regards to the daily needs of patients and ensuring individual preferences were respected. In response to this, the tool was created to provide each staff member with easy access to each patient's plan of care. From there the idea grew into the format used today.

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## PSYCHOGERIATRIC RESOURCE CONSULTANTS OF DURHAM REGION

Sponsored by the Special Services, Whitby Mental Health Centre and the Alzheimer Society of Durham Region, 905-668-5881 or 1-800-341-6323, Jan Katchaluba (ext 6530) or Melanie Kelly (ext. 6256).

# Environments: Understanding the Physical and Social Supportiveness for Persons with Dementia

## Maximize Safety and Security

The safety of residents in long term care facilities is a major concern because of the need to supervision. Staff notes challenges especially with reduced staffing ratios of evenings and weekends. Safety for both residents and care providers is paramount.

Let's look at ways to modify some common problem areas in nursing homes first.

- Because some people put things in their mouths, make sure there are no poisonous plants on the unit or outside in the yard. No cactus or other prickly plants, either. This link offers more information about poisonous plants. <http://www.sickkids.ca/ontariopoisoncentre/default.asp>
- Install motion-sensor lights outside bathroom doors to turn on automatically when residents go into the bathroom. This limits confusion, reduces falls risk. Illuminated light switches are also useful.
- A walk-in shower with a slanted floor with no lip is a good choice for someone who is afraid to bathe.
- Use contrasting colors to distinguish objects. For example, dishes should stand out from your tablecloth, and dark bathroom walls will make the porcelain fixtures more identifiable. Move brightly coloured targets such as hampers and wastepaper baskets so they won't be confused with the commode.
- Don't leave electric razors in the bathroom.
- Make certain windows don't open far enough to climb through.
- Consider camouflaging off-limit doors, closets and locks with painted murals, fabric or wallpaper. You might also hide entrances with these interventions.
- Though you need to deter the person from wandering off the property, make sure there's enough safe space to walk or sit safely and comfortably outside. It's better not to design an overly restrictive environment, as this can agitate many people. If the person is not safe outside alone, plan regular supervised outings.
- If the person gets restless in the middle of the night, set up an activity beforehand. It should be simple, so that it's not overwhelming. Perhaps leave the TV on and have a snack ready.

### Eight therapeutic goals of dementia care environments

1. maximize awareness and orientation
2. maximize safety and security
3. provision of privacy
4. regulation of stimulation
5. quality of stimulation
6. support functional abilities
7. opportunities for personal control
8. continuity of self
9. facilitation of social contact

Quality of life for the residents can be enhanced greatly with some simple environmental modifications. The theme in literature focuses on regulation of environmental stimulation. Modifications to enhance quality of life range from reducing stress by creating a calm quiet environment to socially meaningful activity and stimulation.

- Help ward off depression with as much natural light as possible, using windows and skylights. But keep down glare with window treatments.
- Use even lighting throughout the home, as abrupt changes in light levels can be disorienting.
- Hang colorful artwork at the end of halls to draw the person down the corridor. Make the end of the hall a rest stop by adding a comfortable chair.
- Textures are good as long as they're soothing. Consider putting a sheepskin rug on the wall or piece of furniture.
- Buy furniture with a wide base, so pieces won't tip over. Washable coverings, such as vinyl and leather, are preferable. Patterns should be simple.
- The use of mirrors depends on the individual. Mirrors can trigger delusional behavior in some. Door mirrors might deter some from leaving a room. Some older people are confused by mirrors, because they picture themselves as much younger than the person staring back at them. Some think the image is a ghost and others see someone to keep them company.

*Maximize Safety and Security Continued from Page 3*

- If the person asks the same question repeatedly, write down the answer and put it in an appropriate spot. This might help lower the anxiety level for both you and the resident.
- Music is good, but keep it down. Loud sounds can be agitating.

Another safety issue is the conflict that often erupts between residents. Violent threats and physical aggression can erupt without any notice by those upset about personal space being invaded, rummaging and just walking into their space.

- To discourage wandering into rooms that are off-limits, a contrasting-color floor covering might deter someone with impaired depth perception. Dark rugs and floor tiles may be perceived as holes. Consider if this change in floor colouring is best as a deterrent and is seen as a barrier.
- Some residents may be deterred by large signs that say STOP or Private property. They are available at children's educational stores.
- Motion detectors and alarms can alert staff to resident whereabouts allowing opportunity to redirect intruders before there is an altercation. Make sure the sound of alarms is pleasant.
- Consider the underlying motivation for intrusive behaviour and look at creative ways to meet social needs.

There is an urgent need for safer workplace. The Ontario Safety Association for Community and Healthcare recognizes the importance of developing a facility infrastructure that includes developing client aggression prevention policies and procedures. Communication and education strategies need to be regularly reviewed to maximize safety and security for all staff working with persons living with dementia. Website is [www.osach.ca](http://www.osach.ca)

Next Issue: **PROVISION OF PRIVACY**

References

Retrieved June 12, 2008 from the San Diego Eldercare Directory <http://eldercare.uniontrib.com/?q=node/10540>



# ANXIETY DISORDERS

## ANXIETY DISORDERS

Anxiety should be considered when there is a mix of physical, emotional and behavioural symptoms and when, despite your efforts to provide support or assistance, improvement is slow or not evident. There are a number of causes of anxiety disorders; much anxiety is due to depression.

Anxiety Disorders include:

- Obsessive-Compulsive
- Panic Attacks
- Phobias
- Post Traumatic Stress Disorder
- Primary Psychiatric Disorders

### Living with Phobias

A phobia is an irrational, intense fear of an object or situation that poses little or no actual danger. The phobia may seem similar to a normal fear but it is the extent to which the person is affected that determines if the fear is a phobia.

People suffering from phobia exhibit different symptoms however these are the more common:

- Dizziness, rapid heartbeat, trembling, or other uncontrollable physical response
- Sensation of terror, dread or panic
- Preoccupation of thoughts; inability to change focus from the feared situation
- Intense desire to flee the situation

The APA (American Psychiatric Association) divides phobias into three major types:

- A. **Specific Phobia** - is a phobia of a specific object or situation. If the feared object or situation is common, it could become life threatening. Specific phobias can be divided into 4 major categories:
  - Animals: Dogs, spiders, snakes, etc.
  - Medical: Blood, doctors, dentists, needles, or other medical objects
  - Natural Environment: Storms, water, or other natural objects
  - Situational: Heights, driving, elevators, or other specific situations
- B. **Social Phobia** - is a strong and pervasive fear of being embarrassed in public. Without treatment this phobia can become debilitating.
  - Generally reluctant to perform tasks such as eating, signing a check, or even speaking in front of others
- C. **Agoraphobia** - is the fear of being in a situation that would be difficult or embarrassing to escape, or where help would not be available if a panic attack were to occur.
  - for many develops into a fear of crowds, being alone and eventually a fear of leaving home

The older population tends to underreport feelings of anxiety but may be more willing to discuss physical symptoms which if not caused by medical illness may be sign of anxiety. Studies report a wide percentage of older adults who suffer from phobias (anywhere from 0-10%). However these studies do show that of all phobias, only agoraphobia is statistically likely to develop for the first time in older adults. Other phobias appear to be present almost exclusively in people who have already had them.

In order for a phobia to be diagnosed, it must significantly interfere with the sufferer's daily life and the phobia can not be explained by any other disorders i.e. generalized anxiety disorder, panic disorder.

*Phobias continued from Page 4*

It is difficult especially in the older population to differentiate and diagnose phobias as this population is more likely to suffer from physical conditions that cause similar symptoms. The older population is also more likely to be taking medication regularly which may have side effects that are similar to the symptoms mentioned above. Older adults may develop fears that may be life-limiting but not irrational. For example, an older adult who has several falls may develop a fear of falling. This would not be considered a phobia.

Treatment for phobias is difficult in the older population. The main types of therapy include medication and therapy. The medications that are commonly used (such as SSRI's) can interact with other prescriptions or cause certain physical conditions to worsen. Therapy can be effective if the client is willing and able to accept it. The older population may have financial concerns that make it difficult to seek out therapy or they may be concerned with the negative stigma attached to mental disorders which causes many to refuse treatment. One of the most commonly used forms of therapy to treat phobias is cognitive behavioral therapy (CBT). A trained clinician works with the client to confront the feared situation and change the phobic reaction by changing the autonomic thoughts that occur. Exposure therapy is a leading form of CBT that works well in treating phobias. A popular type of exposure therapy is systematic desensitization, in which the client is gradually exposed to the feared object, learning to tolerate increased exposure bit by bit.

Working with someone who suffers from phobias may be very difficult and challenging to understand but remembering that these fears are very much real to them prepares us to validate their feeling and offer emotional support.

**Next Issue - Post Traumatic Stress Disorder (PTSD)**

**A Day in the Life of...Sharing a Patient's Story**

*Continued from Page 1*

"A Day in the Life of..." is an informative and practical plan of care provided to each receiving facility in a patient's discharge package. A copy is also retained for the patient's record at WMHC. What makes the tool unique is that it is written in first person, as though the patient was writing it him/herself. It is a simple, step-by-step guide detailing activities of daily living and strategies for successful management of challenging behaviours. The strategies are based on the psychosocial rehabilitation model of empowerment, self determination and enablement of optimal function for reintegration into the community. "A Day in the Life of..." might read something like this: "Hello. My name is \_\_\_\_\_. You can call me \_\_\_\_\_. When I have a shower, I like to have someone in the room with me in case I have a dizzy spell. While in the shower I would appreciate it if you could wash my back for me. I am able to do everything else for myself..."

It is our hope that the simplicity of the tool and the intriguing way in which it is written will encourage caregivers to read it and embrace the interventions proposed. Informal feedback from receiving facilities has been extremely positive. Some comments are as follows: "It's lovely. A great tool and a great write-up. I thought it was great and I would not add or change a thing." and "Very good and very helpful. This is a brand new patient to us and it was her in a nutshell."

A Day in the Life of...' embraces the patient experience and provides an exceptional example of innovation and patient centred care.

Sandra Mairs RN, BScN, MHScN, GNC(C)

Clinical Nurse Specialist, Special Services Program, Whitby Mental Health Centre

# GRAND ROUNDS

## Acid/Base Balance

Measured as:                    1) Anion Gap                    Normal Range: 10-20 mEq/L  
    2) Bicarbonate (HCO<sub>3</sub>)                    Normal Range: 22-30 mEq/L

Assess the amount of other blood chemicals not measured in typical electrolyte tests. A change in these values from normal indicates presence of acidosis or alkalosis. Imbalances occur as a result of changes in metabolism and/or changes in the respiratory system.

## Metabolic Acidosis

Occurs in Persons when:	Symptoms	Why Older Adults More Affected	Masquerading Features	Care Plan Actions
Excessive burning of fats due to low carbohydrate intake.  Abnormal carbohydrate metabolism.  Renal Insufficiency.	Hyperventilation  Increased pulse  Decreased blood pressure  Headache  Lethargy  Twitching  Vomiting/diarrhea  Fruity breath  Anorexia  Stupor  Seizures  Coma	Higher incidence of malnutrition.  Higher incidence of diabetes mellitus.  Higher incidence of renal impairment.	May be mistaken for depression.	Ensure balanced diet.  Monitor food intake for person with anorexia or diabetes.  Monitor for signs and symptoms of increased kidney failure, i.e. decreased output, itching, peripheral edema.  Monitor blood sugar.  During episodes of vomiting/diarrhea; monitor intake and output.  Monitor vital signs.  Notify physician of symptoms.

### References:

Hamilton, P., Harris, D., LeClair, K. (2006). Putting the P.I.E.C.E.S. together: A learning program for professionals providing long-term care to older adults with cognitive/mental health needs.

## Metabolic Alkalosis

Occurs in Persons when:	Symptoms	Why Older Adults More Affected	Masquerading Features	Care Plan Actions
<p>1) Loss of Acids</p> <ul style="list-style-type: none"> <li>- vomiting, fistulae</li> <li>- acids lost through kidneys due to use of Furosemide</li> <li>- steroid therapy</li> </ul> <p>2) Retention of Alkali</p> <ul style="list-style-type: none"> <li>- improper use of antacids</li> </ul> <p><b>NB</b> – hypokalemia accompanies alkalosis</p>	<p>Deep, rapid breathing progressing to slow, shallow with increased expiration time</p> <p>Increased pulse</p> <p>Anxiety progressing to hysteria</p> <p>Numbness/tingling of hands and face, chest wall pain</p>	<p>Higher incidence of use of Furosemide and prednisone on long-term basis.</p> <p>More likely to use antacids for prolonged time.</p>	<p>May be mistaken for agitated depression or hysterical reaction.</p> <p>May be mistaken for catastrophic reaction in person with dementia.</p>	<p>Monitor use of medications.</p> <p>Replace fluids.</p> <p>Monitor vital signs.</p> <p>Provide reassurance.</p> <p>Notify physician of symptoms.</p>

### References:

Hamilton, P., Harris, D., LeClair, K. (2006). Putting the P.I.E.C.E.S. together: A learning program for professionals providing long-term care to older adults with cognitive/mental health needs.



## Just a Reminder.....

The Gentle Persuasive Approach Program is available in Durham. If interested, please contact Loretta Tanner (905) 576-2567, Jan Katchaluba or Melanie Kelly.

## MARK YOUR CALENDAR

### September 19, 2008

When Hoarding Causes Suffering: What Works  
Etobicoke, Ontario - For more information:  
(416) 243-3600 or [www.westpark.org](http://www.westpark.org)

### September 23, 2008

Move It, Use It or Lose It: Effects of  
Deconditioning and Excess Disability in Late Life  
Hamilton, Ontario - For more information:  
(905) 525-9140 ext. 24449

### September 25-26, 2008

7<sup>th</sup> International Elder Care Conference: Older People  
Deserve the Best  
Markham, Ontario - For more information contact:  
[www.RNAO.org](http://www.RNAO.org)

### October 17, 2008

8<sup>th</sup> Annual KLARU Conference  
Connecting Research with Clinical Care: Improving  
Safety in Long Term Care Settings  
Toronto, Ontario - For more information contact:  
[www.klaru-baycrest.on.ca](http://www.klaru-baycrest.on.ca)

## Montessori Training Coming to Durham Region

September 4<sup>th</sup> & 5<sup>th</sup>, 2008  
Whitby Mental Health Centre  
700 Gordon St.  
Whitby, ON  
L1N 5S9

To Register Contact:  
The McMaster Centre for Gerontological  
Studies  
1280 Main St. West KTH 204  
Hamilton, ON L8S 4M4  
Phone: (905)525-9140 ext.24449  
[gercntr@mcmaster.ca](mailto:gercntr@mcmaster.ca)



CANADIAN NURSES ASSOCIATION  
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

Don't miss your opportunity to invest in  
your nursing practice by obtaining your  
CNA certification in Gerontology.

Deadline to apply: October 17, 2008  
Exam date: April 4, 2009

For more information:

[www.cna-nurse.ca](http://www.cna-nurse.ca)



## NEXT DURHAM REGION MEETING

October 15, 2008

Contact your  
PRC – RSVP is  
requested!

Whitby Mental Health Centre  
8:30 am to 12:00 pm