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TOOLKIT FOR DIRECT SUPPORT PROFESIONALS

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Educational Toolkit for Direct Support Professionals

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Dedication

While pursuing my doctorate, I had a significant amount of obstacles that I had to overcome. Courage, determination, self-motivation, persistence and having a very strong support system helped me overcome the challenges I was faced with. As such, I dedicate this capstone project to my family and friends and particularly to my dad who passed away a couple of months ago. Daddy, rest in peace and may the gates of heaven open up to welcome you, forever.

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Abstract

The physical and psychological health factors associated with Developmental Disability (DD) puts affected individuals more at risk for being overweight/obese, less likely to receive medical screenings and preventative health care and more likely to develop chronic health conditions than the general population (Krahn, Walker & Correa-De-Araujo, 2015). As such, adults with DD are found to develop chronic illnesses such as high blood pressure, cardiovascular disease, arthritis, and diabetes quicker than their counterparts (Krahn, et al., 2015). Direct support professionals (DSPs), who care for people with DD on a daily basis are expected to manage these illnesses with minimal training. The general requirements for DSPs upon being hired to care for people with DD is usually only based on the possession of a high school diploma, a driver's license and a clean criminal background check. Therefore, DSPs are not required to be clinicians and to have extensive medical training in order to be able to properly manage illnesses in community settings where nurses and other clinicians do not provide direct care. The purpose of this project is to create a toolkit to help enhance DSPs' knowledge on six commonly encountered illnesses within group home settings: 1) the common cold, 2) conjunctivitis, 3) aspiration, 4) dehydration, 5) constipation and 6) seizures. The toolkit is comprised of a pre and a posttest (same test) and a PowerPoint slide presentation outlining the sign and symptoms of these six common illnesses/conditions, treatment interventions, and clinicians or health care entities to contact to avoid possible complications. The results from the pre and posttests is computed and analyzed to determine how much DSPs learned from the presentation of the toolkit.

Keywords: Direct support staff training; lack of training; direct support professionals; toolkit; training; Workforce and department of developmental disabilities.

Background and significance

Institutionalization of children and adults with significant disabilities was a common practice in the United States and in European countries in the mid-19th century (Krahn, et al., 2015). In the mid-20th century, in the state of Massachusetts, following a massive media exposure of the undesirable conditions that people with developmental disability (DD) were subjected to in these institutions and pressure from families and guardians, the courts ordered a closure of the institutions indicating that people with DD could live in community settings such as residential group homes (GH) with appropriate medical and psychosocial support (Rucker, 2015). Even though GHs have proven to be advantageous for residents in many ways, the literature suggests that there is a need for continuous training and monitoring of direct support professionals (DSPs), in order for them to be able to detect health care changes experienced by people with DD and take appropriate actions to avoid major health complications. Carter (2015) examined the impact of lack of staff training on dementia patients in GHs and found that it resulted in many health and safety issues for both the patients and the staff that cared for them (Carter, 2015). Similarly, Ross (2013) argues that lack of training in tertiary care, notably in home care, where frail individuals are left in the hands of untrained staff resulted in significant health care issues. Ross (2013) proposes that at a minimum, standard of care practices be taught to all staff working with patients in tertiary care to insure safe practices. This standard of care is challenging to maintain as DSPs, in addition to managing health care issues, have to help patients with activities of daily living, establish and maintain family connections, do grocery shopping, and participate in financial management and community outreach activities. Furthermore, DSPs have to work alone with minimum supervision in GHs where as in acute care settings and/or inpatient units, DSPs worked side by side on a daily basis with professionals and

clinicians such as registered nurses, physical therapists, occupational therapists and nutritionists from whom they can seek guidance if needed. This complex combination of minimal training and having to manage several aspect of the care of people with DD puts individuals with DD, who already have a fragile health at a higher risk for further health damage. Therefore, there is an imperative need to appropriately train DSPs in GH settings in managing common health care illnesses and conditions to reduce emergency room visits and hospitalizations. This capstone project aims to increase DSPs' capacity to care for residents by enhancing their knowledge and empowering them to take appropriate action should a health issue arise.

Problem Statement

Attaining quality health care has generally been a challenge for people with DD especially for those who live in tertiary care settings such as GHs where the front line caretakers are DSPs with limited health care training (Arnold, 2016). The limited education and skill level as well as the expanded responsibilities of DSPs in other areas make that challenge even harder to overcome (Bogenschutz, Hewitt, Hall-Lande & LaLiberte, 2010). As such, this project is designed to put an educational toolkit in place as a guide to educate DSPs in managing six commonly encountered illnesses among adults with DD in residential GHs in Franklin and Hampshire counties in Western Massachusetts.

Review of the Literature

Nursing and Allied Health Literature (CINHAL), PubMed of the National Library of Medicine, and the Commonwealth of Massachusetts Websites were searched to determine the training needs of DSPs in the field of DD. The search of the literature was conducted using the following keywords alone or in combination: Direct support staff, training, lack of training,

direct support professionals, toolkit, workforce, crisis and department of developmental disabilities. The search yielded 129 results published between 2009 and 2016. One hundred and twenty one articles were deleted for lacking research designs, not addressing DSP training in the field of DD or because they were not published in English. The eight articles that were retained were grouped according to the topic of review.

With the closure of institutions in the state of Massachusetts, indicating that people with DD could live in community settings such as residential GHs with appropriate medical and psychosocial support, the number of individuals living in institutions decreased from 207,356 in 1977 to 62,496 in 2007 (Scott, Larson & Lakin, 2009). This deinstitutionalization resulted in the DSP workforce being more dispersed across the nation and DSPs having to care for people with DD with minimal training and support (Bogenschutz et al., 2010). In institutions, DSPs worked side by side with clinicians who could assist them with detecting and treating health related changes, where as in the community, DSPs are expected to work alone, as mentioned previously. As such, DSPs have had to quickly develop more autonomy, accountability and responsibility and learn to critically think and solve problems without having been given the chance to develop the required skills to do so (Frizzell, 2015). Adequately training DSPs requires a financial commitment that employers have to face in addition to the high cost of health care, cost of living adjustments and increased expectations from families and guardians (Frizzell, 2016). All these demands make it hard for employers to invest in a well-developed training curriculum that is suitable to DSPs. As such, employers have concentrated on only providing state mandated training rather than training that develops problem solving and critical thinking skills, which are essential for the role and responsibilities of DSPs (Providers' Council, 2017). Training programs offered by employers for DSPs are usually limited to classroom training by clinicians such as

infection control, seizures, human rights, and fire safety (Flatt-Fultz & Phillips, 2012) Typically, DSPs are required to do a minimum amount of 40 hours of training, generally in the first six month of employment (Bogenschutz et al., 2010). From a DSP perspective, Arnold (2016) argues that many DSPs are shoved into work after a few hours of online training with no real hands on experience. The fast paced training of DSPs on a variety of subjects in very little time is overwhelming and does not promote learning (Dela Cruz, 2014). The way training is given to DSPs causes them to be overwhelmed and quit, leaving other DSPs with the burden to pick up the slack (Arnold, 2016). This in turn causes unnecessary stress for all the care providers as well as the individuals that are cared for (Arnold, 2016). Frizzell (2016) argues that DSPs are asked to perform tasks far beyond their level of skills and knowledge and do not have the required training to keep up with the demands of their jobs. Similarly, Davis and colleagues (2015) came to the same conclusion after investigating the management of respiratory medications by DSPs in several GHs. The result of their qualitative study revealed a lack of consistency in the management of asthma medications across programs due to lack of proper training (Davis, et al., 2015). The study concluded that DSPs involved in asthma management do not have the skills, education and tools to properly care for patients. This trend, leading to poorly managed health care problems has been noticed across several program sites (Arnold, 2016).

As a response to the lack of DSP training across the nation, a certificate program was developed with the help of a group of activist lead by the Bureau of Developmental Services (Arnold, 2016). During the time this program was being implemented, the field of DD noticed an increase of 89% rate in retention of employees who completed the 20- week certification program. Unfortunately, the program is no longer available in some states due to funding issues (Arnold, 2016). Ensuring that people with DD are properly cared for by a competently trained

work force will require the active involvement of states, legislators, providers and the Department of Developmental Services. The consequences of not having an adequate well trained workforce can have tremendous financial, moral, ethical and physical impact on patients, families and public health services. A qualitative study by Shefer and colleagues (2014) conducted in emergency rooms demonstrated that people with DD sustained delays in treatment, irreversible long-term health damages, and eventually death due to diagnostic overshadowing. As such, when DSPs take people with DD to get medical evaluations, it's crucial that they are trained to provide all important information to the healthcare provider to eliminate the chances of diagnostic overshadowing (Rader, 2012).

Theoretical Framework

Spencer and colleges (2013) claim that a conceptual framework that captures the quality of the evidence and measures the impact of lack of training in community settings is appropriate for analysis for this type of project. Using this framework, this search of the literature found strong evidence that lack of training leads to DSP burn out, high turnovers and poorly managed health issues (Bogenschutz et al., 2010). As such, DSPs should be properly trained to follow protocols put in place by the different members of the health care team to keep people with DD healthy and reduce emergency rooms visits and hospitalizations. Such protocols can be taught using information that is easy to understand and digest. They can be incorporated in the form of a PowerPoint slide presentation such as the one used in this project. The protocols used in this project include information that would educate DSPs about ongoing health problems for the six targeted conditions. The application of a specific theory that is both systematic and predictable can help create and implement these protocols. Patricia Benner's novice to expert theory seems

to be appropriate in helping to accomplish this task. Benner's theory is comprised of five steps towards the development of nursing confidence and comfort: 1) novice, 2) advanced beginner, 3) competent, 4) proficient, and 5) expert (Benner, 1982). Using these five stages of nursing experience, Benner shows that nurses progress from detached observers to involved performers, building on each step as they go. Similarly, DSPs can also be trained to build upon the knowledge they acquire from trainings and thus, become involved performers. Nurses become experts through various situational experiences by testing and refining propositions, hypotheses, and expectations (Benner, 1982). For Benner, problem solving requires the use of critical thinking. Her theory has been used to make innovative changes in many clinical settings. Her model constitutes a road map to build and improve skills based on acquired experiences. As such, the goals and objectives related to improvement and implementation of strategies needed for health prevention and maintenance for people with DD are well suited to Benner's theory. Initially, identifying the skill level of the DSPs to determine which of the five levels of experience they belong to as described by Benner is essential. This unique approach helped detect the experts, in this case the seasoned DSPs, who in turn were asked to help support those who are new to the field and may require additional guidance. The seasoned DSPs, have a profound knowledge about the patients' condition in the GH and will notice as soon as patients start deviating from their baseline. This valuable knowledge is essential as it will allow all DSPs to be alerted regarding patients' health status changes and appropriate actions can be immediately taken to prevent further health issues. This toolkit has been used as a framework to educate both the novice staff and the seasoned DSPs. The seasoned DSPs were able to provide valuable feedback to the health care team when determining which information was essential in developing the toolkit. They helped detect protocols that needed to be reviewed and revamped.

Working in collaboration with the novice staff and management, they helped boost teamwork, improve performance and facilitate cooperation and collaboration among team members when implementing the concepts learned from the presentation of the toolkit. This has contributed to helping different members of the team to understand one another's perspective. A qualitative study by McAlearney and Hefner (2014) determined that management and frontline staff have different perspectives about how to implement strategies to improve patient care. These differences in perspective is also verified when it comes to patient safety and routine practices (McAlearney & Hefner, 2014). As such, Benner's theory will help bridge the gap between the seasoned DSPs and the newer DSPs. It will provide the newer DSPs with the needed confidence to safely and effectively care for patients with the appropriate interventions in place, provided by information in the toolkit.

Project Design and Methods

This Doctor of Nursing Practice capstone project is comprised of a toolkit which includes a PowerPoint slide presentation and a single test used as a pre and posttest. The participants were asked to take the pretest, participate in the PowerPoint slide presentation and take the posttest afterwards. The results from the pre and posttest from each participant, both globally and per illness/condition, was computed and compared to determine the increase in knowledge and gaps in knowledge. A score of 80 % or higher was required from each participant for a satisfactory result. It was anticipated that participants who have less than 80% on the post-test will be required to review the information with a program nurse and retake the test until they achieve a score of 80 or greater.

Setting and resources

This DNP capstone project helped train DSPs working in six residential group homes located in Western Massachusetts. These residences typically are home to five adults with complex medical needs. They are operated by a local agency, which owns several group homes in Western Massachusetts and has been caring for adults with developmental disabilities for over 60 years. The group of DSPs that were trained using the toolkit were asked for feedback at the end of the training session. This valuable feedback was used to improve the contents of the toolkit for future use with all the other group homes that are managed by the agency.

Description of the group, population or community. The pilot group homes chosen for this project are located in the Greenfield area. Each of these residences are home to five adults with complex medical needs ranging in age from 22 to 59. These residents require moderate to full assistance with all aspects of daily living, some are able to speak in single words or short phrases, and answer yes and no questions, others are not able to speak at all. The limited ability of the patients to express themselves in conjunction with behavioral issues require the staff to be vigilant about monitoring for changes in health status and/or deviations from their individual baseline.

Organizational analysis of project site. The GHs managed by this organization, one of the first agencies in Hampden County dedicated to serving individuals with DD, are the setting for this project. The organization has offices in Springfield, Greenfield, Pittsfield, Easthampton and Hadley and now serves about 830 individuals and 469 families. The six pilot group homes where this project is taking place are part of more than a dozen residential homes operated by the organization. At any given time, there should be two DSPs in the home, whether during the day or at night. During the day, Monday to Friday, the residents go off to day programs where they stay until about 3-3:30pm. During the evening hours

and over the week-ends, DSPs are not only responsible for the medical management of the residents but they also help with cooking, activities of daily living and taking residents out into the community to social events, shopping, movies, or other activities as assigned. During the overnight hours, two DSPs are on duty, one is asleep and the other awake. DSPs are responsible for helping the residents with all their health care needs. For instance, they attend to the various needs of the patients such as monitoring them for seizure activity and medication administration. They take each patients' vital signs according to their plan of care and are usually the first people to notice a change in the patient's health and behavior status. When a noticeable health or behavioral change occurs, they contact nursing and/or other clinicians who may come in to do full physical assessments if needed. They are expected to be able to detect and notice all the health care changes without clinical training, which can lead to several issues including not being able to do an appropriate assessment or not noticing that there is a need to do one. Since these individuals have complex medical issues as aforementioned, they require specific written protocols and thorough follow up of their care. The implementation of such protocols requires the development of a specific plan and materials, such as this toolkit, that can be eventually used across the agency if found to be successful. An understanding of the organization's current status regarding quality assurance and an assessment of current activities within the organization is necessary for such a project. The creation and implementation of the toolkit also necessitated input from the frontline staff as they are best suited to know the support they need. This input was obtained during discussion with DSPs at staff meetings and during one to one discussions.

Evidence of stakeholder support. The stakeholder support and letter of agreement has been obtained for this project. The key stake holders are the board of directors and the executive leadership team who make important decisions about the agency's actions, objectives and

policies. The leadership team, comprised of directors and vice presidents of each department reports to the executive director who in turn presents big ideas, projects and new possible directions the agency wants to adopt to the board of directors who has the final say. Smaller projects such as this one are approved by the vice president of each department. This project was presented and approved by the vice president of residential services.

Facilitators and barriers. The implementation of a project in GHs is successful when there is a higher rate of DSPs properly following policies and procedure (Davis, et al., 2015). Developing appropriate, easily understood training sessions would help DSPs be more interested in learning and gaining increased knowledge. This process can be very challenging as it involves both facilitators and barriers. Facilitators include health care providers, the nursing staff, DSPs, the key stakeholders and the policy makers. DSPs who are considered frontline staff would make sure to follow procedures outlined in the toolkit. The group home nurses who will eventually educate DSPs using this toolkit as a framework across the agency will ensure that policies and procedures outlined in the toolkit are properly followed. Policy makers and key stakeholders would take into consideration the available clinical data to develop possible solutions to improve care. All these entities should collaboratively work together as a team to ensure that all policies and procedures are properly developed and implemented. The barriers to this project are the limited knowledge and understanding of the DSPs. A significant number of DSPs are new staff due to turnovers; for some DSPs English is a second language and most DSPs only have a high school degree.

Goals and Objectives

Goals are specifically designed broad channels of organized activities that can accurately specify future results and/or describe the anticipated desired outcomes of a project (Zaccagnini & White, 2014). Objectives are explicit, practical, precise, measurable, and finite statements of the actions that will move the project toward its inevitable goals or desired and expected outcomes (Zaccagnini & White, 2014).

Goals	Objectives
<p>Goal 1: Creation of the toolkit</p>	<p>Objective 1: Data gathering: Information about the most common illnesses/conditions encountered by DSPs while taking care of residents was gathered. This information was successfully obtained from:</p> <ol style="list-style-type: none"> 1. Patient records of illnesses. 2. Revision of emergency room visits and hospitalizations 3. Discussion with DSPs. <p>Objective 2: Development of the toolkit. To properly and thoroughly develop the toolkit the following goals were set and achieved:</p> <ol style="list-style-type: none"> 1. DSPs and program managers were involved and empowered to give input for the toolkit. 2. Proper on call procedures to put in

	<p>place that are suitable to the programs were discusses.</p> <ol style="list-style-type: none"> 3. Decisions about which health care providers/entities to best contact in cases of health deviations were made. 4. Questions for the pre and posttests were developed (Appendix A) 5. Proper methods of outcome evaluations. A minimum of 80% or more was agreed upon for a satisfactory result on the posttest. DSPs who do not achieve this score have to be trained by nurses and retake the test until they pass it.
<p>Goal 2: Presentation of the toolkit to DSPs</p>	<p>Objective 1: The toolkit was presented to:</p> <ol style="list-style-type: none"> 1) Provide DSPs with information about treatment methods they need to do should a patient present with signs and symptoms of the six previously identified illnesses. 2) Teach DSPs about which health care professional/ entities to contact to avoid

	<p>health complications.</p> <p>3) Give DSPs general guidelines on managing health care issues.</p> <p>4) A pre and posttest were administered</p> <p>Objective 2: Ensure that all DSPs understand that everyone has to follow the guidelines in place without exception.</p>
<p>Goal 3: Adjustment, addition, modification and implementation of the toolkit.</p>	<p>Objective 1: Input was obtained from DSPs after the training for adjustments to the toolkit for future. It was noted that some DSPs were more motivated and eager to learn than others.</p>
<p>Goal 4: Outcome measurement</p>	<p>Objective 1: Data from pre and posttests were computed (Appendix B, C and D) and analyzed.</p>

Toolkit Objectives. This project consists in presenting a toolkit to care for patients with six common illnesses: 1) seizures, 2) dehydration, 3) constipation, 4) conjunctivitis, 5) the common cold and 6) aspiration. The overall goal of the PowerPoint slide presentation is to increase DSP’s knowledge, awareness and promptness on taking appropriate actions in handling minor health issues before they turn into more serious health problems.

Presentation of Toolkit. The toolkit consists of a pre and posttest as well as a PowerPoint slide presentation. The day of the presentation, DSPs were asked to take the pretest after they introduced themselves to the class. Using the information from the PowerPoint slides, they were educated about the signs and symptoms of each illnesses and the medical interventions/treatment that need to take place. Examples were given to illustrate how long to wait before contacting a clinician, which clinician to contact and when to contact them. For instance, a nurse who is being called on a particular health deviation could advise that a trip to the emergency room is not warranted and provide additional guidance as to what to do in caring for the patient. After the presentation of the toolkit, DSPs were asked for feedback to incorporate changes in future presentation if appropriate.

Ethics and Human Subjects Protection

This project does not meet the federal definition of human subject research. Therefore it did not require submission to the Institutional Review Board (IRB).

Results

Discussion and Interpretations

The six common illnesses that were targeted for this project are: seizures, constipation, dehydration, the common cold, conjunctivitis and aspiration. A group of twelve DSPs were randomly selected for the project. Results from two participants could not be used because they did not complete and hand in their posttest prior to walking out of the training room. The participants were a mixture of DSPs who had different level of experiences in the field of DD. Their seniority in this field ranged anywhere from 2 months to 20 years.

The participants were asked to take a pretest, participate in a PowerPoint slide presentation and take a posttest afterwards. Results from the project indicate that the average score for the pretest was 23/30 (76.66%) (Appendix B), with one DSP scoring 7/30 being the lowest score and another DSP scoring 28/30 being the highest score. The average score for the post test was 28/30 (93.3%) (Appendix B), with the lowest score being 27/30 and the highest score 30/30. Therefore, the average score post training compared to pre-training has increased 16.67%, or approximately 17%. To be more specific on interpreting the results from the project, a pre- and posttest average was computed for each illness/condition (Appendix C, table 4). The result of the project indicates that the average test score increased 4% for seizures, 24% for the common cold, 22% for constipation, 14% for dehydration, 20% for aspiration and 18% for conjunctivitis. This data reveals that DSPs have a very good knowledge of information about seizures prior to the training (increase average score = 4%). This is probably due to the fact that most of the DSPs had already taken a seizure class prior to the presentation of the toolkit, which is an annual required training at the agency. Surprisingly, the average score for the common cold only increased 24%, with a 72% average score on the pretest and a 96% average score on the posttest. One could have assumed that prior knowledge of DSPs on the common cold prior to taking the pretest should have been higher than 72 % given the frequency of this common illness in the community and the fact that DSPs have to regularly deal with it as noticed during the discussion with DSPs in the development phase of the toolkit. The average score on constipation was the lowest during the pretest (58%) and the posttest (80%). This indicates that there might be a need to emphasize more training on this subject for these DSPs in the future.

Results from the project indicate that 60% of DSPs had a score of 80% or greater on the pretest and 100% of DSPs had a score of 80% or greater on the posttest (Appendix D, table 5).

This shows that the training was effective with 100% of DSPs getting a score of 80% or greater on the posttest. One DSPs in particular scored 23 % on the pretest and 90% on the posttest (Appendix B, table 1). Further investigation revealed that he had just started working in the field for about 2 months and had no previous knowledge on the field of DD. Another DSP scored slightly better on his pretest than the posttest but the gap was not noteworthy (28/30 on the pretest and 27/30 on the posttest). When questioned about this, he stated that he was just not paying attention.

Limitations. This quality improvement project had several limitations, first the cohort of people that participated in this training were randomly chosen. Among them, some had been working in the field of DD for several years and knew a good amount of information prior to attending the training, on seizures particularly. Those participants scored high on the pretest thus, there was not noted significant difference between the results from their pre and posttests. Therefore, it can be assumed that they had knowledge from previous trainings. Another limitation of this project is the small size of the sample. Finally, the results of this project may not be applicable to other human services agency and or globally as the agency where the project took place constantly offers a variety of trainings for DSPs. This explains why DSPs had high scores on the pretest in some areas. The illnesses/conditions used in the toolkit were targeted at the specific population in the GH of a specific agency and may need to be changed or modified for other agencies.

Future improvements. It was noted during the training that seasoned DSPs seemed to be somewhat less motivated to participate. At times, when prompted to participate in the discussions, they would nonchalantly answer the questions that were asked of them. To minimize the impact of such behaviors on the other participations, and increase the level of motivation, some

adjustments will be made to the way the training will be delivered in the future. Participants will be asked in the beginning of trainings if they have very good, good or minimum/no knowledge about common illnesses and will be divided into groups, depending on the number of participants to ensure a good mixture of people with different level of experiences in each group. After the pretest, each group of DSPs will be given a subject of discussion (one of the six illnesses) and will be allowed a few minutes to discuss the signs and symptoms, treatment options and what to do if treatments did not work. At the end of the group discussions, DSPs will be asked to share their discussion notes with the class. The information from the PowerPoint slides will be used to fill in any gaps each group might have missed. After all the information from the PowerPoint slides is shared, the post test will be administered. It is anticipated that this method will get participants motivated and more eager to learn. Additionally, the seasoned DSPs will be empowered to share their knowledge with the newer DSPs.

Ideally, future studies should attempt to determine a correlation between the number of years of experience of participants and the results from pre and posttests. These studies could include such data to differentiate the amount of training needed by new DSPs versus seasoned DSPs.

Conclusion

The movement of people with DD from institutions to community settings has generally been a success in the sense that it has allowed them to live in small community settings, enjoy a meaningful life while having access to valuable community resources. This shift to the community from institutions also created the necessity to have a competent workforce that is desperately in need of a more sophisticated training system which will allow DSPs to be more

competent in detecting minor health care changes and deviations from baseline before they develop into major complications (Davis, et al., 2015). This capstone project highlights the fact that DSPs, who are on the frontline of care for people with DD can be successfully trained using simple methods such as a PowerPoint slide presentation. Future research to facilitate and enhance DSP training would be beneficial for this fragile population, which is so much in need of better health outcomes. Making the DSP workforce knowledgeable, skilled and competent is needed to help us keep our promise, as a nation to citizens with DD. This will take combined efforts from family and guardians, policy makers, local leaders and DSPs themselves.

References:

- Arnold, R (2016). Crisis in Direct Support. The people we serve deserve better. Retrieved from <http://www.drcnh.org/2016WinterRAP.pdf>
- Benner, P. (1982). From novice to expert. *American Journal of Nursing*, 82(3), 402-407
- Bogenschutz, M., Hewitt, A., Hall-Lande, J & LaLiberte, T (2010). Status and Trends in the Direct Support Workforce in Self-Directed Supports. *Intellectual and Developmental Disabilities* 48:5, 345-360.
- Carter, R (2015). Poor training of care home staff leaving residents at risk, investigation finds. Retrieved from <http://www.communitycare.co.uk/2015/10/28/training-deficit-among-care-home-staff-leaving-residents-risk-investigation-finds>
- Davis, S. R., Durvasula, S., Merhi, D., Young, P. M., Traini, D., & Bosnic-Anticevich, S. Z. (2015). The role of direct support professionals in asthma management. *Journal Of Intellectual & Developmental Disability*, 40(4), 342-353. doi:10.3109/13668250.2015.1041100
- Dela Cruz, Y. S. (2014, January). A Developmental Disabilities Program: A Proposed Education Program for Direct Support Staff. *Developmental Disabilities Program*, 107 p.
- Flatt-Fultz, E., & Phillips, L. (2012). Empowerment training and direct support professionals' attitudes about individuals with intellectual disabilities. *Journal Of Intellectual Disabilities*, 16(2), 119-125. doi:10.1177/1744629512443652
- Frizzell, G. (2016). The direct support workforce crisis: A Parent's Perspective. *Exceptional Parent*, 46(2), 50-52. [Check APA]
- Frizzell, G. (2015). The direct support workforce crisis: A Parent's Perspective. *Exceptional Parent*, 45(12), 42-45. [Check APA]

- Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). Persons With Disabilities as an Unrecognized Health Disparity Population. *American Journal of Public Health, 105*(Suppl 2), S198–S206. <http://doi.org/10.2105/AJPH.2014.302182>
- O'Brien-Pallas, L., Meyers, R., Hayes, L., & Wang, S. (2010). The patient care delivery model—an open systems framework: Conceptualization, literature review and analytical strategy. *Journal of Clinical Nursing*. Doi:10.1111/j.1365-2702.2010.03391.x
- Providers' Council (2017). Who will care? The work force crisis in human services. Retrieved from http://b.3cdn.net/pcouncil/da0905ab8e0f3e6270_yvm6vg0ov.pdf
- Rader, R. (2012). The Role of the Direct Support Professional in Attending Healthcare Appointments. *Exceptional Parent, 42*(12), 4-5.
- Rucker, L (2015). Rolland active treatment review. Retrieved from <http://rollandatreview.org/index.htm>
- Ross, T (2013). Care home staff to have compulsory training under government plans to protect elderly. Retrieved from <http://www.telegraph.co.uk/news/health/elder/9919194/Care-home-staff-to-have-compulsory-training-under-government-plans-to-protect-elderly.html>
- Scott, N. , Larson, S, A., & Lakin, K, C (2009) Changes in the Number of People With Intellectual and Developmental Disabilities Living in U.S. Nursing Facilities Between 1988 and 2007. *Intellectual and Developmental Disabilities: June 2009, Vol. 47, No. 3, pp. 242-245.*
- Shefer, G., Henderson, C., Howard, L. M., Murray, J., & Thornicroft, G. (January 01, 2014). Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms--a qualitative study. *Plos One, 9*, 11.)

Spencer, L. M., Schooley, M. W., Kochtitzky, C. S., DeGroff, A. S., Devlin, H. M., Mercer, S. L., & Anderson, L. A. (December 01, 2013). Seeking best practices: A conceptual framework for planning and improving evidence-based practices. *Preventing Chronic Disease, 10*, 12.).

Zaccagnini, M.E. & White, K.W. (2014). *The Doctor of Nursing Practice Essentials: A new model for advanced nursing practice*. Sudbury, MA: Jones and Bartlett Publishers.

Appendix A
Pre/Post Test

Pre-test Score: _____

Post-test score: _____

Staff Name _____

Date _____

1. What is a seizure?

- A) Abnormal bleeding in the stomach
- B) Abnormal electrical activity of the heart
- C) Abnormal bleeding in the brain
- D) Abnormal electrical activity of the brain.

2. Seizure (Epilepsy) may be caused by _____.

- A) A brain injury
- B) A stroke
- C) A congenital abnormality
- D) All of the above

3. There is only one type of seizure

- A) True
- B) False

4. Proper documentation of a seizure is vital information that the _____ will need.

- A) Parents
- B) Neurologist
- C) Program manager
- D) Staff

5. You witness an individual having a seizure who doesn't have a seizure history, you should _____.

- A) Read the clients nursing and safety protocols
- B) Read the clients seizure protocol
- C) Call "911" Immediately
- D) Call the nurse

6. How does the common cold virus spread?

- A) Droplets in the air
- B) Hand to hand contact with someone who has a cold.

- C) By using shared objects
- D) All of the above

7. What causes the common cold?

- A) Bacteria
- B) Mold and fungi
- C) Virus
- D) Allergic reactions

8. How can you prevent the common cold from spreading?

- A) Washing hands and shared items
- B) Thoroughly dry the individual's hair prior to leaving for day program
- C) Take antibiotics
- D) Stay indoors as much as you can.

9. What treatments should not be used for colds?

- A) Hydration and rest
- B) Antibiotics
- C) Pain relievers
- D) Decongestants

10. How long should you wait to contact nursing if you see no improvements on cold symptoms?

- A) Three days
- B) One week
- C) One month
- D) Three weeks

11. Which of the following are common causes of constipation?

- A) Not enough dietary fluid or fiber intake
- B) Not regularly exercising
- C) A & B
- D) Improper perineal hygiene

12. Constipation can lead to bowel obstruction

- A) True
- B) False

13. Which is not a true statement about constipation:

- A) Infrequent bowel movements or difficult passage of stools.
- B) Having less than one bowel movement a day.
- C) Interfering with the ability to accomplish daily tasks.

D) Results in excessive straining.

14. Refusing to eat could be a sign of constipation

- A) True
- B) False

15. Select the most accurate answer about constipation:

- A) Large amounts of blood in the stool
- B) Small stools, loose stools
- C) Stomach bloating
- D) All of the above

16. Dehydration can be caused by :

- A) Sickness
- B) Infection
- C) Excessive sweating
- D) All of the above

17. Some medications can cause dehydration

- A) True
- B) False

18. Severe dehydration can result in increased urinary tract infections, hospitalization and/or death

- A) True
- B) False

19. Complications from dehydration include all but:

- A) Constipation, urinary and kidney problems, seizures.
- B) Low blood pressure
- C) High blood pressure
- D) Fatigue & irritability

20. Severe dehydration needs to be treated in a hospital setting with salts and fluids intravenously (IV).

- A) True
- B) False

21. What position should individuals be kept at while eating?

- A) 30 degree angle
- B) 45 degree angle
- C) 90 degree angle
- D) 1ying position.

22. One the first signs of aspiration is:

- A) Chocking/coughing
- B) Seizures
- C) Bloated stomach
- D) Individual having a blue colored lip.

23. Alternating between solids and liquids decreases the risk of aspiration.

- A) True
- B) False

24. A swallow study may needed for an individual who has been having signs and symptoms of aspiration?

- A) True
- B) False

25. If an individual is confirmed to have aspiration, what type of document will be put in place for them to follow?

- A) Seizure protocol
- B) Flow sheet
- C) Dining guideline
- D) Behavior date sheets.

26. What is the name that is commonly used for conjunctivitis?

- A) MRSA
- B) Pink eye
- C) Allergies
- D) Glaucoma

27. Conjunctivitis can be caused by:

- A) Allergic reaction
- B) A bacterial infection
- C) Viral infection
- D) All of the above

28. Conjunctivitis may affect one or both eyes.

- A) True
- B) False

29. Conjunctivitis can be the manifestation of more serious eye infections

- A) True
- B) False

30. How long should an individual stay home from work or day program after a conjunctivitis infection clears up?

- A) 3 days
- B) Two days
- C) 24 hours
- D) 48 hours

Staff Signature

Date

Appendix B

Table 1***Total Scores for Pre and Posttest***

Participants	Score on pretest	Is Pretest score >=80% (24/30)?	Score on post test	Is Posttest score >= 80%?	Comments
1 st	27/30	Yes	30/30	Yes	
2 nd	24/30	Yes	29/30	Yes	
3 rd	28/30	Yes	30/30	Yes	
4 th	7/30	No	27/30	Yes	Greatest improvement
5 th	25/30	Yes	27/30	Yes	
6 th	22/30	No	28/30	Yes	
7 th	23/30	No	27/30	Yes	
8 th	23/30	No	29/30	Yes	
9 th	28/30	Yes	27/30	Yes	Pretest >Posttest score!
10 th	26/30	Yes	29/30	Yes	

Global average pretest score: 23.3

Global average posttest score: 28.3

Appendix C

Table 2*Pretest Scores in Relation to Illnesses/Conditions*

Participants	Seizures	Common Cold	Constipation	Dehydration	Aspiration	Conjunctivitis
1 st (total score= 27/30)	5/5	5/5	3/5	4/5	5/5	5/5
2 nd (total score= 24/30)	4/5	4/5	4/5	4/5	4/5	4/5
3 rd (total score= 28/30)	5/5	4/5	5/5	5/5	5/5	4/5
4 th (total score= 7/30)	3/5	2/5	0/5	1/5	1/5	0/5
5 th (total score= 25/30)	5/5	2/5	1/5	5/5	5/5	4/5
6 th (total score= 22/30)	3/5	3/5	3/5	4/5	4/5	5/5
7 th (total score= 23/30)	3/5	4/5	3/5	5/5	3/5	5/5
8 th (total score= 23/30)	5/5	3/5	2/5	5/5	4/5	4/5
9 th (total score= 28/30)	5/5	5/5	4/5	5/5	5/5	4/5
10 th (total score= 26/30)	5/5	4/5	4/5	5/5	4/5	4/5

Table 3*Posttest Scores in Relation to Illnesses/Conditions*

Participants	Seizures	Common Cold	Constipation	Dehydration	Aspiration	Conjunctivitis
1 st (total score= 30/30)	5/5	5/5	5/5	5/5	5/5	5/5
2 nd (total score= 29/30)	4/5	5/5	5/5	5/5	5/5	5/5
3 rd (total score= 30/30)	5/5	5/5	5/5	5/5	5/5	5/5
4 th (total score= 27/30)	5/5	5/5	3/5	5/5	5/5	4/5
5 th (total score= 27/30)	5/5	5/5	2/5	5/5	5/5	5/5
6 th (total score= 28/30)	5/5	5/5	3/5	5/5	5/5	5/5
7 th (total score= 27/30)	4/5	4/5	4/5	5/5	5/5	5/5
8 th (total score= 29/30)	5/5	4/5	5/5	5/5	5/5	5/5
9 th (total score= 27/30)	5/5	5/5	3/5	5/5	5/5	4/5
10 th (total score= 29/30)	4/5	5/5	5/5	5/5	5/5	5/5

Table 4*Average Pre and Post Test Scores by Illness/Conditions*

	Seizures	Common Cold	Constipation	Dehydration	Aspiration	Conjunctivitis
Average pretest score	4.5	3.6	2.9	4.3	4.0	3.9
Average pretest score (%)	90%	72%	58%	86%	80%	78%
Average posttest score	4.7	4.8	4.0	5.0	5.0	4.8
Average pretest score (%)	94%	96%	80%	100%	100%	96%
Increase in score average	4%	24%	22%	14%	20%	18%

Appendix D

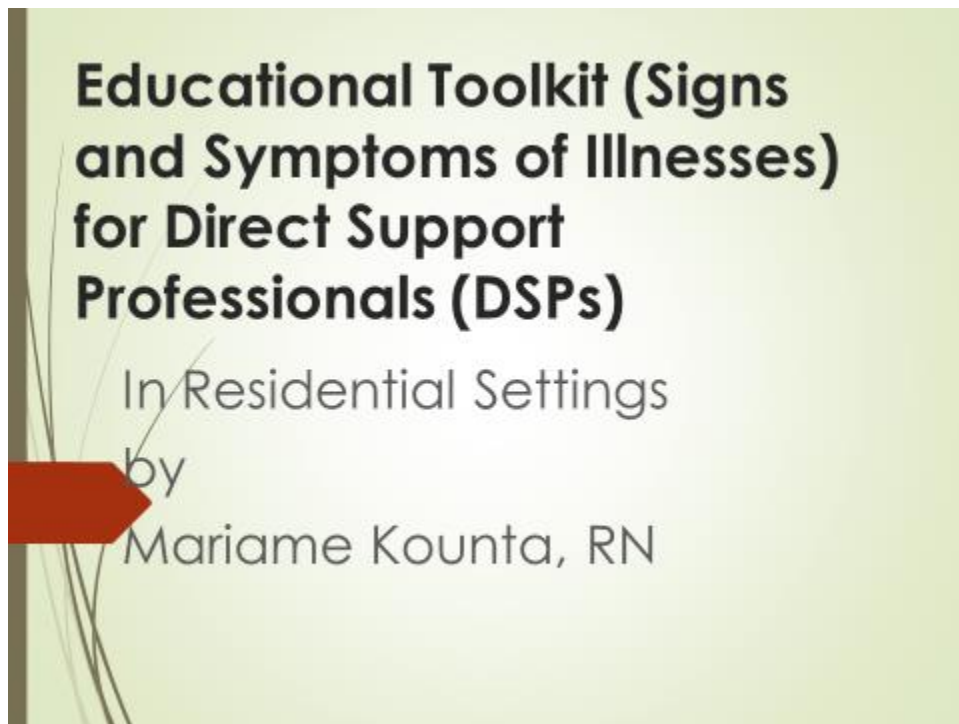
Comparison of % of DSPs who passed the pre and post tests

Table 5*% of DSPs who passed the pre/posttest*

Tests	Pretest	Post Test
% of DSPs who had $\geq 80\%$	60%	100%

Appendix E

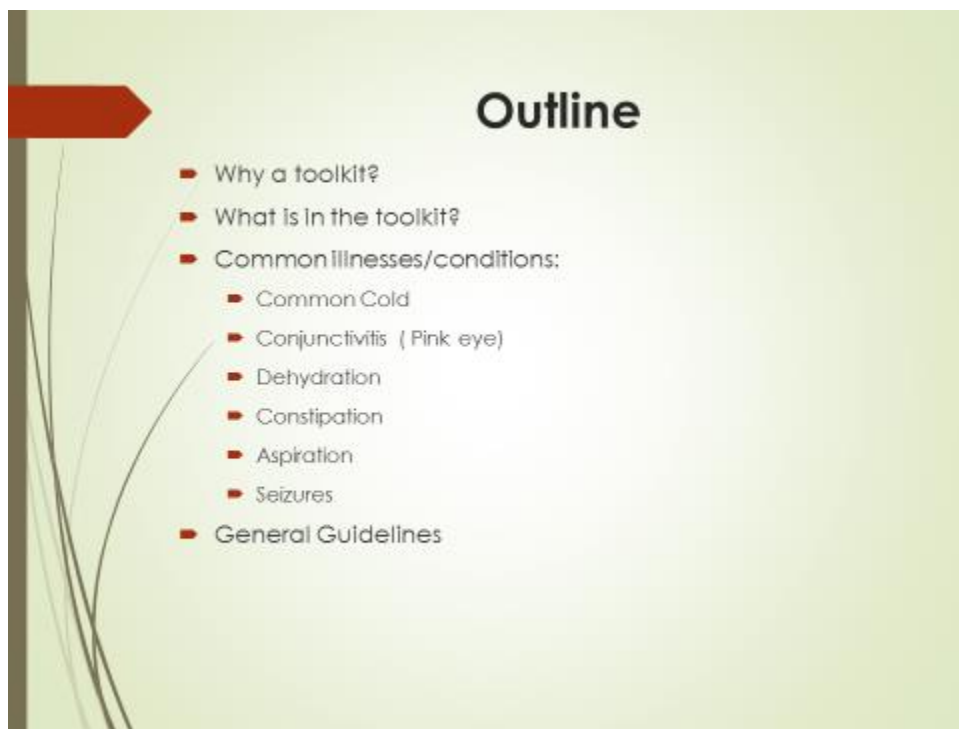
PowerPoint Presentation



Educational Toolkit (Signs and Symptoms of Illnesses) for Direct Support Professionals (DSPs)

In Residential Settings
by
Mariame Kounta, RN

The slide features a light green background with a vertical grey bar on the left side. A red arrow points to the right, partially overlapping the text 'by'. There are also some faint, abstract line drawings on the left side of the slide.



Outline

- Why a toolkit?
- What is in the toolkit?
- Common illnesses/conditions:
 - Common Cold
 - Conjunctivitis (Pink eye)
 - Dehydration
 - Constipation
 - Aspiration
 - Seizures
- General Guidelines

The slide features a light green background with a vertical grey bar on the left side. A red arrow points to the right, partially overlapping the text 'Outline'. There are also some faint, abstract line drawings on the left side of the slide.



Objectives

At the end of this training you will be able to :

- Identify the sign and symptoms of the outlined common illnesses/conditions.
- The most common methods of contamination and how to avoid them.
- Recommended treatments for the outlined common illnesses/conditions.
- Know specific protocols to follow for each illness/condition.
- When to call clinicians to avoid complications



Why a toolkit?

- Individuals with disabilities have been found to have higher rates of chronic illnesses and less likely to get adequate medical care than the general population.
- Adults with disabilities are cared for by DSPs with minimal medical training.
- DSPs are the first line of defense.

Why a toolkit?

- Direct Support Professionals as the first line of defense need to be able to:
 - Maintain awareness of individual health issues.
 - Ensure individuals receive necessary medical attention.
 - Notice deviations from baselines (changes in behavior and habits) and follow outlined protocols to maintain safety.
 - Take appropriate action and contact the appropriate clinicians to ensure health related issues are promptly dealt with.

What's in the toolkit?

- Signs and symptoms of common illnesses.
- Specific actions to take to maintain health and safety.
- Who to contact when there are deviations from baselines.
- Distinction between an emergent situation and one that can be attended to later on.



The Common Cold

- Although more than 100 viruses can cause a common cold, the rhinovirus is the most common virus as it's highly contagious.
- The virus enters the body through the mouth and/or nose.
- The virus can spread through droplets in the air, by hand-to-hand contact with someone who has a cold or by using shared objects.
- Symptoms of a common cold usually appear about one to three days after exposure to a cold-causing virus.

The Common Cold (Signs and Symptoms).

Signs & Symptoms:

- Itchy or sore throat
- Cough
- Congestion
- Slight body aches or a mild headache
- Sneezing
- Watery eyes
- Low-grade fever
- Mild fatigue




The Common Cold: What do I do?

- Hydrate patients
- Ensure they get plenty of rest
- Administer pain relievers, decongestants, nasal sprays and cough syrups as per physicians' orders.
- Know that Antibiotics do not help!

A photograph showing a bowl of soup with crackers on the side, and a red digital thermometer next to it, set against a green background.

The Common Cold: When Do I Notify/Report?

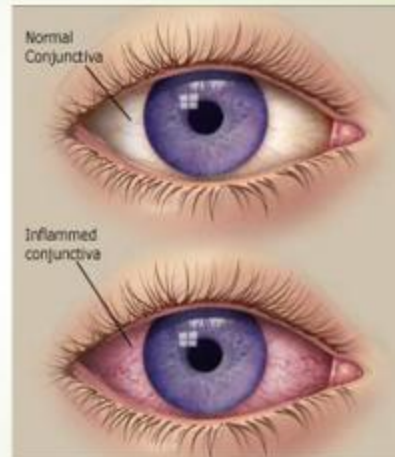
- Purulent nasal discharge, nasal obstruction or facial pain/pressure/fullness.
- Temperature is still elevated after fever reliever has been administered.
- Individual is tugging or pulling at one or both ears.
- Fluid draining from individual's ear(s).
- Difficulty breathing and shortness of breath, wheezing (call 911).
- Treatments from protocols have been used for at least one week with no noticeable improvements.

A cartoon illustration of a person with brown hair, wearing a red shirt, coughing into their hand. The background is a light blue sky with white clouds.

(Sexton & McClain, 2017).

Conjunctivitis (Pink eye)

- inflammation of the thin transparent membrane of the eye (conjunctiva).
- Commonly caused by infections (bacterial or viral), allergies or irritants (shampoo, chlorine).
- Some viruses (adenovirus) can lead to a serious and prolonged conjunctivitis.
- Conjunctivitis can be the manifestation of more serious eye infections.



Conjunctivitis (Signs and Symptoms)

- Inflammation of the conjunctiva
- Itchiness, tearing, reddish or pinkish appearance.
- Mild soreness but usually not painful.
- A discharge in one or both eyes forming a crust during the night that may prevent your eye or eyes from opening in the morning (usually seen in bacterial conjunctivitis).
- Eyelids may swell but vision is not normally affected.

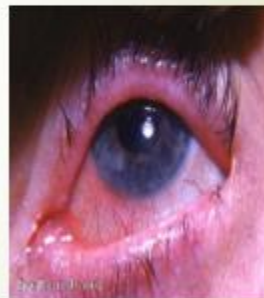


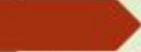
Conjunctivitis (What do I do?)

- Practice careful hand washing.
- Follow treatment guidelines as per physician orders:
 - No treatments for mild or moderate cases.
 - Use cool clean water for bathing of the eyes.
 - Use eye drops, eye ointment, cool compresses and /or artificial tears.
 - Antibiotics may be necessary in some cases.

Conjunctivitis: When Do I Notify/Report?


- Report condition to work or day program to raise awareness and limit exposure.
- Individual stays home from work or day program for 24 hours after infection clears up.
- Contact nursing if no improvement after 1 week, especially if inflammation does not go down.
- Prompt evaluation and treatment can reduce the risk of complications





Dehydration

- Definition: When a person does not have enough fluid in the body to maintain blood pressure and other bodily functions.
- Dehydration can be caused by:
 - Decreased oral intake (sickness, not wanting to consume fluids).
 - Increased fluid needs (fever, excessive sweating, increased urination, diarrhea and/or vomiting).
 - Medications (Diuretics).
- Severe dehydration can result in pain, behavioral problems, unnecessary emergency room visits, hospitalizations and/or death



Dehydration (Signs & Symptoms).

- Irritable or aggressive behaviors
- Fatigue, dizziness and/or confusion.
- Dark colored urine
- Decreased urination
- Low blood pressure

Complications:

- Constipation, urinary and kidney problems, seizures.
- Low blood volume shock.
- Heat injury, fatigue & irritability

Dehydration: What do I do?

- Give small amounts of fluid frequently and increase slowly (start with one teaspoon and increase as tolerated).
- Keep track of I&O.
- Give cool water to hydrate rather than full-strength fruit juice and/or soft drinks.
- Call 911 if Individual looks very sick, has gray skin, or won't wake up.
- Severe dehydration needs to be treated in a hospital setting with salts and fluids intravenously to ensure quick and adequate recovery.



Dehydration: When Do I Notify/Report?

- Dry skin, dry cracked lips, problems with walking or falling;
- Dizziness or headaches;
- Tiredness or sleepiness;
- Dark urine / decreased urination;
- Dry or sticky mouth and tongue; sunken eyes; low blood pressure or constipation.



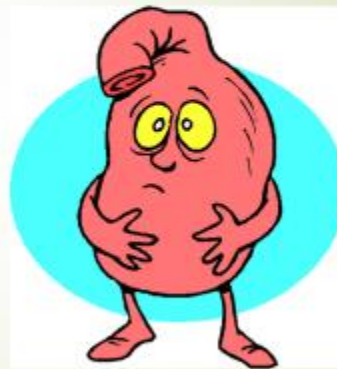
(CDDER, 2013)

Constipation

- Definition:
 - Having fewer than 3 bowel movements a week.
 - A result of increased time for food to pass through the intestines or a problem pushing the stool out.
- Causes:
 - Not enough dietary fluid or fiber intake.
 - No regular exercise.
 - Conditions that affect muscle movement and general weakness.
 - Side effects of medications (calcium and antidepressants).

Constipation: Signs & Symptoms.

- Stomach bloating
- Hemorrhoids/ blood with bowel movement
- Small stools, loose stools
- Refusing to eat
- Irritability and aggressive behaviors.
- May lead to a bowel obstruction which is life threatening!



Constipation: What do I do?

- Monitor constipation daily by keeping a bowel chart
- Increase fluid, dietary fiber and exercise
- Check/ keep track of bowel pattern – if they have only had very small stools they may need a laxative- notify nursing if no results from laxative – Document on flow sheet.



Constipation: When Do I Notify/Report?

- Severe pain, cramping, and intermittent belly pain
 - Vomiting, bloating, or diarrhea.
 - If blockage or obstruction is suspected.
 - Individual has large amounts of blood in their stool
- Research



(CDDER, 2013)

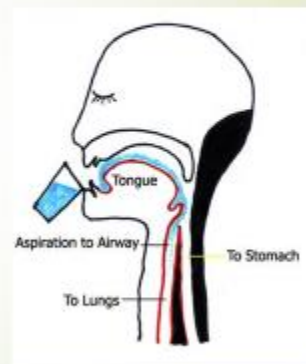
Aspiration

- When a foreign object such food or fluids go into the lungs instead of the stomach.
- When this happens the person will cough in order to clear the food or fluid from the lungs.
- Sometimes the person does not cough and this is known as a "silent aspiration."
- Aspiration pneumonia: the result of infection to the lungs from aspiration which can lead to hospitalization or death
- You tube video: Intra swallow aspiration

http://www.youtube.com/watch?feature=player_detailpage&v=1sfNMk87558

Aspiration(Signs & Symptoms).

- Dysphagia- difficulty swallowing
- Coughing when attempting to swallow.
- Physical disabilities
- Behavioral Influences- PICA, foreign body ingestion
- GERD
- Eating too fast or being fed by others
- Reduced mobility, number of medications, and multiple medical problems can increase the risk of aspiration pneumonia



Aspiration: What do I do?

- Position individuals at a 90 degree angle when feeding them.
- Small bites/ sips
- Slow down by allowing time for an extra swallow/ dry swallow
- Alternate between solids and liquids



Aspiration: When Do I Notify/Report?

- Frequent coughing or throat clearing, especially during or after eating or drinking
- Loss of interest in, or spitting out, certain foods or textures
- Difficulty eating foods that are sticky, stringy, or crunchy
- Frequent blinking and watering of the eyes; runny nose
- Holding breath or gasping during eating or drinking
- Tiredness after eating or drinking
- Increased agitation during meals, especially pushing away or throwing food
- Frequent respiratory infections or colds, reoccurring pneumonia
- Weight loss, dehydration, malnutrition
- Low grade fever or spiking temperature as soon as 30-60 minutes after a meal

(CDDER, 2014)

Seizures

- Abnormal or excess electrical activity in the brain can cause misfire and result in a seizure or convulsion.
- People who have reoccurring seizures are said to have epilepsy (seizure disorder)
- Causes of seizures include but are not limited to :
 - Unknown causes, High fevers in children
 - Brain Injury, tumor, stroke or electric shocks.
 - Poisons or infections of the brain or nervous system
 - Medication overdose, alcohol withdrawals, or congenital abnormalities
 - Hypoglycemia- low blood sugar, heat illness

Seizures: Signs and Symptoms

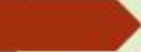
Grand mal

- Affects the whole body
- Drooling, frothing, Grunting and/or snoring
- Loss of consciousness and/or convulsions
- Tingling or twitching in one part of the body
- Loss of bladder or bowel control
- Sudden falls
- Temporary loss of breathing
- Entire body stiffening
- Muscle spasms/twitching and jerking of limbs
- Head or eye deviation (fixed in one direction)
- Aura before the seizure
- Skin color- red or bluish

Partial Seizures

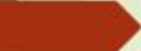
Affects small parts of the brain

- Glassy stare or rapid blinking
- No response when questioned
- Sit, stand, or walk around aimlessly
- Lip-smacking or chewing motions
- Fidget w/or pick at clothes
- Appear drunk, drugged, disorderly psychotic



Seizures: What do I do?

- ✓ Remain calm, be a good observer, speak calmly and softly
- ✓ Help individual into lying position and place something soft under the head.
- ✓ Turn individual onto side, to allow saliva to drain from the mouth
- ✓ Remove glasses, loosen ties, collars, and tight clothing
- ✓ Protect the head/body by clearing the area
- ✓ Do NOT force anything in the individuals mouth or between the teeth
- ✓ Do NOT try to restrain, you cannot stop the seizure



Seizures: What do I do?

- ❑ Stay nearby
- ❑ Clear the airway of saliva and or vomitus
- ❑ Do NOT offer food or drink
- ❑ Document: before, during, length & recovery
- ❑ Report seizures according to policy/protocol. This is vital information to take to the neurologist for review.
- ❑ Allow for rest- most individuals sleep soundly after a seizures

Seizures: What do I do?

Report to nursing:

- A change in seizure activity in an individual with a known seizure disorder- an adjustment in seizure medication may be necessary or may cause a change in seizure activity
- Changes in balance
- Call 911 for a first time seizure
- Document findings



Seizures: When Do I Notify/Report?

- Seizures lasting more than 5 minutes.
- The individual has one seizure after another.
- The frequency of seizures increases unusually.
- The individual has breathing difficulties or appears to be choking.
- The seizure occurs while the individual is in the water.
- The individual gets injured.
- The individual asks for medical help.



General Guidelines: Who do I need to call?

- **Call the Primary care physician(PCP) or Urgent care*** visits for:

- Treatment for illnesses that are typical for the individual
- When follow up is needed for chronic and specific issues
- Minor illnesses and injuries such as minor bites or burns
- Hospitalization/ER follow ups.
- Changes in weight (gain or loss) of more than 5 pounds in a week

*Use urgent care only if PCP is unavailable or cannot be reached.



General Guidelines: Who do I need to call?

- **Use Emergency Room visits for:**

- Excessive bleeding, headaches or sudden changes
- Falls that were not witnessed
- Severe allergic reactions that interferes with breathing (anaphylaxis allergic reaction).
- Severe conditions (excessive bleeding, severe pain and/or injuries)
- Choking for evaluation of the individual after the object has exited the body.

General Guidelines: Who do I need to call?

Call 911 for transport to ER if (do not transport the individual):

- Life threatening conditions
- Individual looks very sick (does not look his or her usual)
- The individual becomes unconscious
- Seizures lasting more than 10 minutes
- The individuals condition could get worst before you reach the ER
- You might get delayed in traffic
- Moving the person might lead to more damages.

Questions?



Resources

- Evaluation and Research Evaluation and Research (CDDER) (2014). Quality is no accident. Dysphagia, Aspiration, and Choking. Retrieved from <http://www.mass.gov/eohhs/docs/dmr/qe-reports/qa-qlia-aspiration.pdf>
- Evaluation and Research Evaluation and Research (CDDER) (2013). Preventable Hospital Use: Dehydration, Constipation, and UTI. Retrieved from <http://www.mass.gov/eohhs/docs/dmr/qe-reports/qa-qlia-dehydration.pdf>
- Health access research and developmental disability (2016). Improving Emergency Care for adults with Developmental Disabilities: A Toolkit for Providers. Retrieved from INAL.pdf/a6b7ef45-2ff1-4121-bdab-3abb817e3e6d
- Kenny, T (2017). Infective Conjunctivitis. Retrieved from <https://patient.info/health/infective-conjunctivitis-leaflet>
- Massachusetts Department of Developmental Services (2017). Retrieved from Evaluation and Research Evaluation and Research (CDDER) (2013). Retrieved from <http://www.mass.gov/eohhs/docs/dmr/qe-reports/qa-qlia-constipation.pdf>
- Mayo clinic (2017). Dehydration: Symptoms and causes. Retrieved from <http://www.mayoclinic.org/diseases-conditions/dehydration/symptoms-causes/dco-20261072>
- Mayo clinic (2017). Dehydration: Treatment. Quality is no accident: constipation/dehydration. Retrieved <http://www.mayoclinic.org/diseases-conditions/dehydration/diagnosis-treatment/treatment/toc-20261153>
- Sexton, J. M & McClain, M. T (2017). The common cold in adults: Diagnosis and clinical features. Update. Retrieved from https://www.uptodate.com/consult.library.umass.edu/contents/the-common-cold-in-adults-diagnosis-and-clinical-features?source=search_result&search=complication%20of%20the%20common%20cold&selectedTitle=1~150

**University of Massachusetts Amherst**

Human Research Protection Office
Mass Venture Center
100 Venture Way, Suite 116
Hadley, MA 01035

Office of Research Compliance

voice: (413) 545-3428
fax: (413) 577-1728

MEMORANDUM – Not Human Subject Research Determination

Date: April 24, 2017
To: Mariame Kounta, Nursing

Project Title: *Educational Toolkit for Direct Support Professionals*

IRB Number: 17-71

The Human Research Protection Office (HRPO) has evaluated the above named project and has made the following determination based on the information provided to our office:

- The proposed project does not involve research that obtains information about living individuals.
- The proposed project does not involve intervention or interaction with individuals OR does not use identifiable private information.
- The proposed project does not meet the definition of human subject research under federal regulations (45 CFR 46).

Note: This determination applies only to the activities described in the submission. If there are changes to the activities described in this submission, please submit a new determination form to the HRPO.

Please do not hesitate to call us at 413-545-3428 or email humansubjects@ora.umass.edu if you have any questions.

A handwritten signature in cursive script that reads "Iris L. Jenkins".

Iris L. Jenkins, Assistant Director
Human Research Protection Office