Direct Support Professional Training
Year 1

Student's Resource Guide

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

Dedication

To everyone who is committed to improving the quality of life for individuals with developmental disabilities.

Acknowledgements

These Direct Support Professional (DSP) Training materials reflect the tremendous effort by many people throughout the state of California and across the nation who contributed their time and expertise. In doing so, these individuals have demonstrated their personal commitment to promoting quality services for people with developmental disabilities. Special thanks are extended to:

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Foreword

In 1998, the California Legislature established the Direct Support Professional (DSP) Training Program. The purpose of the program is to increase quality of care for people with developmental disabilities living in licensed Community Care Facilities by ensuring core competencies or skills for all Direct Support Professionals. The statewide training program requires all Direct Support Professionals to successfully complete 70-hours of training over two-years, or to pass a challenge test for each of two, 35-hour training segments. Upon successfully completing either of these requirements, Direct Support Professional Certification will be provided.

The California Department of Developmental Services formed an Advisory Committee, consisting of representatives from the developmental services community, to provide direction for the training program. This was accomplished through statewide meetings, mailings, focus groups and pilots of draft training and testing materials. A formal job analysis was conducted to identify core competencies for Direct Support Professionals. The training and testing materials were then developed from these core competencies.

The Department of Developmental Services has engaged the California Department of Education's Regional Occupational Centers and Programs to implement the training and testing program. The training program is being coordinated and taught by Regional Occupational Centers and Programs in local communities. Local Regional Occupational Centers and Programs have also established Advisory Committees to assist in meeting community needs.

The training materials include: a *Teacher's Resource Guide* with lesson plans, applicable instructor dialogue and background information, classroom activities (with teaching ideas/ tools for use with LCD or overhead projector, TV-VCR, charting activities, group and individual work), homework assignments, reference and resource materials for each of the eleven training sessions. The *Resource Guide* for the Direct Support Professional includes extensive information related to each of the eleven training sessions, in-class activities, homework assignments, session review questions/answers, reference and resource materials. Both guides have a Key-Word Dictionary encompassing all the key-words used throughout the eleven training segments, and general information to help Direct Support Professionals in preparing for the required competency test at the end of the training.

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Year 1
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Session #1
Introduction, Overview

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Activity:
Getting to Know Each Other

Please pair up with someone, ask each other the following questions and record them here:

What is your name?

Where do you work?

What do you do?

What are three separate words that describe the <u>positive</u> ways that you feel about your job?

Information Brief

How DSPs View Their Jobs*

When asked to describe how they felt about their work, the overwhelming majority of caregivers (in a New Hampshire survey) gave positive responses. When asked to use three separate words that best describe how they feel about the work they do, participants responded:

- Rewarding (34)
- Frustrating / Stressful (25)
- Challenging (19)
- Satisfying / Enjoyable (17)
- Caring / Helpful (12)
- Positive Adjectives: creative, valuable… (59)
- Negative Adjectives: unappreciated, bored… (14)

When asked what things they most wanted to have continue, the caregivers' primary concerns were for the individuals they served. One worker summed it up this way: "I want to continue, assisting people with their independent living; giving them the chance to live the life I take for granted." Talking about changes they'd like to see in their jobs, caregivers spoke of the need to place more importance on the person's quality of life and less emphasis on meeting tasks and objectives. Those providing direct supports wanted to be acknowledged and respected for the role they play in the service system. They wanted better pay, full benefits, and increased training opportunities. Caregivers wanted to be represented not only on the person's planning teams, but also included in the agency's decision-making process.

DSPs were asked what it would take to make things better in care and support in their own agencies. They identified the following four necessary changes.

- *More Respect for Individuals with Disabilities.* Suggestions included: administrators need to get a taste of the reality and issues for both individuals and staff; and individuals must be provided with as much information as possible so they can make informed decisions about what happens in their lives.

- *Include Caregivers in the Agency Decision Making Process.* Ideas included: invite caregivers to serve on agency committees; have a committee of employees meet regularly with directors and other administrators.

- *More Training Opportunities.* Requests included: more conferences and workshops for caregivers; and use the experience of caregivers in training.

- *Focus on Quality of Life.* Recommendations included: make quality of life the first priority for everyone; and learn as much as possible about the person being supported, and [develop] services that work for that individual.

- Excerpted and adapted from Frontline Initiative, **New Hampshire Listens & Learns from DSPs**

Direct Support Professional
Year 1 Training Series
Listing of Class Sessions

Session	Topic	Time
1	**Introduction, Overview of Developmental Disabilities, Values, Diversity**	**2 hours**
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Direct Support Professional
- Developmental Disability
- Communication
- Diversity
- Teamwork
- Values

Notes For Your In-Class Review

This is a place for you to take notes on the review questions during this session.

1. **What is a Direct Support Professional? What are the two major goals of the statewide training effort?**

2. **What is a developmental disability? What are some of the possible causes?**

3. **What is "people first" language?**

4. What are four of the six core values of services for Californians with developmental disabilities?

   What are the goals or outcomes of these values?

5. How does one appreciate diversity?

6. What is teamwork? What are some of the basics of successful teamwork?

Information Brief

Who Are Direct Support Professionals (DSP) and What is the DSP Statewide Initiative?

A Definition

The term *Direct Support Professional* (DSP) was selected by the *National Alliance for Direct Support Professionals* to describe individuals who work with people with disabilities in the places where they live and work. The DSP is also described as the person that assists individuals and their families in making choices; in leading self-directed lives; and in contributing to their communities. Finally, it is also the responsibility of the DSP to encourage attitudes and behaviors in the community that support the inclusion of individuals with developmental disabilities.

What is the Statewide Training Effort for DSPs and What Are Its Goals?

Recent legislation (1998) established a statewide, competency-based training requirement for *Direct Support Professionals*. The goal of this legislation is to improve quality of care for individuals with developmental disabilities living in licensed community settings. The Department of Developmental Services (DDS) is implementing this training in collaboration with the Department of Education, Regional Occupational Centers and Programs. Additionally, through the provision of this training and other initiatives, DDS hopes to:

1. Increase the professional status of *Direct Support Professionals.*

2. Provide opportunities for all *Direct Support Professionals* to have quality educational experiences (for example, inservice training, continuing education) and life-long learning that supports the development of greater skills and, in turn, greater quality services for people with developmental disabilities.

3. Strengthen the working relationships and partnerships between *Direct Support Professionals*, the individuals they serve, families, regional center staff and other service providers.

4. Promote financial and career incentives for educational experiences, increased compensation, and access to career advancement for *Direct Support Professionals.*

Direct Support Professional Training Program Frequently Asked Questions (FAQs)*

1) **Who will be required to take the *Direct Support Professional* training?** Anyone working in a community care facility (CCF) licensed by the Community Care Licensing Division, Department of Social Services, and providing direct care to people with developmental disabilities who are serviced by the regional center, will be required to take the 2-year, 70-hour training or pass a competency test.

2) **Who will provide the testing and training?** Regional Occupational Centers and Programs (ROCPs) will administer the competency test and the training program.

3) **How and when will the 70-hours of training be delivered?** The required 70 hours of training will be delivered in two thirty-five (35) hour segments over two years.

4) **How long will the *Direct Support Professional* have to complete the training or pass a competency test?** Each *Direct Support Professional* employed in a CCF before January 1, 1999, must satisfactorily complete the first required 35-hour competency-based training course or pass a Department-approved competency test by March 31, 2000 and satisfactorily complete the second 35-hours of training or pass a department-approved competency test applicable to that training segment by March 31, 2001. Each *Direct Support Professional* person whose employment in a CCF facility begins on or after January 1, 1999, must satisfactorily complete the first required 35-hour competency-based training course, or pass a Department of Developmental Services approved competency test applicable to that training segment within one year of the date the staff person was hired. Those same staff must satisfactorily complete the second 35-hours of training, or pass a Department-approved competency test applicable to that training segment within two years of the date the person was hired. Satisfactory completion of each 35-hour training segment includes passing the applicable competency test.

5) **Will the *Direct Support Professional* have to take a competency test if they complete the required training?** Yes. All *Direct Support Professionals* will be required to either pass a challenge competency test for each of the 35-hour training segments in lieu of the training, or pass a competency test after completing the training to ensure that the required skills have been learned.

6) **Is there any cost to *Direct Support Professionals* for taking the required competency-based testing and training?** There is no cost to those who are required to complete the test and/or training.

- Excerpted and adapted from Department of Developmental Services (1998).

7) What is competency-based training? Competency-based training is training designed to teach skills necessary for satisfactory job performance. Training is based upon a set of competencies or job skills that have been identified through a detailed job analysis.

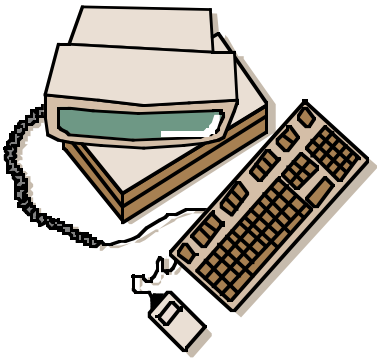
8) What is competency testing? Competency testing is a means to determine if an individual has skills necessary for satisfactory job performance, either as a result of experience, training, or combination thereof. The competency test for the *Direct Support Professional* training will be based upon the same set of competencies or skills as the training. There will be a separate competency test for each 35-hour segment of the training.

9) Is the training program required by law? Recent legislation (1998) requires that all existing and new *Direct Support Professionals* either pass a challenge test or take the training and pass a competency test for each of the 35-hour training segments.

10) What if the *Direct Support Professional* fails the competency test after completing the training? After completing each of the 35-hour training segments, *Direct Support Professionals* will take the competency test. Individuals who fail the test may not continue to provide direct care in a CCF, unless that individual can show good cause and the regional center approves a waiver of the requirement to pass the competency test. Conditions for a waiver are specified in regulations.

11) Will the *Direct Support Professional* receive credit or certification after passing a competency test? Individuals who either pass the challenge test or the competency test after completing the training will receive a "Certificate." The certificate will be valid throughout the state of California in Community Care Facilities for people with developmental disabilities.

To get more questions answered, and to see a copy of the regulations for the *Direct Support Professional* Training Program, go to the *California Direct Support Professional* website at **<http://www.dds.cahwnet.gov/DSPT/dsptmain.cfm>**. To learn more about national efforts on behalf of Direct Support Professionals, go to the *National Alliance for Direct Support Professionals* website at **<http://www.ici.coled.umn.edu/dsp/nadsp.html>**.



Activity:
What Are Your Goals?

What are the things your group would like to learn or learn more about during these sessions?

What are the top 3 things?

-
-
-

Information Brief

Developmental Disabilities*

What is a Developmental Disability?

According to a California law called the *Lanterman Developmental Disabilities Services Act*, a developmental disability:

- begins before someone reaches 18 years of age;
- is something that goes on throughout a person's life;
- is a substantial disability for the individual; and
- often means there is a need for some kind of assistance in daily living.

Included are mental retardation, cerebral palsy, epilepsy and autism. Also included are people who need the same kinds of support as those who have mental retardation. It does not include people who have only physical, learning or mental health challenges.

What Causes a Developmental Disability?

A number of things can cause a developmental disability:

- **Before birth causes**
  For example, the mother has a serious illness, or has poor eating habits, poor health care, smokes, drinks alcohol or uses drugs. Developmental disabilities can also be caused by things that are inherited or by chemical or chromosome differences (like Down Syndrome).
- **During birth causes**
  For example, a lack of oxygen to the brain, low weight, or a difficult birth.
- **After birth causes**
  For example, serious accidents, abuse, lead poisoning, or poor nutrition.

Often the cause is not known. A developmental disability can happen in any family.

* Adapted from Lanterman Regional Center Website at **<http://www.lanterman.org/>** and Kennedy Kreiger Community Resources, **The Characteristics and Needs of Individuals with Developmental Disabilities.**

What Are the Major Kinds of Developmental Disabilities?

The following are the major kinds of developmental disabilities:

Mental Retardation
The legal definition has to do with how an individual scores on an intelligence test and how intelligence affects a person's ability to do certain things. However, it is easier to explain that people with mental retardation are likely to:

- learn more slowly;
- have a hard time remembering things that are learned;
- have a hard time using what is learned in a new situation;
- think about things in more real-life or concrete ways; and
- keep learning and developing throughout life like all of us.

There are different levels of mental retardation from mild to moderate to severe. This means that people need different types of assistance in daily living.

Mental retardation is very different from mental illness. Some people who have mental retardation also have mental illness, but most people who have mental illness do not have mental retardation.

Cerebral Palsy
Cerebral palsy is a condition caused by damage to the brain which often happens before, during or shortly after birth. "Cerebral" refers to the brain, and "palsy" to a condition which affects physical movement. As with mental retardation, this condition can range from mild to severe. People with cerebral palsy may have:

- awkward or involuntary movements
- poor balance
- unusual walk
- poor motor coordination
- speech difficulties

Cerebral palsy is not a disease and you can't catch it. While it doesn't usually get worse, people can lead more independent lives through physical therapy and the use of special devices (for example, computers, and wheelchairs). Individuals with cerebral palsy may also have mental retardation and/or epilepsy.

Autism
Autism affects people in many different ways. The causes are not very well understood. Some people who have autism also have mental retardation. People with autism may:

- have a hard time making friends;
- get happy or upset about things that don't make sense;
- have a difficult time communicating with other people;
- hurt themselves; and
- want to stick to a certain way of doing things and get upset if things get changed around

Epilepsy
Epilepsy is a physical condition that occurs when there is a sudden, brief change in how the brain works. When brain cells are not working well, a person may become unconscious, or his/her movement, or actions may be very changed for a short time. These changes are called epileptic seizures. Epilepsy is sometimes called a seizure disorder. Individuals with epilepsy may also have mental retardation, cerebral palsy or autism.

Other
Includes people who need the same kinds of support as those who have mental retardation. It does not include people who have only physical, learning or mental health challenges. Examples are conditions like Neurofibromatosis, Tuberous Sclerosis and Prader-Willi Syndrome.

What is a Developmental Delay?

A developmental delay is a very large difference between a young child's (up to 36 months of age) abilities and what is usually expected of children of the same age. Infants and toddlers who have a developmental delay can receive *early intervention services*. These services support the child in learning the things that will help him/her start to catch up.

A Guide to Talking and Writing about People with Disabilities - People First*

In talking and writing about people with disabilities, remember *it's people first, the disability comes second.* The subtle difference between calling Joe "a person with mental retardation" rather than a mentally retarded person is one which acknowledges Joe as a person first.

AVOID:	*USE:*
victim	**individual with a developmental disability**
invalid	**individual with a seizure disorder**
crippled	**individual with cognitive disabilities**
afflicted with	**a person who is non-ambulatory**
suffers from	**individual with Down Syndrome**
DDs	**individual**
TMRs	**person**
EMRs	**participant**
confined to a wheelchair	**worker**
mongoloid	**student**
the retarded	
the handicapped	
mentally deficient	
patient	

* Adapted from **Put in a Good Word for Me**, North Los Angeles County Regional Center.

Information Brief

Regional Centers

In California, many services for people with (or 'at risk' of) a developmental disability are coordinated through a network of twenty-one, non-profit regional centers established by the Lanterman Act. If a person is eligible, regional centers provide planning and related services, including service coordination. Service coordinators help individuals and families with information, guidance, and assistance in accessing and using appropriate generic services and natural supports.

If the service is related to the person's developmental disability and is included on the *Individual Program Plan* (the IPP is developed by an individual and his/her planning team, it states the goals that an individual is trying to achieve and the services and supports needed to reach those goals), a regional center may purchase the service from an approved service provider. Here are some *typical* services provided through a regional center:

- *Advocacy* – assisting individuals to get needed services from community and government agencies;
- *Assessment and consultation* – gathering information about individual service needs and supports;
- *Positive Behavior Support* – classes and individual consultation around positive behavior supports;
- *Early intervention programs* – for children not yet in public school; includes neighborhood preschools, and infant development programs, with involvement by parents and other specialists;
- *Independent/Supported living* – services and supports for adults to live more independently in their own homes;
- *Medical* – identifying and accessing needed health services, typically (but not always) paid for by private insurance or government health care programs (for example., county hospitals; Medi-Cal fee-for-service; EPSDT; CCS; etc.);
- *Residential* – licensed or certified residential options including long-term health care facilities, foster family homes, community care homes, and family home agencies;
- *Respite Care* – added help for the family in order to provide a break from care-giving responsibilities (may involve nursing or positive behavior support, as needed);
- *Social/Recreational* – locating a variety of social/recreational activities through various community organizations;
- *Therapy and Counseling* – referral to various therapists and public or private mental health agencies; and
- *Vocational* – assistance in accessing a variety of work-related services and supports that include job placement, job coaching, training for employment, sheltered work, and pre-vocational programs, some of which are funded by regional centers, others of which are funded through the Department of Rehabilitation.

Activity:
What's Most Important In the Job?

After you have moved into small groups, look at the following list of important qualities of employees. Now, as a group, rank them from **1** (most important) to **10** (least important) the way you see them. That means you all have to decide what is the first most important, second most important (and so on) together. Next, rank them again the way you think (as a group) your supervisor sees them. Now, in the third column, rank them again as you think the people with developmental disabilities you support see them.

Quality	**Your Own**	**Your Supervisor**	**People You Support**
Good appearance	_____	_____	_____
Learns from mistakes	_____	_____	_____
Honest and truthful	_____	_____	_____
Accountable for actions	_____	_____	_____
Responsible	_____	_____	_____
Customer/individual is first	_____	_____	_____
Gets things done	_____	_____	_____
Accepts change and is flexible	_____	_____	_____
Manages time well	_____	_____	_____
Positive attitude	_____	_____	_____

Information Brief

A Brief History of Developmental Disabilities Services

Three Major Changes

There have been three major changes in how citizens in general have thought about people with developmental disabilities. These views have changed the way that services for individuals and families are provided:

1. **Taken Care Of.** Up until the 1960s, citizens thought that individuals with developmental disabilities should be *taken care of* and that this could be best accomplished in an institution away from the community.
2. **Education and Training.** From the mid-1960s to the mid-1980s, citizens began to see that individuals with developmental disabilities could grow and learn through *education and training*. During these years, special schools, training programs, and group homes were developed in large numbers in communities throughout the United States.
3. **Community Members**. From the mid-1980s to the present, citizens began to see individuals with developmental disabilities as their neighbors, co-workers, friends, and fellow *community members*. Now, the focus is on providing the services that individuals and families need and want in the communities of their choice.

These major changes in the attitudes of citizens as well as in the way services are provided were largely due to: (1) the public education efforts of the families of individuals with developmental disabilities; (2) changes in the national and state laws; and (3) individuals with developmental disabilities speaking up for themselves.

In California

In California, institutions were the primary way that people with developmental disabilities were served through the mid-1960s. In fact, there was a demand for building more institutions. However, a study by the California Legislature showed that not everyone needed institutional services and that the cost of building more would be very high.

This study encouraged the Legislature to look for alternatives. In 1966, the Legislature funded two pilot regional centers. Their focus was on supporting individuals in their home communities as an alternative to living in a state institution. Those first two regional centers were so successful, the Legislature funded a total of twenty-one as well as a system of community-based services.

In 1972, the Legislature expanded the law to include people with mental retardation, cerebral palsy, epilepsy, autism, and other neurological problems under the term *developmental disability*. You will learn more about the *Lanterman Act* and other laws and regulations in another class.

Information Brief

What Are the Values of Developmental Disabilities Services in California*

Services for people with developmental disabilities in California are based on an important set of values. These values can be found in the Lanterman Developmental Disabilities Services Act (the Lanterman Act). This is the piece of legislation that helped start our current statewide system of services back in the 1970s. It begins by mentioning that a vision for the future of California is one where individuals with developmental disabilities can participate in everyday life with their friends, neighbors, and co-workers.

It also mentions that services for people with developmental disabilities are based on the values of choice, relationships, regular lifestyles, health and well-being, rights and responsibilities, and satisfaction. Below is a brief description of those values.

Here is what California law (the Lanterman Act) says about the value of **choice**:

- services and supports should be based on the individual and his/her needs and preferences;
- individuals (with help from parents, legal guardians, or conservators when needed) should take part in decisions about their own lives (like where and with whom they live, their relationships with others, the way in which they spend their time, and setting goals for the future);
- people need to have a chance to practice making decisions and choices;
- an individual's choice (or parents, conservator, or guardian where support is needed) of service providers should be honored; and
- services and supports should change based on the changing needs or preferences of an individual.

Here is what California law says about the value of **relationships**:

- people with developmental disabilities have the right to develop relationships, marry, be part of a family, and to be a parent if they choose;
- support may be needed to develop intimate relationships (like transportation, family counseling, or training in human development and sexuality);
- support may be needed to help people start and keep relationships with friends and other community members.

Here's what California law says about the value of **regular lifestyles**:

- people should have a chance to be involved in the life of their community in the same ways as their neighbors, friends and fellow community members;

* Adapted from **Looking at Life Quality**, Department of Developmental Services (1996).

- services should be provided whenever possible in the home and community settings where people live and work;
- cultural preferences should be honored;
- individuals should have the training needed to be as independent and productive as possible;
- when an individual needs change, services should be changed as well to make sure that people can stay living where they choose to live;
- people should be comfortable where they live, have privacy when they need it, and should have a say in the way their living space is decorated and arranged; and
- there should be services and supports which would allow minors with developmental disabilities to live with their families whenever possible.

Here's what California law says about the value of **health and well-being**:

- people have a right to be free from harm and to live a healthy lifestyle;
- individuals should have a chance to learn how to keep themselves safe, or have services and supports which will provide safety;
- individual's have a right to quick medical, mental, and dental care and treatment when they need it; and
- people should have a chance to learn how to keep themselves healthy, or have services and supports which will keep him/her healthy.

Here's what California law says about the value of **rights and responsibilities**:

- people with developmental disabilities have the same basic legal rights as other citizens;
- individuals with developmental disabilities have a right to treatment and habilitation, dignity, privacy, and humane care, prompt medical care and treatment, religious freedom, social interaction, physical exercise, and, to be free from harm;
- people have the right to make choices in their own lives, such as where to live, who to live with, who to have relationships with, education and employment, leisure, and, planning for the future;
- along with all of these rights are responsibilities, such as respecting the privacy of others, and being an informed voter; and
- individuals should have a chance to learn about their rights and responsibilities, and how to advocate for themselves.

Here's what California law says about the value of **satisfaction**:

- individuals should have a chance to plan goals for the future and to work towards them;
- individuals should be satisfied with the services and supports they receive and should have a chance to change them when they are not satisfied; and
- people should have a chance to have a good quality life.

Individual Life Quality Outcomes

CHOICE

1. Individuals identify their needs, wants, likes and dislikes.
2. Individuals make major life decisions.
3. Individuals make decisions regarding everyday matters.
4. Individuals have a major role in choosing the providers of their services and supports.
5. Individuals' services and supports change as wants, needs and preferences change.

RELATIONSHIPS

6. Individuals have friends and caring relationships.
7. Individuals build community supports which may include family, friends, service providers/professionals and other community members.

LIFESTYLE

8. Individuals are part of the mainstream of community life and live, work and play in integrated environments.
9. Individuals' lifestyles reflect their cultural preferences.
10. Individuals are independent and productive.
11. Individuals have stable living arrangements.
12. Individuals are comfortable where they live.
13. Children live in homes with families.

HEALTH and WELL-BEING

14. Individuals are safe.
15. Individuals have the best possible health.
16. Individuals know what to do in the event of threats to health, safety and well-being.
17. Individuals have access to needed health care.

RIGHTS

18. Individuals exercise rights and responsibilities.
19. Individuals are free from abuse, neglect and exploitation.
20. Individuals are treated with dignity and respect.
21. Individuals receive appropriate generic services and supports.
22. Individuals have advocates and/or access to advocacy services.

SATISFACTION

23. Individuals achieve personal goals.
24. Individuals are satisfied with services and supports.
25. Individuals are satisfied with their lives.

Information Brief
Diversity*

Definition of Diversity

Diversity is the important mixture of people who bring different backgrounds, styles, values, perspectives and beliefs as assets to the groups and teams with which they work.

Diversity and Work

We all have an opportunity to experience diversity in our lives every day. It may be diversity in age, ethnicity, nationality, religion, gender, ability or disability. Our openness to those experiences will determine whether we thrive in the diversity of the people we encounter or struggle with it.

It's projected that by the year 2000, the majority of individuals with developmental disabilities in California will be non-white and non-Anglo. Even if you did not know this information, it just makes good sense to be as culturally aware as possible in your work.

What is It to Appreciate Diversity?

Sensitivity is the awareness of the feelings, values and attitudes of others. To be sensitive to and *appreciate diversity*, it's important to:

- Let yourself try to experience life situations from the perspective of the individuals and families you support as well as your co-workers.
- Be aware of your own thoughts which might exaggerate and misinterpret the differences of individuals from another culture.
- Remember that, your role as a *Direct Support Professional* and team member is to support and respect the decisions of individuals and families.

* **Cultural Sensitivity**, prepared by Jose Hurtado, Eastern Los Angeles Regional Center (1996); **Cultural Connection: Cross Cultural Competency Training**, prepared by the Eastern Los Angeles Regional Center and the University of Southern California (1993).

Information Brief

The Platinum Rule*

A good starting point for valuing and appreciating diversity is to view everyone as different from us, and to view them as people about whom we can't make assumptions. Appearances are deceptive; people who appear to be very similar to us are often different, and those who appear to be very different can turn out to be quite similar.

The most important principle for valuing diversity is The Platinum Rule. This is an expansion of The Golden Rule. The Golden Rule is a time-honored practice that is a foundation of many religious disciplines. In telling us to "treat others as you want to be treated," its intentions are sound. It was designed to prevent us from doing harm to others – things which others obviously would not like.

With the increasing complexity of our society, we now need to extend The Golden Rule because it does not account for people's different and unique needs. We cannot assume that others want to be treated exactly the way we do. By assuming that everyone else wants what we do, we perpetuate the values and beliefs of the dominant culture. The Platinum Rule gives others permission to be different from us, and reminds us to honor that difference.

The Platinum Rule is:

Treat others as they want to be treated.

Using The Platinum Rule makes it okay for us to have differences. In the classic 1973 Harvard Business Review article, "What It's Like to Be a Black Manager," Edward Jones notes that removing the "taboo" of discussing differences is the first step toward valuing them.

The "fine line" of discussing differences is that they should be work related and behaviorally oriented. People should not feel they are being judged or labeled because of their differences.

Why do you think The Platinum Rule may be more effective for appreciating diversity than The Golden Rule? How do we find out how others want to be treated?

- **The ASTD Trainer's Sourcebook: Diversity**, by Tina Rasmussen (1996).

Activity:
Stereotypes

You will notice the four large sheets of flip-chart papers on the wall. Below each paper are several marker pens. When your facilitator gives you this activity, go to the paper on the wall closest to you and grab a marker. Start writing the stereotypes of people with developmental disabilities that you have heard from others. Make sure everyone has a chance to write down their thoughts. It doesn't matter if you write something that someone else has already written. Don't worry about spelling and grammar.

Information Brief

Diversity, Communication, and Teamwork*

Differences in Culture and Communication

There are some important differences in communication style that are influenced by culture. Here are some things to think about in communicating with individuals or families who are culturally different from you.

Eye Contact and Facial Expressions
Individuals with European cultural backgrounds (for example, English, German) usually appreciate eye contact. However, among many Asian cultures, eye contact between individuals who do not know each other is not appreciated and long periods of eye contact may be seen as not respectful.

Many individuals from European cultures show their emotions through expressions on the face (for example, lifting the eyebrow). However, individuals form Native American or Asian cultures may not communicate emotion through facial expressions unless they know someone well.

Closeness and Touching
Individuals from European cultures tend to stay a distance of about 3 feet, or an arm's length, between themselves and others during conversations. However, individuals from Latin cultures are comfortable with closer conversational distances, while those from Asian cultures often prefer more space between the speaker and listener.

Among many Asian cultures, hugging, back slapping, and handshaking are not typical and should be avoided. Among some individuals from Middle Eastern cultures, use of the left hand to touch another person is a *not okay* because the left hand is used for personal hygiene.

Many individuals from European cultures show affection for children by patting them on the head. However, this is not an acceptable form of touch among many Asians who believe that the head is the where the soul lives. Also, some East Indians believe that the head is fragile and should not be touched.

Gestures
Individuals from European cultures tend to use some gesturing while they talk as do some Latinos and Middle Easterners.

Nodding the head up and down is taken as a sign of understanding and agreement in many cultures, but among Asian, Native American, Middle

* **Developing Cross-Cultural Competence**, by Eleanor W. Lynch and Marci J. Hanson, Brookes Publishing (1992) and **Regional Center Service Coordinator Orientation**, Southern California Regional Center Director's Association (1999).

Eastern, and Pacific Island groups, it often only means, *I hear you speaking*. It does not mean that the person understands what is being said or agrees.

Also, individuals from European cultures often ask people to come their way by pointing with the index finger palm up and curling it toward the body while people from other cultures use this gesture only when summoning animals. In those cultures, it is never used with children or adults in such cultures.

Good Communicators

Effective communication with individuals from other cultures works best when you:

- are flexible and can tolerate different points of view;
- make sincere attempts at trying to understand things from another point of view;
- are open to learning about another culture; and
- have a sense of humor.

Diversity and Teamwork

You will find diversity in the people you work with as well as the people you support. The information above about differences in culture and communication will also help you work as an effective team member. Teamwork is a key to successful service for people with developmental disabilities. In addition to the people you work with and support, your team will likely include family members, consultants, health professionals regional center and licensing staff, as well as staff from other community services. So, it's important to know some basics about teams and how they work best.

Some Team Basics

What is "teamwork"? Teamwork is about sharing, cooperating, and helping one another. An effective team is a group of people working together with a common purpose, who value each others contributions and are working toward a common goal. Working through teams usually gets better results than a lot of individual efforts which may be working against each other.

Many experts say trust is basic to successful teamwork. Trust takes time, because it depends on people sizing up each other to see whether they say what they mean, do what they say, and contribute to the work of the team.

Besides ***trust***, other values that support teamwork are:

- open, honest communication;
- equal access to information; and
- focus on the goal.

In-Class Review

1. What is a Direct Support Professional? What are the two major goals of the statewide training effort?

A Direct Support Professional is an individual who works with people with disabilities in the places where they live and work.

The two major goals of the training effort are:

1. To increase the professional status of *Direct Support Professionals*.

2. To provide opportunities for all *Direct Support Professionals* to have quality educational experiences (for example, inservice training, continuing education) and life-long learning that supports the development of greater skills and, in turn, greater quality services for people with developmental disabilities.

2. What is a developmental disability? What are some of the possible causes?

According to a California law called the *Lanterman Act*, a developmental disability: (1) begins before someone reaches 18 years of age; (2) is something that continues throughout life; and (3) often means there is a need for some kind of assistance in daily living.

A number of things can cause a developmental disability: (1) **Before birth** (for example, serious illness, poor eating habits, poor health care, smoking, drinking alcohol, drugs, genetic, chemical or chromosome differences); (2) **During birth** (for example, a lack of oxygen to the brain, low weight, or a difficult birth); and (3) **After birth** (for example, serious accidents, abuse, lead poisoning, or poor nutrition).

3. What is "people first" language?

The person comes first and the disability second. For example, a person with a developmental disability instead of a disabled person.

4. What are four of the six core values of services for Californians with developmental disabilities?

Choice, relationships, regular lifestyles, health and well-being, rights and responsibilities, and satisfaction

What is the goal or outcome of these values?

To promote an opportunity for individuals with developmental disabilities to: participate in everyday life with their friends, neighbors, and co-workers; make choices, lead independent lives and contribute to the community; achieve and maintain the best possible health; and exercise their rights and responsibilities.

5. How does one appreciate diversity?

- Let yourself try to experience life situations from the perspective of the individuals and families you support.
- Be aware of your own thoughts which might exaggerate and misinterpret the differences of individuals from another culture.
- Remember that, your role as a *Direct Support Professional* is to support and respect the decisions of individuals and families.

6. What is teamwork? What are some of the basics of successful teamwork?

An effective team is a group of people working together with a common purpose, who value each other's contributions and are working toward a common goal. In addition to ***trust***, other values that support teamwork are:

- open, honest communication;
- equal access to information; and
- focus on the goal.

If You Want to Read More About
Developmental Disabilities, Values, Communication, Diversity, and Teamwork

Communicate With Confidence: How to Say It Right the First Time and Every Time
by Dianna Daniels Booher (December 1994); McGraw-Hill; ISBN: 007006606X

In a book designed to be read by professionals on the go, communications *dynamo* Booher covers speaking, listening, and all the dynamics of verbal communication on the job. Each savvy tip is based on real-life problems raised by participants in Booher Consultants workshops.

Cultural Connection: Cross Cultural Competency Training
prepared by the Eastern Los Angeles Regional Center and the University of Southern California (1993)

A self-guided workbook and video which helps to teach, reinforce and integrate cross-cultural competency.

Lanterman Developmental Disabilities Services Act
distributed by the Organization of Area Boards

The full text of Division 4.5 of the Health and Welfare Statutes, including all amendments to the Act through 1997. This document is available at all local Area Boards. You may also find the complete text at the Department of Developmental Services website at <http://www.dds.cahwnet.gov/>.

The 10 Minute Guide to Teams and Teamwork
by John A. Woods (1997); Macmillan Spectrum/Alpha Books; ISBN: 0028617398

This 10 Minute Guide has a variety of 10-minute lessons on types of teams, the stages of team development, how to hold team meetings that generate consensus and cooperation, how to set up and train self-directed teams, dealing with conflict within and between teams, and how to use proven problem-solving techniques.

Where Do We Come From?
by Harbor Regional Center Orientation Manual (1998)

This section of the orientation provides a thorough chronology of events regarding the history of the developmental services system in the nation as well as California. It covers the major legislative, judicial, and social events which have influenced this evolving service system.

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Additional Resource Information

Why Do People Work*

What would you do? Try to imagine how you would fill in 24 hours a day, every day, if you didn't have to work. There you go – off to the beach in summer, the movies in winter, watch TV on rainy days, go skating, read a lot of books or magazines, sleep . . .

But would you? Where would the money come from to pay your bus fares, to go to the movies, to buy your TV or to pay for the electricity, or your skates and books?

Let's say that money grew on trees, and that no one had to worry about that *small* problem. Now you could do all those things, right?

Probably not, because if no one had to worry about earning money, then who would bother driving your bus to the beach – for that matter, who would bother building your bus, or making your movies, skates, books, etc.? Why would they have to?

What you'd probably end up doing would be spending most of your time farming your own food, looking after your cows for milk and meat, your sheep for clothing, and growing bamboo for the walls of your vacation beach hut.

Why would you need to do this? Because no one else would need to earn money, because money grows on trees, right?

Obviously, money in that sort of society doesn't really exist, and is of no value to people.

So, in our society, is MONEY the NUMBER ONE reason for working !!! ???

A lot of people might agree with this statement, but is money the main reason why so many people spend so much of their time working?

Surely work gives us other things as well as money? Go back to your farm for a second . . . and think of all the things you would have to do for yourself. What would happen if, for example, you weren't able to repair your hand-plow if it broke down?

Now, some other farmer probably discovered that they were particularly good at repairing broken down plows, and when everyone found this out, they all asked this farmer to repair theirs. Soon a thriving business had been set up - plows repaired in exchange for corn, or milk, or rugs or any other thing the repair person needed.

---

* Adapted from R. Klimes, **LearnWell Resources** (1997)

Pretty soon, other people began specializing in all sorts of things, and they didn't have to worry about doing everything for themselves, as they were able to trade their special skills for the things they wanted.

So, the main reason why "work" exists today is since we cannot possibly do everything for ourselves, we get other people to do things for us, and pay them for their work. In order to do that, we must also do things for other people so that we can earn money.

Think of everything you do - All of it costs money. Electricity isn't free, nor is water, food, housing, clothing, etc. So, we appear to be back at the point again where money is still the MAIN REASON for working, but probably not in the way you were originally thinking about it. We have uncovered another couple of reasons why people work:

- because they are good at doing something special;
- other people need their skills, and vice versa;
- to satisfy our needs for shelter and food; and
- to provide "luxuries" to make our lifestyle more enjoyable.

You can get a lot out of working. It doesn't just have to be something "you gotta do!"

Although money might appear to be the main reason for working, it isn't always the main "thing" people get from their job. In fact, many people stay in their jobs because they get a lot of personal satisfaction from other aspects of that job.

Additional Resource Information

More About Work*

Top Ten Skills of Good Employees

Employability skills are the basic skills needed to do a job, no matter what kind of work you do. Employers rated the following as the top skills of their best employees:

1. Customer is first
2. Learns from mistakes
3. Honest and truthful
4. Positive attitude
5. Responsible
6. Gets things done
7. Accepts change and is flexible
8. Accountable for actions
9. Good appearance
10. Manages time well

The Changing World of Work

The world of work has changed a lot in recent years and will keep changing in the future. Yet many people still carry around outdated beliefs or myths about jobs and careers. The following will set the record straight about the changing world of work and the way it will unfold in future:

- The concept of a single occupation for life is no longer the norm.
- Most people will go through 6 - 10 changes of occupation during their lifetimes.
- Individuals, on average, change jobs every 3 years.
- The average person changes occupation every 5 years.

Jobs are changing also:

- more people are working part-time, part of the year;
- more workers are making a living through a combination of different types of work;
- the services industry is growing and keeping customers happy is becoming more and more important;
- there will be fewer opportunities for workers with lower education and skills; and
- there will be a greater emphasis on trades and technology.

More training will be required:

- by the year 2000, 50% of the jobs will require some education after high school; and
- 64% of the jobs will require high school graduation.

- **Employability Skills for British Columbia**, The Ministry of Human Resource Development (1996) website at **http:/www.aett.gov.bc.ca/employability/** and the Calgary Educational Partnership Foundation.

Additional Resource Information

Important Questions that Promote Quality of Life

As you go about your work in supporting people with developmental disabilities and promoting life quality, ask yourself these simple questions every day:

- **Participation**
  Are there opportunities for participation (even if only partially) in a variety of community and social activities?

- **Friendship**
  How many friends does the person have? Are there lots of opportunities to interact with and meet people (including people without disabilities who are not staff)?

- **Relationships**
  What opportunities do people have to be "givers" in a relationship? How are people recognized for their individual gifts and talents?

- **Interdependence**
  How are we supporting people to get connected within their communities? What types of natural supports exist in people's lives?

- **Independence**
  What skills are people learning and are they able to have personal privacy; especially at home?

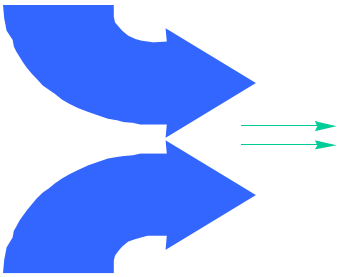
- **Meaningful activities**
  Are people provided with purposeful activities in meaningful (real) situations? We shouldn't be asking people to do "busy work" that has no real reason or purpose.

- **Motivation**
  Are the activities people engage in motivating and interesting to them? Are we "catching" people when they are good?

- **Choice**
  How much choice do people have throughout their lives?

- **Respect**
  How are people's routines and choices respected? How well do we listen to the people we support?

Mesaros & Shepard, revised 1999



Additional Resource Information

Core Competencies for Direct Support Professionals

VALUES AND SELF-DETERMINATION

- The DSP demonstrates professional workplace behavior.
- The DSP demonstrates respect for the individual.
- The DSP demonstrates support for individual choice-making.
- The DSP demonstrates strategies to encourage and develop individual confidence.

COMMUNICATION

- The DSP demonstrates knowledge of various means of effective communication.
- The DSP demonstrates effective communication skills.
- The DSP demonstrates the ability to modify his/her communication to ensure understanding.
- The DSP encourages and supports problem solving and coping skills.

POSITIVE BEHAVIOR SUPPORT

- The DSP uses assessment strategies to evaluate how past, present and future events and environmental factors affect behavior.
- The DSP demonstrates effective methods to teach positive replacement behaviors and support existing positive behaviors.
- The DSP demonstrates ability to work as part of a team in implementing positive behavior support strategies.

TEACHING STRATEGIES

- The DSP demonstrates the ability to identify the steps required to complete a task or activity.
- The DSP applies least-to-most assistance and/or prompts.
- The DSP demonstrates the use of positive feedback.
- The DSP demonstrates the ability to follow a plan for successful teaching.
- The DSP demonstrates the ability to do individualized teaching.
- The DSP demonstrates the ability to assess and teach individual choice-making skills.
- The DSP assesses the effectiveness of teaching.

INDIVIDUAL RIGHTS, LAWS AND REGULATIONS

- The DSP demonstrates a basic understanding of the statutory and regulatory structure of services for people with developmental disabilities.
- The DSP understands and supports individual rights and responsibilities.
- The DSP demonstrates correct procedures for mandated reporting requirements.
- The DSP demonstrates knowledge of community resources to assist and educate individuals in securing needed services and supports.

WELLNESS

- The DSP demonstrates correct use of Standard Precautions.
- The DSP has knowledge of medications.
- The DSP demonstrates healthful meal planning and food preparation, storage and handling procedures.
- The DSP utilizes strategies to ensure safety, and to prevent injuries and accidents.
- The DSP responds in a timely manner to medical emergencies.
- The DSP responds to environmental emergencies.
- The DSP demonstrates knowledge and understanding of an individual's medical, mental and dental health care needs.
- The DSP recognizes and respond to signs and symptoms of illness and/or injury.
- The DSP maintains documentation of individual health status and medical needs.
- The DSP accesses community health care resources.

GOAL ATTAINMENT AND DOCUMENTATION

- The DSP demonstrates ability to participate in the process of individual goal development.
- The DSP demonstrates knowledge of documentation requirements for individual goal attainment.

DAILY LIVING

- The DSP recognizes and supports the individual's daily routine.
- The DSP supports individuals in establishing and maintaining relationships with family and friends.

LEISURE AND RECREATION

- The DSP promotes community participation.
- The DSP researches, develops and maintains information on community and other resources that meet individual needs.

Homework Assignment #1: Your Team

As a *Direct Support Professional*, you are a member of a team at the home where you work. Read through this assignment and think about it while you work for the next few days. Then answer the following questions or complete the assignment with your co-workers.

1. Members and Roles. Who is on your team? Your co-workers, supervisor, the people you work with, family members, regional center staff, licensing workers? Who else? What are their roles (for example, *helps with planning activities, parent, does the paperwork, supervisor, service coordinator*)?

Member	Role

2. Goal. Based on what you see and the work that you do, what is the goal of your team?

3. Working together. How does your team work well together and what could it do better?

4. Accomplishments. What does the team accomplish?

5. How does it feel to be member of this team?

Homework Assignment #2 for Session #2: Communication with Pictures

Sometimes it is helpful for people to have a way to let someone know what's on their mind that they can carry with them. Some people might use a board that has letters on it, like a computer keyboard. They can point to the letters that spell words so someone can understand them. Some people have electronic systems that use pictures or symbols, or attach to computer monitors. Some systems have a voice that repeats the word or sign or symbol that the person points to. Some people use pocket sized cards that can be stapled together so the person can use them when they are out.

Many communication books, boards and cards can be bought. You can make your own communication board or cards by using magazines, photographs, or using hand made drawings.

Your homework is to gather some pictures that will tell others in the class about you and the things you like to do. You will be communicating about a page of information if it were written. Your pictures can be photographs or pictures from magazines. Some material will be available in class, but you will want to bring the most important pictures to class with you.

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #2
Communication

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	**Communication**	**3 hours**
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Verbal and Nonverbal Communication
- Communication and Behavior
- Active Listening
- Speech and Language Disorders
- Communication Systems

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **What are some of the reasons we communicate?**

2. **Can you describe some of the barriers to effective communication for people with developmental disabilities?**

3. **What are the three components of all communication?**

4. **What are some examples of nonverbal communication?**

5. **What are behaviors that show you that a person has an interest in socializing in some way?**

6. **What are some types of communication systems? What are the advantages or disadvantages of each of those systems?**

7. **Why is communication so important to people with developmental disabilities? What are some ways that you can assist people with communication?**

8. **What are the elements of active listening?**

Information Brief

Why Do We Communicate?

There are a number of reasons why we communicate. Most of the examples have to do with work, but would be important outside of work as well.

Giving and getting information • This could mean getting information from staff at other programs the individual attends, and comparing how each of you responds to that person. It might also mean giving information to parents or family members about a person's progress, or letting the regional center know about an unusual incident. Or it could mean asking everyone in the program his or her opinion on an activity before deciding what to do. Or checking with the regional center, your administrator, and the family before changing the way in which you approach a training objective.

Expressing feelings • People may want you to know when they have had a great day, or when they are feeling bad.

Helping with problem solving • You may need to communicate with two people at your program to work out problems and to help those people to solve their own issues.

Teaching • You will be teaching people how to gain skills, either hygiene skills, or cooking or taking care of their money, and about how to make their needs known.

Socializing • This is how we get to know other people - by finding out what the other person likes, and doing things together.

Persuading • This is where we want to have someone see things the way that we do. This could mean getting a person to wear different clothing than he/she has chosen because the weather makes their choice inappropriate. Or it could mean getting your supervisor to consider additional funds to take two people on a shopping trip.

Decision-making • You would be communicating with a number of people on how to best make a decision that affects people in your program. Maybe you are trying to figure out the best way to deal with the behavior of someone in your program. There might be communication among the staff, the consultants, other programs, and the regional center so that the best decision can be made.

Building relationships • You communicate with friends, with people where you work and with the people you support. What relationship would happen without some form of communicating?

Regardless of the reason we are communicating, it is so important to be clear about the message, and be certain that we understand another person's message to us.

Information Brief

What Does Behavior Communicate?

People's behavior usually communicates three things:

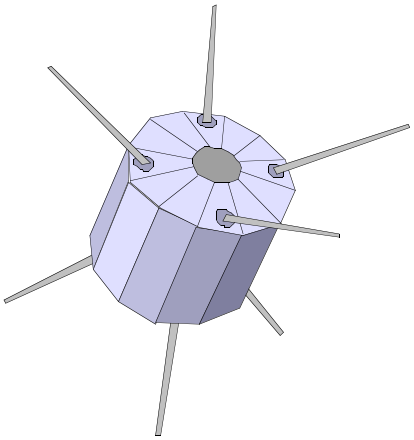
What the person wants
What the person doesn't want
When the person wants attention

How would a person's behavior tell you that they want something? They might point to an apple on the table, which lets you know the person wants the apple. The person might come to you and shake your hand, which lets you know they want to greet you. The person might come to you with a toothbrush in one hand and toothpaste in the other, and a puzzled look on their face. That might let you know that the person needs some assistance. When you offer a person a choice of foods for dinner, they might point to what they want or look in the direction of the food they prefer.

Sometimes it is easier to figure out what a person doesn't want. Sometimes these are the behaviors that make it hard for the person to be with other people. The person might spit out food they didn't enjoy, or push away the staff person who wants to help. Imagine if you didn't have words to use. How would you let someone know that something was making you unhappy.

Often, people just want someone to pay attention to them. Some people have learned that making loud noises is what gets the attention of the staff. Or that they need to wave their arms to get staff to focus on them when there is a lot of activity going on. A person might just pull at your arm to get your attention.

A person's behavior will give us information about their interest and ability to be social, as well. A person who doesn't use spoken words can often very clearly greet us and say goodbye. That person can give a lot of information through facial expressions.



Information Brief

Social Skills that Help Communication

Reason	Example
Showing attention to partner, object or event	Turn toward person walking in
Providing information	Asked if thirsty, smiles
Requesting information	Points to picture with puzzled look
Responds to name	Makes a sound when called
Greets	Lifts head and looks at person
Says goodbye	Waves
Directs attention to self	Waves arms, repeats when someone looks

Information Brief

Active Listening

Listening is one of the most difficult skills to learn. We are taught from a very early age NOT to listen. Remember in first grade when the teacher would ask the class "Okay, can someone tell me a word that begins with…" and before she can even get the question out, hands go up around the classroom. And the child whose hand is raised first gets called on. So that child is rewarded for NOT listening.

Did you know that we can hear at a rate of 650 words per minute? The average person talks at a rate of 150 words per minute. That leaves a lot of space in your brain for other information. Like making a shopping list, or thinking about something that happened at home. Did you ever find yourself thinking about how you will respond to a question before the question is asked? Have you ever asked someone the same question more than once, because you didn't remember that they had answered the question?

Test yourself on your listening skills.

Agree or Disagree?

1. It is easy for me to focus on what others are saying.

2. I never pretend to be paying attention.

3. I never interrupt a person who is talking.

4. I ask questions to be sure that I understand what the other person is saying.

5. I am a patient listener.

Do you need more practice at active listening?

Information Brief

Communication Disorders

Some of the things can get in the way of people being understood include limited or no speech, hearing loss, poor control of muscles needed to produce speech (like with cerebral palsy), damage to the part of the brain that controls speech and complex behaviors. When it's hard to make your needs known, it's also difficult to meet people, to do things you like to do, and may make a person behave in a negative way.

There are two kinds of communication disorders: Speech disorders and language disorders. Sometimes a speech disorder is caused by speech muscles that don't work, cleft palate, or from having no teeth. Incorrect articulation is a common speech disorder. You may hear a speech therapist for someone you support talk about this. Some sounds may be missed when a person is talking, like saying "nake" for "snake," or "moke" for "smoke." Or a person might say "dis" and "dat" instead of "this" and "that."

Language disorders are sometimes caused by damage to some area of the brain. With a language disorder a person may be limited in their ability to understand language. This is called receptive language. A person's ability to talk might be limited, which is called their expressive language. Or, a person may talk as if they are much younger.

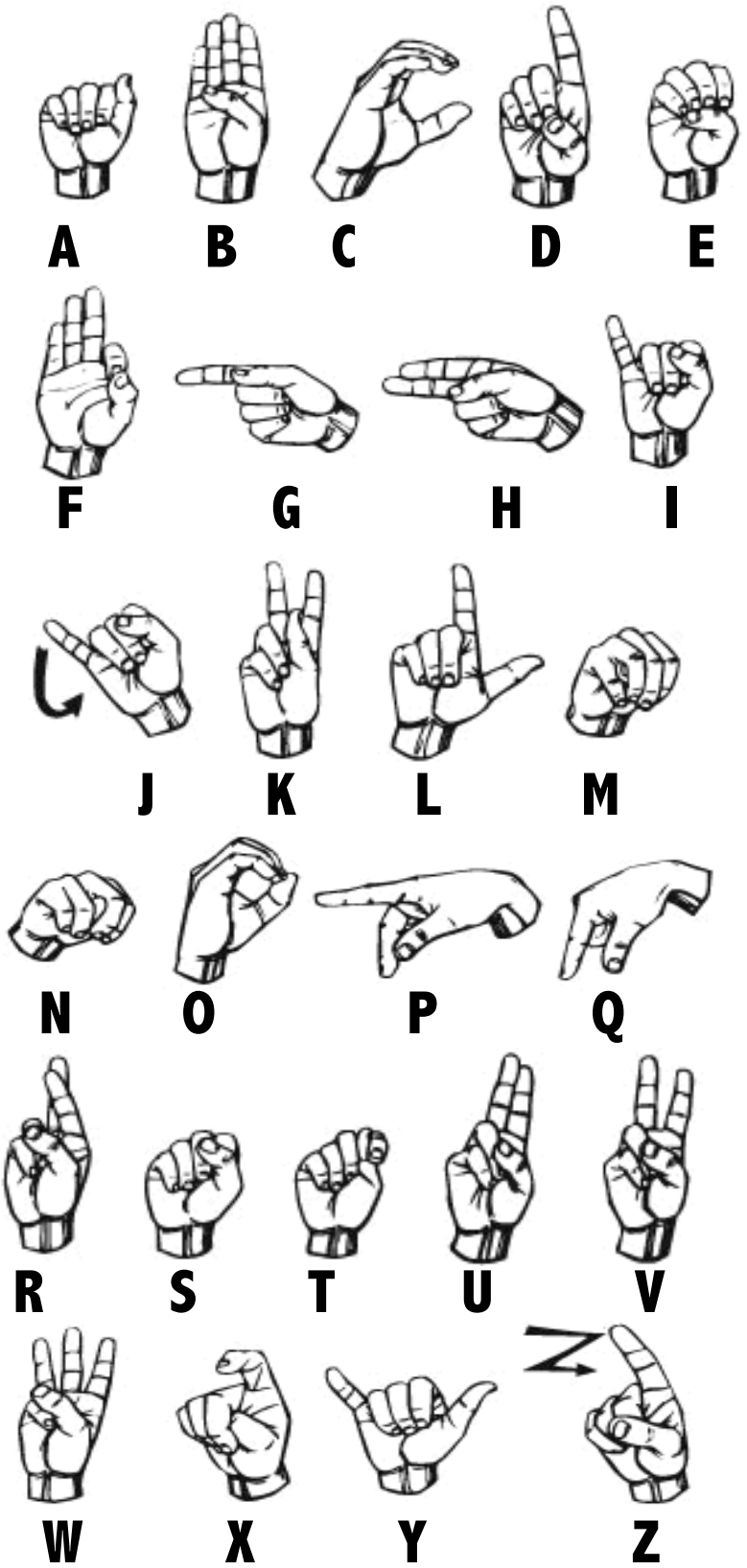
Information Brief

Suggestions for Making Communication a Part of Every Day

- Use words when the person feels something (sore, hurt, tired....)
- Use all chances to name objects in daily routine
- Describe everything as you assist the person (dressing, serving meal)
- Point to pictures of objects in books, saying them clearly
- Point out objects while on a walk, in car, at park, at store
- Have person watch your mouth as you say words
- Speak in short sentences when giving directions
- Be sure to pronounce the entire word
- Encourage progress in making sounds and saying words
- Be sure your movements are simple when teaching
- Encourage people to use all of their senses
- Listen carefully to what the person says or attempts to say

ASL Manual Alphabet

From the unnamed website at <http://members.tripod.com/~imaware/aslalpha.html>



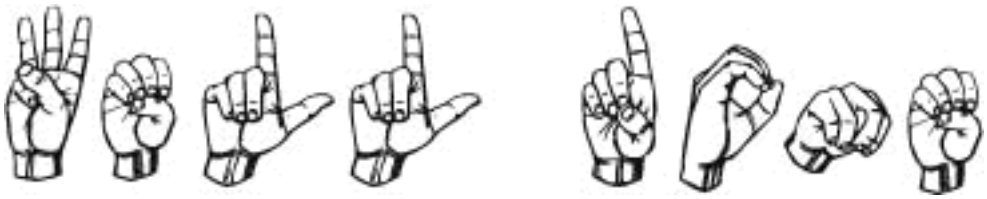
Spelling Words with the Manual Alphabet

Now that you've learned the alphabet, what are these 4 phrases?*

_ _ _ _ _ _

_ _ _ _ _ _ _ _

_ _ _ _ _ _ _ _ _ _



_ _ _ _ _ _ _ _

*See answers on the next page

Saying Words with American Sign Language

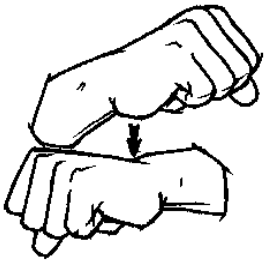
Excerpted from Vicars American Sign Language Course Introductory Signing Concepts at <http://www.lifeprint.com/concepts.htm>

HOME

The sign for "home" is made by touching your fingers and thumb together at the mouth. Then move your hand from your mouth to your right cheek.

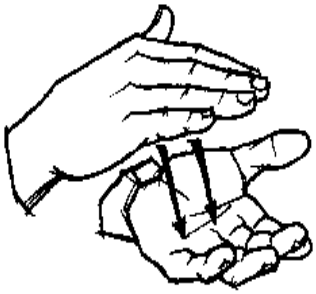
WORK

The sign for "work" is made by shaping both hands into the letter "s." With your palms facing downward, tap your left wrist or the back of your hand a few times with your right wrist.



SCHOOL

The sign for "school" is made by clapping your hands. Repeat two or three times.

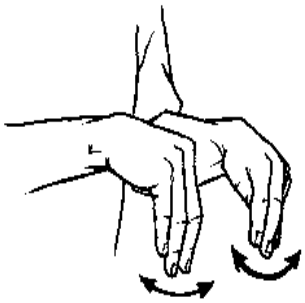


Answers

1. The cat
2. World web
3. Bazooka Joe
4. Well done

STORE

The sign for "store" is made by bending both wrists and pointing both hands down. Pivot both of your hands toward and away from your body. Repeat a few times.



HUNGRY

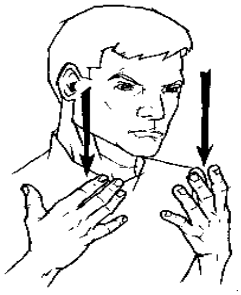
The sign for "hungry" is made by forming your right hand into the letter "c." Move your hand down the middle of your chest, starting under your throat. Note: Some people use the sign for "wish," and prefer to start "hungry" from a slightly lower position.

THANK YOU

The sign for "thank you" is made by touching your lips with one or both of your hands. Your hand(s) should be flat. Move your hand(s) away from your face, palms upward. Smile. Note: Most people use only one hand for this sign.

SAD

The sign for "sad" is made by placing both hands in front of your face, palms in. Bring both of your hands down the length of your face. Tilt your head forward slightly, and make a sad

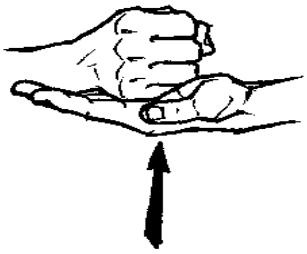


LOVE

The sign for "love" is made by crossing both hands over your heart. Your hands may be closed or open, but the palms should face toward you.

HELP

The sign for "help" is made by closing your right hand. Place your right hand on the outstretched palm of your left hand. Raise both hands. Note: Many people make this sign by placing the left "s" or "a" hand on the right "b" palm.



BATHROOM

The sign for "bathroom" is made by forming the right hand into the letter "t." With your palm facing away from you, shake your hand in front of your chest.

Answers to In-Class Review

1. What are some of the reasons we communicate?

To get information, to give information, to teach others, to socialize

2. Can you describe some of the barriers to effective communication for people with developmental disabilities?

Lack of speech, speech difficult to understand, hearing loss, damage to the part of the brain that controls speech, behavior

3. What are the three components of all communication?

Message, sender, receiver

4. What are some examples of nonverbal communication?

Eye contact, gestures, symbols, voice tone

5. What are behaviors that show you that a person has an interest in socializing in some way?

Smiling when you enter the room, waving, looking at you

6. What are some types of communication systems? What are the advantages or disadvantages of each of those systems?

Sign language – requires training and skill, known throughout the United States

Communication boards – need to know what pictures or symbols are meaningful, Can be very inexpensive to make and use; some of the electronic boards which also talk for the person can be very expensive

Gestures – staff can understand fairly easily; need to communicate gestures to Other staff so everyone responds to the gestures

7. Why is communication so important to people with developmental disabilities? What are some ways that you can assist people with communication?

Communication is important to all people. The DSP can assist by talking while training, pointing out objects, giving names to objects, having the person watch you talk, pointing out objects in the park and at the store and everywhere the chance exists.

8. What are the elements of active listening?

Hear the words, figure them out, then respond

If You Want to Read More About
Communication

Communicate with Confidence: How to Say it Right the First Time and Every Time

by Dianna Booher (1994); R.R. Donnelly and Sons Company; ISBN: 0-07-006455-5

The book starts with a touching story about miscommunication, and goes on to give 23 chapters of practical and easy to read advise on improving communication in business as well as in our personal lives. Booher says that personally or professionally, communication is a life or death issue. The book has over 1,000 tips for improving communication, including how to ask questions, how to answer questions, apologizing, criticizing, and negotiating, among others.

Partners in Everyday Communicative Exchanges

by Nancy Butterfield, Michael Arthur and Jeff Sigafoos (1995); MacLennan and Petty Pty Limited; ISBN: 0 86433 088 X

This book is written for teachers, speech pathologists, and everyone who may communicate with a person who has severe disability. It is complete with case studies and a chapter on challenging behavior. It contains workshop material for the person who may have to teach others about communication.

Augmenting Basic Communication in Natural Contexts

by Jeanne M. Johnson PhD, Diane Baumgart, PhD, Edwin Helmstetter, PhD, and Chris A. Curry MS (1996); Paul H. Brookes Publishing Co. Inc.; ISBN 1-55766-243-6

This book includes a step-by-step guide to completing an assessment of communication and creating a system for people with severe disabilities. Chapter 10, about Kevin will show the reader some systems that work.

Communicating in Sign: Creative Ways to Learn American Sign Language

by Diane P. Chambers (1998); Fireside; ISBN 0-684-83520-7

Language comes from the way we use our bodies to communicate and how we understand the emotions that are communicated to us. The five components of ASL are eye contact, facial expression, body language, mouth movements, and hand movements. Chambers walks the reader through these components, giving illustrated signs as well as offering a chapter on deaf culture.

For those who surf the web:

http://dww.deafworldweb.org/pub/a/asl.html has a host of information about sign language in different languages, as well as ASL, and illustrates stories for someone learning to sign.

http://www.familyvillage.wisc.edu/general/signlanguage.html has several links to other sites for information about sign language. Many of the links get the reader to books and videos that might be helpful for the DSP.

There are several companies that sell communication aids. The DSP can check with a speech therapist for names of some of those companies.

Homework Assignment for Session #3: One-Day Food Diary

DIRECTIONS: In preparation for the module on *Wellness*, please track what you eat and drink over a 24-hour period, and record the information below. Please include water, coffee, tea, juice, and soda. Be sure to include meals out, snacks and "just grazing." Include every pat of margarine, every spoonful of sugar, how much of what was on the sandwich, etc.

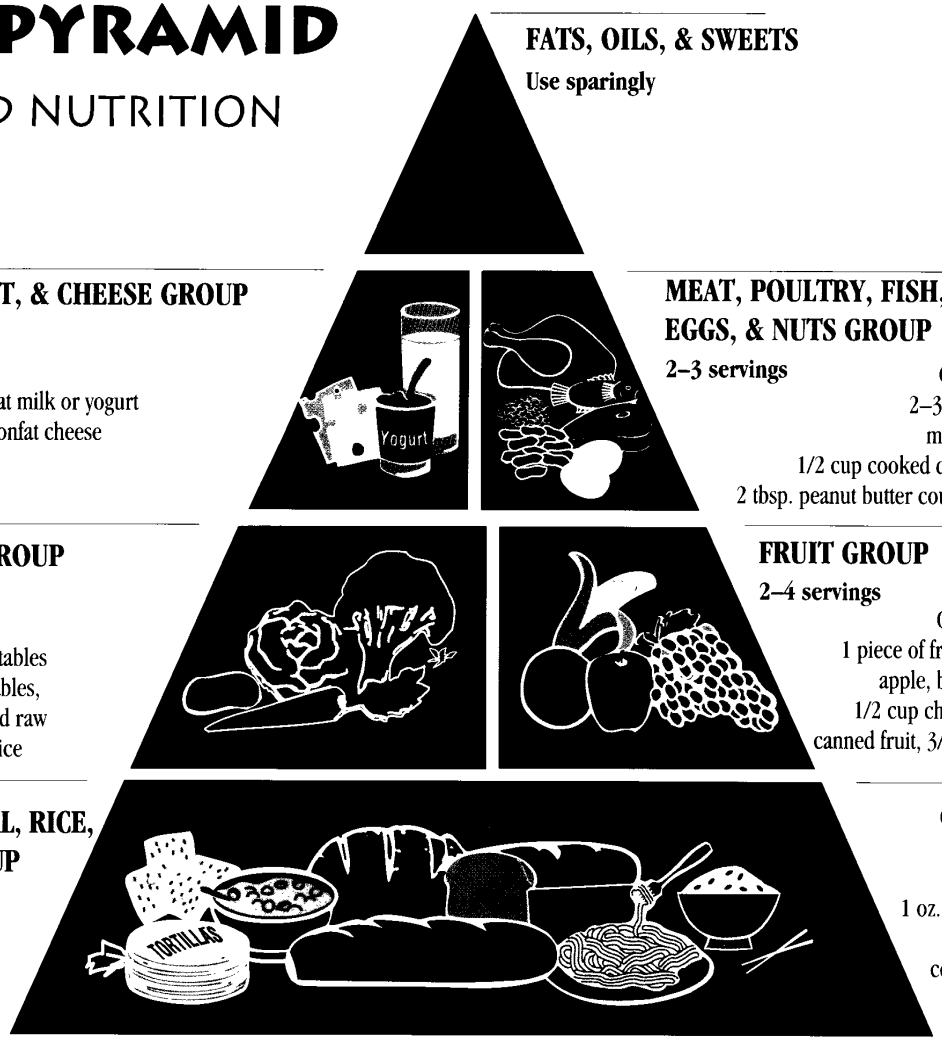
When?	**What?**	**How much?** (e.g., 16 oz. T-bone; bowl of cereal w/milk; etc.)
BREAKFAST:		
Between BREAKFAST & LUNCH		
LUNCH		
Between LUNCH & DINNER		
DINNER		
Between DINNER & BREAKFAST the next morning		

Now, please estimate the number of *servings*, from the six food groups in *The Food Pyramid* and indicate how many 8 oz. glasses of fluid you took in.

Food Group	**No. of servings**
BREAD, CEREAL, RICE & PASTA GROUP	_____
VEGETABLE GROUP	_____
FRUIT GROUP	_____
MILK, YOGURT, & CHEESE GROUP	_____
MEAT, POULTRY, FISH, DRY BEANS, EGGS, & NETS GROUP	_____
FATS, OILS, & SWEETS	_____
About how many 8 oz. glasses of fluid do you take in?	_____

THE FOOD PYRAMID

A GUIDE TO GOOD NUTRITION



FATS, OILS, & SWEETS
Use sparingly

MILK, YOGURT, & CHEESE GROUP
2–3 servings
One serving equals:
1 cup nonfat or lowfat milk or yogurt
1 1/2 oz. lowfat or nonfat cheese

MEAT, POULTRY, FISH, DRY BEANS, EGGS, & NUTS GROUP
2–3 servings
One serving equals:
2–3 oz. of cooked lean meat, poultry, or fish
1/2 cup cooked dry beans, 1 egg, or 2 tbsp. peanut butter count as 1/2 a serving

VEGETABLE GROUP
3–5 servings
One serving equals:
1 cup raw leafy vegetables
1/2 cup other vegetables, cooked or chopped raw
3/4 cup vegetable juice

FRUIT GROUP
2–4 servings
One serving equals:
1 piece of fruit (like a medium apple, banana, or orange)
1/2 cup chopped, cooked, or canned fruit, 3/4 cup of fruit juice

BREAD, CEREAL, RICE, & PASTA GROUP
6–11 servings
One serving equals:
1 slice of bread
1 tortilla
1 oz. ready-to-eat cereal
1/2 cup cooked cereal, rice, or pasta
1/2 bagel
4-6 crackers

What is the Food Guide Pyramid?

The Food Pyramid is a daily nutrition guide, to assist you in choosing a healthy diet. For good nutrition, choose a variety of foods each day, from each of the 5 food groups. Also, eat at least the recommended number of servings from each food group, so your body gets the nutrients it needs. Active people, children, teens, and pregnant women usually need more than the minimum daily servings listed above. To stay healthy you also need to get regular physical activity.

from the **Kaiser Permanente Healthwise Handbook**

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #3
Wellness:
Nutrition, Exercise and Safety

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	**Wellness: Nutrition, Exercise and Safety**	**3 hours**
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Nutrition and Hydration
- Movement, Exercise, and Physical Fitness
- Infection Control
- Hand-Washing (thorough and frequent)
- Standard Precautions
- Safety (around the house)
- Lifting (helping with transfers)
- Environmental Emergencies

Cautionary Statement

The material in this module is **not intended to be medical advice** on personal health matters. Medical advice should be obtained from a licensed physician. This module highlights several nutrition, exercise and safety measures. We urge you to talk with nurses, dietitians, and other professionals (for example, disaster experts; occupational therapists; sports physiologists) to broaden your understanding of the fundamentals covered in this module.

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **What is good nutrition and why is it important?**

2. **What changes can most Americans make in their drinking and eating habits to improve their health and well-being?**

3. **What is the proper way to handle, prepare, and store food?**

4. **What are some of the positive effects of movement and physical activity?**

5. How are infections spread, and what can you do to limit their spread?

6. Can you describe at least three principles of good body mechanics when lifting things?

7. Why is preparation, planning, and practice important in dealing with possible environmental emergencies (for example, fires, earthquakes)?

Information Brief

Health, Wellness, and Safety

This session, and the next two, focus on health, wellness, and safety. *Health* is not just the absence of disease, it is being in the *best possible health* -- physically, mentally, emotionally, spiritually. Good nutrition is one element of a healthy lifestyle. Other elements include physical activity, avoiding smoke and other toxic substances (for example, too much alcohol), management of stress, and early detection and treatment of health problems. *Wellness* is about habits that maintain good health, such as hand-washing, eating properly and getting plenty of exercise and good personal hygiene. *Safety* is about avoiding hazards of being injured. Certain practices (for example, locking up toxic substances; proper body mechanics when lifting) increase safety by reducing the risk of being injured.

The content of the three *Wellness* modules is as follows:

- **Wellness, Part One (Nutrition, Exercise, and Safety)** Food and nutrition, adequate fluid intake (hydration), movement and exercise (physical fitness), infection control, standard precautions, safe practices (for example, lifting techniques), assuring a safe environment, and dealing with environmental emergencies.

- **Wellness, Part Two (Medications)** Administration of medications and documentation, uses and side effects of common medications, pharmaceutical symbols and abbreviations, correctly storing/recording and destroying medicines, side effects and interactions (for example, with other medications or alcohol) and responding appropriately.

- **Wellness, Part Three (Responding Individual Health Care Need)** Personal hygiene, health history, scheduling routine medical and dental exams, recognizing and advocating for age/gender health screenings, using community resources, working effectively with health care professionals (for example, preparation, advocacy, documentation, follow-up), recognizing signs and symptoms of illness or injury, and handling medical emergencies.

Some overlap is unavoidable, and is helpful in emphasizing certain fundamentals (or basics). Here are a couple of illustrations:

1. Attention is paid to signs and symptoms of infection in Part One. Part Two considers intended (and unintended) effects of medications. Detecting signs and symptoms, illness and/or injury in general, is taken up in Part Three.

2. Some people are allergic to certain foods (for example, shell fish, dairy products), and in some rare instances the allergic reaction is a threat to life itself. Such rare occurrences constitute medical emergencies, a topic considered in Part Three. Restrictions in response to food allergies are discussed in Part One.

Information Brief

Some Food and Nutrition Basics

Why is Nutrition Important?

We are what we eat! Good nutrition helps keep us healthy. Poor nutrition can shorten our lives, and make our lives less fulfilling.

- Coronary heart disease is the most common cause of death: more than 500,000 each year, and poor diets contribute to these deaths.

- Hypertension (high blood pressure) affects nearly 58 million Americans, contributes to stroke and heart disease, and is linked, in part, to diet.

- Cancer is the second most common cause of death in the United States, killing about 475,000 people per year. High-fat, low fiber diets increase the risk of certain cancers occurring.

- Obesity affects about 30% of American adults and about 50% of adults with developmental disabilities. Obesity contributes to heart disease, hypertension, diabetes, and other health conditions. Diabetes affects approximately 11 million Americans, contributes to heart, kidney, eye, and circulatory problems.

- Osteoporosis affects 15 to 20 million Americans, especially women beyond menopause. Osteoporosis contributes to 1.3 million bone fractures a year in those over 45 years of age. Eating foods rich in calcium, and staying active, can reduce bone loss.

- Dental disease (caries, and periodontal disease especially) is related, in part, to diet (for example, excess sugar lingering in the mouth) and whether the water is fluoridated.

Individual Needs, Preferences, and Restrictions

Water and other fluids

Water is fundamentally important to life. Water regulates many processes (body temperature; waste removal), and carries minerals. Most people should drink eight 8-ounce glasses of water a day, or its equivalent. Water, itself, has no calories (units of energy); many sodas and juices contain added sugar; and caffeine is dehydrating. Hence, if you drink lots of coffee, cola (even diet), and other such liquids, you need to take in more water than average. Indeed, some would say that caffeine drinks should not be counted toward the 64 ounces of fluid needed daily.

Nutrients and other food components

We need nutrients (for example, protein, carbohydrates, fat, vitamins, minerals) and other food components (for example, fiber) in proper quantity, given our size, activity level, and the rate at which our bodies use energy. Let's look at these nutrients.

Carbohydrates. – Carbohydrates are categorized as follows:

- *Complex carbohydrates* are fiber and starches. These are found in large amounts in vegetables, whole grains, peas, and beans.

- *Simple carbohydrates* are simple sugars (fructose, sucrose, etc.). Sugars are especially plentiful in fruits. Without processing, these sugars contain vitamins and minerals. Granulated or powdered sugar, on the other hand, has been crystallized (from sugar cane or sugar beets) and essentially stripped of vitamins and minerals.

- *Dietary fiber* (a type of carbohydrate, sometimes referred to as "roughage") comes from plants, especially fruits, vegetables, whole grain breads and cereals, brown rice, legumes and beans.

Except for fiber (the non-digestible carbohydrate), both simple and complex carbohydrates are converted into glucose, which directly provides energy for the body, or is stored for future use. Carbohydrates are the main source of blood glucose, a major fuel for all cells, and the only source of energy for the brain and red blood cells. Many Americans ingest way too much sugar (in soda and candy especially), and not enough of other plant foods rich in complex carbohydrates. Dietary fiber performs several critical functions. It promotes a feeling of fullness; it prevents constipation, hemorrhoids, and other intestinal problems; it helps lower blood cholesterol, thereby reducing the risk of heart disease. Many Americans do not have enough fiber in their diets.

Protein. – Foods rich in protein include milk, eggs, cheese, fish, meat, and poultry. Other good sources of protein are whole grains, nuts, beans, and peas. Protein is essential for growth and development. Besides energy, protein contributes to the production of hormones, antibodies, enzymes, and muscle tissue. It also helps maintain the proper acid-alkali balance in the body.

Fat and Cholesterol. Fat provides energy, is essential for growth and development, and helps maintain healthy skin, hair, and nails. Fat also makes things taste good. Fats are categorized as follows:

- *Saturated fat* comes from animal foods, palm and coconut oil
- *Polyunsaturated fat* comes from vegetables oils such as corn, sunflower, safflower, and soybean.
- *Monounsaturated fat* comes mainly from oils such as olive, peanut, and canola

Cholesterol is a white, waxy, fatty substance found in all food from animal sources. Cholesterol helps build cell membranes, produce hormones, and manufacture bile acids. Our liver is capable of producing all the cholesterol our bodies need. Hence, there is no need to obtain cholesterol from the fat in animal foods.

Sodium. – Sodium (salt), in small amounts, is an important nutrient. It helps regulate body fluids, helps muscles function properly, and supports the blood and lymph systems. Too much sodium in the diet can result in high blood pressure, and aggravate many medical problems, including PMS (premenstrual syndrome), heart and kidney disorders.

Other vitamins and minerals. – Calcium, iron, folic acid, magnesium, zinc, potassium, and other elements are essential in small amounts. In developed countries, it is rare to encounter vitamin deficiency diseases like *scurvy* (Vitamin C deficiency); *blindness* (Vitamin A); *beriberi* partial paralysis (Vitamin B1); *pellagra* and its symptoms dermatitis, diarrhea, and dementia (Vitamin B3), and *rickets* (Vitamin D). The eight B vitamins and Vitamin C are water-soluble and not stored in the body. Vitamins A, D, E, and K are fat-soluble and stored in the body. Each has a recommended daily requirement, which for most people indicates how much of each vitamin needs to be in the diet. Excessive heat, freezing, light, air, and cooking in water can reduce vitamins and minerals from food. Smoking, alcohol, laxatives, diuretics, antacids, antihistamines, and other things we use can affect absorption of vitamins and minerals. Thus, it is a good idea to consult with each individual's physician as to whether any dietary supplements are indicated. If so, they should be part of a physician's treatment order, and documented.

Different kinds of diets

There are three kinds of diets:

- *Regular diet.* – This is the typical diet of most individuals, with no texture modifications and nothing added (or subtracted) because of health needs and conditions.
- *Modified diet.* – This is a diet altered in texture. At one extreme, the food may be *pureed.* At the other, some foods (for example, steaks, roasts, carrots) may be cut into small bite sizes to facilitate chewing and swallowing. If a person has trouble chewing and swallowing (for example, due to cerebral palsy,

absence of teeth, or some other condition), a *modified diet* may be ordered by the physician or other health care professional (for example, nurse practitioner or dietitian).

- *Therapeutic diet.* – Developed to contain certain elements that contribute to good health, and to avoid elements that are problematic because of an underlying health condition.

Another example of a therapeutic diet is the diabetic diet. In the diabetic diet the emphasis is on nutrition and good eating habits. People with diabetes need to avoid excess blood sugar. Actual diets go well beyond the "principles," with careful weighing of food using ounce scales, because serving sizes are fundamentally important in controlling diabetes. While essential for diabetics, avoiding too much sugar is a good idea for nearly everyone. People with (and without) diabetes would be well served by following the practices outlined in the "Principles," below: (1) not skipping meals; (2) avoiding too much fat; (3) controlling portion sizes (if overweight); (4) distributing foods evenly throughout the day; and (5) increasing daily exercise, subject to the doctor's approval.

Principles of the Diabetic Diet

Purpose: (1) nutritionally complete diet; (2) control blood sugar and minimize spilling of sugar into the urine; (3) prevent or delay complications.

Omit Sugar and Concentrated Sugar: Minimize sugar, honey, molasses, jams, jellies, pies, cakes, donuts, cookies, candy, soft drinks and other foods high in sugar. When reading labels, watch for: corn syrup, dextrose, sucrose and fructose. These are other names for sugar and should not appear as the first or second ingredient. Limit fruit or fruit juices to one small serving with meals. Artificial sweeteners such as saccharin (Sweet 'n Low, Sugar Twin) and Nutrasweet (Equal) are allowed.

Weight Control: Minimize high fat foods, such as fried foods and those in gravies and sauces. Increase daily exercise with your doctor's approval.

Eat 3 Balanced Meals: Include some protein foods (milk, meat, beans, eggs, lowfat cheeses) and some carbohydrate food (bread, cereals, rice, potatoes, noodles, fruits and vegetables) at each meal. Distribute foods evenly throughout the day. Avoid alcohol.

Meal Regularity: Eat meals at regular, set times. Don't skip meals. Space meals approximately 4-5 hours apart. Get in the habit of carrying a snack in case too much time lapses between meals.

Source: Kaiser Permanente (1998)

Calories

A *calorie* is a unit of energy. Here are two key points about calories:

- Carbohydrates and protein provide 4 calories per gram. (There are 115 grams in an ounce.) Fat, on the other hand, contains 9 calories per gram.

- If one takes in more calories than are used, the excess will be transformed into body fat.

In other words, gram-for-gram, fat has many more calories (or much more energy) than protein or carbohydrates. Thus, when people want (or need) to lose weight, they are typically advised to cut down on fatty foods. Avoiding heart disease is another reason.

Here are some "rough and ready" estimates of daily caloric need:

1,600 calories – many sedentary women and some older adults;

2,200 calories – most children, teenage girls, active women, and many sedentary men; and

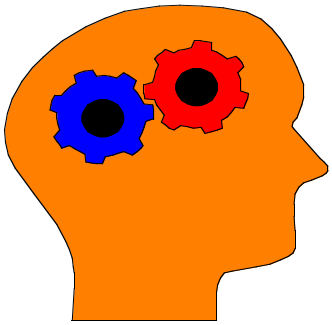
2,800 calories – many teenage boys and active men, some very active women.

Food labels, as we shall see shortly, express desired minimums and maximums based on a 2,000 calorie diet.

Food preferences, aversions, and restrictions

Preferences and aversions. — Most people have food *preferences*, and a few food aversions. Some are related to what each person ate while growing up. Here are just a few examples. Most people *like* foods that are sweet (for example, ice cream) or that have been cooked in fat (for example, French fries). French fries are vegetable, but more than one-half the calories in the typical serving are from fat. Cultural and religious traditions can be important, so it pays to ask and not to make assumptions about what someone wants to eat (or avoid eating). Typically, the DSP can respond sensibly to *preferences,* unless whole classes of important food (for example, vegetables; fruit; legumes; whole grains) are ruled out. In that case, we suggest getting advice from the person's physician and others (for example, dietitian, behavior specialist).

Restrictions are often in response to food allergies (or sensitivities). Food allergies (or sensitivities) become evident because of the body's reaction to food. Hives, itchy watery eyes, diarrhea, mucous build-up, and other responses are fairly common. A rare occurrence is *anaphylactic (septic) shock*, which is life threatening. Breathing can stop without immediate medical intervention. When a "food allergy" or sensitivity is suspected, the DSP should be careful to keep the person away from such foods, and the individual should see his/her physician.



Information Brief

Meal Planning and the Food Guide Pyramid

Over the years, the U.S. Department of Agriculture has emphasized the importance of a "well-balanced diet," but the meaning has changed as more has been learned about the relationship between food, nutrition, and good health. Meal planning is important, because it helps assure a balanced, nutritious diet, while attending to cost, attractiveness (taste and appearance), and ease of preparation. **Menus are the plan for good nutrition.** Menus make food shopping go more smoothly. Over half of all grocery shoppers use a list. Lists can be constructed from menus.

In 1996, the U.S. Department of Agriculture changed it's dietary recommendations, replacing the old system with the Food Pyramid Guide. In your packet is a copy of the Guide, courtesy of Kaiser Permanente.

Food Categories

The Food Pyramid Guide uses five (six, if "fats, oils, and sweets" are included), rather than the earlier four categories (with recommended servings in parenthesis), as follows:

- **Milk, Yogurt, and Cheese Group** (2-3 servings)
- **Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts Group** (2-3 servings)
- **Vegetable Group** (3-5 servings)
- **Fruit Group** (2-4 servings)
- **Bread, Cereal, Rice, and Pasta Group** (6-11 servings)

For example, a person who needs only 1600 calories per day would reduce the size of each serving, or take in a number of servings toward the lower end of the range (for example, 6, 7, or 8 servings from the Bread, Cereal, Rice, and Pasta Group rather than 9, 10, or 11).

Serving Sizes

Food package labels show serving sizes, so that calculations can be made. Dietitians typically use serving sizes along these lines:

- 2-3 oz. of meat, poultry, or fish, which is about as much as will fit into your cupped hand, or two or three slices of packaged meat, or a drumstick or thigh;

- 1 cup (or 8 fluid ounces) of milk or yogurt;
- 1 cup of raw, leafy vegetables or of cooked dry beans;
- 2 eggs;
- 4 Tbsp. Of peanut butter;
- 1/2 cup of cooked or chopped raw vegetables;
- 3/4 cup of vegetable or fruit juice;
- 1 piece of fruit (for example, medium apple, orange, banana);
- 1 slice of bread or 1 tortilla;
- 1 oz. of ready-to-eat cereal;
- 1/2 cup cooked cereal, rice, or pasta; and
- 1/2 bagel or 4-6 crackers.

Food Service: Some General Considerations

Here are some basics to consider in deciding about food service:

- What contributes to good nutrition?
- What is tasty and attractive?
- Who likes to cook? Are they good at it?
- What is the emphasis on planning, participation, and training among individuals living in the home?
- How much time is available?
- What equipment is available?
- How much do we want to spend on food?
- How can food be prepared and kept safe?
- What does Community Care Licensing require?

Involving residents in food service makes good sense, in most instances. Enjoyment of food is universal, and many people take great interest in planning, shopping for and preparing meals. Individuals should be encouraged to participate in meal planning and preparation.

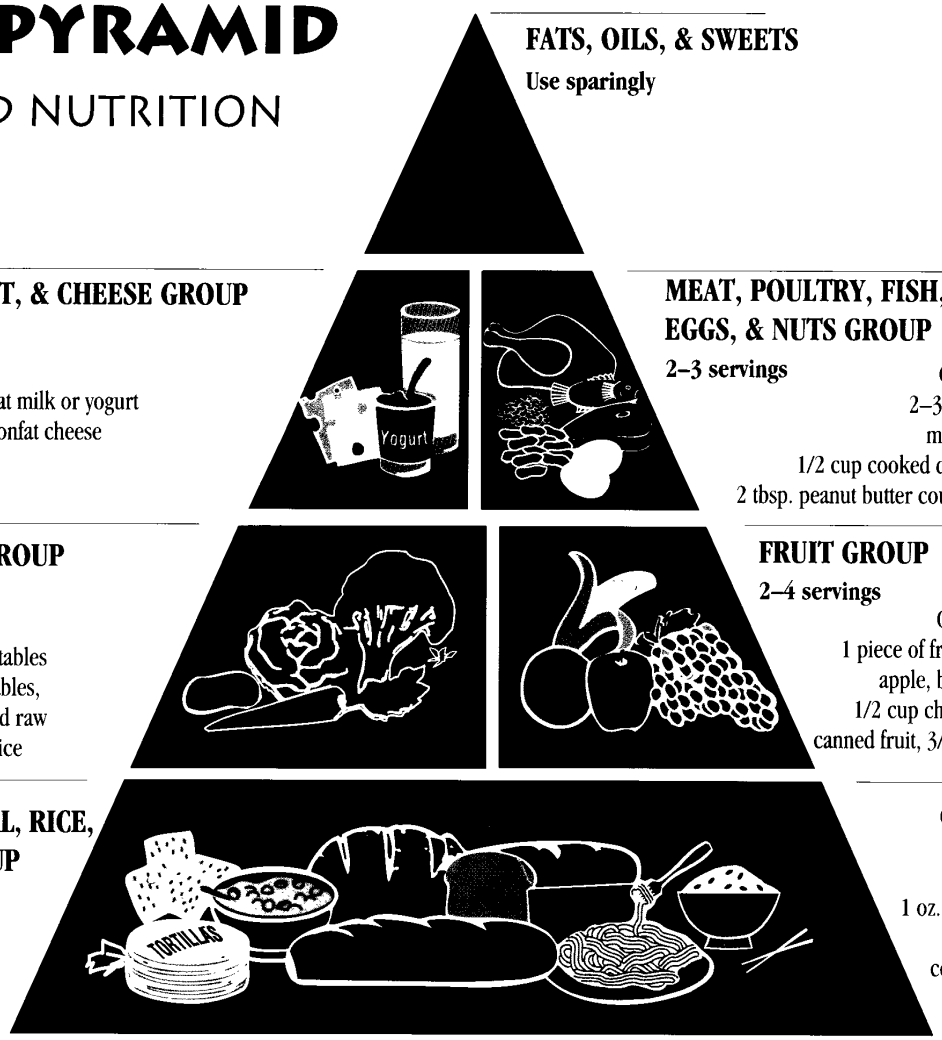
Some Community Care Licensing Requirements

Here are some general, Community Care Licensing requirements for food service:

- Weekly menus written one week in advance, copies dated and kept on file for at least 30 days.
- Food must meet nutritional needs of those served.
- Each meal to meet at least 1/3 of servings recommended in USDA basic food group plan—daily food guide for age group served.
- Allow for a variety in menu planning.

THE FOOD PYRAMID

A GUIDE TO GOOD NUTRITION



FATS, OILS, & SWEETS
Use sparingly

MILK, YOGURT, & CHEESE GROUP
2–3 servings
One serving equals:
1 cup nonfat or lowfat milk or yogurt
1 1/2 oz. lowfat or nonfat cheese

MEAT, POULTRY, FISH, DRY BEANS, EGGS, & NUTS GROUP
2–3 servings
One serving equals:
2–3 oz. of cooked lean meat, poultry, or fish
1/2 cup cooked dry beans, 1 egg, or 2 tbsp. peanut butter count as 1/2 a serving

VEGETABLE GROUP
3–5 servings
One serving equals:
1 cup raw leafy vegetables
1/2 cup other vegetables, cooked or chopped raw
3/4 cup vegetable juice

FRUIT GROUP
2–4 servings
One serving equals:
1 piece of fruit (like a medium apple, banana, or orange)
1/2 cup chopped, cooked, or canned fruit, 3/4 cup of fruit juice

BREAD, CEREAL, RICE, & PASTA GROUP
6–11 servings
One serving equals:
1 slice of bread
1 tortilla
1 oz. ready-to-eat cereal
1/2 cup cooked cereal, rice, or pasta
1/2 bagel
4-6 crackers

What is the Food Guide Pyramid?

The Food Pyramid is a daily nutrition guide, to assist you in choosing a healthy diet. For good nutrition, choose a variety of foods each day, from each of the 5 food groups. Also, eat at least the recommended number of servings from each food group, so your body gets the nutrients it needs. Active people, children, teens, and pregnant women usually need more than the minimum daily servings listed above. To stay healthy you also need to get regular physical activity.

from the **Kaiser Permanente Healthwise Handbook**

- Special diets provided according to the recommendations of a physician or dietitian.
- No more than 15 hours between third meal of one day and first meal of following day.
- Between meal snacks must be made available.
- Cut, chop or grind food to meet individual needs.
- Eat a variety of foods.

Good Rules of Thumb

Listed below are a dozen tips in developing a menu at the home where you work:

1. Strive for *balance*, based on the food pyramid (numbers of servings and serving sizes);
2. Plan to eat a wide *variety* of foods (for example, different kinds of vegetables within the same class – for example, spinach, kale, and other dark leafy greens);
3. Emphasize a variety of *colors*, including green (for example, broccoli; green beans; lettuce), orange (for example, carrots, cantaloupe), red (for example, strawberry, tomatoes), and yellow (for example, summer squash) in addition to white, brown, beige, etc.;
4. Be sure to eat dark greens and yellow vegetables at least two or three times a week;
5. Emphasize non-animal sources of protein or lean meats, fish (excellent source of Omega-3 oils), and poultry – removing fat and skin, whenever possible;
6. Cook in ways (for example, steaming, roasting) that maintains vitamins and minerals;
7. Try alternative condiments (for example, salsa; humus) to butter, margarine, and sour cream;
8. Wash the outside of fruits (and vegetables) before eating or cooking, but keep as much of the skin as possible (fiber);
9. Avoid putting extra salt on foods;
10. Use oils, fats, and sweets sparingly, and when you do, use of canola or olive oil is recommended; and
11. Look for non-fat, low-fat, or reduced-fat alternatives, when using yogurt, milk, and cheese.

Improving Nutrition Gradually

Taste and habits play a major role in what we eat. If moving in a healthier direction, do so gradually, so as to avoid a sense of loss and to give the body time to adjust to the changes.

A Note on Dietary Supplements

Most people do not need food supplements, in the form of vitamin and mineral formulas (for example, One-a-Day Multiple Vitamins; calcium supplement), if they eat a nutritious, well-balanced diet. There are exceptions, especially if a person is taking certain medications regularly. The use of supplements should be discussed with each person's physician. In particular, ask:

- for anyone on anti-seizure medications, whether the person should take a One-a-Day Multiple Vitamin to get adequate folic acid.
- for a child on anti-seizure medication, whether he or she should take a Calcium and Vitamin D supplement.

Some Concluding Thoughts on Food and Nutrition

A good place to end this discussion of food and nutrition is with recommendations contained in the Surgeon General's *Report on Nutrition and Health.* According to the Surgeon General, most people should:

- Decrease intake of fat and cholesterol.
- Maintain appropriate weight.
- Increase intake of complex carbohydrates and fiber.
- Decrease intake of sodium (salt).
- Avoid too much sugar.
- Drink alcohol in moderation (two or fewer drinks per day) or not at all.

Activity:
Some Ways to Reduce Fat in the Diet

Let's brainstorm substitutes (or other changes) that would result in less *fat* in the diet.

Instead of:	***Choose:***
1. Whole milk	_____
2. Ice cream	_____
3. Butter, margarine	_____
4. Regular cheese	_____
	_____
5. French fries or hash browns	_____
	_____
6. Sour cream	_____
7. Oil-packed tuna	_____
8. Cooking oil, lard, shortening.....	_____
9. Fatty meats	_____
10. Vegetables in cream, or butter sauce	_____
11. Potato chips	_____

Adapted with thanks from work by Terri Lisagor, MS, RD.

Information Brief

Shopping, Handling, Preparing, and Storing Food

Shopping

Some helpful hints

Most households shop twice a week for food, sometimes picking up milk and fresh produce (vegetables, fruits, milk, meats) more frequently. Here are some ways to make your food dollar go farther, without sacrificing taste or nutrition:

- **Shop with a list** whenever possible. Starting with a list cuts down on *impulse buying* and food waste.

- **Larger sizes are usually a better value.** A half gallon (or, often two half gallons) of milk are cheaper than two one-quart containers. Just be sure you need the quantity and won't be throwing unused food away.

- **Know your way around the store.** If you don't need to hunt, shopping will go faster, and by spending less time in the store you will save money.

- **Buy store brands to save (up to 50%) over brand-names.** Check on store brand quality. If it is good, you can save (price per unit) some money.

- **Choose produce (fruits & vegetables) when they are "in season" and the price is relatively low.** This is an excellent way to save money, while assuring variety and balance.

- **Start by wheeling your shopping cart around the outside aisles**, because that is where fresh produce, dairy, and meat and fish are found. Prepackaged foods ease preparation time, but are more costly (per food unit) and often contain excessive amounts of sodium and other preservatives.

- **Watch out for sale items.** This caution applies especially to produce, since such sale items are often about to spoil. Check freshness dates on shelf items.

- **You can save with coupons and preferred shopper cards.** As long as the coupon is for an item you will use, it pays to use coupons and your preferred shopper card.

- **Convenience foods.** Weigh the value of convenience foods. One pays more for sliced than whole loaves of bread, for salad mixes, for packaged cake and cookie mixes. Salads, cookies, and other items are fun to fix, and good ways to involve members of the household in food preparation.

- **It pays to stoop down to lower shelves.** Food at eye level tends to have a higher mark-up than food on shelves near the floor. So, it pays to stoop.

- **Read labels, especially when buying a new item.** On packaged foods, new labeling requirements went into effect in 1994. These labels say a lot about calories and nutrients. Most shelves are labeled as well, and one can check out the cost per unit of products that vary in size.

Food Preparation

Food preparation is important for three reasons. First, one wants to conserve nutrients (for example, vitamins and minerals). Second, some foods (for example, ground beef, poultry) should be cooked well-done (for example, ground beef gray; poultry not bleeding), in order to be sure most (if not all) harmful bacteria have been killed. Third, taste and texture change with cooking. These factors call for steaming vegetables, quick-frying in water and little oil (for example, in a wok), and roasting (for example, potatoes). In the case of vegetables, it is important not to cook them too long, especially where nutrients will be washed away. Frying vegetables (or any other items) is also problematic. Frying improves taste for most of us, but excess oil can be a problem.

Vegetables. Proper preparation results in tastier, more nutritious food. Food that is badly prepared can end up being a third as nutritious as when it is prepared well. Fresh vegetables should be eaten soon after being purchased. Vegetables should be washed in running water (but not left to soak). Some (for example, potatoes) will need scrubbing to get the dirt off. It is better not to peel such vegetables, because a lot of nutritional value will be lost. Avoid boiling vegetables, because nutrients will end up in the water. Rather, microwave, steam, or stir-fry in water or a little bit of oil. Vegetables should not be overcooked, and they should be eaten right away. They should maintain their fresh color, generally, and not end up wet and soggy.

Meat, poultry, and eggs. Various methods of cooking have their *pros* and *cons.* For example, frying in oil or fat will retain most vitamins, but add to the fat content of the food. Wok cooking (high heat, little water or oil) works well, unless too much salt is added. Steaming works well, as does roasting, baking or broiling, although some nutrients will be lost. Cooking temperatures (165 degrees F internal temperature and up) destroy most bacteria.

The higher the temperature, the less time it takes to kill bacteria. At temperatures from 140 – 165 degrees F (internal temperature), bacteria will not grow, but they will survive.

Handling and Storage

Here are some safe handling tips, to avoid contamination and to kill bacteria:

- Ask the store clerk to put frozen items together in a bag. This will help maintain their temperature.

- Take items directly home, unpack them, and put them away – in the refrigerator, the freezer, or on shelves.

- Don't leave food items in the car, some items (for example, milk, poultry, meat) can quickly spoil.

- Always wash your hands before touching food, and throughout the process.

- Be sure food and water is from safe sources.

- Refrigerator: Keep the temperature of the refrigerator at or below 40 degrees Fahrenheit, but above freezing. Keep the freezing compartment at 0 degrees F.

- Meat and poultry: Keep meat and poultry refrigerated or frozen. Thaw meat and poultry in refrigerator. Keep raw meat and poultry separate from other foods. Do not put cooked meat or poultry on surfaces where the raw meat or poultry stood. (NOTE: This is often a problem when barbecuing.) Cook poultry and ground meat thoroughly.

- Keep hot foods hot (above 140 degrees F).

- Wash working surfaces (including cutting boards), utensils, dishes in hot, soapy water, or better, in a dishwasher. If washed in the sink, let items air dry.

- Keep all equipment (for example, toaster, mixers, etc.) clean and in good working order.

- Cover and refrigerate leftovers immediately or discard. (It is good practice, to write a date on the cover.)

Bacteria like warm temperatures and moist places. They grow best (and produce toxins) between 60 degrees F and 120 degrees F. Refrigerator temperatures (between 32 and 40 degrees F) allow the slow growth of bacteria. Freezing temperatures (0 – 14 degrees F) prevent growth of bacteria but do not kill them.

Avoid outdated and spoiled food
When in doubt, throw it out!

Many food items – both at the store, and in the refrigerator — have *expiration dates.* Such items should not be purchased beyond the expiration date, and should either be thrown away or checked carefully for wholesomeness before being used. Products vary greatly in how long, even in the refrigerator, they will remain edible. Often it is only a day or two. If individuals in the home have open access to food in the refrigerator, it is important to exercise sufficient supervision to assure that no one eats food that has spoiled. In terms of emergency supplies (for example, canned goods), dating the containers is very important, because while canned goods remain wholesome much longer than fresh produce, dairy products, non-frozen meat and the like, their "shelf life" is not endless, and every six months or so, such food should be used up or thrown out and replaced.

Activity:
Food Label Exercise

See food labels on the next page.

1. **What do the labels tell you about calories?**

2. **What, if anything, does the order of ingredients tell you?**

3. **What can you learn from these labels about fat, cholesterol, sodium, and fiber?**

4. **What else can one learn from food labels?**

Brand X Pure Premium OJ

32 FL OZ (1 QT) 946mL

Nutrition Facts

Serving Size 8 fl oz (240 ml)
Servings Per Container 4

Amount Per Serving	
Calories 110 Calories from Fat 0	
	% Daily Value*
Total Fat 0g	0%
Sodium 0mg	0%
Potassium 450mg	13%
Total Carbohydrate 26 g	9%
Sugars 22g	
Protein 2g	
Vitamin C 60% • Calcium 2%	
Thiamin 10% • Niacin 4%	
Vitamin B6 6% • Folate 15%	
Not a significant source of saturated fat, cholesterol, dietary fiber, vitamin A and iron	
*Percent of Daily Values are based on a 2,000 calorie diet.	

Other container labeling:

Meets American Heart Association food criteria for saturated fat and cholesterol for healthy people over age 2.

Naturally **sodium** free.
No **water** or **preservatives** Added.

Keep Refrigerated

Best if used within 7 to 10 days after opening.

Pasteurized

Deli Macaroni Salad

Net Wt. 16 OZ. (1LB) 454g

Nutrition Facts

Serv. Size 3/4 cup (145g)
Servings: 3

Amount Per Serving	
Calories 330 Fat Cal. 210	
Amount per Serving	% Daily Value*
Total Fat 23g	36%
Saturated Fat 3.5g	17%
Cholesterol 15mg	5%
Sodium 770mg	32%
Total Carb. 27 g	9%
Fiber 2g	7%
Sugars 22g	
Protein 5g	
Vitamin A 0% • Calcium 2%	
Thiamin 10% • Niacin 4% Vitamin C 0% • Iron 10%	
Not a significant source of saturated fat, cholesterol, dietary fiber, vitamin A and iron	
*Percent of Daily Values are based on a 2,000 calorie diet.	

INGREDIENTS: Cooked Enriched Macaroni (semolina, niacin, iron, thiamin mononitrate, riboflavin, folic acid), Mayonnaise (soybean or canola oil, egg yolks, water, vinegar, corn syrup, salt, spice, calcium disodium EDTA), Sweet Pickles (pickles, high fructose corn syrup, water, vinegar, salt, modified food starch, sodium benzoate, natural flavorings, calcium chloride), Corn Syrup, Celery, Water, Onions, Red Bell Peppers, Salt, Vinegar, Mustard (water, vinegar, mustard seed, salt, sugar, soybean oil, spices, tumeric, zanthan gum, annato, calcium disodium EDTA), Potassium Sorbate, to protect flavor, Sugar Zanthan Gum, Annato Coloring

Brand X Beef & Green Chili Burritos

10-4 OZ BURRITOS,
NETWT 40 OZ (2.5 LBS) 1,134g

Nutrition Facts

Serving Size 1 Burrito (113g)
Servings Per Container 10

Amount Per Serving	
Calories 290 Calories from Fat 120	
	% Daily Value*
Total Fat 14g	21%
Saturated Fat 5g	24%
Cholesterol 15mg	5%
Sodium 270mg	10%
Total Carbohydrate 34 g	11%
Dietary Fiber 3g	13%
Sugars 1g	
Protein 8g	
Vitamin A 0% • Vitamin C 6%	
Calcium 2% • Iron 15%	
*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs	

	Calories:	2,000	2,500
Total Fat	Less than	65g	80g
Sat. Fat	Less than	20g	25g
Cholesterol	Less than	300mg	300mg
Sodium	Less than	2,400mg	2,400mg
Total Carbohydrate		300g	375g
Dietary Fiber		25g	30g

Calories per gram:
Fat 9 • Carbohydrate 4 • Protein 4

INGREDIENTS: Flour Tortilla (bleached wheat four enriched (niacin, reduced iron, thiamin mononitrate, riboflavin, folic acid), water, soybean oil . . . .

Information Brief

Importance of Regular Physical Activity

Regular physical activity helps to maintain physical (and emotional) fitness. Moving about aids digestion and elimination, stresses muscles and joints (helping maintain bone density), and maintains strength. If stretching is a part of regular physical activity, flexibility is enhanced. And, if a person exercises vigorously every other day, for thirty minutes or more, the cardiovascular system will become more efficient.

If a person has not been exercising regularly, it is wise to check with one's physician before embarking on an exercise plan, and to move slowly in the new direction, paying close attention to how the person reacts to increased effort.

Walking, Hiking, Swimming

Brisk walking is among the very best ways to exercise. Such walking will increase the person's heart rate, but not stress joints like jogging will. Hiking, with changes in terrain, is another excellent exercise. Swimming or water aerobics is great as well. Swimming, because the water holds up the body, puts minimal (or no stress) on knees and other joints.

[1] This section relies heavily on Karen Green McGowan & Jim McGowan, *Assessing Health Risk in Developmental Disabilities (1995)*, pp. 2-17 to 2-21.

Other Physical Fitness Activities

Many other physical fitness activities contribute to wellness. Different people like different activities. Some like team sports such as basketball, baseball, and volleyball. Other individuals likes sports such as hiking, walking, or jogging. Most communities put on a variety of walks and runs where the individual with a disability can readily participate with non-disabled people who enjoy the same activity. Here is a list of potential benefits from regular exercise:[2]

- Relieves tension and stress
- Provides enjoyment and fun
- Stimulates the mind
- Helps maintain stable weight
- Controls appetite
- Boosts self-image
- Improves muscle tone and strength
- Improves flexibility
- Lowers blood pressure
- Relieves insomnia
- Increases "good" cholesterol (HDL)
- Prevents diabetes

[2] Kaiser Permanente, *Healthwise Handbook* (1998), p. 245.

Information Brief

Infection Control

The world contains millions of microorganisms, the vast majority of which are harmless, or actually play a positive role (for example, in digestion, elimination). A few can cause illness or infection. For this reason, they are called *pathogens.* In this section, we will talk about (1) common germs; (2) ways they are spread or transmitted to us; (3) barriers (or defenses) to their invasion; (4) how to tell whether illness or infection has occurred; and (5) treatment. Two major classes of microorganisms are **bacteria** and **viruses.** One reason to distinguish these microorganisms (or germs) is because *antibiotic* medication (for example, penicillin) works for bacterial infections, but not viral. Other microorganisms that can cause illness include **yeast**, **molds**, **fungi,** and even bits of protein (for example, **prions** and "Mad Cow Disease").

Signs of Infection

A change in activity level (slowing down) or in appetite (not eating) may be the first sign of infection, especially for the person who uses few words. DSPs need to pay attention to subtle changes in both activity level and/or appetite, to assure that illness and infection is reported to the individual's physician and the individual is treated early. Here are sets of symptoms and what they *may* mean.

WOUND	Pain, swelling, redness, tenderness, pus and/or red streaks from the wound.
EYES	Redness, swelling of the eyelid, eyes burning or painful, discharge. Could be allergy if discharge is clear; infection likely if yellowish or greenish.
EARS	Pain, pulling at ear, redness, fever, diminished hearing, drainage possible.
THROAT	Pain with swallowing, refusal to eat, redness, possible whitish patches at back of throat, hoarse voice, possibly fever or skin rash.
TEETH	Pain, refusal to eat, facial or gum swelling, gum bleeding, fever.
RESPIRATORY SYSTEM	Cough, phlegm (mucous), shortness of breath or wheezing, fever. A fever or chills that develop near the end of a cold may indicate pneumonia. Fever with rash, stiff neck, headache, irritability or confusion

may indicate meningitis. Nasal congestion with severe headache and pain in the nose, cheeks, or upper teeth may indicate sinus infection.

DIGESTIVE SYSTEM — Abdominal pain that keeps getting worse and is accompanied by vomiting and/or loose stools, fever.

URINARY TRACT — Difficult urination, pain or burning, changes in urine color (clear to cloudy; light to dark yellow), fever. May also be vomiting and/or loose stools. Complaints of pain on one or both sides of the mid-back, fever, chills, nausea, and vomiting may indicate kidney infection.

TOXIC SHOCK SYNDROME — Women who develop fever, vomiting, diarrhea, rash, especially during menstruation.

VAGINAL INFECTION — Vaginal discharge, itching, unusual odor, burning.

The DSP should seek a physician's advice regarding any of these symptoms. The DSP should always take precautions to prevent the spread of infections.

How Infections Spread

Understanding the way germs enter the human body is crucial. Some *pathogens* are largely or exclusively:

(1) blood-borne (for example, HIV; Hepatitis B);

(2) air-borne (for example, Chicken Pox, Tuberculosis, Common Cold);

(3) food-borne (for example, E. coli; Salmonella);

(4) water-borne (for example, Dysentery, "flu");

(5) insect-borne (for example, mosquitoes and Malaria; ticks and Lyme disease); or

(6) passed on through direct human contact (for example, exchange of bodily fluids).

If a person has a Cold, and sneezes, droplets in the air can enter another's body. Or, if the person wipes their nose without washing their hands, the germs can be spread readily through touch. Mucous membranes of the nose, mouth, and eyes are particularly susceptible.

Some germs enter through breaks in the skin. For example, a person with Hepatitis B nicks his face while shaving and leaves the infected blood on the razor. If another person uses the razor and then nicks himself, he may become infected with the Hepatitis B virus.

Other infections are spread through semen or vaginal secretions; saliva (for example, "Mono"); or bodily waste products (feces or urine). Many germs enter the body in more than one way (for example, HIV is

spread largely through blood, semen, or occasionally breast milk).

One should be careful not to transmit infection to others and equally important, one should be careful not to be infected by others. Hand-washing and the use of disposable gloves are two ways to prevent infection.

Hand-Washing

To prevent the spread of germs, frequent and vigorous hand-washing is considered the most important single thing a person can do. Here is the technique for proper hand-washing (See Figure 1):

- Remove rings and watch.
- Wet hands under running water, from wrist down.
- Apply soap (liquid preferred, rather than bar).
- Wash vigorously for at least 15 seconds. Scrub all surfaces with particular attention to fingertips and nails.
- Rinse hands, from the wrist down, under running water.
- Use paper towels, single-use cloth towel, or warm air dryer to dry hands, rather than a cloth towel used repeatedly and by others.
- Avoid recontamination by not touching germ-laden surfaces (for example, toilet seat, sink) after washing. Use a second paper towel to turn off faucet.

Be sure to wash hands upon arrival at work, and *before* touching:

- Food,
- Someone's medicine,
- Kitchen utensils or equipment,
- Someone's non-intact skin,
- Gloves to be put on.

Be sure to wash hands *after*:

- Going to the toilet,
- Sneezing, coughing, or blowing your nose,
- Touching your mouth, nose, or other part of your body,
- Touching any bodily fluids (except sweat),
- Touching someone's soiled clothing or linens,
- Providing assistance with medications,
- Removing and disposing of your gloves,
- Touching anything else that could be contaminated with germs.

Standard Precautions

Standard Precautions are an approach to infection control. These precautions apply to all blood, all body fluids, secretions, and excretions (except sweat), whether or not they contain visible blood. They also apply

Figure 1
Hand-Washing Technique

Assemble Equipment: Soap (bar or liquid), paper towels, warm running water, waste container.

Standing away from sink, turn on faucet and adjust water temperature. Keep your clothes dry moisture breeds bacteria.

Wet hands and wrists, keeping your hands lower than your elbows so water runs off your fingertips, not up your arm.

Use a generous amount of soap, rubbing hands together and fingers between each other to create a lather. Friction helps clean.

Continue to rub, push soap under your finger-nails and cuticles with a brush or by working them in the palm of your hand. Use soap above your wrist about two inches. Wash for one minute.

Being careful not to touch the sink, rinse thoroughly under running water. Rinse from just above the wrists down to fingertips. Do not run water over unwashed arm down to clean hands.

Using a clean paper towel, dry from tips of fingers up to clean wrists. Again, do not wipe towel on un-washed forearm and then wipe clean hands. Dispose of towel with out touching waste contain If your hands ever touch the sink or waste container, start over.

Using a clean paper towel, turn off faucet, which is considered contaminated. Properly discard towel. Apply lotion if hands are dry or chapped.

to mucous membranes and where there is a cut or abrasion. *Universal Precautions,* the earlier concept, did not call for use of gloves when dealing with urine, feces, tears, and saliva unless visibly contaminated with blood. One doesn't necessarily know whether a person has Hepatitis B or HIV, two blood-borne pathogens. Nor can one always be sure certain fluids do not contain blood.

Disposable gloves

Disposable (single-use) latex or vinyl gloves should be worn when assisting a person with:

- Cleaning the rectal or genital area,
- Giving mouth care (for example, helping with tooth-brushing),
- Shaving with a disposable blade razor,
- Cleaning toilets,
- Cleaning up urine, feces, or vomit,
- Menstrual care and disposal or sanitary supplies,
- Performing wound care.

It's a good idea to wear gloves when helping a person bathe or shower, if there are any openings (cuts, rashes, etc.) on the DSP's hands. For protection of the person being bathed or helped in the shower, one should always start at the top (for example, hair, face, etc.) and work down, being careful to avoid self-contamination via wash clothes and splashed water in and around the face. It is vitally important to change gloves, use a fresh wash cloth (if one is being used), and to wash hands when assisting one person, and then moving on to help a second person, since one is seeking to avoid cross-contamination. Figure 2, on the next page, describes the way in which gloves should be put on (to protect the person assisted) and removed (to protect the DSP). If contaminants on the gloves touch your skin, or if a glove breaks, simply take it off, and vigorously and thoroughly wash your hands.

Other protective equipment

Depending on your job, you may be expected to wear other personal protective equipment (PPE), like a face mask or eye shields. If you need these, get expert help in how to use and dispose of them properly.

Infection control is a two-way street. Occasionally, one sees a person wear dirty or contaminated gloves, using them over and over. To be sure, this may protect the wearer from infection, but it does nothing to prevent spreading infection to others. Indeed, just the opposite – without frequent and thorough washing, it is almost guaranteed to spread germs.

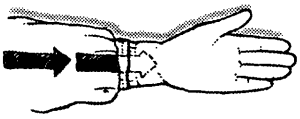
Immunizations

Vaccinations have largely eliminated many diseases, such as Polio, Whooping Cough, and Measles. Older people, plus younger ones whose health is compromised in certain ways, can also benefit from "flu shots" and vaccination against Pneumonia. (Figure 3, is a typical schedule of

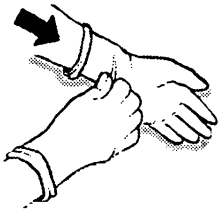
Figure 2
Gloving Technique

Putting on non-sterile gloves

- Wash your hands following proper procedure.
- If you are right handed, remove one glove and slide it on your left hand (reverse, if left handed).
- Pulling out another glove with your gloved hand, slide the other hand into the glove.
- Interlace fingers to smooth out folds and create a comfortable fit
- Carefully look for tears, holes or discolored spots and replace the glove if necessary.

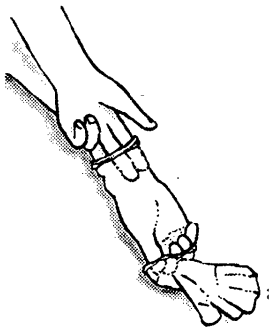


- If wearing a gown, pull the cuff of the gloves over the sleeve of the gown.



Removing non-sterile gloves

- Touching only the outside of one glove, pull the first glove off by pulling down from the cuff.
- As the glove comes off your hand it should be turned inside out.
- With the fingertips of your gloved hand hold the glove you just removed. With your ungloved hand, reach two fingers inside the remaining



glove, being careful not to touch any part of the outside.

- Pull down, turning this glove inside out and over the first glove as you remove it.
- You should be holding one glove from its clean inner side and the other glove should be inside it.
- Drop both gloves into the proper container.
- Wash your hands using proper procedure.

Figure 3

Immunization Schedule

Immunization → / Age ↓	Diphtheria Pertussis Tetanus (DPT)	Polio (OPV/IPV)	Measles Mumps Rubella (MMR)	Chickenpox (Varicella)	Hepatitis B (HBV)	*Haemophilus influenzae* b (Hib)	Tetanus Diphtheria (Td) booster
Birth - 2 months					✓		
1 - 4 months					✓		
2 months	✓	✓				✓	
4 months	✓	✓				✓	
6 months	✓					✓	
6 - 12 months					✓		
6 - 18 months		✓					
12 - 15 months			✓			✓	
12 - 18 months	✓			✓			
4 - 6 years	✓	✓	✓[1]				
11 - 12 years			✓[1]	✓[2]	✓[3]		
11 - 16 years							✓
Adult			✓[4]		✓[5]		Every 10 years
Over 65	Pneumococcal vaccine (one time only)[6] Influenza (flu) vaccine (annually)[6]						

[1] The second MMR may be given at either ages 4-6 or 11-12 years.

[2] Those who have not been vaccinated, have not had chickenpox, or for whom a blood test indicates they are not immune should be vaccinated at this age.

[3] HBV vaccination at these ages is recommended if it was not given earlier.

[4] Vaccine recommended for adults without record of two doses in childhood. Women trying to get pregnant should have a blood test to check for rubella immunity.

[5] Adults under 25 or at increased risk for hepatitis B infection should receive the hepatitis B vaccine series (see page 28).

[6] People younger than 65 who have chronic diseases, especially respiratory illnesses, such as asthma, should also consider receiving the pneumococcal vaccine and annual flu shots.

Adapted from *The Advisory Committee on Immunization Practices,* American Academy of Pediatrics, 1996.

vaccinations for individuals in good general health. Recommendations are from Kaiser Permanente.)

Antibiotics

Bacteria are both good and bad. Our bodies need certain bacteria to stay healthy. However, even these "good" bacteria can turn "bad." Infection is caused when the body's natural defenses break down, and normally harmless bacteria invade and grow in tissue where they don't belong.

Antibiotic medications are effective in the treatment or infections because of their ability to kill bacteria without harming tile body. There are many types of bacteria that can cause infection and a particular antibiotic may or may not be the right one to kill the bacteria causing the current infection. If the prescribed antibiotic doesn't start to work within 2 days, call the physician. The physician may try a different antibiotic or order a lab test to identify the type of bacteria and the antibiotic that will work best. Be sure to tell the physician about all of the medications being taken, especially if the medications have been prescribed by another doctor.

Bacteria can become resistant to antibiotics which makes treatment more difficult. If you keep in mind the following guidelines when assisting an individual with antibiotic medicine, it will help complete a successful treatment:

- the antibiotic should be taken until it is completely gone;
- follow the directions and schedule exactly and don't skip doses;
- if there is any left, do not use it later for the same person or another person with the same symptoms; and
- always wash your hands before and after assisting someone with medicine.

Other Ways to Reduce Spread of Infection

- Cleaning up spills of bodily fluids and disinfecting, using 1/4 cup of chlorine bleach per gallon of water (1:10 solution)
- Handling soiled laundry as little as possible
- Washing soiled clothing and linens separately from other clothes
- Use of paper towels through out house
- Making sure residents follow good hand-washing practices (for example, before touching food, after using the bathroom)
- Keeping clean hands away from the face and other areas of the body
- Use of own toiletries and equipment (for example, combs, brushes, razors, etc.)

- Use of own cloth towels, frequently washed, and kept in each person's room

- Frequent cleaning of contaminated surfaces (for example, kitchen counters, toilets and sinks, bathtubs, showers)

- Not rinsing mop in kitchen sink

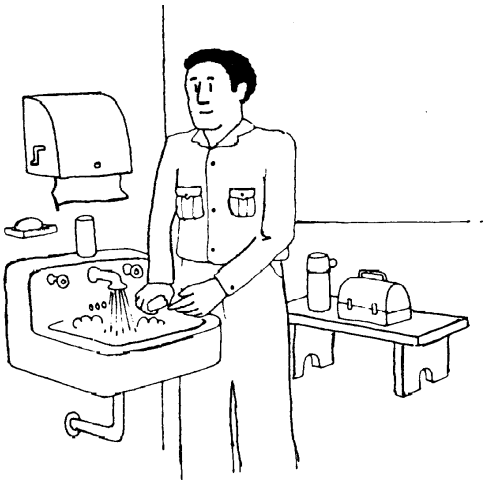
- After washing the dishes, putting sponge in dishwasher, or nuking it in microwave for a minute or two

- Keep rooms in home clean and well-ventilated

- Use disposable tissues to cover mouth and nose when coughing or sneezing

- Caregivers who are in a contagious stage of an illness should not work closely with others

- Get vaccinated

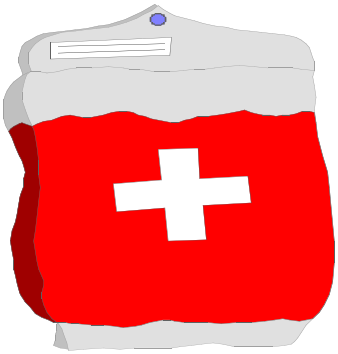


Information Brief

Safety Around the House

DSPs can increase safety around the house and reduce the likelihood of injury or death by doing the following:

- ✓ Eliminating hazards (for example, slippery floors) around the house;
- ✓ Doing things in a safe manner (for example, lifting, helping with transfers);
- ✓ Education and training to reduce risk and to respond appropriately when injuries happen;
- ✓ Sharing information about hazards; and
- ✓ Preparation, developing contingency plans, and practice.



Chemicals and Other Toxic Substances

Labeling and Storage

Here is a list of common household poisons:

Alcohol
Air freshener
Aspirin
Bleach
Cigarettes and tobacco
Cosmetics
Dishwasher detergent
Dishwashing detergent
Drain cleaner
Drugs of any kind
Furniture polish
Glass cleaner
Grease remover
Insecticide
Laundry detergent
Moth balls
Nail polish and nail polish remover
Oven cleaner
Paint and paint thinner
Scouring pads
Scouring powder
Toilet cleaner
Weed killer

These items must be (1) stored in their original containers, (2) kept separate from food items, and (3) be inaccessible (for example, locked up) to people who might not know how dangerous it would be to ingest them, get them on their skin or in their eyes.

Preparation and responding

1. Post phone numbers of doctors and Poison Control Center near the main phone;

2. Keep *ipecac syrup*[1] on hand, under lock and key. Do not use it to induce vomiting unless Poison Control says to do so; if vomiting occurs, save what is thrown up (vomitus).

3. When a poisoning incident occurs, and you call the Poison Control Center:
   - remain calm;
   - report the source of the poisoning (brand name and label, if possible);
   - report the amount ingested (if you don't know, say so);
   - report age and weight of the person; and
   - report elapsed time.

4. Flush eyes, if chemicals or other toxic substances have been splashed.

In 1997, the California State Poison Control System was inaugurated. Everyone in California can use a common number, **1-800-876-4766** (or **1-800-8POISON**), and your call will be automatically routed to the appropriate division able to respond to your call.

[1] *Syrup of ipecac* will induce vomiting. Some poisons (for example, petroleum-based products, acids) are such that inducing vomiting is not a good approach, because of potential added damage to the esophagus, lungs, and mouth. Ipecac syrup in the bottle loses its effectiveness with the passage of time. Therefore, check expiration dates and replace, as indicated.

A Safe Environment, and Being Careful

Home accidents in the United States claim about 20,000 lives per year, more than work-related accidents, but less than motor vehicle accidents. A 1992 National Health Interview Survey revealed that 1 of every 13 Americans suffered a home injury that required medical attention. We have dealt with poisonings (the second leading cause of home accident deaths). Here are other hazards. [Figure 4 shows the Disaster Plan form that most Community Care facilities use. .Make sure you know where the Disaster Plan is posted and are familiar with the information and the information is current.]

Falls

One of every three home accidents is a fall. Some 7,000 Americans die each year from falls at home. Where there are flights of stairs, stepping on an unseen object (for example, marbles, a skate) is particularly hazardous. Other falls occur in bathtubs, on ladders, from roofs, and even falling out of bed. Yet, one of every four falls is on a level surface. Some people are in too much of a hurry, horse around, failed to see an object, or fall for some other reason (for example, dizziness; tripping over one's own feet).

What can be done? We can help by:

✓ Encouraging everyone to *watch their step;*

✓ Being sure nothing (clothes, toys, books, etc.) is on stairways;

Figure 4
Disaster Plan

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

EMERGENCY DISASTER PLAN FOR RESIDENTIAL CARE FACILITIES FOR THE ELDERLY, COMMUNITY CARE FACILITIES AND CHILD DAYCARE CENTERS

INSTRUCTIONS:
Post a copy in a prominent location in facility, near telephone.
Return a copy to the licensing office. Licensee is responsible for updating information as required.

NAME OF FACILITY	ADMINISTRATOR OF FACILITY
FACILITY ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )

I. AFFIRMATION STATEMENT

AS ADMINISTRATOR OF THIS FACILITY, I ASSUME RESPONSIBILITY FOR THIS PLAN FOR PROVIDING EMERGENCY SERVICES AS INDICATED BELOW. I SHALL INSTRUCT ALL CLIENTS/RESIDENTS, AGE AND ABILITIES PERMITTING, ANY STAFF AND/OR HOUSEHOLD MEMBERS AS NEEDED IN THEIR DUTIES AND RESPONSIBILITIES UNDER THIS PLAN.

SIGNATURE	DATE

II. ASSIGNMENTS DURING AN EMERGENCY (USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

NAME OF STAFF	TITLE	ASSIGNMENT
1.		DIRECT EVALUATION AND PERSON COUNT
2.		HANDLE FIRST AID, AS NEEDED
3.		TELEPHONE EMERGENCY NUMBERS
4.		TRANSPORTATION, IF NEEDED
5.		OTHER (DESCRIBE)
6.		

III. EMERGENCY NAMES AND TELEPHONE NUMBERS (9-1-1 NOT ACCEPTABLE)

FIRE/PARAMEDICS	POLICE OR SHERIFF
RED CROSS	OFFICE OF EMERGENCY SERVICES
PHYSICIAN(S)	POISON CONTROL
HOSPITAL(S)	AMBULANCE
DENTIST(S)	CRISIS CENTER
CHILD PROTECTIVE SERVICES	OTHER AGENCY/PERSON

IV. FACILITY EXIT LOCATIONS (USING A COPY OF THE FACILITY SKETCH [LIC 999] INDICATE EXITS BY NUMBER)

1.	2.
3.	4.

V. TEMPORARY RELOCATION SITE(S)

NAME	ADDRESS	TELEPHONE NUMBER ( )
NAME	ADDRESS	TELEPHONE NUMBER ( )

VI. UTILITY SHUT—OFF LOCATIONS (INDICATE LOCATION(S) ON THE FACILITY SKETCH [LIC 999])

ELECTRICITY

WATER

GAS

VII. FIRST AID KIT (IF REQUIRED)

VIII. EQUIPMENT

SMOKE DETECTOR LOCATION (IF REQUIRED)

FIRE EXTINGUISHER LOCATION (IF REQUIRED)

TYPE OF FIRE ALARM SOUNDING DEVICE (IF REQUIRED)

LOCATION OF DEVICE

LIC 610 (10/92) (PUBLIC)

- ✓ Installing night lights;
- ✓ Carpeting stairs (for example, rubber runner on stairs to basement);
- ✓ Replacing worn out carpet, and making sure it doesn't come loose;
- ✓ Installing and maintaining handrails;
- ✓ Taking one step at a time;
- ✓ Using well maintained ladders and being spotted by someone;
- ✓ Getting a better ladder (or moving one) rather than stretching to reach;
- ✓ Using a rubber mat in the bathtub or shower stall;
- ✓ Installing and using grab bars in the bathtub or shower stall;
- ✓ Making sure throw rugs are securely fastened to the floor; and
- ✓ Where it is icy, having sand or salt to put on porches and other icy pathways.

Fires

Fires are the third leading cause of accidental deaths in the home, and often result in serious injury and cause extensive property damage. Many fires are the result of neglect, indifference, carelessness, or laziness. One-third of deaths from fire (burning or smoke inhalation) occur between midnight and 4:00 A.M., when most people are sleeping. The most common cause of fire is careless smoking. To minimize this hazard, enforce the following rules:

- Don't ever smoke in bed;
- If smoking inside or outside the home, set a burning cigarette down in an ashtray;
- Use a tin can with sand, and dispose of cigarette butts there; and
- Never empty this can just after burying a butt in the sand.

Lightening and brush fires can engulf homes. Installing a lightening rod (for a home on a hilltop) and building firebreaks around a home in a wooded or grassy area are two things people can do to reduce the hazard. Frequent cleaning of ovens and fireplaces is important; not leaving matches around for people to get into; not overloading electrical circuits; avoiding frayed or shredded electrical cords by not using extension cords running under rugs are additional preventive measures. Space heaters are especially dangerous, and wet clothes should never be dried on such heaters, electric lamps, or the furnace.

Here are some other things you can do to prevent and respond to fires:

1. Don't let rubbish (especially paper, rags and old clothes) accumulate under stairs, in the attic, or basement.
2. Keep flammable liquids in tightly closed metal containers, away from heat sources.
3. Rags used to wipe up oil or paint should be stored in tightly closed metal containers, and disposed of quickly.

4. Do not leave matches or cigarette lighters around.

5. Keep a close eye on gas appliances, and be sensitive to gas leaks; call the gas company and get out of the house if you smell gas.

6. Be careful with all electrical appliances and make sure they are in good working condition (for example, hair curling iron; toaster).

7. Check smoke detectors monthly and replace batteries once a year (say, on the Administrator's birthday) or as needed .

8. Have fire extinguishers in the house, know how to use one, and have them serviced periodically.

9. Teach everyone in the home what to do if a fire occurs, and practice.

Fire arms

Fire arms exist in many homes. They should always to locked up, be unloaded, and have trigger locks as well. Ammunition should be stored under lock and key elsewhere in the house. It is important to teach everyone about guns: for example, never to point even a toy gun at someone (lest the person think it is real, and shoot back), and to call a responsible adult if a gun is ever encountered in the home.

Drowning

People can drown not only in natural bodies of water, but in bathtubs, swimming pools, and hot tubs. Community Care Licensing requires fences around swimming pools with locked gates, and careful supervision by someone trained and certified in water safety. Here are other tips:

- Teach everyone water safety (and, if possible, how to swim).

- Don't allow diving into water less than four feet deep.

- Don't allow horsing around, running on the deck, or game-playing where a person could hit their head on the side of the pool.

Never leave a small child or anyone else with cognitive or physical conditions (for example, uncontrolled seizures) in a bathtub, shower stall, hot tub, swimming pool or other body of water for any reason.

Tools and appliances

While tools and appliances result in few deaths each year, they account for a very large number of injuries and trips to emergency rooms. Most homes have a variety of tools and appliances for the yard (lawn mowers, saws, etc.) and within the home itself (lamps, toasters, ovens, freezers, TVs and stereo equipment, and the like). Remember ***water and electricity don't mix!*** Electric shocks can be fatal if the person is sitting or standing in water, or has water on his or her hands. Thus:

- Don't use any, plug-in electrical appliance in the bathroom or any place where there is water (for example, near the swimming pool);

- Don't get your hands wet and reach for an electrical plug, or touch an electrical appliance like a toaster;

- Cover electric outlets that are not in use; and

- Always unplug appliances before trying to repair or clean them. Even if unplugged, be especially careful of television sets, because they store electricity.

As for hand and power tools in workshop, lawn or garden, (1) keep away from saw blades; (2) wear goggles when hammering, sawing, trimming, or mowing the lawn; and (3) have someone explain (and demonstrate) what to do (and, what not to do). Go slowly and focus on learning.

Communicating Potential Hazards to Co-workers and Individuals

Here are some ways to communicate potential hazards:

1. Put up signs that people can read and understand (for example, universal safety symbols);

2. Rope off (or block off) dangerous areas;

3. Remove for repair any broken appliance or appliance with cut or frayed electrical cords;

4. Remove broken glass (if window broken), and use cardboard and tape to cover the area where the glass was;

5. Tell people of the danger, and show/explain what to do and not to do;

6. Report the hazard immediately to your administrator, and determine what actions to take; and

7. Write a note in the Staff Communication Log, if you have one, alerting others to the hazard.

Implementing Strategies to Correct Unsafe Conditions

In the event of structural damage to the home, or the smell of gas, or other hazardous condition whose significance is not completely understood, it makes sense to evacuate the home and to get immediate help from outside the home (say, by calling the gas company to come out and look for a gas leak).

When other damage occurs (for example, broken window; sparks from the toaster), one should remove the item or block use of it, until such time as it can be repaired or replaced.

Do not ignore hazardous practices (for example, using equipment improperly; leaving matches around; not locking up guns and ammunition). Inform the licensee or administrator about the hazardous condition. Talk about and agree on how to correct the unsafe condition. In the meantime, one must do everything possible to protect people from injury.

Activity:
Practice Dealing with Poisoning or Drug Overdose

DIRECTIONS: Pair up with another student, and role-play calling the Poison Control Center . One person will pretend to call the Poison Control Center. The other person will play the Poison Control Center representative. There are four situations. Each student should make two of the calls.

Scenario #1. – "One of our children was playing in the field beside our house, and picked up a mushroom growing there and ate it. He brought in a small piece of the stem, but I don't know how to identify poisonous from non-poisonous mushrooms. What should I do?"

Scenario #2. – "We just admitted a new resident to the home. You won't believe this, but he had various strength THORAZINE (chlorpromazine) in his clothes and various boxes. Apparently, his roommate found at least one on the floor and ate it. The pills do look like M&Ms. The roommate fell asleep eating dinner. We roused him and tried to find out what color the pill was, but he is unsure. It was either brown or red. What should we do?"

Scenario #3. – "A man with a developmental disability who lives with me was doing the dishes, and he says that he tried some of the dishwasher detergent (granule form). What should I do?"

Scenario #4. – "Sam was using Super Glue on his model airplane project. When he was brushing back his hair, he got a gob of the glue in his eye, . . . or, at least I think he did, because his eye is closed. What should I do?"

Information Brief

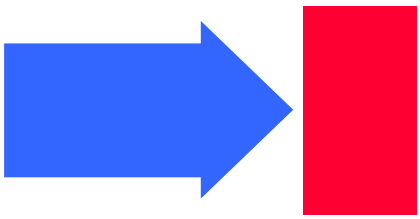
Safe Practices When Lifting and Assisting Others

Lifting and Protecting One's Back

At some time during their lives, four out of five people experience back problems (muscle spasms, slipped discs, etc.). Minimizing back problems calls for two things: (1) proper use of your body when lifting, pushing, or reaching for things; and (2) exercises to strengthen your back. Regarding the former, it is a good idea to:

- ✓ Push, not pull (a garbage container; a dolly; a cart);
- ✓ Move, not reach (to get the things you need);
- ✓ Squat, not bend (when you have to reach down to get something); and
- ✓ Turn, not twist (when you want to go in a different direction).

Figure 5 shows proper body mechanics when lifting, moving or reaching for things.



Helping with Transfers, Positioning

Helping individuals with impaired mobility

Individuals with greatly impaired mobility (for example, due to cerebral palsy, spinal cord injury, spina bifada, and the like) need extra, more skillful support to remain comfortable and healthy.

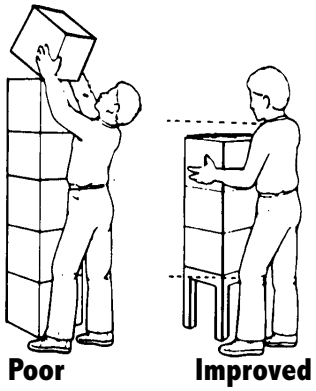
- *Hypertonus (spasticity)* is too much muscle tone. Muscles become stiff and resist moving.
- *Hypotonus* is too little muscle tone, such that they have too little strength to move.
- *Fluctuating muscle tone (athetosis or ataxia)* involves unpredictable fluctuation from too much to too little tone. The movements appear uncontrollable.

Individuals need to be up as much as possible, rather than lying in a horizontal position. Gravity (2.2 pounds per square inch of body surface) plays havoc with body systems, especially respiratory, digestive, and urinary. Disability stemming from immobility or lack of motion was identified in 1960, by the U.S. Public Health Service, as one of ten preventable health problems.[1] Pneumonia,

[1] Cited by McGowan & McGowan, *Assessing Health Risk in Developmental Disabilities* (1995), p. 1-14.

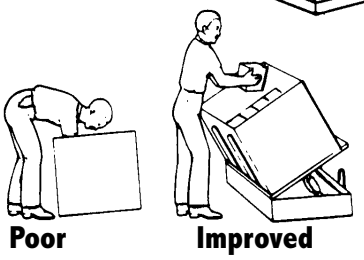
Figure 5
Principles of Good Body Mechanics

Keep the natural curve of the spine intact A commonly recognized problem is lifting loads from the floor. But overhead loads can also be hazardous. It is better to build platforms to store loads off the floor (above knee height) to eliminate bending over, and to keep loads below shoulder height.

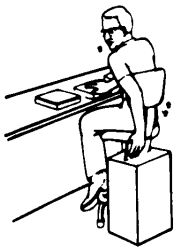


Lift loads at about waist height
Ideally, loads should be at about waist height when lifted. For example, adjustable height stands can be used to raise pallets of boxes up and down to the right height (and also accommodate employees of varying heights).

Adjustable-height 'Scissors Lift'



Reaching down into tubs and bins is a common source of back stress. Possible solutions include hydraulic tilters, springloaded bottoms, and drop-down or removable sides.



Eliminate twisting motions
Twisting motions, especially with a heavy load. place considerable stress on the spine. Improved layout is usually the best approach for eliminating this issue.

osteoporosis (due to absence of weight bearing), gastro-esophageal reflux disease (GERD), and other conditions arise. Poor muscle tone often impacts chewing and swallowing. The person may push food out of the mouth; bite down forcefully on a metal utensil causing discomfort if not injury; or not be able to cough well enough to expel food or fluid that slips into the air pipe. Abnormal posture, combined with gravity, can make eating punishing. Pressure within the abdomen can rise; the normal opening in the diaphragm may be stretched; food (mixed with acid) may back up into the esophagus, causing damage. Constipation, bowel obstruction and impaction are common, and often exacerbated by years of taking laxatives, seizure and other medication.

Positioning and movement

One should seek advice from an individual's physician for any individual who needs help with positioning or mobility, so that ways of assisting are safe and effective. Typically, physical or occupational therapists are consults for plans regarding an individual's position or movement needs. If a person cannot change position on his/her own, someone must assist in repositioning. And, because the absence of movement can result in discomfort and skin breakdown, someone needs to watch for places on the skin that are red or warm to touch. These are warning signs of skin breakdown, and should be written down in the individual's record, and brought to the attention of the individual's physician.

Body mechanic principles

The North Dakota Center for Disabilities' staff training module on "Positioning, Turning and Transferring" (1995, pp. 60-62) recommends these basic principles:

1. **Do not lift loads heavier than those prescribed by your agency.**
   Prior to lifting or moving an object or person, test the weight of the load to make sure it can be moved safely. Get help or use an assistive device if necessary.

2. **Plan the move.**
   Do not move the object any further than is absolutely necessary. Arrange the surface to which the object is to be moved as close as possible to the surface from which it is to be transferred. Provide firm, stable surfaces and, if possible, transfer between surfaces of equal height.

3. **Use a wide, balanced stance with one foot ahead of the other.**
   The solid base of support reduces the likelihood of slipping and jerking movements. Keep your feet flat on the floor and spread them about the width of your shoulders. Place one foot in the direction toward which you will move. This foot position gives you a wider base of support and allows a weight shift from one foot while maintaining your stability.

4. **Keep the lower back in its normal, arched position while lifting.**
   Bend at the knees or hips. With the back arched, the forces are more evenly distributed on the support structures.

5. **Bring the load as close to the body as possible.**
   Throughout the move, keep your arms and the object or person as close to your body as possible. This keeps your back from acting as the fulcrum and reduces the stress.

6. **Keep the head and shoulders up as the lifting motion begins.**
   This helps to keep the arch in the lower back.

7. **Tighten the stomach muscles as the lift begins.**
   This shifts some of the weight of the load from the spine to the abdominal cavity.

8. **Lift with the legs and stand up in a smooth, even motion.**
   Using the large, strong muscles of the legs to straighten the knees and hips as the lift is completed decreases the lower back stress. Use your whole body when pushing, pulling, or lifting, not just your back and arms.

9. **Move the feet (pivot) if a direction change is necessary.**
   Throughout the move, your back, feet and trunk should all move together in the same direction, going to the same place. Avoid keeping your feet flat on the ground while twisting your body to move an object or person. When a turn is necessary, shift your feet and take small steps rather than twisting at the waist. Keep your feet pointed in the direction in which you are moving.

10. **Communicate if two or more individuals are involved in the movement.**
    This helps ensure the movement will be smooth, rather than sudden or jerking. It's a good idea to count 1,2,3...with the person helping.

11. **Don't lift when you can pull or push an object.**
    It's safer and easier that way.

12. **Teach and preach.**
    Help fellow employees use the rules of good body mechanics.

Some specific transfers and positioning guidelines

Individuals vary in size, muscle tone, and control of their bodies. They also have different needs with regard to help in moving about. Some people need help turning in bed. Some need help to sit up. Some need help in scooting forward or backward in a chair or bed. Some need help moving from bed to a chair, from a chair to the toilet, from a chair to bed, or from a chair (or bed) to the floor. Some need help walking from one place to another without falling. A plan (with whatever training is needed) should be devised for each person. Sometimes, a single helper can assist someone. Sometimes, two or more people may need to work together. Sometimes, mechanical aids (for example, lifting equipment) may be needed.

In general, helping people with positioning and transfers should attend to the following principles:

- Good planning;
- Asking the person how they want to be assisted;
- Encouraging as much participation as possible by the person being assisted;
- Using equipment (boards, sheets, lifts, etc.) when possible;
- Teaming up with another person when a two-person lift is needed; and
- Use of good body mechanics (good technique).

Wheelchair Safety

Wheelchairs are an example of adaptive equipment. Handrails, lifts, sliding seats (for example, into and out of the shower), and other devices are available to help with mobility and to reduce the risk of injury to both the person assisted and the person(s) assisting. The North Dakota staff training module, cited above, also lists the following guidelines for DSPs helping with wheelchairs (pp. 77-78):

- Self mobilization: Can the individual move themselves? If yes, encourage them to transport themselves as much as possible.
- Individual sitting position: Before starting check for the following:

  Are the individual's hips all the way back in the wheelchair?

  Does the seat belt need to be attached?

  Are footrests in place and are the person's feet on the footrests?

  Are the individual's hands on the armrests or in his or her lap away from the wheels?

- Brakes: Make sure that brakes are locked prior to assisting a person into or out of a wheelchair.
- Holding on: Grasp both push handles on the wheel chair firmly.
- Starting and stopping: Always start and stop slowly, take corners slowly, and maintain a steady pace while moving. This is to avoid jostling the person or throwing him/her off balance.
- Surface levels: Be alert for changes in surface levels—for example, doorjambs or the floor of an elevator. Hitting a half inch rise at standard wheelchair speed can bend the front casters and pitch the person forward.
- Opening doors: Never open doors by pushing with the front of the wheelchair. This can damage the wheelchair's footrests, the person's feet, or the door. Stop the wheelchair, open the door by hand, and bring the wheelchair through. If the door does not stay open on its own, hold it with on hand or your backside. Do not let the door bang the side of the wheelchair.

- Inclines and ramps: The person's weight should always be pushing back toward you on inclines and ramps. Going uphill means pushing the person; to go downhill, turn the chair around and walk backwards. In this manner, the person's weight will be pushing back toward you.

- Outdoor surfaces: Be alert for anything that can trap front casters or cause the wheelchair to tilt, such as holes, cracks, stones, sand, or soft shoulders.

- Curbs: Up curbs—Stop at the curb, raise the front casters by pressing down on the foot lever, roll the front casters onto the sidewalk, and roll the large wheels over the curb by lifting slightly on the push handles as you push forward. Down curbs—Always come down curbs facing backwards with the large wheels coming first. Maintain some upward pressure on the push handles as you pull the wheelchair toward you.

Back Exercises for You As a DSP

In addition to using proper techniques for lifting and moving people and objects, the DSP may be able to help him/herself by doing exercises to strengthen the back. However, be sure to check with your physician or other health care professional before starting the exercises shown in Figure 6.

Figure 6
Exercises to Prevent Back Problems

From *Kaiser Permanente Healthwise Handbook*

Strengthening your entire body prevents future back problems and also improves your general health. Many exercises and sports strengthen your arms and legs. Doing special exercises to strengthen your abdominal muscles is also encouraged.

Keeping your body flexible helps you to use proper body mechanics that protect your back.

These exercises are not recommended for use during an acute back problem or spasm.

- If any exercise causes increased or continuing back pain, stop the exercise and try something else. Stop any exercise that causes the pain to radiate away from your spine into your buttocks or legs, either during or after the exercise.

- You do not need to do every exercise. Stick with the ones that help you most.

- Start with five repetitions three to four times a day, and gradually increase to 10 repetitions. Do all exercises slowly.

The basic types of exercises that can help your back include: flexion, extension, and stretching and strengthening.

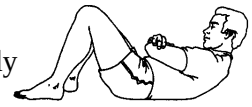
Flexion Exercises
Flexion exercises stretch the low back muscles and strengthen the stomach muscles.

Curl-Ups
Curl-ups strengthen your abdominal muscles, which work with your back muscles to support your spine.

- Lie on your back with knees bent (60' angle) and feet flat on the floor, arms crossed on your chest. Do not hook your feet under anything.

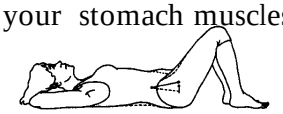
- Slowly curl your head and shoulders a few inches up until your shoulder blades barely rise from the floor. Keep your low back pressed to the floor. To avoid neck problems, remember to lift your shoulders and do not force your head up or forward. Hold for 5 to 10 seconds (do not hold your breath), then curl down very slowly.

Pelvic Tilts
This exercise gently moves the spine and stretches the low back.



- Lie on your back with knees bent and feet flat on the floor.

- Slowly tighten your stomach muscles

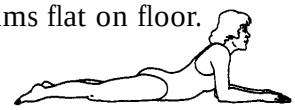


  and press your low back against the floor. Hold for 10 seconds (do not hold your breath). Slowly relax.

Extension Exercises
Extension exercises strengthen your low back muscles.

Press-Ups
Begin and end every set of exercises with a few press-ups (see illustration).

- Lie face down with hands at shoulders, palms flat on floor.



- Prop yourself up on your elbows, keeping lower half of body relaxed. If it's comfortable, press your chest forward.
- Keep hips pressed to the floor. Feel the stretch in your low back.
- Lower upper body to the floor. Repeat 3 to 10 times, slowly.

Backward Bend
Practice the backward bend at least once a day, and do it frequently when working in a bentforward position.

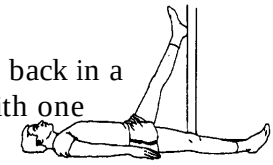
- Stand upright with your feet slightly apart. Back up to a counter top for greater support and stability.
- Place your hands in the small of your back and gently bend backward. Keep your knees straight (not locked) and bend only at the waist.
- Hold the backward stretch for one to two seconds.

Strengthening and Stretching Exercises

Prone Buttocks Squeeze
This exercise strengthens the buttocks muscles, which support the back and aid in lifting with the legs.

- Lie flat on your stomach with your arms at your sides.
- Slowly tighten your buttocks muscles. Hold for 5 to 10 seconds (do not hold your breath). Slowly relax.
- You may need to place a small pillow under your stomach for comfort.

Hamstring Stretch
This stretches the muscles in the back of your thigh that allow you to bend your legs while keeping a natural curve in your back (see illustration).



- Lie on your back in a doorway with one leg through the doorway on the floor and the leg you want to stretch straight up with the heel resting on the wall next to the doorway.
- Keep the leg straight and slowly move your heel up the wall until you feel a gentle pull in the back of your thigh. Do not overstretch.
- Relax in that position for 30 seconds, then bend the knee to relieve the stretch. Repeat with the other leg.

Hip Flexor Stretch
This stretches the muscles in the front of your hip, which avoids "swayback" caused by tight hip muscles.

- Kneel on one knee with your other leg bent and foot in front of you. Keep a natural curve in your back.
- Slowly shift your weight onto your front foot, maintaining a natural curve in your back. Hold for 10 seconds. You should feel a stretch in the groin of the leg you are kneeling on. Repeat with the other leg.

Information Brief

Environmental Emergencies

Some disasters are "internal," as when a fire occurs within the home. Others are "external," as when an earthquake, flood, tornado, toxic spill, or other event outside the home interferes with power, water, food supplies, or other essential services. Some "external" disasters trigger "internal" ones as well, as when a flood damages a home, or an earthquake triggers a fire. Regardless of the nature of the disaster, four matters are central to what needs to be done:

- Are there injuries that require first aid and medical attention?
- Does the home have to be evacuated, or is it safe to occupy?
- Are there sources of food and water?
- Has the disaster interfered with public utilities, such as gas, electricity, and communications?

Fires and Fire Drills

Preparation, planning

Residential sprinkler systems are the *best way* to control fires. Such systems will suppress 9 out of 10 fires. Smoke detectors wired into an alarm system are important. If the detectors are battery-operated, they should be checked monthly and replaced at least yearly (say, on the administrator's birthday).

Community Care Facilities are required to have fire drills regularly, with documentation of the results. In preparation for drills, or in addition to drills, a lot of valuable teaching and learning is possible. Here are some things to teach individuals living in your home:

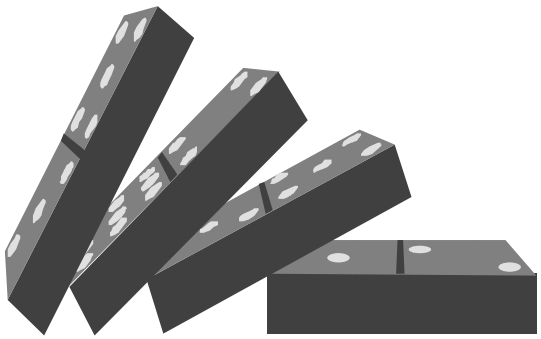
- Reacting to an alarm, by exiting along a path that avoids the fire.
- *Remaining calm* and walking (or crawling) out of the house.
- Once outside the house, going to an agreed-upon rendezvous point (for example, edge of the street in front of the neighbor's house), in order to be accounted for.

Homes should have fire escape plans for both drills and the real thing. Here are some things that belong in the plan:

- ✓ Floor plans, showing escape routes.
- ✓ Making sure fire exits open easily and are free of clutter.
- ✓ The rendezvous point is outside the home and away from danger.
- ✓ Roles and responsibilities of DSPs and residents.
- ✓ Location of multi-purpose, labeled (ABC) fire extinguishers. – Fire extinguishers have a role if a fire is small and can be readily contained, but the order in which actions are

taken should accord with ***RACE,*** as explained below.

One can then teach (and reinforce) behaviors consistent with the plan. It is a good idea to blockade principal exits from the house, regularly, so that people remain aware of various routes to the outside. Drills should be scheduled to cover various shifts, and some should be when individuals and staff are inconvenienced (in bed, taking a shower).



Responding to the real thing

Community Care Facilities should get acquainted and use the prevention services of their Fire Departments. Plans should be checked out with such officials, and revised according to recommendations made by these fire prevention experts. In general, if you smell smoke or discover a fire in your home, you should do the following in the order outlined:

RACE

Rescue	Rescue the resident and anyone else in immediate danger.
Alert	Alert the fire department by calling **911** from a phone out of harms way.
Contain	Contain the fire by closing doors between you and the fire.
Extinguish	Extinguish the fire if it is small and easy to contain; *or* otherwise,
Evacuate	Evacuate (leave) the building immediately.

External Disasters and Mass Casualties

External disasters which include floods, earthquakes, high winds, toxic spills, even the “Y2K problem,” and the like typically disrupt travel, communications, and basic utilities (such as gas, water, and electricity),

and put an intense strain on emergency services, including medical care.

Preparation

Here is a list of survival items (in addition to fire extinguisher and smoke detectors) that every home should have:

For the household

- A battery-powered radio, flashlight and plenty of extra batteries;
- First aid kit and first aid book;
- Adjustable wrench for turning off gas and water;
- Bottled water sufficient for the number of members in the household (1 gal. per person per day);
- A one-week food supply of canned and dried foods for each household member. (NOTE: These should be replaced regularly: water every six months, and canned goods once a year. These containers should, of course, be dated.)
- Non-electric can opener;
- Portable stove such as butane or charcoal;
- Matches (NOTE: Do not light matches, if any smell of gas.);
- Credit cards and cash;
- An extra set of keys; and
- A current posted Disaster Plan, with information about relocation, Poison Control, physician names and telephone numbers, etc.

For each resident of the home

- List of current medications being taken and prescribing physician;
- Currently prescribed medications on hand;
- Emergency information (for example, name; DOB; home address; phone number; name address and phone number of administrator; Medi-Cal or other medical insurance numbers; known allergies and food sensitivities; name address and phone numbers of nearest relatives or closest friends);
- Medi-Cal or other insurance card;
- Signed consent-to-treatment form, with phone number of the regional center or other placement agency;
- Other personal and health-related information in a readily accessible form;
- A change of clothing, rain gear and sturdy shoes;
- Blankets or sleeping bag;
- Any needed adaptive equipment or assistive device (for example, wheelchair; extra pair of glasses).

Basic things you need to know

In responding appropriately to an external disaster, you need to know:

1. How to turn off gas, water, and electricity;

2. First Aid; and

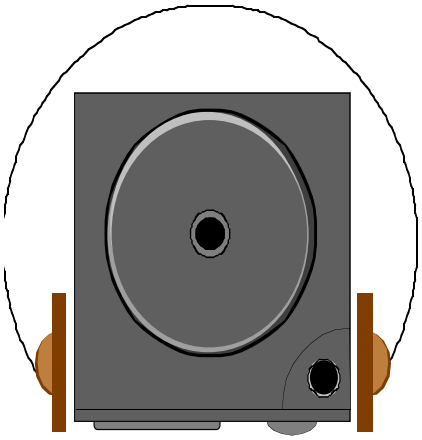
3. Where each person went (if unsafe to stay at home, or medical care is needed), so that the household can be reunited quickly.

Responding to an external disaster

The nature of an external disaster dictates how best to respond at the time. It is always advisable to *stay calm.* Then, if an earthquake hits, the best way to respond depends on where you are at the time. If inside a building, stay away from windows; stand in a doorway; or crouch under a sturdy desk or table. If outside, stand away from buildings, trees, telephone and electrical lines. If in a car, drive away from underpasses or overpasses; stop in a safe area; and stay in the car.

After an earthquake, one should:

- ✓ Check for injuries and provide any needed first aid;
- ✓ Wear shoes;
- ✓ Check for gas, water, electrical or other breaks. Turn off utilities where danger exists (for example, smell of gas – turn off gas near meter). Check for building damage (for example, around chimneys and foundations);
- ✓ Clean up dangerous spills (glass; water);
- ✓ Turn on your radio and listen for instructions; and
- ✓ Do not use the telephone to make local calls, except for emergencies.



Activity:
Disaster Planning and Response

DIRECTIONS: At your table, agree on a particular type of disaster, other than an earthquake, to discuss: flood; fire; tornado; toxic spill in the neighborhood; Y2K; or something else.

1. **What would be a "worst case" scenario for you and the home where you work?**

2. **What steps could you take to be better prepared?**

3. **What would you do if the disaster were to occur?**

Answers to In-Class Review

1. What is good nutrition and why is it important?

Getting the right number of calories; eating a variety of nutritious foods; getting the vitamins and minerals needed; eating the right number of servings from the five food groups; avoiding too much fat (particularly saturated), salt and cholesterol in the diet.

2. What changes can most Americans make in their drinking and eating habits to improve their health and well-being?

Drink at least eight 8-ounce glasses of water each day, more if you drink caffeinated beverages because they are dehydrating. Eat less salt, simple sugars, and fat; eat more fiber; more fruits and vegetables; more complex carbohydrates.

3. What is the proper way to handle, prepare, and store food?

Carefully! It should go directly from store to home, and be stored properly (shelves, refrigerator, freezer) until used. Preparation should be under sanitary conditions (washed hands, surfaces, etc.). Meat and poultry should be cooked at 165 (internal temperature) degrees F. or higher and long enough to kill bacteria. Poaching, steaming, roasting, boiling and broiling (for short periods) is better than frying. Wok cooking is fine. Cooked food should not be left out long. All leftovers should be discarded, or covered, refrigerated, labeled and dated.

4. What are some of the positive effects of movement and physical activity?

Movement and physical activity can help: relieve tension and stress; provide enjoyment and fun; stimulates the mind; help maintain stable weight; control appetite; boosts self-image; improve muscle tone and strength; improves flexibility; lower blood pressure; relieve insomnia; increase “good” cholesterol (HDL); and prevent diabetes.

5. How are infections spread, and what can you do to limit their spread?

Germs (bacteria, viruses, etc.) are spread in droplets in the air; from one person to another; and from another place (for example, fly; cutting board; etc.) to a person. Natural defenses include our skin, organs of elimination, our immune systems, and the like. Immunizations help. Gloves help. Colds, flu, and more serious diseases can be spread through coughing, sneezing, not washing after going to the toilet, etc., and by the things we touch afterwards. Germs enter through our mouths, eyes, nose, and mucous membranes. That is why hand-washing is so important.

6. Can you describe at least three principles of good body mechanics when lifting things?

Push, don't pull. Move (for example, a ladder), don't reach. Squat, don't bend, using your legs not your back and arms. Turn, don't twist, when changing direction. Plan the move. Hold the item close to your own body. Ask for assistance!

7. Why is preparation, planning, and practice important in dealing with possible environmental emergencies (for example, fires, earthquakes)?

Preparation means having what you need (for example, smoke detectors; fire extinguishers; battery-powered flashlight and radio with lots of extra batteries; emergency food supply; insurance cards and basic health records for each person; etc.). Planning means deciding, in advance, what to do (for example, to gather outside the home at a particular rendezvous site). Practice improves our skill in handling potential emergencies (for example, learning to respond to alarms, by leaving the house).

If You Want to Read More About
Wellness (Safety, Nutrition and Exercise)

Shopping on the Internet
Experts believe that within ten years, 15% of groceries will be sold through the internet. NetGrocer (www.netgrocer.com) allows shopping for nonperishables by computer, with FedEx delivery within two to four business days. This is a shipping charge, but the price of food items is less than at food stores.

The American Dietetic Association's Complete Food and Nutrition Guide
by Roberta Larson Duyff (1998); Chronimed Publishers; ISBN: 1565611608

Named a top health book by *Ladies Home Journal,* The American Dietetic Association's *Complete Food & Nutrition Guide* teaches how to combine "good taste and good health" in every meal and snack. No matter how nutritionally impaired you think you are, you'll find clear, understandable information on the basics of metabolism and weight management, vegetarianism, nutrition for athletes, food allergies, and more. (Source: Amazon.com Review)

Eating for Good Health
by Reader's Digest (1995); Reader's Digest Association; ISBN: 0895778327

This short, beautifully illustrated book, is packed with useful information for anyone eager to learn more about the connection between food and health.

The Food Shopping Counter
by Annette B. Natow and Jo-Ann Heslin (1999); Pocket Books revised edition; ISBN: 0671004522

This book, one of a series, has calorie, fat, sodium, carbohydrate, and fiber values for more than 20,000 items, both generic and brand names, organized into more than 350 categories.

Fast Food Restaurant Nutrition Counter

by Dr. Art Ulene (1996); Avery Publishing Group; ISBN: 0895296667

This book has over 3,000 restaurant chain food items listed, in terms of serving size, total calories, protein, carbohydrates, sodium, fiber, total fat, saturated fat, and cholesterol. Art Ulene, M.D., received is medical degree from UCLA School of Medicine, and has appeared nationally on TV programs, such as NBC's Today Show. He is the author of more than forty books and home video/audio programs.

Disaster Preparedness for People with Disabilities

by American Red Cross Disaster Services (1996); Author; ISBN: None.

This is a self-instructional manual for people with disabilities. It contains a number of exercises and checklists. It includes a number of considerations (for example, protecting one's assistance dog) not found in more generic guides.

Poison! How to Handle the Hazardous Substances in Your Home

by Jim Morelli (1997); Andrews and McMeel; ISBN: 083622721 (pbk.)

The back cover begins: "You live in a toxic dump. There's no getting around it. If you wash dishes, do laundry, or clean the toilet, oven, or sink, chances are good that you use a poisonous material to do it." Morelli worked in a Poison Control Center, and thus has first-hand knowledge of the kinds of work involved.

Hazards at Home

by Bill Gutman (1996); Twenty-First Century Books; ISBN: 0805041419

This book deals with falls, fires and burns, poisons, firearms, swimming pools and other drowning dangers, tools and machinery, and how to help if there is an accident.

Homework Assignment for Session #4: Over-the-Counter Medication in the Home

Directions: Your homework assignment is to check around either the home where you work or your own home, and to record some information about non-prescription, Over-the-Counter medications: things like aspirin, Tylenol, Nyquil, anti-diarrhea medicine, heartburn medications, and the like.

1. **What kinds of over-the-counter medications (for example, pain; inflammation; heartburn; cold/flu symptoms) – that is, non-prescription medications -- are in the home?**

2. **How many over-the-counter containers (for example, packages; bottles) were you able to find?**

3. **How many have expiration dates in the past?**

4. **How many are under lock and key, accessible only to someone who has a key?**

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #4
Wellness:
Medications

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	**Wellness: Medications**	**3 hours**
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Prescription
- Pharmacy/Pharmacist
- Medication
- Medication Self-Administration
- Adverse Reactions
- Side Effects
- Drug Interactions (including food and alcohol)
- Medication Recording (and storage)

Cautionary Statement

The material in this module is not intended to be medical advice on personal health matters. Medical advice should be obtained from a licensed physician. This module highlights medication. This module does not cover all situations, precautions, interactions, adverse reactions, or other side effects. A pharmacist can assist you and the doctor with questions about medications. We urge you to talk with pharmacists, nurses and other professionals (e.g., dietitians) as well, to broaden your understanding of the fundamentals covered in this module.

Your In-Class Review Notes

Here are some review questions about the presentations and activities for this class session.

1. **What are the Five Rights to be followed when assisting individuals with medication?**

2. **Is it ever okay to package up a dose of medicine to be taken when away from the home?**

3. **When can "as needed" medicine, including over-the-counter remedies, be administered?**

4. **In your own words, what is an adverse drug interaction or side effect? How should you respond?**

5. It is important to communicate with physicians, pharmacists, nurses and other health care professionals about an individual's medications?

   ❒ True ❒ False

6. It is important to have a system to communicate changes in an individual's medication to DSPs and to the individual.

   ❒ True ❒ False

7. Medications are one of the most potentially dangerous aspects of providing services and supports to individuals living in the home where you work.

   ❒ True ❒ False

8. You need to know and be aware of potential side effects of medications.

   ❒ True ❒ False

9. You need to know about and watch for potential adverse reactions or side effects of medications.

   ❒ True ❒ False

10. Best practices includes documentation of each dose of both prescription and non-prescription (over-the-counter) medications?

    ❒ True ❒ False

Information Brief

Assistance with Medication

Introduction

In this module, we cover:

- Assisting with the **self-administration of medications**, with some attention to **basic pharmaceutical terminology and symbols**;
- **Recognizing (by observation) side effects** and **interactions**, and **responding** appropriately;
- Correct **handling of medications within the home** (e.g., **ordering**, **storing, recording**, and **destroying** unused or outdated medications); and
- Some **common medications**, their purposes (**prescribed uses**), and **known side effects**.

Medications

Medications are powerful substances which many of us have come to depend on as an important part of our lives. Medications are substances taken into the body (or applied to) for the purpose of prevention, treatment, relief of symptoms, or cure. Medications include the following:

- Prescription medications which must be ordered by a physician (or other person with authority to write prescriptions).
- Over-the-counter medications which can be purchased without a prescription.
- Vitamins, naturopathic remedies, and homeopathic remedies are all medications.

Some Reasons Why Learning About Medications Is Important

Many medications do a lot of good. However, medications or drugs may also cause harm. Knowing about medications, their use and abuse, and how to assist individuals in using them, is vital to the health and well-being of those you serve.

Sometimes when a person takes a medication, it might make them feel confused, dizzy, anxious, or cause change in one or more of the body functions (for example appetite, sleep, elimination). This is called an unwanted effect or side effect from the medicine. It is not uncommon for two or more medications to interact with one another causing an unwanted side effect.

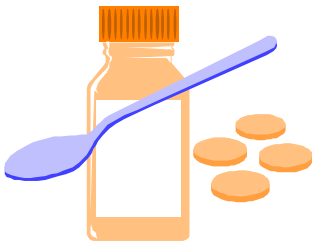
In order for the physician to prescribe the best treatment and medication, he or she needs to be informed of the person's medical history, any drug allergies, current

medications the person is taking and the purpose, medical and dental conditions, and observations of recent physical or behavioral changes.

In addition, it is a good idea to get all prescriptions and over-the-counter medications at the same pharmacy or drug store so the pharmacist can maintain an active listing of all medications and check for potential drug-drug or food-drug interactions.

Consider the following:

- ✓ The Food and Drug Administration estimates that hospitalization resulting from inappropriate prescription drug use costs the nation $20 billion annually.
- ✓ Seventeen percent of hospitalizations of elderly Americans are the result of adverse side effects.
- ✓ Of the 2.3 billion prescriptions that are filled annually, approximately one half are not taken properly.
- ✓ Americans' failure to take their medications as instructed costs more than $100 billion a year in increased hospital and nursing home admissions, lost worker productivity, and premature death.



Abbreviations and Symbols Related to Medications Usage

A variety of abbreviations and symbols used by health care professionals that you may see and need to know are listed below:

q. (Q) =	Every
Oz. =	Ounce
d. =	Day
tsp. =	Teaspoon (or 5 ml.)
h. =	Hour
Tbsp. =	Tablespoon (3 tsp., or 15 ml.)
b.i.d. =	Twice a day
gr. =	grains
t.i.d. =	Three times a day
mg. =	milligrams
q.i.d. =	Four times a day
GM, gm. =	grams (1,000 mg.)
h.s. (HS) =	Hour of sleep (bedtime)
Cap =	Capsule
p.r.n. =	when necessary, or as needed
Tab =	Tablet
A.M. =	Morning
OTC =	Over-the-counter
P.M. =	Afternoon/evening
Rx =	Prescription
Qty =	Quantity

Labels

California law requires the following information on all prescription labels:

- ✓ Pharmacy/pharmacist name and address;
- ✓ Prescription number or other means of identifying the prescriber (used in requesting refills);
- ✓ Name of medication;
- ✓ Strength;
- ✓ Directions for how to use the medication;
- ✓ Patient's name;
- ✓ Manufacturer;
- ✓ Name of person who prescribed the medication;
- ✓ Quantity (for example, number of pills, or other measurement of the amount of the prescription); and
- ✓ Date the prescription was filled.

Most pharmacies also include:

- ✓ Expiration or discard date;
- ✓ Number of refills remaining; and
- ✓ Condition for which prescribed, if the physician conveys that information to the pharmacist.

A medication label will typically state (1) name of the medication; (2) the form (e.g., cap, tab, fluid); (3) the content or volume (e.g., 200 mg tabs); (4) how many units are to be administered (or taken) at a time (the *dose)*; and (5) when that dose is to be administered (or taken). Here is an example:

Name	Unit	No. of units to be taken (dose) and when
TEGRETOL	200 mg tabs	2 tabs at 7a.m.; 2 tabs at 2p.m.; and 1 tab at 9p.m.

In this example, the person is taking five 200 mg tabs (or 1,000 mg) per day: If a medicine interacts with food or drink, the prescriber (or pharmacist) will point that out, and may say "not with meals; take at least one hour before eating or two hours after."

If the label doesn't have all of the information it must have, ask the pharmacist (or the physician) to add the needed information. **Do not "scratch out" or write over or change a drug label in any way.** Just take it back to the pharmacy, and have them make any necessary changes to the label. If the prescriber has orally changed the prescription (e.g., dose change, or timing change), be sure (1) to write the change down; (2) ask the physician to send the change to the pharmacist; (3) note the change on a Drug Administration Sheet or Log; and (4) affix a sticker (without covering the drug label) to the package, alerting staff to a change. Pharmacists have such stickers; ask for a few.

A Typical Label

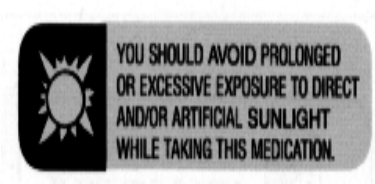
ABC Memorial Pharmacy

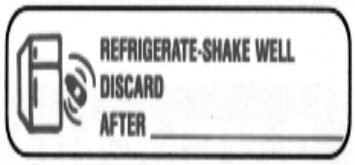
RX 577524 **Dr. McDaniel**
7/28/97

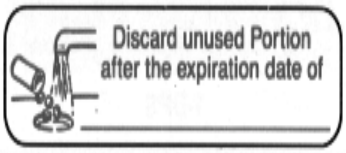
Amoxicillin 500 mg **#30 capsules**
Take 1 capsule 3 times daily for 10 days.

Expires: 8/3/97
No refills **Discard after: 8/3/01**

Common Label Warnings







Activity:
Prescription Label Exercise

What problems can you identify in the following prescription labels numbered 1-4? (NOTE: These labels do not include name, address, and phone number of pharmacy, number of refills remaining, and name of manufacturer.)

No.	Today is . . .	Label (partial)	Problem(s)
Ex.	00/00/00	Rx number Prescriber's name Patient's name Date prescribed/filled Name of medication and strength Directions for how to use the medication Quantity (e.g., number of pills) in prescription Expiration date	None- Example has necessary information
1.	2/24/99	Rx# 325-486 Dr. Jones John Raymond 10/30/97 FOLIC ACID Take one tablet orally daily. Qty: 100 tabs Discard after	
2.	2/24/99	Rx# 765-432 Dr. Molina Susan Jones 12/15/98 Chlorpromazine 25 mg tablets For: THORAZINE Take 1 tablet as needed. Qty: 20 tabs Discard after 12/15/01	
3.	2/24/99	Rx# 123-456 Dr. Watson Sydney Smith 6/30/97 Meclizine 25 mg tablets For: ANTIVERT Take 1 tablet every four hours as needed for dizziness Qty: 30 tabs Discard after 9/30/98	
4.	2/24/99	Rx# 001-002 Dr. Smith Jose Arriba VICODIN Take 2 tablets as needed for pain or headache Qty: 100 TABS Discard after _____	

Key Points When Assisting With Medications

In a Community Care Facility, the DSP can only assist with self-administration of medication. Only a licensed health professional can administer medications. A physician must document an individual's ability to safely self-administer medications without assistance from the DSP.
In order to safely and effectively assist individuals with medications, the DSP must:

- Assure that all medications are correctly self-administered.
- Watch carefully for adverse reactions and other side effects;
- Document changes in the illness or behavior, and in symptoms, adverse reactions, other side effects and apparent interactions in the individual's record.
- Bring this information to the attention of appropriate persons (for example, administrator of the home, nurse, the individual's physician, other DSPs) in a timely manner and be sure it is acted upon.
- When accompanying a person on a physician visit, or getting a prescription filled, ask the physician and the pharmacist questions to get necessary information about the medication: **what is the name of the medication?**; **when to take it?**; **what food or drinks should be avoided?**; and, **are there any side effects?**
- Read up on any medications being considered or prescribed.

Getting More Information (Books, Web Sites)

Most bookstores will have *The PDR (Physician's Desk Reference),* which is the most comprehensive source of information on prescription drugs. It is fairly expensive ($75 - $100). There are a number of other excellent sources. Ask the individual's physician or pharmacist to recommend one. Here are a few to consider:

Donald Sullivan, *The American Pharmaceutical Association's Guide to Prescription Drugs* (Signet: October 1998), $5 - $10.

Springhouse Corporation, *Nursing 99 Drug Handbook* (Springhouse: July 1998), $35 - $40.

United States Pharmacopia, *Complete Drug Reference: 1999* (Annual) (Consumer Reports Books: 1999), $25 - $40.

H. Winter Griffith, *Complete Guide to Prescription & Nonprescription Drugs, 1999* (Serial) (Perigee: November 1998), $10 - $20.

Physician's Desk Reference, *The PDR Pocket Guide to Prescription Drugs* (Pocket Books: January 1999), $5 - $10.

Physician's Desk Reference, *The PDR Family Guide to Over-The-Counter Drugs* (Three Rivers Press: December 1998), $15 - $25.

http://www.intelihealth.com This is home for Johns Hopkins Health Information.

http://www.fda.gov This is the web site for the United States Food and Drug Administration.

Information Brief

The Five Rights

The Five Rights are basic to assisting with medications. The DSP needs to be sure he/she has the:

- ❒ Right Person
- ❒ Right Medication
- ❒ Right Dose
- ❒ Right Time
- ❒ Right Route

This procedure is a "must" each time the DSP assists with any medication - including those which a person has been taking for a long time and will probably continue to take for a long time. An example might include medications to control seizures or high blood pressure. There is always a possibility that some change has been ordered that you are unaware of, or that you accidentally removed the wrong container.

Right Person
In order to make sure that you have the right person, you have to know the person. If you are not certain that you are assisting the right person, seek assistance from another staff member who knows the identity of the person.

Right Medication
In order to make sure you have the right medication for the right person:

- Check for the name of the person on the pharmacy label.
- Double check the label to make sure that you have the right medication for the right person before actually giving the medication to the individual.

Right Dose
Be sure you assist with the right dose by checking the pharmacy label to make sure of the dose.

Right Time
When a physician prescribes a medication, he/she will specify how often the medication is to be taken. Some medications must be self-administered only at very specific times of the day, for instance, before meals, one hour after meals, at bedtime, etc. It is very important that medications be self-administered as prescribed.

Right Route
The pharmacy label should state the route by which the drug should be self administered other than oral. Follow the route directions carefully.

If you have any doubt as to whether the medication is in the correct form as ordered, or can be self-administered as specified, consult with the prescribing physician or your pharmacist.

In the case of pills (tablets, capsules, caplets, etc.), the right route is "oral", that is, the medication enters the body through the mouth. Dermal patches and ointments are applied to the skin. Some sprays are taken in through the nose, others through the mouth. Place eye drops in the eyes. **In licensed Community Care Facilities, when a more intrusive route is involved, for example, an injection or suppository, because of the risks involved, a person can only be assisted by a licensed health professional.**

Good practice

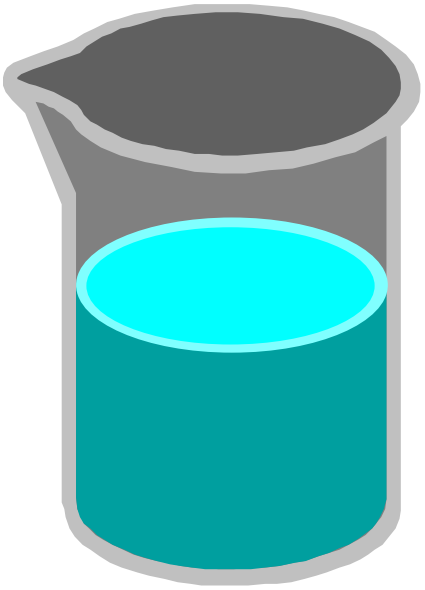
The use of a Medication Log as a way to prevent medication errors is strongly recommended. The Medication Log should, at a minimum, contain information about an individual's medications (strength, form and dose) and list times for administration. The DSP should write down the date and time and initial for each dose of medication for which the DSP assisted. Refer to the sample Medication Log. The following best practice guidelines are written assuming the use of a Medication Log.

Preparation

Here are several things to do, to minimize medication errors:

- ✓ Get the Medication Log for the individual you are assisting.
- ✓ Put out all the necessary items, for example, water and a glass or any other necessary items.
- ✓ Always prepare medication in a clean and well lighted area.
- ✓ Allow plenty of time (to avoid rushing) and stay focused.
- ✓ Prepare and assist in a quiet place, to minimize distractions.
- ✓ Make sure labels are readable and correct.
- ✓ Always wash your hands before assisting with medications.

Only one DSP should be assisting an individual with medications at any given time and that DSP should be allowed to focus only on the medications.



Information Brief

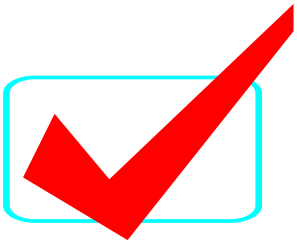
Do's and Don'ts When Assisting With Medication

It's important to:

- Check and compare at least three times the pharmacy label with the Medication Log.
- Check for RIGHT Person, RIGHT Medication, RIGHT Dose, RIGHT Time, and RIGHT Route each time.
- Stay with person until you are sure he/she has taken the medication.
- Immediately initial the Medication Log.
- Ask for help from the prescribing physician or pharmacist if you are unsure about any step in the preparation of, assistance with, or documentation of medications.

For medications in tablet or capsule (pill) form

1. Pour (or punch out, if bubble pack) the correct dose into the bottle cap and THEN into the container used for holding the tablets or capsules before the person takes them. (If too many pills pour out, return the pills from the bottle cap into the container. If using a bubble pack, punch out the covered dose into the container. It is important not to touch the tablets or capsules returned to the container. Doing so may contaminate the medication that remains in the bottle.)
2. Again check the medication label to assure the ordered dosage has been removed from the container.
3. When assisting the person who is taking the pills, always provide a glass of water. If pills are not taken with liquids they can irritate the throat and intestinal tract and they may not be correctly absorbed. Again, check the pharmacy label. Some medications must be taken with FOOD, and there may be other special instructions.
4. If someone has problems taking pills:
   - Taking a small sip of water before placing the pill in the mouth can make swallowing the pills easier.
   - Tilting the head forward slightly, taking a drink of water and swallowing is often helpful. (Throwing the head back may increase the risk of choking.)



Some Reminders

General reminders:

- NEVER crush any kinds of tablets unless the prescribing physician has given specific directions to do so.
- DO NOT open capsules and empty out the contents.
- Altering the form of capsules or tablets may have an impact on their effectiveness by changing the way a person's body absorbs them. If there is any question about what is safe to do, contact the prescribing physician or pharmacist.
- Some foods can change the way certain medications work. Read the medication label, it may tell you what to avoid.

For liquid medications:

1. Check the label for any directions to "shake well" and do so if indicated.
2. Remove the cap from the bottle and place it upside down on the work surface.
3. The liquid medication should come with a measuring device such as a spoon or cup. If there is no measuring device available, check with your pharmacist or physician to determine exactly how the medication should be measured. Be sure to use a cup with markings, or specially-designed spoon with markings, or a fluid syringe (without needle) with clear markings, when taking teaspoons and tablespoons of a liquid medication. Regular eating spoons (metal or plastic) are simply not accurate enough.
4. Locate the marking for the ordered amount on your medicine cup or other measuring device. Keeping your thumbnail on the mark, hold the cup at eye level and pour the correct amount of medication. (Accuracy is important, so you may want to place the cup on a flat surface to pour and measure. Pour the medication away from the label to prevent staining same with any spills.)
5. If too much liquid is poured, do not return it to the bottle — discard it.
6. After pouring the medication, double check that the amount is the amount that has been indicated on the label.
7. Wipe the lip of the bottle with a clean, damp paper towel before replacing the cap.
8. If any liquid is spilled on the outside of the bottle, also wipe with a clean paper towel.
9. Provide water after the liquid has been swallowed. Again, check the pharmacy label for any special instructions.
10. Wash the measuring device with warm water and air dry on a paper towel.

For other types of medications
When assisting an individual with other types of medications such as topical creams and ointments, ear drops, nose drops, eye drops, consult with the prescribing physician, and the pharmacist for specific procedures for self-administration of the medication.

Other "Do's" and "Don'ts"

- One person should be assigned to assist individuals with medications at a given time. If more than one person has these duties, check orally with one another before assisting with medications, in the off chance that the other person gave the medications but failed to mark it down.
- Ask the physician (and pharmacist) to give you the medicine in the proper form for the individual based upon their needs and preferences.
- Only initial the Medication Log for dosages of medication for which you personally have provided assistance.
- Never write on a drug label. Do not alter a drug label in any way. If a sticker (for example, Change; date: _____) is affixed, make sure it doesn't obscure the label.
- If, in opening a new container, the new medication is different from the old (in shape, size, color, etc.), don't give it until you have determined the reason for the difference. It could be a drug dispensing error!
- Watch carefully for and document all adverse reactions and other side effects, especially with new medications or change in dose.
- If a person misses a dose, check with the individual's physician, and get directions on what to do. Don't double up the next time the drug is taken.
- While licensing regulations permit the set up of medications up to 24-hours in advance, there are many potential problems with this practice. It is advised to set up medications immediately before assisting individuals with medications.
- Never hand a medication to one person to pass on to another.

Activity: Assisting Individuals with Self-Administration

Medication Log

Molina Family Home, 123 Main Street, Any City, CA 90000 (Ph: 123-4567)

Name: J. Doe

Insurance: ❑ Medi-Cal • ❑ Medicare • Insurance No._____

Drug/Strength/Form/Dose	Hour	Month & Year (MM/YY) _____ & Date																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JELLY BEANS RED (generic for *Jelly Belly* JELLY BEANS RED) 1 bean now																																

Primary care physician:_____ Pharmacy:_____

Legend: Initials means given. Meds given at . . . D=day program • H=Relative or friend's home • E=Elsewhere

Signatures & initials: __ for _____ __ for _____ __ for _____

Notes & comments: *(Suggest color-coding times of day with light highlighter.)*

Allergies

Penicillin

What If a Person Refuses to Take Their Medication?

An individual has the right to refuse to take their medication. If an individual refuses to take their medication, ask them why. **Do not try to crush or hide the medication in the person's food in order to get the individual to take the medicine.** It is the DSP's responsibility to work with the individual and to support them to take their medicines. Individuals may resist taking medication for a variety of reasons. The following is a list of some common reasons why a person might refuse to take their medication and a suggestion on how to assist them.

REASON	SUGGESTION
Unpleasant taste	Use an ice cube to numb the taste buds for a few minutes before person takes medication. Provide crackers, apple, or juices afterwards to help cover up bad taste. Ask the prescribing physician about a different form of medication or a different medication.
Unpleasant side effect (e.g. Drowsiness)	Ask the prescribing physician about the person taking the medication at a different time (e.g. before bedtime), changing medication, or treating the side effect.
Lack of understanding	Provide simple reminders on what the name of the medication is and what the medication does. "This is Lasix, your water pill."
Denial of need for medication	Discuss need, but do not argue. It may help to show the person a statement written by the physician, for example, "Alma, you take your heart medication every day."

After you have discussed with the individual why he/she refused to take their medications, you need to document the refusal and bring it to the attention of the prescribing physician right away to help develop a plan that makes sense for the individual, given their health care needs. The dose should be set aside and destroyed in an acceptable way. (More on this matter, later.)

What if the person needs medication while away from the home?
The DSP may package a single dose for each of the medications needed that day (but no more) to be taken at work, day program, or elsewhere (home visit). With the physician's approval in writing, the medication can be carried by the individual who will take it. Otherwise, the medication is to be given to a responsible party in an envelopes (or similar containers) labeled with:

- The facility's name and address;
- The individual's name;
- Name of the medication(s); and
- Instructions for assisting with self-administration of the dose.

If a person will always be taking a dose of medication at school or a day program, tell the physician and pharmacist. The pharmacist should be able to provide separate medication for use at the school or day program.

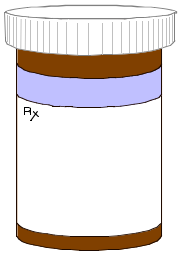
"As needed" (or PRN) medication
Some medications may be ordered by the physician to be taken as needed (PRN). Medications for headaches, constipation and upset stomach are some examples that may fall into this category. <u>There should be specific written instructions from the physician regarding when, and under what conditions the medication should be administered.</u>

Both the physician's order and the pharmacy label must specify the symptoms, exact dosage, minimum time between doses (e.g., "may repeat every six hours"); and (4) maximum dosage over 24 hour period (e.g., "not to exceed 4 caps over 24 hours"). Many **bad things** that happen are the result of drug errors. The physician also needs to document the individual's ability to relate symptoms and the documentation must be in the individual's record.

If, if the written judgment of the physician, an individual has the ability to relate symptoms ("I have a headache") and communicate that he or she wants to take medication ("I want two aspirin"), staff in a Community Care Facility may assist a person with the medication. Otherwise, staff need to contact the physician before each dose.

What to do if a medication error does occur
Many **bad things** that happen are the result of medication errors. The DSP's job is to do the very best in assisting individuals to get the benefits of medications, while minimizing adverse effects. A medication error has occurred when:

- The wrong person took the wrong medication.
- The wrong dosage was taken.
- A medication was taken at the wrong time.



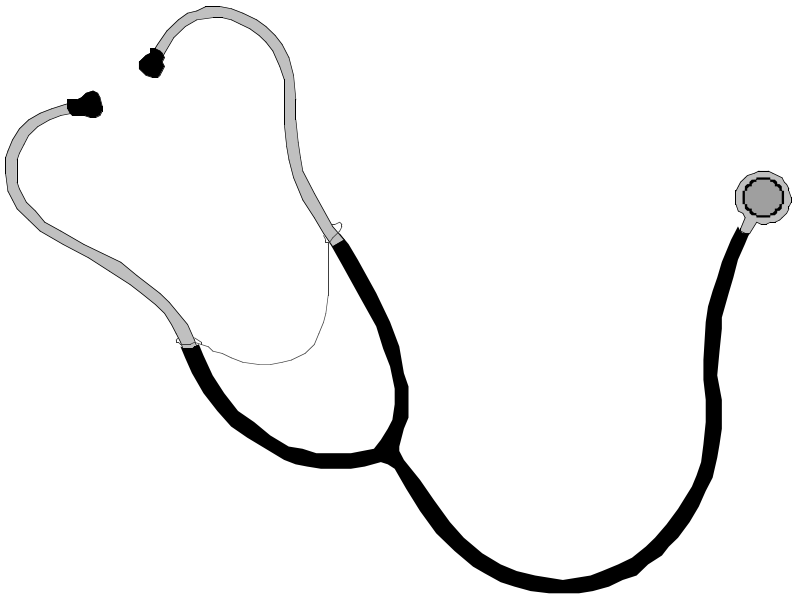
- A medication was taken by the wrong route.
- A medication was not taken at all.

Every medication error is potentially serious and could be life-threatening. If an error does occur, it must be reported immediately to the prescribing physician, and necessary action taken. The error must be recorded and the policies of your care home followed.

Remember, you can prevent medication errors by:

1. Staying alert, and always observing the "Five Rights" of medication assistance.
2. Avoiding distractions when preparing, assisting and documenting medication.
3. Being knowledgeable about medications.
4. Asking for help from the prescribing physician if you are unsure about any step in preparing, assisting and documenting medications.

Requirements for assisting with medications in statute and regulation
In California the licensing law and regulations are very specific regarding requirements for assisting with medications. Some of the laws and regulations are different based upon the age of people living in the home and the licensing category of the home, for example, Adult Residential Facility or small family home. Refer to the Information Brief entitled "Assisting With Medications from A to Z" for a summary of both best practices and statutory and regulatory requirements.



Information Brief

Monitoring the Effects of Medication

Physical and behavioral changes that are due to the effect of a medication are often difficult to sort out from those that are not due to medication. There may be many different reasons for the same sign or symptom. A change in behavior may be due to a medication change or a change in the person's environment. A sore throat may be one of the first symptoms of a cold or may be an adverse effect of a medication.

Interpretation (deciding the meaning) of a sign or symptom is the responsibility of a physician. Your responsibility as the DSP is to consistently and accurately observe, report and record any change in physical conditions or behavior. It is also your responsibility to give the appropriate care to the person in the meantime if it is an emergency or potentially health-threatening condition.

Monitoring for Adverse Reactions and Other Side Effects

Know what medications are being used by people in the home where you work and learn about them. Know what possible side effects may occur, and be sure to ask the physician what kind of reactions should be brought immediately to his/her attention. Write these down, and be sure everyone knows what to do, and does what they are supposed to do.

Watch for intended and unintended consequences of the medication, document, report to the prescribing physician, and following the physician's directions to continue, change, or discontinue the medication. It is particularly important to watch for side effects when a new drug is being taken, or a dose increased.

What To Tell The Physician

The following is a basic guideline for assisting staff in assuring important basic information is given to the physician when calling regarding a person with a suspected reaction to medications:

- Inform the physician about current medications.
- Describe how the person looks (pale, flushed, tearful, strange facial expression).
- Any changes in behavior or level of activity (excited, lethargic, confused).
- What does the person say is wrong?
- What hurts?
- When did the symptoms first start?
- Is the person eating or drinking - good appetite or no appetite.

- Any vomiting, loose stools, problems urinating?
- If qualified, obtain and provide pulse, temperature, and blood pressure.
- Let the physician know if there is any recent history of the person having similar symptoms, any other recent injury or illness, any chronic health problems.
- Any allergies to food, medication, etc.

More About Adverse Reactions and Side Effects

While some unintended effects of some drugs are trivial or minimal, others may produce effects that cause serious impairment to health (Gadow, 1986). Adverse reactions or side effects are unintended effects that are especially serious, causing injury, illness, or even death in some cases. Here are examples of unintended effects of drugs prescribed for epilepsy:

- Sleepiness, lethargy, cognitive impairment, altered gait, seizure breakthrough, and memory loss. These side effects are typically related to the amount of the dose.
- Diarrhea; gum changes (growth and swelling); weight gain; and hair loss or growth.
- Liver/kidney dysfunction, hyperactivity, aplastic anemia, allergic response.

Adverse reactions or side effects can occur at any time during the course of the drug therapy. Some mild side effects may disappear on their own after a short period of time. Others will persist for the entire length of drug therapy, and sometimes beyond.

Written material should come with every new medication. Pharmacists are supposed to talk with each person receiving a new medication (or change in dose), but you may have to ask questions and request written material. Don't be bashful. Pharmacists often have more working knowledge about drugs, side effects, and interactions than prescribers. Asking both the physician and the pharmacist is a good idea, because that strategy makes use of "checks and balances" within the system of health care.

Drug Interactions

Adverse reactions or side effects may be caused by interactions between two or more drugs and by interactions between drugs and food and drink. In taking any kind of pills, it is best to take the with water. Graedon & Graedon (op.cit., p. 51) introduce their chapter on food and drug interactions with this statement: "Who would ever guess that taking your blood pressure medicine with grapefruit juice instead of orange juice could make you sick? Or that licorice could be lethal when eaten with Lanoxin or Lasix? How could cheddar cheese, pepperoni pizza, or pickled herring combined with an antidepressant create a hypertensive crisis? Yet all of these interactions are real and could lead to disaster."

Beer, Wine, and Other Alcohol

Adverse reactions or side effects may also be caused by mixing drugs and alcohol. Alcohol in combination with any of the following is especially dangerous:

- Anti-anxiety drugs, such as LIBRIUM, VALIUM, OR XANAX;
- Antidepressants;
- Anti-seizure medicines;
- Antihistamines;
- Ulcer and heartburn drugs, such as ZANTAC and TAGAMET; and
- Heart and blood pressure medicines, such as the calcium channel blockers CALAN, ISOPTIN, and VERELAN.

Following Physician Orders for Tests

Some drugs (e.g., lithium, carbamazepine, even TYLENOL, an over-the-counter pain reliever) have rather narrow therapeutic ranges, and can be toxic (and cause damage) above a certain level in a person's blood, especially if taken for a long period of time. Then, too, individuals respond differently, some metabolizing such drugs slower (or faster) than others. For this reason, physicians sometimes start a new medication at low therapeutic doses, and increase these in response to signs of a positive effect (e.g., reduction in seizures; better sleep patterns; etc.).

Checking serum levels, by analyzing the concentration of drugs in a person's blood, can be important. A physician's orders for lab test and follow up appointments must be kept. The results will indicate whether the drug is within the therapeutic range, below that range, or above that range. If below the therapeutic range, the drug may not be doing any good. If above the range, it may be toxic or have bad effects for the individual (e.g., slurring of speech). Serum level tests will help the physician determine the effectiveness of the medication and future course of action.

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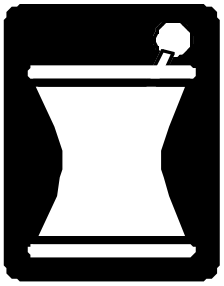


Example of a Written Insert to Accompany a Drug Dispensed by the Pharmacist

Medication: Dilantin (Phenytoin - Oral)

USES: This medication is used to treat seizures and epilepsy.

HOW TO TAKE THIS MEDICATION: Take with food or milk if stomach upset occurs. Capsules should be swallowed whole unless otherwise directed. The tablets must be chewed thoroughly before swallowing. The suspension must be shaken well before measuring each dose. This medication must be taken as prescribed. Do not stop taking this drug suddenly without consulting your doctor as seizures may occur. It is important to take all doses on time to keep the level of medication in your blood constant. Do this by taking doses at the same time(s) each day. Do not skip doses. While taking this medication, lab tests may be done, especially in the first few months, to check if the drug is working properly.

SIDE EFFECTS: May cause drowsiness, dizziness, or blurred vision. Use caution performing tasks that require alertness. Other side effects include stomach upset, headache, muscle twitching or sleep disturbances. These should subside as your body adjusts to the medication. Notify your doctor if seizures occur or if you develop severe nausea and vomiting, joint pain, swollen or tender gums, sore throat, uncoordinated movements, unusual bleeding or bruising, uncontrolled side-to-side eye movements or skin rash while taking this medication. May cause enlargement of the gums. This can be minimized by maintaining good oral hygiene with regular brushing, flossing and massaging of the gums.

PRECAUTIONS: This drug should be used during pregnancy only if clearly needed. Discuss the risks and benefits with your doctor. Small amounts of phenytoin appear in breast milk. Consult with your doctor before breast-feeding. Use of alcohol and other sedative type medications can lead to extreme drowsiness. Try to limit their usage. This medication may decrease the effectiveness of oral contraceptives. Consult your pharmacist or doctor about other methods of birth control. Be sure your doctor knows your complete medical history.

DRUG INTERACTIONS: Inform your doctor about all the medicine you use (both prescription and non-prescription) especially if you take “blood thinners” (Coumadin), cimetidine (Tagamet) for stomach problems, disulfiram (Antabuse) for alcoholism, oral antifungal medication or xanthine drugs (theophylline) to treat asthma as your dose may need to be adjusted. Limit your caffeine usage.

NOTES: It is recommended to wear or carry medication identification indicating you are taking this drug. Do not change from one brand of this product to another without consulting your doctor or pharmacist. Products made by different companies may not be equally effective.

MISSED DOSE: If you miss a dose and take 1 dose daily: take as soon as remembered unless you do not remember until the next day. In that case, skip the missed dose and resume your usual dosing schedule the following day. If you take several doses daily and should miss a dose: take as soon as remembered unless it is within 4 hours of the next dose. In that case, skip the missed dose and resume your usual schedule. Check with your doctor if you miss doses for more than 2 days in a row. Do not double the dose to catch up.

STORAGE: Store at room temperature away from moisture and sunlight. Do not store in the bathroom.

Activity:
Asking the Physician and Pharmacist, a Safety Check

Name	**Dose (e.g., ___ mg) and form (e.g., tabs)**	**When to take each dose?**	**For how long?**
Brand: _____ Generic:_____			

1. What is the medication supposed to do?

2. How long before we will know it is working or not working?

3. What about serum (blood) levels? Other laboratory work? How often? Where? Standing order?

4. If I miss a dose, what should I do?

INTERACTIONS?

5. Should I take this medication with food? ❑ Yes ❑ No
   At least one hour before or two hours after a meal? ❑ Yes ❑ No

6. Are there any foods, supplements (e.g., herbs, vitamins, minerals), drinks (e.g., alcoholic), or activities that I should avoid while taking this medication?
   ❑ Yes (Which ones?) _____
   ❑ No

7. Are there any other prescription or over-the-counter medications that I should avoid?
   ❑ Yes (Which ones?) _____
   ❑ No

SIDE EFFECTS? IF SO, RESPONSE?

8. What are common side effects?

9. If I have any side effects, what should I do? How do I know whether to go to the emergency, call you right away, or just make an appointment to see you?

10. If it is being prescribed for a long period of time, are there any *long-term effects?*

Information Brief

Correct Handling: Ordering, Storing, Recording and Destroying

Ordering

Some pharmacists provide extra services, and will package medications in ways that can be helpful. Bubble-packs are popular, but be sure you understand how each person's packet is to be used It is a good idea to order refills about 7 days in advance of running out.

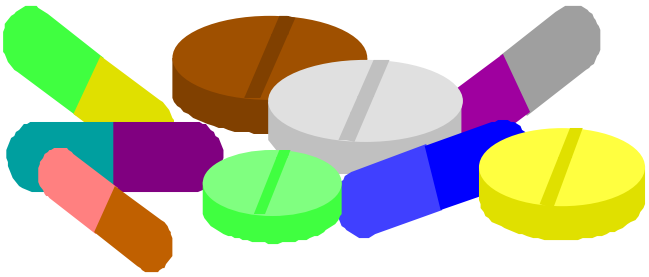
Storing

Medications must be stored appropriately. If an individual takes medication on his/her own with no assistance, the medication must be locked (for example, in a bedside, locked drawer or elsewhere), to keep it away from others. When medications are "centrally stored," they must be stored in locked cabinets or drawers. If a centrally-stored medication requires refrigeration, it must be in a locked container inside the refrigerator. If stored in the refrigerator, it's recommended that you use a thermometer and keep the refrigerator in the 36-40 degree range.

Recording

We have already talked about Medication Logs.

In addition, all drugs entering the home must be listed when they enter the home, and if a medication is discontinued, or if an "as needed" medication outlives its usefulness, or if a person leaves the home and does not take his/her medicine to the new residence, the medicine needs to be destroyed in the presence of another adult who is not a client, with appropriate entries made on LIC Form 622.



Activity: Medication Forms Exercise

Susan Anthony, age 8, lives at the *Molina Family Home.*

She has two prescriptions as follows:

Rx: 012345		Date
Dr. Mary Rodriquez		
SUSAN ANTHONY		
Sprinkle 4 caps over food & eat 2 times daily to prevent seizures.		
DEPAKOTE 125 MG Sprinkle CAP		
#300	Expires: 06/01	Refills: 1

Rx: 012346		Date
Dr. Mary Rodriquez		
SUSAN ANTHONY		
Take 2 tablets orally, 3 times a day.		
(May be crushed and taken with food.)		
LAMICTAL 25 MG TABLET		
#200	Expires: 01/02	Refills: 2

1. On the blank **Medication Log Sheet** which follows, complete the first two columns for each prescription. In the first column, write in name of drug, strength, form (e.g. cap or tab), and dose at the time indicated in the second column. Assume breakfast is typically at 7am, Susan comes home from school and has a snack around 3pm, and Susan goes to bed about 9pm. In the first column, write in the name of the **medicatio**n (e.g., LAMICTIL), **strength** and **form** (e.g., 25mg TABS), and **dose** (2 TABS), along with any "Do's" or "Don'ts," such as "Take with food."

2. On the page after the **Medication Log Sheet** is an excerpted LIC 622, *Centrally Stored Medication and Destruction Record*. Make entries on the Medication Administration Sheet and/or on LIC 622, based on the following information:

   - On the 5th, Mrs. Molina called in for a refill of the LAMICTAL, at Lucky's Pharmacy, picking it up on the 8th, and starts using it on the 12th.

   - On the 17th, after Mrs. Molina reports some hand tremors, Dr. Rodriquez says, over the phone, to give Susan 2 Tabs of LAMICTAL, 2 times a day, rather than 3, at breakfast and dinner time.

   - On the 28th, after seeing Susan and Mrs. Molina at her office, Dr. Rodriquez orders discontinuation of the LAMICTAL entirely.

Medication Log

Name:____________________

Molina Family Home, 123 Main Street, Any City, CA 90000 (Ph: 123-4567)

Insurance: ❑ Medi-Cal • ❑ Medicare • Insurance No.____________

Drug/Strength/Form/Dose	Hour	Month & Year (MM/YY) ________ & Date																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Primary care physician:____________________ Pharmacy:____________________

Legend: Initials means given. Meds given at . . . D=day program • H=Relative or friend's home • E=Elsewhere

Signatures & initials: __ for ____________ __ for ____________ __ for ____________

Notes & comments: *(Suggest color-coding times of day with light highlighter.)*

Allergies

Penicillin

STATE OF CALIFOR ALTH AND WELFARE AGENCY

DEPARTME OCIAL SERVICES
COMMUNIT LICENSING

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

I. CENTRALLY STORED MEDICATION

FACILITY NAME

FACILITY NUMBER

INSTRUCTIONS: *Centrally stored medications shall be kept in a safe and locked place that is not accessible to any person(s) except authorized individuals. Medication records on each client/resident shall be maintained for at least one year.*

NAME (LAST FIRST MIDDLE)	ADMISSION DATE	ATTENDING PHYSICIAN	ADMINISTRATOR

MEDICATION NAME	STRENGTH/ QUANTITY	INSTRUCTIONS CONTROL/CUSTODY	EXPIRATION DATE	DATE FILLED	DATE STARTED	PRESCRIBING PHYSICIAN	PRESCRIPTION NUMBER	NO. OF REFILLS	NAME OF PHARMACY

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: *Prescription drugs not taken with the client/resident upon termination of services or otherwise disposed of shall be destroyed in the facility by the Administrator or Designated Representative and witnessed by one other adult who is not a client/resident. All facilities except Residential Care Facilities for the Elderly (RCFEs) shall retain destruction records for at least one year. RCFEs shall retain records for at least three years.*

MEDICATION NAME	STRENGTH/ QUANTITY	DATE FILLED	PRESCRIPTION NUMBER	DISPOSAL DATE	NAME OF PHARMACY	SIGNATURE OF ADMINISTRATOR OR DESIGNATED REPRESENTATIVE	SIGNATURE OF WITNESS ADULT NON-CLIENT

Information Brief

Common Medications and Their Uses

Drugs are classified into categories or classes with other medications that affect the body in similar ways. Many drugs, because of their multiple uses, can be found in more than one category. For instance, BENADRYL is classified as an antihistamine (e.g., to relieve allergy symptoms), but is also used as a sedative to promote sleep.

Thousands of medications are on the market, in many categories. Here is the way the *Nursing Drug Handbook* categorizes them:

Anti-infective Drugs (for example, antifungals; antibiotics; etc.);

Cardiovascular system Drugs (for example, antiarrhythmics; antihypertensives; etc.);

Central nervous system Drugs (for example, analgesics; sedative-hypnotics; anticonvulsants; antidepressants; antianxiety; antipsychotics; etc.);

Autonomic nervous system Drugs (for example, adrenergics; skeletal muscle relaxants; etc.);

Respiratory tract Drugs (for example, antihistamines; expectorants; etc.);

Gastrointestinal tract Drugs (for example, antacids; antidiarrheals; laxatives; etc.);

Hormonal Drugs (for example, estrogens and progestins; antidiabetic drugs and glucagon; thyroid hormones; etc.);

Drugs for fluid and electrolyte balance (for example, diuretics; acidifier and alkalinizers);

Hematologic Drugs (for example, anticoagulants);

Antineoplastic Drugs (for example, alkylating drugs; antimetabolites; etc.);

Immunomodulation Drugs (for example, immunosuppressants; vaccines and toxoids; etc.);

Ophthalmic, Otic, and Nasal Drugs (e.g., ophthalmic anti-inflammatory drugs; nasal drugs; etc.);

Topical Drugs (for example, local anti-infectives; scabicides; topical corticosteroids);

Nutritional Drugs (for example, vitamins and minerals; calorics); and

Miscellaneous Drug Categories (for example, antigout drugs; enzymes; gold salts).

We highlight two categories on the following pages: *psychotropics* and *antiseizure* medications.

Psychotropics

Psychotropics are intended to affect thinking or feeling, and are taken by sizable numbers of people with developmental disabilities. Some of these medications, alone or alongside other interventions (e.g., talk therapy, desensitization), are used to treat psychiatric disorders, which can involve serious impairments in mental or emotional function that affects an individual's ability to perform normal activities and to relate effectively to others. These disorders are sometimes classed as (1) *mood disorders,* the most common of which are *depression* (lasting 2 weeks or more), which can mean feelings of hopelessness or even self-destruction, not wanting to eat or get out of bed in the morning, and the like, and *bi-polar disorder* (manic-depression), often marked by extremes in mood, from elation to deep despair, and/or manic periods consisting of excessive excitement, delusions of grandeur, or mood elevation; (2) *schizophrenia*, which can mean misinterpretation and retreat from reality, ambivalence, inappropriate affect, bizarre, withdrawn, or aggressive behavior, hallucinations (distorted sensory perceptions), and/or delusions (strange ideas or false beliefs, including paranoia); and (3) *anxiety disorders,* such as *generalized anxiety disorder* or *obsessive-compulsive disorder,* which are typified by tension, fear, apprehension, discomfort, and distress.

Commonly used *psychotropic medications* include:

- ESKALITH (lithium), which is often used for treatment of bi-polar disorder, under very carefully controlled conditions, because the therapeutic dose and the toxic dose are quite close together and, therefore, frequent blood tests are needed.

- Major tranquilizers (phenothiazines), including THORAZINE (chlorpromazine), HALDOL (haloperidol), PROLIXIN (fluphenazine), SERENTIL (mesoridazine), MELLARIL (thioridazine), RISPERDAL (risperidone) and others, used for various psychoses, anxiety, severe behavior problems, or acute agitation.

- Antidepressants of various kinds, including tricyclic ones (ELAVIL, TOFRANIL, and NORPRAMIN, among others); WELLBUTRIN (bupropion); and newer antidepressants, such as the seritonin reuptake inhibitors PROZAC (fluoxetine), ZOLOFT (sertraline), PAXIL (paroxetine), and LUVOX (fluvoxamine).

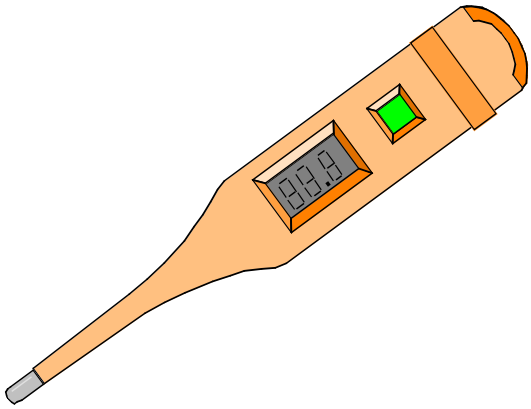
- *Anti-anxiety agents,* such as XANAX (alprazolam), BUSBAR (buspirone), LIBRIUM (chlordiazepoxide), VALIUM (diazepam), or ATIVAN (lorazepam), are used to combat anxiety disorders of various kinds, often with other approaches (desensitization; thought-stopping techniques).

Side effects and interactions. – Earlier, we discussed common side effects, and some of the interactions to be aware of. The DSP needs to know what to look for, and to be observant in recognizing and documenting all changes that could possibly be related to taking a medication (especially a new one, or a different dose). And, he/she needs to know what to do, when an adverse effect is noted. Clearly, if a person's temperature rises, sweating occurs, breathing becomes difficult or labored, one must take action right away, and talk with the physician or get to the Emergency Room at the local hospital.

Anti-seizure Medications

Some common ones. — Prior to discovery of DILANTIN (phenytoin) in 1938, bromides and barbiturates, such as phenobarbital, were about the only drugs available to treat seizures. Today, one anti-epileptic drug (monotherapy) controls seizures acceptably (i.e., prevents generalized seizuring) in about 70% of new cases. Often the drug is either TEGRETOL (carbamazepine) or DEPAKOTE (valproate acid), relatively new, less sedating anti-seizure medications. Compared with one-drug therapy, two-drug adds 10%; three-drug therapy another 5%.[2] NEURONTIN (gabapentin) and LAMICTAL (lamotrigine) have shown promise. FELBAMATE, approved by FDA in 1993, showed promise where an individual experienced one or more seizures a day, but there are serious risks in terms of aplastic anemia and liver failure, and therefore it is used only as a last resort.

Side effects and interactions. – A number of prescription and over the counter medications (for example, antipsychotics, Ibuprofen, pseudoephedrine), as well as alcohol and illicit drugs (for example, cocaine, amphetamines) may lower the "seizure threshold," or increase the likelihood of a seizure. Most anti-convulsants have central nervous system effects (for example, dizziness, sedation, mood changes, nervousness, fatigue), including effects on thinking (especially phenobarbital). Many anti-convulsants, when taken with other drugs in the same or different categories, *interact,* that is, affect the amount, usefulness, or impact of each other. Some anti-convulsants deplete vitamins, and therefore the person may need a multivitamin supplement and extra folic acid. Be sure to ask the physician or pharmacist. The physician may not have thought about this nutritional issue until you brought it up.



[2] Study cited by McGowan & McGowan, Assessing Health Risk in Developmental Disabilities (1995), p. 4-10.

Medications and the DSP: Some Concluding Thoughts

The central task of the DSP is to assist with the taking of medications. Equally important is paying close attention to *changes* in behavior, thinking, and symptoms that occur with the introduction of the medication (or a change in dosage), documenting those changes, and otherwise acting on them. If a serious adverse reaction occurs, one must contact the prescribing physician, **911**, or take the person to the emergency room for treatment. Other, more minor changes should be brought immediately to the attention of those responsible for the home. **When in doubt, always err on the side of caution.**

Health care is a team enterprise, with the physician quarterbacking the team. Others, including the pharmacist and nurses, can help a great deal. Seek them out, and ask them for advice in handling anything you are not sure of. They are there to help, and they typically want to help.

Information Brief

Assisting with Medications A to Z

Medication handling represents an area of great responsibility. If not managed properly, medications intended to help a person's health condition may place that individual's health and safety at risk. The information contained in this portion of the training represents medication procedures you are required by regulation to perform, and some procedures not required by regulation, which if implemented will provide additional safeguards in the management of medications in your community care home. If you operate or work in a community care facility (CCF), the specific medication regulation you must comply with are sections 80075 (h)-(j). If you operate a Residential Care Facility for the Elderly (RCFE), the specific medication regulations you must comply with are sections 87575 (c)-(e). (**Adapted from** Community Care Licensing Technical Support Publication.)

What you (Direct Support Professionals/DSP) should do when:

1. Individual moves into home	• Contact physician to ensure physician is aware of all medications currently taken by the individual. • Verify medications that are currently taken by the individual and instructions for taking the medications. • Inspect containers to ensure the labeling is accurate. • Log medications accurately on forms for individual records. (Centrally-Stored Medication Log). • Discuss medications with the individual, if possible, or the responsible person/authorized representative. • Store medications in a locked cabinet, drawer, etc.
2. Medication is refilled	• Communicate with physician or others involved in refilling the medication. • Never let medications run out unless indicated by the physician. • Make sure refills are ordered promptly (if less than 7 days supply it's time to reorder). • Inspect containers to ensure all information on the label is correct. • Note any changes in instructions and/or medication; for example, change in dosage, change to generic brand etc. • Log medication when received. • Discuss any changes in medications with individual, and appropriate staff.

3. Physician changes dosage between refills	• Communicate with the physician; document in writing the date, time and content of the discussion. • Prescription labels are not to be altered by facility staff. • Have dispensing pharmacist relabel container or have new prescription filled. • Have a facility procedure, for example a card file, notebook, and/or cardex and a flagging system to alert all staff of change. • Discuss changes in medication with the resident, staff and responsible person/authorized representative.
4. Medication is discontinued	• Confirm discontinuation of medication with the physician. • Discuss discontinuation of medication with the individual and/or responsible/authorized representative. • Obtain written documentation of the discontinuance from the physician, prior to destroying, or document the date, time, and person talked to in the resident record. Check with local community care licensing office for information regarding disposal of medications. Some local areas have different requirements for disposals because of environmental concerns. • Medication is to be destroyed by facility administrator or designee, and one other adult who is not a resident. • Destroy medications at facility site. • Sign record/log for destruction of medications.
5. Medication is temporarily discontinued by physician	• Medications temporarily discontinued by the physician may be held by the facility and must be centrally stored. • Discuss change with the resident and/or responsible/authorized representative. • Have a written order from the physician to HOLD the medication, or document in the individual's record the date, time and name of person talked to regarding the HOLD order. • The physician order (verbal or in writing) should include a date when the medication is to be resumed. • Without obscuring or altering the label, mark or identify in a consistent manner medication containers that have HOLD orders. For example place in a zip lock bag labeled HOLD.

6. Medication reaches expiration date	• Check containers regularly for expiration date. • Communicate with physician and pharmacy promptly. • Do not use expired medication. • Remember over-the-counter medications and ointments have expiration dates (for ointments the expiration date is usually at the bottom of the tube). • Destroy medications at the facility site according to regulations. • Log/record destruction as required.
7. Individual moves, dies, or leaves medication behind	• Medication is to go with the individual when possible. • If the individual dies, the medication is to be destroyed. • Log/record the destruction as required. • Document when medication is sent with the individual. • Obtain the signature of the person accepting the medications. • Maintain medication records for at least 3 years (RCFE) and 1 year (CCF).
8. Individual refuses medications	• No individual can be forced to take any medication. An individual has the right to refuse treatment. • Medication cannot be disguised in food or liquid. • Refusal of medications should be documented on the individual medication record, and the prescribing physician notified immediately. • Refusal of medications may indicate a change in the individual that may require a reassessment of his/her needs.
9. Medications are PRN or "as needed"	***The DSP may assist the individual with self administration of prescription and nonprescription medication when:*** • The physician has stated in writing that the individual can determine and clearly communicate the need for a prescription or nonprescription PRN medication. • The physician provides a signed, dated, written, order on a prescription blank which is maintained in the individual's file. • The physician order and the PRN medication label specify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24 hour period.

The DSP may also assist the individual with self-administration of nonprescription PRN medication when the individual cannot determine his/her need for a nonprescription PRN medication, but can communicate the symptoms clearly, when:

- The physician has stated in writing that the individual cannot determine his/her need for nonprescription medication, but can communicate his/her symptoms clearly.
- The physician provides a signed, dated, written order on a prescription blank which is maintained in the individual's file.
- The written order identifies the name of the individual, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for re-evaluation.
- The physician order and the PRN medication label specify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24 hour period.
- A record of each dose is maintained in the individual's record, and must include the date, time and dosage taken, and the individual's response to the medication.

9. Medications are PRN or "as needed"

The DSP may also assist the individual with the self-administration of his/her prescription or nonprescription PRN medication when the individual cannot determine his/her need for a prescription or nonprescription PRN medication, and cannot communicate his/her symptoms when:

- The DSP contacts the individual's physician before giving each dose, describe the individual's symptoms, and receive direction to assist the individual with each dose.
- The date and time of each contact with the physician and the physician's directions are documented and maintained in the individual's record.
- The physician provides a signed, dated, written order on a prescription blank which is maintained in the individual's record.
- The physician order and the PRN medication label specify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24 hour period.
- A record of each dose is maintained in the individual's records and includes the date, the time, and the dosage taken, and the resident's response to the medication.

9. Medications are PRN or "as needed"	***Small family home DSPs may assist a child with prescription or nonprescription PRN medication without contacting the child's physician before each dose when the child cannot determine and/or communicate his/her need for a prescription or non prescription PRN medication when:*** • The child's physician has recommended or prescribed the medication and provided written instructions for it's use on a prescription blank. • Written instructions include the name of the child, the name of the PRN medication, instructions regarding when the medication should be stopped and an indication when the physician should be contacted for reevaluation. • The physician order and PRN medication label specify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses allowed in a 24 hour period. • The date, time, and content of the physician contact made to obtain the required information is documented and maintained in the child's record. • The date, time, dosage taken, symptoms for which the PRN medication was given and the child's response to the medication are documented and maintained in the child's records.
10. Sample Medications	• Sample medications may be used if given by the prescribing physician. • Sample medications must have all the information required on a regular prescription label except pharmacy name and prescription number.
11. Medication Storage	• All medications including over-the-counter, must be locked at all times. • All medications must be stored in accordance with label instructions.; refrigerate, room temperature, out of direct sunlight, etc. • Medications in the refrigerator need to be locked in a receptacle, drawer or container, separate from food items.

12. Over-The-Counter Medications	• Over-The-Counter preparations can be dangerous; for example aspirin, vitamins, etc. • Over-The-Counter preparations must be centrally stored, to the same extent that prescription medications are centrally stored. • There must be a physician's order for any Over-The-Counter medications taken by an individual. The physician provides a signed, dated written order on a prescription blank which is maintained in the individual's record. • Individual's name should be on the Over-The-Counter medication container, when: * Over-The-Counter medication purchased for that individual's safe use. * Over-The-Counter medication purchased by individual's family. * Individual's personal funds were used to purchase the medication.
13. Medication for Home Visits, Outings, Etc.	• When an individual leaves a facility for a short period of time, during which only one dose of medication is needed, the facility may give the individual's medication to a responsible person/authorized person in an envelope or similar container labeled with the facility's name and address, individual's name, name of medication, and instruction for administering the dose. • If the individual is to be gone for more than one dose period the facility may: * Give the full prescription container to the resident or responsible representative. * Have the pharmacy fill a separate prescription, or separate the existing bottle into two bottles. * Have the individual's family obtain a separate supply of the medication for use when the individual visits the family. • If it is not safe to give the medication to the individual, it should be entrusted to the person who is escorting the individual. • If medications are being sent with the individual, check the Physician's report (LIC 602) to ensure that they are given only to individuals whose physicians have indicated they may control their own medications.

Reference: **Community Care Licensing Division Self Assessment Guide to Medications (Technical Support Program TSP 8/1997)**

Answers to In-Class Review

1. What are the Five Rights to be followed when assisting individuals with medication?

Right person;
Right medication;
Right time;
Right dose; and
Right route (e.g., oral).

2. Is it ever okay to package up a dose of medicine to be taken when away from the home?

Yes, it is permissible for a single dose, so long as the envelope or other container carries the following information:

- the facility's name and address;
- the resident's name;
- name of the medication(s); and
- instructions for administering the dose.

The facility's phone number should also be listed, to aid in communication. If the individual has more than one medication that needs to be taken when away from home, the same information applies to each medication.

3. When can "as needed" medicine, including over-the-counter remedies, be administered?

One needs a physician's order, which indicates dose, how long before a second (or third, fourth) dose is given, maximum dose over twenty-four hour period, when to stop, and when to contact physician for reevaluation. A record must be kept of "as needed" medications given, what the medication is for, and if the person cannot determine need and cannot communicate symptoms clearly, staff (except in small family homes for children) need to contact the physician for instructions before each dose.

4. In your own words, what is an adverse drug interaction or side effect? How should you respond?

A drug interaction occurs when one drug (or other substance) affects another, either limiting its effect or strengthening its effect. Unintended effects are either serious (causing injury, risk of death, illness) or relatively minor and often transitory. The former are called adverse reactions. The latter constitute other side effects.

5. It is important to communicate with physicians, pharmacists, nurses and other health care professionals about an individual's medications?

   ☑ True ❒ False

6. It is important to have a system to communicate changes in an individual's medication to DSPs and to the individual.

   ☑ True ❒ False

7. Medications are one of the most potentially dangerous aspects of providing services and supports to individuals living in the home where you work.

   ☑ True ❒ False

8. You need to know and be aware of potential side effects of medications.

   ☑ True ❒ False

9. You need to know about and watch for potential adverse reactions or side effects of medications.

   ☑ True ❒ False

10. Best practices includes documentation of each dose of both prescription and non-prescription (over-the-counter) medications?

    ☑ True ❒ False

If You Want to Read More About
Wellness (Medication)

The American Pharmaceutical Association's Guide to Prescription Drugs
by Donald Sullivan, Ph.D., R.Ph. (1998); A Signet Book; ISBN: 0451199438

Written in clear, easy-to-understand language, and organized alphabetically, this book provides the most up-to-date information you need to know abut the most commonly prescribed drugs.

Wellness Digest, Vol. 1, No. 2
by California Department of Developmental Services (n.d.); The Department

This issue is devoted to Medication Administration. Ed Anamizu, PharmD., served as consulting editor, and was assisted by Mary Jann, R.N. Both have extensive background and experience with medications usage by people with developmental disabilities.

Self-Assessment Guide: MEDICATIONS
by the Technical Support Program, Community Care Licensing Division, California Department of Social Services

This short document provides a quick review of relevant Title 22 regulations, along with best practice ideas.

Dangerous Drug Interactions: The People's Pharmacy Guide
by Joe Graedon & Teresa Graedon (1999); St. Martin's Press revised edition; ISBN: 0312968264

This book summarizes much of what is known about drug interaction, not only with other medications (both prescription and Over-The-Counter), but with foods, vitamins and minerals, herbs, and alcohol. One chapter on drug interactions of particular interest to women, children, and the elderly. Excellent index. Dean Edell, M.D., Medical Journalist in San Francisco, says: "At last, someone has tackled this most complex and critical area. Only the Graedons could make this clear and understandable. A 'must have' for anyone interested in their health."

FDA Tips for Taking Medicines: How to Get the Most Benefit with the Fewest Risks
by U.S. Food and Drug Administration (n.d.); reprint Publication No. FDA 96-3221.

Write FDA, 5600 Fishers Lane, Rockville, MD 20856, Attn: HFE-88 (for single copy, which is free). This reprint includes a patient check-off chart for help in taking medications at the right time. Special sections advise patients on medications while in the hospital, protection against tampering, medication counseling, and tips for giving medicine to children.

Food and Drug Administration
http://www.fda.gov

This site has information about FDA activities and a variety of other information, such as drug testing, newly approved drugs, drug warnings, etc. It also has the FDA Consumer, the agency's official consumer magazine. Some specific pages to check out at this site are: "Making it Easier to Read Prescriptions," "FDA Proposes Program to Give Patients Better Medication Information," and "Tips for taking Medication."

Health and Wellness Reference Guide

by Smith Consultant Group and McGowan Consultants; developed for the Commission on Compliance, State of Tennessee (July 1998)

This is an excellent general reference for nurses and others working with DSP in various settings.

Homework Assignment for Session #5: Community Resources - Health & Safety

Directions: DSPs are to pair up, choose a person or organization, and learn (by telephone, personal interview, or just stopping by the place) what that individual or organization can provide in terms of information or other services that might meet a health or safety need of people living in the home where you work. Call around and see if you can find an appropriate resource. Individuals and organizations can be identified in the Yellow Pages under such headings as:

Safety Equipment
Health Care Services
First Aid and Safety Instruction
Health Clubs
Safety Consultants
Weight Control Services
Waste Disposal—Hazardous
Fire Alarm Systems
Waste Disposal—Medical and Infectious
Fire Extinguishers
First Aid Supplies
Clinics
Hospitals, nursing homes
YMCA, YWCA
Fire Department
Red Cross
Social Service Organizations, such as American Heart Association, American Diabetes Association, American Cancer Society, etc.
College, University, or Regional Occupational Centers and Programs
Any other person/organization that contributes to health or safety.
A health or safety topic addressed by a phone service. (NOTE: In the Los Angeles area, this can be found in the telephone book. Kaiser Permanente also has such a service.)

On the next page, you will find a set of basic questions to ask. Please jot down a summary of what the person you spoke with had to say.

Homework Assignment for Session #5: Learning About Local Health and Safety Resources

Name of Organization or Person Contacted: _____

Type of Business/Organization: _____

Note: First, say who you are and why you are calling. For example, My name is . . . and I have a class assignment to learn more about health and safety resources in my community. I'd like to ask you a few questions.

1. **What services do you provide?**

2. **Who are your customers? Who uses your services and why?**

3. **Are your services accessible to people with disabilities?**

4. **How does your business/organization contribute to good health and reasonable safety for people living in our community?**

Note: Close by thanking the person you spoke with.

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #5
Wellness:
Responding to Individual Needs

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	**Wellness: Responding to Individual Needs**	**3 hours**
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Postive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Health Care Assessment, History and Plan
- Personal Hygiene
- Personal Health Advocacy
- Signs and Symptoms (of Health Problems)
- Medical Emergency
- First Aid
- Emergency Services

Cautionary Statement

The material in this module is not intended to be medical advice on personal health matters. Medical advice for a particular person should be obtained from a licensed physician. We urge you to talk not only with physicians but also with other health care providers, including pharmacists, nurses, dietitians, and therapists of various kinds. These specialists, along with advocates and emergency service personnel, can broaden your understanding of the fundamentals covered in this module.

Your In-Class Review Notes

Here are some review questions about the presentations and activities for this class session.

1. **How do health assessments relate to health care plans? What are two elements of an initial health assessment?**

2. **Why are physical examinations helpful?**

3. **In helping people care for their teeth and nails, what should the DSP do?**

4. What should you do to get ready for an appointment with a health care professional?

5. What is the relationship between the following: (a) observation; (b) change; (c) objective signs; and (d) subjective feelings?

6. What is a medical emergency? When should a person call 911?

Information Brief

Health Assessment and Planning

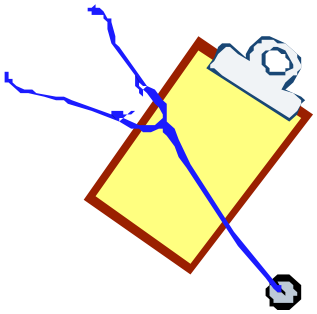
Introduction

This module is about *responding to the health needs of the individual*. This involves (1) determining health needs; (2) planning ways to meet such needs; (3) carrying out those plans; (4) evaluating the results; and (5) making adjustments in services and supports that result in the "best possible health" of the individual. Proper health care is an on-going process. New needs arise over time, triggered by a host of factors, including simply the effects of aging. All community-care facilities (CCFs) must assure that each person has access to all needed medical and dental services and that their health care needs are met.

By law, CCFs provide *non-medical, residential services.* Over the years, however, legislative and regulatory changes have permitted certain health-related services to be delivered in CCFs. These exceptions include (a) hospice care in homes for the elderly; (b) certain specialized health care services for medically fragile children; and (c) incidental medical care for adults.

It is unlawful for CCF's to accept (or retain) individuals who have certain health care needs that require nursing services. Individuals with *restricted health conditions* (for example, the need for oxygen, insulin-dependent diabetes) can be served in CCFs if certain standards are met. These include:

- ✓ Willingness of the licensee to provide needed care;
- ✓ The condition being stable (or, if not, temporary and expected to return to what is normal for the individual);
- ✓ The person being under the care of a licensed professional; and/or
- ✓ A licensed health professional providing training and supervision to unlicensed staff assisting with special or incidental medical care.



Services and supports to children and adults with special or incidental medical care needs are beyond what is covered in this module, and will not be discussed further. Staff working in homes that provide special or incidental medical care must be trained and supervised by a licensed health care professional and follow an individual Health Care Plan.

Initial Health Assessments

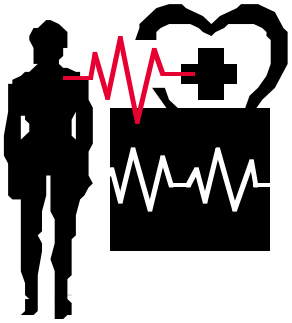
Health assessments identify health problems or needs. Plans are developed by health care professionals in response to identified problems. Plans provide direction for DSP, health professionals, and others in assisting the individual to meet their needs. Plans include a means to determine if what is being done is having the desired effect. A current physical examination and a health history are two essential elements of a health assessment.

A *Physician's Report for Community Care Facilities*, should be completed by the primary care physician when he/she is conducting a physical examination. The *Physician's Report* (a sample follows) describes an individual's current health status, including: the results of tuberculosis testing; the presence or absence of allergies and communicable diseases; whether the person is ambulatory or non-ambulatory; physical health care needs; mental health status; capacity for self-care; over-the-counter medications and conditions for use; and, a list of prescribed medications being taken by the person.

In order to have a complete understanding of an individual's health care needs, it is also important to know and understand an individual's health history. The health history includes information about past (and/or present) illnesses, a family medical history, and a medications history. A typical form for the completion of a comprehensive assessment is the *Health History (*sample follows). Information about each person's health history is obtained from discussion with the individual and those who have known the individual in the past, and from a review of records. Informants may include the individual, parents, regional center service coordinator and clinicians, previous care givers and the primary care physician.

If a person is changing his or her primary care physician, it is a good idea to have the person (or authorized representative) request a copy of his/her medical records be sent to the new primary care physician. It is very important that the new physician have the individual's complete health history. The *Health History* form may be useful to the DSP in gathering this information and sharing it with the primary care physician and others involved in planning and provision of services.

This information from both the *Physician's Report and the Health History* helps those caring for an individual to identify needs for health care services and to assist them in planning for and meeting those needs. For example, information from the *Health History* about a family history of breast cancer may affect plans as the person is at higher risk and may benefit from more frequent or earlier screening.



Health Care Needs or Problems

The DSP should be familiar with the current health status and health history of individuals they work with and be knowledgeable and competent in implementing plans for health care. In order to meet individual health care needs the DSP should be able to identify and understand:

- On-going health maintenance needs, for example, regular physical and dental examinations and screening; and

- How to meet on-going health care needs.

The regional center's Individual Program Plan (IPP) provides information and direction for proper health care and identifies specific responsibilities of the DSP. The IPP is developed by a planning team which includes at a minimum the individual, parents (authorized representative), regional center service coordinator. Planning should involve others including service providers, regional center clinicians, the primary care physician and other invited by the individual to participate. [An *Appraisal/Needs and Services Plan* form (sample follows) is a licensing form that may be used in addition to the IPP.] Problems or needs should drive plans, and plans should provide sufficient direction to everyone, including the DSP, involved in the person's health care to support the individual to meet each need, specifying who, what, how and when and a method of evaluating progress. **Good care depends upon the coordinated, effective teamwork of all of the people involved in the individual's health care.**

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES

For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).

NOTE TO PHYSICIAN:
The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.
The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: | TELEPHONE:

ADDRESS: NUMBER STREET CITY

LICENSEE'S NAME: | TELEPHONE: | FACILITY LICENSE NUMBER:

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME: | TELEPHONE:

ADDRESS: NUMBER STREET CITY | SOCIAL SECURITY NUMBER:

NEXT OF KIN: | PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS: | LENGTH OF TIME UNDER YOUR CARE:

AGE: | HEIGHT: | SEX: | WEIGHT: | IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ NO If YES, list below:

Ambulatory status of client/resident: ☐ Ambulatory ☐ Nonambulatory

Health and Safety Code Section 13131 provides: "Nonambulatory persons" means persons unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. The determination of ambulatory or nonambulatory status of persons with developmental disabilities shall be made by the Director of Social Services or his or her designated representative, in consultation with the Director of Developmental Services or his or her designated representative. The determination of ambulatory or nonambulatory status of all other disabled persons placed after January 1, 1984, who are not developmentally disabled shall be made by the Director of Social Services, or his or her designated representative.

LIC 602 (7/96) *(OVER)*

I. PHYSICAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO	ASSISTIVE DEVICE	COMMENTS:
1. Auditory Impairment				
2. Visual Impairment				
3. Wears Dentures				
4. Special Diet				
5. Substance Abuse Problem				
6. Bowel Impairment				
7. Bladder Impairment				
8. Motor Impairment				
9. Requires Continuous Bed Care				

II. MENTAL HEALTH STATUS: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able To Follow Instructions				
3. Depressed				
4. Able to Communicate				

III. CAPACITY FOR SELF CARE: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO	COMMENTS:
1. Able to care For All Personal Needs			
2. Can Administer and Store Own Medications			
3. Needs Constant Medical Supervision			
4. Currently Taking Prescribed Medications			
5. Bathes Self			
6. Dresses Self			
7. Feeds Self			
8. Cares For His/Her Own Toilet Needs			
9. Able to Leave Facility Unassisted			
10. Able to Ambulate Without Assistance			
11. Able to manage own cash resources			

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS	OVER-THE-COUNTER MEDICATION(S)
1. Headache	_____
2. Constipation	_____
3. Diarrhea	_____
4. Indigestion	_____
5. Others *(specify condition)*	
_____	_____
_____	_____

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

1. _____	4. _____	7. _____
2, _____	5. _____	8. _____
3. _____	6. _____	9. _____

PHYSICIAN'S NAME AND ADDRESS:	TELEPHONE:	DATE:
PHYSICIAN'S SIGNATURE		

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)
I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE	ADDRESS:	DATE:

97 35381

Health History

Biographical information:

Name_____ Gender: ❒ Male ❒ Female Date of birth_____
Nature and origin of disabling condition:_____
Where lived over the past few years:

From/to (MM/YY)	Address (Street, City, State, ZIP)	Person(s) lived with	Phone#

Sources of information (medical records; informants; individuals; etc.):_____
_____
_____
_____

Social Security No._____ Blood type:_____
Medicare No._____ Medi-Cal No._____
Emergency Contact_____ Relationship_____
Phone (days)_____ (other)_____
Emergency Contact_____ Relationship_____
Phone (days)_____ (other)_____
Guardian/conservator_____ Phone:_____
RC Service Coordinator_____ Phone:_____
Primary Physician_____ Phone:_____
Dentist_____ _____

Basic current health information

Allergies_____
Special Medical Conditions_____
Regularly Taken Medications (name; reason, schedule)_____
_____
_____

Personal illnesses

Do you have, or have you had, any of the following?	Yes	No	Year
Allergies	❒	❒	_____
Anemia	❒	❒	_____
Angina or chest pain	❒	❒	_____
Anxiety or Panic Attacks	❒	❒	_____
Arthritis	❒	❒	_____
Asthma	❒	❒	_____
Blood infection	❒	❒	_____
Breathing problem	❒	❒	_____
Cancer or Leukemia	❒	❒	_____
Chicken Pox	❒	❒	_____

Name: _____

	Yes	No	Year
Compulsiveness, persistent	❒	❒	_____
Constipation	❒	❒	_____
Convulsions or seizures	❒	❒	_____
Depression (persistent 'down' mood)	❒	❒	_____
Diabetes or Hypoglycemia	❒	❒	_____
Diarrhea, persistent	❒	❒	_____
Ear Infection	❒	❒	_____
Emphysema	❒	❒	_____
Encephalitis	❒	❒	_____
Glaucoma or cataracts	❒	❒	_____
Hay Fever, Hives or Skin Rash	❒	❒	_____
Headaches, persistent	❒	❒	_____
Hearing Voices	❒	❒	_____
Heart Attack	❒	❒	_____
Heart Murmurs	❒	❒	_____
High Blood Pressure	❒	❒	_____
Immune System Problems	❒	❒	_____
Kidney Trouble	❒	❒	_____
Knee or Hip Replacement	❒	❒	_____
Liver Problems or Hepatitis	❒	❒	_____
Meningitis	❒	❒	_____
Obsessiveness, persistent	❒	❒	_____
PKU	❒	❒	_____
Pneumonia	❒	❒	_____
Reflux or Heartburn	❒	❒	_____
Rheumatic Fever or Rheumatic Heart Disease	❒	❒	_____
Scarlet Fever	❒	❒	_____
Seizures	❒	❒	_____
Stroke	❒	❒	_____
Stomach Ulcers	❒	❒	_____
Thrombophlebitis or Blood Clots	❒	❒	_____
Thyroid Trouble, Goiter	❒	❒	_____
Tuberculosis	❒	❒	_____
Vomiting, persistent	❒	❒	_____
Whooping Cough	❒	❒	_____
Other (specify:_____)	❒	❒	_____
Other (specify:_____)	❒	❒	_____
Other (specify:_____)	❒	❒	_____

Name: _____

Family Medical History

Family member/Name	Health status	Major illnesses*	Cause of death	Age of death
Father				
Mother				
Sibling				
Grandparents				
Others (e.g., uncles, aunts, cousins)				

*Be sure to include arthritis, cancer, diabetes, heart condition, lung disease, mental illness, and stroke.

Medication History

Drug, Dose, Frequency*	Purpose used for	When began?	Stop-ped?	Problems, Side Effects, Allergic Reactions, etc.

*Be sure to include antibiotics that have been problematic, as well as OTC medications

Date Completed: _____ Signed: _____

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

APPRAISAL/NEEDS AND SERVICES PLAN

CLIENT'S/RESIDENT'S NAME	DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE	DATE
FACILITY NAME	ADDRESS			CHECK TYPE OF NEEDS AND SERVICES PLAN: ☐ ADMISSION ☐ UPDATE
PERSON(S) OR AGENCY(IES) REFERRING CLIENT/RESIDENT FOR PLACEMENT			FACILITY LICENSEE NUMBER	TELEPHONE NUMBER ( )

Licensing regulations require that an appraisal of needs be completed for specific clients/residents to identify individual needs and develop a service plan for meeting those needs. If the client/resident is accepted for placement the staff person responsible for admission shall jointly develop a needs and services plan with the client/resident and/or client's/resident's authorized representative referral agency/person, physician, social worker or other appropriate consultant. Additionally, the law requires that the referral agency/person inform the licensee of any dangerous tendencies of the client/resident.

NOTE: *For Residential Care Facilities for the Elderly, this form is not required at the time of admission but must be completed if it is determined that an elderly resident's needs have not been met.*

BACKGROUND INFORMATION: *Brief description of client's/resident's medical history/ emotional, behavioral, and physical problems; functional limitations; physical and mental; functional capabilities; ability to handle personal cash resources and perform simple homemaking tasks; client's/resident's likes and dislikes.*

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
SOCIALIZATION — Difficulty in adjusting socially and unable to maintain reasonable personal relationships				
EMOTIONAL — Difficulty in adjusting emotionally				

LIC 625 (5/93) CONFIDENTIAL

(Continued on Reverse)

NEEDS	OBJECTIVE/PLAN	TIME FRAME	PERSON(S) RESPONSIBLE FOR IMPLEMENTATION	METHOD OF EVALUATING PROGRESS
MENTAL — Difficulty with intellectual functioning including inability to make decisions regarding daily living.				
PHYSICAL/HEALTH — Difficulties with physical development and poor health habits regarding body functions.				
FUNCTIONING SKILLS — Difficulty in developing and/or using independent functioning skills.				

We believe this person is compatible with the facility program and with other clients/residents in the facility, and that I/we can provide the care as specified in the above objective(s) and plan(s).

TO THE BEST OF MY KNOWLEDGE THIS CLIENT/RESIDENT DOES NOT NEED SKILLED NURSING CARE.

LICENSEE(S) SIGNATURE ▶ DATE

I have reviewed and agree with the above assessment and believe the licensee(s) other person(s)/agency can provide the needed services for this client/resident

CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S)/FACILITY SOCIAL WORKER/PHYSICIAN/OTHER APPROPRIATE CONSULTANT SIGNATURE ▶ DATE

I/We have participated in and agree to release this assessment to the licensee(s) with the condition that it will be held confidential.

CLIENT'S/RESIDENT'S OR CLIENT'S/RESIDENT'S AUTHORIZED REPRESENTATIVE(S) SIGNATURE ▶ DATE

Activity: Toward a Health Care Plan

Information about Walter: Walter is a 36 year old and has Down Syndrome. He has lost his left eye and has a glass eyeball that occasionally gets goopey with whitish-gray discharge. He doesn't like to brush his teeth and resists the efforts of staff to help him brush his teeth. When he does brush his teeth, he doesn't do a very good job. Walter has occasional constipation. He is overweight and doesn't get much exercise. He will eat fruits and vegetables, but prefers hamburgers and french fries.

Health Problems: What health and health-related problems (or needs) does Walter have?

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

What questions would you ask Walter's physician and others involved in his health care (parents, regional center clinicians and others who know Walter well) to learn how you can assist Walter to meet the health care needs you identified above? Limit your response to only three of the identified needs.

REMEMBER: Health care plans include (1) identification of a need; (2) plans to meet the need (Who will do what? How often? When?); (3) a method to evaluate the results to determine progress.

Problem: ***Questions to Ask:***

#_____

#_____

#_____

Information Brief

Meeting Medical and Dental Health Care Needs

Scheduling Routine Medical and Dental Examinations

A complete physical examination provides a great deal of useful information, including baseline information (for example, blood pressure, weight) against which subsequent test results can be compared. Each person's IPP should specify how frequently routine physical and dental examinations are to be obtained. The planning team decision will be based upon the individual's current health status, family history, age and gender.

Historically, an annual physical examination was the norm. Increasingly, physicians are recommending age-gender specific schedules for physical examinations and screening. The chart in this guide titled *Preventive Health Care for Children, Adolescents and Adults* provides recommend frequency for health check-ups, vision and hearing teats, Tuberculosis, Pelvic/Gynecological exams and many other screening exams, as well as, recommended schedule for immunizations.

Generally speaking, if you are 18 to 64 years old, you should get health check-ups every 1-3 years, depending upon your health and risk factors. For those who are 65 years of age or older, the individual should get a health check-up every year. Routine examinations should include the physician talking to and observing the individual; measurement of height, weight, and blood pressure; checking immunizations and bringing then up to date; and, doing any procedures called for because of risk factors, age, or gender. A vision and hearing screening may also be included. It is important that a person have routine health check-ups with their physician even if they are not sick or having problems.

Scheduling an Appointment

Call the physician and arrange a mutually convenient time. If the visit is routine, the physician may only schedule a 15 minute appointment. Be sure to mention any specific concerns the individual has that may require more of the physician's time, for example, discussion of an emerging health issue. Also, if the person gets anxious if he/she has to sit and wait for the doctor or has some other special need, mention these when making the appointment and ask for accommodations. Many physician's offices are understanding, and will make arrangements to make things comfortable.

Preparing for an Appointment

Here are some tips to help you and the person in your care prepare for the physician visit and make the most of your time together:

1. Prior to the visit, talk with the individual and other involved in his/her health care to identify any health concerns;
2. Bring a written list of any concerns and questions you and/or the individual may have;
3. Make sure the questions get asked, whether by you or the individual;
4. Make sure you understand what the physician is saying and don't be afraid to ask for clarification;
5. Ask any questions you have about diet, exercise, or smoking;
6. Ask about treatment options;
7. Tell the physician about all medications the person is taking;
8. When the physician writes a prescription, ask questions about the medication;
9. Ask about next steps to be sure you understand what the physician wants done.
10. Encourage the individual to ask questions and express concerns.

Always arrive early or on time for each appointment. If you cannot get there, call well in advance and reschedule.

Recognizing and Advocating for Age and Gender Health Screening Needs

According to *Kaiser Permanente's Healthwise Handbook* (1998):

"Many doctors used to recommend a complete physical every year. Now, most doctors recommend specific medical exams based on age, gender, and risk factors (for example, diabetes, being overweight, high blood pressure, breast cancer in the family). These exams are more effective than the annual physical in detecting treatable illness."

The following health screening guidelines are based on the Report of the U. S. Preventive Services Task Force, which is regularly modified and updated as new evidence accumulates on the cost and effectiveness of screening.

Self-exams
Health screening starts with self-examination. If the individual is able (with or without prompting), he or she should complete regular (or at least monthly) breast and testicular self-exams. When conducting a self-examination, one is looking for change in tissue density (lumps), contours, and the like. Self-examination of a woman's genital area can also be helpful. Here, one is looking for sores, warts, red swollen areas. A physician, nurse or health educator can help individuals in your care learn procedures for self-examinations.

Clinical breast and pelvic exams
Clinical breast examinations (in women) should start at age 20, and be done every 1-2 years. (If the woman has a mother or sister with breast cancer prior to menopause, an earlier start may be warranted.) These exams are done by physicians, practitioners, or gynecologists. A pelvic examination, which includes a pap smear, should be done every 1-3 years starting when a woman becomes sexually active or upon reaching adulthood, whichever occurs earlier. Pap smears detect 90-95% of cervical cancers.

Mammograms
Here, X-rays or ultrasound are used to detect suspicious lumps, tumors, or cysts. Beyond menopause, mammograms save lives, reducing deaths from breast cancer by a third. Most guidelines call for mammograms every 1-2 years after menopause, starting earlier if breast cancer is evident within the family.

Breast cancer is the leading cause of cancer deaths among women 40 to 55 years of age. In accordance with the above guidelines, breast self-examination, clinical breast exams and mammograms can save lives.

Screening for prostate cancer
A prostate cancer screen by a doctor should be done starting at age 50 and yearly thereafter. Cancer of the prostate gland is the most common cancer in men, and the second leading cause of cancer deaths in men. Most such cancer, however, occurs after age 65. The risk is higher-than-average among African-American men, men who eat a high-fat diet, and men with fathers and brothers who have had prostate cancer.

Screening for sexually-transmitted diseases (STDs)
STDs are at epidemic levels in the United States. If a person is sexually active, it is wise to screen for some STDs yearly: Chlamydia and Gonorrhea, in particular. Symptoms for some STDs are difficult to detect (for example, Chlamydia), others may include painful urination (for example, Gonorrhea), jaundice (Hepatitis B), and small, red blisters (for example, Syphilis). If signs or symptoms occur, they need to be brought to the physician's attention right away.

In general, STDs can be prevented by not having sex or by using a latex condom every time a person has sex, whether vaginal, anal, or oral. Hepatitis B and HIV/AIDS can also be spread through exchange of blood (and semen, in the case of HIV).

Other exams
Many other tests should be routinely done periodically at or beyond certain ages. These examinations include blood pressure, sigmoidoscopy (to detect colon cancer) or some other colon cancer screen, and cholesterol readings. Refer to the Preventive Health Care for Children, Adolescents and Adults (following) for information about specific examinations.

Reported Low Rate of Gender Related Screening

A major concern is the very low rate at which gender-related health screening takes place for men and women with developmental disabilities. Findings from a recent review of health records (for one year for women receiving regional center

Preventive Care for Adults

To keep yourself healthy, it is important to have health check–ups with your doctor even if you are not sick or having problems. If you are 18-64 years old, you should get health check-ups every 1 – 3 years, depending on your health and your risk factors. For those who are 65 years old or older, you should get health check-ups every year. If you are a new member of the health plan, you should get a health check-up within 4 months with your primary care provider. Below is a list of tests that should be done for your age group, but your doctor may want to do some tests more often.

TESTS	19 to 39 years	40 to 59 years	60 to 64 years	65 & older
Height & weight	every 3 years	every 3 years	every 3 years	every year
Blood pressure	every 2 years	every 2 years	every 2 years	every year
Stool blood *(colorectal cancer screen)* **OR** Sigmoidoscopy *(colorectal screen)*		at 50 and every year after at 50 and every 10 years after	every year every 10 years	every year every 10 years
Cholesterol *(for men)*	at 35 and every 5 years after	every 5 years	every 5 years	every 5 years
Cholesterol *(for women)*		at 45 and every 5 years after	every 5 years	every 5 years
Immunizations				
Diphtheria - Tetanus vaccine	every 10 years	every 10 years	every 10 years	every 10 years
Tuberculosis *(TB)* test	for people at high risk; every 2 years	for people at high risk; every 2 years	for people at high risk; every 2 years	for people at high risk; every 2 years
Hepatitis B test	18 to 35 and for people at high risk	for people at high risk	for people at high risk	for people at high risk
Pneumovax *(to protect against pneumonia)*				at 65 & as doctor recommends
For Men				
Prostate Cancer Screen *(by a doctor)*		at 50 and every year after	every year	every year
Testicular self-exam *(check for lumps)*	monthly	monthly	monthly	monthly
For Women				
Breast exam by doctor *(to check for cancer)*	every 3 years	every year	every year	every year
Breast self-exam *(do 1 week after menstrual period; check for lumps)*	monthly	monthly	monthly	monthly
Mammogram *(breast x-ray)*	at 35 if you have a family history, you can decide when to have one	at 40 to 49 you can decide when to have one; at 50 to 69 every year	at 50 to 69 every year	at 50 to 69 every year; at 70+ you can decide when to have one
Pap smear *(to check for cervical cancer)*	every 1-3 years	every 1-3 years	every 1-3 years	every 1-3 years

Source: *Adapted from a Newsletter insert, published by* Partnership Health Plan of California (PHC), 1998. PHC is a county-based Health Maintenance Organization, serving Medi-Cal patients in Solano and Napa counties.

Preventive Care for Children and Adolescents

The health plan recommends regular health check-ups for children and teens. Regular health check-ups can help you learn ways to keep your child healthy and to find out about possible health problems early on. As a member, your child or teen is eligible to have preventive health check-up as part of the Child Health and Disability Program (CHDP). The plan recommends health check-ups at the same ages as recommended by the American Academy of Pediatrics and CHDP as shown in the chart below. Your doctor's staff or your doctor should ask questions about your child's health history, growth, development and behavior during healthy check-ups. During health check-ups, you can also expect to learn ways to prevent injury and to learn what to expect as your child grows. Your doctor may recommend additional visits or screenings if needed.

	Ages for Infants and Toddlers (age in months)	**Early Childhood** (age in years)			**Middle and Late Childhood** (age in years)			**Adolescence** (age in years)										
HEALTH CHECK-UPS History, height, weight, blood pressure (starting at age 3) and other important assessments	At newborn, 2-4 days (if needed) 1,2,4,6,9,12,15, 18 and 24 months	3	4	5	6	8	10	11	12	13	14	15	16	17	18	19	20	21
Vision test		•	•	•			•		•			•			•			
Hearing test		•	•	•			•		•			•			•			
Test for Anemia *(blood test)*	Between about 7-9, 13-15, and 24 months	•	•		•			•				•				•		
Urine Test				•	•			•				•				•		
Test for Lead (blood test). Your doctor or staff will also ask questions about possible exposure to lead at check-ups between 2 months and 4-5 years	At 10-12 months and at 24 months																	
Tuberculosis test (TB) (Also recommended for children at higher risk)					•							•						
Pelvic/Gynecological Exam	Recommended for sexually active females and females age 18 years and older																	

Recommended Schedule of Immunizations from Birth to 16 Years Old

Immunizations (shots) protect your child from many serious diseases. It is important to complete all shots in order to help your child to be fully protected. Keep your child's shot record in a safe place and bring it with you to your child's doctor appointments. If you think your child may have missed a shot, or should not have a shot let your child's doctor know. Your doctor may recommend a different shot schedule in order to catch up on missed shots.

AGE	DtaP or DTP (diphtheria, tetanus, pertussis)	POLIO	POLIOMMR (measles, mumps, rubella)	HIB (haemophilus influenza type B)	HEPATITUS B	VARICELLA (chicken pox)
At birth					✿ (between birth-2 mo)	
2 months	✿	✿		✿	✿ (between 1-4 mo)	
4 months	✿	✿		✿		
6 months	✿			✿ (If required)		
6-18 months		✿	✿ (12-15 months)		✿	
4-6 years	✿	✿	✿			
11-12 years	✿ (Tetanus/ Dip booster)				✿ (If child has not already had 3 doses)	✿ (If child has not had vaccine or chicken pox)
14-16 years	✿ (if needed)					

services in one California County) indicate that:

- ✓ only 22% of women 40 years of age or older had a mammogram during the year; and
- ✓ only 4% of the women 18 years of age or older had a pap smear.

In effect, this means that older women were getting mammograms about every five years (recommended every 1-2 years after menopause), and pelvic examinations about every 20 years (recommended every 1 to 3 years for all women). Clearly, these rates are unacceptable. Among non-disabled women, 80% have a pap smear every two years. It is important for the DSP to be aware of age-gender related screening guidelines in order to assist in the identification of individual needs.

Routine dental examinations
Yearly dental examinations for each individual should include (1) professional cleaning; (2) X-rays; (3) a visual examination of the teeth and mouth by the dentist and (4) the dentist reading the X-rays to identify any problems needing follow-up. If additional work is needed, follow-up visits are scheduled.

Denti-Cal (dental insurance) routinely covers one dental office visit per year. If a person has a health condition, for example cerebral palsy, that calls for seeing the dentist more often, dentists can apply for a Denti-Cal treatment authorizations to see the person more frequently.

Minor Illnesses

If a person has some of the following symptoms, he or she probably has a cold or the flu: stuffy nose; runny nose; cough; sore throat; headache; fever; tiredness; and/or muscle aches. Both are viral infections. Plenty of rest, fluids and over-the-counter medicines (with a physician's order) are probably all that the person needs to get better. Keep the person comfortable, while his or her body fights off the infection. Remember, thorough handwashing can help prevent the spread of infection.

Especially if the person has impaired physical health (for example, medical fragility), be sure to call the physician and see if he or she should be seen. While antibiotics will not affect the course of a viral infection, secondary bacterial infections can arise, and need to be addressed quickly.

Managing Chronic Health Care Conditions

We have already spoken about the importance of health care plans. This applies to both minor and major illnesses. For major illnesses, such as asthma or diabetes, more intensive planning, training, supervision, and other support are needed. As this curriculum is designed for *all* DSPs, details on proper care or management of chronic health conditions will not be discussed. Talk with the person's physician and other health care providers. Your regional center nurse may be helpful, and should have procedural guidelines (called *protocols)* for most chronic health conditions requiring specialized care.

Personal Hygiene (Hair, Skin, and Nails) and Care of Teeth

Hair
Hair should be shampooed regularly. Skin cells flake off. If the skin cells are on the scalp, they mix with oil and dust and are called ***dandruff***. Frequent and vigorous shampooing may help to prevent dandruff. If a person develops dandruff, a dandruff shampoo may help prevent flaking.

Occasionally, people get head lice (tiny, white, wingless insects) that feed on the skin and blood. Lice lay tiny eggs, called nits, and cause mild to severe itching and rash. If a person in your care gets lice, check with their physician. The physician typically recommends treatment with over-the-counter medications (medicated shampoo).

Anyone coming in contact with a person who has lice can get lice (it's very contagious). Indirect contact with clothing of the infected person may spread lice to others. Clothing and linens should be washed in hot soapy water or dry cleaned. Follow the physician's recommended treatment and wash clothing and linens to guard against spread and re-infestation.

REMEMBER: Over-the-counter medications cannot be used in a CCF without a physician's specific written order.

Skin
Guard against ***sunburn***, by wearing a broad-brimmed hat and loose clothing, and staying out of direct sunlight. If spending a lot of time out of doors in sunlight during the hottest part of the day, use a sun screen with a sun protection factor (SPF) of at least 15.

Skin breakdown is a serious and ever present concern for people who use wheelchairs and/or do not move about and change positions. When skin breakdown occurs or is suspected, the person must be seen by a physician immediately and treated according to their directions. Skin breakdown can be prevented by frequent moving about and/or changing positions and keeping the skin dry and clean.

Athlete's foot (tinea pedia) and Jock Itch (tinea cruris) are fungal infections. Like bacteria, fungi grow best in warm, moist areas of the skin, such as between the toes or in the groin. Problems can be prevented by thorough drying off, wearing sandals or shoes that "breath", wearing cotton underclothes and socks, and using talcum powders. Be sure to clean both areas.

The number of skin problems is very long. Here are some additional skin problems to be concerned about:

acne
bee stings
boils
chickenpox
cool, clammy, pale skin
cradle cap
diaper rash
eczema
fungal infections
hot, dry and red skin
ingrown toenails
itching
jellyfish stings
melanoma
mosquito bites
atopic dermatitis
blisters
burns
cold sores
corns & calluses
cuts
dry skin
frostbite
hives
impetigo
insect bites
jaundice
Lyme disease
moles
pimples

plantar warts
prickly heat
rashes
roseola
scrapes
skin cancer
unusual sores
yellow skin
poison ivy, etc.
psoriasis
ringworms
scabies
shingles
spider bites
warts

Some skin problems are very serious. Others are uncomfortable and passing. Some skin problems can be prevented, or at least minimized through diet, proper clothing, and other actions. Some skin problems may be spread by contact, so remember to use handwashing and other infection control techniques. Always seek advice and treatment from the person's physician when new problems arise, or existing problem don't get better.

Teeth

Proper dental hygiene, combined with regular professional exams and cleaning, pays great dividends. The DSP can help by encouraging good dental hygiene practices, helping the person obtain any adaptive equipment needed (for example, large handle toothbrush), and offering training and assistance when needed. Individuals should:

- ✓ Brush their teeth at least twice a day, using a soft-bristle toothbrush;
- ✓ Fluoride toothpaste, and spending at least three minutes brushing all surfaces thoroughly, especially around the gum line. (It is the mechanical motion that loosens and sweeps away plaque.)
- ✓ Floss periodically and every day if possible.
- ✓ Purchase new toothbrushes frequently.
- ✓ Avoid long periods of time with sugary substances (or residue) in the mouth.

Nails

Fingernails and toenails should be kept trimmed and clean. Toenails should be cut straight across, so that the nail edges do not cut into the skin at the edge. Shoes should be loose enough in the toe box, so that pressure is not placed on the toe and nail. Ingrown nails can be quite painful, and infection can develop.

The services of a podiatrist may be particularly helpful when cutting toenails, especially if the person:

- ✓ Has diabetes (any foot infection can be very serious - **always consult the physician before trimming the toenails of someone with diabetes**);
- ✓ Has circulatory problems (for the same reason); and
- ✓ Has toenail fungus (specialized equipment may be needed and again there is risk of infection).

Be sure to ask the individual's physician for directions. Always seek medical attention if signs of infection occur: swelling, redness, red streaks extending from the area, discharge of pus, fever of 100 degrees F or higher with no other cause.

Information Brief

Vital Signs

Temperature

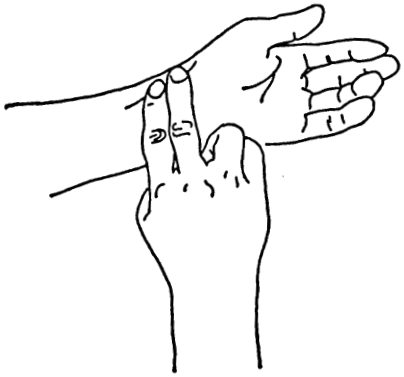
There are various methods of taking body temperature: (1) skin temperature (not very accurate); (2) ear temperature (very accurate); and (3) conventional glass thermometer (not very accurate). If a person's temperature is taken by a conventional thermometer: (1) wash the thermometer in cold or lukewarm, soapy water; (2) soak in alcohol; and (3) shake down the thermometer, so the reading is about 95 degrees F.

Typically, a person's temperature is taken under the tongue, with mouth closed (breathing through the nose), for several minutes. An oral thermometer should not be used for someone with a history of seizures, breathing through mouth, has just had oral surgery, or is unconscious.

Normal temperature is 98.6 degrees F. Anything within a degree either side (97.6 to 99.6) is considered normal. One can take a person's temperature under the armpit (with tip of the thermometer against dry skin and held in place by the arm), waiting 5 minutes (not 4). Electronic thermometers and pulse meters have dropped in price, and are very convenient for taking temperatures and pulses, either in the ear or at a person's fingertip.

Pulse

Typically, a person's pulse (beats per minute) is taken on the inside of the wrist, using the first two fingers pressed against the skin. Don't use your thumb, because you could end up "reading" your own heart beats. Count the number of beats over a fifteen second interval, and multiply by 4. Repeat the process to check for consistency. A normal pulse will be about 70 beats per minute. Anything from 50 to 90 is not uncommon for an adult. If it is hard to feel the pulse in the wrist, locate



Taking a Pulse

the carotid artery in the neck, just to either side of the windpipe, and press gently. Count the beats for 15 seconds, and multiple by 4 to estimate the number of beats per minute.

Respiration

Respiration (breaths in) is best counted without telling the person what you are doing. Awareness can change how a person breathes. It sometimes helps to be looking down, so as to see expansion of the chest. In children above the age of 7 through adulthood, a normal respiration rate will be 12 to 24 breaths per minute. Pay close attention not only to rate, but to wheezing, other sounds, ease or difficulty breathing.

Blood pressure

Blood pressure refers to the force of blood pushing against the walls of the blood vessel. Blood pressure for adults 18 years of age and older in the following categories:

- *Normal* – Below 130/85;
- *High-normal* – 130-139/85-89;
- *High* – 140/90 or higher.

Normal blood pressure for children is lower. The first number is the *systolic* measure, where the device that measures pressure by constricting the arm (or leg) first lets blood course through the vessels; the lower number is the *diastolic* measure that records pressure when the blood is no longer heard. High blood pressure (*hypertension)* is often called a "silent killer," because symptoms of any kind are rare, and such pressure, if persistent, can harden arteries and result in strokes, heart attacks, and kidney damage.

Blood pressure is affected by time of day (low at night; peak about 8 hours after awakening); emotions (stress increases blood pressure); weight (obesity typically increases blood pressure); activity level; excess sodium (salt) intake; excess alcohol consumption; and use of certain drugs, including birth control pills, steroids, decongestants, and anti-inflammatories. If high blood pressure is suspected, the DSP should make sure consistent readings are taken over a period of time. Blood pressure should be measured with the same device, same time of day, same arm (or leg), with individual in same position (for example, sitting up). Mark down anything that might have affected the blood pressure, such as exercise (for example, came in 10 minutes before from riding a bike).

Observation of Signs and Symptoms

Observation is about noticing ***change*** in a person's attitude, behavior, or communication (ABCs). When we observe changes, these are called *signs.* The sign may be of a *symptom* of a disease, illness, or injury. It may also mean that someone is getting better. Signs and symptoms are objective if the DSP can observe them using senses of:

- Sight (for example, rash; reddened area; swelling; rapid breathing; cloudy urine; tears; emotional outburst; aggression; property destruction; change in eating or sleeping pattern; etc.)

- Hearing (for example, labored or noisy breathing; crying; moaning with pain, coughing; yelling)

- Touch (for example, skin hot, moist, or cold; change in pulse rate; puffiness of skin; slight finger pressure results in wincing), or

- Smell (for example, fruity breath; foul smelling urine; foot odor; etc.).

It is helpful to distinguish objective *signs* and *symptoms* from subjective ones. The latter are experienced by the person. Subjective experiences are things a person feels (for example, pain) and describes to others. Aside from pain, several matters, such as ringing in the ears, headache, feelings of sadness, and the like, are important subjective experiences (or felt) which can be signs and symptoms of illness or injury, or changes in function. The distinction between the objective and the subjective is important, because many people with developmental disabilities have difficulty communicating with others. If a person cannot express how he/she feels, one may have to rely totally on objective indicators. This puts the pressure of discovery on the DSP and others. And, it makes awareness of health issues and diagnosis of health problems more challenging than it is for people who can communicate well. In general, more diagnostic tests will be needed to rule out possibilities.

In some cases, the objective and the subjective coincide. For example, a person may have a "feeling of dizziness," and crouch down and extend the arms to prevent a fall. Itching (an internal feeling) may coincide with scratching (something an outsider can see). Here is a list of some *signs* and *symptoms* of possible health issues:

skin rash	crying
bad dreams	rapid pulse
headache	nausea
vomiting	cloudy urine
gas pains	toothache
edema or swelling	coughing
ringing in the ears	depression
difficult, painful breathing	drainage
redness	not eating
elevated temperature	dizziness
inability to sleep	fruity breath
noisy breathing	chest pain
itching	scratching
chewing of hand	uneven sitting
head banging	head tilt
rubbing chest	rocking
pica	

Recognizing signs and symptoms of illness or injury, and responding appropriately can save lives.

Abnormal Pattern of Bowel Movement

Each person has a pattern of bowel movements that is "normal" for that person. Part of getting to know about individual needs is learning what the normal pattern of bowel movements is for that person. Once the normal pattern of bowel movements is established the DSP should look for any indication of a change. When an individual is not able to tell you that they had a bowel movement, the plan for that individual may include keeping a record of bowel movements.

Constipation is a symptom of a problem. Untreated constipation can lead to serious consequences including the need for surgical removal of the impacted fecal matter, rupture of the bowel and even death. People who are inactive, drink small amounts of fluids, have a low fiber diet, and take certain medications may be prone to constipation.

Signs and symptoms of a problem with constipation include:

1. A change in the normal pattern of bowel movements.
2. Loss of appetite, increase in sleepiness and fussiness.
3. Abdominal bloating.
4. Persistent abdominal pain (person is holding their abdomen).
5. Oozing of liquid stool.

If you observe any of these symptoms, call the individual's primary physician immediately.

Activity: Signs and Symptoms

DIRECTIONS: At each table, list at least three **signs** or **symptoms** observable by the DSP, or told to the DSP, in the following areas: (*NOTE:* You can ask a question to learn a symptom. For example, "Do you itch anywhere?")

1. Eyes, Ears, and Nose	
2. Mouth and Throat	
3. Head, Neck, and Shoulders	
4. Muscles and Bones	
5. Eating and Drinking	
6. Breathing	

7. Abdomen, Bowels, and Bladder	
8. Pain	
9. Sleeping	
10. Skin	
11. Thinking, feelings, emotions	
12. General level (or type) of activity	

Remarks, if any:

Information Brief

Seizures

Seizures call for mindful observation, especially when occurring for the first time in a person's life (or recent experience). Seizures were once classified as *petit mal* and *gran mal.* Today, the classification has two major categories, *partial* and *generalized.* This refers to origin in the brain. If a seizure begins locally in the brain it is *partial*; if it encompasses the entire brain, it is *generalized*. A *petit mal* is now known as an "absence seizure" (person stares off into space for a moment or two), and is not followed by confusion. Knowing general types of seizures is important to the neurologist in finding the right medication to prescribe. The DSP's job is not to diagnose, but to report on what happened during a seizure and, as appropriate, how long the person was unconscious.

Partial —

1. *Simple Partial*. Person remains conscious; seizure starts in a particular area of the brain; symptoms can involve movement, sensations, or feelings; an "aura" is a simple partial seizure, that may generalize.

2. *Complex Partial.* Consciousness is altered (person cannot remember it; confusion afterwards); often involve motor movements (lip smacking, tonic posturing, wandering about aimlessly).

3. *Partial, Secondarily Generalized*. Here, the partial seizure generalizes (i.e., quickly encompasses the whole brain).

Generalized —

4. *Tonic/clonic* (previously *gran mal).* – If truly a generalized seizure from the outset, there can be no "aura." This type of seizure results in a total extension of the trunk for some period of time (say, 15-30 seconds), followed by a number of seconds of shaking, followed by flexion and extension of the arms. With muscles contracting, blood pressure rises, pulse increases quickly, and dilation of the pupils occurs. The person may lose control of bodily functions and urinate. Recovery time can vary from a few minutes to a few hours.

5. *Absence* (previously *petit mal).* – These seizures, seen in some preadolescent children, typically last only a few seconds and often involve simple staring or eye blinking. Motor control is generally maintained.

6. *Myoclonic seizures*. – These often look like startle responses, and are often frequent but missed in persons with complex physical disabilities.

7. *Atonic seizures* (or, drop attacks). – These often result in facial or other head injuries. To prevent injury, many people subject to such seizures wear protective head gear.

8. *Tonic seizures*. – These seizures involve total body extension, stiffening of the extremities, and abrupt loss of consciousness. Such seizures only occur among individuals with mental retardation.

Status epilepticus, stemming from either a partial or generalized seizure, is potentially life-threatening. It is defined as either repetitive tonic/clonic convulsions (without recovery) or a single, prolonged seizure. Brain damage can occur after about 20 minutes of seizuring. Hence, if this is a person's first [known] seizure, and it lasts for 10 minutes or more, get help right away. Call **911.** Otherwise, call the physician, who may want to see the person at his/her office or at the Emergency Room. The physician may want to examine spinal fluid to rule out infection or do other tests. If a person has a history of seizures, consult with the neurologist. He may want to prescribe an "as needed" medication for repetitive seizuring on a given day. He may want you to call **911** after some number of minutes (say 10, 15, or 20), depending on the individual.

Seizures: what to do

When a seizure occurs, the DSP should do two things. One is to help protect the person from injury. The other is to observe the event carefully, and to document what occurred, including how long the person was unconscious (if loss of consciousness occurred). This information can be vitally important to the person's health care professional, especially if there is something new. Details are helpful in making a proper diagnosis which, in turn, is related to the intervention (for example, a particular drug or class).

Here are first aid rules for seizures:

1. Keep calm! The person is usually not suffering or in danger.

2. If falling, ease to the ground (or floor) and keep head away from objects (for example, furniture) to avoid injury. If a pillow is available, place under head.

3. Loosen tight clothing. Do <u>not</u> restrain movements.

4. If the person is unconscious, turn the person on side with face turned gently sideways or slightly down.

5. Do <u>not</u> put anything into the person's mouth.

6. Give nothing to drink.

7. Reassure the individual.

8. Stand by until consciousness returns and confusion abates. A test is whether the person can respond to questions or directions.

9. Allow a rest period (10-30 minutes for most people), then encourage participation in regular activities.

10. Document in individual's log.

It is rarely necessary to call Paramedics; however, in cases of prolonged seizures, recurring seizures, or injury, get professional advice and assistance.

Activity:
Understanding Seizures and Seizure First Aid

Watch the videotape from the Epilepsy Foundation of America, and then answer the following questions:

1. **When a seizure occurs, what is happening inside the person's brain?**

2. **To assist a person having a tonic-clonic (i.e., gran mal) seizure, what should you do? Not do? Why?**

3. **To assist a person having a partial seizure that doesn't generalize, what should you do? Not do? Why?**

4. **Under what circumstances involving a seizure would it be appropriate to seek medical care right away?**

Information Brief

Working with Health Care Professionals

Personal Health Advocacy

There are two ways of working with doctors and other health care professionals. One is to be an active partner, providing information, asking questions, discussing options, and contributing ideas as to what actions will be taken. The other, more traditional approach is to be *passive and accepting*, treating the doctor and others with great deference and asking them to do all the thinking and all the work. With rare exceptions, physicians prefer the former to the latter.

We strongly recommend the *active partner* approach, because it will improve the quality of care. Here are some basic attitudes that will help you to help individuals achieve the best possible health:

- ✓ *Believe* that every person is entitled to *quality care* and that you can make a positive difference in advancing the good health of the person in your care.
- ✓ *Be persistent*. Talk with people, ask for leads, and don't give up until the person in your care gets appropriate care.
- ✓ *It's never too early and it's never too late.* If the person in your care has not been well taken care of, don't continue that practice. Do the very best you can from here on out.
- ✓ If you don't take good care of your own health, or if you are skittish about seeing health care professionals, do not convey that to the person in your care by words, body language, or in any other way. If you cannot be confident and an *active partner*, get the help of someone who can.
- ✓ Don't be afraid to *ask for help* and any other support you need. There is a solution to most health care problems, but you may have to work to find it. You are not alone; other people (parents, regional center staff, other DSPs, friends) are there to help.
- ✓ *Be prepared*. Know what you want to talk about when meeting with health care professionals, many of whom are very busy. Keep good records, and summarize symptoms and signs accurately. If a diagnosis is unclear, and the person in your care uses few if any words, ask for tests to rule things in or out.
- ✓ *Choose a primary care physician with a reputation for good service*. Make sure he/she has hospital privileges at a nearby hospital. If the person in your care is hospitalized, stay with the person and advocate for prompt, good quality service.

Preparing for Medical Visits

Working in partnership with health care professionals calls for (1) a common goal (good quality care); (2) shared effort (each one doing the right thing); and (3) good communication. Here are five ways to be a good partner (adapted from materials by Kaiser Permanente):

1. Take good care of yourself and of others in your household.
2. At the first sign of a health problem, observe and record signs and symptoms. Record when, how long, how painful, etc. Measure and record vital signs, such as temperature and pulse rate.
3. Provide good care at home for minor problems; call the physician if minor problems don't go away or get worse.
4. Prepare for office visits, by doing your homework and being well organized. Prepare an *Ask-the-Doctor Checklist* like the one on the next page. Update and bring the list of signs and symptoms and of what has been done to help. Write down your main concern (chief complaint) and practice describing it. Write down any hunches about what is wrong. Write down the three questions you want answered the most. Bring along a list of medications the person is taking.
5. Play an active role in the office visit. Be candid and honest. Share your hunches and fears. Don't hold back. Get information regarding drugs, tests, treatments. Take notes. Keep good records.

Documentation and Follow-Up

Title 17 regulations require the residential service provider to keep an accurate record of office visits, phone calls, and other interactions with health care providers. (See sample forms and tips for staff in documentation later in this guide.)

Community Health Care and Safety Resources

In responding to a person's health care needs, you must often search out resources relevant to those needs and access them. Basic resources are:

1. a primary care physician (or group);
2. a dentist who does family or general dentistry;
3. specialists (for example, an eye doctor, gynecologist, podiatrist);
4. regional center clinicians;
5. other resources needed to address individual needs (for example, a support group for people struggling with kidney disease); and
6. information sources (for example, self-care handbooks; voluntary organizations like the American Cancer Society, the Heart Association; internet resources).

If there is a "need," there is something or someone who can help somewhere. It is up to the DSP and others on the individual's team to find and use services appropriate to each individual's needs.

Ask-the-Doctor Checklist

Date: _____

Individual's Name: _____

Step 1. Before the visit:

a. Complete the "Keeping Track and Initial Care," on the next page.

b. List all medications being taken:

Name	Purpose	Prescriber	Dose/frequency

Step 2. During the visit:

c. The main health problem is_____

_____

d. Signs and symptoms have been (from preceding page) . . .

e. Past experience with this problem has been_____

_____

Step 3. Write down:

f. Temperature_____ Blood pressure_____/_____

g. The diagnosis (what's wrong) is _____

h. The prognosis (what might happen next) is _____

i. The home care plan is _____

_____

_____

_____

Step 4. For drugs, tests, and treatments, ask:

j. What's its name?_____

k. Why is it needed?_____

l. What are the risks? Expected benefits?_____

m. Are there alternatives?_____

n. What are the risks? Likely benefits?_____

o. [*for drugs*] How should it be taken?_____

p. [*for tests*] How do I prepare?_____

Step 5. At the end of the visit:

q. What danger signs should I look for?_____

r. When do I need to report back?_____

s. Are we to return for another visit?_____

t. Are we to phone in for test results?_____

u. What else do we need to know?_____

_____

_____

_____

_____

Keeping Track, and Initial Home Care

Date: _____

Individual's Name: _____

Step 1. Observe the Problem.

a. What are the signs? symptoms?_____

b. When did they start?_____

c. Vital signs?

Temperature_____ Blood pressure_____/_____

Pulse_____ Breaths_____/minute_____

d. Thinking back:

Had the problem before? ❒ Yes ❒ No

What did you do for it?_____

Any change in life (stress, medications, food, etc.)?_____

Anyone else at home or work have these signs or symptoms?_____

Step 2. Learn more about it.

e. Books, articles, web sites_____

f. Advice from others (lay, professional)_____

Step 3. Make an action plan.

g. "Tentative" diagnosis_____

h. Home care plan_____

i. When to call the doctor_____

Step 4. Evaluate progress.

j. Are your actions working?_____

Log of Health Care Visits and Consultations

Name:_____ DOB:_____

Date	Health care professional (name)	Phone? Y N	Reason/ Subject	Outcome/ Result	Follow-up or Notes (e.g., meds)

Smith Family Care Home, 1234 Main Street, Any City, CA 90000. Ph: (123) 456-7890

Activity:
Recording Visits and Phone Calls with Health Care Providers

Client's Name: Jane Doe DOB: 7/30/74

Events:

1. It is March 27th. Over the past month, Jane Doe, who is 5' 2" tall, and currently weighs 175 lbs., gained 7 lbs. She and her care-provider are concerned about her weight. They call her primary care physician, Dr. Burns, whose front-office staff schedule an appointment for April 10.

2. On April 10, Jane is seen by Dr. Burns. At the office, the nurse writes down Jane's complaint (being overweight; rapid recent weight gain), and takes a few measures: Weight: 178 lbs.; Pulse: 76; Blood pressure: 140/92. Dr. Burns talks with Jane and Mrs. Smith, the care-provider, and does some checking with his stethoscope, a light, and tongue depressor. He orders some blood tests at a local lab. He learns that Jane, in a rush to get to her job, typically skips breakfast. She began working at a fast food restaurant six weeks ago, and eats her lunch there (sometimes 2 double-hamburgers and 2 large orders of French fries). Dr. Burns recommends that Jane (1) eat breakfast at home; (2) cut back to 1 hamburger and 1 order of French fries at lunch (or, even better, a grilled chicken sandwich and a small salad); (3) begin walking at least one mile each day; and (4) come back in for a blood pressure check in three months.

3. The next day, April 11th, Jane has blood drawn at the lab used by Dr. Burns's patients, and the lab says they will fax the results to Dr. Burns. They say "no news is probably good news," if you don't get a call from Dr. Burns's office about the lab work.

4. A month later, concerned that Jane hasn't lost any weight (but hasn't gained any either), Mrs. Smith calls Dr. Burns's office, and after checking with him, his nurse asks Jane to come in the next day (May 15) for a blood pressure check.

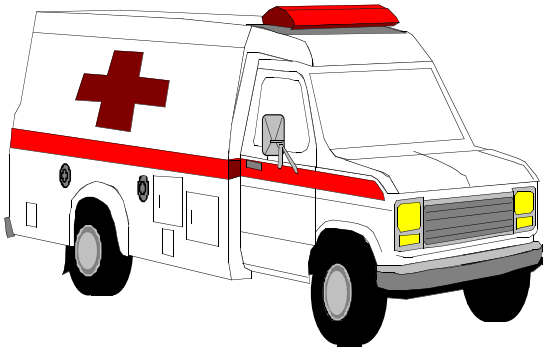
5. On May 15, Jane has her blood pressure checked, and it is 138/86. Her pulse is 76. Her weight at the office is 174 lbs. The nurse asks questions about breakfast, lunch and walking; encourages Jane (and Mrs. Smith) to continue their effort; and no change is made in Jane's scheduled appointment with Dr. Burns on July 7th.

Information Brief

Medical Emergencies

What is a Medical Emergency?

A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention. Some emergencies call for an immediate response to protect life. All emergencies call for prompt medical attention, either by calling **911,** and having paramedics involved, or by calling a Poison Control Center (**1-800-8-POISON**) and getting advice, or by taking the person to an Emergency Room (ER) or Urgent Care Center where a triage nurse will determine the speed of response. If the implications of the emergency are uncertain, it helps to be at the ER to wait and see. That way, if the person takes a turn for the worse, getting medical help can take less time.



Call for Help

In general, one should always call **911** if the person:

- is or becomes *unconscious;*
- has *no pulse;*
- has *trouble breathing* or is *breathing* in a strange way;
- has *chest pain* or *pressure;*
- is *bleeding severely;*
- has *injuries to the head, neck, or back;* or
- has gone into *shock.*

If the above conditions do not apply, but any of the following is present, one should either call **911,** or POISON CONTROL, or take the person quickly to the Emergency Room at a local hospital:

- has persistent pressure or pain in the abdomen;
- is vomiting blood or has blood in bowel movement (red or black);
- has a seizure lasting 10 minutes or more;
- appears to have been poisoned;
- has possible broken bones, but can be moved without further damage;
- has systolic blood pressure reading over 200 (or under 80), or diastolic pressure under 50 (or over 120).

Regardless of the nature or extent of injury, as viewed at the scene, it is wise to call **911** if any of the following circumstances apply:

- fire or explosion;
- downed electrical wires;
- swiftly moving or rapidly rising water;
- presence of poisonous gas;
- vehicle collisions with injuries; or
- the person needs medical attention and cannot be moved easily.

What to do until medical help arrives

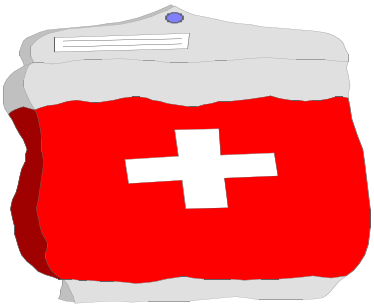
1. STAY CALM, so that you can reassure the person and not add to fear and concern, which in and of itself is understandable but not helpful.

2. STAY WITH THE PERSON.

3. MAINTAIN AIRWAY, if necessary by tilting the head back.

4. CONTROL BLEEDING, by application of pressure, or use of a tourniquet if necessary.

5. TREAT FOR SHOCK, by having the person lie down, loosen clothing, cover with a blanket, and seeking medical attention.



6. HAVE A CURRENT MEDICAL HISTORY READY TO GIVE TO THE PARAMEDICS TO INCLUDE, AT A MINIMUM

   - Name, DOB, current address, and phone#;
   - Current medications;
   - List of allergies;
   - Insurance information (for example, Medi-Cal card);
   - Information about what happened and when; and
   - Physician's name and telephone number.

It is a good idea to have *all* health information, including a copy of the person's health history and consent-to-treatment forms, in a separate folder. An excellent example is the *H.E.A.R.T. Wellness Journal*, developed under a Wellness Grant from the Department of Developmental Services, for Alta California Regional Center. (See Additional Resources, near the end of this *Resource Guide.)*

First Aid

Immediate, life-saving techniques are learned and are taught in first aid and CPR classes. First aid is required by Community-Care Licensing regulations. CPR is a great skill to have. The Red Cross and other organizations offer these classes.

Medical emergencies call for action. Some (not being able to breathe, and/or no pulse) call for immediate action on the scene. First aid techniques include:

- ✓ Abdominal Thrusts;
- ✓ Rescue Breathing; and/or
- ✓ Cardio-Pulmonary Resuscitation (CPR).

For example, common causes of choking include trying to swallow large portions of poorly chewed food; eating while talking excitedly or laughing; eating too fast; and walking, playing, or running with food or objects in the mouth. Signs and symptoms of choking include:

- clutching the throat with one or both hands;
- unable to speak, cough forcefully, or breath; and/or
- high-pitched wheeze.

If someone is choking, quick, upward abdominal thrusts (Heimlick Maneuver) will usually dislodge the object stuck in the person's windpipe.

Major injuries

Shock. – Major injuries can cause shock, as can exposure to some allergens (certain foods, medications). Bleeding, loss of body fluids, infection and lack of oxygen cause shock. Signs are pale bluish skin, moist clammy skin, weakness, rapid pulse, harder breathing, thirst, vacant expression, dilated pupils, and death.

Head/brain, neck, or back injuries. – Maintain airway, control bleeding, treat for shock, seek medical attention, immobilize if possible, and record the extent and duration of unconsciousness.

Broken bones. – Immobilize, splint (if time and materials permit), control bleeding, treat for shock, and seek medical attention.

Minor injuries

Wounds. – A "wound" is a break in the continuity of the tissues of the body, either internal or external. Accidents (for example, being hit by a car; falls; mishandling sharp objects) are the usual cause. First aid involves:

- ✓ stopping the bleeding (pressure bandage or direct pressure);
- ✓ protecting from contamination and infection;
- ✓ treating for shock; and
- ✓ obtaining medical attention, if needed.

Removal of foreign object. – Wood splinters and other items just under the skin can be removed by most people, using tip of sterilized needle or sterilized tweezers. A flame or boiling water will kill contaminants. If an object is embedded deeper in tissue or protruding, go to Doctor's office, the Emergency Room or Urgent Care Center.

Blisters caused by friction. – Best to leave unbroken; apply sterile dressing for protection from further irritation; treat as open wound is blister is broken (i.e., wash with soap and water; cover with sterile dressing).

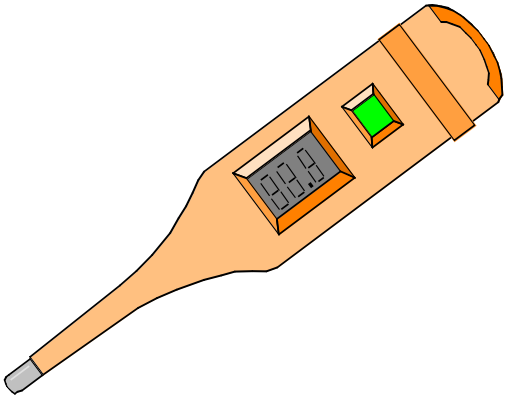
Burns. – Minor burns (for example, sunburn; contact with hot objects) are treated by submerging in water and applying a dry dressing if necessary. *Second degree* burns, which are deeper, causing blisters and being wet in appearance, are treated by immersing in cold (not ice) water, blotting dry, applying sterile dressing, avoiding ointments, and elevating limbs. *Third*

degree burns are those with complete loss of all layers of skin and a white, charred appearance, are treated by leaving clothes in tact, watching for possible breathing complications, not immersing in ice water (can cause shock), apply cold packs to face, hands, or feet for comfort, and seeking immediate medical attention.

Eye injuries/foreign objects. – Keep person from rubbing eyes; wash hands before examining eye; if not embedded, flushing with water. If embedded, applying dry dressing and seeking medical attention.

First aid supplies

Every community-care facility (CCF) must have the following minimum supplies at a central location within the home:



- a current edition of a *first aid manual* approved by the American Red Cross, the American Medical Association or a state or federal health agency.
- Sterile first aid dressings.
- Bandages or rolled bandages.
- Adhesive tape.
- Scissors.
- Tweezers.
- Thermometer.
- Antiseptic solution.

Make sure that you know where these supplies are in the home where you work.

Answers to In-Class Review

1. How do health assessments relate to health care plans? What are two elements of an initial health assessment?

Health assessments identify health problems or needs. Plans are developed in response to identified problems. Plans provide direction for DSP, health professionals, and others in assisting the individual to meet their needs. Plans include a means to determine if what is being done is having the desired effect. A current physical examination and a health history are two essential elements of a health assessment.

2. Why are physical examinations helpful?

Physical examinations are helpful in picking up health problems in early stages.

3. In helping people care for their teeth and nails, what should the DSP do?

Good dental hygiene contributes importantly to keeping one's teeth and avoiding the cost and pain of major restorations and other work (for example, deep scaling because of periodontal disease). The DSP should encourage and assist with such hygiene, and actually brush a person's teeth if the quality of their own brushing and flossing is inadequate. Fingernails, and especially toenails, need to be cut carefully and in a way (straight across) that avoids injury and infection. This is especially true for individuals with diabetes, circulatory problems, and toenail fungus. In these instances, a professional (for example, podiatrist) should typically cut toenails.

4. What should you do to get ready for an appointment with a health care professional?

Talk to the individual ahead of time about their health concerns. Have written questions or concerns ready to talk about the things important to the person. Be able to report signs and symptoms can be very helpful for the practitioner in coming up with a diagnosis. And, if medicine is prescribed, the physician will want to know what other medications (both prescription and over-the-counter) are being taken.

5. What is the relationship between the following: (a) observation; (b) change; (c) objective signs; and (d) subjective feelings?

Observation is based on sight, hearing, touch, and smell. Through these senses, the DSP is alert to change that can signal a health problem. Objective signs and symptoms are thing that an outsider (like the DSP) senses. Subjective signs (for example, pain, headache, dizziness, itching) are feelings of the person, and may (or may not) be conveyed through some form of communication. Sometimes, subjective feelings (for example, itching) coincide with objective signs or symptoms (for example, rash; scratching).

6. What is a medical emergency? When should a person call 911?

A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention. In general, one should always call 911 if the person (a) is unconscious; (b) has no pulse; (c) has trouble breathing; (d) has chest pain or pressure; (e) is bleeding severely and it cannot be stopped; (f) has injuries to the head, neck, or back; or (g) has gone into shock.

If You Want to Read More About
Wellness

A Parent's Guide to Medical Emergencies

by Janet Zand, Rachel Walton, and Bob Roundtree (1997); Avery Publishing Group; ISBN: 0895297361

This book provides guidance for parents in meeting the emergency needs of their children.

Assessing Health Risk in Developmental Disabilities

By Karen Green McGowan & Jim McGowan (1995); McGowan Publications; ISBN: None

This book explains the rationale and use of KMG Fragility Scale.

First Aid Fast

by American Red Cross (1995); Stay Well Printer; ISBN: 0815102585

This booklet, complete with pictures and diagrams, indicates what to do in a variety of emergency situations.

Health and Wellness Reference Guide

by Smith Consultant Group and McGowan Consultants; developed for the Commission on Compliance, State of Tennessee (July 1998)

This is an excellent general reference for nurses and others working with direct care staff in various settings.

Health Care Protocols: A Handbook for DD Nurses

by McGowan Consultants and Smith Consultant Group; developed for the Commission on Compliance, State of Tennessee (August 1998)

This handbook contains a large number of Protocols to guide the treatment and management of various illnesses, injuries, and conditions.

Kaiser Permanente's Healthwise Handbook

by Donald W. Kemper, the Healthwise Staff, and Kaiser Permanente Physicians and Staff of Northern California (1998); Healthwise, Incorporated; ISBN: 1877930458

This handbook, distributed to members, contains a wealth of information related to self-care and when to get professional help. Part I covers Self-Care Basics, which includes using the Kaiser Permanente System, being a wise medical consumer, and prevention and early detection. Part II covers an array of health problems, including those of special interest to men, women, and children. Part III is about Staying Healthy, and covers mouth and dental problems, fitness and relaxation, nutrition, and mental wellness. Part IV, on Self-Care Resources, concludes the book.

Mayo Clinic Family Health Book

by David Larson, editor (1996); William Morrow & Company; ISBN: 0688144780

A revised edition of the popular medical reference contains updated data on more than one thousand diseases and disorders, facts on exercise and nutrition, and information about health-care options, stress management, the human life cycle, and more.

Nursing Assistants: A Basic Study Guide

by Beverly Robertson, MSC (1996); First Class Books, Inc.; ISBN: 1880246074

This Study Guide contains 16 Step-by-Step Modules and 32 Flash Cards, covering the fundamentals of being a competent Nursing Assistant in long-term care.

The [H.E.A.R.T.] Wellness Journal

by Health Concepts; developed for Alta California Regional Center (1998)

This handy, portable Wellness Journal, designed as part of a Wellness Grant from the Department of Developmental Services, can be carried by the person to meet with health care professionals. It contains personal background information, a health history, and log sheets for entries to be made. H.E.A.R.T. stands for Health Education Awareness Resource Tool. The Journal also includes a variety of resource tools, including pictorial/diagrams to assist individuals who use few if any words to communicate what they need and want.

The Merck Manual of Medical Information: Home Edition (1st Edition)

by Robert Berkow and others, editors (1997); Merck & Co.; ISBN: 0911910875

The world's best-selling medical reference is now available in every day language. Comprehensive, accurate information is offered, with contributions from more than 300 leading medical experts. 300+ illustrations.

Homework Assignment for Session #6: Positive Environment Checklist

Please complete the *Positive Environment Checklist* in the environment where you work and support people (licensed home, and/or other setting). There are some fairly easy to follow instructions on the first page of the checklist to assist you. Review each question and circle one of the answers given: YES, NO, or UNCLEAR (if the answer is hard to determine, or if it is sometimes "yes" & sometimes "no").

This tool is good to use for two main reasons:

1. By completing it, you may identify specific areas within the environment, that may need to be looked at more closely, as they may impact the behavior of the people you are supporting. DSPs and/or administration may be able to adapt or change some of these areas to improve the quality of services you provide.

2. This is a good "self-assessment" tool that you can use to grade your environment. You may find that you are already positively addressing the areas listed and can "pat yourself on the back" with the results.

   Your results should be brought with you to the next session. We will discuss the following questions:

   a) what area(s) did you rate well on (circling "YES" responses).

   b) what areas did you rate "NO" or "UNCLEAR" on.

   c) of the areas rated "NO" & "UNCLEAR," what suggestions do you have to make any practical changes within the learning environment to address those needs (or, have you done so already)?

POSITIVE ENVIRONMENT CHECKLIST*

The Positive Environment Checklist (PEC) is designed for use in evaluating whether the settings in which persons with moderate to severe disabilities live, work and go to school are structured in a manner that promotes and maintains positive, adaptive behaviors. The PEC looks at whether settings provide the conditions that support positive behaviors and do not present conditions that make negative behaviors more likely. It also addresses several concerns related to the ways in which program staff support and interact with the people with disabilities in the setting.

The checklist should be used as part of a proactive, preventive approach to addressing challenging behaviors. The checklist can be used as a general tool to provide an overall assessment of a setting. Also, when a particular individual is selected, it can be used as part of a comprehensive analysis of challenging behavior(s) to determine whether environmental conditions are contributing to it.

The PEC focuses on the physical, social, and programmatic structure of the environment. Checklist questions are divided into 5 sections:

1) Physical Setting,
2) Social Setting,
3) Activity & Instruction,
4) Scheduling and Predictability, and
5) Communication.

Responses to questions in each area should be based on direct observation of the environment, review of written program documents and personnel. Three response options are provided for each question: **YES, NO**, and **UNCLEAR.** The term "staff" applies to paid and volunteer personnel who provide support and services in the setting. The term "people" refers to the people with disabilities who live, work, or attend school in the setting.

Scoring the completed PEC is simply a matter of determining which questions received a **YES** response, and which received **NO** or **UNCLEAR** responses. **NO** responses indicate areas or issues that should be addressed to create a more positive environment. **UNCLEAR** responses indicate the need for further analysis, perhaps by extended observation or by questioning a larger number of program personnel.

* *R & T Center on Community Referenced Positive Behavior Support*
University of Oregon

SECTION 1: PHYSICAL SETTING

1.	Is the physical setting clean, well lit and odor free?	YES	NO	UNCLEAR
2.	Is the temperature regulation in the setting adequate?	YES	NO	UNCLEAR
3.	Is the physical setting visually pleasant and appealing?	YES	NO	UNCLEAR
4.	Does the arrangement of the setting promote easy access for all individuals within the setting?	YES	NO	UNCLEAR
5.	Is the setting arranged in a manner that facilitates needed staff support and supervision?	YES	NO	UNCLEAR
6.	Does the setting contain or provide interesting, age-appropriate items and materials for people to use?	YES	NO	UNCLEAR
7.	Is the setting located and structured in a manner that promotes and facilitates physical integration into the "regular" community?	YES	NO	UNCLEAR

SECTION 2: SOCIAL SETTING

1.	Is the number of people in this setting appropriate for its physical size and purpose?	YES	NO	UNCLEAR
2.	Are the people who share this setting compatible in terms of age, gender and support needs?	YES	NO	UNCLEAR
3.	Do the people that share this setting get along with each other?	YES	NO	UNCLEAR
4.	Do staff actively work to develop and maintain a positive relationships with the people here?	YES	NO	UNCLEAR
5.	Do staff promote and facilitate opportunities for social integration with people who are not paid to provide service?	YES	NO	UNCLEAR

SECTION 3: ACTIVITIES AND INSTRUCTION

1.	Do people participate in a variety of different activities?	YES	NO	UNCLEAR
2.	Do people participate in activities that occur in regular community settings outside of the home, school or workplace?	YES	NO	UNCLEAR
3.	Do people in this setting receive instruction on activities and skills that are useful and meaningful to their daily lives?	YES	NO	UNCLEAR
4.	Is the instruction that people receive individualized to meet individual needs?	YES	NO	UNCLEAR
5.	Are peoples' personal preferences taken into account when determining the activities and tasks in which they participate and receive training?	YES	NO	UNCLEAR

SECTION 4: SCHEDULING AND PREDICTABILITY

1.	Is there a system or strategy used to identify what people in this setting would be doing and when?	YES	NO	UNCLEAR
2.	Is there a means to determine whether the things that should be occurring actually do occur?	YES	NO	UNCLEAR
3.	Do people in this setting have a way of knowing and predicting what they will be doing and when?	YES	NO	UNCLEAR
4.	Do staff prepare people in this setting in advance for changes in typical schedules or routines?	YES	NO	UNCLEAR
5.	Do people in this setting have opportunities to exercise choice in terms of what they will do, when, with whom & what rewards they will receive?	YES	NO	UNCLEAR

SECTION 5: COMMUNICATION

1.	Do people in this setting have "acceptable" means to communicate basic messages (e.g., requests, refusals, need for attention) to staff or others in the setting?	YES	NO	UNCLEAR
2.	Do staff promote and reward communication?	YES	NO	UNCLEAR
3.	Do staff have "acceptable" means to communicate basic messages to the people in this setting?	YES	NO	UNCLEAR

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #6
Positive Behavior Support

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	**Positive Behavior Support**	**3 hours**
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Choice
- Antecedent (Before)
- Behavior (During)
- Consequence (After)
- Replacement Behavior
- Positive Reinforcement
- Communication

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **What is the basic strategy you would use with someone with a challenging behavior?**

2. **What are some of the reasons why challenging behaviors occur?**

3. **What are some of the things that influence behavior?**

4. **What is the most accurate thing you can say when you observe a challenging behavior?**

5. What kinds of things can lead to challenging behaviors?

6. Where are the best places and people to model appropriate behaviors?

7. What are some things you can do to find out more about a challenging behavior?

8. Who should participate in looking at positive behavior support plans?

Activity:
My Life Quality

My Home

My Work/Career

Community

My Free Time

Information Brief

A Brief History

In the past. We thought that the activities people engaged in and the places they lived, worked & played in didn't have anything to do with their behavior.

Behavior plans relied almost entirely on consequences; like rewards and punishment.

We made people with disabilities "earn" the right to go to a regular school, have a real job, and to live in their own home. We told people with severe disabilities and their families, "Your behaviors and skills have to improve first, **before** you can do these things".

Things We've Learned about Positive Behavioral Support. Environments have a lot to do with behavioral, social and communication development. What people are doing, where, and with whom they spend time have a lot to do with their behavior.

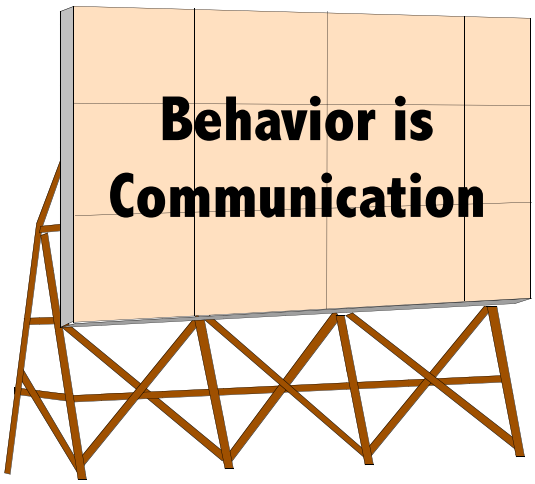
All behavior has a communicative purpose. All behavior is communication. By "listening" to what the behavior is saying, we can discover the reason why the behavior is happening.

Behaviors are strategies people use to get their needs met. Part of our job is to figure out which social/communicative behaviors currently "work" best for the person.

We should try to **"smooth the fit"** between a person and his or her environment by identifying "triggers" in the environment that set the behavior off, and removing those "triggers" as much as possible. We also need to identify each persons learning style. Does the person learn best by what they hear (auditory); by what they see (visual); or by actually doing the activity (kinesthetic/motor).

We should focus on teaching replacement behaviors and skills as an alternative to the problem behavior, instead of trying to "get rid of challenging behaviors".

(Mesaros and Shepard, revised 1999)



Information Brief

Important Values in Promoting Positive Behavior Change

In order to support positive behavior change, there are questions that the DSP should ask each day:

Participation
Are there opportunities for participation (even if only partially) in a variety of community and social activities?

Friendship
How many friends does the person have? Are there lots of opportunities to interact with and meet people (including people without disabilities who are not staff)?

Relationships
What opportunities do people have to be "givers" in a relationship? How are people recognized for their individual gifts and talents?

Interdependence
How are we supporting people to get connected within their communities? What types of natural supports exist in people's lives?

Independence
What skills are people learning and are they able to have personal privacy; especially at home?

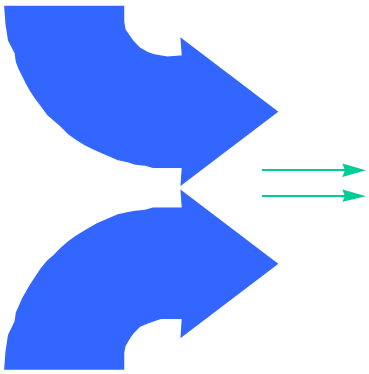
Meaningful activities
Are people provided with purposeful activities in meaningful (real) situations? We shouldn't be asking people to do "busy work" that has no real reason or purpose.

Motivation
Are the activities people engage in motivating & interesting to them? Are we "catching" people when they are good?

Choice
How much choice do people have throughout their lives?

Respect
How are people's routines and choices respected? How well do we listen to the people we support?

Mesaros & Shepard, revised 1999



Information Brief

Things that Influence Behavior

Antecedent situations occurring **before** the behavior include:

1. Personal expectations are the expectations the person has about the environment, what will be happening to him/her and how predictable these events are, etc.

2. Expectations of others concerning the person; what others assume they can or can't do. People often live up, or DOWN to the expectations that others have of them. If we expect a person to display behavior challenges, they probably will!

3. Nature of materials that are available to the person. What is their reinforcement value, functional appropriateness, age appropriateness, are they meaningful, etc.

4. Nature of the activity in which the person is engaged. How difficult is the activity for the individual? Does the person enjoy doing it, is it meaningful, age appropriate, etc.

5. Nature of the instructions given to the individual refers to how clear the instructions are given; are they given verbally, visually (pictures, written cues, modeling, showing the student, etc.), through signed information, or other?

6. Number of people present in the environment?

7. Behavior of other people present can have a big influence on behavior, both good and bad.

8. Environmental pollutants include noise, crowding, temperatures, lighting, etc.

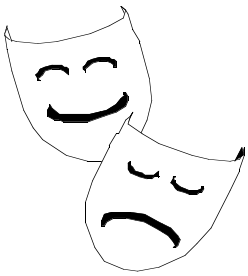
9. Time of day when behaviors occur or when they don't occur; you can use a "Scatter Plot" to help find patterns in behaviors (e.g., when are behaviors most and least likely to occur?).

10. Person's physiological state such things as hunger, medication, seizures, pain, medical issues, lack of sleep, etc.

11. Length of activity is the amount of time it takes to complete an activity (especially an activity the person doesn't like) can have a big influence on behavior. Sometimes, breaking down an activity into smaller parts can help.

12. Sudden change in routine can act as a "trigger" for behaviors to occur.

13. Predictability means that person has a way of knowing what they will be doing, and when, and with whom.



Scatter Plot

Name:_____ **Month/year:**_____

Behavior Definition:_____

_____

☐ **Behavior did NOT occur** ☐ **Behavior DID occur** ■ **Behavior occurred 3x or more**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
6:00-6:30am																															
6:30-7:00																															
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Scatter Plot

Name: Dennis Bockman **Month/year:** 3/99

Behavior Definition: Taking clothes off in public

☐ Behavior did NOT occur ☐ Behavior DID occur ■ Behavior occurred 3x or more

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	17	28	29	30	31
6:00-6:30am																															
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7:30-8:00																															
8:00-8:30			X	X	X				X		X	X			X		X	X	X				X		X					X	X
8:30-9:00	X	X	X	X	X			X	X			X			X		X	X	X			X	X		X	X				X	X
9:00-9:30			X	X	X			X	X	X	X	X			X	X	X		X			X	X	X	X	X			X	X	
9:30-10:00					X							X																		X	
10:00-10:30																															
10:30-11:00																			X				X								
11:00-11:30		X			X				X								X		X							X			X	X	
11:30-12:00		X										X			X							X	X			X				X	
12:00-12:30p					X				X		X	X					X		X					X	X					X	X
12:30-1:00			X		X					X		X			X		X					X	X			X					
1:00-1:30			X																										X		
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2:30-3:00		X										X				X			X			X				X				X	
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Activity: A-B-C Scenario #1

Directions: After you have broken into groups, read the following observations of Annette. When you are finished reading, use the A-B-C list on the following page to describe what you read. In the **Antecedent** section, write down the antecedent events which happened **before** (that preceded) Annette's behavior. In the **Behavior** section, write down Annette's actual **behavior** (what did she say or do?). In the **Consequence** section, write down the consequences which happened **after** the behaviors occurred (what did other people say or do?).

Annette

Father is late for work and he is rushing Annette to her bus which takes her to her day program. Annette says, "Nobody likes Annette." Her father stops and says, "Of course we like you; you're a good girl", and kisses Annette on the cheek as she gets on the bus.

Annette and some of her classmates go to the grocery store with a staff person. Annette has finished her shopping and approaches the staff person. She tells Annette, "Go look at some magazines until everyone else is finished shopping." Annette replies, "Everyone hates Annette; she's no good." The staff member says, "Stop it, Annette, or you'll have to go to the van." Annette continues to say negative statements about herself and the staff member ignores her.

Annette is sitting with some other students at school in the cafeteria. All the students are talking with each other for several minutes except for Annette. All of a sudden, Annette says, "Annette's bad." One of the students says, "It's okay, Annette, you're all right"; while another student says, "Just ignore her. She's always saying stuff like that."

Questions to discuss:

1. What are some **antecedent** patterns you noticed? What are some **consequence** patterns you noticed?

2. What are some consequences that may be maintaining her behavior?

3. What do you think Annette is getting or avoiding through her behavior?

4. Using a positive approach, what strategies would you suggest to her support team?

ANTECEDENT *What happens **BEFORE** the behavior* Time of day, location or environment, who was around, what was happening, task or activity, etc.	**BEHAVIOR** *What happened **DURING** the situation* Describe the behavior	**CONSEQUENCE** *What happened **AFTER** the behavior* What was the response from people or the environment; what did others say or do; other consequences

Activity: A-B-C Scenario #2

Directions: After you have broken into groups, read the following observations of Franco. When you are finished reading, use the A-B-C list on the following page to describe what you read. In the **Antecedent** section, write down the antecedent events which happened **before** (that preceded) Franco's behavior. In the **Behavior** section, write down Franco's actual **behavior** (what did he say or do?). In the **Consequence** section, write down the consequences which happened **after** the behaviors occurred (what did other people say or do?).

Franco

Franco is at home helping with dinner. His DSP asks him to stir the stew in the kitchen. Franco picks up the ladle and stirs three times in a circular motion and then stops. The DSP comes back in the kitchen and says again, "Franco, stir the stew." Franco whines and stirs three more circular motions before stopping. The DSP looks up and says, "Franco, I told you to keep stirring!" Franco responds by hitting himself repeatedly in the face. The DSP tells Franco to go to his room. Franco stops hitting himself and goes to his room.

Questions for your team to discuss:

1. What are some **antecedent** patterns you noticed? What are some **consequence** patterns you noticed?

2. Why do you think Franco behaved in this way?

3. What could Franco's behaviors of whining and then hitting himself be communicating?

4. What are some suggestions you would make to the DSP and the support team assisting Franco? What could they do differently when attempting to encourage Franco to participate in similar tasks?

ANTECEDENT *What happens **BEFORE** the behavior* Time of day, location or environment, who was around, what was happening, task or activity, etc.	**BEHAVIOR** *What happened **DURING** the situation* Describe the behavior	**CONSEQUENCE** *What happened **AFTER** the behavior* What was the response from people or the environment; what did others say or do; other consequences

Information Brief

Information Needed to Develop a Positive Behavior Support Plan

1. Identify *Quality of Life* areas which may be lacking and contributing to behavior challenges. Figure out how to improve these areas in the person's life, for example, adding more opportunities for choice & variety, meaningful activities, person centered planning, so on.

2. Identify and define the challenging behavior(s). Determine the frequency and duration or intensity of the behavior. (Use a **scatter plot**, frequency chart, or **A-B-C observation data** to measure frequency, duration and how intense the behavior is).

3. Identify the **antecedents** (behavioral "triggers" and other events, including medical variables, activity, environment, people present, time of day) that are present BEFORE the challenging behavior occurs. (Use **A-B-C** observation data and interview others in the person's life to find patterns in Antecedents.)

4. Identify **other events** (behavioral ecology), including medical variable, activity, environment, people present, time of day, etc., that may influence behavior. (Use **A-B-C observation data**, **scatter plot**, and **PBS Simple Worksheet** questions examining Where, When & Why behaviors may be occurring to find patterns.)

5. Identify the **consequences** that happen AFTER the behavior which may be reinforcing (maintaining) the challenging behavior(s). (Use **A-B-C observation data** to identify these).

6. Identify "learning characteristics" of the person, so we know how the person learns best. We need to match our teaching style to match the persons learning style when we teach new skills and replacement behaviors.

7. Identify possible reasons for the challenging behavior. What is the person getting or avoiding through their behavior? (Review your assessment information and the results from a **Motivation Assessment Scale** to help you develop a hypothesis or "best guess" as to WHY the behavior is happening and WHAT the behavior is saying).

8. Identify REPLACEMENT behaviors or skills:

   a) That allow the person to get their needs met in a more socially appropriate way, and

   b) That will "work" just as well as the challenging behavior.

   (Refer to "teaching replacement behavior" information)

Positive Behavior Support – Simple Worksheet

(Scott Shepard; Adapted from Research & Training Center)

1. Provide a brief description of the focus person, their living situation, school or work situation and typical community involvement.

2. Describe the problem issue(s) and/or challenging behavior(s) in measurable terms. Include data on the frequency & intensity (how often & how long does it happen).

3. Describe assessment tools that were used to document the frequency and intensity of the challenging behavior across different environments. (Scatter plot, A-B-C, Motivation Assessment Scale, Functional Analysis Data Summary, etc.).

4. List the patterns in the **BEFORE** (Antecedent) and **AFTER** (Consequence) conditions that were identified by the team through your assessments. (**When** is behavior most & least likely to occur; **Where** is behavior most & least likely to occur; **With Whom** is the behavior most & least likely to occur; during **What activities** is behavior most & least likely to occur; what **Consequences** are reinforcing or maintaining the challenging behavior?)

When most likely: _____

When least likely: _____

Where most likely:_____

Where least likely: _____

With whom most likely: _____

With whom least likely: _____

What activities most likely: _____

What activities least likely: _____

Consequences maintaining behavior: _____

_____

Medical/medication influences:_____

5. Give your hypothesis of the function(s) of the challenging behavior(s).

Hypothesis:

How was the hypothesis tested/supported:

Support Strategies

6. What **replacement** behaviors/skills did you identify to **TEACH** as positive alternatives to replace the challenging behavior?

   Communication Skills:

   Social Skills & assertiveness skills:

   Coping strategies & relaxation skills:

   Other replacement behaviors/skills:

7. Antecedent change strategies:

8. Consequence manipulations:

9. QUALITY OF LIFE/LIFE ENHANCEMENT Changes:

10. What are your future hopes & dreams for the individual?

11. What are existing “barriers” that you need assistance with?

What are the next steps in supporting this person???

Motivation Assessment Scale

Name: _____ **Date:** _____

Behavior Description: _____

_____

_____

Instructions: The Motivation Assessment Scale is a questionnaire designed to identify those situations in which a person is likely to behave in certain ways. From this information, more informed decisions can be made concerning the selection of appropriate rewards and treatments. It is important that you identify the behavior of interest *VERY SPECIFICALLY.* ***Aggressive,*** for example, is not as good a description as ***hits others.*** Once you have specified the behavior to be rated, read each question carefully and circle the one number which best describes your observations of this behavior. You may complete this individually, or as a team; it is often useful to compare answers and differing perspectives.

Questions

	Never	Almost Never	Seldom	Half the time	Usually	Almost Always	Always
1. Would this behavior occur continuously if the individual was left alone for long periods of time? (For example, one hour)	0	1	2	3	4	5	6
2. Does this behavior occur following a command to perform a difficult task?	0	1	2	3	4	5	6
3. Does this behavior occur when you are talking to other persons in the room?	0	1	2	3	4	5	6
4. Does this behavior ever occur to get food, a game that he or she has been told that she/he can't have?	0	1	2	3	4	5	6
5. Does this behavior occur repeatedly, over and over, in the same way? (e.g. rocking back and forth for five minutes)	0	1	2	3	4	5	6
6. Does this behavior occur when a request is made of the person?	0	1	2	3	4	5	6
7. Does this behavior occur whenever you stop attending to the person?	0	1	2	3	4	5	6
8. Does this behavior occur when you take away a favorite activity or pastime?	0	1	2	3	4	5	6

	Never	Almost Never	Seldom	Half the time	Usually	Almost Always	Always
9. Does it appear to you that the person enjoys performing this behavior and would continue even if no one was around?	0	1	2	3	4	5	6
10. Does the person seem to do this behavior to upset or annoy you when you are trying to get him/her to do what you ask?	0	1	2	3	4	5	6
11. Does the person seem to do this behavior to upset or annoy you when you are not paying attention to him/her?	0	1	2	3	4	5	6
12. Does this behavior stop occurring shortly after you give the person something she/he requested?	0	1	2	3	4	5	6
13. When this is occurring, does the person seem unaware of anything else going on around him/her?	0	1	2	3	4	5	6
14. Does this behavior stop occurring shortly after (one to five minutes) you stop working or making demands of him/her?	0	1	2	3	4	5	6
15. Does he or she seem to do this behavior to get you to spend some time with him/her?	0	1	2	3	4	5	6
16. Does this behavior seem to occur when the person has been told that she or he can't do something she/he wanted to do?	0	1	2	3	4	5	6

1. _____	2. _____	3. _____	4. _____
5. _____	6. _____	7. _____	8. _____
9. _____	10. _____	11. _____	12. _____
13. _____	14. _____	15. _____	16. _____
(Sensory)	(Escape)	(Social Attention)	(Tangible Consequences)
_____	_____	_____	_____
Total	Total	Total	Total

Adapted from V. Mark Durand, Suffolk Child Development Center, N.Y.

How to Score the Motivation Assessment Scale (MAS)

1. Follow the directions given to complete the MAS.

2. When finished, write down the score that was circled (1 – 6) for each question at the bottom of the back page on the line with the corresponding question number.

3. Once all 16 scores have been entered, add up the total for each of the four columns.

4. If the total on the left is highest, that would indicate a higher behavioral motivation in the **Sensory** area. If the total in the second column from the left is highest, it would indicate a higher behavioral motivation in the area of **Escape,** and so on, for the remaining two columns labeled **Social Attention,** and **Tangible Consequences.**

5. Oftentimes, more than one total will come out high. Usually, any total over 10 can be significant and worth looking at as a possible motivator.

6. If all totals come out the same, it may be that the behavioral definition being used is too broad. You may want to retry the assessment with a more specific definition.

Information Brief

Teaching Replacement Behavior

The steps are:

1. Identify & define the challenging behavior.

2. Observe the individual and interview family & team members (using the assessment tools) to help figure out the meaning of the challenging behavior.

3. Identify new replacement behavior(s) to teach the individual that fill the same need as the challenging behavior.

Use these guidelines to help teach replacement behaviors & skills:

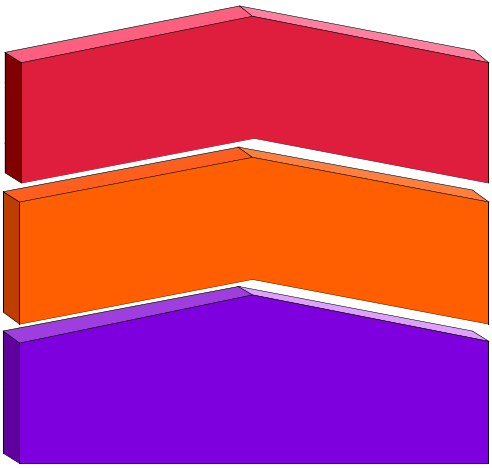
A. The replacement behavior must receive "payoff" (reinforcement) as soon or sooner than the challenging behavior.

B. The replacement behavior must receive as much or more "payoff" (reinforcement) than the original behavior.

C. The replacement behavior must require the same amount of effort (or less) to perform.

Samples of *Replacement Skills* include:

- communication skills;
- social skills;
- leisure and recreational skills;
- self-care, domestic, and community living skills; and
- coping strategies and problem solving skills.



The Language of "Us" and "They"
By Mayer Shevin

We like things.
They fixate on objects.
We try to make friends.
They display attention-seeking behaviors.
We take a break.
They display off-task behaviors.
We stand up for ourselves.
They are noncompliant.
We have hobbies.
They self-stim.
We choose our friends wisely.
They display poor peer socialization.
We persevere.
They perseverate.
We love people.
They have dependencies on people.
We go for a walk.
They run away.
We insist.
They tantrum.
We change our minds.
They are disoriented and have short attention spans.
We have talents.
They have splinter skills.
We are human.
They are??????????????

Answers to In-Class Review

1. What is the basic strategy you would use with someone with a challenging behavior?

Teaching replacement behavior and skills that serve the same purpose as the challenging behavior.

2. What are some of the reasons why challenging behaviors occur?

The behavior is reinforced by attention or escaping something that someone does not want to do or it feels good.

3. What are some of the things that influence behavior?

Time of day.
Type of activity.
Number of people present.
People are not given choices in what they are doing.
It may be a medical issue like a pain, allergies, etc.

4. What is the most accurate thing you can say when you observe a challenging behavior?

The person is trying to communicate something.

5. What kinds of things can lead to challenging behaviors?

Changes in weather
Changes in staff
Changes in noise level
Changes in routine

6. Where are the best places and people to model appropriate behaviors?

In typical settings, for example, at work, home and in the community..

7. What are some things you can do to find out more about a challenging behavior?

Talk with the individual whenever possible and observe the behavior.
Talk with family members or staff who know the person.

8. Who should participate in looking at positive behavior support plans?

A team that includes the person, family, staff, administrator and other agencies involved.

If You Want to Read More About
Positive Behavior Support

Positive Behavioral Support: Including People With Difficult Behavior in the Community

by Lynn Kern Koegel, Robert L. Koegel, Glen Dunlap, Editors (1996); Paul H Brookes Pub Co; ISBN: 1557662282

Offers case studies, research-based strategies, and discussion on behavioral intervention with people who engage in challenging and self-injurious behavior, highlighting the significant role of parent and family support. Topics include naturalistic language intervention; early intervention; school inclusion for children with autism; and person-centered planning. Contains activities and a sample course syllabus.

Why Jason Behaves That Way and What to Do About It; a Dialogue about Problem Behaviors and Positive Behavioral Support for Family Members and Friends

by Virginia Institute for Developmental Disabilities (1996)

A brief article about the influences of the environment on behavior and some practical things you can do about it.

Note: Preparation of some of the materials herein was supported by contract #GOO87CO234, Research and Training Center on Community-Referenced Nonaversive Behavior Management, and CFDA #133B-6, Rehabilitation Research and Training Center on Positive Behavior Support, from the National Institute on Disability and Rehabilitation Research. However, the opinions expressed herein do not necessarily reflect the position or policy of the U.S. Department of Education, and no official endorsement should be inferred.

Homework Assignment for Session #7: Teaching Strategies: Relationships, Task Analysis and Prompts

To be ready for your next class session on Teaching Strategies, make sure that you read all of the information for session #7 and complete the homework assignment **before the next class**. You will find it on page 9 of your *Resource Guide* for session #7.

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #7

Teaching Strategies: Relationships, Task Analysis and Prompts

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services
1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	**Teaching Strategies: Relationships, Task Analysis and Prompts**	**3 hours**
8	Teaching Strategies: Postive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Learning Goals
- Task Analysis
- Teachable Steps
- Prompts
- Modeling
- Documenting Progress

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **The very first thing a DSP must do before attempting to teach anything to anyone is to develop a good relationship with the learner. Describe some of the things DSPs can do to build a good relationship with individuals whom they support.**

2. **What are two important reasons for using a task analysis when teaching a new skill?**

3. **Give an example of the following types of prompts:**

   Verbal

   Gestural

   Physical

4. **Describe how you might use a least-to-most assistive prompting strategy to teach an individual to turn on the light when he enters the room (consider turning on the light a one-step task analysis).**

Information Brief

Getting Ready for Session #7

Preparation

Before you attend Session 7, please remember to:

1. Read all of the information for Session #7 in this *Resource Guide*.

2. After reading the information and before Session 7, **answer the questions that you will find on page 9**. You may need your supervisor's help in completing the activity.

Introduction to Teaching Strategies

Teaching useful skills is one of the most important types of support offered by human service agencies to people with disabilities. Support staff must have the ability to teach a wide variety of skills if people with disabilities are to be as independent as possible. As people learn to do more things for themselves, they have more control over their lives. When people have more control over how they spend their time, they are usually happier. Because teaching new skills is so important, agencies providing support for people with disabilities are required to make treatment plans for each individual for whom they provide support. These plans describe useful skills for each individual to learn. Staff must become familiar with the service and support plans of each person with whom they work.

Establishing A Relationship With The Learner

Many teaching tools to help individuals with disabilities learn useful skills will be discussed in the next two classes. The first and most important teaching tool is to have a good relationship with the person who is being taught. Without a good relationship, staff will not be very successful teachers. Some of the ways a good relationship with a learner can be developed include:

- Get to know what the individual likes
- Interact often doing things the individual likes to do
- Get to know the individual's dislikes
- When reasonable, help the individual avoid things he/she dislikes
- Interact often to become familiar with each other's communication style

Information Brief
Task Analysis

What Is A Task Analysis?

When teaching a new skill, it is important to teach in a consistent way so that individuals can learn skills more quickly. Often, the skills being taught are complex, requiring the individual to learn the many actions involved in completing each skill. Complex skills can be broken down into small steps that an individual can more easily learn to perform. Listing the sequence of actions or steps involved in completing a skill is called a TASK ANALYSIS. The following is an example of a task analysis for drinking from a cup.

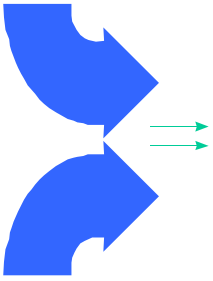
1. Grasp handle of cup
2. Lift cup to mouth
3. Drink
4. Set the cup on the table

Using A Task Analysis For Teaching New Skills

Not every skill to be taught needs a task analysis. Teaching an individual when to use a skill that the individual already knows how to do, does not require a task analysis. Another type of teaching objective that does not require a task analysis is when teaching an individual to perform a skill more quickly or for a longer period of time. During Session 8, ways to help individuals use skills they already know how to do will be discussed. Task analysis is useful when teaching an individual to do something he/she does not already know how to do correctly.

One of the most important reasons for listing the steps of a skill in a task analysis is to define exactly what the individual is learning to do so that the skill can be taught the same way every time. Teaching the individual to do the skill the same way every time helps the person learn the skill more quickly. If everybody who teaches an individual follows the task analysis, the skill will be taught the same way each time no matter who does the teaching.

When creating a task analysis for teaching a skill, it is important for staff to practice the skill themselves by following the task analysis before the task analysis is used to teach the person with disabilities. By practicing the skill, staff can make sure the task analysis is complete and the steps are arranged in a logical order.



In-Class Activity:
Drawing a Place Setting

On the place mat below, draw a picture of a dinner place setting including a plate, knife, fork, spoon, napkin and cup.

Using the task analysis for table setting the instructor has placed on the overhead, draw a picture of a dinner place setting including a plate, knife, fork, spoon, napkin and cup.

In-Class Activity:
Completing and Ordering Steps in a Task Analysis

Number the steps listed below in the order that the steps should be completed for operating a video cassette recorder (VCR).

_____ Turns on the VCR and TV

_____ Pushes the "PLAY" button on the VCR

_____ Slides video into the VCR in the appropriate place

_____ Holds video with title side toward palm of hand and tape side toward the VCR

_____ Turns channel on TV to Channel 3

In the following task analysis for shaving with an electric razor, several of the steps have been left out. Find at least two steps that have been left out of the task analysis.

1. Picks up electric razor

2. Shaves right side of face

3. Rubs hand over right side of face to check for smoothness

4. Reshaves remaining beard on right side of face

5. Shaves chin

6. Rubs hand over chin to check for smoothness

7. Reshaves remaining beard on chin

8. Shaves neck

9. Rubs hand over neck to check for smoothness

10. Reshaves remaining beard on neck

11. Turns electric shaver off

Homework Activity
(to be completed before Session #7)

Locate the Individual Program Plan and any additional service plans for three people with whom you work. (You may need to ask your supervisor for help with this assignment.) Below, make up fictitious names (to assure confidentiality) for those three people. Beside each name, list some of the skills that each individual may want or need to learn to achieve his/her goals (from the IPP).

	Person's first name	**Skills to be learned**
1.		
2.		
3.		

Information Brief

Prompting

Introduction

When an individual with disabilities is learning a new skill, it may be necessary for staff to help the individual with the skill at first. The help a support staff gives an individual to learn a new skill is called prompting. The goal is to support someone in learning something they want to learn, not to force someone to do something they do not want to do.

Different Types of Prompts

There are many different types of prompts staff can use to help an individual complete a new skill. A verbal prompt can be any spoken question, instruction or direction which helps the individual to do any step of the task analysis that he/she cannot do independently. For example when teaching Susan to play a cassette tape, a verbal prompt for the first step of the task analysis might be to say, "Pick up the tape." Verbal prompts can be less directive than actually telling a person what to do. A less directive verbal prompt to pick up the tape might be to ask a question like, "What do you do first?" Verbal prompts should include only as many words as needed to give clear directions because too much talking may confuse the learner. It may also be helpful if staff use the same words as prompts each time the skill is taught.

Another type of prompt to help an individual in completing a skill is a *gestural prompt*. A gestural prompt can be pointing to or touching something and any other body motion by staff which directs the learner's attention toward what should be done next.

Modeling is another way to assist an individual in completing a skill. Modeling involves showing the learner how to do part or all of a skill. Modeling can be helpful to any learner but is probably most helpful with individuals who learn quickly. Individuals with severe to profound mental retardation may not benefit as much from modeling prompts as others with less severe disabilities.

Also, modeling usually is best used at the beginning of teaching. If a learner responds to the modeling with a correct skill response, then the modeling can be repeated with subsequent teaching trials. However, if the first use of modeling does not result in a correct learner response, then it is usually best to stop using modeling as part of the teaching approach. Modeling can be a time consuming teaching strategy, so it is best to make sure it is effective early in the teaching process before using it over and over.

Physical prompts involve physical guidance or touch from staff to help an individual in completing a skill. Physical prompts can range from a brief touch to complete guidance whereby support staff move the learner completely through a given step of the task analysis. Physical guidance can

vary in intensity depending on where on the learner's body the physical assistance is provided. For example, when teaching an individual who has severe movement problems to pick up a leisure material, staff can begin by guiding the learner's arm toward the material. A more helpful physical prompt would be to hold the learner's wrist to guide the hand toward the material. The most assistive physical prompt for helping the learner to pick up a leisure material would be staff placing his/her hand over the learner's hand and guiding the learner's hand to pick up the material.

Suiting Prompts To The Individual Learner

Prompts can vary in strength depending upon how much help the prompt is to the learner. As a general rule, verbal and gestural prompts usually provide only a little help whereas full physical guidance provides the most help. However, which prompts are most or least helpful depends a lot on the learner. For example, if the learner has very good language skills, a slight physical prompt may be less helpful than telling the individual what to do. Some prompts are not useful at all for certain individuals. For example, if an individual has a hearing impairment, verbal prompts will probably not be helpful at all. Similarly, if an individual has visual impairment, gestural prompts are not likely to be helpful. If a person becomes upset when touched or physically guided to do something, physical prompts may not be a good idea for use with that person. The types of prompts used with each learner must be selected with the individual learner in mind. Suiting prompts to the individual learner will be easier if staff have taken the time to get to know the individual before attempting to teach.

Least-to-Most Assistive Prompting

To help an individual learn a skill as quickly as possible, prompts should be provided following a simple guideline. **Staff should never provide more help than the individual needs to complete any of the steps in the task analysis of the new skill.** When beginning to teach a new skill, staff must find out how much help the learner needs to complete each step of the task analysis. Staff should begin by having the learner try to complete the first step of the task analysis without help. If the learner cannot complete the step correctly without help, staff should provide a mild prompt such as a verbal prompt. If the verbal prompt is not helpful enough so that the learner completes the step correctly, staff should give more help such as with a verbal prompt and a gesture prompt at the same time. If the learner does not complete the step after the verbal and gesture prompt, staff should next provide more help such as with partial physical assistance (guiding the learner through part but not all of the step). If partial physical assistance does not result in the learner completing the step then, staff could then give more help such as by guiding the learner completely through the step. With all prompting, it is very important that staff give the learner enough time to respond to a prompt before providing another more helpful prompt.

Once staff know how much help an individual usually needs to complete each step of the task analysis, then whenever the learner practices the skill, staff should begin by giving less help than the learner usually needs to correctly complete the step. If the first prompt given for the step is not enough help for the learner to correctly complete the step, the staff should give more and more helpful prompts until the learner completes the step correctly. For example, when teaching the learner to drink from a cup, if partial physical assistance is usually needed for the learner to complete Step 1 (grasping the cup), then staff might begin teaching by prompting the step with a verbal or a gestural prompt. If the verbal or gestural prompt does not help the individual enough to complete the step, then a partial physical prompt may be provided. If partial physical guidance does not help enough, staff could provide full physical guidance so that the step is completed correctly before the next step in the task analysis is tried. After Step 1 is completed, staff should prompt Step 2 by giving a little less help than the learner usually needs to complete Step 2 (lifting the cup to the mouth). Increasing amounts of help are given on Step 2 until the learner completes the step correctly. If prompts are provided in this way, the learner should receive the least amount of help necessary for successfully completing any step in the task analysis. In other words, staff never give more help than the learner needs. Using prompts in the way just described is called a "Least-to-Most Assistive Prompting Strategy."

There are several mistakes that staff sometimes make when using least-to-most assistive prompting. One mistake is that staff repeat prompts at the same level for a given step. For example when a staff person tells a learner to "grasp the cup" (verbal prompt), if the prompt is unsuccessful in helping the person to complete the step, the next prompt for the step should be more helpful such as telling the learner to "grasp the cup" while pointing to the cup (verbal and gestural prompt). New staff may repeat the verbal prompt several times ("Grasp the cup.", "Come on, you can grasp the cup.", "Pick up the cup, ok?", etc.) Repeating the same type of prompt for a given step is not a good idea. It only makes the teaching session longer and can confuse the learner. If the learner does not correctly complete the step when given one prompt, then either the learner does not understand the prompt or is not motivated to complete the step. Repeating the prompt does not help with either situation. Rather, a second prompt on any step in the task analysis should always be more helpful than the first. Similarly, if a third prompt is needed, it should be more helpful than the second prompt.

Another prompting mistake is using full physical guidance as the first prompt on any step of the task analysis. If full physical guidance is given as the first prompt for a step, the individual being taught has no chance to learn.

A third mistake occurs when staff do any step of the task analysis for the learner instead of helping the learner do the step for him/herself. Staff should provide as much help as is needed for the learner to complete any step, but staff should not complete any step without involving the learner.

Information Brief

Documenting the Learner's Progress

The result of good teaching is that an individual makes progress toward learning new skills. One way to check for progress is by comparing how much of a skill the individual has learned from week to week or month to month. One way of checking for progress will be discussed in our next session. For each skill identified as important to learn in the individual's treatment plan, a progress record form similar to the one included in this packet can be prepared. On the progress recording form, the learner's name and the steps of the task analysis should be listed. At least once each week, when the skill is taught (the skill should be taught many times each week but on only one of the teaching sessions is progress recording usually necessary), staff should record a "+" beside each step that is completed independently (without prompting) and an "0" beside each step that requires any prompt by staff. When the progress record shows that all steps are being completed independently, then staff can see that the skill has been learned. When the skill has been learned, staff's job is to motivate the learner to use the skill at the right time and in different places as part of the natural routine. Again, how to teach during natural routines will be discussed more in the next session.

Progress Record

Name _____ Skill _____

"**+**" = independent "**O**" = prompted

Task Analysis: Dates:

1. _____										
2. _____										
3. _____										
4. _____										
5. _____										
6. _____										
7. _____										
8. _____										
9. _____										
10. _____										
11. _____										
12. _____										
13. _____										
14. _____										
15. _____										

Answers to In-Class Review

1. The very first thing a DSP must do before attempting to teach anything to anyone is to develop a good relationship with the learner. Describe some of the things DSPs can do to build a good relationship with individuals whom they support.

Get to know the things the individual likes and dislikes. Create opportunities to do things with the person that the individual likes to do. Interact often so that you learn each other's communication styles.

2. What are two important reasons for using a task analysis when teaching a new skill?

1) When you use a task analysis to teach a skill, the skill is the same every time it is taught. 2) When you follow a task analysis, the steps of the skills are always taught in the same order. By being consistent and teaching the steps in the same order, complex skills become easier to learn.

3. Give an example of the following types of prompts:

Verbal	Telling a person to pick up the napkin
Gestural	Pointing to the napkin
Physical	Guiding the person's hand to pick up the napkin

4. Describe how you might use a least-to-most assistive prompting strategy to teach an individual to turn on the light when he enters the room (consider turning on the light a one-step task analysis).

First tell the person to turn on the light (verbal prompt). If the verbal prompt does not result in the learner turning on the light, then point to the light switch while telling the person to turn on the light (verbal and gestural). If the verbal and gestural prompt do not result in the person turning on the light, then guide the person's hand to switch on the light (physical).

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Presents information and techniques instrumental in training teachers in the field of severe disabilities. Includes contributing authors who are recognized experts on the topic. Explains the current technologies and practices that best work in the classroom. Provides an overall reference for teaching practices, including procedures, programs, assessment instruction and research, concerning students with severe disabilities.

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Homework Assignment:
Session #8: Teaching Strategies: Positive Feedback and Teaching at Natural Times

To be ready for your next class session on Teaching Strategies, make sure that you read the *Resource Guide* for Session #8 and complete the homework assignment **before the next class**. You will find it on pages 7 and 12 of your *Resource Guide* for session #8.

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #8 Outline

Teaching Strategies: Positive Feedback and Natural Times to Teach

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services
1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	**Teaching Strategies: Postive Feedback and Natural Times to Teach**	**3 hours**
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Positive Consequence
- Reinforcer
- Praise
- Error Correction
- Natural Teaching

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **Describe why it is important to use positive consequences in teaching.**

2. **Why is it a good idea to change the positive consequences we use as reinforcers when teaching?**

3. **Why is praise often used as a positive consequence?**

4. **Describe two ways we can help learners avoid making errors when learning a new skill.**

5. **Tell some ways we can identify teaching opportunities during the routine day.**

6. **What is a very important goal of teaching that DSPs should keep in mind when looking for times to teach during the daily routine?**

Information Brief

Getting Ready for Session #8

Preparation

Before you attend Session 8, please remember to:

1. Read all of the information for Session #8 found in this *Resource Guide*.

2. After reading the information and before Session 8, **complete the assignments on pages 7 and 12**. You may need your supervisor's help in completing the activity.

Introduction

We all learn better when we are encouraged and positively motivated to learn. When teaching individuals with disabilities, providing positive consequences for an individual's effort can help the individual learn more quickly. Positive consequences used in teaching can take many forms. Praising the learner for doing something right is one way to motivate many individuals as they learn new skills. Opportunities to get a preferred item or participate in preferred activities are other ways that may motivate an individual to learn a new skill.

Positive Consequences As Reinforcers

Reinforcement is one of the most important teaching tools. When a positive consequence follows a behavior and makes the behavior more likely to occur again in the future then the positive consequence is acting as a reinforcer. Therefore, a reinforcer is a special kind of consequence because it has an effect on learning. The only way to know if a consequence is working as a reinforcer is if the individual shows progress on the skill over time. If the learner does not show progress on the skill over time, then the positive consequence is probably not a reinforcer for learning that skill even if the consequence is an item or an activity the individual seems to like. Again, the only way to know if a positive consequence – whether it be praise, opportunities to take part in preferred activities, etc. – is a reinforcer is by checking to see if the learner is making progress over time. If each month, steps of a skill are being performed with less help than during the previous month, then it is likely that a positive consequence is acting as reinforcer.

Homework Activity:
Preferred Activities

List the names of three individuals with whom you work and teach. Beside each name list some of the items or activities that you know the individual likes.

Name	Preferred items and activities
1.	•
	•
	•
	•
	•
2.	•
	•
	•
	•
	•
3.	•
	•
	•
	•
	•

Information Brief

Reinforcement

Reinforcement For Each Individual

Because every person is different, everyone has an individual set of reinforcers. No single item or event is reinforcing to everybody. An important job of a DSP is to find out the reinforcers that motivate the learner. There are several ways to find out what kinds of consequences might act as reinforcers for learning.

- Ask the individual (friend, family member) what things the individual likes
- Observe to see what the individual does during free time
- Provide choices of items, events and activities

However, the only sure way to know if something is a reinforcer is to use it when teaching a new skill and see if the learner improves his/her ability to do the skill over time.

Change Reinforcers

It is important to use many different reinforcers during teaching. When a reinforcer is provided too frequently, it can lose its reinforcing value. For example if an individual is provided with extra time to look at magazines as a frequent reinforcer, the individual may lose interest in magazines. When many different consequences act as reinforcers for an individual, reinforcers can be changed and are less likely to lose reinforcing value. As a result, individuals who respond to a variety of reinforcers have more opportunities to learn.

The most common type of positive consequence used in teaching is praise and positive feedback. Praise and positive feedback can act as reinforcers for almost anybody. There are a number of good reasons to reinforce a learner using praise and positive feedback.

- Praise is a normal consequence for individuals with and without disabilities.
- People rarely get tired of being praised.
- Praise is readily available and costs nothing.
- Praise can be provided briefly and without disruption to ongoing activities.

However, even praise and positive feedback do not always act as reinforcers in all teaching situations. In the previous

session, building a positive relationship with the learner was discussed. Having a positive relationship with the individual helps to make praise and feedback more reinforcing. Working to develop a good relationship with the learner by interacting often doing things the learner likes to do will help make a staff member's praise and positive feedback more reinforcing to the learner.

Provide Positive Consequences When Teaching

When an individual is beginning to learn a new skill, positive consequences can be provided after each correctly completed step of the task analysis as well as when the learner has correctly completed the whole task. Praise is a good reinforcer to use after the learner correctly completes steps within the task analysis because praise usually does not disrupt the teaching process.

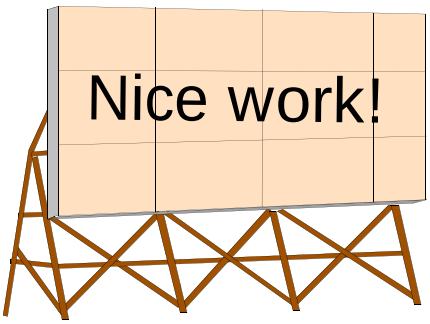
Consequences involving preferred items and activities may be better to provide after the individual completes the whole task. As the individual learns to do more of the skill independently, a positive consequence such as praise is probably not needed every time the learner does one of the steps in the task analysis. For example, if Jason does not need many prompts to complete his tooth brushing, praise is probably not needed for each step such as after turning on the water, wetting his toothbrush, etc. However, staff should continue to provide a positive consequence when the whole task is completed until the individual can do the skill independently during the daily routine.

Error Correction

Individuals will learn more quickly if they are able to practice new skills while making few or no errors instead of practicing the skill with many errors. An error is when a person does the wrong thing.

To illustrate, if a learner is being instructed to pick up a napkin and the individual tosses the napkin to the floor, the tossing of the napkin is an error. If staff see that the learner is about to make a error on one of the steps of a skill, staff should increase the help provided (give a more assistive prompt) to avoid the error. However, as anyone who has ever taught will agree, sometimes learner errors cannot be avoided.

Once an error occurs on a given step, staff should have the learner try the step again and make sure that the error does not occur the second time the learner tries the step. For example, if the learner has been verbally prompted to pick up the napkin but tosses the napkin instead, staff should return the napkin to the learner's lap, provide a more assistive prompt than the verbal prompt (i.e., a gesture or physical prompt) and ensure that the second prompt is helpful enough so that individual correctly completes the step of picking up the napkin. By providing assistance in this way, a person should never make more than one error on a given step of the task analysis during a teaching session.



Information Brief

Naturalistic Teaching

Sometimes formal teaching sessions are arranged by staff when staff can work 1:1 with an individual teaching a new skill. For example, staff may decide that 3:00 in the afternoon is a good time to work with Lucinda on using the telephone to call her friends. Scheduled teaching sessions may be needed in the early stages of learning to ensure that the individual gets enough practice on a new skill to learn it. However, it is important to teach the skill at any time during the day or in any place when and where the need for the skill arises. For example, a natural time during the day for Lucinda to practice using the telephone could be when the group decides to order a pizza for supper. Lucinda could make the telephone call to place the order.

Discovering Opportunities To Teach During The Natural Routine

Individuals will learn more quickly if they have many opportunities to practice those skills that have been identified as priorities for teaching. There are countless opportunities to teach throughout the day. As has been discussed, the more things an individual can do independently, the more control the individual has over his/her life. Typically, the more control we have over our lives, the more enjoyable our lives become. Staff should be on the "look out" for opportunities to teach new skills to help an individual become more independent. Opportunities to teach can be signaled when:

1. An individual uses a newly learned skill during the day without being prompted. (In this case, staff should praise the individual to reinforce the skill.)

2. An individual asks for help to complete a task (Staff should use a least-to-most assistive prompting strategy to help the individual correctly complete the skill and then praise his/her effort.)

3. A staff member is completing tasks for an individual that the individual could learn to do him/herself. (Staff should use a least-to-most assistive prompting strategy to help the individual correctly complete part or all of the skill and then praise his/her effort.)

Overall Goal: Assisting The Individual To Attain An Enjoyable Life Through Successful Teaching

Although opportunities to teach are found throughout the day, staff should always keep in mind that teaching must be balanced with many opportunities for individuals to participate in enjoyable, preferred activities that may not require teaching. Also, staff should look for ways to make teaching and learning a pleasant experience. The overall goal should be to help individuals with disabilities enjoy their lives. Although learning new skills can contribute to life enjoyment, staff must be careful not to let teaching efforts interfere with an individual living an enjoyable, fulfilling life.

Activity:
Identify the Positive Consequence

Read each scenario. Underline the skill being taught and circle the positive consequence used to support learning.

1. Henry is learning to prepare a pizza. After Henry has completed all the steps in the task analysis for preparing the pizza, he can eat the pizza.

2. Lisa is learning to balance her checkbook. When she correctly subtracts a check from her previous balance, the DSP smiles and says, "You got that one right!"

3. Jackie is learning to cross the street in town. The first step in the task analysis is to press the crosswalk button. The DSP says, "Jackie, press the button" and Jackie presses the button. The DSP pats Jackie on the back.

4. Anna, a child with multiple severe disabilities, is learning to look at the teacher when the teacher calls her name. When the DSP calls her name, if Anna looks in the DSP's direction, the DSP gives Anna her favorite toy.

Homework Activity:
Natural Teaching Times

In the first column list the name of an individual with whom you work. In the second column, list one of the skills you are teaching or would like to teach him or her. In the third column, list times during the day the skill is needed or activities the person does in which the skill could be practiced. An example has been included.

Name	Skill being taught	Times of day or activities in which the skill could be practiced
Joe	*Hand washing*	*Before meals, after using the restroom, after a messy art activity*

Answers to In-Class Review

1. Describe why it is important to use positive consequences in teaching.

Positive consequences: 1) motivate the individual to learn more quickly and 2) make teaching activities more enjoyable.

2. Why is it a good idea to change the positive consequences we use as reinforcers when teaching?

Learners may become tired of the same items, activities and events so that these things lose their reinforcing value from overuse. When we change positive consequences we are also more likely to find things that will motivate learning. Many opportunities to enjoy a variety of preferred activities will make an individual's life more enjoyable.

3. Why is praise often used as a positive consequence?

Almost everybody enjoys being praised. Praise is a normal consequence for people with and without disabilities. Praise is always available and costs nothing. People rarely get tired of praise.

4. Describe two ways we can help learners avoid making errors when learning a new skill.

1) If the DSP sees that the learner is about to make an error, the DSP should increase assistance so that the error is not made. 2) If the learner does make an error on a step in the task analysis, the DSP should provide enough assistance on the second attempt at completing a step so that a second error is not made.

5. Tell some ways we can identify teaching opportunities during the routine day.

Teach during times when the individual needs to use the skills they are learning as part of the normal routine. Opportunities to teach are signaled by times when an individual asks the DSP for assistance or when the DSP is doing something for an individual that the person could learn to do for him/herself.

6. What is a very important goal of teaching that DSPs should keep in mind when looking for times to teach during the daily routine?

Teaching should be positive, encouraging and as enjoyable as possible for the learner. Although we look for many opportunities to teach throughout the day, we should never teach so much that we take away from an overall enjoyable lifestyle for the individuals whom we support.

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Homework Assignment for Session #9: Making Connections

Directions: At our next meeting, we will be looking at how to help people make acquaintances, connections and friends. Before that meeting, please do the following:

1. **Think about and write out five things that your friends say they like about you.**

   •

   •

   •

   •

   •

2. **Think about and write down how you met two of the people you call friends.**

   •

   •

Year 1
Direct Support Professional Training

Resource Guide

Session #9
Daily Living

Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	**Daily Living**	**3 hours**
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Individual Routines
- Relationships
- Friendships
- Social Skills

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **What is the importance of individual routines in our daily lives? Why is understanding people's routines so important?**

2. **What can you do to encourage the development of friendships?**

3. **What is the value to helping people develop friendships?**

4. What are some of the social skills a person might need to encourage friendship?

5. What can you do if you feel unprepared to answer questions about issues relating to intimate relationships?

Activity
Daily Routines

Write down, in as much detail as possible, everything you do from the minute you wake up in the morning until you arrive at work. Be very specific. You will be sharing this list, so don't include things that might embarrass you.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16.

17.

18.

Discussion
Routines, Routines, and More Routines

Daily

Weekly

Monthly

Yearly

Life cycle

Information Brief

Individual Routines

Most of us hardly think about our daily routines as they help get us through the day. Maybe, that's why we haven't thought much about the role that individual routines play in the quality of the lives of people we support.

We all have routines for the week, the month, the year and those rites of passage and life cycle events that are positive parts of our lives. We need to consider the role that individual routines play and insure that positive routines are respected.

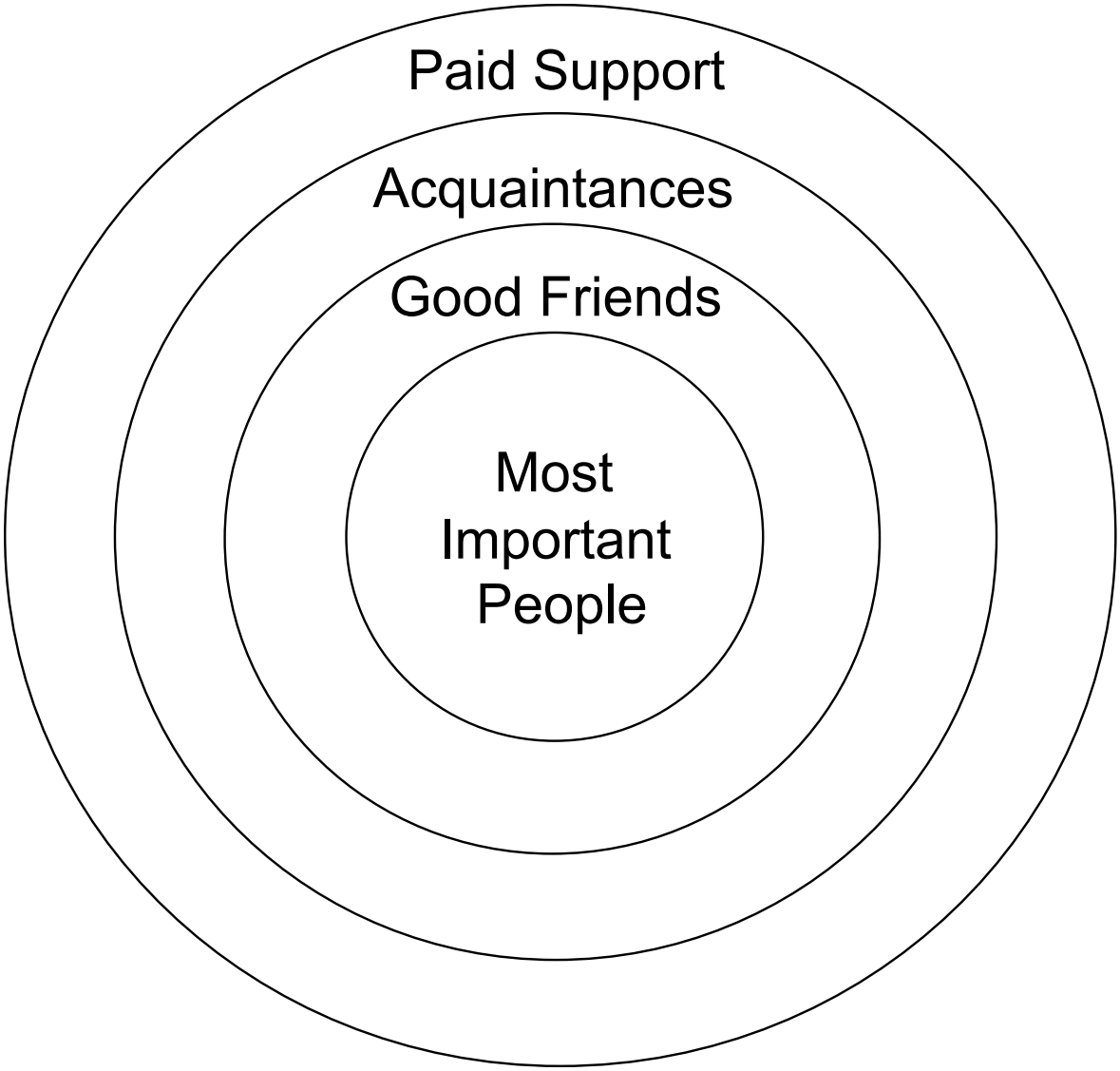
Our individual routines begin each morning. We all have a pattern of activities that we do daily and which are comforting to us. How does that comfort change for the people we support? Do you take a bath or a shower? Whether a person takes a bath or shower could change with each staff member and the variety of ways to bathe increases depending on the number of people who support each person. Could you change your morning pattern very easily?

There are emotional routines that we all have as well. When you have had a bad day at work, you might need to go home and lay down. Others might need to scream, others might need to take a walk, others might need to talk with someone. For the people we support, the reaction to a bad day could be seen as bad or inappropriate behavior, even though we might need to behave in the same way in that situation. It is important to know how people would like us to respond to their emotional calming routines.

Not every moment needs to be programmed for people. The DSP may be responsible for getting many people ready to leave the house in the morning. Through that, individual routines can still be identified and honored.

Could you live by someone else's morning routine?

Activity
Your Circle of Friends



Information Brief

Why Work on Friendships?

- Friendships are important to all people
- Health and well-being are improved
- Balancing the number of people who are paid to be part of someone's life with people who are just friends
- More power and control
- Reducing personal stress and staff burnout
- Giving back to the community

Information Brief

Why Friends Are Important?

We all take friendship for granted. We might miss our friends if they are gone for a while, but most of the time we don't really think about the fact that we **have** friends. We have started to see the importance of people with developmental disability labels having connections with ordinary people. So many of the people in the lives of the people we support are paid to be there. While those may be satisfying relationships, there still is the element of paid friendships that is very different from most of our lives.

Friends don't care what's in the person's IPP objectives. They like the person "just because." There is no program for starting a friendship. There are no data to maintain.

Friends can offer people a way to practice what we teach in our programs. Have you ever had to do something difficult – like give a speech, or register a complaint – and you practiced first with a friend?

Friendships have an energy that can't be otherwise created. When two people do things together, more can be accomplished than if they had each tried on their own.

Friends accept us as we are. Our friends are used to some of our unusual behaviors or mannerisms, and don't try to change them. The people we support need someone who also accepts unusual behavior as "just a part of the person they like."

As DSPs, we can't write programs for making friends. We can, though, help to set up ways in which friendships can happen. People can join activities that they enjoy and meet people in the course of the activity. People can "hang out" at places where other people get to know them. Think about some ways that you can help people make connections.

Information Brief

As Relationships Grow

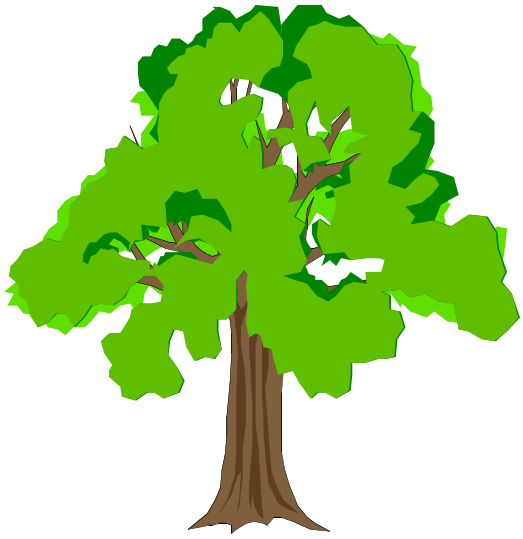
Studies show that the reason that friendships grow is because people live close to each other and are able to see each other on a regular basis. The lesson for DSPs is that we may have to assist people in starting relationships, and be available to encourage their continuation. We might have to provide transportation so people can spend time away from our homes, assist in planning activities, and assist with training on social skills that are needed to continue relationships.

Some of the skills that friendship requires have never been taught to people with developmental disabilities. People need to know things like how to listen to another person. We know that listening is a very difficult skill requiring practice. All people have a very tough time listening. Yet, listening to someone is the best way to learn more about them.

A friend needs to be able to communicate well enough to get their message across to another person. A person needs to know either what words or what gestures to use to assure that the person to whom they are speaking will understand what they are trying to say.

Friends are thoughtful, and do thoughtful things for each other. Are there ways that people you support either need to learn to think about what might please another person or think about ways they can let another person know they care?

These are some of the skills that are important to starting and keeping friendships. Perhaps you can think of others as well.



Answers to In-Class Review

1. What is the importance of individual routines in our daily lives? Why is understanding people's routines so important?

Our individual routines help us get through each day, as well as each week, month and year. Routines are comforting and add to our quality of life. The same is true for the people we support. The order in which a person's face is washed or whether they shower or bathe is very important to the people we support. Individual routines need to be discovered and respected.

2. What can you do to encourage the development of friendships?

Help people to find out who they might want to get to know better, provide transportation for people, help make phone calls, find activities that people like to do, can share with another person, and build on shared interests.

3. What is the value to helping people develop friendships?

People feel like they have more power and control over their lives if there is a friend who cares about them. Studies show that people are healthier when someone cares, stress and burnout to the staff is reduced because staff don't have to take so many roles in a person's life. People can give back to the community.

4. What are some of the social skills a person might need to encourage friendship?

Listening to another person, communicating well, doing thoughtful deeds.

5. **What can you do if you feel unprepared to answer questions about issues relating to intimate relationships?**

Talk with the regional center service coordinator to find someone who IS comfortable, and to identify resources in your area for further information, and read materials referenced in the Resource Guide.

If You Want to Read More About
Daily Living

A Guide to Consent
by Robert D. Dinerstein, J.D. , Stanley S. Herr, J.D., Ph.D., and Joan L. O'Sullivan, J.D.; (1999); AAMR, ISBN 0-940898-58-61

What happens when an individual with limited cognitive abilities makes a decision that could harm him or her? This book deals with the broad range of issues related to decision-making, including consent to sexual activity.

Rituals for Our Times: Celebrating, Healing, and Changing Our Lives and Our Relationships
by Evan Imber-Black and Janine Roberts; (1992); Harper Collins, ISBN 0765701561

This book provided the background for Michael Smull's discussion on the importance of the rituals in our life.

Friendships and Community Connections between People with and without Developmental Disabilities
by Angela Novak Amado (1993); Paul H. Brookes Publishing Co.;
ISBN 1-55766-121-9

Being "integrated" into a community goes beyond living in a home in a regular neighborhood. It means having friendships with others in that community who do not have disability labels. Colleen Wieck Ph.D. comments on the back cover that we need to help people to not merely be in the community but to be part of the community as well. There are a number of very touching and honest stories of friendships from people outside of the professional field of disabilities.

The Great Good Place – Cafes, Coffee Shops, Community Centers, Beauty Parlors, General Stores, Bars, Hangouts and How They Get You through the Day
by Ray Oldenburg (1997); Marlowe and Company; ISBN 1-56924-778-1

The book talks about places Oldenburg refers to as "third places," where people can get together and hang out just to enjoy people and have conversations. The book shows that we all have a strong need to associate with other people.

Just Say Know! Understanding and Reducing the Risk of Sexual Victimization of People with Developmental Disabilities

by Dave Hingsburger (1995); Diverse City Press; ISBN 1-896230-00-8

Just Say Know! is an easy to read book full of powerful information and real stories about real people. Dave Hingsburger writes about the practices and assumptions the field has offered and how those practices and assumptions have hurt people with disabilities. Through the book, the notion that sex is a natural part of our lives is repeated as an important message for people as well as a way to help people to protect themselves from sexual assault.

Socialization and Sexuality: A Comprehensive Training Guide for Professionals Helping People with Developmental Disabilities that Hinder Learning

by Winifred Kempton (1993); Winifred Kempton Associates

This book offers information, resources and materials for teaching about sexuality and disability. The book is full of training materials for teaching sexual safety, sexual pleasure and responsibility.

Homework Assignment for Session #10: Looking at Physical Accessibility

At your next session, you will be talking about **Individual Rights, Laws and Regulations**. One of the laws you will talk about is the Americans with Disabilities Act (ADA). Here's an opportunity to find out what the ADA really means about physical accessibility. Grab yourself a tape measure, the Physical Accessibility Checklist and go check out a public building. It could be a city hall, a library, a sheltered workshop, a place of business (large or small) such as a bank, grocery store, flower shop, your regional center, or the place where you work. Be sure to check out a restroom too. Bring your completed survey to class to discuss.

Physical Accessibility Checklist

(Excerpted from Jewish Family and Children's Services)

When choosing a meeting site or checking a public building for physical accessibility, consider the following:

	YES	NO	N/A
1. If parking is provided, there should be reserved parking places that are clearly marked with the access symbol.	☐	☐	☐
2. There should be an unobstructed path of travel from the parking space to the curb cut to the building entrance or the event area.	☐	☐	☐
3. The entrance to the building should be at least 32" wide in order to accommodate a wheelchair. The doorway threshold should be no higher than 1/2". The entrance door(s) should open easily (automatic doors or levered handles; minimal pressure).	☐	☐	☐
4. Directional signs should be in large print or braille.	☐	☐	☐
5. Building corridors should be at least 36" wide and free of obstructions.	☐	☐	☐
6. The meeting room or event area should be on the building entry floor or accessible by elevator. If the event is an open-air event, it should be held on a flat outside surface.	☐	☐	☐
7. Any ramped or steep areas should be sloped 1:10-1:12, must be durable (for portable ramps) and should have handrails on either side.	☐	☐	☐
8. There should be brailled numbers on the elevator control panels.	☐	☐	☐
9. The meeting room entry should be a minimum of 32" wide, with a threshold no higher than 1/2" and with easily opened door(s).	☐	☐	☐
10. For open-air events, there should be flat-surface area(s) for viewing/ participation which has an accessible path of travel.	☐	☐	☐
11. The drinking fountains should be no higher than 48" from the floor, or if higher, then drinking cups should be provided.	☐	☐	☐
12. Telephones should be no higher than 48" from the floor and be equipped with sound amplifiers. TDDs should be available.	☐	☐	☐
13. In order to be accessible, a restroom facility should have the following factors:			
a. signage to indicate accessibility	☐	☐	
b. entries free from obstructions	☐	☐	
c. doorways with 32" minimum clearance width	☐	☐	
d. doorway threshold no higher than 1/2"	☐	☐	
e. easily opened door(s)	☐	☐	
f. restroom stall door which swings outward; at least 32" clearance width.	☐	☐	
g. stall at least 36" wide, 60" deep	☐	☐	
h. grab bars in stall	☐	☐	
i. raised commode 17-19" from floor	☐	☐	
j. faucets with lever-type handles	☐	☐	
k. basin with 30" clearance underneath and wrapped pipes	☐	☐	
l. towel racks and mirrors no higher than 40" from floor	☐	☐	

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #10
Individual Rights, Laws and Regulations

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services
1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Postive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	**Individual Rights, Laws and Regulations**	**3 hours**
11	Leisure and Recreation	3 hours
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Laws and Regulations
- Title 17, Title 22
- Lanterman Act
- Regional Center
- Community Care Licensing
- Special Incident Report
- Mandated Reporter
- Confidentiality

Your In-Class Review Notes

This is a place for you to take notes on the review questions during this session.

1. **Name at least three agencies/organizations that are a part of the Developmental Disabilities services system in California.**

2. **Name at least three laws or regulations that regulate/monitor services to individuals with developmental disabilities.**

3. **Parents continue to be "natural guardians" and make decisions for adult sons/daughters with developmental disabilities if they are still living at home with their parents.**

   True_____ False_____

4. **Name at least three rights guaranteed by the U.S. Constitution.**

5. **Welfare and Institutions Code recognizes the rights of individuals with developmental disabilities to choose where to live and with whom.**

   True_____ False_____

6. If a resident gets into a fight with a roommate it is OK to deny them the use of the telephone for 2 weeks as punishment.

True_____ False_____

7. Name at least three things that are considered abuse under the Child Abuse and Dependent Adult Abuse laws.

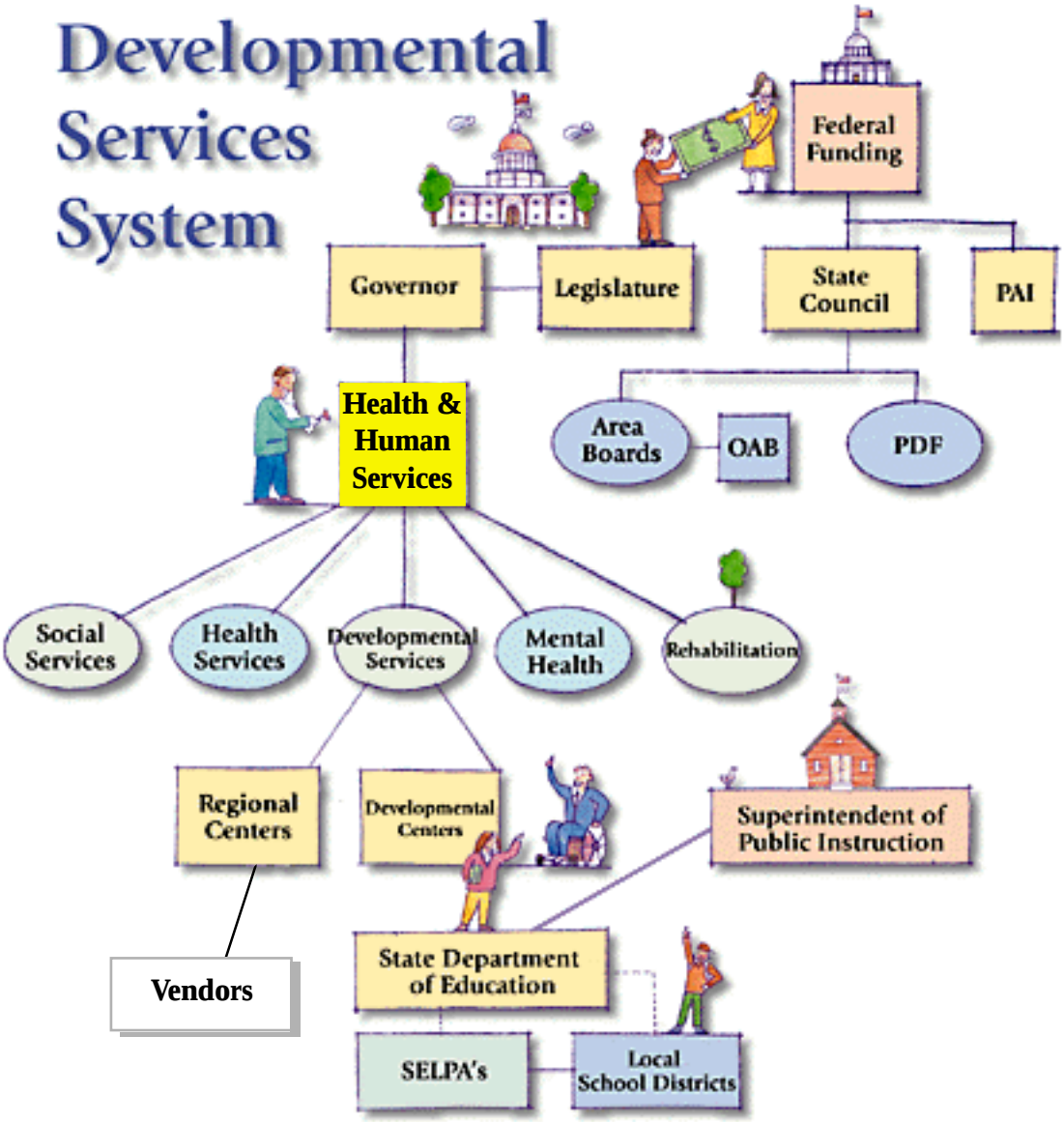
8. Failure to report physical abuse is a misdemeanor, punishable by ____ months in jail or a fine of $_____ or both.

9. Licensee shall furnish the licensing agency with reports (check all that apply)

a. When a resident dies for any reason, in any place.
b. Gets in a verbal fight with another resident.
c. A resident is injured and requires medical treatment.

10. A written Special Incident Report shall be submitted to the regional center within _____ 24 hours _____ 7 days _____ immediately

11. Name one way to be sure that an individual who is non-verbal, understands information to make the best choices in his or her life.



Adapted from *Tri Counties Regional Center* website at **http://www.tri-counties.org/tritour.html**

Information Brief

A Brief Description of Major Agencies

The following are the major state agencies in the developmental disabilities services system in the State of California:

Health and Human Services Agency
The umbrella agency for the Departments of Social Services, Health Services, Developmental Services, Mental Health and Rehabilitation.

Department of Social Services (DSS)
The Community Care Licensing Division licenses homes for children and adults with developmental disabilities.

Department of Health Services (DHS)
Administers the Medi-Cal program that pays for health care. Also, licenses and monitors homes for people with developmental disabilities and significant health needs.

Department of Developmental Services (DDS) Contracts with 21 Regional Centers to provide services to children and adults with developmental disabilities including service coordination and funding of services which cannot be provided by generic, community agencies. DDS is also responsible for managing the state developmental centers.

Department of Mental Health Oversees county mental health services.

Department of Rehabilitation (DR)
Furnishes funding for Work Activity Programs (WAP) which included work support services in sheltered and community-based employment settings.

Department of Education (DOE)
Manages special education programs in public school system. **Special Education Local Planning Agencies (SELPA)** Determine own structures to provide programs to students. **Local School Districts** Provide classes and training to children with disabilities.

State Council on Developmental Disabilities (SCDD) Develops a state plan which looks at the future of developmental disabilities services; reviews and comments on budgets and regulations of state agencies which provide services to people with developmental disabilities; and, funds the Area Boards.

Protection and Advocacy (PAI) Protects the civil and service rights of Californians with developmental disabilities through legal advocacy.

Area Boards Protects the rights of Californians with developmental disabilities through public information, education, monitoring policies and practices of publicly funded agencies.

Organization of Area Boards (OAB)
Coordinates and supports the activities of local Area Boards.

Information Brief

Community Care Licensing Offices

NORTHERN REGIONAL OFFICE
8745 Folsom Blvd., Suite 130
Sacramento, CA 95826
(916) 229-4500 FAX (916) 229-4508

CHICO DISTRICT - RESIDENTIAL AND CHILD CARE
520 Cohasset Road, Suite 6
Chico, CA 95926
(530) 895-5033 FAX (530) 895-5934
Counties: Butte, Colusa, Del Norte, Glenn, Humboldt, Lassen, Modoc, Plumas, Shasta, Siskiyou, Sutter, Tehama, Trinity and Yuba

COASTAL REGIONAL OFFICE
801 Traeger Ave., Suite 105
San Bruno, CA 94066
(650) 266-8860 FAX (650) 266-8877

SACRAMENTO DISTRICT - RESIDENTIAL
2400 Glendale Lane, Suite C
Sacramento, CA 95825
(916) 574-2346 FAX (916) 574-2382
Counties: Alpine, Amador, Calaveras, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Stanislaus, Tuolumne and Yolo

SACRAMENTO DISTRICT- CHILD CARE
8745 Folsom Blvd., Suite 200
Sacramento, CA 95826
(916) 229-4530 FAX (916)387-1933
Counties: Alpine, Amador, Calaveras, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Stanislaus, Tuolumne and Yolo

REDWOOD EMPIRE DISTRICT-RESIDENTIAL AND CHILD CARE
101 Golf Course Drive, Suite A-230
Rohnert Park, CA 94928
(707) 588-5026 FAX (707) 588-5080
Counties: Lake, Marin, Mendocino, Napa, Solano, and Sonoma

FRESNO DISTRICT-RESIDENTIAL AND CHILD CARE
770 E. Shaw Avenue, Suite 330
Fresno, CA 93710
(209) 445-5691 FAX (209)445-5097
Counties: Fresno, Kern, Kings, Madera, Mariposa, Merced and Tulare

CENTRAL COAST AREA-RESIDENTIAL AND CHILD CARE
360 S. Hope Avenue, Suite C-105
Santa Barbara, CA 93105
(805) 682-7647 FAX (805) 682-8361
Counties: San Luis Obispo, Santa Barbara, and Ventura

BAY AREA DISTRICT-CHILD CARE
1515 Clay Street, Suite 1102
Oakland, CA 94612
(510) 622-2602 FAX (510) 622-2641
Counties: Alameda and Contra Costa

PENINSULA DISTRICT-CHILD CARE
801 Traeger Avenue, Suite 100
San Bruno, CA 94066
(650) 266-8843 FAX (650) 266-8847
Counties: San Francisco and San Mateo

SAN FRANCISCO BAY-RESIDENTIAL
851 Traeger Avenue, Suite 360
San Bruno, CA 94066
(650) 266-8800 FAX (650) 266-8841
Counties: Alameda, Contra Costa, San Francisco, and San Mateo

SAN JOSE-CHILD CARE
111 North Market Street, Suite 300
San Jose, CA 95113
(408) 277-1286 FAX (408) 277-2071
Counties: Monterey, San Benito, Santa Clara and Santa Cruz

SAN JOSE DISTRICT-RESIDENTIAL
111 North Market Street, Suite 350
San Jose, CA 95113
(408) 277-1289 FAX (408) 277-2045
Counties: Monterey, San Benito, Santa Clara and Santa Cruz

SOUTHERN REGIONAL OFFICE
5900 Pasteur Court, Suite 125
Carlsbad, CA 92008
(760) 929-2121 FAX (760) 929-2133

MISSION VALLEY DISTRICT- CHILD CARE
8765 Aero Drive, Suite 300
San Diego, CA 92123
(619) 467-4388 FAX (619) 492-1755
Counties: San Diego and Imperial

SAN DIEGO DISTRICT-RESIDENTIAL
8745 Aero Drive, Suite 200
San Diego, CA 92123
(619) 467-2367 FAX (619)467-2373
Counties: San Diego and Imperial

SAN GORGONIO OFFICE-CHILD CARE
3737 Main Street, Suite 700
Riverside, CA 92501
(909) 782-4200 FAX (909) 782-4985
Counties: Inyo, Mono, Riverside and San Bernardino

INLAND EMPIRE OFFICE-RESIDENTIAL
3737 Main Street, Suite 600
Riverside, CA 92501
(909) 782-4207 FAX (909) 782-4967
Counties: Inyo, Mono, Riverside and San Bernardino

ORANGE COUNTY-CHILD CARE
750 The City Drive, Suite 250
Orange, CA 92668
(714) 703-2800 FAX (714) 703-2831
Counties: Orange

ORANGE COUNTY-RESIDENTIAL
770 The City Drive, Suite 7100
Orange, CA 92668
(714) 703-2840 FAX (714) 703-2868
Counties: Orange

LOS ANGELES REGIONAL OFFICE
100 Corporate Pointe, Suite 350
Culver City, CA 90230
(310) 665-1940 FAX (310) 665-1979

LOS ANGELES RESIDENTIAL EAST
1000 Corporate Center Drive, Suite 200A
Monterey Park, CA 91754
(213) 981-3300 FAX (213) 981-3309

L.A. RESIDENTIAL NORTHERN VALLEYS
21731 Ventura Blvd., Suite 250
Woodland Hills, CA 91364
(818) 596-4334 FAX (818) 596-4376

LOS ANGELES RESIDENTIAL WEST
6167 Bristol Parkway, #210
Culver City, CA 90230
(310) 568-1807 FAX (310) 417-3680

L.A. NORTHWEST CHILD CARE
6167 Bristol Parkway, #400
Culver City, CA 90230
(310) 337-4333 FAX (310) 337-4360

L.A. CHILD CARE EAST
1000 Corporate Center Dr., Suite 200B
Monterey Park, CA 91754
(323) 981-3350 FAX (323) 981-3355

Information Brief

Regional Centers

Alta California Regional Center
2031 Howe Avenue, Suite 100
Sacramento, CA 95825
Phone: (916) 614-0500 Fax: (916) 929-1036
Areas served by the regional center: Colusa, Placer, El Dorado, Alpine, Sierra, Nevada, Sacramento, Yuba, Yolo, and Sutter Counties.

Central Valley Regional Center
5168 North Blythe
Fresno, CA 93722
Phone: (559) 276-4300 Fax: (559) 276-4450
Areas served by the regional center: Merced, Mariposa, Madera, Fresno, Kings, and Tulare Counties.

Eastern Los Angeles Regional Center
1000 S. Fremont Avenue
P.O. Box 7916
Alhambra, CA 91802-7916
Phone: (626) 299-4700 Fax: (626) 281-1163
Areas served by the regional center: East Los Angeles, Northeast Los Angeles, Whittier District, Alhambra District.

Far Northern Regional Center
1900 Churn Creek Road, #319
P.O. Box 492418
Redding, CA 96002
Phone: (530) 222-4791 Fax: (530) 222-6063
Areas served by the regional center: Butte, Glenn, Shasta, Siskiyou, Tehama, Modoc, Plumas, Lassen, and Trinity Counties.

Golden Gate Regional Center
120 Howard Street, Third Floor
San Francisco, CA 94105
Phone: (415) 546-9222 Fax: (415) 546-9203
Areas served by the regional center: San Mateo, Marin, and San Francisco Counties.

Harbor Regional Center
21231 Hawthorne Blvd.
Torrance, CA 90503
Phone: (310) 540-1711 Fax: (310) 540-9538
Areas served by the regional center: Bellflower, Harbor, Long Beach, and Torrance Health Districts.

Inland Regional Center
674 Brier Drive
P. O. Box 6217
San Bernardino, CA 92412-6217
Phone: (909) 890-3000 Fax: (909) 890-3001
Areas served by the regional center: Riverside and San Bernardino Counties.

Kern Regional Center
3200 North Sillect Avenue
Bakersfield, CA 93308
Phone: (661) 327-8531 Fax: (661) 324-5060
Areas served by the regional center: Kern, Inyo, and Mono Counties.

Lanterman Regional Center
3440 Wilshire Blvd., Suite 400
Los Angeles, CA 90010
Phone: (213) 383-1300 Fax: (213) 383-6526
Areas served by the regional center: Pasadena, Hollywood, Wilshire, Central Los Angeles, Glendale/Foothill.

North Bay Regional Center
10 Executive Court, Suite A
P.O. Box 3360
Napa, CA 94558
Phone: (707) 256-1100 Fax: (707) 256-1112
Areas served by the regional center: Napa, Sonoma, and Solano Counties.

North Los Angeles County Regional Center
15400 Sherman Way, Suite 300
Van Nuys, CA 91406
Phone: (818) 778-1900 Fax: (818) 756-6140
Areas served by the regional center: San Fernando, Antelope, Santa Clarita, Conejo Valleys.

Redwood Coast Regional Center
808 E Street
Eureka, CA 95501
Phone: (707) 445-0893 Fax: (707) 444-3409
Areas served by the regional center: Humboldt, Del Norte, Mendocino, and Lake Counties.

Regional Center of the East Bay
7677 Oakport Street, Suite 1200
Oakland, CA 94621
Phone: (510) 383-1200 Fax: (510) 633-5020
Areas served by the regional center: Alameda and Contra Costa Counties.

Regional Center of Orange County
801 Civic Center Drive West
P.O. Box 22010
Santa Ana, CA 92702-2010
Phone: (714) 796-5222 Fax: (714) 547-4365
Area served by the regional center: Orange County.

San Andreas Regional Center
300 Orchard City Drive, Suite 170
Campbell, CA 95008
Phone: (408) 374-9960 Fax: (408) 376-0586
Areas served by the regional center: San Benito, Monterey, Santa Clara, and Santa Cruz Counties.

San Diego Regional Center
4355 Ruffin Road
San Diego, CA 92123
Phone: (619) 576-2996 Fax: (619) 576-2873
Areas Served by the regional center: San Diego and Imperial Counties.

San Gabriel/Pomona Regional Center
761 Corporate Center Drive
Pomona, CA 91768
Phone: (909) 620-7722 Fax: (909) 622-5123
Areas served by the regional center: San Gabriel, Pomona, Monrovia, Glendora and El Monte.

South Central Los Angeles Regional Center
2160 West Adams Blvd.
Los Angeles, CA 90018
Phone: (323) 734-1884 Fax: (323) 730-2286
Areas served by the regional center: Compton, San Antonio, South Los Angeles, Southeast Los Angeles, and Southwest Los Angeles Health Districts.

Tri-Counties Regional Center
520 East Montecito Street
Santa Barbara, CA 93013
Phone: (805) 962-7881 Fax: (805) 966-5935
Areas served by the regional center: Ventura, Santa Barbara, and San Luis Obispo.

Valley Mountain Regional Center
7109 Danny Drive
P.O. Box 692290
Stockton, CA 95269-2290
Phone: (209) 473-0951 Fax: (209) 473-0256
Areas served by the regional center: Amador, Calaveras, San Joaquin, Stanislaus, and Tuolumne.

Westside Regional Center
5901 Green Valley Circle, Third Floor
Culver City, CA 90230
Phone: (310) 337-1155 Fax: (310) 649-2033
Areas served by the regional center: Inglewood and Santa Monica West Health Districts.

Information Brief

Area Boards

Area Board I
Del Norte, Humboldt, Lake, Mendocino
P.O. Box 245
Ukiah, CA 95482
(707) 463-4700 Fax: (707) 463-4752

Area Board II
Butte, Shasta, Glenn, Siskiyou, Lassen, Tehama, Plumas, Modoc, Trinity
1367 E. Lassen Ave., #B3
Chico, CA 95926
(530) 895-4027 Fax: (530) 899-1562

Area Board III
Alpine, Sacramento, Colusa, El Dorado, Sutter, Nevada, Yolo, Placer, Yuba, Sierra
1010 Hurley Way, Ste. 195
Sacramento, CA 95825
(916) 263-1150 Fax: (916) 263-1155

Area Board IV
Napa, Solano, Sonoma
236 Georgia St., Suite 201
Vallejo, CA 94590
(707) 648-4073 Fax: (707) 648-4100

Area Board V
Alameda, Contra Costa, Marin, San Francisco, San Mateo
360 22nd Street, Ste 730
Oakland, CA 94612
(510) 286-0439 Fax: (510) 286-4397

Area Board VI
Amador, Calaveras, Tuolumne, San Joaquin, Stanislaus
250 Cherry Lane, Ste 113
Manteca, CA 95336
(209) 239-6700 Fax: (209) 239-3081

Area Board VII
Monterey, San Benito, Santa Cruz, Santa Clara
359 Northlake Drive
San Jose, CA 95117-1261
(408) 246-4355 Fax: (408) 246-6658

Area Board VIII
Mariposa, Madera, Merced, Fresno, Kings, Tulare, Kern
770 East Shaw Ave., Suite 123
Fresno, CA 93710
(559) 222-2496 Fax: (559) 248-2886

Area Board IX
San Luis Obispo, Santa Barbara, Ventura
7127 Hollister Ave., Ste 22
Goleta, CA 93117
(805) 685-8395 Fax: (805) 685-4896

Area Board X
Los Angeles
411 North Central Ave., Suite 620
Glendale, CA 91203-2020
(818) 543-4631 Fax: (818) 543-4635

Area Board XI
Orange
250 S. El Camino Real, Ste 110
Tustin, CA 92680
(714) 731-4787 Fax: (714) 573-1839

Area Board XII
Inyo, Mono, Riverside, San Bernardino
1960 Chicago Ave., Ste E8
Riverside, CA 92507
(909) 782-3226 Fax: (909) 781-0896

Area Board XIII
San Diego, Imperial
4711 Viewridge Ave., Suite 160
San Diego, CA 92123
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Information Brief

Protection and Advocacy, Inc.

- E-mail: legalmail@pai-ca.org
- Toll Free - Legal Offices/TDD - - 1-800-7765746
- Toll Free - Office of Patients' Rights - - 1-800-254-5166
- Administrative Office, 100 Howe Avenue, Suite 185-N
  Sacramento, CA 95825 (916) 488-9955
- Sacramento Legal Office, 100 Howe Avenue, Suite 235-N,
  Sacramento, CA 95825 (916) 488-9950
- Southern California Legal Office, 3580 Wilshire Blvd.,Suite 902, Los Angeles, CA
  90010 (213) 427-8747
- Bay Area Legal Office, 449 15th Street, Suite 401
  Oakland, CA 94612 (510) 839-0811
- Office of Patients' Rights, 100 Howe Avenue, Suite 240-N
  Sacramento, CA 95825 (916) 575-1610

Information Brief

Key Laws and Regulations

Laws

Rehabilitation Act of 1973 This Act is known as the first federal civil rights law protecting the rights of individuals with disabilities. It prohibits discrimination based on disability in the following areas: (1) Education; (2) Vocational Education; (3) College Programs; (4) Employment; (5) Health, social service programs, welfare; and (6) Federally funded programs.

The Americans with Disabilities Act (ADA) Congress passed this law in July of 1990. It is a landmark civil rights bill that extends protection against discrimination to people with disabilities. It requires modifications, accessibility and reasonable accommodations, covers state and local governments, and it addresses four main areas of potential discrimination: (1) Employment; (2) Public facilities; (3) Transportation; and (4) Communication.

Individuals with Disabilities Education Act (IDEA) Guarantees six important rights: (1) Free and appropriate public education for all children with disabilities; (2) Education in the least restrictive environment; (3) An individualized education program (IEP); (4) Provision of necessary related services in order to benefit from special education; (5) Fair assessment procedures; and (6) Due process and complaint procedures.

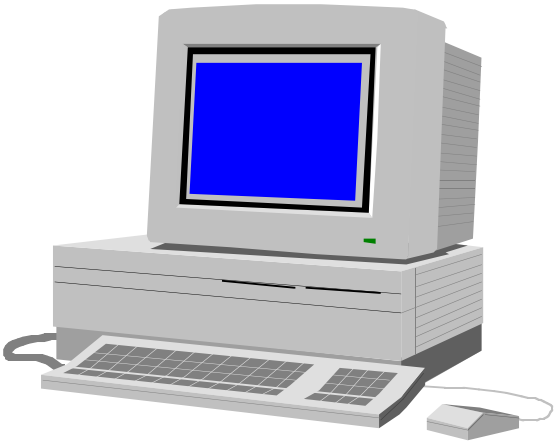
IDEA, Part C Early education opportunities available to infants and toddlers less than 3 years of age who have low incidence disabilities or are developmentally delayed or at risk of such delay.

The Lanterman Developmental Disabilities Services Act (Lanterman Act) This Act provides a statement of the service rights and responsibilities of individuals with developmental disabilities; an entitlement to services and supports; and, it creates the regional center system of providing services throughout the state.

Regulations

Title 17, Department of Developmental Services Regulations These regulations govern how services are delivered within the California developmental disabilities services system (which includes licensed homes). Copies of Title 17 may be obtained at a local regional center or by contacting **Barclays Law Publishers,** 400 Oyster Point Blvd., P.O. Box 3066, South San Francisco, CA 94080 (415) 244-6611 or at the Department of Developmental Services website.

Title 22, Division 6, Licensing of Residential Facilities These are the **Department of Social Services** regulations, policies and procedures for licensing, monitoring and evaluating **Community Care Facilities**. Individuals or agencies who are granted a license to operate a residential facility must comply with all of the Title 22 regulations. Copies of Title 22 may be obtained at a local licensing office or by contacting **Barclays Law Publishers,** 400 Oyster Point Blvd., P.O. Box 3066, South San Francisco, CA 94080 (415) 244-6611 or at the Department of Social Services website.



Title 22 Regulations are now available on the Internet from the Community Care Licensing Division of the Department of Social Services at

<http://www.dss.cahwnet.gov/getinfo/cacoderegs.html>

Title 17 Regulations are now available on the Internet from the Department of Developmental Services at

<http://www.dds.cahwnet.gov/laws003.cfm>

Information Brief

Lanterman Act

The Lanterman Act sets out the rights and responsibilities of individuals with developmental disabilities, and creates the agencies, including regional centers, responsible for planning and coordinating services and supports for individuals with developmental disabilities and their families.

The Lanterman Act establishes that the State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge.

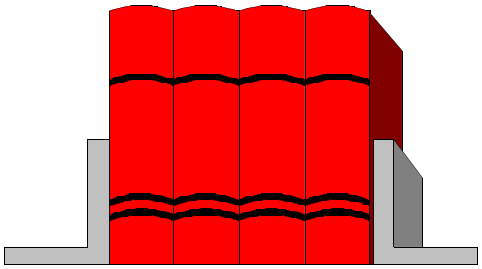
It establishes an entitlement to services and supports for persons with developmental disabilities, those at risk of developing a developmental disability, and their families.

The Lanterman Act states that individuals with developmental disabilities and their families have the right to receive services and supports which will enable them to make decisions and choices about how, and with whom, they want to live their lives; achieve the highest self-sufficiency possible; and lead productive independent and satisfying lives as part of the communities in which they live.

In addition to the entitlement to services and supports, the Lanterman Act creates the regional center as the central coordinating agency in a community network. The regional center has the mandate to ensure that individuals for whom it is responsible receive services and supports which will assist them in living productively in their communities.

In addition to regional centers, the Lanterman Act established the agencies necessary to fund and monitor the developmental service system:

- Department of Developmental Services
- Area Boards
- State Council on Developmental Disabilities
- Protection and Advocacy
- Vendor Agencies



Information Brief

Basic Rights

Constitutional Rights

Individuals with developmental disabilities have the same rights as everyone else under the Constitution of the United States and the California Constitution. Those rights include:

Freedom of Speech
Right to Due Process
Freedom of Religion
Freedom of Association
Freedom of Assembly
Equal Protection of the Law
Right to Privacy

In addition, the United States and California governments have passed statutes, which set out particular rights for individuals who have developmental disabilities.

Citizens of the State of California

In California, the Lanterman Act spells out these rights:

A right to treatment and habilitation services and supports.

A right to dignity, privacy and humane care.

A right to participate in an appropriate program of publicly supported education.

A right to prompt medical care and treatment.

A right to religious freedom and practice.

A right to social interaction and participation in community activities.

A right to physical exercise and recreational opportunities.

A right to be free from harm.

A right to be free from hazardous procedures.

A right to make choices including, but not limited to, where and with whom to live; relationships with people in their community; the way they spend their time, including education, employment and leisure; the pursuit of their personal future; and program planning and implementation.

A right to have relationships, marry, be part of a family, and to parent if they so choose.

The Lanterman Act also states that individuals with developmental disabilities who live in residential facilities have these additional rights:

To wear their own clothes.

To keep and use their own personal possessions, including toiletry or personal hygiene articles.

To keep and be allowed to spend a reasonable sum of their own money.

To have access to individual storage space for private use.

To see visitors each day.

To have reasonable access to telephones, both to make and receive confidential calls.

To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

To refuse electroconvulsive therapy.

To refuse behavior modification techniques which cause pain or trauma.

To refuse psychosurgery.

To make choices in areas including, but not limited to: daily living routines, choice of companions, leisure and social activities, and program planning and implementation.

To choose and to have information needed to make an informed choice.

In addition, the *Lanterman Act (Welfare and Institutions Code)* recognizes the rights of individuals with disabilities to have relationships, marry, be part of a family and to parent if they so choose.

Individuals living in community care residences have:

The right to make personal choices about sexual values, preferences, and behavior.

The right to be given accurate information about sex education in an understandable way.

The right to sexual expression.

The right to privacy.

The right to have a "significant other" or to marry, if the person so chooses.

The right to choose parenthood; this also requires the right to be given information about birth control options, and to choose or refuse contraception and/or sterilization.

The right to receive services needed: counseling, legal aid, social and recreation services with the opposite sex.

Denial of Rights

Most individual rights may not be denied for any reason. A few rights may be denied for a limited period of time and under a very narrow set of circumstances called the ***Denial of Rights Procedure***. <u>These rights may be denied only when certain conditions are documented and the denial is approved by the regional center.</u>

Information Brief

Parents and Others as Legally Authorized Representatives

There are some terms you need to know in order to understand the rights and responsibilities of parents and other legally authorized representatives.

Competence
Competence (or incompetence) is about the ability of an individual to make decisions. Until a person reaches the age of majority (age 18 in California), he/she is ***presumed to be incompetent***. That is, not able to manage alone or to come to reasoned decisions about certain important matters. Upon reaching the age of majority, even if the person has a significant intellectual impairment, he/she is ***presumed to be competent***.

Parents
Parents are considered ***natural guardians*** of their biological or adopted children and have certain rights and responsibilities in making decisions on behalf of their children.

Guardianship
Some minors need a court-appointed guardian, if parents have died, abandoned a child, or had their parental rights removed by a court of law. The issues surrounding guardianship are few, precisely because the law ***presumes incompetence***. Since 1981 guardianships have only been available for minors.

Conservatorship
A conservatorship is a legal arrangement in which a competent adult oversees the personal care or financial matters of another adult considered incapable of managing alone. Some parents incorrectly presume (as was traditional years ago) that as ***natural guardians*** of children, their legal responsibilities continue for a child with a developmental disability, if he/she has "not grown up and left the nest."

General conservatorship
This is the conventional kind of conservatorship for incapacitated adults unable to meet their own needs or manage their own affairs.

Limited conservatorship
The purpose of limited conservatorship is to protect adults with developmental disabilities from harm or exploitation while allowing for the development of maximum self-reliance. If granted by the court, the limited conservator can have decision-making authority (or be denied authority) in as many as seven areas:

1. To fix the person's place of residence.
2. Access to confidential records and papers.
3. To consent or withhold consent to marriage.
4. The right to contract.
5. The power to give or withhold medical consent.

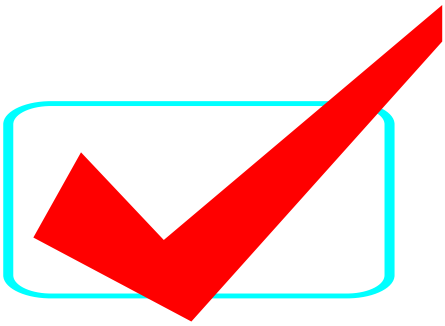
6. Decisions regarding social and sexual contacts and relations.
7. Decisions concerning education or training.

Short of a special court order, the limited conservator **may not**, however, provide substitute consent in the areas of:

1. Experimental drug treatment.
2. Electroshock therapy.
3. Placement in a locked facility.
4. Sterilization.

The **limited conservator** should have:

1. Personal knowledge of the conservatee.
2. Knowledge of what constitutes the "best interest" of the conservatee.
3. A commitment to providing that which is in the person's "best interest."
4. Financial management skills (as appropriate).
5. A knowledge of programs and services, their availability and effect.
6. Knowledge of appropriate methods of protection.
7. Proximity to the conservatee.
8. Availability in terms of time and energy.



Information Brief

Privacy and Confidentiality

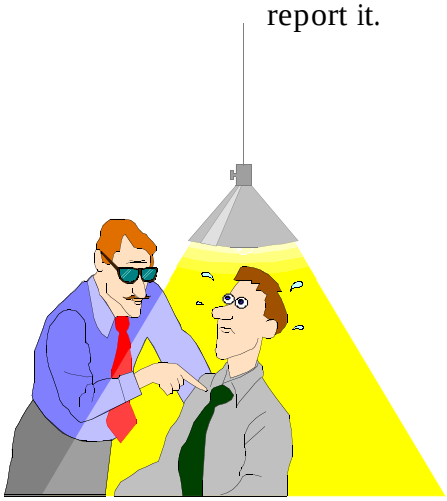
Privacy is a right guaranteed to all individuals under law. Individual **privacy** must be respected in all areas of care and supervision:

- Personal hygiene
- Personal information
- Personal possessions
- Sexual expression
- Time to be alone
- With friends and family
- Personal space in individual's bedroom
- Mail and telephone conversations

Confidentiality means that:

- You do not discuss information about individuals with your friends.
- You do not take individuals' files out of the facility.
- You do not give information to persons who might ask for it without the signed consent of the individual or legal representative.
- You do not discuss confidential information about an individual with another individual in the facility.

The DSP must respect an individual's right to confidentiality when they tell you **not** to tell, even when you feel it is important to tell someone. However, if the individual plans to/or has **broken the law**, or it is a **health and safety** issue, then you **must** report it.



Information Brief
Advocacy

Advocacy Is

Helping people help themselves
Building self confidence
Supporting independence
Telling people their rights
Telling people their options
Providing assistance and training
Helping locate services
Asking people what they want
Treating adults like adults

Advocacy Is Not

Taking over a person's life
Making a person dependent
Doing everything for a person
Not informing a person of his/her rights
Making decisions for people
Controlling people
Making adults feel like children
Limiting options
Knowing what is best because you are a professional
Not respecting choices

Locating and Using Advocacy Resources

The Lanterman Act provides for advocacy services for persons with developmental disabilities through the following agencies:

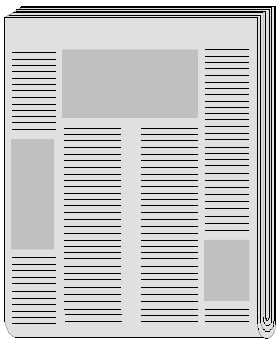
Area Boards
There are thirteen Area Boards in California which can provide individual advocacy. A vendor may contact them to obtain information on behalf of an individual with disabilities. *A list of Area Boards is included in this packet.*

Protection and Advocacy, Inc.
This federally funded, state designated agency is designed to protect the rights of individuals with disabilities. Services include legal counseling and representation if necessary. They may only represent the individual, not a vendor. *A list of addresses and phone numbers is included in this packet.*

In California there is a resource for self-advocacy called:

People First of California, Inc.
1225 8th Street, Suite 590
Sacramento, CA 95814
(916) 552-6625

In addition to the Sacramento office, there are many chapters of **People First** throughout California. The Sacramento office may be called to inquire about other chapters and obtain subscriptions to their news letter **"PEOPLE FIRST STAR."**



Activity:
What Are Your Findings?

After reading the scenario, work as a group to list the possible rights issues. You can refer back to the sections on individual rights.

SCENARIO #1: CHARLES

Charles is a 42-year-old man who has both a developmental and a physical disability (cerebral palsy, epilepsy) and it is difficult to understand his speech. There seems to have been no family contact in many years, and it is unknown if he even has family still living. He has a history of wandering away when not watched closely and tends to "borrow" tape recorders and clothing from other individuals living in the home. Charles often has what appears to be a poor appetite, plays with food on his plate and occasionally throws food. He doesn't like getting up in the morning and has to be repeatedly coaxed out of bed.

The DSP in the home makes Charles get up early on weekends because he won't get up on weekdays. He loves to sit outside on weekends and listen to his radio. It is repeatedly taken away for bad behavior and not getting up in the mornings. When other residents have family or visitors, Charles gets very excited and wants to go with them if they leave the home. Charles often sneaks out of the home right after visitors leave, and gets very angry when he is brought back home. He is only allowed to leave the facility once per month when the group goes on an outing together.

He seldom initiates activities but will participate with other residents when made to do so. He tends to hang out in the kitchen when meals are being prepared but gets in the way and DSP often make him leave the room until the meal is ready.

Possible Advocacy Issues?

SCENARIO #2: MICHAEL

Michael is a 18 year old male who uses a wheel chair and is totally dependent on others for his daily care. He often yells very loudly and is locked in his room and left there alone as punishment.

He has use of his arms and hands, but not enough strength to transfer himself. He is able to manage his manual wheel chair. He is usually uncooperative with DSPs in daily grooming, bathing, and tooth brushing. DSPs sometimes comb his hair and forget the other grooming tasks when he is especially uncooperative.

Michael has a very involved family who visits him in his home and takes him to their home on a monthly basis. The visit is often a disaster. He says he doesn't want to go and he is unhappy and grumpy for several days afterward.

Michael gets along well with one of the other young men living in the home and often spends hours in his company. He likes to share his personal possessions and often gives them away. He likes to talk on the telephone and will spend hours talking to friends. As a result, he often looses his telephone privileges for long periods of time, until he promises not to talk so long.

Possible Advocacy Issues?

SCENARIO #3: MARY

Mary is a 34-year-old woman with a history of depression and outbursts (for example, yelling, screaming, cursing, self-abuse, and threats of physical aggression). She also bosses and threatens peers at home and in the community. Mary is often kept home and in her room as a punishment for behaviors. She is not allowed to go on outings with the group if she has been bossing and threatening peers and because it is embarrassing for DSP when she acts out in the community. So, it is easier to leave her at home.

Mary also has a history of crying and screaming for several hours at night which keeps staff and other individuals in the home awake. When the DSPs reach their "wits end" they ignore her and let her cry and scream until she wears herself out and finally goes to sleep.

Mary states she wants to help handicapped children, feel loved, and not be so lonely. She states she is not a baby and feels bad when she is treated like one. She wants to go to church and sing in the church choir, learn how to take care of herself, cook and do her own laundry.

The DSP will not let Mary do any special things that she wants to do because she has such **bad** behavior and tell her that when she has **better** behavior they will help her learn to do some of the things she wants to do.

Possible Advocacy Issues?

SCENARIO #4: CHARLENE

Charlene is a 35-year-old woman who is very verbal, healthy, active at home, at work and in the community. She loves to shop for clothing, go to movies, dancing, parties, and helping with chores at home. She also likes to collect brochures, newspapers, magazines and small pieces of paper which she puts in her dresser drawers. DSPs go into her room periodically and remove her collection, throwing it in the trash, because there isn't enough room in her drawers anymore for her clothes.

Charlene knows all the merchants in her neighborhood. She tends to purchase lots of "junk" items so the DSP keep her money and make her wait until they can go with her to the store.

Charlene has a male friend, Sam, and wants to have him visit her at her home once in awhile. The administrator of the home has told Charlene that she is not allowed to have male visitors. She has also been told that she cannot go out on a date with Sam, or any other male friend.

Possible Advocacy Issues?

Information Brief

Protection from Abuse

Introduction

There is a special concern for the abuse of children, dependent adults, and the elderly. As they are more vulnerable than others, such individuals face greater risk of abuse. Reporting suspected abuse will, hopefully, not occur often in your work as a DSP. However, it's important to know your responsibilities should you need to act.

Dependent adult abuse is defined as physical abuse, neglect, financial abuse, abandonment, isolation, abduction or other treatment with resulting physical harm of pain or mental suffering, or the deprivation by a care provider *of goods and services which* are necessary to avoid physical harm or mental suffering. **Child abuse** is defined as physical injury, which is inflicted by other than accidental means on a *child by* another person, sexual abuse, willful cruelty or unjustifiable punishment *of a child, unlawful* corporal punishment or injury and neglect.

Protection Against Abuse

The DSP can help protect individuals from abuse through:

Observation - pay attention to individuals in your care. Many are nonverbal and can't tell you when something is wrong.

Communication - talk with individuals and other DSP daily.

Conversation - talk with day programs, work and others.

Documentation - write down what you see and hear.

Review - look at what you have written for patterns.

Report - if abuse is **known or suspected**.

Reporting Requirements for Child Abuse

California law requires that any child care custodian, health care practitioner, or employee of a child protective agency who knows or reasonably suspects child abuse **must** report the abuse to a child protective agency immediately or as soon as practically possible by telephone and to send a written report within **36** hours of receiving the information concerning the incident.

Reporting Requirements for Adult Abuse

A **dependent adult** is any California resident 18 to 64 years of age, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. Included is any person 18-64 years of age, regardless of physical or mental condition, who is admitted as an inpatient to a 24-hour health facility.

An **elder** is anyone residing in California, who is 65 years of age or older, whether or not impaired mentally or physically.

California law requires care custodians and health practitioners to report certain kinds of abuse. Care custodians are administrators of certain public or private facilities, including but not limited to, community care facilities, 24-hour health facilities, respite care facilities, foster homes, schools, sheltered workshops, regional centers and offices or clinics.

Mandatory Reporting

DSPs are considered mandated reporters with a legal duty to report suspicion or knowledge of child, dependent adult, or elder abuse. Failure to report can result in a mandated reporter being held liable for both criminal and civil consequences. Conversely, the mandated reporter has complete immunity from legal actions even if the report turns out to be false.

All allegations of *abuse shall be reported* by telephone as soon as possible to either Child Protective Services, Adult Protective Services or the Ombudsman's office depending upon the age of the victim and the location of the alleged abuse. If the victim is a child the report will be made to *Child Protective Services with* a written follow up *report* to be submitted within 36 hours. If the victim is an adult *and* the abuse occurred in a long term care facility, the *alleged abuse is reported* to the Ombudsman's office. If the alleged abuse occurred at any other location, the report is made to Adult Protective Services. The telephone report concerning an adult shall be followed up with a written report within two working days.

Ombudsman Office Department of Aging

Each county is required to have an office devoted to the Ombudsman. This office receives reports of abuse to dependent adults if the abuse occurs in any long-term facility (nursing homes, residential facilities, foster homes, any licensed or unlicensed *residential* facility providing care and supervision).

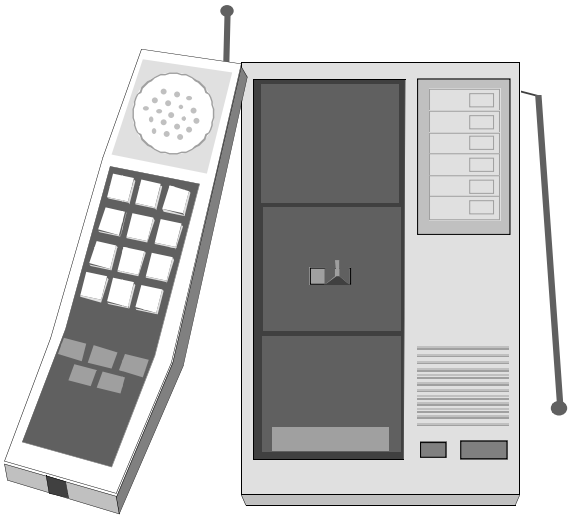
Adult Protective Services California Department of Social Services

Each county is required to have an office devoted to Adult Protective Services. This office receives reports of abuse to dependent adults. Each report is assigned to a case worker for investigation, assessment, and referral to appropriate agencies. The law requires mandated reporters to make a verbal report immediately, followed by a written report within two working days. When the suspected victim resides in a domestic setting, the abuse should be reported to the county Adult Protective Services Agency. If the abuse occurs in any long-term care facility (nursing homes, residential facilities, foster homes, or any licensed or unlicensed facility providing care and supervision), it must be reported to the local ombudsman program.

Child Protective Services Department of Social Services

Each county is mandated to have an office devoted to Child Protective Services. This office receives reports of abuse to children. Each report is assigned to a case worker for investigation, assessment and referral to appropriate agencies.

Child Protective Services is usually housed in the county Social Services department. To find the nearest office, look in the county government pages of the telephone directory under "Social Services; Children's Services and/or Child Protective Services." Many counties have 24-hour hotlines.



Elder and Dependent Adult Abuse

(excerpted from Los Angeles Infoline)

Quick Checklist. When an elderly person or dependent adult is being abused, neglected or exploited, prioritize for safety:

1. Is the person being injured or otherwise endangered at that moment? If **YES**, call the police or paramedics.
2. Is the suspected abuse occurring in a residential facility or adult day health center? If **YES**, report to the local Long Term Care Ombudsman.
3. Is the abuse occurring outside of a residential facility? If **YES**, report to Adult Protective Services.

Definitions. Listed below are possible indicators of abuse (adapted from guidelines developed by Adult Protective Services):

Physical Abuse: Pushing, shoving, shaking, slapping, or beating, or unreasonable restraint.
Indicators: unexplained bruises, welts, or burns; friction marks; bleeding scalp; detached retina; unset broken bones or other untreated injuries; any repeated injuries. Frequent emergency room visits. Frequent changes of doctors. Conflicting or implausible explanations of injuries.

Neglect: Failure to provide basic needs such as food, shelter, or medical treatment, or abandonment.
Indicators: dehydration or malnourishment; untreated bed sores; medication withheld or improperly self-administered; poor personal hygiene; soiled clothing or bedding left unchanged; keeping appliances the person needs such as bedside commode or walker out of reach; lack of clothing or other necessities; inadequate heat or ventilation; safety hazards in home.

Psychological Abuse: Verbal threats or insults, or other intimidating behavior.
Indicators: caregiver accuses the abused person of being incontinent on purpose; threatens him with placement in a nursing home.

Financial Exploitation: Mismanagement of money; theft of property.
Indicators: missing property; unpaid bills or rent; lack of clothing or other basics; unexplained bank account or auto-teller withdrawals; unexpected changes in wills or titles to property; adult's money not being spent on clothes or other basics needs.

Other Indicators of Abuse: Abused adult is kept isolated from family or friends and not allowed to speak for himself. Caregiver resists assistance from social service agencies. Caregiver has a history of abusing others. Caregiver appears angry at elder or dependent adult. Abused person may appear fearful, withdrawn, depressed, or confused (and these conditions are not caused by mental dysfunction).

Child Abuse

(excerpted from Los Angeles Infoline)

Quick Checklist. When a child is abused or neglected, prioritize for safety:

1. Is the child being injured or otherwise endangered at that moment? If **YES**, call the police.

2. Is abuse or neglect suspected? If YES, report to Child Protective Services.

Definitions. Child abuse (the abuse of a person under 18 years of age) may include physical, sexual, or emotional abuse; neglect; exploitation; or abandonment. Listed below are possible indicators adapted from Department of Children's Services guidelines:

Physical abuse: deliberate injury (usually overpunishment).
Indicators: unexplained and/or untreated fractures; multiple fractures; unexplained welts; bruises on parts of the body which aren't normally bruised in accidental bumps or falls; friction marks (rope burns); cigarette burns; immersion burns, caused by immersion in scalding water, (sock-like burns on feet, doughnut-shaped burns on buttocks, glove-like burns on hands). Pattern of injuries regularly appearing after weekends, vacations, or other absences. Injuries where the explanation doesn't match the injury.

Sexual Abuse: oral, anal, or vaginal intercourse; fondling; exhibitionism.
Indicators: difficulty in walking or sitting down; pain or itching in genital area; vaginal or anal bleeding; bruised genitalia; bloody underclothing; sexually transmitted disease or pregnancy in children who are probably too young to have dating relationships.

Neglect: inadequate food, shelter, clothing, supervision, or medical or dental care; abandonment.
Indicators: constant hunger; poor hygiene; inadequate clothing; lack of supervision, especially for long periods or when child is engaged in dangerous activities; medical needs left untreated; medical diagnosis of malnourishment or non-organic failure to thrive.

Emotional Abuse: cruelty; unjustifiable punishment.
Indicators: child reports punishment which is excessive, bizarre or humiliating; medical diagnosis of non-organic failure to thrive; child's inappropriate behavior (infantile or antisocial); child's suicide attempts.

Information Brief

Incident Reporting

Title 22

Each licensee shall furnish to the licensing agency reports including, but not limited to:

1. Death of any client from any cause.
2. Any injury to any client which requires medical treatment.
3. Any unusual incident or absence which threatens the physical or emotional health or safety of any client.
4. Any suspected physical or psychological abuse of any clients.
5. Epidemic outbreaks.
6. Poisonings.
7. Catastrophes.
8. Fires or explosions which occur in or on the premises.

A REPORT BY TELEPHONE SHALL BE MADE TO THE LICENSING AGENCY WITHIN THE AGENCY'S NEXT WORKING DAY DURING ITS NORMAL BUSINESS HOURS. A WRITTEN REPORT SHALL BE SUBMITTED TO THE LICENSING AGENCY WITHIN SEVEN DAYS FOLLOWING THE OCCURRENCE OF EVENT.

A sample reporting form is on the following two pages.

Title 17

Special Incident Reporting is the documentation prepared by DSPs detailing special incidents and provided to the regional center. Special incidents are those incidents which:

1. Have resulted in serious bodily injury, serious physical harm, or death.
2. Have resulted in the use of emergency intervention procedures.
3. May result in criminal charges or legal action.
4. Result in the denial of a client's rights.
5. Or, are any of the following: epidemic outbreaks, poisonings, catastrophes, fires or explosions.

ALL PROVIDERS SHALL NOTIFY, BY TELEPHONE, THE REGIONAL CENTER OF ANY SPECIAL INCIDENTS, AS SOON AS POSSIBLE, AND IN NO CASE LATER THEN THE END OF THE VENDOR'S BUSINESS DAY. A WRITTEN REPORT SHALL BE SUBMITTED TO THE REGIONAL CENTER WITHIN 24 HOURS OF THE INCIDENT.

Some Regional Centers have a form for your use, others allow use of the Licensing Form. **IF IN DOUBT - FILL IT OUT.**

DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
(REPLICATION OF ORIGINAL)

UNUSUAL INCIDENT/INJURY/ DEATH REPORT

CHECK ONE OR MORE BOXES:

❑ Incident ❑ Injury ❑ Death

Date of Occurrence:

INSTRUCTIONS: NOTIFY THE LICENSING AGENCY AND, APPLICABLE, PERSON(S) AND/OR PLACEMENT AGENCY(IES) RESPONSIBLE FOR CLIENT(S) WITHIN THE AGENCY'S NEXT WORKING DAY OF ANY UNUSUAL EVENT, INCIDENT, INJURY REQUIRING MEDICAL TREATMENT AS DETERMINED BY PHYSICIAN OR DEATH. COMPLETE SECTIONS I, II, AND/OR III AS APPROPRIATE. ATTACH SHEET IF ADDITIONAL SPACE IS NEEDED. SEND ORIGINAL TO THE LICENSING AGENCY WITHIN 7 DAYS OF THE EVENT. RETAIN A COPY IN CLIENT(S) FILE. RESIDENTIAL FACILITIES FOR THE ELDERLY SHALL COMPLY WITH SECTION 87508 REGARDING THIS REQUIREMENT.

Name of Facility	Facility File Number	Telephone Number ( )
Address		

Client(s) Involved	Age	Sex	Date of Admission
1.			
2.			
3.			
4.			
5.			

I UNUSUAL EVENT OR INCIDENT - UNUSUAL INCIDENTS INCLUDE CLIENT ABUSE, UNEXPLAINED ABSENCES, OR ANYTHING THAT AFFECTS THE PHYSICAL OR EMOTIONAL HEALTH AND SAFETY OF ANY CLIENT AND EPIDEMIC OUTBREAKS, POISONINGS, CATASTROPHES, FACILITY FIRES OR EXPLOSIONS.

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION AND NATURE OF INCIDENT)

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN - INCLUDE PERSONS CONTACTED AND IF INJURY OCCURRED COMPLETE SECTION II

DESCRIBE WHAT FOLLOW-UP ACTION IS PLANNED - INCLUDE STEPS TO BE TAKE TO PREVENT OCCURRENCE

II. INJURY REQUIRING MEDICAL TREATMENT
DESCRIBE HOW AND WHERE INJURY OCCURRED

WHAT APPEARS TO BE THE EXTENT OF THE INJURIES?

PERSONS WHO OBSERVED THE INJURY

ATTENDING PHYSICIAN'S NAME, FINDINGS AND TREATMENT

III. DEATH REPORT

DATE AND TIME OF DEATH	PLACE OF DEATH

DESCRIBE IMMEDIATE CAUSE OF DEATH (IF CORONER REPORT MADE, SEND A COPY WITHIN 30 DAYS)

DESCRIBE CONDITIONS CONTRIBUTING TO DEATH

WHAT ACTION DID YOU TAKE?

NAME OF ATTENDING PHYSICIAN

NAME OF MORTICIAN

SIGNATURE OF PERSON REPORTING	**DATE**
SIGNATURE OF LICENSEE ADMINISTRATOR	**DATE**

Activity:
How Do You See It?

As a group, describe this room in as much detail as you can within 5 minutes.

Information Brief

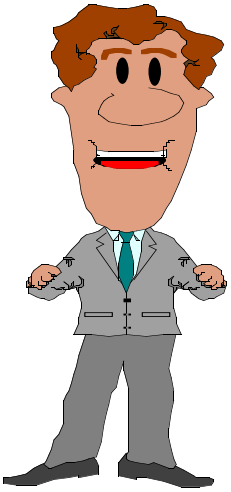
Understandable Information

Providing information about services and supports for the individual in a manner that he/she understands is necessary to insure that individuals have the information and understanding to make the best choices in their lives.

Provide interpreter services to individuals who are deaf/hearing imparied in order to insure they understand information being presented.

DSP in residential settings should be trained in American Sign Language.

An interpreter should be present during an individual's IPP and other important events, such as medical appointments, instruction at a sheltered workshop or on the job training.



Picture boards, notebooks, synthesized voice machines and computers should be furnished for individuals who can not tell you what they want or need.

When individuals speak a language other than English make sure that a staff person who speaks that language is available.

When appropriate, have Braille printers available for individuals who are blind or visually impaired.

Talking books for individuals who have low vision or are blind.

Possible Answers to Advocacy Issues

#1.
He borrows tape recorders and clothing from other individuals living in the home. He violates their rights to have and use personal possessions.

He hates getting up in the morning. DSP makes him get up on weekends as punishment. Violation of his right to decide when to get up.

Radio is often taken away as punishment for bad behavior. Violation of his right to have and use personal possessions.

His rights to leave the facility and participate in activities in the community are violated when he is only allowed to leave once per month.

Making him participate in activities violates his right to choose how he spends his time.

His right to choose how he spends his time is also violated when he is asked to leave the kitchen area during meal preparation. **Additionally,** if he was able to participate in food choice and preparation he might be willing to eat better and not throw food.

#2
His right to treatment and habilitation services and supports are violated when he is locked in his room for outbursts.

He has a right to some method for communicating with the world - picture board, computer, synthesized voice machine, etc.

His right to dignity, privacy and humane care are also violated when he is locked in his room.

His right to humane care is violated when grooming is not done.

His right to choose how he spends his time is violated when he is taken home by his family if he really doesn't want to go.

Someone needs to determine if he gives away his personal possessions or if they are being taken away. He has a right to keep and use his personal possessions.

The right to use the telephone may not be taken away for long periods of time unless the **denial of rights** has been done, and then only for 30 days. During that time, a plan must be developed to help him limit the time on the telephone, such as a timer to help him realize how long he is on the telephone.

#3
She violates the rights of others to humane treatment when she screams and cries for several hours at night, bosses and threatens them.

Her rights to social interaction and participation in community activities is violated when she is kept at home and in her room as punishment for behaviors and for the convenience of the DSP because her behavior is embarrassing.

Her right to treatment and habilitation services and supports, right to dignity, right to religious freedom and practice, right to social interaction and participation in community activities are all violated when she is not allowed to do any **special** things because of her behaviors.

#4
Her right to privacy and her right to have individual storage space for private use is violated when DSP removes her collection from her dresser drawers and throws it in the trash.

Her right to keep and spend a reasonable amount of her own money when they keep it and make her wait until they can go to the store with her.

Her right to have visitors, make personal choices about choice of companions, leisure and social activities, the right to have a “significant other” are all violated when the administrator tells her she cannot have a male visitor or go on a date.

She has a right to make choices in areas including, but not limited to, daily living routines, choice of companions, leisure and social activities, as well as a right to have relationships.

Answers to In-Class Review

1. Name at least three agencies/organizations that are a part of the Developmental Disabilities services system in California.

1. State Council
2. Protection and Advocacy
3. Area Boards
4. Organization of Area Boards
5. Program Development Funds
6. Health and Human Services
7. Social Services
8. Health Services
9. Developmental Services
10. Regional Centers
11. Developmental Centers
12. Mental Health
13. Rehabilitation
14. Education
15. SELPA
16. School Districts

2. Name at least three laws or regulations that regulate/monitor services to individuals with developmental disabilities.

1. Rehabilitation Act of 1973
2. Americans with Disabilities Act (ADA)
3. Individuals with Disabilities Education Act (IDEA)
4. Individuals with Disabilities Education Act - Part C
5. Lanterman Act
6. Title 22 - Division 6 - Department of Social Services (Licensing of Community Care Facilities)
7. Title 17 - Department of Developmental Services

3. Parents continue to be "natural guardians" and make decisions for adult sons/daughters with developmental disabilities if they are still living at home with their parents.

No! Nonconserved adults can make their own decisions whether they live with their parents or not.

4. Name at least three rights guaranteed by the U.S. Constitution.

1. Freedom of Speech
2. Freedom of Religion
3. Freedom of Assembly
4. Right to Privacy
5. Right to Due Process
6. Freedom of Association
7. Equal Protection of the Law

5. Welfare and Institutions Code recognizes the rights of individuals with developmental disabilities to choose where to live and with whom.

True

6. If a resident gets into a fight with a roommate it is OK to deny them the use of the telephone for 2 weeks as punishment.

False! Rights cannot be denied for punishment or DSP convenience. They are limited to 30 days, and may only be denied with regional center approval. A denial of rights must be directly related to the right denied.

7. Name at least three things that are considered abuse under the Child Abuse and Dependent Adult Abuse laws.

1. Physical abuse
2. Neglect
3. Mental abuse
4. Intimidation
5. Verbal abuse
6. Sexual abuse
7. Abandonment
8. Cruel punishment
9. Isolation
10. Financial abuse

8. Failure to report physical abuse is a misdemeanor, punishable by ____ months in jail or a fine of $_____ or both.

6 months and $1,000.00

9. Licensee shall furnish the licensing agency with reports (check all that apply).

a. When a resident dies for any reason, in any place.
b. Gets in a verbal fight with another resident.
c. A resident is injured and requires medical treatment.

a and c

10. A written Special Incident Report shall be submitted to the regional center within

24 hours

11. Name one way to be sure that an individual who is non-verbal, understands information to make the best choices in his or her life.

Picture Board • Notebook • Synthesized Voice Machine • Talking computer

If You Want to Read More About
Individual Rights, Laws and Regulations

Americans with Disabilities Act, A Comprehensive Overview
California Department of Rehabilitation (1994)

A good resource guide with understandable information about the Act and its implications for people with disabilities.

Keeping the Promise of the Lanterman Act: Report 1
by the Assembly Office of Research (1984); California State Assembly

The Assembly Office of Research completed a study of the impact of the Lanterman Act fifteen years after it was signed into law. This first of a two part series chronicles their findings.

Lanterman Developmental Disabilities Services Act
Distributed by the Organization of Area Boards (1998)

The full text of Division 4.5 of the Health and Welfare Statutes, including all amendments to the Act through 1997. This document is available at all local Area Boards. You may also find the complete text at the Department of Developmental Services website at <http://www.dds.cahwnet.gov/>.

Homework Assignment for Session #11: Your Community

This assignment is to help you start to build a resource for finding recreation and leisure opportunities in your community. Please fill out the form and bring the requested information to class. This may require a bit of research.

Name of local newspaper(s): _____

Identify the Section in the newspaper that lists what's happening each week: (include the name of the section and day it's published; bring a sample, if possible)

_____

Name two or three restaurants within walking distance of where you work or live.

_____ _____

_____ _____

Name two to three places within a mile of where you live or work where people gather: (examples include coffee shops, parks, bowling alleys, stores, etc.)

_____ _____

_____ _____

Find and bring to class examples of publications that tell people about interesting classes in your community. (Examples are bulletins from Parks and Recreation or Adult Education, The Learning Annex)

Find out if there is any Special Olympics organization in your community. Record the name and phone number for the contact person.

_____ _____

Contact the Chamber of Commerce and ask if there is any information they have about clubs in your community. Bring anything the Chamber may have given you.

Find out about the YMCA and/or YWCA in your community. Write down the cost of joining and monthly dues. Ask if there is any special rate for low income individuals or people with disabilities.

_____

Get a copy of the bus schedule for the area around where you live or work.

Bring any additional information that you can find about recreation and leisure opportunities in your community.

Homework Assignment for Session #11: Modifications

Please read this information on modifications before the next class session.

The following are ways to make modifications or accommodations so that people with disabilities are more easily able to participate in recreation activities:

- **Rule changes should be available for all participants, if needed**
  Examples: Lengthening the three-second lane rule in basketball
  Using different ways to bat (whiffle bat, tennis racquet)

- **Make everybody feel welcome**
  State rules in the positive (e.g. Instead of saying "no dogs" say "only service dogs permitted")

- **Ask young people their age (for grouping) instead of grade**

- **Ask about special accommodations on an application form**

- **Assistive devices! Be creative!!**
  Use everyday items such as alarm clocks, velcro, rope, tape

  Use specialty items such as a nonskid mat

  Help a person to use his/her own device, such as a language board

- **Physical environment-think!**
  Consider the obvious: stairs, doorways

  The not-so-obvious: acoustics, wind conditions, bright lights, unusual odors

- **People power**
  Grouping

  "Buddies"

  Volunteer assistants

- **Time/place**

  Accessible buildings/floors

  Meeting times to accommodate school/work/bus schedules

Adapted from Developing Inclusive Recreation, Institute for Community Inclusion, Children's Hospital, Boston, MA.

Homework Assignment for Session #11: Success Stories

Please read the following brief stories and answer the questions.

Project Rec Success Stories
Taken from "The Institute Brief," May, 1991

Beth, who lives with three other roommates in a staffed apartment, is 43 years old and has multiple disabilities. She has always loved swimming and uses the separate program at the local Arc for participation in this activity. Recently, the staff at a nearby YMCA received training and reassurance from a DSP that their program could include people with Beth's abilities. Although she is not yet a full member at the Y, Beth now goes to their adult swim one time a week.

In this story, what would be the "special service" that Beth received?

What regular service was Beth able to use because of training by a DSP?

Mickey is nine years old and also has multiple disabilities. In school, he attends a resource room and receives physical therapy services, but goes to physical education with other children in the school. Although physically integrated into P.E., Mickey did not participate with the other children. His partner in group activities was always the gym teacher. After meetings with the physical education department and the physical therapist, the DSP was able to help the teacher and the other kids how to include Mickey through modeling and verbal instruction. Mickey now participates fully.

What happened so that Mickey was able to participate fully in regular P.E.?

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #11
Leisure and Recreation

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services
1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Positive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	**Leisure and Recreation**	**3 hours**
12	Competency Test	3 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Leisure
- Community Connections
- Natural Support
- Family, Friends, Associations

Your In-Class Review Notes

Here are some review questions about the presentations and activities for this class session.

Using the words listed below, fill in the blank in each sentence.

first aid supplies	**modifying**	**connector**
friends	**ASK**	**information**
natural	**natural support**	**specialized**
work	**FUN**	**encouraging**
generic		

1. **The number one reason most people participate in recreation is to have _____.**

2. **Services and supports available to everyone are called _____ supports.**

3. **It is called _____ an activity if you make changes to make it easier for everyone to participate.**

4. **Three roles of the DSP in assisting people to participate in recreation is to provide _____, be _____, and act as a _____.**

5. Getting support from a regional center is using a _____ service.

6. The first thing you should do to figure out if a support is needed is _____.

7. For children, _____ often are made at school.

8. For an adult, friends are often made at _____.

9. A final thing to keep in mind when supporting a person in a recreational activity is knowing where _____ are kept.

10. If people at work help a co-worker, this would be using _____ support.

Information Brief

Leisure and Recreation

The topic of Leisure and Recreation is one that is particularly important because this can be an area that is neglected when thinking about services for children and adults with developmental disabilities. The following are the definitions for Leisure and Recreation:

Leisure: Time free from work

Recreation: Refreshment of strength after work, play

The word leisure comes from Latin and it means "to be permitted."

Licere (latin): to be permitted

It is interesting that leisure involves the idea of being permitted, since quite often people with disabilities are often not allowed to be in typical leisure activities.

Why do people have leisure and recreation activities?
There are many reasons people participate in leisure and recreation. These include being with friends, relaxing, reducing stress, improving health and fitness, competing, learning new skills, having an outlet for creativity and FUN. Most people would agree that the number one reason people are involved in leisure and recreation is FUN!

Personal style and routine is important. Everyone has their own personal daily routine. When you have the ability to make your own choices, that routine usually indicates what sort of person you are and what sort of leisure and recreation you prefer. Some people like doing most things alone, while others like activities that involve just one additional person, or a small group or a large group. Some people like a balance of doing things alone or in a group.

The thing to remember is that people with disabilities are often more limited in the opportunities they have for leisure and recreation and they may be dependent on you, the DSP, to connect them to leisure and recreation activities.

Information Brief

The Role of the DSP as a Community Connector

The Direct Support Professional:

Knows the community
The DSP has the responsibility of getting to know the community. The DSP should make a notebook or file that has lots of information about the community in it. This might include:

- Identifying the local newspaper and knowing the sections of the paper that contain information about recreation opportunities and special events
- Locating places where people in the community often get together
- Knowing about the community's transportation, including bus schedules and any special transportation like "Dial-a-Ride"
- Finding out about opportunities for classes and activities through Parks and Recreation, the local Community College and Adult Education
- Contact people for groups such as Boy Scouts, Girl Scouts, the Boys & Girls Club, Special Olympics and the YW/YMCAs

Knows and likes the person he/she supports
It is very important to know and like the person you support. If you do not, the people you and the person you support meet will immediately realize it and it will become impossible to do a good job of connecting. You show you like the person you support by understanding and respecting the person's likes and dislikes and knowing and using his/her method of communicating.

Expects success
It is often said that whatever you expect is most likely to come true. This is true for a DSP as well. You must believe that you will have success in your role of Community Connector. If your expectation is that organizations will be unwilling to allow the person you support to be a part of their group, that is what is likely to happen.

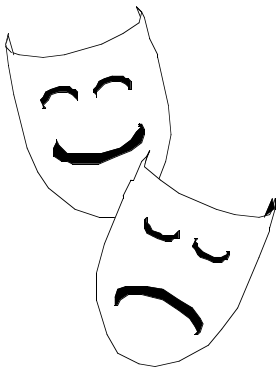
Trust others to be welcoming
You will find that most people in community groups will be welcoming once they understand that the person you support has a genuine desire to be a part of the group and that you will be available to help, if needed.

Forgive easily and build on mistakes
We all make mistakes every day. The DSP must be able to forgive their own as well as others' mistakes and learn from them.

Focuses on gifts and abilities, not "needs"
Knowing and appreciating the gifts the person you support has, is a good way to figure what activities might be good to try. Every person has gifts and abilities, and in leisure and recreation we are trying to have fun. The goal is to provide an opportunity for fun…and we have the most fun when we get the chance to use our gifts and have them appreciated.

Understands how to "assist gently"
Assisting gently has a lot to do with respecting the person with a disability. When you assist gently, you are sensitive to what the person wants to do…you are not attempting to force the person to do what you want or think he/she should do.

Have a good sense of humor . . . be willing to laugh
Having fun is very important…and a good indicator of people having fun is laughter. People relax and get to know each other better when they are laughing together.



Activity Checklist:
My Own Leisure/Recreation Style

I prefer activities where I am:

Alone **With a couple of friends** **In a big group**

When I have free time, I: (circle as many as you wish)

Watch TV	**Go to the health club**	**Read a book**
Work on a hobby	**Go out to dinner**	**Travel**
Go on a walk	**Listen to music**	**Take a class**
Make something	**Hang out with friends**	**Camp**
Take a nap	**Play on a team**	**Go shopping**
Hike	**Go to a concert**	**Play**
Think	**Watch sports**	**Play with pets**
_____	_____	_____
(other)	**(other)**	**(other)**
_____	_____	_____
(other)	**(other)**	**(other)**

Activity:
A Good Match!

First, read the descriptions of the following five individuals.

Susan is a young woman in her mid-twenties. She has many important gifts. She loves being around people and is usually happy and outgoing. She smiles often and people respond to her quickly. She has excellent fine motor skills. In fact, she works part time for a computer chip company putting together very small pieces of equipment with tweezers. She is able to understand one or two-part simple directions. At work, she uses an enlarged picture to remind her of how to do her job. She also has multiple disabilities: difficulty speaking, difficulty walking (she uses a wheelchair for long distances), and she understands best when only one idea at a time is discussed. She likes music and pictures in magazines. She also likes to be well groomed and have her clothes match well.

Dionne is eight and he is all boy! He likes to roughhouse with his dad and older brothers, wrestling around on the floor with them. However, he is pretty timid around strangers. Dionne has a hard time staying with any activity for long and he requires a 1:1 aide in school to keep him paying attention to what the teacher is saying or what the assignment is. He can read a little and seems to always choose books or magazines about sports. He is very coordinated and can run quite fast. One concern is that Dionne doesn't seem to have a very good idea about how to keep himself safe…he will run away from people with him and has run into the street a few times without looking.

Sam is in his early fifties. He lives in a home with five other men. Sam keeps to himself a lot, and refuses to go into the living room when the TV is on. All kinds of noise seems to bother him. Sam enjoys music played softly and he also likes to spend time outdoors. He often will pick flowers from the yard and put them in a vase for the dining room table. Sam likes everything to be organized and in its place. Having something moved or being prevented from following his daily routine can result in Sam becoming very upset and screaming…sometimes even hitting himself. Sam does like going out for coffee when there aren't many people in the shop.

Sherril is seventeen and lives with a foster family. Sherril has cerebral palsy and uses a motorized wheelchair to get around. She uses a communication device that prints what she types on a piece of paper. She is able to move her right hand and arm fairly well. She is able to feed herself, but needs a lot of assistance. She goes to a regular high school, where she has resource room support. She intends to transfer into a junior college program when she graduates. She hopes to be able to learn to get more experience with adapted computer equipment so she can get a good job when she's older. Sherril is quite shy and seems to do best with just one other person or in a small group, so there aren't too many conversations going at once.

Diego is in his mid-thirties and doesn't have a lot of skills. He does have a great smile, and it is obvious to everyone he meets when he likes something: he smiles and yells in delight. It is just as obvious when he doesn't like something….he cries and screams. He can feed himself, but he is not able to take care of his toileting needs. He can walk and often takes walks with staff. He also seems to like going in the car, especially if the trip includes a stop at Dairy Queen. He goes to an adult day activity program, where he seems to cry and scream a lot more than he smiles. There isn't a lot to do there that he can take part in, so mostly he just sits for long periods. He has, at times, gotten really upset and has knocked over work tables. But on the days when the "music therapist" comes by, he is always happy. He loves hitting his hand on the table in time to the music.

Next, work with your group on the following page to complete this activity.

Draw a line between each name on the right and at least two activities that seem like a good match based on the information you just read about each person.

1. Taking a class about getting college scholarships
2. Taking a drumming class
3. Fishing with one other person
4. Joining a soccer team through the "Y"
5. Learning to make ceramics
6. Going on a "garden walk" with the garden club
7. Joining Cub Scouts
8. Learning to play bridge
9. Taking a class in water painting
10. Going to a rock concert
11. Joining the Computer Club
12. Taking a class to learn to swim

Susan

Dionne

Sam

Sherril

Diego

Information Brief

Support

Support has become almost a buzz word today in the field of developmental disablities…it even is included in DSP: Direct Support Professional. Generally the idea of support means things like: looking for strengths, not being judgmental, being a friend, assisting - not doing, encouraging, and "being there" for a person.

Natural supports are something often talked about when working with people with developmental disabilities. For so long there have been very few natural supports in the lives of people with disabilities, particularly adults…or in the case of children, the only natural support has been family members.

Natural supports are services and supports, freely available, from family members, friends, co-workers, and associations of one kind or another (e.g., churches; clubs; community service organizations). Natural supports are for all people and not specifically for people with disabilities.

Natural supports make you feel part of something, give you friends, are your most important relationships, help you, make you feel good.

There are many ways that *natural supports* can assist individuals in leisure and recreation activities, including: helping make friends, being a "buddy", helping make accommodations, "smoothing the way" if there are problems, leading to more independence, and, besides, they "just feel good."

Generic services are services that everyone in the community uses-they are not just for people with disabilities. Generic services include Parks and Recreation programs, Big Brother/Big Sister organizations, the Boys and Girls club, Boy Scouts and Girl Scouts, any volunteer/service organizations such as Rotary or Lions club or the Chamber of Commerce.

Developmental services include any organization developed to provide assistance solely to people with disabilities and their families. The best known examples are Regional Centers and Special Olympics. Some communities have classes designed especially for people with disabilities; for example, monthly dances through Parks and Recreation, or "Swim Classes for People with Disabilities."

Information Brief

A Closer Look at Natural Supports

One of the goals of the DSP training is to do more in helping people with disabilities have lives similar to the general population. Therefore, understanding the idea of Natural Support becomes even more important. There are a few questions that come to mind:

Is the natural support needed by the person?
Many times a person with a disability doesn't really need any help once he or she becomes familiar with a situation. Or the Natural Support may develop without a DSP's assistance.

Is the natural support available to the person?
Although the most common Natural Support is the family, sometimes family just isn't available. Parents may be too ill to be supportive…or, in some cases, there may be no family at all.

Does the natural support meet the person's needs?
Sometimes people prefer someone other than family to provide assistance. For instance, an adult with personal care needs may prefer a paid attendant to help with toileting instead of a friend or family member.

Peer Support: Neighborhood, School and Work

Play
Playing with neighborhood children and the children of friends are often the best way children with disabilities can form friendships with kids their own age. When people become used to seeing and playing with a child with a disability in their own neighborhood, it can *open the door* to other opportunities.

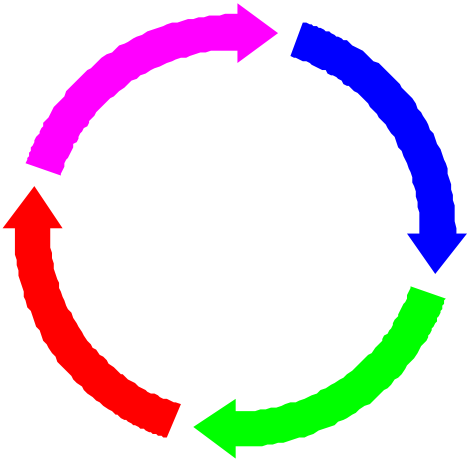
The DSP can help the family of a child with a disability reach out to others with children so they get to know each other. Children are remarkably willing to include a child with a disability if they are encouraged and supported to do so. Often it can help to plan special events or parties in the neighborhood or provide treats to all the kids to help them get to know each other. This is a good place to use the Community Connecting skills the DSP has learned.

School
When children with disabilities were first able to spend time with children without disabilities in school, a lot of "special projects" got started that

matched up kids with and without disabilities. This caused many of the children without disabilities to act and feel like a teacher's helper instead of a friend. We are finding that when the opportunity is available and adults are encouraging, children with and without disabilities choose to spend time together. They all receive some value from each other. A special education teacher can be important in helping figure out how to adapt activities.

Work

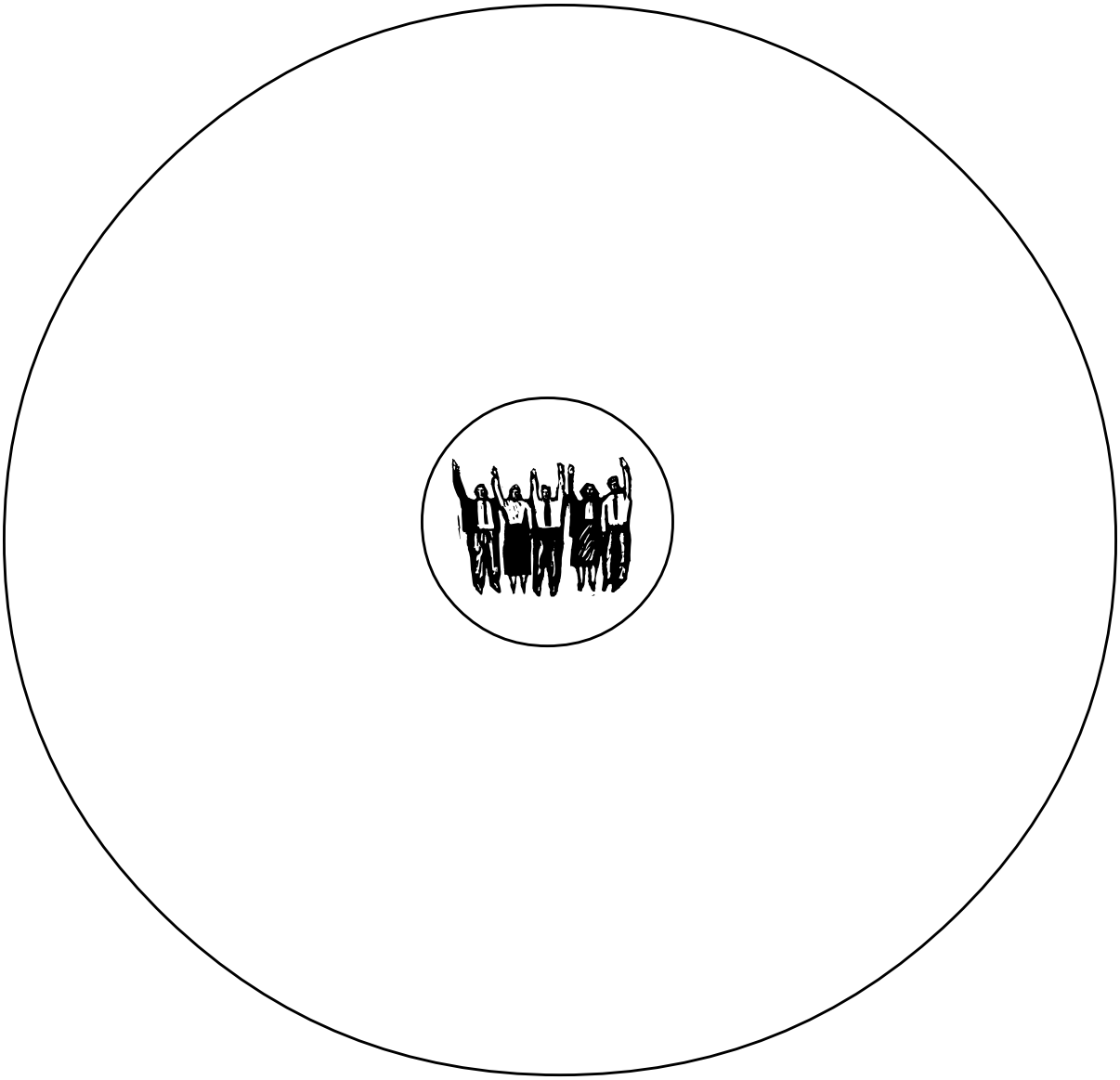
There are people whose job is to be a coach for a worker with a disability. They are often called job coaches. Often, though, a paid job coach is not necessary. The job coach can provide training to co-workers, if necessary, and assistance in connecting within the workplace. There is plenty of evidence that co-workers can contribute a great deal to the quality of a person's work life and will develop relationships that extend to life after work (such as bowling leagues and parties). The DSP can use their Community Connection skills to support participation in those after-work activities.



Some Additional Issues and Opportunities

Many people (and families) do not like to ask for help. They may fear they won't be accepted or they don't want to bother other people. Or the person with a disability may have such challenging needs that those around the person feel "why bother." The DSP can help by talking to the person or family, making connections, thinking of modifications and going with the person or family to find supports.

Activity:
A Circle of Natural Support



Who are the people in the circle of natural supports for someone with whom you work? Who are family, friends, staff members, community members, others that know and care about this person? With which people does this person like to spend time?

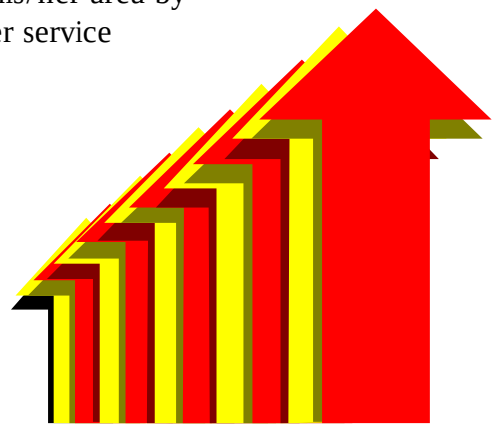
Information Brief

Associations or Community Organizations Exclusively for People with Developmental Disabilities

1) **People First** is a national self-advocacy organization that has many local chapters in California. People First can provide social opportunities as well as instruction in advocacy. Members often learn how to give speeches and become involved in local issues such as improving accessible transportation. There is an annual international convention where people with disabilities come together for seminars and fun.

2) **Best Buddies** is a national organization that pairs college students with children with developmental disabilities, somewhat like the Big Brothers/Big Sisters organization. Each Buddy commits to making contact weekly and spending time together a couple times a month. There are several Best Buddy chapters in California. The DSP can find out if one exists in his/her area by asking the regional center service coordinator.

3) **Special Olympics** was started in 1968 by Eunice Kennedy Shriver. This organization has matured in recent years and is trying to change its image to one where people with disabilities are respected as athletes. A program within Special Olympics is Unified Sports, which provides opportunities for athletes with special needs to participate alongside their peers who are non-disabled, for example, in road races and on community basketball teams.



Activity:
A Role-Playing Exercise

Making Connections

Listed below are several situations involving three people: (1) an individual with a disability (or that person's family), (2) a person to be approached in hopes of getting access to community resource and (3) a DSP, who is going to act as a go-between. Choose one of the situations and have each member of your group play a role. Select another situation, and each person in the group should select a different role. Finally, repeat the exercise one more time, playing the remaining role. After three exercises have been completed, each person in the group will have played each role. Be prepared to discuss with the larger group what worked (and what didn't) in gaining access to community resources and natural supports.

Situation A:

(1) Joe is a young man with autism. He uses few words. He jogs 20 miles a week and likes to run in local road races. He is new in town.
(2) Raul is the head of a local running club, which has about 30 members. Raul is totally "into his sport" but has no experience with people with developmental disabilities.
(3) As the DSP, your job is to introduce Joe to Raul, and to get Raul to help find someone willing to run with Joe once or twice a week and to take him to local road races.

Situation B:

(1) Sally has just moved into town and wants very much to attend a Methodist church close to her home.
(2) Rev. Anderson supports diversity, but wonders whether Sally might be more comfortable going to the neighboring developmental center to worship.
(3) As the DSP, your job is to introduce Sally to Rev. Anderson, and to find a way for Sally to be welcomed into their church community.

Situation C:

(1) Billy, who lives with his foster parents, has Down Syndrome and really likes baseball. He has been in Challenger baseball, but he wants to join a "real" Little League team. He is pretty good at batting, but he has a hard time catching and throwing the ball.

(2) The coach is a man who believes all kids should be able to play Little League ball. He is worried about what the other parents would think if he lets Billy on the team.

(3) Your job, as DSP, is to think of a way to convince the coach that Billy should be on the team (he's really not a lot worse at baseball than some of the other kids.)

Situation D:

(1) Candace has always wanted to be like her mother and be a member of the Soroptomists, a service organization for women.

(2) Emily is the membership chairman for the local chapter. She is generous to a fault and likes to give money to charitable causes. She is hesitant, however, about how her fellow members might respond to Candace, who uses a wheelchair and has trouble understanding complex conversations. What if Candace is at a meeting and needs help to go to the bathroom or gets upset about something?

(3) As the DSP, it's your job to introduce Candace to Emily and to convince the Soroptomists to welcome her into the club.

Information Brief

Supporting the Supports

- **BE AVAILABLE TO ANSWER QUESTIONS**
- **MAY NEED TO PROVIDE TRAINING**
- **PROVIDE ENCOURAGEMENT**
- **DON'T FORGET TO "CHECK IN"**

Answers to In-Class Review

Using the words listed below, fill in the blank in each sentence.

first aid supplies	**modifying**	**connector**
friends	**ASK**	**information**
natural	**natural support**	**specialized**
work	**FUN**	**encouraging**
generic		

1. **The number one reason most people participate in recreation is to have <u>FUN</u>.**

2. **Services and supports available to everyone are called <u>generic</u> supports.**

3. **It is called <u>modifying</u> an activity if you make changes to make it easier for everyone to participate.**

4. **Three roles of the DSP in assisting people to participate in recreation is to provide <u>information</u>, be <u>encouraging</u>, and act as a <u>connector</u>.**

5. Getting support from a regional center is using a specialized service.

6. The first thing you should do to figure out if a support is needed is ASK.

7. For children, friends often are made at school.

8. For an adult, friends are often made at work.

9. A final thing to keep in mind when supporting a person in a recreational activity is knowing where first aid supplies are kept.

10. If people at work help a co-worker, this would be using natural support.

If You Want to Read More About
Leisure and Recreation

A Guide to Developing Community Connections
Compiled by Patsy Davies & Claudia Bolton (1996) Self-Published; available from Allen, Shea & Associates, 1040 Main Street, Suite 200B, Napa, CA 94559.

A user-friendly workbook that can help a DSP increase skills needed to connect people to community.

Don't Forget the Fun: Developing Inclusive Recreation
by Komissar, Hart, Friedlander, Tufts and Paiewonsky at Project Rec (1997) Institute for Community Inclusion (UAP), Children's Hospital, Boston, MA 02115

An excellent, comprehensive manual that is very readable and well-organized. Includes such topics as "Developing Supports" and "Accommodation Strategies."

Lifelong Leisure Skills and Lifestyles for Persons with Developmental Disabilities
by Luanna Meyer, et al, (1995); Paul Brooks Publishing Co.; ISBN 1-55766-147-2

Provides information on teaching various leisure skills. Also includes forms and assessment strategies.

Inclusive Leisure Services
By John Datillo, Venture Publishing Co. (1994); ISBN 0-910251-68-1

Provides information about various disabilities, including blindness and other physical challenges. Also includes a summary of ADA and its application to leisure services.

Homework Assignment for Session #12: Your Test

Study the information in Session #12 about test-taking, review the *Key Words Dictionary* and the Resource Guides for all eleven sessions.

Year 1
Direct Support Professional Training

Student's Resource Guide

Session #12
Additional Resources and Preparing For Your Test

California Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services
1999

List of Class Sessions

Session	Topic	Time
1	Introduction, Overview of Developmental Disabilities, Values, Diversity	2 hours
2	Communication	3 hours
3	Wellness: Nutrition, Exercise and Safety	3 hours
4	Wellness: Medications	3 hours
5	Wellness: Responding to Individual Needs	3 hours
6	Positive Behavior Support	3 hours
7	Teaching Strategies: Relationships, Task Analysis and Prompts	3 hours
8	Teaching Strategies: Postive Feedback and Natural Times to Teach	3 hours
9	Daily Living	3 hours
10	Individual Rights, Laws and Regulations	3 hours
11	Leisure and Recreation	3 hours
12	**Competency Test**	**3 hours**
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Additional Resources

Key Word Dictionary

Active Listening
The key elements of active listing are: (1) hear the words; (2) figure them out; and (3) then respond.

Adverse Reactions
Harmful physical and behavioral changes that are due to the effect of a medication are considered adverse reactions. A change in behavior may be due to a medication change or a change in the person's environment. A sore throat may be one of the first symptoms of a cold or may be an adverse effect of a medication.

Antecedent
The behavioral "triggers" and other events (including medical variables, activity, environment, people present, time of day) that are present BEFORE the behavior occurs.

Behavior
All behavior is communication. By "listening" to what the behavior is saying, we can often discover the reason why the behavior is happening.

Choice
How much choice do people have throughout their lives? Choice or lack of choice can affect the way that individuals respond to their environment.

Communication
The process of sending and receiving information to others. We communicate for many reasons, including: (1) giving and getting information; (2) expressing feelings; (3) helping with problem solving; (4) teaching; (5) socializing; (6) persuading; (7) decision-making; and (8) building relationships. Regardless of the reason we are communicating, it is important to be clear about the message, and be certain that we understand another person's message to us.

Communication and Behavior
People's behavior usually communicates three things: (1) what the person wants; (2) what the person doesn't want; and (3) when the person wants attention. All behavior has a communicative purpose.

Communication Systems
The basic types of communication systems are: (1) sign language; (2) communication boards; and (3) gestures.

Community Care Licensing
The Community Care Licensing Division of the Department of Social Services licenses homes for children and adults with developmental disabilities.

Community Connections
The DSP has a responsibility of getting to know the community and helping the people that he or she supports in making connections. This is important for developing friendships and providing opportunities for lesiure-ime activities based on individual preferences.

Confidentiality
Confidentiality means to respect the privacy of the people that you support. You do not discuss information about individuals with your friends; you do not take individuals' files out of the facility; you do not give information to persons who might ask for it including family members without the signed consent of the individual, conservator, or legal representative. You do not discuss confidential information about an individual with another individual in the facility.

Consequence
What happens AFTER a behavior which may be reinforcing (maintaining) it.

Developmental Disability
According to a California law called the *Lanterman Developmental Disabilities Services Act*, a developmental disability: begins before someone reaches age 18; is something that goes on throughout life; is a substantial disability for the individual; and often means there is a need for some kind of assistance in daily living. Included are mental retardation, cerebral palsy, epilepsy and autism. Also included are people who need the same kinds of support as those who have mental retardation. It does not include people who have only physical, learning or mental health challenges.

Direct Support Professional
The term *direct support professional* (DSP) describes persons who work with people with disabilities in the places where these individuals live and work. They also assist individuals and their families in making choices; in leading self-directed lives; and in contributing to their communities. Finally, they encourage attitudes and behaviors in the community that support the inclusion of individuals with developmental disabilities.

Diversity
Diversity is the important mixture of people who bring different backgrounds, styles, values, perspectives and beliefs as assets to the groups and teams with which they work.

Documenting Progress
The result of good teaching is that an individual makes progress toward learning new skills. One way to check for progress is by comparing how much of a skill the individual has learned from week to week or month to month.

Drug Interactions
Adverse reactions or side effects may be caused by interactions between two or more drugs and by interactions between drugs and food and/or drink.

Emergency Services
All emergencies call for prompt medical attention, either by calling **911,** and having paramedics involved, or by calling a Poison Control Center (**1-800-8-POISON**) and getting advice, or by taking the person to an Emergency Room (ER) or Urgent Care Center where a triage nurse will determine the speed of response. If the implications of the emergency are uncertain, it helps to be at the ER to wait and see. That way, if the person takes a turn for the worse, getting medical help can take less time.

Environmental Emergencies
Some disasters are "internal," as when a fire occurs within the home. Others are "external," as when an earthquake, flood, tornado, toxic spill, or other event outside the home interferes with power, water, food supplies, or other essential services. Some "external" disasters trigger "internal" ones as well, as when a flood damages a home, or an earthquake triggers a fire. Regardless of the nature of the disaster, four matters are central to what needs to be done: (1) Are there injuries that require first aid and medical attention? (2) Does the home have to be evacuated, or is it safe to occupy? (3) Are there sources of food and water? (4) Has the disaster interfered with public utilities, such as gas, electricity, and communications?

Error Correction
Individuals will learn more quickly if they are able to practice new skills while making few or no errors instead of practicing the skill with many errors. If staff see that the learner is about to make a error on one of the steps of a skill, staff should increase the help provided to avoid the error. If an error occurs on a given step, staff should have the learner try the step again with additional prompts and make sure that the error does not occur the second time the learner tries the step.

Family, Friends, Associations
These persons and relationships are all a part of an individuals natural support system.

First Aid

A response to either a serious medical emergency or a minor first aid situation. Serious medical emergencies call for immediate action. First aid techniques include: Abdominal Thrusts; Rescue Breathing; and/or Cardio-Pulmonary Resuscitation (CPR). Your confidence in dealing with both major and minor emergencies will be reassuring to an injured person.

Friendships

Friends don't care what's in the person's IPP objectives. They like the person "just because." Friends can offer people a way to practice what we teach in our programs. Friendships have an energy that can't be otherwise created.

Hand-Washing

To prevent the spread of germs, frequent and vigorous hand-washing is considered the most important single thing a person can do.

Health Care Assessment, History and Plan

Health assessments identify health problems or needs. Plans are developed by health care professionals in response to identified problems. A current physical examination and a health history are two essential elements of a health assessment.

Hydration

Water is fundamentally important to life. Water regulates many processes (body temperature; waste removal), and carries minerals. Most people should drink eight 8-ounce glasses of water a day, or more if one drinks caffeinated beverages. Caffeinated beverages (for example, coffee, tea, soda) are dehydrating.

Individual Routines

We hardly think about the daily routines that get us through the day. We have individual routines for the week, the month, the year and those rites of passage and life cycle events that are positive parts of our lives. We need to consider the role that individual routines play in the lives of the people we support and insure that positive routines are respected.

Infection Control

One should be careful not to transmit infection (germs which can cause illness or disease) to others and equally important, one should be careful not to be infected by others. Hand-washing and the use of disposable gloves are two ways to prevent infection.

Intimacy

Studies show that teaching people about sex makes it less likely that they will be sexually abused. To help protect people from abuse, it's important to talk about: accurate terms for body parts; that giving and getting sexual pleasure belongs in the context of a loving relationship; basic information about pregnancy, and safe sex behavior; and, sexually transmitted diseases and how to protect against their spread.

Lanterman Act
This Act provides a statement of the service rights and responsibilities of individuals with developmental disabilities; an entitlement to services and supports; and, it creates the regional center system of providing services throughout the state.

Laws and Regulations
The legal authority by the state and federal governments to monitor services and supports for people with developmental disabilities.

Learning Goals
These are individual goals which require learning skills for completion. For example, if someone wants to go fishing and has never fished before, it would require a series of learning goals.

Leisure
Leisure is time free from work The word leisure comes from Latin and it means "to be permitted."

Lifting
At some time during their lives, four out of five people experience back problems (muscle spasms, slipped discs, etc.). Minimizing back problems calls for two things: (1) proper use of your body when lifting, pushing, or reaching for things; and (2) exercises to strengthen your back. Regarding the former, it is a good idea to: push, not pull (a garbage container; a dolly; a cart); move, not reach (to get the things you need); squat, not bend (when you have to reach down to get something); and turn, not twist (when you want to go in a different direction).

Mandated Reporter
DSPs are considered mandated reporters with a legal duty to report suspicion or knowledge of child, dependent adult, or elder abuse. Failure to report can result in a mandated reporter being held liable for both criminal and civil consequences. Conversely, the mandated reporter has complete immunity from legal actions even if the report turns out to be false.

Medical Emergency
A medical emergency is an unexpected event calling for first aid, followed by prompt medical attention. Some emergencies call for an immediate response to protect life. Other times the immediate response can be simply cleaning and applying sterile covering to a cut or abrasion.

Medication
Medications are powerful substances which many of us have come to depend on as an important part of our lives. Medications are substances taken into the body (or applied to) for the purpose of prevention, treatment, relief of symptoms, or cure.

Medication Recording

The use of a Medication Log as a way to prevent medication errors is strongly recommended. The Medication Log should, at a minimum, contain information about an individual's medications (strength, form and dose) and list times for administration.

Medication Self-Administration

In a Community Care Facility, the DSP can only assist with self-administration of medication. Only a licensed health professional can administer medications. A physician must document an individual's ability to safely self-administer medications without assistance from the DSP.

Modeling

Modeling is another way to assist an individual in completing a skill. Modeling involves showing the learner how to do part or all of a skill.

Movement, Exercise, and Physical Fitness

Regular physical activity helps to maintain physical (and emotional) fitness. Moving about aids digestion and elimination, strengthens muscles and joints (helping maintain bone density). If stretching is a part of regular physical activity, flexibility is enhanced. And, if a person exercises vigorously every other day, for thirty minutes or more, the cardiovascular system will become more efficient.

Natural Support

Natural supports are services and supports, freely available, from family members, friends, co-workers, and associations of one kind or another (e.g., churches; clubs; community service organizations). Natural supports are for all people and not specifically for people with disabilities.

Natural Teaching

It is important to teach the skill at any time during the day or in any place when and where the need for the skill arises. For example, a natural time during the day for Lucinda to practice using the telephone could be when the group decides to order a pizza for supper. Lucinda could make the telephone call to place the order.

Nutrition

Good nutrition helps keep us healthy. Poor nutrition can shorten our lives, and make our lives less fulfilling. Poor nutrition can contribute to: coronary heart disease; hypertension; cancer; obesity; osteoporosis; and dental disease

Personal Health Advocacy

There are two ways of working with doctors and other health care professionals. One is to be an active partner, providing information, asking questions, discussing options, and contributing ideas as to what actions will be taken. The other, more traditional approach is to be *passive and accepting*, treating the doctor and others with great deference and asking them to do all the thinking and all the work. With rare exceptions, physicians prefer the former to the latter.

Personal Hygiene

Hair should be shampooed regularly. Guard against ***sunburn***, by wearing a broad-brimmed hat and loose clothing, and staying out of direct sunlight. ***Skin breakdown*** is a serious and ever present concern for people who use wheelchairs and/or do not move about and change positions. Proper dental hygiene, combined with regular professional exams and cleaning, pays great dividends. Fingernails and toenails should be kept trimmed and clean.

Pharmacy/Pharmacist

Pharmacists at your local pharmacy are licensed to fill the prescriptions written by physicians. They often have more working knowledge about drugs, side effects, and interactions than prescribers. Asking both the physician and the pharmacist is a good idea, because that strategy makes use of "checks and balances" within the system of health care.

Positive Consequence

When teaching individuals with disabilities, providing positive consequences for an individual's effort can help the individual learn more quickly. Positive consequences used in teaching can take many forms. Praising the learner for doing something right is one way to motivate many individuals as they learn new skills. Opportunities to get a preferred item or participate in preferred activities are other ways that may motivate an individual to learn a new skill.

Praise

Praising the learner for doing something right is one way to motivate many individuals as they learn new skills.

Prescription

Prescription medications which must be ordered by a physician (or other person with authority to write prescriptions).

Prompts

The help given an individual to learn a new skill is called a prompt. There are many different types of prompts (for example, verbal, gestural) staff can use to help an individual learn and complete a new skill.

Positive Reinforcer

Reinforcement is one of the most important teaching tools. A reinforcer is a special kind of positive consequence because it has an effect on learning. The only way to know if a consequence is working as a positive reinforcer is if the individual shows progress on the skill over time.

Regional Center

In California, many services for people with (or 'at risk') of a developmental disability are coordinated through a network of twenty-one, non-profit Regional Centers established by the Lanterman Act. If a person is eligible, Regional Centers provide planning and related services, including service coordination.

Relationships

Studies show that the reason that friendships grow into important relationships is because people live close to each other and are able to see each other on a regular basis. We may have to assist people in starting relationships, and be available to encourage their continuation.

Replacement Behavior

A behavior or skills that allows a person to get their needs met in a more socially appropriate way, and, that will "work" just as well as the challenging behavior.

Safety

Home accidents in the United States claim about 20,000 lives per year, more than work-related accidents, but less than motor vehicle accidents. DSPs can increase safety around the house and reduce the likelihood of injury or death by doing the following: eliminating hazards (for example, slippery floors) around the house; doing things in a safe manner (for example, lifting, helping with transfers); education and training to reduce risk and to respond appropriately when injuries happen; sharing information about hazards; and preparation and development of contingency plans, and practice.

Side Effects

Know what medications are being used by people in the home where you work and learn all you can about medications. Know what possible side effects are, and be sure to ask the physician what kind of reactions should be brought immediately to his/her attention. Write these down, and be sure everyone knows what to do, and does what they are supposed to do.

Signs and Symptoms

Observation is about noticing ***change*** in a person's attitude, behavior, or communication (ABCs). When we observe changes, these are called *signs.* The sign may be a *symptom* of a disease, illness, or injury. It may also mean that someone is getting better.

Social Skills
The skills that it takes to develop and maintain friendships like listening to another person, communicating well, doing thoughtful deeds.

Special Incident Report
Special Incident Reports are the documents prepared by service providers detailing special incidents and provided to the regional center.

Speech and Language Disorders
There are two kinds of communication disorders. A speech disorder is caused by speech muscles that don't work, cleft palate, or from having no teeth. Incorrect articulation is a common speech disorder. Language disorders are sometimes caused by damage to some area of the brain. With a language disorder a person may be limited in their ability to understand language. This is called receptive language. A person's ability to talk might be limited, which is called their expressive language.

Standard Precautions
Standard Precautions are an approach to infection control. These precautions apply to all blood, all body fluids, secretions, and excretions (except sweat), whether or not they contain visible blood. They also apply to mucous membranes and where there is a cut or abrasion. *Standard Precautions* protect both the individual being assisted and the DSP.

Task Analysis
Listing the sequence of actions or steps involved in completing a skill is called a task analysis.

Teamwork
Teamwork is about sharing, cooperating, and helping one another. An effective team is a group of people working together with a common purpose, who value each others contributions and are working toward a common goal. Working through teams usually gets better results than a lot of individual efforts which may be working against each other.

Teachable Steps
The purpose of a task analysis is to provide a series of teachable steps.

Title 17
These regulations (developed by the Department of Developmental Services) govern how services are delivered within the California developmental disabilities services system

Title 22
These regulations (developed by the Department of Social Services) provide policies and procedures for licensing, monitoring and evaluating Community Care Facilities.

Values

Values are feelings and beliefs about how life and relationships should be. Our values guide us in our daily interactions with others. Services for people with developmental disabilities in California are based on an important set of values. These values can be found in the Lanterman Developmental Disabilities Services Act. Services for people with developmental disabilities are based on the values of choice, relationships, regular lifestyles, health and well-being, rights and responsibilities, and satisfaction.

Verbal and Nonverbal Communication

Verbal communication occurs when you use words while non-verbal communication can include: (1) sign language; (2) communication boards; and (3) gestures.

Additional Resources

Preparing For Your Test

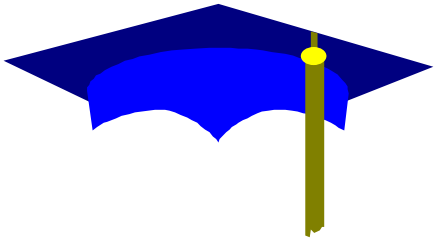
Size Up The Test

Here's what you should know before you take the test:

- Are the questions primarily from the presentations, *Resource Guide*, or both?
- Do the questions focus on main themes, details, or both?
- What types of questions will it include: essay, short-answer, multiple choice?

Here's how you can get the information:

- Ask your teacher.
- Ask someone who has already taken the exam about it.
- Look over the *Resource Guide*, *Key Words*, *Review Questions* and your notes for clues.



The Five Steps of Taking a Test

Step #1
Catch your breath.

Step #2
Read the directions - carefully.

Step #3
Skim through the test.

Step #4
Budget your time.

Step #5
Attack the questions.

Strategies to Get You Out of A Jam When Taking The Test

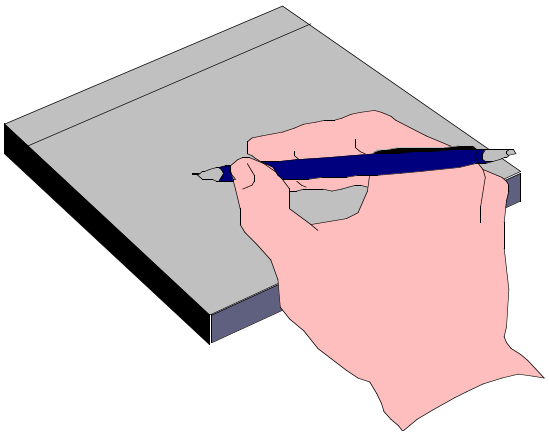
- Try rephrasing the question yourself.
- Postpone the question until later.
- If you can't remember some fact, try visualizing where in the *Resource Guide* or your notes it was located.
- Examine the precise wording of the question for potential clues.
- If you are running short of time, consider leaving some questions blank.

Multiple-Choice and True-False Tests

- Read every word of the question and choices carefully.
- Take questions at face value.
- After reading the question, anticipate the answer and look for it among the choices.
- If you still can't find the answer, "back into" it by using the process of elimination.
- Read each choice.
- If you can't decide among the remaining choices after using the process of elimination, circle the question number and move on immediately.
- Always guess if you can eliminate at least one choice.
- If a question seems suspiciously simple, ask yourself why anyone would ask it.

These notes were taken from *WHAT SMART STUDENTS KNOW*: Maximum Grades, Optimum Learning, Minimum Time by Adam Robinson.

Good Luck on Your Test!



Year 1 Student

Quizzes

Direct Support Professional Training Year 1
Session 1: Introduction *Quiz*

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	The main goal of this training is to improve the quality of care for people with developmental disabilities.
2.	**T / F**	A developmental disability starts after someone turns 18.
3.	**T / F**	A developmental disability can be caused by something that occurs before, during, or after birth.
4.	**T / F**	A “mentally retarded person” is an example of people first language.
5.	**T / F**	*Diversity* means that everyone should be the same.
6.	**T / F**	One of the values of the California developmental disabilities service system is that people have the choice of where and with whom to live.
7.	**T / F**	A Direct Support Professional supports people with developmental disabilities in a variety of settings and activities.
8.	**T / F**	Trust is necessary to make a team work.
9.	**T / F**	A good team works toward a goal everyone agrees upon.
10.	**T / F**	All people with mental retardation and cerebral palsy have slurred speech and an unusual walk.

Direct Support Professional Training Year 1
Session 2: Communication ***Quiz***

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	When communicating with other people it is important to be clear about your message.
2.	**T / F**	A person's behavior is often an attempt to tell others what he or she wants or doesn't want.
3.	**T / F**	A limited ability to understand language is an example of a speech disorder.
4.	**T / F**	One reason people communicate is to get information.
5.	**T / F**	Gesturing is an example of verbal communication.
6.	**T / F**	Sign language, communication boards, and gestures are examples of barriers to communication.
7.	**T / F**	*Active listening* means answering a question before understanding what the person was trying to say.
8.	**T / F**	A facial expression is an example of nonverbal communication.
9.	**T / F**	It takes at least two people to communicate.
10.	**T / F**	Speaking in short sentences helps to facilitate communication.

Direct Support Professional Training Year 1
Session 3: Wellness ***Quiz***
Nutrition, Exercise, and Safety

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	Good nutrition keeps us healthy.
2.	**T / F**	People need to drink <u>only</u> one glass of water every day.
3.	**T / F**	Disposable gloves should always be worn when shaking hands with another person.
4.	**T / F**	Food that needs to be refrigerated can be left in the car for several hours before you bring it in.
5.	**T / F**	Regular physical activity helps relieve stress and increase strength.
6.	**T / F**	Frequent and thorough hand washing is the most important way to stop the spread of germs.
7.	**T / F**	A change in a person's activity level could mean the person is sick.
8.	**T / F**	It is important to have a plan and be prepared because accidents and emergencies can happen at any time or any place.
9.	**T / F**	When moving a heavy object, one way to protect your back is to "push, not pull."
10.	**T / F**	Store poisons in a locked area away from food.

Direct Support Professional Training Year 1
Session 4: Wellness ***Quiz***
Medications

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	When assisting with medication, be sure you have the Right person, Right medication, Right dose, Right time, and Right route.
2.	**T / F**	It's okay to prepare a single dose of medication for a person to take with them to work.
3.	**T / F**	In a licensed community care facility, a physician's order is required for over-the-counter medication.
4.	**T / F**	It is important for you to ask the physician and/or pharmacist about both intended and unintended side effects of prescription medication.
5.	**T / F**	You don't need to lock up a medication if the person can give it to himself or herself without assistance.
6.	**T / F**	A medication log contains information about a person's medications, including when the medications should be given.
7.	**T / F**	Assisting people with medications is one of the most serious and important things you do.
8.	**T / F**	You may prepare and assist with medication in a dirty, dimly lit, noisy area.
9.	**T / F**	Part of your job is to observe, report and document any adverse side effects of medications.
10.	**T / F**	Each time a dose of medication is taken, it should be documented in the medication log.

Direct Support Professional Training Year 1
Session 5: Wellness ***Quiz***
Responding to Individual Needs

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	A current physical exam and a health history are two essential parts of a health assessment.
2.	**T / F**	Constipation is a symptom of a problem and if untreated can lead to serious health conditions.
3.	**T / F**	All adults, regardless of age, need the same type of medical screenings and exams.
4.	**T / F**	Before an individual you support goes to see a doctor, you should work with him or her to write up a list of questions for the doctor.
5.	**T / F**	*Good dental hygiene* means brushing your teeth once a day.
6.	**T / F**	A temperature within two degrees of 98.6 is considered normal.
7.	**T / F**	To assist a person having a seizure, yell at them to stop, make sure they stay seated in a chair, give them a drink of water.
8.	**T / F**	When people can't use words, you may learn how they feel by observing their behavior and appearance.
9.	**T / F**	A medical emergency is an unexpected event that requires first aid, followed by prompt medical attention.
10.	**T / F**	Abdominal pain and decreased appetite may be symptoms of constipation.

Direct Support Professional Training Year 1
Session 6: Positive Behavior Support ***Quiz***

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	Behavior is communication.
2.	**T / F**	Behavior is a way of getting something the person wants or avoiding something that person doesn't want.
3.	**T / F**	An antecedent is something that happens after a behavior.
4.	**T / F**	An effective replacement behavior works as well as the challenging behavior in meeting an individual's needs.
5.	**T / F**	Reinforce the replacement behavior as soon or sooner than the original behavior.
6.	**T / F**	A challenging behavior will continue if it is the best way the person knows to get his or her needs met.
7.	**T / F**	A person's behavior is <u>not</u> affected by the time of day, the activity or the people involved.
8.	**T / F**	One way to find out why a challenging behavior may be happening is to talk with the people who know the person well.
9.	**T / F**	Staff and administrators should help develop a positive behavioral support plan.
10.	**T / F**	All people learn best by reading the information.

Direct Support Professional Training Year 1
Session 7: Teaching Strategies ***Quiz***
Relationships, Task Analysis and Prompts

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	The more things people can do for themselves, the more control they have over their lives.
2.	**T / F**	Getting to know what the person likes or dislikes will help you understand the best way to support that individual.
3.	**T / F**	New skills need to be taught in a different way every time.
4.	**T / F**	The goal of teaching is to help a person learn something that he or she wants to do.
5.	**T / F**	You should practice a skill before teaching it to another person.
6.	**T / F**	Of the three types of prompts (verbal, gestural, or physical), verbal prompts always provide the most help when teaching new skills.
7.	**T / F**	If a person doesn't respond to a prompt immediately, repeat the prompt right away.
8.	**T / F**	You should always use physical guidance as the first prompt.
9.	**T / F**	When teaching a skill, one way to check for progress is by comparing how much of the skill the person has learned from week to week.
10.	**T / F**	A task analysis is a complex skill broken down into smaller, more teachable steps.

Direct Support Professional Training Year 1
Session 8: Teaching Strategies ***Quiz***
Positive Feedback and Natural Times to Teach

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	Everyone learns better when encouraged and positively motivated.
2.	**T / F**	A reinforcer is any item, event, or activity that follows a behavior and makes the behavior more likely to occur again.
3.	**T / F**	Everyone responds to the same set of reinforcers.
4.	**T / F**	Use the same reinforcers every time you teach a new skill.
5.	**T / F**	If coffee was a reinforcer for Sally when she learned to wash the dishes, then coffee will be the only effective reinforcer for teaching Sally any skill.
6.	**T / F**	People enjoy and benefit from frequent praise.
7.	**T / F**	Giving an individual a favorite item after he or she finishes a task is an example of a positive consequence.
8.	**T / F**	The best way to teach is to minimize learner errors.
9.	**T / F**	Teach at a time when the person needs to use the skill.
10.	**T / F**	Teaching should be as positive and enjoyable as possible.

Direct Support Professional Training Year 1
Session 9: Daily Living ***Quiz***

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	Daily routines are an important part of everyone's lives.
2.	**T / F**	Taking a walk every day at the same time can be comforting.
3.	**T / F**	People's routines should change to meet the needs of staff.
4.	**T / F**	A good schedule should not allow for <u>any</u> flexibility.
5.	**T / F**	People with disabilities enjoy life without friends.
6.	**T / F**	Being a friend includes finding a way to resolve differences.
7.	**T / F**	You can help people learn the social skills necessary to be a friend.
8.	**T / F**	Helping an individual join a gym is one way to help him or her make friends.
9.	**T / F**	Friendships may grow when people can spend time together.
10.	**T / F**	Listening to an individual is a good way to learn more about that person.

Direct Support Professional Training Year 1
Session 10: Individual Rights, Laws and Regulations ***Quiz***

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	Regional centers provide services to adults and children with developmental disabilities.
2.	**T / F**	People with developmental disabilities have different constitutional rights than everyone else.
3.	**T / F**	The courts authorize a conservator to make certain decisions for an adult with a developmental disability.
4.	**T / F**	The Lanterman Act establishes the right of every person with developmental disabilities to be treated with dignity and respect.
5.	**T / F**	California Code of Regulations, Title 22 and Title 17, include the requirements for licensed community care facilities serving people with developmental disabilities.
6.	**T / F**	You should wait to report child abuse until you're absolutely sure you know it's happening and who is doing it.
7.	**T / F**	A Special Incident Report must be submitted to the regional center within a week of the incident.
8.	**T / F**	*Confidentiality* means that you can discuss information about the individuals you support with anyone who asks.
9.	**T / F**	*Advocacy* means treating adults like children and making choices for them.
10.	**T / F**	All adults with developmental disabilities are incompetent and unable to make decisions for themselves.

Direct Support Professional Training Year 1
Session 11: Leisure and Recreation ***Quiz***

Directions: Answer each question by circling **T** for **True** or **F** for **False**. Look at the example in the box below:

1. **T / F** DSP stands for *Direct Support Professional.*

The answer is **True**, so the **T** is circled.

	Answer	Question
1.	**T / F**	People play sports and games to have fun.
2.	**T / F**	It is important to know the likes and dislikes of the individuals you support when planning recreational activities.
3.	**T / F**	Part of your job is to match an individual's interests to leisure and recreational activities.
4.	**T / F**	All leisure and recreational activities should be provided in the home.
5.	**T / F**	Natural supports rarely include family, friends, staff members, community members and others who care about a person.
6.	**T / F**	Generic services are just for individuals with developmental disabilities.
7.	**T / F**	Helping a co-worker is called a natural support.
8.	**T / F**	A person's family should be his or her only natural support.
9.	**T / F**	The local parks and recreation program is an example of a generic service.
10.	**T / F**	It is important that you help individuals find ways to participate in community activities.