

Nurse to Nurse

Oregon's community-based care nursing newsletter



Vol. 5 No. 2. 2008

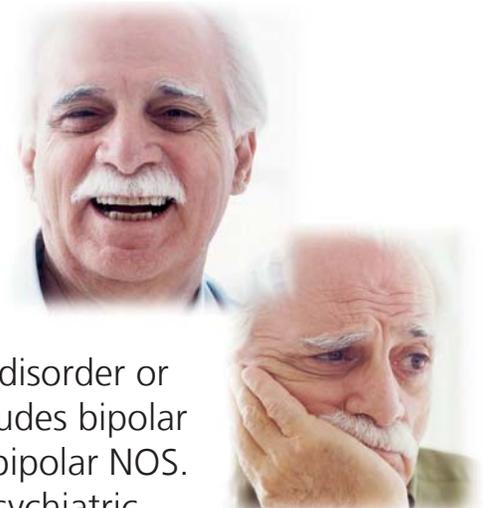
Summer 2008

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Bipolar disorder

— Bipolar disorder is a category of mood disorders characterized by episodes of mania. Formerly referred to as manic-depression, bipolar disorder or bipolar affective disorder includes bipolar I, bipolar II, cyclothymia and bipolar NOS. According to the American Psychiatric Association, bipolar disorder affects 1.2 percent of the general population. It can typically be well managed with appropriate treatment. Home health care and community nurses can make a significant contribution toward the success of such treatment.



Bipolar I

Mania

According to the DSM IV-R, one or more episodes of mania or mixed episode is required for a diagnosis of bipolar I disorder. Mania is characterized by an elevated, expansive or irritable mood over a distinct period of time. Individuals in a manic state often display increased energy and less need for sleep. They may be irritable and easily distracted.

Some people become overconfident or grandiose. If severe, individuals can develop delusions or suffer from other forms of psychosis. Judgment and inhibition are often impaired.

Individuals experiencing mania may engage in self-destructive behavior, such as going on shopping sprees with disregard for finances.

Others experience increased sex-drive and may engage in risky sexual behavior. Those with psychosis, extreme anxiety or irritability may become combative.



To meet the DSM-IV-R criteria for mania, an individual must exhibit symptoms of mania for at least one week, or with such severity to require hospitalization.

Depression

There is no requirement for the presence of depression for a diagnosis of bipolar I disorder. That said, many people with Bipolar I disorder do experience major depressive episodes. Symptoms of major depression include persistent feelings of hopelessness and helplessness. Individuals in a depressive phase of bipolar disorder often express feeling empty and apathetic. Others report anxiety, anger, or guilt.

Depression often leads to changes in an individual's eating or sleeping patterns. Many individuals report ongoing restlessness. Others report a lack of energy despite an increase in sleep. Some people experience suicidal ideation. If severe, a person can become psychotic.

Mixed affective episodes or a mixed state is an episode in which an individual experiences both symptoms of mania and depression simultaneously. An example of this would be someone who reports feeling hopeless and sad yet displays increased energy.

Bipolar II

Hypomania

Bipolar II disorder is characterized by hypomanic episodes and at least one major depressive episode.

Hypomania shares some characteristics with mania but to a lesser degree. Individuals experiencing hypomania also experience fewer symptoms than those in a full-blown manic state. People in hypomanic states report an increase in energy and confidence. The negative social and functional effects of mania are typically absent in hypomanic episodes. Hypomania

should be monitored, however, as it can become worse leading to full-blown mania. Another concern is the risk of a major depressive episode.

Cyclothymia

Cyclothymia is characterized by both episodes of hypomania and periods of depression. For this diagnosis, however, the depression is not characterized as major in severity. This is a low-grade cycle of moods which can impact functioning but to a lesser extent than what might occur with Bipolar I and II disorders. An individual with cyclothymia may experience some difficulties with relationships or work, but would generally be able to maintain social supports and employment despite experiencing symptoms.

Etiology

As with most major psychiatric disorders, the cause of bipolar disorder is unknown. Current research, however, attributes the disorder to various potential factors. There is an established genetic factor to the condition. There is also good evidence to link environmental stressors to the disorder. Most mental health practitioners agree that there is likely a genetic predisposition to the disorder that may be triggered by external factors.

The onset of bipolar disorder typically occurs in adolescence or young adulthood. Children and young adolescents are increasingly being diagnosed with bipolar disorder. This has been somewhat controversial, particularly for children.

Common comorbid conditions for children such as depression or ADHD, can be misdiagnosed as bipolar disorder. Also, developmental factors, such as hormonal changes, should always be considered. Such factors can produce signs that look like symptoms of bipolar disorder.

Treatment

The emphasis of treatment for these disorders is typically on the management and prevention of acute episodes. Lithium has been the best known and most commonly used mood stabilizing medications for years. The therapeutic range for lithium is narrow, with adverse effects if exceeded. Lithium levels, therefore, require monitoring. High plasma lithium levels can cause gastrointestinal problems and fatigue. Lithium toxicity can lead to cardiac arrhythmia, seizures and even coma. Long-term use of lithium can lead to kidney changes or renal failure. For this reason, kidney functions should also be monitored.

Anticonvulsants, such as carbamazepine are also used to stabilize moods. Antipsychotics can be helpful in managing agitation during acute episodes of mania. Likewise, antidepressants are used to treat episodes of depression. Their use, however, has been debated, as some researchers have associated antidepressant use with the onset of manic or mixed state episodes.

Research indicates that specific factors increase the likelihood of recurrent symptoms. Decreased sleep, caffeine consumption, and other kinds of substance

use have been linked to increased and more severe manic episodes. Other substances, increased stress, and abrupt changes in medication may trigger episodes of both mania and depression.

Considerations

There is a high rate of substance abuse associated with these disorders. Substances are often used as a way to self-medicate or to quell the symptoms related to bipolar disorder. Unfortunately, many substances can have adverse reactions when paired with medications that your patient may have been prescribed. Commonly used substances, such as alcohol, can also increase the severity of symptoms as well as risk of dangerous or impulsive behaviors. As a nurse, you can educate your patient about the risks of substance abuse.

The risk of suicide for people diagnosed with bipolar disorder is also of concern. The American Psychiatric Association reports that 10-15 percent of individuals with bipolar I disorders complete suicide. The suicide rate for people diagnosed with bipolar is 10-20 percent greater than that of the general population.

Individuals are at the greatest risk for suicide when first emerging from a major depressive episode. During this time, your patient may continue to express suicidal feelings and may have an increase in energy to act on such feelings. As a nurse,

you can help to protect your patient by monitoring for risk, offering support, and with your patient's consent, communicating with other service providers. This is particularly true if your patient has a history of suicidal ideation or attempts. Some individuals have developed a crisis plan with their psychiatrist or other mental health care provider. As a nurse, you should be informed of any plan for crisis that has been developed. If your patient expresses suicidal thoughts or a plan to hurt herself, take it seriously. If necessary, she should be assessed by a psychiatrist or a designated mental health professional for hospitalization.

Individuals with bipolar disorder can live full and independent lives. As a nurse, you may play an important role in supporting the ongoing symptom management necessary to do so. This can entail ensuring good communication and collaboration between other service providers in your patient's life. It may include providing ongoing education to both your patient and to her family about symptoms, treatment, adverse side effects of medications, and their precautions. Monitoring symptoms as well as changes in diet, sleep, and other behaviors, will allow you to work with your patient to intervene prior to the onset of an acute episode. ■■■

Nine strategies for brain fitness

by Roger Anunsen

While everyone hopes that cures for Alzheimer's disease and other dementia will be announced in the near future, it is now very clear that we can (and should) do much more than just worry and wait. Roger Anunsen, neuroscience researcher and host of the new *Brain Wellness Series*, recommends that anyone concerned about memory decline (their own and/or their loved ones) consider some or all of the following evidence-based suggestions:

- 1. Exercise your mind:** Without regular and adequate mental activity, brain cells deteriorate. With mental activity, brain cells thrive and only then can memory be improved. Use your **BrainTime**. Find a variety of challenges that you enjoy and regularly engage your brain.
- 2. Get regular sleep:** Memory problems cannot be successfully managed without first establishing the amount of sleep your brain (and body) needs.. and then doing all you can to maintain your regular sleep pattern. You should identify the source of a sleep disturbance and then consider some of the many recent advances in sleep therapies. New studies on naps reveal the brain health value of a 20 to 90 minute nap and rejects the myth of a nap interrupting a good nights sleep.
- 3. Feed and hydrate your brain:** Our brains receive nutrition from two sources: oxygen (see number 5) and food (see



Find a variety of challenges that you enjoy and regularly engage your brain.

numbers 8 and 9). **Oxygen and fuel** from food are carried by your blood and a healthy brain **MUST** have regular and adequate supplies of these raw materials. Learn what your brain and your body need to thrive and then do what you need to do to maintain your personal balance.

Hydration: Get enough liquids because your brain **MUST** have enough liquids and dehydration can put your brain health at risk.

4. Socialize with others: Recent studies found that regular, meaningful interaction with others adds something to the brain that appears to build a barrier of protection against the symptoms of memory loss. Tomorrow's prescription for cognitive improvement just might be: Enjoy one another's company!

5. Take a deep breath: Oxygen is delivered to the brain as a fuel necessary for good brain health, especially your hippocampus. Your three-pound brain consumes a huge amount of your oxygen intake and will thank you when you take those deep breaths. That deep breath can also reduce your stress. (See number 7).

6. Add even a little more physical

activity: Make a move toward a healthier brain. Moving any part of your body will, in fact, increase, even if only slightly, the flow of blood needed to keep your brain fresh. More blood flow generated from each extra physical movement will cause more blood flow into the brain, so....

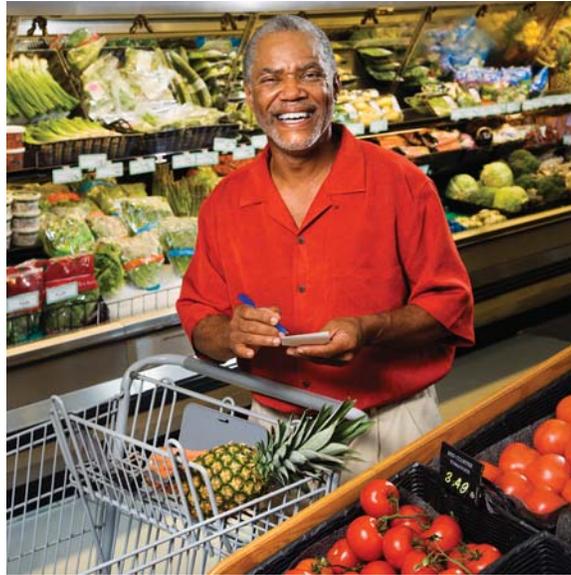
Just move it!

7. Eat antioxidants:

Your mother was right: Eat your fruits and vegetables especially the brightly colored ones that are full of brain-healthy antioxidants. Think raspberries, blueberries, red beans, dried plums, strawberries, concord grape juice and green tea.

8. Eat Omega 3 fats: Get a weekly supply of good brain fats, high in Omega-3 fatty acids. These are reported to be especially important for myelination, the process that creates the myelin needed to “insulate” our brain’s neurons thus protecting its efficiency and transmission speed. Our brains are 60 percent fat, so eat good fats

such as olive oil, walnuts, flax seed, tofu and other soy products and certain fish including salmon. Fish oil supplements could help, but fresh is best.



Eat your fruits and vegetables.

9. Lower stress every

day: Stress, especially long-term chronic stress, has been directly linked to memory decline. Purposefully interrupt stress several times each day. Harvard recently urged 1-minute, 2-minute and 3-minute stress therapies. Try reducing stress for a few seconds at a time

by learning how to take a mindful deep breath. Try doing and finishing one thing before you even think of doing the next thing. Completely enjoy focusing on something or someone you love for a moment or two....every day.

Roger Anunsen is the creator of MemAerobics and host of the new Brain Wellness Series as well as a cognitive wellness program consultant. Mr. Anunsen was appointed as a voting delegate to the 2005 White House Conference on Aging and has presented at the national ASA/INCoA conferences since 2006. For more information, call 503-636-7400.

Megacolon and Megarectum

— Megacolon is a descriptive term for an enlarged and flaccid colon where feces accumulation no longer triggers peristalsis and bowel movements. Normally, feces in the colon is moved along the intestinal track by muscle contractions. However, a person with a megacolon lacks or has inadequate muscle contractions to move intestinal contents through the gastrointestinal track. Overtime the colon dilates to accumulate large amounts of stool and an impaction can occur. For a few individuals bowel care can become so unmanageable that a colonostomy or ileostomy is the only treatment.

The most common cause of flaccid colon is Hirshsprung's disease. In this disease there is a lack of or disruption of certain nerve fibers in the colon. Hirshsprung's is a congenital disease and is usually recognized within the first three months of life, depending on the severity. Occasionally an adult will be diagnosed with a variation of the disease. Hirshsprung's disease occurs in about one in 5000 births and is four times more common in males than females. Treatment is to surgically remove the diseased, nonfunctioning segment of the bowel, anastomose the normal two portions to restore bowel function. Most surgical outcomes are successful but if there is a lingering problem with feces retention, bacteria can overgrow causing enterocolitis and sepsis.



Megarectum is not an uncommon condition in persons with developmental disabilities who can't communicate the need or recognize the need to use the toilet.

Megarectum is a descriptive term for an enlarged and flaccid rectal vault where fecal matter no longer triggers muscle contractions and bowel evacuation. The normal function of the rectal vault is to collect feces until the pressure of accumulating feces triggers muscle contractions and a bowel movement. If for some reason a bowel movement does not occur, more feces will enter the vault, water will be reabsorbed making the feces hard and difficult to force through the anal sphincter. If this process occurs frequently, the rectal vault will lose muscle tone, become flaccid and enlarge. Once the rectal vault expands, it can hold large amounts of stool and regular bowel movements become impossible. Megarectum can lead to megacolon and be life threatening if an impaction, perforation and sepsis occurs. The goal in managing these two conditions is to encourage as normal bowel elimination pattern as possible.

Nurses may care for individuals with megarectum and megacolon due to congenital conditions, such as myelomeningocele or spina bifida. In both of these conditions there is an impairment of the sensation of rectal filling and rectal fullness. Individuals cannot recognize when they need to have a bowel movement. Careful bowel management is an essential intervention starting in infancy. Many other children with developmental disabilities and neurological impairment never attain voluntary control of their bowels. They may suffer from obstipation which usually goes unrecognized because they cannot communicate their needs of discomfort and other life threatening medical conditions may take higher priority. In the past it was not uncommon for parents and caregivers to start giving enemas and suppositories during infancy thinking that this was the only way to manage constipation.

Today, developmental professional encourage establishing a bowel routine that is more normal even if it does involve medication intervention.



Many other children with developmental disabilities and neurological impairment never attain voluntary control of their bowels.

Megarectum is not an uncommon condition in persons with developmental disabilities who can't communicate the need or recognize the need to use the toilet. Other factors include hypotonia, lack of skeletal muscle coordination with skeletal deformities, prolonged immobility and poor toileting habits. Also, poor chewing and swallowing skills frequently lead families and caregivers to offer soft foods low in fiber. Chronic dehydration

compounds the problem. In addition, many individuals take medications that slow GI motility, such as anticholinergics and opiates. One of these contributing conditions may not be difficult to overcome but some individuals have all of these factors from birth which makes their

chances of developing megacolon/rectum very high.

Management of constipation is important for all individuals but for persons with megacolon/rectum it is essential that it be managed diligently. Bowel care requires keeping a bowel diary, having a protocol, daily dietary fiber, good hydration, stool softeners, laxatives and occasional use of enemas/suppositories. Once a bowel

care pattern has been established (fiber, hydration, stool softeners, laxatives, etc.) nurses should encourage caregivers to follow the regimen carefully as reestablishing a normal pattern of evacuation without these interventions

is unrealistic. Even with an established pattern of evacuation, any change in routine may cause an impaction and need for hospitalization. ■



Continuing education for community-based nurses

■ The Office of Licensing and Quality of Care is pleased to announce its first self-study continuing education course for community-based nurses. The course, "Self directed learning series: Registered Nurse Delegation in Oregon," is available at no charge for download at the DHS Web site www.oregon.gov/DHS/spd/provtools/nursing/. You can also e-mail your request for the course to CRNHSU@state.or.us.

If you do not have a computer and would like the course mailed to you, please send your written request to Bernadette Murphy,

SPD, 500 Summer Street NE E-13, Salem, OR 97301. Please be sure to write clearly.

Upon completion of the course you can apply for 2.0 contact hours of nursing continuing education (CE). The cost of CE hours is \$20. Instructions to apply for CE hours are contained in the self-study course. We thank you for taking the time to complete this RN self-study course that demonstrates your commitment to professional nursing excellence within Oregon's long-term care system. ■

Restraint use review

— Providing safe care for residents with physical and cognitive impairments is a high priority for health care providers. For ten plus years, there has been increased concern surrounding the use of restraints to prevent falls, control agitated residents and prevent wandering. Studies have shown that restraints are more likely to cause harm than prevent it. Bed rails, vest and waist restraints have caused various injuries including death. According to a report by the U.S. Food and Drug Administration (FDA), there are an estimated 100 or more deaths that occur annually in care settings in the United States as a result of restraint use. Reducing the use of restraints, and ensuring that any restraint in use is necessary has become a national goal.

A restraint is any method, device or chemical substance which restricts the freedom of movement or normal access to the body.

It is important to note that each care facility is bound by an Oregon Administrative Rule (OAR) rule that is established for their different care setting. The following language is taken from both the 24 Hour Residential Services for Children and Adults OAR and the Adult Foster Homes for Individuals with Developmental Disabilities OAR.



Physical restraint

A physical intervention (24 Hour Residential Services OAR) or restraint (Adult Foster Homes OAR) is inappropriate or unauthorized if:

- It is applied without a functional assessment of the behavior justifying the need for the restraint; or
- It is used for behaviors not addressed in a behavior support plan ;or
- It uses procedures outside the parameters described in a behavior support plan; or
- It does not use procedures consistent with the Oregon Intervention System (OIS).

A restraint or physical intervention is not appropriate if:

- There is not a physician's order when the restraint is used as a health related procedure: or
- It is applied without ISP team approval as identified on the ISP and is described in a formal written behavior plan.

It is not abuse if it is used as an emergency measure, if absolutely necessary to protect the individual or others from immediate injury and only used for the least amount of time necessary.

Mechanical restraints include, but are not limited to, posey vest, soft ties or vests, straight jackets, wheelchair seatbelt, locked chairs, safety bars, lap trays, Lap Buddy, hand mitts, helmets, restrictive clothing, Geri chairs or any specialized chair that prevents rising, body positioning which limits free access in a home or community.

It is important to take into consideration the intent of the use of a device. For example the use of a seatbelt to protect an individual from falling out of a wheelchair is a safety device, however, if the intent of the seatbelt is to stop a client from getting up to walk it becomes a restraint. Another example would be brakes on a wheelchair. If the intent is to stop the individual from harm it is a safety device however, if the intent is to not allow the individual to leave the area it is a restraint.

Chemical restraints are any medication (psychotropic or otherwise) which is given to alter or control one's behavior. An example of a chemical restraint could be Tylenol given for agitation vs. Tylenol given for pain which would not be considered a chemical restraint.

As nurses, who provide oversight, we have the perfect opportunity to ensure that if a restraint of any kind is being used, it is being used appropriately and with the proper intent.



Chemical restraints are any medication (psychotropic or otherwise) which is given to alter or control one's behavior.

Here are some things to keep in mind when reviewing restraint use:

1. Prior to the use of a restraint there must be an assessment that includes consideration of all other alternatives.
2. The least restrictive restraint must be used and as infrequently as possible.
3. Check to determine what program rule(s) require a physician's order and/or consent from the resident or legal representative.
4. Ensure that all caregivers have been instructed on the correct use and precaution related to the use of the restraint.
5. Ensure that any restraint use is reassessed on a regular basis to determine whether or not their continued use is necessary.
6. Restraints are never to be used for discipline and/or for the convenience of the staff.

Please refer to each setting specific rules regarding restraints for further guidance.

As nurses out in the community, you have the ability to ensure that any use of a restraint is necessary and in the resident's best interest. ■■■

*** Attention first time readers* Date:** _____

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

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Attention all nurses

Seniors and People with Disabilities will be holding a one day conference for nurses working in the SPD contract nurse program and others who work in community based care settings. These conferences will be one day and will include such topics as: delegation; running a small business and documentation. Registration is open to everyone but contract nurses will get first preference. A registration flyer will be sent out prior to each conference. To request a flyer, if you did not receive one, please email Bernadette Murphy at Bernadette.J.Murphy@state.or.us.

Locations:

July 8th Redmond — Deschutes Fair & Expo

July 10th Baker City — Geiser Grand Hotel

July 15th Wilsonville — Clackamas Community College

July 17th Roseburg — Douglas County Fairgrounds

We need your feedback!

A survey was sent out to SPD Contract RNs to determine what health related training topics they were interested in learning more about. The survey also inquired as to what additional training they felt was needed in order to do their job better. For those that have turned in their surveys, thank you!! For those that haven't, please mail them in by June 10th. If you didn't receive a survey, or need a new one, please contact Bernadette Murphy at Bernadette.J.Murphy@state.or.us.

*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.*

To contact the editorial team with a suggestion call 1-800-232-3020, ask for Bernadette Murphy.

