



Nurse to Nurse

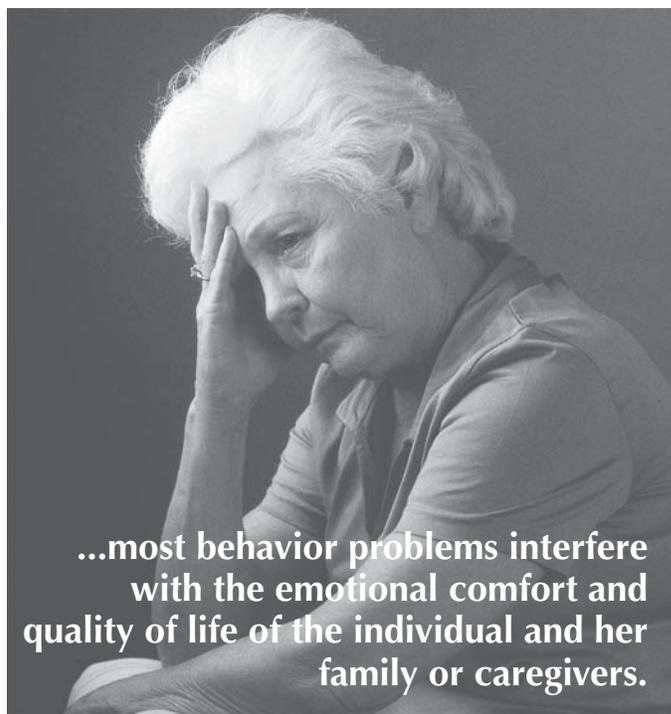
Oregon's Community Based Care Nursing Newsletter

Daily living with behavior symptoms

Lynda Crandall

Just as nurses must be knowledgeable in the signs and symptoms of physical health problems and skillful in their assessment and treatment, so must they be prepared to intervene in the assessment and management of behavior symptoms. Behavioral symptoms very often create significant challenges that try the patience and skill of caregivers. What may appear to be a simple behavior is generally layered with complexity and requires a thoughtful assessment to identify what is going on and what to do about it.

All people experience periods of agitation and restlessness, hostility and aggression, social withdrawal, and forgetfulness or confusion. These responses and behaviors can create difficulties in daily living at any age. But in the elderly or persons with compounding physical disabilities who are at higher risk for a variety of reasons, these behaviors can be not only disruptive but life-threatening. They can interfere with essential elements of daily living such as sleeping, eating, drinking, eliminating and being mobile. Long-term consequences can include malnutrition, electrolyte imbalance, urinary tract infections, and other pathology that may contribute in turn to further central nervous system



...most behavior problems interfere with the emotional comfort and quality of life of the individual and her family or caregivers.

dysfunction. Some behaviors can endanger other persons and threaten the security of the person's living environment, and most behavior problems interfere with the emotional comfort and quality of life of the individual and his family or caregivers.

Continued on page 2

In this issue

Daily living with behavior symptoms.....	1
Office of MinorityHealth to help nurses provide culturally competent care	7
Community-based care nursing continuing education	7
Tuberculosis in Oregon: What's the risk?.....	8

Although changes in physical status tend to be more obvious, behavioral and cognitive dysfunctions have a powerful effect on the social, interpersonal and physical character of daily living. With the aged there are risks of overlooking changes or of attributing the observed signs and symptoms to normal aging rather than to other factors that can be equally potent in creating mental and behavioral problems.

Other significant factors include pathophysiology, drugs (prescription or nonprescription), malnutrition, change in the environment and other life changes. Therefore physical causes must always be ruled out prior to designing care plans addressing behaviors. Most behavior problems tend to be more disabling when accompanied by confusion and memory loss.

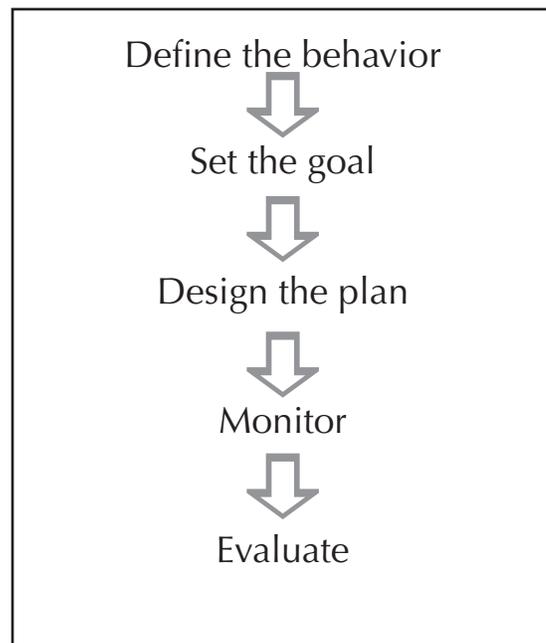
A fundamental premise is that the presenting behavior is rarely the primary problem. Most often behaviors are symptoms of the real problem, i.e., the way the problem manifests itself. For example, wandering is a symptom of a primary problem that may be confusion, boredom or an emotional driven need to get some place. Similarly, combativeness is a symptom of the basic problem that may be pain, misinterpretation of caregiver intent, paranoid delusions, etc.

Family members and direct caregivers of elderly persons with behavioral symptoms should be included in the assessment, diagnoses, treatment plans and evaluations. The ability of the family members, spouse or companion to adapt to or work with behavior symptoms in the older family member can be hampered by

their own lack of understanding of what is happening.

Addressing behavior symptoms

Addressing behavior symptoms requires following the nursing process:



The first step is defining the behavior.

Addressing behavior symptoms must start with a clear description of what the behavior is and how it is problematic to the person and/or those around him. The fact that a behavior has been identified as “problematic” or “deviant” does not necessarily indicate a need for intervention. It is the effect of the behavior on the person and those around him or her that determines both the need for and the level of intervention required. Addressing the symptoms includes investigation as to the frequency and intensity of the behavior.

Behaviors that are annoying or even those that are obnoxious to others may or may not require intervention to modify them.

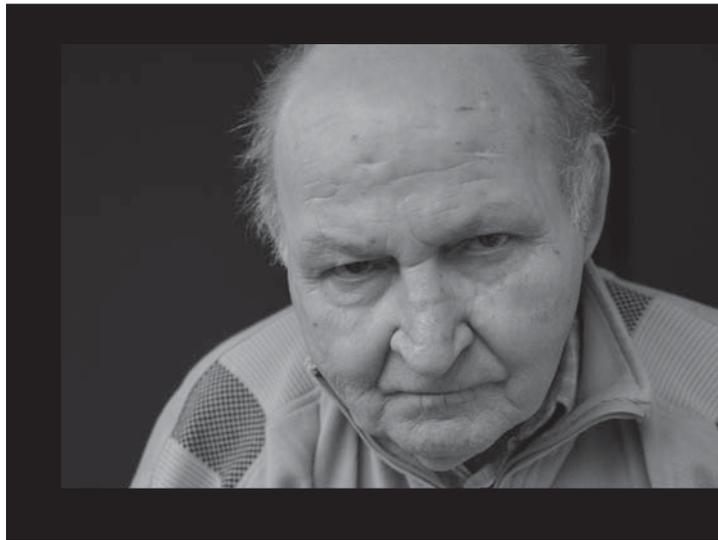
It may be helpful to ask, “Is this behavior dangerous, disruptive or distressing and to whom?” and use this as a springboard for discussion about what truly is the problem, whose problem is it and what level of intervention is needed, if any.

Interpretation of the behavior is not always apparent and often requires a fair amount of detective work, particularly when the person suffers from cognitive impairment. In many cases a tedious process of empirical trial and error interventions using one’s “best guess” is required to derive the etiology. Directing attention toward reducing the problem or target behavior without understanding why it is occurring may do little to alter the behavior and may in fact exacerbate the problem or create new ones.

The second step is setting goals. The ultimate reason for any care plan is to support an individual in having a meaningful and pleasurable life. Behavior plans are not solely for the purpose of eliminating “problematic” behaviors. Goals aimed at total elimination of a behavior are rarely achievable or realistic. Consider how the behavior might interfere with quality of life for the individual and build a goal with him or her that supports the life he or she desires. Often behaviors take on new

meaning when the approach is shifted in this manner. This is not to say that reducing the frequency of the target behavior and safety elements are not important. They are just not the first things to be attended to.

A good rule of thumb when addressing behavior reduction is to word the goal in positive language rather than negative action, i.e., what do you want the person



A fundamental premise is that the presenting behavior is rarely the primary problem. Most often behaviors are symptoms of the real problem, i.e., the way the problem manifests itself.

to do rather than what you want him or her to stop doing.

The third step is designing the plan. The plan may include further investigation measures to continue the process of identifying the underlying cause, e.g., trial of a routine analgesic to help determine if pain is a cause, offering routine daily opportunity to get outside, or using a behavior monitor chart to better pinpoint the triggers, times and circumstances around which the behavior occurs. If triggers and underlying causes are clear, then interventions will be directed at reducing or minimizing the distress the

Continued on page 4

person experiences from these triggers.

Nursing intervention includes components directed toward both the older individual as well as the family or caregiver. This includes a working knowledge of treatment options and proficiency in designing intervention strategies appropriate to helping older persons and their families to manage everyday living that is complicated by behavior problems. Impressions and recommendations for managing daily living need to be communicated in a usable manner to families and primary caregivers.

Nursing intervention involves helping the older person to:

- Discover what quality of life means for this person;
- Minimize emotional discomfort, and potential injury related to the problematic behavior;
- Gain insight into the impact of the behavior on this person and others;
- Expand coping abilities and problem-solving skills for managing his or her behavior and daily living as it relates to the behavior; and
- Modify the behavior to more appropriate, socially acceptable or safer levels.



Discover what quality of life means for this person;

Nursing intervention involves helping the family and caregivers to:

- Understand the nature of the phenomena they are living with; and
- Develop feasible plans for managing daily living for both the focus person and the caregiver. This often involves anticipatory care planning, i.e., identifying what the person may need before the behavior symptoms or escalation occurs.

Specific intervention strategies should use the person's identified strengths, known likes and dislikes, as well as interventions that by history have been helpful. Basic prevention and behavioral management principles form the backbone of the plan. A measure of creativity in intervention design is frequently necessary as there are generally no management protocols addressing some of the most difficult behavior symptoms.

No plan should include medication as a sole intervention and all plans should include behavioral, psychosocial, physical

Continued on page 11

*** Attention first time readers***

Nurse to Nurse: Oregon's Community Based Care Nursing Newsletter

To subscribe to this newsletter, please complete and return the following subscription survey.

Please indicate all settings where you practice.

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Nursing facility | <input type="checkbox"/> Private home | <input type="checkbox"/> Assisted living | <input type="checkbox"/> Public health |
| <input type="checkbox"/> Clinic setting | <input type="checkbox"/> Foster care | <input type="checkbox"/> School health | <input type="checkbox"/> Residential care |
| <input type="checkbox"/> Nursing education program | <input type="checkbox"/> Government | <input type="checkbox"/> DD 24-hour residential | |
| <input type="checkbox"/> Other _____ | | | |

Nursing issues of interest? Check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Gerontology | <input type="checkbox"/> Illness profiles | <input type="checkbox"/> Syndrome profiles | <input type="checkbox"/> Palliative care |
| <input type="checkbox"/> Abuse & neglect care | <input type="checkbox"/> Transitions in | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Administration |
| <input type="checkbox"/> Evidence-based practice | | <input type="checkbox"/> Nursing resources | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Role of the CBC nurse | | <input type="checkbox"/> Legal issues | <input type="checkbox"/> Infection control |
| <input type="checkbox"/> Continuing education | | <input type="checkbox"/> Leadership skills | <input type="checkbox"/> Care coordination |
| <input type="checkbox"/> Developmental disabilities | | <input type="checkbox"/> Other: _____ | |

Topics and issues you would like to see discussed in this newsletter:

What is your preferred method of newsletter delivery?

- Internet (saves taxpayer dollars) Mail

Name _____

Address _____

City/State/Zip code _____

E-mail _____

Please fold, affix first class postage, and place this pre-addressed survey in the mail.

Thank you for your interest in *Nurse to Nurse: Oregon's Community Based Care Nursing Newsletter.*



Affix
1st class
postage
here

Nurse to Nurse: Oregon's CBC Nursing Newsletter
500 Summer St. N.E., E-13
Salem, OR 97310-1074

Office of Minority Health to help nurses provide culturally competent care

The U.S. Department of Health and Human Services' Office of Minority Health has released a new accredited continuing education program for nursing professionals that has been endorsed by the American Nurses Association (ANA). Entitled *Culturally Competent Nursing Care: A Cornerstone of Caring* and provided at no cost, this course is designed to help nurses integrate cultural competency awareness, knowledge and skills to more effectively treat increasingly diverse patient populations.

Culturally Competent Nursing Care: A Cornerstone of Caring is a Web-based training course available at www.thinkculturalhealth.org. The course features video-based case studies and interactive tools that can be completed "anytime and anywhere" to accommodate busy nurses.



Accredited for up to nine hours through the American Nurses Credentialing Center, *Culturally Competent Nursing Care: A Cornerstone of Caring* was developed through input from national leaders in cultural competency and nursing education. Nurses now can complete the entire curriculum, or any combination of its three components, which are focused on culturally competent care, language access services and organizational supports for cultural competency.

Community-based care nursing continuing education

Seniors and People with Disabilities (SPD) self-directed study course for nurses titled *Registered Nurse Delegation in Oregon* is scheduled for publication this fall. The goal of this three-part learning module is to assist the registered nurse practicing in Oregon's long-term care system in attaining a fundamental understanding of R.N. delegation.

SPD contract R.N.s will receive the module in early October. Listserv subscribers to *Nurse to Nurse: Oregon's Community Based Care Nursing Newsletter* will receive notification on where to access a copy of the self-study course.

To subscribe to our listserv, or update your e-mail address, e-mail Bernadette Murphy at Bernadette.J.Murphy@state.or.us with "Listserv Subscription" in the subject line.

Tuberculosis in Oregon:

What's the risk?

Katrina Hedberg

With all the recent media coverage of a globe-trotting lawyer with drug-resistant tuberculosis, TB has been launched once again into the public spotlight. The sudden attention brings back all too recent memories of TB sanatoriums in the United States, which housed those infected with the bacteria for months or years while they underwent treatment. While advances in screening, diagnosis and treatment decreased the burden of the disease in the United States, it has not been eradicated. On the contrary, TB is an enormous health problem worldwide, with one out of every three people on the planet infected. Recent events point out our vulnerabilities, reminding us that issues such as drug-resistant TB, the fluidity of the world's population, and deteriorating public health infrastructure could bring tuberculosis back into our daily lives. This article steps back to review the basics of TB, and focuses on the responsibilities and risks relevant to health care workers in Oregon.

TB basics

The cause: Tuberculosis is caused by *Mycobacterium tuberculosis*, a very slow

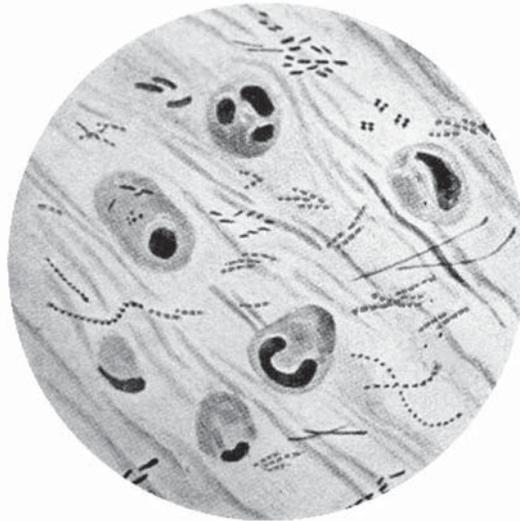
growing yet persistent bacteria spread from person to person through the air. When someone with infectious TB coughs or sneezes, tiny droplets containing *M. tuberculosis* are sprayed into the air. If someone nearby inhales these droplets, introducing the bacteria deep into their

lungs, they may become infected. However, not all people who become infected will go on to develop the disease. In fact, only one out of every 10 people infected with *M. tuberculosis* will become sick at some point during their lives.

Mycobacterium tuberculosis is not easily destroyed, and most people with competent immune systems will contain the infection by walling the bacteria off in an area

called a granuloma. While the bacteria are contained this way, they are not eradicated. Inside the granuloma, the slow growing and persistent *M. tuberculosis* can reproduce for decades. If for any reason the immune system becomes weakened, these granulomas can break down, allowing the bacteria to cause disease by spreading throughout the body. This dual nature of tuberculosis infection, becomes very important in our efforts to control the disease in the overall population.

Latent TB infection: People who have been infected by *M. tuberculosis* but are



Mycobacterium tuberculosis

This bacterium can attack any part of the body, though usually the lungs, causing Tuberculosis, and is spread through inhalation of infected sputum from a coughing or sneezing individual.

Photo courtesy of the Center for Disease Control

not sick because their immune systems are effectively containing the bacteria, are said to have latent tuberculosis infection (LTBI). These people are not contagious, but are at risk of getting sick at some point in their lives. The purified protein derivative (PPD) tuberculin skin test and the Quantiferon blood test are used to detect people with LTBI so they can be treated before they become ill. Those who are sick because their immune systems have not been able to control the bacteria are said to have active tuberculous disease.

Active TB disease: While the most familiar form of active TB involves the lungs (pulmonary tuberculosis), the bacteria also can cause active disease anywhere in the body, including the brain, skin, bones and kidneys (extrapulmonary tuberculosis). This is an important distinction, as only those people with active pulmonary TB who are coughing are considered infectious. While people with active extrapulmonary TB may be extremely ill, they are unlikely to spread the bacteria. Symptoms of pulmonary disease include a persistent cough, chest pain and hemoptysis. Less specific symptoms of active TB disease in general include fevers, night sweats and unexplained weight loss, while extrapulmonary disease will have symptoms based on the body system involved.

While overall the lifetime risk of a patient progressing from LTBI to active tuberculosis is only 10 percent, the risk is not the same for all people. People with compromised immune systems, particularly those with HIV infection, are more likely to develop active TB. This includes young children and the elderly, people on corticosteroids or immune-suppressant therapy, and those with HIV, cancer, diabetes or renal failure.

In general, people with LTBI are also more likely to progress to active disease within the first two years of becoming infected.

Diagnosis and screening: Because they do not have symptoms, diagnosis of LTBI in patients is accomplished by screening people who are at increased risk of exposure with a PPD or Quantiferon test. Oregon has a fairly low burden of tuberculosis with only 81 cases reported in 2006, a full two-thirds of which were in people born outside of the United States. This means that the general population in Oregon is at very low risk of exposure to tuberculosis, and widespread screening is not beneficial. Instead, screening should be focused on specific high-risk populations. These include people who have been exposed to known or suspected active pulmonary TB, refugees and immigrants from high-incidence countries, and health care workers. Because their risk of progressing from LTBI to active tuberculosis is high, all immunocompromised people also should be screened. Patients with suspicion for active tuberculosis should be screened and referred immediately for a general medical evaluation.

If the PPD or Quantiferon screening test is positive, patients are referred for medical evaluation and chest X-ray to rule out active tuberculous disease. A patient cannot be considered to have LTBI until the medical evaluation and chest X-ray come back negative. If the chest X-ray is suspicious for active pulmonary TB, sputum samples are collected. The sputum sample provides an opportunity to grow the bacteria in culture, and also helps determine how infectious the patient may be.

Continued on page 10

Treatment: Fortunately both LTBI and active tuberculous disease can be treated. However, the mechanisms our bodies use to contain the infection also make it more difficult to treat. Granulomas not only isolate the bacteria from spreading, but also make them more difficult to reach with antibiotics. *M. tuberculosis* is also a very adaptable organism and has the intrinsic ability to develop resistance to antibiotics. Combined with the fact that *M. tuberculosis* is a very slow growing organism, prolonged treatment regimens are required in order to be effective.

In LTBI the number of bacteria in the body is relatively low, and a 9-month course of isoniazid is usually sufficient. In active tuberculosis, the number of bacteria is very high, increasing the chance that some of those bacteria will be resistant to one or more antibiotics. Therefore, four antibiotics are usually given to ensure that all the bacteria are killed. The length of treatment in active disease varies according to the body system involved and the antibiotic susceptibility pattern of the specific bacteria, but is also months at minimum. Incomplete or irregular adherence to antibiotic treatment can lead to the development of resistance, which in turn requires the use of alternative antibiotics, which are less effective and have greater side effects. *Directly observed therapy* is a strategy used to decrease the development of resistant organisms, and involves a health care worker witnessing a patient take their medications on a regular basis.

TB risk to Oregon health care workers

So what does this all mean for health care workers in Oregon? In terms of the risk of becoming infected with TB, the bottom line

is that most health care settings in Oregon have a low incidence of tuberculosis, and therefore the risk of exposure to health care workers is also low. Employee tuberculosis screening in these settings should only be upon hire, and yearly screening is not necessary. In Oregon, the only exceptions involve specific higher incidence settings, such as clinics for migrant workers, refugees, homeless people and correctional facility inmates. In these specific instances, annual screening should be performed.

Know your patients: Healthcare workers should not only be knowledgeable about the diagnosis and treatment of TB, but should also understand which of their patients are at increased risk. For example, an 80-year-old female who lived in Laos for most of her life and now has breast cancer and a new cough is at very high risk for active tuberculosis. She may have been infected as a young adult, harboring LTBI for many years, and finally progressing to active disease due to her advanced age and new cancer. On the other hand, an 80-year-old female with a new cough, who was born in the United States and is otherwise healthy, is probably at low risk for having TB. Understanding the difference will help health care workers better care for both their patients and themselves.

For more information about TB please contact:

*Oregon DHS Health Services
Tuberculosis Control
800 NE Oregon Street, Suite 1105
Portland, OR 97232
Phone: 971-673-0153*

<http://www.oregon.gov/DHS/ph/tb/index.shtml>

*The Centers for Disease Control:
<http://www.cdc.gov/tb/>*

*The Francis J. Curry National Tuberculosis Center
<http://www.nationaltbcenter.edu/aboutus/index.cfm>*

environment and spiritual components. Psychoactive medication can be a very useful adjunct to the above measures when these interventions alone do not produce measurable behavioral change. A key principle is to initiate only one medication change at a time. Careful monitoring of both therapeutic and adverse effects is indicated.

Often several problem behaviors present concurrently. Not all can be addressed at the same time. It is necessary to prioritize the behaviors, weighing their impact on both the person and those around him or her in order to select which one or two problems should be addressed first.

The fourth step is monitoring

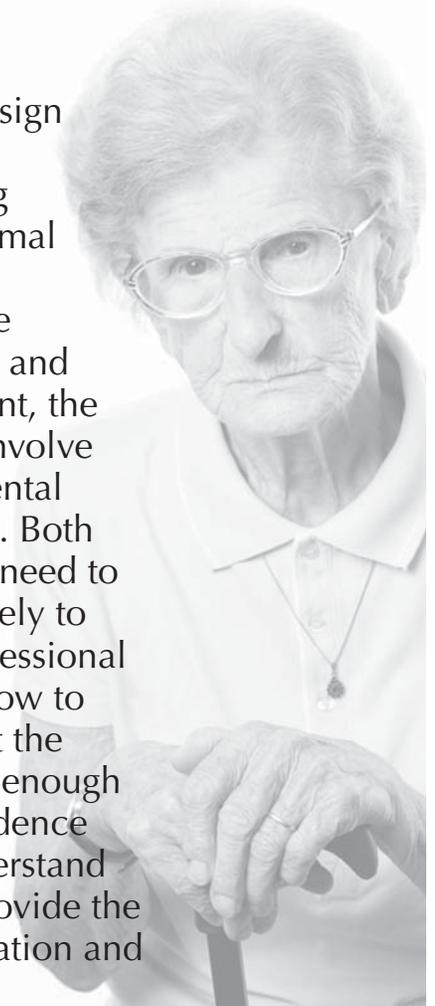
Throughout the assessment and intervention steps, ongoing observation and documentation will assist in refining the plan of care. Monitoring can take several forms: a formal behavior monitor chart may be used for short or long periods, e.g., five or seven days or longer; behavior description logs, in which direct care workers could indicate on daily ADL notations whether the behavior was observed; progress note entries that describe behaviors; and routine check-ins with staff and family. Don't forget to ask the person how he or she feels things are going.

The fifth step is evaluation of the plan

This may take place only days after implanting interventions or at a monthly or quarterly review, etc. Whatever the increment of time, the purpose of evaluation is to review the assessment, the course of action taken, the monitoring

done and determine if the current plan is effective or requires some modification.

When thorough assessment, plan design and intervention by the entire caregiving team results in minimal behavioral change and the effect on the individual's comfort and life remain significant, the team may elect to involve the assistance of mental health professionals. Both nurses and families need to know when it is timely to seek additional professional help and to know how to communicate about the person's status with enough precision and confidence that others can understand the situation and provide the appropriate consultation and care.



The *Nurse to Nurse* newsletter now has its own email address! If you have ideas for future issues, want to be placed on our mailing lists, are interested in receiving future editions electronically or need to change your email address, please contact us at N2N.HSU@state.or.us. When sending an email, please list "Email" in the subject line.

Nurse to Nurse – Oregon’s Community
Based Care Nursing Newsletter
Oregon Department of Human Services
Seniors and People With Disabilities
500 Summer Street NE, E-13
Salem, OR 97301

Seniors and People with Disabilities Mission Statement: Assisting seniors and people with disabilities of all ages to achieve individual well-being through opportunities for community living, employment and services that promote choice, independence and dignity.

Nurse-to-Nurse is published by Seniors and People with Disabilities, Office of Licensing and Quality of Care, Oregon Department of Human Services, 500 Summer Street NE, E-13, Salem, OR 97301-1074
Editorial Team: Deborah Cateora, Health Service Unit Manager and
Bernadette Murphy, Health Service Unit. Design and layout by Becki Trachsel-Hesedahl, Web and
Publication Design Team, DHS Office of Communications