

Association for Individuals
with Disabilities



Attendant Training & Referral
Manual

ATTENDANT
MANAGEMENT



Resource Center On Independent Living
8625 King George Ste. #210
Dallas, Texas 75235

ATTENDANT TRAINING TEST

I. DISABILITIES

1. What does C-4, T-2 refer to?
 - a. Disabled person's address
 - b. Educational level
 - c. Level of spinal cord injury

2. A spinal cord injured person cannot feel:
 - a. Above the level of injury
 - b. Below the level of injury
 - c. When they are asleep

II. ATTENDEE CARE

3. A pressure sore can be caused by:
 - a. Wearing tight clothes
 - b. Staying in one position too long
 - c. Both a and b

4. A catheter allows:
 - a. Bowel contents to be collected
 - b. Urine to flow from the bladder to the legbag
 - c. A person to go all day without going to the bathroom

5. A person with a flaccid bowel:
 - a. Can have a bowel movement by "bearing down" without help from the attendant
 - b. Needs rectal stimulation by attendant
 - c. Only uses the bathroom in the morning

III. GENERAL CONSIDERATIONS

6. Hyperreflexia (dysreflexia):

- a. Is caused by a virus
 - b. Could be a fatal problem and needs immediate attention
 - c. Is a minor problem that will go away by itself
7. What is transferring?
- a. Catheter insertion
 - b. Changing the bowel movement schedule
 - c. Changing a disabled person from a wheelchair to bed, shower, chair, etc.
8. A disabled person's sexuality:
- a. Depends on the severity of their disability
 - b. Is the attendant's responsibility to fulfill
 - c. Is based on their own needs and desires
9. When a person has a seizure, the attendant should:
- a. Move things away from them that could harm them, and let the seizure run its course
 - b. Pry their mouth open and insert a stick to prevent them from swallowing their tongue
 - c. Hold the person down to stop the jerking

IV. FIRST AID

10. A first degree burn should:
- a. Be covered with butter or ointment
 - b. Immersed in cold water until pain subsides
 - c. Wrapped tightly with a bandage
11. To stop bleeding:
- a. Put direct pressure on wound
 - b. Cut off circulation with tight tourniquet
 - c. Lower the wounded limb below the heart
12. To restore breathing:
- a. Turn the victim's head, clean out the mouth, pinch the nose, and gently blow into their mouth

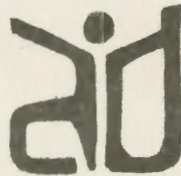
- b. Set the victim up in a chair, slap their back and give them something to drink
 - c. Leave them there while you go find help
13. To stop a person from choking:
- a. Use Cardiopulmonary Resuscitation
 - b. Give the person water to drink
 - c. Grasp the person from behind, hands on stomach, and push in and up

V. POLICIES AND PROCEDURES

14. An attendant is:
- a. A medical person trained in complicated procedures
 - b. Employed by the attendee (disabled person) to provide daily living needs
 - c. Spiritual leader of the disabled person
15. An attendee is:
- a. The employer of the attendant
 - b. Dependent on the attendant to make decisions for them
 - c. Needs "mothering" from the attendant

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ASSOCIATION FOR INDIVIDUALS WITH DISABILITIES
ATTENDANT TRAINING AND REFERRAL



TRAINING MANUAL

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Referral-AID

TABLE OF CONTENTS

I. Introduction

II. Disabilities

III. Attendee Care

IV. General Considerations

V. First Aid

VI. Policies and Procedures

INTRODUCTION

The following text was compiled with the purpose in mind being to provide general information for use in independant living situations where attendee supervised attendant care is desired. It is by no means comprehensive, but seeks to provide a broad base of knowledge covering a variety of aspects of attendant care for independent individuals with disabilities.

GLOSSARY

ATTENDANT - One who cares for the personal needs of the disabled person and performs household duties for that person.

PARA - Paraplegic. A person who is partially or completely paralyzed from the waist down.

QUAD - A person whose arms and legs are partially or totally paralyzed. Quadriplegic.

T-4, T-12, etc. - refers to the specific vertebra injury level in a spinal cord injured person.

BOWEL PROGRAM - Establishment of a "habit pattern" so a specific time to empty the bowel regularly can be achieved.

CATHETER - Specially designed rubber tube which is placed in the bladder to drain urine out of the body. A substitute for normal urination.

URETHRA - the canal through which urine is discharged from the bladder.

LEG BAG - Rubber container which is strapped to the leg for collection of urine.

INCONTINENT - Unable to control bladder function, bowel function, or both.

CONTRACTURE - Any body joint which has become stiffened to the point where it can no longer be moved through its normal range.

DECUBITUS - Any break in the skin caused by prolonged pressure which causes ulcers and skin breakdown which are extremely hard to treat.

PRESSURE SORE - Same as decubitus.

POSITIONING - Placing the body, whether in bed or wheelchair, in such a way as to best prevent the development of contractures or pressure sores. Involves a regularly scheduled change of position.

PRONE - To lie flat on one's stomach.

SPASM - A sudden, often uncontrollable, contracture of a muscle. (muscle jerk).

RANGE OF MOTION - The normal range of movement of any body joint. Exercises to design to maintain the normal range and prevent contractures.

TRANSFER - Movement from one place to another, as from bed to wheelchair, wheelchair to toilet, or wheelchair to car.

DISABILITIES

The following section includes some, but not all of the disabling conditions the attendant will come in contact with during the course of employment as an attendant. Within each disability, there are of course individual variances and implications which are too numerous to include. Each attendee should provide detailed information regarding their own specific needs and idiosyncracies to their attendant.

The information that follows, which is general in nature, coupled with the specific information provided by the attendee, should give the attendant a good base for understanding the major disabilities and their implication for the disabled individual.

SPINAL CORD INJURIES

Injury to the spinal cord can be caused by a puncture, laceration, compression, contusion, concussion and physical transection, as a result of penetrating wounds, vertebral dislocation, or fracture dislocations. Direct injury to the spinal cord results in the impairment of motor and sensory function at the level of the injury and distally (below). With the advances of the medical sciences, individuals with spinal cord injuries have been able to experience markedly increased life spans and life styles.

The degree of motor and sensory loss depends on the level of the injury in the spinal cord and the extent of damage at that level. In identifying the level of the spinal cord injury, the level of injury refers to the spinal cord segment and not to the site of vertebral injury. In determining the normal function remaining in body segments, all those that receive innervation from the cord above the site of injury will have normal function. Areas of body innervation at the site of injury and below will have impaired function. Severance of the spinal cord or cauda equina (lumbar 2 and below) results in a complete lesion which immediately produces sensory and motor paralysis, loss of reflexes, generative function disorders, and loss of voluntary bowel and bladder function. An incomplete spinal cord injury results when a portion of the spinal cord is spared and can be described by a mixed pattern of sensory and motor functions which are preserved.

The following list is related to the critical levels of spinal cord functioning following injury. The lower the level of the injury, the greater the amount of muscle function available to the spinal cord injured individual for his/her rehabilitation. Each level includes all functions of the previous level. (1)

C ₄ and above	Rarely does an individual who sustains complete injury to the third or fourth cervical cord segments survive, since respiratory difficulties secondary to loss of function of the diaphragm ensues.
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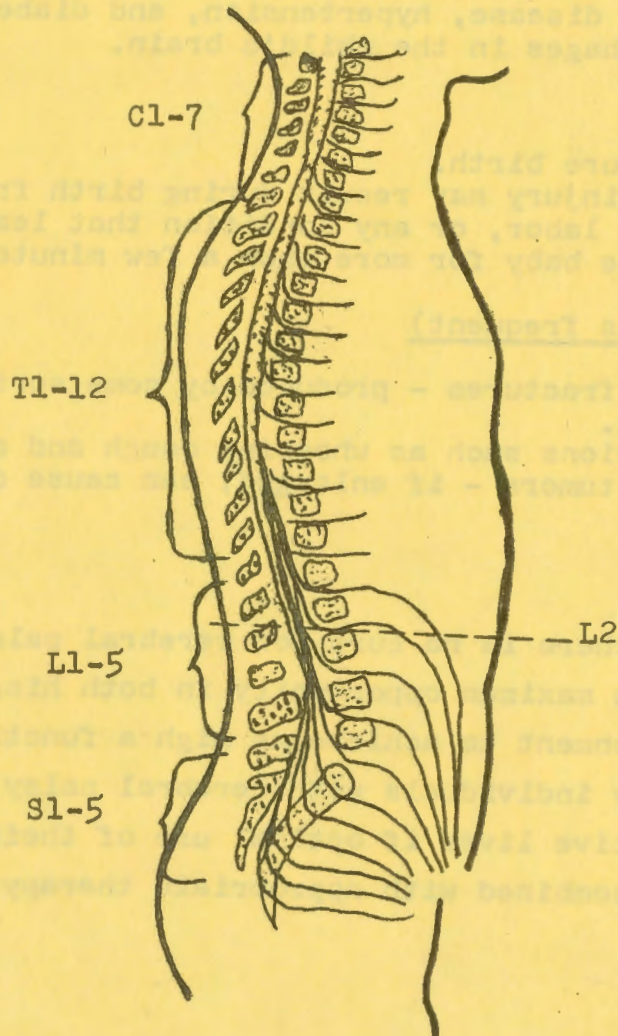
Quadriplegia and Paraplegia

An individual with a spinal cord injury in the cervical area is described as a quadriplegic when there is impairment in all four extremities and trunk musculature. An injury in the thoracic and lumbar sacral area results in paraplegia or impairment of the lower extremities and trunk musculature. The paralysis is flaccid when no muscle tone is demonstrated, while that with increased muscle tone is termed spastic.

Knowledge of the level of cord involvement permits, in the absence of complications and given a well-motivated individual, a prediction of functional potentials which spinal cord injured individuals at Southwest State University can be expected to demonstrate:

- C₄ Totally dependent for most personal care needs. Should be able to operate electric wheelchair. Requires many supportive services to meet demands of college life.
- C₅ Dependent for hygiene activities and partial dressing. Can feed self with specially adapted utensils, propel manual wheelchair for short distances on level, use electric typewriter and assist with transferring.
- C₆ Added increment permits activities of C₅ with more ease and with simpler adaptive devices. Wrist motion provides a grasping mechanism (tenodesis) to hold large objects. Should be able to empty own leg bag, minimal assistance with transfer, should be able to dress upper extremities. Spinal cord injuries at this level, and distally, demonstrate the greatest potential for developing physical independence.
- C₇ Manages transfer, dressing, and hygiene activities with minimal assistance. Is able to push wheelchair long distances. Should have enough hand function to be able to get along without specialized splinting.
- T₁ Should be totally independent in all manual activities. Requires only minimal, if any, help in transfer, dressing, and hygiene activities.
- T₆ Ambulation with braces for physiological purpose is possible.
- T₁₂ Ambulatory on level or stairs with bracing of knees and feet.
- L₄ May be able to manage without wheelchair. Bracing required for loss of function in ankles and feet.

- C₅ Partial strength of all shoulder motions and elbow flexion.
- C₆ Normal power of all shoulder motions and elbow flexion, wrist extension which indirectly permits gross grasping by the fingers.
- C₇ Elbow extension, flexion, and extension of fingers.
- T₁ Completely normal arms and hands.
- T₆ Upper back extensors, upper intercostal muscles.
- T₁₂ All muscles of thorax, abdomen, and back.
- L₄ Hip flexion, knee extension.
- L₅ Partial strength of all hip motions with normal flexion, partial strength of knee flexion, partial strength of ankle and foot motion.



CEREBRAL PALSY

Definition

Cerebral palsy is any disorder that is characterized by a motor abnormality with or without sensory impairment and/or mental retardation, due to injury or disease of the brain that is manifested before the fifth birthday.

Etiology

Injury, disease, or malformation of brain cells can cause effects identical to those of cerebral palsy. Since it is difficult to determine the exact cause, cerebral palsy is frequently classified by the time of life of its onset.

Pre-Natal (most frequent)

1. Rh factor - incompatibility of maternal and fetal blood.
2. Infection in the early months of pregnancy (German measles).
3. Functional disturbances of the mother, which include kidney disease, hypertension, and diabetes, may produce hemorrhages in the child's brain.

Natal

1. Premature birth.
2. Brain injury may result during birth from difficult or prolonged labor, or any condition that leads to lack of oxygen for the baby for more than a few minutes during delivery.

Post-Natal (less frequent)

1. Skull fractures - produced by some sort of accident or trauma.
2. Infections such as whooping cough and encephalitis.
3. Brain tumors - if enlarged, can cause damage to brain cells.

Prognosis

Although there is no cure for cerebral palsy, the individual should be given maximum opportunity in both his/her home and educational environment to achieve as high a functional level as possible. Many individuals with cerebral palsy can live relatively normal, productive lives if optimal use of their abilities can be realistically combined with appropriate therapy and satisfactory

adjustments to their disabilities.

There are four major groups of cerebral palsy classified according to predominant neurological findings that are demonstrated by each group. (1) Mixture of the characteristic of all groups may occur in any individual case.

Spastic

Occurs in approximately one-half or more of the cases of cerebral palsy. (6) Flexor muscles are under a continuous state of tension. Increased reflex activity is demonstrated causing awkward and stiff movement.

Athetoid

Athetosis is seen in approximately one fourth of the cases and demonstrated by purposeless, incoordinate and involuntary motions by the extremities, neck and trunk. (7) Initiation of any motor function will cause an increase of trunk and limb motion. Many of these cerebral palsy individuals will have a hearing loss. (6)

Ataxia

A less common type of cerebral palsy and is characterized by loss of sense of balance which results in the incoordination of activity and function. Depth perception is usually poor. (6) Muscle groups are flabby and lack good tone.

Rigidity

Resistance to slow, passive movement; of a lead pipe or cogwheel type. Co-contraction of opposing muscle groups that cross the same joint is prevalent.

MUSCULAR DYSTROPHY

Muscular dystrophy is an inherited disease characterized by degeneration and wasting away of muscle fibers without involvement of the central or peripheral nervous system.

Three well defined clinical types of muscular dystrophy have been indentified. Classification depends chiefly on the age of the individual at onset, on whether or not pseudohypertrophy (false appearance of increase in size of muscle group) is the initial symptom, and the particular muscle groups first affected. (7)

Types

1. Facioscapulohumeral - This form of muscular dystrophy is progressively slow and often remains static for years after mild to moderate involvement of the hip muscles. Onset occurs at the time of puberty, and the cases are equally distributed among the sexes. Clinically, facial musculature will usually demonstrate first involvement with individual having difficulty in closing lips, progressive weakness of the shoulder girdle and muscles of the upper arm follow. Since this type of muscular dystrophy follows a slow, progressive course resulting in moderate disability, some individuals are able to live normal life spans with minor symptoms.
2. Limb-girdle type - This type of muscular dystrophy is distinguishable from the facioscapulohumeral type because there is no facial musculature involvement. Inital weakness occurs more frequently at the hips than the shoulder girdle. The onset is usually early childhood, but it can occur as late as the second and third decade of life. Muscular wasting varies, but this type is characterized by an individual being severely disabled and death in the fourth or fifth decade.
3. Childhood type - This is the most progressive, most serious and most common of all the types of muscular dystrophy. This type is most common in boys usually around five years of age. The

deterioration process is very rapid with the individual severely involved within 6 to 12 years after diagnosis. Death may occur early in life and is usually due to failure of the respiratory system or cardiac involvement.

Etiology

The cause is unknown except that it is presumably related to the genetic deficiency or abnormality of some metabolic process resulting in degeneration of muscle fibers and their replacement by fibrous and fatty tissue.

Prognosis

In a majority of motor unit diseases there is no specific treatment to effect a cure. Therefore, medical management is directed toward the symptoms that appear during the course of the disease.

1. Weakness - Weakness is present in all motor unit diseases. Physical treatment includes exercise programs that will maintain maximal strength. For some individuals, bracing may be recommended to compensate for weak muscle groups in providing function.
2. Tightness - Soft tissue shortenings is usually present in all stages of motor unit diseases. Again, exercises and bracing are used to help alleviate or prevent contractures.
3. Deformity - Conservative management consists of positioning, selective stretching and bracing to prevent deformations. For some individuals, surgical reconstruction is done to restore range of motion and functional ability.
4. Activities of daily living - These individuals will need assistance with activities of daily living depending on the severity of involvement.

The Muscular Dystrophy Association of America has identified the following criteria for rating eight stages of functional ability for individuals with muscular dystrophy: (7)

1. Ambulates with mild waddling gait and lordosis. Elevation activities adequate (climbs stairs and curbs without assistance).
2. Ambulates with moderate waddling gait and lordosis. Elevation activities deficient (needs support for curbs and stairs).
3. Ambulates with moderately severe waddling gait and lordosis. Cannot negotiate curbs or stairs, but can achieve street posture from standard height chair.
4. Ambulates with severe waddling gait and lordosis. Unable to arise from a standard height chair.
5. Wheelchair independence: good posture in the chair; can perform all activities of daily living from chair.
6. Wheelchair with dependence. Can roll chair but needs assistance in bed and wheelchair activities.
7. Wheelchair with dependence and back support. Can roll the chair only a short distance, needs back support for good chair position.
8. Bed patient: can do no activities of daily living without maximum assistance.

MULTIPLE SCLEROSIS

Multiple sclerosis is a condition involving the loss of myelin sheaths (white matter) of nerve fibers in various areas of the central nervous system. Scarring (sclerosis) occurs which interrupts the passage of impulses along the nerve fibers.

There is no classical syndrome of neurological findings which establishes the diagnosis of multiple sclerosis. The diagnosis is suggested by the (young) age, history of previous transitory symptoms, tendency toward remission and exacerbation, the frequent presence of early visual disturbance and symptoms of ataxia (poor balance). (8)

Multiple sclerosis follows a progressive course of deterioration. After each recurrence, although the individual may improve medically, he/she usually does not achieve the level of function that he/she had previously. The disease has been known to progress over several decades.

Etiology

The specific cause of multiple sclerosis is unknown. The disease is found in males and females most often between the ages of twenty and forty. It is commonly found in colder climates. Attempts have been made to link it to infections, intoxication, nutritional deficiency states, lead poisoning and allergic reactions altering the metabolism of the myelin sheath.

Prognosis

Since this is a progressive demyelinating disease, there is no specific treatment of the condition. Medical management is based on the treatment of the individual's disorders as they develop. The following working scale has been devised by Kurtze for evaluating disability in multiple sclerosis: (9)

- 0 - Normal neurological examinations
- 1 - No dysfunction: minimal signs (Babinski positive; minimal finger to nose ataxia; diminished vibration sense)
- 2 - Minimal dysfunction (slight weakness or stiffness; mild disturbances of gait; awkwardness; mild visuo-motor disturbance)
- 3 - Moderate dysfunction (monoparesis; mild hemiplegia; moderate urinary or eye symptoms; a combination of lesser functions)
- 4 - Relatively severe dysfunction not preventing ability to work or carry on normal activities of living, including sexual functions.
- 5 - Dysfunction severe enough to preclude working, with maximal motor function (walking unaided up to several blocks)
- 6 - Assistance required for walking (canes, crutches, braces)
- 7 - Restricted to wheelchair (able to wheel self and enter and leave chair alone)
- 8 - Restricted to bed, but with effective use of arms
- 9 - Totally helpless bed patient
- 10 - Death due to multiple sclerosis

ARTHRITIS

The term arthritis means inflammation of a joint.

The clinical picture is usually that of single or multiple joint involvement with symptoms of pain, swelling, stiffness and heat (redness) in the joint(s), and fever and malaise (discomfort - often indicative of infection) in the individual. With arthritis, the inflammation itself is damaging to tissue causing muscle wasting, loss of range of motion, joint destruction, and eventually deformity.

Most major forms of arthritis are chronic conditions, meaning that once started, they continue for life in most individuals. Nearly all individuals with arthritis may have remission periods, when the disease seems to have gone completely. During the remissions, the individual with arthritis may feel perfectly well while X-ray and blood tests still reveal that the arthritis is still active but at a lesser degree. A "flare-up" is the terminology used to describe the period of time that the disease is in a very active form.

Common Forms of Arthritis

The five most widespread kinds of arthritis, with explanations of how they are different, are: (10)

Rheumatoid arthritis: This is the most serious, the most painful, the most crippling. Inflammatory and chronic, it can effect the whole body. Primarily it attacks the joints, but it can also cause disease in the lungs, skin, blood vessels, muscles, spleen, heart and even the eyes. In children it occurs in a form known as juvenile rheumatoid arthritis.

Osteoarthritis: Also called degenerative joint disease, this is principally a wear-and-tear disease of the joints which comes with getting older. It is usually mild and is not generally inflammatory. It does not cause general illness. Sometimes there can be considerable pain. Mild to severe disability may develop gradually.

Ankylosing spondylitis: This is chronic inflammatory arthritis of the spine. It affects men ten times as often as women, usually beginning in the teens or early twenties.

Rheumatic fever: This is an acute disease which follows a streptococcus infection. It frequently damages the heart. It causes arthritis which usually subsides quickly without crippling.

Gout: Also called gouty arthritis, this is an inherited disease which most often attacks small joints, especially the big toe. Most victims are men. It is intensely painful.

Etiology

The exact cause of arthritis is unknown. Two theories have been suggested but have not been proven through research: (10)

1. Arthritis may be caused by a virus. Present research has not been able to prove definitely that any germ is responsible for the disease.
2. Many experts think that arthritis may be caused by a derangement of the body's own defense or immunity mechanism. The thought being that complicated body chemistry is thrown out of balance so that the body produces antibodies which attack its own joints and tissues.

Arthritis is seen more often in women than men in a ratio of about 2 to 1. (1) Hereditary factors have been suspected since some families demonstrate multiple cases occurring. It is most likely to affect people between ages 20 to 50, but it can occur at any age. (10)

Prognosis

Each case of arthritis is different and must be treated accordingly. The medical management will depend on how severe the disease is, the joints affected, the nature of clinical symptoms, the individual's age, occupation and his/her life style.

Initial treatment is directed at conservative management consisting of rest, heat, physical therapy and aspirin. The goal of this treatment regimen is to support the individual physically and psychologically in expectation of a remission. Other types of medication

are available which are effective in reducing the inflammation of arthritis but have secondary side effects because of toxic potential.

More radical treatment will consist of orthopedic procedures to prevent or correct deformities. At times, with the individual under anesthesia, joints may be manipulated to improve range of motion. In other cases, scar tissue may be too heavy or when cartilage and bone destruction are present, various reconstructive surgical procedures may be carried out.

Special Considerations:

1. Rest is dependent on the individual's tolerance for physical stress. Some individuals may need more rest while others do not. Proper rest is always recommended with an arthritic "flare-up". Proper rest is always necessary. Enforced bed rest may vary for each individual.
2. Whirlpool, hot wet packs and warm baths may be recommended by the physician for relaxing muscles, relieving pain and soreness in an arthritic joint. Baths should be approximately 100' to 101' degrees farenheit and should last 20 minutes. Baths may be done two to three times a day. Hot wet packs or heating pads may be used frequently throughout the day for 20 to 30 minutes duration with a four hour time lapse between each application.
3. Exercises are extremely important to maintain maximal range of motion and functional strength. It is used as a preventative measure for contractures that lead to joint deformity.
4. Activities of Daily Living (ADL's) - Deformities that are caused by the fusion of a joint, or excessive wasting of muscle tissues may make arthritic individuals dependent in their activities of daily living. Attendant usage is provided only for the activities the individual is not functionally able to do for himself/herself. Self help devices can make tasks easier and productive and should be encouraged.

SPINA BIFIDA

Spina bifida is a congenital anomaly that is characteristically a malformation in which the posterior portion of a vertebral body may fail to close and the contents of the spinal canal are allowed to protrude. Three types of spina bifida will be discussed. (12)

Spina Bifida Occulta in which the defect is only in the vertebra. The spinal cord and meninges are normal.

Meningocele - in which the cord membranes protrude through the opening in the spinal canal forming a cyst with cerebral spinal fluid and covered with skin.

Meningomyelocele - in which both the spinal cord and the cord membranes protrude through the defect in the bony rings of the spinal canal.

Etiology

Unknown, except that the condition is characterized by an arrest in the orderly formation of the vertebral arches during the fourth and sixth weeks of embryo development. It is more common in females but usually found to be more severe in males. Other congenital deformities may accompany spina bifida. (12)

Prognosis

With improved medical management, individuals with spina bifida are able to assume different life styles and have a reasonable life expectancy. The management and treatment of medical problems of an individual with spina bifida is similar to that described in the section on spinal cord injuries.

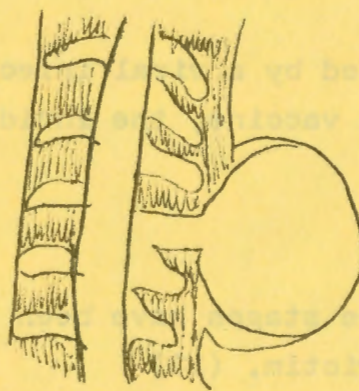
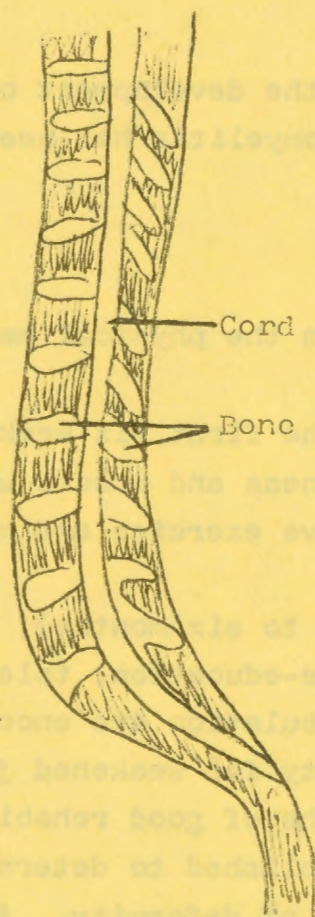
Additional Considerations:

1. Motor function: Motor function is usually absent below the level of the defect. Orthopedic deformities may be present in the lower extremities, especially the feet.
2. Sensory function: Sensation may be totally absent or greatly

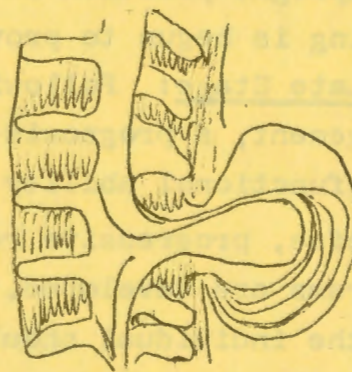
impaired below the level of the defect. Pressure sores and skin breakdown are a common occurrence.

3. Urinary and bowel problems: Bowel and bladder incontinence may be present along with interference of sexual function. Repeated urinary tract infection is present which may lead to damage of the kidneys and lower urinary tract.

4. Bacterial contamination: Bacterial contamination of the spinal fluid which causes meningitis is prevalent in young infants and presents a life threatening situation.



Spina Bifida with Meningocele



Spina Bifida with Meningomyelocele

ANTERIOR PARALYTIC POLIOMYELITIS

Polio is a virus infection that produces lesions in the anterior horn cells (motor areas) of the spinal cord and to areas of the lower brain centers. Varying degrees of involvement are demonstrated - from no residual paralysis to involvement of the trunk, limbs, and musculature of the respiratory system and swallowing. The posterior gray matter (sensory area) is not affected, resulting in no loss of sensory function.

Etiology

Caused by a viral infection. With the development of the Salk and Sabin vaccine, the incidence of poliomyelitis has been greatly reduced.

Prognosis

Three stages have been identified in the physical management of a polio victim. (13)

1. Early Stage: This represents the first six weeks of the disease. Muscle pain, muscle tightness and muscle weakness are present. Proper positioning, passive exercise and moist hot packs are indicated.
2. Intermediate Stage: (Six weeks to six months). Graded activities are started for muscle re-education; toleration of the upright position and limited ambulation are encouraged. Bracing is begun to provide stability for weakened joints.
3. Late Stage: Following six months of good rehabilitation management, a prognosis can be established to determine potential functional ability and sources of deformity. Active exercise, progressive resistive exercises and gait training programs are developed. Substitution patterns must be observed and the individual should be instructed on the effects they will have as he/she attempts motor activities.

Surgical management:

1. Acute Stage: Tracheostomy

2. Intermediate Stage: Release of soft tissue contractures and urinary calculi removal

3. Late Stage: Arthrodesis (joint fusion) and tendon transfers to improve function and correct deformity

What to do if a person is having a seizure:

1. Find a safe place where the individual cannot fall and do not hurt during the seizure (bed, rug or pad).
 2. Tight clothes, especially at the neck, should be loosened.
 3. Saliva and froth should be wiped away from the mouth during the seizure so that it is not inhaled.
 4. It is important not to restrain movements and to have a calm reassuring attitude.
 5. Do not force anything into the mouth. If jaws are clenched, it is unwise to attempt to open mouth.
 6. Usually, an individual may have prolonged cessation of breathing and will turn blue; mouth to mouth may be necessary.
 7. If this is the first seizure, notify an M.D. at once.
- Always report seizures to the medical staff.

Some of the conditions that make seizures more frequent are:

1. Emotional stress and fatigue.
2. Illness, menstrual periods, constipation.
3. Improper diet.
4. Alcoholic beverages.
5. Most common cause may be irregular use of medication.

EPILEPSY

Epilepsy is a disorder of the central nervous system which results in periodic disturbances of consciousness, during which convulsions may occur. Convulsions are beyond the voluntary control of the individual and are caused in part by the over-activity of brain cells. A seizure is not a disease but merely a symptom of the disease.

What to do if a person is having a seizure:

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4. It is important not to restrain movements and to have a calm reassuring attitude.
5. Do not force anything into the mouth. If jaws are clenched, it is unwise to attempt to open mouth.
6. Rarely, an individual may have prolonged cessation of breathing and will turn blue; mouth to mouth may be necessary.
7. If this is the first seizure, notify an M.D. at once.
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ATTENDEE CARE

SKIN CARE

As an attendant, one of your most important functions will be to assist the attendee you are assigned to with proper skin care. Unless properly cared for, the disabled individual could develop pressure sores. A pressure sore can begin in as little as three hours and can take up to six months to heal. Many times, corrective surgery is required if the sore is allowed to go unattended. Pressure sores can kill!

Proper skin care takes only a few minutes each day. However, daily skin care is the best preventive medicine for pressure sores. Only you and the individual you are assisting can prevent pressure sores.

For your information, the following narrative will give you a good working outline for the prevention of pressure sores. Please read it carefully, then discuss the routine with your attendee. He or she should have an established routine to assist in the prevention of pressure sores that he or she is comfortable with.

WHAT ARE PRESSURE SORES?

Pressure sores are sometimes called "bed sores" or decubitus ulcers. A disabled individual can get a pressure sore from many different things. Basically, a pressure sore will occur if the position of the body's weight is not periodically changed. Additionally, certain trauma can accelerate the development of pressure sores. Some examples would be:

1. Bruises caused by rough treatment in the transferring process;
2. Excessive sun;
3. Puncture or scrapes;
4. Pimples or irritations.

If the body's weight is not periodically shifted, the following

occurs:

1. The skin is pinched between the bone and the surface on which the bone is resting;
2. When the skin is pinched, the blood that feeds the skin and tissue underneath cannot get to it;
3. When the blood doesn't get to the skin, the skin and the tissue underneath dies. The result is a pressure sore.

PROGRESSION OF A PRESSURE SORE

When a pressure sore begins to develop, it looks like this:

1. Red area on the skin. This reddened area may feel hard. At this stage, the spread of the pressure sore can be reversed. All pressure must be removed from this area until the skin returns to its normal color.
2. A blister, a pimple, or a scab may quickly form over the red, hard area of the skin. This means the tissue underneath is dying.
3. A hole or ulcer forms in dead tissue. This ulcer is only the "tip of the iceberg". Most of the damaged tissue lies underneath the ulcer, sometimes going all the way to the bone.
4. Infection and decay of underlying bone.

PREVENTION OF PRESSURE SORES

Pressure sores don't have to happen. They can be prevented from developing by:

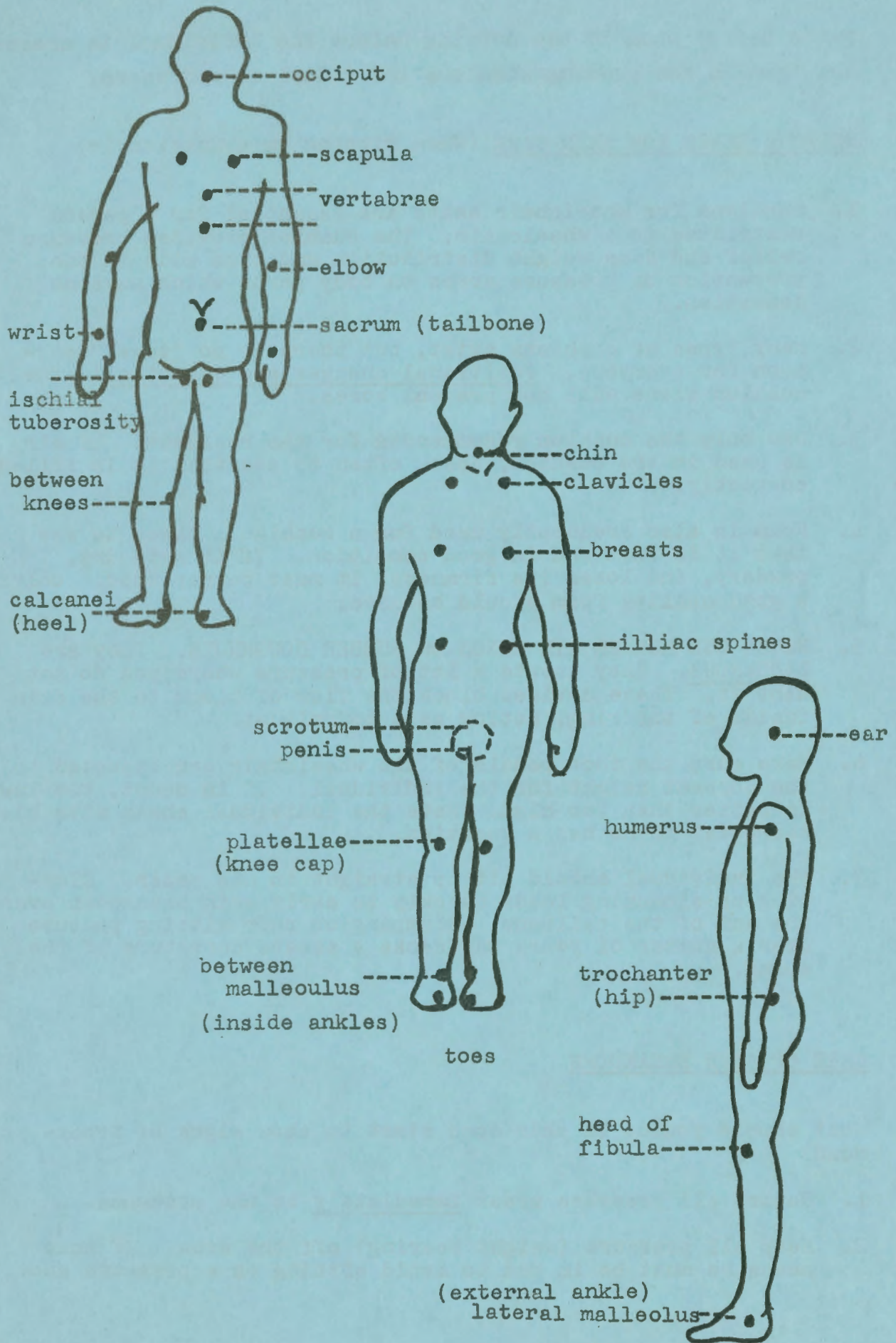
1. Inspecting the skin (particularly the buttocks and lower back areas) every morning and every night.
2. Take measures to relieve skin pressure often.

Shifting the individual's weight while in the wheelchair or bed is essential to relieving skin pressure.

HOW AND WHERE TO INSPECT SKIN

Pressure sores are likely to develop at any one of the areas shown on Figure #1. You should inspect these areas

Figure:#1



twice daily; once in the morning before the individual is dressed and then in the evening when the individual is undressed.

HELPFUL HINTS FOR SKIN CARE (When Sitting in a Wheelchair)

1. Cushions for wheelchair seats are essential for a person restricted to a wheelchair. The cushion provides pressure relief and some weight distribution and thus aids in the prevention of pressure sores on body parts which have no sensation.
2. Many types of cushions exist, but there is no "ideal" cushion for everyone. Positional changes are essential! The cushion alone will not prevent sores.
3. Use only the cushion recommended for the resident. If air is used in the cushion, check often to see that it is filled correctly.
4. Foam is also frequently used for a cushion. Check to see that it is firm and in good condition. If it gets dry, powdery, and loses its firmness, it must be replaced. Only a good quality foam should be used.
5. NEVER USE RUBBER AIR RINGS OR RUBBER DOUGHNUTS. They are DANGEROUS. They create a lot of pressure where you do not want it. These devices block the flow of blood to the skin inside of the ring, acting as a tourniquet.
6. Make sure the foot pedals of the wheelchair are adjusted to the correct height for the individual. If in doubt, too low is better than too high. Have the individual check with his therapist if he has a question.
7. The individual should sit up straight in his chair. Slumping or slouching leads quickly to early skin breakdown over the end of the tailbone. Slumping or poor sitting posture over a number of years may cause a severe curvature of the spine.

CARE OF SKIN BREAKDOWN

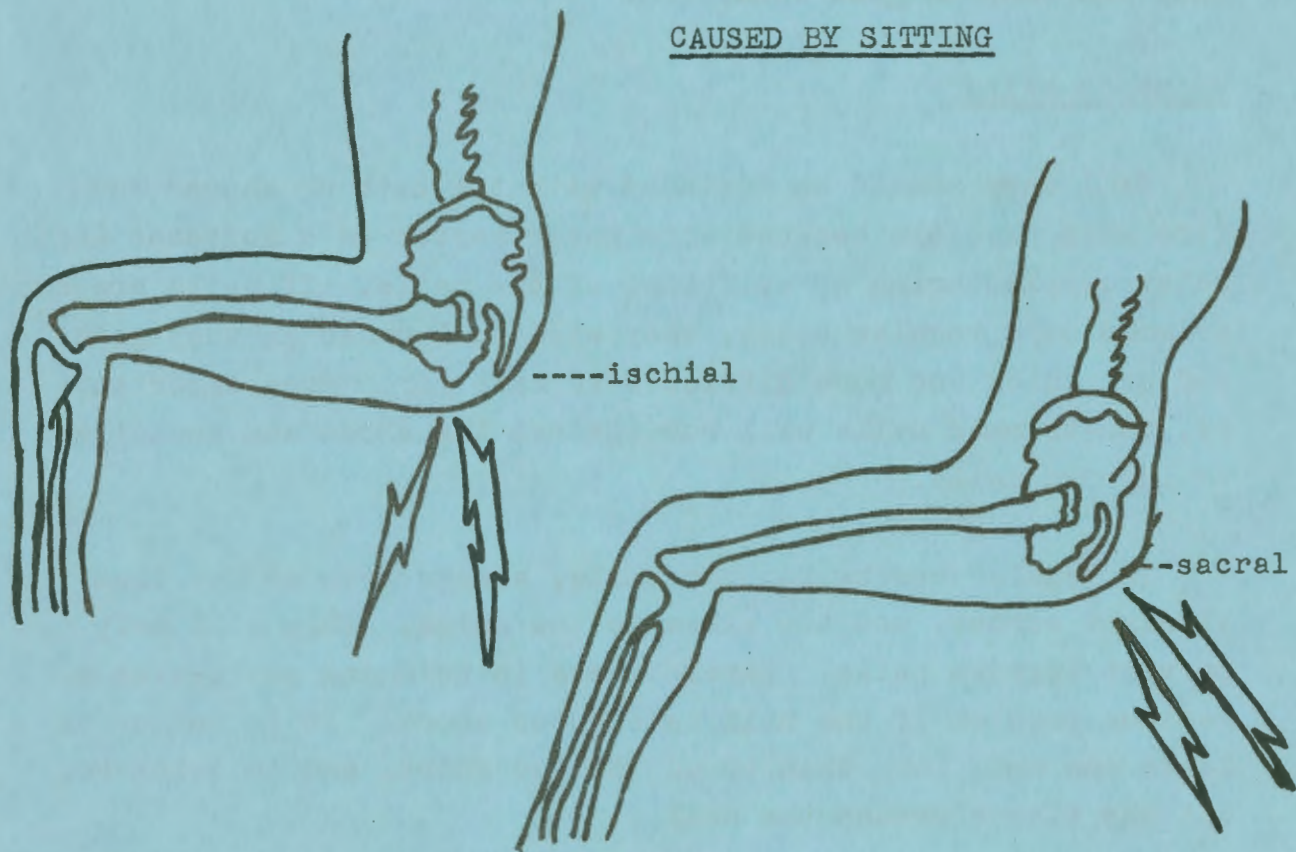
What should you do if skin does start to show signs of breakdown?

1. Report all pressure areas immediately to the attendee.
2. Keep all pressure (weight bearing) off the area. If this means he must be in bed to avoid sitting on a pressure spot,

then he should go to bed until the skin looks normal in color. Remember to keep using the turning schedule and sleep prone at night.

3. If the skin has broken, you may cleanse the sore with soap and water. Do not use anything else on it unless ordered by medical personnel. Leave it open to air as much as possible and cover with a plain, dry, sterile dressing if the sore is draining. Change the dressing as prescribed. Clean the sore only as prescribed.
4. If it is a burn and/or blister that develops, DO NOT open them. Remember, the broken skin will allow harmful germs to enter the body. Leaving the blister unopened will prevent infection. The immediate treatment of minor burns (within 30 minutes) is to soak the burned area in cold water for 20 minutes. Do not apply any medicine or ointment. Cover any blister with a dry, sterile dressing in case it should break. You should gently wash blister and surrounding area with soap and water twice each day. Keep all pressure off the area.

COMMON PRESSURE SORE AREAS



FEET AND NAIL CARE

The information contained in this section is primarily designed to give the attendant an understanding of the necessity for feet and nail care among disabled persons.

Because the feet are located farthest from the heart and because circulation is an accepted problem among the disabled, regular care is necessary. This includes prevention of dry and cracked skin on the feet, proper trimming of both toe nails and fingernails to prevent ingrown nails which could result in infection, care of infected areas, and proper cleaning.

PREVENTION OF DRY AND CRACKED SKIN

Baby oil or lotion can be rubbed into the feet about once a week to prevent cracking dryness. These measures will help keep the feet in good condition.

TRIMMING NAILS

Nail care should be included with the bath or shower routine when possible because warm water serves as a softener which retards splintering or splitting of the nails. If nails are not trimmed on a regular basis, they will curl under as they grow and get thick and more difficult to care for. More importantly, non-trimmed nails will rub against the shoes and could lead to ingrown nails.

In regular caring for the nails, always trim or cut them straight across, not too close to the quick. This will help prevent ingrown nails. Carelessness in trimming can create a serious problem if the nail is cut too short. It is better to leave the nail long than to cut it too short, and in doing so, cut the tissue around the nail.

Be alert to muscle spasms, because the associated jerking

motion could cause an unintended cut or scratch which could lead to an infection.

CARE OF INFECTED AREA

Redness and/or swelling around the nail can mean the beginning of ingrown nails. If redness or swelling occurs, follow this procedure:

1. Keep the pressure off toes by:
 - a. checking the shoe size;
 - b. remove linens and other articles from feet.
2. Prevent further trauma such as bumping the feet.
3. Follow all treatment instructions.

FEET & LEG ELEVATION

Common among most severely handicapped individuals is occasional swelling of the feet and legs. The proper medical terminology for swelling is edema. Edema of the face, abdomen, hands, and other body parts generally signifies serious problems. Basically stated, edema of the legs and feet is caused by decreased circulation to the lower extremities due to changes in the muscle tone and circulation. Edema should never be ignored because sluggish circulation is conducive to the formation of blood clots (Thrombosis). Elimination of edema is generally easily accomplished by 3 methods:

1. Increased Fluids-Increasing the fluid intake will assist in regaining normal circulation.
2. Elevation of Legs and Feet-By elevating the legs and feet approximately 15° from the hip of the individual when he or she is in bed or a little higher than the seat of the wheelchair if the individual is in the seated position, edema can be reduced. CAUTION: When elevating the feet, never place them in a manner where injury may occur such as feet falling off the bed.
3. Elastic Stockings-Only as prescribed by a physician, elastic stockings are occasionally used to retard edema. They can assist in proper blood flow based on the constriction of the blood veins principle. Elastic stockings can cause damage if not put on properly.

RESPIRATORY CARE

The disabled individual is no more susceptible to colds than any other individual. But because of their paralysis, they can develop life threatening complications rather quickly and easily. Many severely handicapped individuals have impaired respiratory function. The command for muscle contraction that is sent by the brain cannot reach the diaphragm or abdomen to produce an effective cough. Coughing pushes secretions out of the lungs. Those individuals with a higher level injury are unable to breathe deeply to force air into the lower portions of the lungs. Therefore, when a disabled person catches a cold, he or she can develop pneumonia or bronchitis quickly because he can't breathe deeply or cough adequately.

At the first sign of a cold, treatment must be started quickly and requires complete diligence on the part of the attendant. As the attendant, much of the care will be your responsibility.

Of course, the best treatment of colds, pneumonia, or other respiratory infections is prevention. This is accomplished by adequate rest, diet of proteins, carbohydrates, and vitamins, especially Vitamin C.

Respiratory infections are communicable; therefore, it is important that the attendants take care of themselves as well.

BLADDER CARE

One portion of your job as attendant is to assist the individual with proper bladder care. In very general terms, this requires proper installation and maintenance of collective devices on a daily basis.

The following pages will be beneficial in helping you understand the intricacies involved in daily bladder care. Some of the information will not pertain to the person that you will be attending. However, I highly recommend that you study all of the material carefully.

As in all areas of attendant care, the individual you are attending should know the best method of bladder care for him or her. Communication, therefore, is essential for your understanding, for his or her confidence in your abilities, and to overcome any embarrassment associated with this portion of your work.

One note of caution. Improper or sloppy work on your part could cause a costly and inconvenient bladder and/or kidney infection. Be careful.

CATHETERS

The two basic types of catheters are: 1) indwelling and 2) external. The indwelling catheter is inserted into the bladder through the urethra and also requires regular care and irrigation. The external catheter is a sheath which fits over the penis. The most common type is similar to a condom and is secured at the base with skin cement and/or elastic tape. At this time, no acceptable external urine collecting device is available for females.

All types of catheters are attached by tubing to a legbag. A legbag is a collecting pouch for urine secured around the

leg by two elastic bands. It is a one-way flowing apparatus which is emptied at the base by either a cork-type stopper, a cap, or a mechanical clip. Legbags require daily cleaning to prevent the growth of harmful organisms and to minimize unpleasant odors. The two common types of legbags are a disposable plastic model with an average life of two weeks, and a rubber type that is kept about six months. With the latter, it is imperative to cleanse it every day. Bedbags should be emptied and cleansed every morning and have an average life of three months.

MALE EXTERNAL CATHETER APPLICATION

EQUIPMENT

1. Skin adhesive
2. Rubbing alcohol
3. External collector
4. Paper towel
5. Scissors
6. One-inch elastoplast tape

PROCEDURE

1. The shaft of the penis is cleansed using the rubbing alcohol.
2. A small hole can be cut or torn in a paper towel and placed around the penis to protect pubic hair from the spray.
3. The shaft of the penis is sprayed with the medical adhesive or painted with skin glue until a thin layer is formed and allowed to become tacky.
4. The external collector is rolled on down to the base of the penis, leaving $\frac{1}{4}$ to $\frac{1}{2}$ inches from the rubber insert of the collector to the glans of the attendee's penis.
5. A strip of the one-inch elastoplast is placed around the base of the external collector above the ring. This should spiral around the penis but not overlap.
6. The ring of the collector is clipped with the scissors. The external tubing can then be attached to a legbag or bedside drainage bag.

GENERAL CONSIDERATIONS FOR MEN USING EXTERNAL COLLECTORS

1. Watch care fully for leakage as damp clothing will cause skin problems.
2. When using skin glue to attach externals, do not mix two different chemicals (such as skin prep and Hollister glue).
3. When removing a collector which has been cemented on, roll the external off; don't jank it as this may cause a rip in the skin.
4. Each time an external collector is removed, the skin of the penis and surrounding area should be washed well with soap and water, and thoroughly dried. Before applying a new collector, wipe the penis with an alcohol sponge to remove any excess skin oils which may cause the external to pop off prematurely.
5. A legbag with an external collector should be worn below the knee. This will help prevent urine from standing in the bottom of the external and causing excoriation of the tip of the penis.
6. The tubing attached to a collector can be, but does not necessarily have to be sterile.
7. When an attendee goes to bed for the night, he should be connected to a closed drainage unit and have his legbag removed, the same as with an indwelling catheter.

APPLICATION OF INTERNAL CATHETER

MALES

To apply an internal catheter, position your attendee on his back, with a bed protector under his hips and thighs. If a catherization kit is used, remove the outer wrapping and carefully open inside wrapping, being certain not to touch the inner side so that it can be used as a sterile field to arrange equipment. Pull down catheter wrapping and use forceps to place catheter on sterile wrap. Pour cleaning solution into sterile container, and place lubricating jelly in sterile container or on sterile gauze pad. Unless contra-indicated by spasticity, position drainage basin between attendee's thighs.

Cut off tip of balloon tube intake of old catheter and allow water to drain into basin. Remove old catheter and discard. Put on sterile gloves. With left hand, raise penis to a 45° angle. With other hand, moisten sterile sponge, gauze, or cotton ball with the cleaning solution and wash anterior urethra and glans. Still holding penis, pick up corner of paper drape with right hand. Shake to fully open, and place under penis. With the right hand, pick up the catheter about 2 inches from the balloon between thumb and index finger, holding the end between the third and fourth fingers. Drop lower end of catheter into drainage basin. Generously lubricate the tip of the catheter in lubricating jelly. Use the thumb and fore finger of the left hand to gently pull back on the skin of the glans, which will open the urethral orifice slightly. Insert the tip of catheter; then, maintaining the 45° angle, stretch the shaft of the penis upwards to straighten the canal. Insert the catheter without using force. If resistance is encountered, maintain a gentle pressure, but DO NOT JAB OR PUSH HARD! If resistance remains, withdraw the catheter slightly, change the position of the penis, and try again. DO NOT ATTEMPT TO CATHETERIZE IF YOUR ATTENDEE HAS AN ERECTION. Insert until urine begins to flow, then advance one more inch to insure that the balloon is well inside the bladder. Using syringe, inflate balloon with appropriate amount (usually 10cc) of sterile water. Be certain not to put in more than the specified amount of water. Gently pull the catheter until resistance is met. Irrigate according to your normal procedure until the returns are clear. Connect the catheter to bedbag or legbag, washing both connections with cleaning solution before attaching.

FEMALES

Proceed as in males to arrange equipment and remove catheter. Put on sterile gloves. Moisten sterile sponge, cotton balls, or gauze with cleaning solution. With your right hand, use moistened swab to cleanse external vaginal labia. With the left hand, and with a fresh moistened swab, clean the urethral

meatus thoroughly. Keep labia separated, use the right hand to pick up the catheter about two inches from the balloon between thumb and index finger, holding the end between the third and fourth fingers. Drop the lower end of the catheter into the drainage basin. Generously lubricate the tip of the catheter. Being careful that the tip does not come in contact with the skin of the thighs or labia, gently insert the catheter into the urethral opening. (If you feel resistance, wait a minute, maintaining gentle pressure, for the sphincter to relax. If the catheter does not slip into the bladder in a few minutes, remove it and seek assistance. NEVER PUSH HARD OR TRY TO FORCE THE CATHETER).

Insert until urine begins to flow, then advance one more inch to insure that the balloon is well inside the bladder. Using syringe, inflate the balloon with the appropriate amount (usually 10cc) of sterile water. Gently pull the catheter until resistance is met. Irrigate according to your normal procedure until the returns are clear. Connect the catheter to the bedbag or legbag, cleaning both connections with cleaning solution before attaching.

CATHETER MAINTAINANCE

CATHETER IRRIGATION

Catheter irrigation is a method of flushing out the bladder. It is necessary to prevent clogging of the system. Clots, mucus, or debris can be removed. In the event that your attendee cannot fully empty his bladder, injection of certain solutions will dissolve sediment, lessen the possibility of calculi formation, and wash out bacteria.

Each individual will have his own routine, timing, and equipment, but the general procedure will be outlined for information purposes.

Catheters should be irrigated daily unless the individual's physician instructs him to follow a different routine. Various solution are available and your attendee will know what his doctor has prescribed.

The basic equipment for irrigation includes a sterile irrigation syringe (generally 60cc), a solution basin, irrigating solution, alcohol swabs or other cleaning solution, and a drainage basin.

Always wash your hands thoroughly before irrigating, and maintain sterility of equipment to the greatest degree possible. Pour irrigating solution into solution basin. Position drainage basin between your attendee's legs, unless spasticity makes this impractical. Disconnect catheter from drainage tubing, allowing catheter to drain in basin between legs. Cleanse tips of both catheter and drainage tubing with swab dipped in cleaning solution and place drainage cap on tubing. Set the tubing aside.

Fill syringe with approximately 50cc of irrigation solution, being careful not to contaminate the tip of the syringe. Insert nozzle of syringe into tip of catheter and GENTLY squeeze solution into the bladder. DO NOT USE FORCE. If the solution does not flow easily into the bladder, it will probably be necessary to change the catheter immediately as it is probable that sediments or deposits are blocking the catheter.

Slowly withdraw the solution back into the syringe, being careful not to draw out more than you have put in. IF YOU FIND THAT THE SOLUTION CAN BE EASILY INSTILDE, BUT NOT EASILY WITHDRAWN, INFORM ATTENDEE. Empty syringe into drainage basin, and repeat with the prescribed number of irrigations. Remove cap from drainage tubing, cleanse again with cleaning solution swab, and reconnect catheter to drainage apparatus.

CLEANING LEGBAG OR BEDSIDE DRAINAGE BAG

EQUIPMENT

1. Plastic tub - (i.e. dish pan)
2. Funnel - (should fit inside legbag drainage tube)
3. Cleaning solution

PROCEDURE

1. Empty contents into toilet.
2. Rinse out urine, allowing water from tap to flow freely through legbag.
3. Fill bedside bag with water repeatedly until rinsed.
4. Wash with hot soapy solution - (dish pan)
 - a. Fill legbag (or bedside drainage bag) with soapy water and shake for 1 minute.
 - b. Rinse thoroughly with water.
5. Fill interior of the bag with cleaning solution.
 - a. Remove drainage tube and cap.
 - b. Soak tubing and cap separately.
 - c. Use the funnel and fill through bottom of legbag.
 - d. Seal both the top and bottom openings with legbag caps.
6. Immerse bag and tubing in cleaning solution for 10 minutes.
7. Open lower drain and empty legbag. Rinse thoroughly. Hang to dry.
8. To attach legbag or bedside bag to catheter:
 - a. Clean outside end of catheter and top opening of legbag or bedbag with a piece of cotton damp with rubbing alcohol.
 - b. Attach open end of catheter to top opening (flutter valves) on legbag.

BOWEL TRAINING AND CONTROL

BOWEL TRAINING

Regular bowel evacuation through habit will minimize the possibility of embarrassing accidents.

The bowel is trained to empty at a specific time by a reflex action. Therefore, it is important to use the same method at the same interval each occasion. It may be possible to increase the time interval between bowel movements as the attendee's program is established. If the attendee consistently has small results one time and large results the next time, that is an indication that an increase between the intervals should be attempted. If diarrhea suddenly occurs for no apparent reason, the rectum should be checked for fecal blockage or impaction and have it extracted.

GENERAL TERMS

Bowel - The intestine (a hollow tube through which the body's solid waste material passess).

Rectum - The lower end of the bowel.

Bowel Sphincter - A ring-like muscle (the anus) that controls the opening and closing of the rectum. There is an external and an internal sphincter.

Fecal Material or Stool - Waste products of the bowel.

Bowel Program - Established regular time for bowel emptying.

Elimination - The process of emptying the waste produce of the bowel

Dillie - Finger stimulation of the bowel.

DIET

The attendee should eat three well balanced meals a day. High roughage foods, including fresh or cooked fruit and vegetables, whole grain bread and cereals, and leafy vegetables, help regulate elimination. At least three quarts of liquids daily is recommended. Physical activity is also essential.

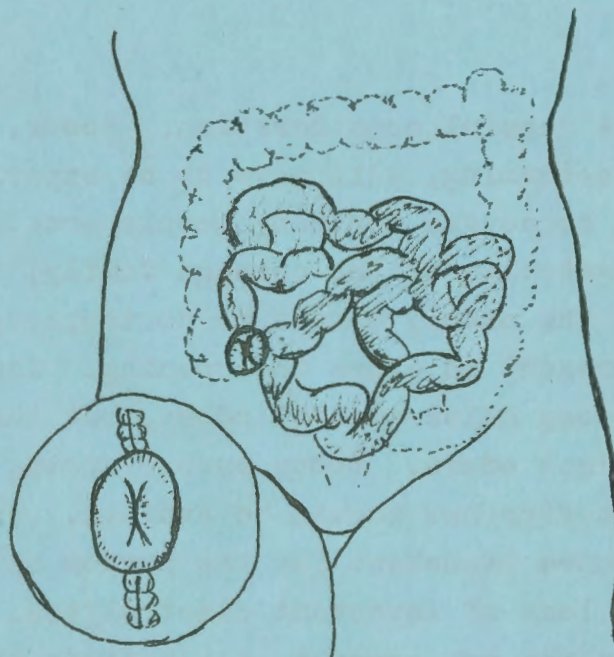
The attendant may be asked to help the person clean the skin or to dispose of the contents of the bag. Some points to remember are:

- bags with an end opening can be rinsed out with an asepto syringe as needed and do not need to be changed as often, which reduces skin irritation;
- the person will want two bags so one can air out while the other is worn;
- some people with colostomies who have good bowel regulation prefer to wear only a gauze dressing over the stoma
 - . clean and dry skin around the stoma and cover it with a 4" x 4" dressing held in place by tape
 - . use care not to spread germs when changing the dressing; put the soiled dressing into newspaper and dispose of it in the trash
 - . men may wear an elastic supporter or a homemade muslin binder with ties to keep the dressing in place
- the ileostomy bag requires a tight fit because of the liquid bowel contents and constant drainage; the appliance or bag must be changed when there is leakage; it may need to be emptied every 3 to 4 hours and changed every 5 to 5 days.

The diet needs careful consideration. Foods, particularly those that are gas-forming, will have to be experimented with. Common foods that cause gas for many people are: nuts, beans, onion, melons, vegetables of the cabbage family, sugar and sweets. Gas escaping from the ostomy cannot be controlled, since there are not muscles present to close the opening. The tight-fitting rubber or plastic bag helps control odors, but the dressing gives no protection against odors. Foods such as nuts, raisins or prunes which cause diarrhea should be avoided. Prevention of diarrhea is even more important for the person with an ileostomy because of the loss of important electrolytes. A person with ileostomy should never eat coconut, as it tends to "ball up" and could cause an obstruction. All food should be chewed well.

The emotional reactions to the loss of bowel control require a great deal of support and understanding. It is important to be a good listener. Another person who has successfully adjusted to his colostomy often provides great assistance in demonstrating how well one can manage. Local contacts may be made through the American Cancer Society or the United Ostomy Association. Part of the grief process felt by the person over loss of a body part might have occurred before leaving the hospital. It is important to help him or her express their emotions, as he still may not accept the surgery and be repulsed by the stoma. Try to help him feel as calm as possible. Help him understand that adverse emotions affect the bowel motion and the regulation of the bowel. The attendant must be very careful to show no distasteful reaction to the stoma. The person needs to feel accepted by those around him, particularly those giving him care.

Location of the Stoma of an Ileostomy



CONSTIPATION

DANGER SIGNS OF CONSTIPATION:

1. A bowel time is missed twice.
2. A hard or distended abdomen.
3. Lack of appetite.
4. Pain or discomfort in the stomach or side.
5. Small amount of very hard stool.
6. Very loose stool leaking around hard stool which is blocking the intestine.

Constipation can lead to autonomic dysreflexia in patients who have spinal cord injuries at the fifth thoracic vertebra or above. the signs and symptoms are:

Sweating of the forehead;
Goose bumps;
Chilling;
Restlessness;
Severe headache.

IF THE ATTENDEE IS CONSTIPATED:

1. If two "bowel times" have been missed, the attendee may require two tablespoons of milk of magnesia six to eight hours before the next usual time of elimination.
2. If the attendee has a spastic bowel they may require a medicated suppository even if they don't usually use these.
3. If the milk of magnesia and the suppository fail to work, then an enema should be given.
4. Types of enemas:
 - first try two cups of lukewarm water as an enema while attendee is on left side in bed. Be sure to use adequate protection for the bed.
 - then try an oil enema (disposable enemas can be purchased at a drug store).
 - Second, if this is not available try $\frac{1}{2}$ cup of mineral oil as an enema.

FOR DIARRHEA

If diarrhea is not present because of illness, check the diet to see if a certain food or lack of high fiber foods may be the cause. Discontinue use of stool softeners and laxatives. If diarrhea persists, or illness develops, contact a physician.

OSTOMY CARE

The care of the ostomy will be done by the professional. In some instances it may be necessary to clean the surrounding area and give care to the skin. It is important that the attendant know what an ostomy is and general care such as diet and the support needed by the individual.

An ostomy is a surgical opening into the intestine through the abdominal wall. The opening may be on the right or left side of the abdomen and is called a stoma. The waste matter from the bowel discharges through this opening, which takes the place of the anus. One can live comfortably with part or all of the large intestine removed, since it functions primarily to absorb water and store waste material.

Surgery which removes part of the large intestine (colon) is called a colostomy. Surgery removing all of the colon and leaving the small intestine is called an ileostomy. The removal of the urinary bladder is another operation that makes an opening in the abdominal wall, which is called a urinary bypass or ureterostomy.

The care of the ostomy depends on where the surgery occurs; the farther down the colon it is, the more closely the bowel contents will resemble the normal bowel movements before surgery; the higher up the bowel, the more liquid the bowel contents will be.

Persons who have had any of the surgical procedures creating an ostomy will be using a bag or device for collecting body waste. There are various types of ostomy bags. The individual will use the type of bag best suited to his needs and life style. The types of bag include:

- a disposable, temporary bag with an end opening to discard contents.
- a one-piece bag with an attached piece of adhesive around the opening of the stoma
- a one-piece bag with attached mounting piece which is supported by a lightweight belt and requires no adhesive.

SELECTING A BOWEL PROGRAM

The way the attendee's bowel will be regulated will depend upon their disability. If they have a "spastic bowel" (muscle tone in a spastic bowel is more active than normal) the bowel can be regulated by the use of suppositories or a gloved, lubricated finger to stimulate the bowel sphincter. With a "flaccid bowel" the bowel can be regulated by removing the stool from the rectum with a gloved, lubricated finger. The attendee knows the type of bowel they have and type of program that is best suited to their needs.

EQUIPMENT

Rubber glove

Water-based lubricant (Lubrifax or KY jelly)

Suppository

Defecation pads (Chuxs)

PROCEDURE FOR SPASTIC BOWEL:

1. If stool is present, remove it with a gloved hand and then proceed;
2. Remove suppository from foil wrapper. Insert it, pointed end first, high into the rectum. Do not push the suppository into a mass of stool. Push the end of the suppository sideways so that it touches the wall of the rectum. If two different kinds of suppositories are being used, put the stronger one in first. If the suppository is inserted in the sitting position, it will be easier if the attendee's feet are placed on a stool or foot rest and they bend forward. If unable to get up on a toilet or commode chair, the attendee should lie on their left side in bed with knees flexed, right leg crossed over left. A protective pad should be used rather than a bed pan because the bed pan pressure might injure the skin.
3. You may help a bowel movement by massaging the attendee's abdomen. Starting in the right groin, move up the abdomen, massage across to the left side and move down to the left groin. While massaging the abdomen, the attendee should attempt to strain or bear down as when having a bowel movement. If no results occur after

fifteen or thirty minutes, the attendee should stretch the bowel sphincter. To do this, insert your gloved finger into the rectum and move it gently in a circular motion. This procedure is sometimes called a "dillie".

4. A second suppository may be inserted at this time if there has been no elimination.
5. After an additional 15 or 20 minutes, massage abdomen and press downward. The attendee should try to strain and lean forward. Insert gloved finger into the rectum and move it gently in a circular motion against the internal sphincter.
6. Finally, you may have to remove the stool with your gloved finger. This must be done carefully to not damage the bowel.

PROCEDURE FOR THE FLACCID BOWEL:

1. The attendee should strain and bear down as when having a normal bowel movement.
2. Massaging the abdomen as described above also may help.
3. Then use the gloved lubricated finger to remove the fecal matter from the rectum.

HELPFUL INFORMATION

- The bowel program should be consistent to be successful. After the morning and the evening meal is a convenient time for many people. This takes advantage of the body's reflex stimulation of the bowel which normally occurs after eating.
- Routine enemas and laxatives are not recommended because they tend to make the bowel sluggish and hamper its natural functioning.
- The most common types of suppositories prescribed are Glycerine and Dulcolax. Glycerine is gentle and Dulcolax is considerably stronger.
- Regular elimination allows the disabled person to have an active life without fear of "accidents". Irregular and frequent bowel movements are irritating to the skin and will contribute to tissue breakdown or sores. Help keep the skin dry and clean.
- A well balanced diet, plenty of liquids and activity will help make a bowel program a success.

GENERAL CONSIDERATIONS

GENERAL CONSIDERATIONS

The following considerations should be reviewed by the attendant to better understand the attendee.

RANGE OF MOTION

Passive range of motion will not restore function to the limbs. It can help to prevent stiffening or "contracture" of the joints. The normal activities of daily living; bathing, dressing, eating, getting out of bed, usually provides enough motion to the joints to prevent contractures. Unless done correctly, passive range of motion can cause injury to the joints. The attendant should never do any range of motion exercises unless properly instructed by the attendee's therapist.

SPASMS

Sometimes, even though the arms and/or legs are paralyzed, the muscles will contract. These contractions or movements are not controlled by the individual, they are involuntary movements. Here is an example of what happens:

1. A pin pricks the foot.
2. The nerve tries to send a message to the brain.
3. The message goes up to the spinal cord (along a sensory nerve path).
4. This message is stopped at the point where the cord is injured.
5. The message turns around and goes back down the spinal cord (along a motor pathway), to the foot.
6. The foot muscles move or jerk.
7. This spinal cord reflex is called a spasm.

This happens because the spinal cord below the injury is

still working, up to the point of injury. Because a message can not pass the injured part of the spinal cord, the message can't get to the brain. Since the brain doesn't get the message, it can't control the force with which the muscles react to a stimulus. So, in a person with a spinal cord injury, unintentional and often repetitive movements occur. This is a result of some form of stimulation. Because the person cannot feel as before, he often does not know what is causing the spasm.

An increase in the severity or frequency of spasms may be a warning that there is something wrong. Constipation, urinary infection or stones, burns, and pressure sores are some of the more common causes of an increase in the severity of muscle spasms.

Spasms can be helpful to an attendant in performing certain tasks, but he has to know how to take advantage of triggering off a spasm at the right time. These spinal cord reflexes are sometimes confusing to paralyzed persons and their companions. They are often mistaken for a return of function to the limbs. It is important for both the attendant and the handicapped person to know that spasms are not voluntary responses, they are involuntary reflexes.

WHEELCHAIRS

Most quadriplegic individuals use an electric wheelchair to carry out their daily routines. Their wheelchair is their mobility. It is important that the attendant know the condition of the wheelchair at all times. Major problems with a wheelchair may require taking it in to an authorized dealer. The following list should be checked frequently:

1. Charging the Battery- Most attendees have busy routines. Because of this, it is imperative that you charge the battery every night, all night long.
 - A. Always plug the battery charger into the connector

before you plug the battery charger into the wall socket. When batteries are charging they give off a hydrogen gas and any spark could cause a minor explosion. Plugging the charger into the wall last will prevent this from happening.

- B. Check to be sure that the water in every cylinder of the battery is at the proper level.
 - C. Be certain that the battery terminals are tight and free of corrosion.
2. Belts- The electric wheelchair cannot function without belts. As an attendant, you should check the belts weekly for tightness, frays, or cracks.
 3. Tires- More and more persons are using wheelchairs which have pneumatic-type (air) tires. While these tires are not as easily punctured as you would initially think, they do lose air frequently. See that proper air pressure is maintained at all times. The appropriate amount of air pressure is stenciled on the tire. If abnormal leakage is noticed, or if the tires appear to be substantially worn, consult the attendee. Never allow the wheelchair to run on low or flat tires.
 4. Lubrication- Like all vehicles, proper lubrication is important. If removable parts become hard to move, or if squeaks or other abnormal noises are apparent, consult the attendee.

Remember, the wheelchair is the person's mobility. Never allow it to be abused.

TRANSFERRING

As an attendant, you may be involved daily with transfers. While some spinal cord injured quadriplegics have developed their remaining abilities to allow themselves to independently attend to this important function, most need some degree of assistance. Assistance is needed primarily for these reasons:

1. The disabled individual more often than not does not have the arm strength to move his body freely.
2. The disabled individual does not have trunk balance which allows the body to remain in a firm position while transferring.

3. Because of these physical limitations, it is not always safe for the disabled person to attempt completely independent transfers.

The chances are good that you will be assisting the individual with transfers:

1. In and out of bed.
2. In and out of the wheelchair.
3. In and out of the shower.
4. Occasionally in and out of a vehicle.

When doing so, remember the following:

1. The disabled individual has been transferred by one method or another since the disability occurred. As a result, the individual knows basically the techniques of transfer that will and will not work for him or her. One of your first duties as an attendant will be to discuss transfer techniques with your attendee. Do not assume that you can simply muscle the person around.
2. If the individual has learned to use a transfer board, do not attempt to institute another method of transfer. It has possibly taken a long time to learn this technique and if not used, the refined skills involved could be lost. Assist only when instructed, as it is best for the individual to transfer himself if at all possible.
3. When transferring to and from a wheelchair or a shower chair, be certain that the chair does not roll away from you. It could easily cause you to trip and injure both the person you are assisting, and yourself as well.
4. In all transferring procedures, never allow parts of the individual's body to be scraped by exposed edges or to be bumped. Remember, bruises or scrapes can easily result in pressure sores.
5. Protect yourself. Learn to lift in a manner which will not result in bodily injury to you. Never try to lift more than you can safely lift.

There are several possible methods of accomplishing transfers. It is important to note that whatever method you choose, it is essential that you lock the wheels of the chair before attempting a transfer.

The pivot transfer is based on leverage, and is probably

the most flexible transfer. It can be used in transferring into and from an armchair, or onto a toilet in a bathroom with little space to maneuver the chair, as well as in and out of bed.

To transfer to or from a wheelchair to a toilet or another chair, roll the wheelchair perpendicular to the seat or surface to be transferred to, so that the foot pedals are about midpoint in front of the chair or toilet, as close as possible. Lock the brakes, and remove the foot pedals and the arm on the side closest to the place of transfer. With your attendee's feet between your own, brace his knees between yours to prevent any lateral or forward movement. Slide your hands under his armpits and rest them on his shoulder blades. Have your attendee put his arms around your neck and lock if he is able. Arch your lower back, pushing your hips forward, keeping your shoulders over your hips as much as possible, and with a smooth rocking motion, bring your attendee to a semi-standing position. Pivot by shuffling your feet in a 90° turn, and gently lower your attendee onto the chair or toilet.

In using this transfer into bed, the basic process is the same. In this case, roll the chair parallel to the bed, facing the foot of the bed, and as close as possible. Position the foot pedals approximately even with the knees, lock the brakes, and remove the pedals and armrest closest to the bed. Perform the transfer as above, lowering your attendee at an angle toward the head of the bed, then lift his legs and position appropriately.

A direct transfer is useful in moving your attendee from chair to chair, or onto a toilet or shower chair. Lock the wheelchair into position directly beside the object onto which you are transferring. Remove the arm of the wheelchair on the side next to the place of transfer. Place your attendee's feet into the position in which they will be resting when the transfer is completed. Stand behind your attendee and reach forward under his armpits to grasp his wrists. Be sure that

the palms of his hands are toward his body, and that you reach down, over the wrists, making sure that attendee's hands are not pressed against each other. Pull back so that your fore-arms are under his armpits, and his wrists are against his chest. Lift your attendee, using your legs, NOT your back, and swing him to the new location.

A two-person lift is the most efficient method of picking an attendee up from the floor, and can also be used for other types of transfers. One person interlocks his hands under the knees of the attendee. The second person uses the procedure described in direct transfer to grasp the attendee's wrists, and in synchronization, they lift and transfer.

AUTONOMIC HYPERREFLEXIA (DYSREFLEXIA)

Every person with a spinal cord injury above T4-6, and everyone who works with such a person, must be aware of autonomic hyperreflexia. The acute emergency, if not treated immediately, may lead to bleeding in or near the brain. The acute phase will show any or all of the following signs:

1. Pounding headache, caused by severe rise in blood pressure.
2. Sweating above the level of injury.
3. Goose bump flesh.
4. Blotching of the skin.
5. Nasal obstruction.

A variety of stimuli will set off this reaction. The most common are irritation to the bladder caused by over-distention (overfilling), severe spasms, infection, stones, or instrumentation. Distention of the bowel by hard stool or rectal examination is the next most common factor, although various other stimuli, such as an ingrown toe nail or a pressure sore may be the culprit. Since bladder distention is the usual cause, it will be discussed in more detail.

The overfilling of the bladder stimulates nerve endings in the bladder wall to send impulses through the nerves to the spinal cord and upward to the brain. On their way up the spinal cord, these impulses activate a reflex which causes tiny blood vessels in the skin and some internal organs to constrict and become very narrow. Since it takes more force from the heart to push blood through the narrowed blood vessels, the blood pressure rises. Normally, the increased blood pressure would cause nerve endings along the aorta (the large artery leading from the heart) and the carotid sinus (a large blood vessel in the neck) to send signals to the brain to slow down the heart and dilate the tiny blood vessels. But in injuries above T-4-6, the only response is the slowing of the heart rate.

In high cervical injuries, even this might not be accomplished and a rapid heart beat will be noted. In either case, the brain cannot communicate with the nerves below the level of injury which would dilate the narrowed blood vessels. Consequences are a severe high blood pressure, as well as the other signs of hyperreflexia. It has often been noted that persons with higher spinal cord injuries experience a drop in blood pressure when they raise from a lying to a sitting position. This is recognized as a feeling of light-headedness, or as a black-out. This can be very useful in emergency treatment of a person suffering from autonomic hyperreflexia. If the signs of this reflex develop and the person is in a horizontal position, elevate his head if it can be done quickly and easily. Immediately check the bladder drainage system to detect possible obstruction, i.e., clamps which have not been removed, kinks in the catheter or drainage tubing, corroded inlets to the leg bag, or an overfull bag. If none of these are evident, determine if the catheter is plugged or sluggish by irrigating gently with 30-60cc of solution. If acute hyperreflexia is caused by rectal stimulation, the evacuation of the bowel should NOT be done until symptoms have subsided. Then nupercainal ointment may be inserted into the rectum 10-15 minutes prior to beginning the bowel program. If neither the bladder nor the bowel seem to be the causative factor, check for such things as pressure areas or ingrown toe nails.

If first aid procedures do not lower the blood pressure and relieve the headache, summon medical aid.

This reflex reaction can be very serious, but with proper care, it can often be prevented or relieved. Remember, it is an emergency situation.

POSTURAL HYPOTENSION

The same persons who display autonomic hyperreflexia when flat in bed may display, when erect on the tilt table or while

sitting in wheelchairs, a marked drop in blood pressure. Expressed as blackouts, this condition is actually postural hypotension. It is not uncommon for the average quadriplegic person to have a blood pressure of 90/60 or lower in sitting position. Occasionally, these persons will complain that the urinary output is negligible while in the sitting position, but as soon as they are placed back in bed in the horizontal position, the bladder will again fill with urine.

This is explained by the fact that in the sitting position, in some of these persons, the blood pressure decreases below that required for kidney filtration. Postural hypotension is usually observed when the person is initially in his wheelchair or on the tilt table for the first time following injury. The person usually becomes stabilized to postural hypotension spontaneously. To prevent this, legs can be wrapped with elastic bandage or elastic hose and an abdominal support applied before the person is transferred from his bed to the wheelchair; it is also helpful to raise the person's head in bed for fifteen or twenty minutes prior to being placed in a wheelchair.

If postural hypotension (blackout) occurs in the wheelchair, the attendant should firmly grab the handles of the wheelchair and tilt the disabled person backwards and lower him until the head and neck are nearly horizontal with the floor. This will increase the blood pressure and the blackout will disappear. The person is then gradually raised and dropped until he is stabilized. If stabilization is difficult, the person is placed in bed in the horizontal position.

All high level quadriplegics with continuing postural hypotension should have a safety belt attached to the wheelchair. Then if postural hypotension occurs while an attendant is not present, he may bend forward in his chair in order to increase the blood pressure without taking the chance and sustaining injuries.

SEXUALITY AND THE HANDICAPPED PERSON

The attendant needs to understand that handicapped individuals are sexual beings with the same desires and needs of the average person. Like the average person, the disabled person varies in sexual preferences and attitudes, too. No person is too handicapped to enjoy a sexual life if he desires it. The type of disabling condition is not an obstacle to many types of sexual activities.

It is important for the attendant to be aware of his feelings as well as those of the attendee. If a clear understanding of the dynamics of sexual emotions is not clarified, strife and tension may arise in the attendant-attendee relationship. Due to the personal nature of attendant care, with many intimate situations arising, the attendant may need to confront these issues head on with the attendee.

The relationship between attendants and attendees should be relaxed and we hope you will seek proper aid if you encounter situations which you are not able to resolve.

FIRST AID

The attendant is not a trained medical person. However, should the need arise, the attendant will need to know the following first aid emergency procedures.

As with all aspects of the attendant's job, use good judgment. It may save a life.

FIRST AID

First aid is immediate action taken to treat a person who has been injured or has become suddenly ill. Time can be critical, minutes, even seconds, can mean the difference between life and death. First aid fills the time gap until medical help arrives, and first aid is your job if you happen to be there. Knowing what to do can save someone's life, prevent further injury, relieve pain..... but do know what you're capable of and competent in doing.

FIRST AID TO RESTORE BREATHING

In such cases as near drowning, gas poisoning, electric shock, heart failure and suffocation.....every second counts when breathing has stopped. Six minutes without oxygen may mean death.

1. Remove foreign matter from victim's mouth.
2. Tilt victim's head back. Chin points up. Remove dentures.
3. Close victim's nostrils with your fingers.
4. Inhale, place your mouth tightly over victim's.
5. Exhale into victim's mouth until chest expands.
6. Start rapidly then repeat every 5 seconds.
7. Blow into nose and mouth of small victim.
8. Use less pressure, faster frequency for children.
9. Keep trying until victim begins to breathe by self, doctor pronounces dead or victim is dead beyond all doubt.



FIGURE #1



FIGURE #2



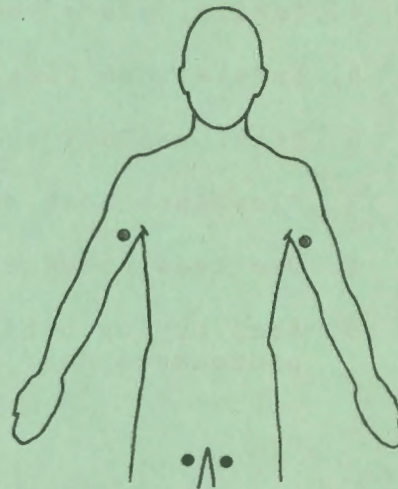
FIGURE #3

FIRST AID TO CONTROL BLEEDING

1. Open wounds usually cause visible bleeding and immediate concern is to stop bleeding.
2. Cover wound with cleanest cloth available, or with bare hand apply direct pressure on the wound. Add bandage if blood soaks through. Keep firm pressure until doctor arrives.
3. If other emergency care is necessary, apply pressure bandage to hold cloth in place.
4. Elevate wounded limb above heart if there is no bone fracture.
5. If direct pressure and elevation do not stop bleeding, continue both and apply pressure to the pressure point between heart and wound. Release pressure point when bleeding stops.



Direct pressure on wound.



Pressure points.

6. Surface Injuries: Wash injury with soap and water. Rinse by flushing with clean water, blot dry. Apply clean, sterile bandage.
7. Deep Wounds: Do not try to clean wound. Apply direct pressure. Keep area immobilized; if possible, elevate.
8. Punctures: Clean skin surface, apply light bandage. Send victim for tetanus booster shot.
9. Watch for Infection: Redness, tenderness, swelling may mean infection (invasion and growth of bacteria in body). If symptoms persist, see doctor.
11. Closed Wounds: (Injury to underlying tissue). May cause internal bleeding without visible sign of injury.
 - a. Symptoms: Cold, clammy skin; rapid pulse and breathing; deep pain; extreme restlessness or thirst; blood in vomit, urine and/or feces.
 - b. Treatment: Maintain open breathing passage; give artificial respiration if necessary. Keep victim still and watch for signs of shock. DO NOT GIVE DRINK OR MEDICATION. GET MEDICAL CARE AS SOON AS POSSIBLE.

FIRST AID FOR BURNS

Burns are classified and treated according to DEPTH and DEGREE of skin damage.

1. First Degree Burns (Skin reddened, mild pain)
 - a. Immerse quickly in cold water to relieve pain until pain subsides.
 - b. Cover lightly with dry, sterile bandage.
 - c. Do NOT apply butter or other liquids.

2. Second Degree Burns (Mottled appearance, blister, great pain)
 - a. Cut away loose clothing.
 - b. If burn is mild, immerse in cold water for 1-2 hrs.
 - c. Apply clean, cold, moist cloths.
 - d. Cover with sterile cloth. Do not disturb blisters or use ointment.
 - e. Treat for shock. GET MEDICAL HELP.

3. Third Degree Burns (Skin destroyed, white or charred)
 - a. Do not remove clothing or apply wet packs. Cover with a thick sterile dressing.
 - b. Keep victim quiet. Elevate burned limbs.
 - c. Treat for shock. GET MEDICAL HELP.

4. Sunburn: To relieve mild soreness, use non-medicated oil or cream. When blisters, fever or chills occur, seek medical help.

5. Chemical Burns: Flood the affected area with luke-warm running water for at least five minutes. Cover with sterile dressing and get medical care.

DRESSINGS

Dressings are used to cover or protect wounds or areas for various purposes. They are made of different materials and may be applied dry or moist, sterile or nonsterile, according to the purpose.

Important Points in Applying or Changing Dressings

The attendant should be familiar with the main principles underlying sterile technique which is involved with changing dressings. The attendant's regular duties may or may not include the use of sterile technique and the changing of dressings; however, under certain circumstances, he/she may be expected to apply and change simple dressings. The following points regarding sterile techniques are used in changing surgical dressings:

1. Hands are washed and scrubbed well with soap and water before and after changing any dressing.
2. Sterile forceps or sterile gloves are used to handle sterile equipment, articles, or materials.
3. Open packages of sterile supplies carefully. The inside of the wrapper must not be touched. The way that a package is opened depends upon the method used to wrap it.
4. Avoid reaching over a sterile field or area.
5. Discard, as contaminated, sterile equipment or supplies coming in contact with anything unsterile.
6. Use sterile lifting or handling forceps to remove sterile supplies from containers.
7. Lift and use the sterile lifting forceps with the tips pointed down.
8. Replace the lifting forceps in their solution when not in use, being careful not to touch the tips on the edge of the container.
9. Do not use the sterile lifting forceps to apply a dressing.
10. Remove and hold cover to container of sterile supplies, with the inside surface turned down, while removing the supplies with the lifting forceps. If the cover cannot be held, it should be inverted and placed on a clean surface. The cover should be replaced on the container as soon as the needed supplies have been removed.

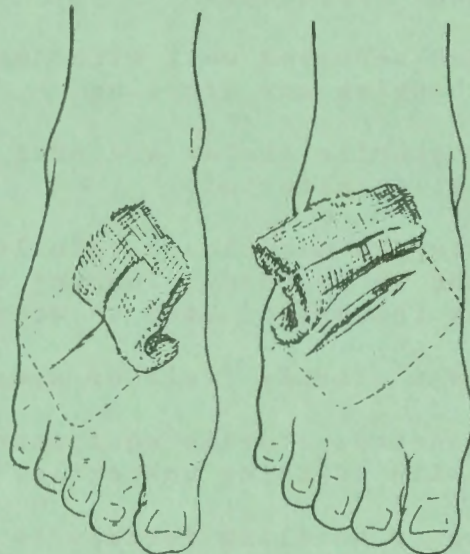
13. Avoid opening packages of sterile supplies or equipment until ready for use. Exposure to air or unnecessary handling increases the possibility of contamination.
14. Instruments and other equipment used in changing one dressing must not be used in changing another.

Purposes of Dressings

Some of the main reasons for applying dressings are to:

1. Protect against injury.
2. Prevent contamination.
3. Apply medication.
4. Absorb drainage.
5. Apply pressure.

A. Correct



B. Incorrect

A.

B.

Removal of dressing from wound.

THE HEIMLICH METHOD - A Lifesaving Maneuver to Prevent Food Choking

Food choking can be recognized easily. The victim cannot speak or breathe; he/she suddenly becomes pale, then deeply cyanotic and collapses. Because death is sudden (occurring in four to five minutes), the episode is sometimes confused with a heart attack, although symptoms and signs of the two are different.

Maneuver to Prevent Food-Choking

Rescuer Standing: (Fig. #2) Stand behind the victim and wrap your arms around his/her waist. Grasp your fist with your other hand and place the thumb side of your fist against the victim's abdomen, slightly above the navel and below the rib cage. Press your fist into the victim's abdomen with a quick upward thrust. Repeat several times if necessary. When victim is sitting, the rescuer stands behind the victim's chair and performs the maneuver in the same manner.

Rescuer Kneeling: (Fig. #3) A variation of the maneuver can be performed when the victim has collapsed or the rescuer is unable to lift him/her. Victim is lying on back. Facing victim, kneel astride hips. With one of your hands on top of the other, place the heel of your bottom hand on the abdomen slightly above the navel and below the rib cage. Press into the victim's abdomen with a quick upward thrust. Repeat several times if necessary. Should the victim vomit, quickly place on side and wipe out victim's mouth to prevent aspiration.

Fig. #1

Signal for "I'm choking on food".



Fig. #2

Application of maneuver when victim is standing.



Fig. #4

Demonstration of maneuver with victim supine; position of hands.



Fig. #3

Position of rescuer's hands.

POLICIES AND PROCEDURES

ATTENDANT-ATTENDEE ROLES

As an attendant, you will be working directly with, and for disabled adults. You will be hired, paid and supervised by the disabled client(s) you work with. The Association for Individuals with Disabilities (AID) is responsible only for interviewing, screening, and training the attendants and then referring them to the disabled adults for possible hiring. AID will also assist in initial scheduling of attendant hours. After the probationary period, however, all scheduling and salary procedures will be negotiated between the attendant and the disabled employer. In the event that you want to work more hours; work with a different client or in a different location, you can contact AID for additional matching referrals. If you are already placed with a disabled person, and wish to terminate your placement with that person, you must inform them of this and give proper notice (2 weeks) before you leave. AID will not refer you to someone else unless this procedure is followed.

The following is a description of some forms your attendee may or may not elect to use. Samples of the forms are also provided.

Attendant Worksheet is the form you will fill out daily to indicate the amount of hours you worked, what tasks you performed, and who you performed these tasks with. The date should be filled in at the top of the form; the client's initials filled in opposite the time you are working with them; the task letter code filled in under "TASK"; your initials under "ATT. INIT", and the client's signature (the person you worked with) at the bottom of the form.

It is to the attendant's advantage that the Attendant Worksheet be filled out daily since this is the form recommended to be used as payroll timesheet by the disabled employer. The result of not filling it out may be an omission of some or all of the attendant's hours worked and a corresponding loss of pay.

Client A.M., Afternoon and Evening, and P.M. Task Lists

These three forms are to be filled out jointly with the disabled employer and the attendant. The Task Lists should serve as a guide to the attendant as to the disabled person's needs and routine. This should be filled out in advance and posted in the attendee's apartment so the attendant can tell what needs to be done for the disabled person and when.

The name of the client should be listed, the activity they need doing, and the attendant who is to help them should all be written opposite the time it needs to be done. Upon completion of the activity, a check should be placed under the "COMPLETED" column and opposite the time it was completed.

The following of these procedures by the attendant and attendee should assist in eliminating confusion over what needs to be done by whom, for whom, and when, which should make the job of attendant and attendee much simpler..

DATE:

TIME	CLIENT	TASK	ATT. INIT.	CLIENT	TASK	ATT. INIT.	CLIENT	TASK	ATT. INIT.	CLIENT	TASK	ATT. INIT.	
6:00am													W WAKE UP
6:30													G GET UP
7:00													
7:30													S SHOWER
8:00													
8:30													E EAT
9:00													
9:30													D DISHES
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10:30													H CLEAN HOUSE
11:00													
11:30													L LAUNDRY
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1:00													
1:30													M MEDICATION
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2:30													B BULLET
3:00													
3:30													R RETIRE
4:00													
4:30													T TURN
5:00													
5:30													✓ CHECK
													F SHOP

CLIENT SIGN: _____ CLIENT SIGN: _____

CLIENT SIGN: _____ CLIENT SIGN: _____

CLIENT A.M. TASK LIST

TIME	NAME	ACTIVITY	ATTENDANT	COMPLETED
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CLIENT AFTERNOON & EVENING TASK LIST

TIME	NAME	ACTIVITY	ATTENDANT	COMPLETED
2:00				
2:15				
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CLIENT P.M. TASK LIST

TIME	NAME	ACTIVITY	ATTENDANT	COMPLETED
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