

# CLINICAL NOTES

I N N O V A T I V E H E A L T H C A R E S O L U T I O N S

## Overcoming compassion fatigue: Eight tips for professionals

By Françoise Mathieu, MEd, CCC

Dr. Charles Figley, a trauma expert and pioneer researcher in the field of helper burnout, has called compassion fatigue a “disorder that affects those who do their work well.” It is characterized by deep emotional and physical exhaustion, symptoms resembling depression and post-traumatic stress disorder, and a shift in the helper’s sense of hope and optimism about the future and the value of their work.

### Caregiver in crisis

Compassion fatigue can strike the most caring

and dedicated nurses, social workers, physicians and personal support workers alike. These changes can affect their personal and professional lives with symptoms such as difficulty concentrating, intrusive imagery, loss of hope, exhaustion and irritability. It can also lead to profound shifts in the way helpers view the world. Additionally, helpers may become dispirited and increasingly cynical at work, make clinical errors, violate client boundaries, lose a respectful stance towards their clients, and contribute to a toxic work environment.

### A normal consequence

We believe that compassion fatigue is a normal consequence of working in the helping field. The best strategy to address it is to develop excellent self-care strategies. Following are eight strategies to help you transform compassion fatigue into compassion satisfaction:

1. *Discover what’s on your plate.* You can’t aim to make changes and improvements without truly knowing where the problem areas are. Start by taking a nonjudgmental inventory of where

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## Preventing musculoskeletal injuries: How health care workers can protect themselves

By Anita Dubey

It is a well-established fact that health care workers face a higher risk than other workers of developing painful musculoskeletal disorders (MSDs), which affect muscles, tendons, nerves or other soft tissues. In health care workers, back pain is one of the most common MSDs.

There are many programs designed to prevent MSDs in health care workers, ranging from the use of mechanical patient lifts to physical exercise programs to ergonomic programs. But are these programs all effective? And which ones are better? The Institute for Work & Health recently completed a systematic review of all the research on programs designed to prevent MSDs in health care workers.

### Effective programs

One goal was to provide decisionmakers with scientific evidence to help choose effective programs. “One of the main causes of MSDs in health care workers occurs from lifting or transferring patients,” says Dr. Benjamin C. Amick III, the Institute’s scientific director, who led the review. These patient-handling activities place high levels of force on the low back. In fact, they far exceed the lifting limits recommended by the U.S. National Institute for Occupational Safety and Health.

Recent research also suggests that MSDs in health care settings may also result from other

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# Establishing therapeutic relationships: A cornerstone of care

By Registered Nurses' Association of Ontario

As with other health care professions, effective nursing practice is dependent on an effective therapeutic relationship between the professional and the client. With this tenet in mind, the Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, developed a best practice guideline (one of 30 created) called "Establishing Therapeutic Relationships."

Through 14 recommendations, this best practice guideline addresses the therapeutic relationship and its central importance to practice. The guideline addresses the qualities and capacities of an effective therapeutic relationship, the state of knowledge, and the knowledge needed to be effective in a therapeutic relationship.

A summary of the guidelines' fourteen recommendations are as follows:

**1. The nurse must acquire the necessary knowledge to participate effectively in therapeutic relationships.** Different kinds/fields of knowledge are needed for the nurse to be effective in a therapeutic relationship. There is knowledge that forms the background of all his/her relational practice, and there is knowledge necessary to the specifics of the client.

**2. Establishment of a therapeutic relationship requires reflective practice.** This concept includes the required capacities of self-awareness, self-knowledge, empathy, awareness of boundaries and limits of the professional role.

- It is possible for the nurse to know him/herself, albeit incompletely, through the process of self-reflection.
- Self-knowledge creates the possibility for the

nurse to act purposefully, rather than automatically. Thus, a nurse with self-knowledge is able to consider a range of ways of being with the client.

- Awareness of his/her potential response options creates opportunity for the nurse to deliberately choose to express thoughts and feelings that are most congruent with the client's needs, goals and values.
- The ability of the nurse to engage genuinely and professionally in a relationship with a client helps to create the conditions in which the client's needs are understood, appropriate action is taken, meaning is created, and healing occurs.
- The client is a partner in the development of the therapeutic relationship.

**3. The nurse needs to understand the process of a therapeutic relationship and be able to recognize the current phase of his/her relationship with the client.** Each relationship, although not linear, has a beginning, middle and end. All phases may occur in a single nurse-client encounter or may take place over a number of encounters. Nursing theorist H. Peplau refers to these phases as orientation, working and resolution.

**4. All entry-level nursing programs must include in-depth learning about the therapeutic process, including both theoretical content and supervised practice.**

Nursing education provides the foundational knowledge required to establish nurse-client therapeutic relationships at the beginner level. Educational development in the area of therapeutic relationships is needed for nurses

in all specializations and practice settings to provide additional background, expertise in obtaining client knowledge, and knowledge of self. The student nurse needs to observe expert practitioners working with clients, as well as have expert practitioners observe him/her in clinical practice, who will then assist to develop the student's interpersonal skills.

**5. Organizations will consider the therapeutic relationship as the basis of nursing practice and, over time, will integrate a variety of professional development opportunities to support nurses in effectively developing these relationships. Opportunities must include nursing consultation, clinical supervision and coaching.**

The nurse is responsible for pursuing professional opportunities. Specifically, organizations must provide professional development opportunities for nurses that are tailored to individual and group learning styles. Key learning strategies that are interpersonal include clinical supervision, coaching, group exercises, demonstration interviews, role modeling and case consultation.

Additional strategies to support professional development could include didactic presentations, journal writing, conferences, workshops and seminars, computer-based programs and development of individual learning plans. Areas of content should include

- self reflection
- overview of theories and models related to therapeutic communication and the nurse-client relationship
- principles of engaging, maintaining and terminating relationships
- core concepts of therapeutic relationships such as reciprocity, self-awareness, boundaries, trust, empathy and confidentiality

**6. Health care agencies will implement a model of care that promotes consistency of the nurse-client assignment, such as primary nursing.** The nurse and the client need the opportunity to develop an awareness of, and a familiarity with, one another. Models of care that facilitate a greater continuity of

## Central to practice

The therapeutic relationship is central to all nursing practice. For example, in mental health and community nursing, the therapeutic relationship may be the primary intervention to promote awareness and growth and/or to work through difficulties. In other areas of nursing practice, the therapeutic relationship may be more in the background, serving as the intervention through which comfort, support and provision of care are facilitated. Regardless of setting and clinical situation, the therapeutic relationship always needs to be established.

care and caregiver provide the opportunity for a trusting relationship to form.

**7. Agencies will ensure that at minimum, 70 per cent of their nurses are working on a permanent, full-time basis. Having nursing staff employed on a casual basis is a key contributor of nurse dissatisfaction.** Over the past several years, many agencies moved to “increase their flexibility” through the “casualization” of nursing care. Permanent, full-time positions have been reduced and casual and part-time positions have increased. As a result, client care has become fragmented and the nurse’s satisfaction in being able to assist clients through an entire recovery process has been lost, thus leaving clients dissatisfied and nurses frustrated.

The development and maintenance of a therapeutic relationship is hampered when the nurse is working on a casual basis. The panel recommends organizations target having 70 per cent full time nursing staff in order to return to the pre-restructuring period in Ontario.

**8. Agencies will ensure that nurses’ workload is maintained at levels conducive to developing therapeutic relationships.** With the increased acuity across all sectors, workload has increased significantly. A persistently high workload is not sustainable for the nurse, highly unsatisfactory for clients, and incompatible with therapeutic relationships. Support is required by administrative and managerial levels to ensure the nurse has adequate time to engage in the therapeutic process. Several studies have shown that inadequate nurse-to-patient ratios are associated with adverse outcomes such as complications, increased resource use and decreased patient satisfaction. Additionally, a large retrospective study found nursing skill mix (number of registered nurses compared to less qualified nursing personnel) and nurses’ years of experience associated with increased 30-day mortality for hospitalized patients. That is, better mortality outcomes were associated with a skill mix that included a richer registered nurse composition as well as with more experienced registered nurses.

**9. Staffing decisions must consider client acuity, complexity level, complexity of work environment, and the availability of expert resources.** Widespread de-skilling of client care has occurred over the past few years

with the replacement of registered nurses and registered practical nurses with unregulated care providers. This is occurring at the same time that client acuity has increased in all sectors. Care needs in the community sector have increased dramatically. Some Community Care Access Centres, in particular, have reported an increase in acuity of 20 to 30 per cent. In acute care hospitals, fewer beds and a decreased length of client stay mean that those who remain in hospital are sicker and require more complex care.

Clients in long-term care facilities today are older, frailer and have more complex health care needs than ever before. It is important that the level of knowledge and skills of those providing care is adequate and appropriate for the complexity of client need.

**10. Organizations will consider the nurse’s well-being as vital to the development of therapeutic nurse-client relationships and support the nurse as necessary.** Maintaining an effective nurse-client relationship in increasingly acute, complex and, at times, violent surroundings are emotionally and often physically demanding for the nurse. Promoting and monitoring nurses’ emotional health is critical to effectively engaging and maintaining optimal therapeutic relationships.

Literature on hospitals in the U.S. emphasizes that caring of nurses leads to significantly lower rates of nurse-burnout. Hospitals that support the well-being of the nurse have higher nursing retention rates, satisfaction, and improved client outcomes. Organizations that support the well-being of the nurse must make various strategies available for addressing job-related stress.

**11. Organizations will assist in advancing knowledge about therapeutic relationships by disseminating nursing research, supporting the nurse in using these findings, and supporting his/her participation in the research process.** To effectively develop and maintain therapeutic relationships, the nurse needs to be aware of current knowledge generated in this area. Research in the area of the therapeutic relationship needs to be continuously generated and disseminated. Research needs to consider process and outcome measures; nurse and client perspectives; and could be quantitative or qualitative in nature. Evidence-based practices need to be

promoted and disseminated across organizations in a timely fashion.

**12. Agencies will have a highly visible nursing leadership that establishes and maintains mechanisms to promote open conversation between nurses and all levels of management, including senior management.** Nursing leadership that is stable, visible, highly accessible, and fosters frequent and open communication between the nurse and senior managers creates an environment that supports the creativity, innovation, risk-taking and trust required to develop and maintain therapeutic relationships.

**13. Resources must be allocated to support clinical supervision and coaching processes to ensure that all nurses have clinical supervision and coaching on a regular basis.** Interpersonal skills can only be fully acquired or developed by interpersonal processes such as clinical supervision, coaching, role modeling and peer supervision. To accomplish this, nursing leaders must allocate financial resources to cover the cost of clinical supervision and coaching. A staffing mix that includes ongoing clinical supervision and coaching by a senior clinician would help nurses to identify their own professional strengths and weaknesses. Such a senior clinician needs to have experience, education, and the ability to facilitate objective self-evaluation. This process is enhanced if the clinical supervision is provided by a clinician with no administrative authority over the nurse.

**14. Organizations are encouraged to include the development of nursing best practice guidelines in their annual review of performance indicators/quality improvement, and accreditation bodies are also encouraged to incorporate nursing best practice guidelines into their standards.** Over time, it is expected that all health care agencies, professional bodies and accreditation bodies will work towards incorporating the therapeutic relationship and all other best practice guidelines into their accreditation standards.

*References are available in the original source document.*

*Excerpted with permission from “Establishing therapeutic relationships,” a nursing best practice guideline produced by the Registered Nurses’ Association of Ontario. The full document as well as supplementary material can be found at [www.rnao.org/Page.asp?PageID=924&ContentID=801](http://www.rnao.org/Page.asp?PageID=924&ContentID=801).*

# Adolescents with chronic conditions: How professionals can provide the best care

Abstracted from the Canadian Paediatric Society

It is estimated that between 14.8 per cent and 18 per cent of all youths in North America have a chronic health condition or a special health care condition (e.g., impairments, such as musculoskeletal impairments, speech defects, deafness and hearing loss, blindness and visual impairments; and diseases, such as asthma and heart disease) that affects them and their families. They may have survived life-threatening illnesses that, until recently, had a high mortality rate, or survive longer with improved medical care and technology. Some may also have physical and mental disabilities resulting from their primary illness. Many have to deal with the psychological consequences of their condition and the continuing involvement of numerous medical personnel in their lives.

The care and follow-up of many of these adolescents are often fragmented, and relies heavily on subspecialists and therapists who may practice far from their home. Adolescents with chronic health conditions that are less obvious or less serious may not get the support they need from professionals or other adults.

## Developmental issues

**Independence and assertiveness.** The Council on Child and Adolescent Health for the American Academy of Pediatrics has stated, "Children with disabilities, regardless of the cause, should be encouraged to develop the highest level of independence based on a realistic and objective evaluation of their abilities and limitations."

Preparing parents for separation from their teenager is an essential part of long-term management and may allow parents to think about their children surviving into and beyond adolescence. A number of factors make separation and independence more difficult for adolescents with chronic conditions and for their parents. These factors include the adolescent's need for treatment, parental over-protection, and a physical appearance that is more youthful than the adolescent's chronological age and limited physical freedom.

Disease control measures should take adolescent behavioural needs into consideration. Adolescents need to be aware of treatment choices and should be encouraged to be

assertive by discussing and participating in this decision-making. Allowing the adolescent to take control in simple ways, such as choosing the form of medication (e.g., pill or liquid), will foster autonomy and improve adherence to proposed treatment plans. This may increase parental anxiety over the well-being of the child. Health care professionals are encouraged to help parents strike a balance between the increased control of care by the adolescent and parental supervision.

Learning self-care skills is an important way to enhance self-esteem and autonomy, and to empower the adolescent to become a responsible individual as she or he gets older. If the adolescent can participate in his or her own personal care, self-esteem will be enhanced and the mechanics of separation eased. If the youth requires assistance, it is appropriate to seek a caregiver who is not a family member, preferably someone of the same sex.

Adolescents often achieve autonomy by engaging in behaviours that parents may perceive as dangerous; adolescents with chronic illness are no different. Parents need help to recognize and accept safe forms of self-expression and discourage those likely to be harmful. Health care providers should screen youths with special health care needs for risk behaviours and protective factors as they do for healthy youth.

The adolescent with a chronic health condition may have a greater need for coping skills, such as a good sense of humour and a positive view of life. Combined with supportive teachers, these can greatly reduce the risk of dysfunction. They may also need to be encouraged to pursue interests and hobbies. Occupational therapists can help these adolescents to achieve goals, such as learning to drive or participating in a sport.

**Peer relationships.** At adolescence, the young person's focus shifts from family to peers. This important move should be no different for adolescents with chronic health conditions. However, it can be difficult for them to maintain

friendships. Hospitalization, frequent appointments and restrictions, both inherent to the condition and those imposed by parents and others, may lead to social isolation.

Health care professionals can help the adolescent develop strategies to deal with being teased. Humour, for instance, can often help defuse a painful situation. Potential friends may be intimidated by the nature of the disease. Health care professionals can advise adolescents how to find supportive friends and to explain the disease and the restrictions it poses.

Support groups allow both parents and adolescents to share experiences, challenge misconceptions and fears about the illness, and develop methods of coping. Adolescent groups also foster the acquisition of age-appropriate social skills.

Learning self-care skills [will] empower the adolescent to become a responsible individual as she or he gets older.

**School and work.** Teenagers spend a large portion of their days in school and, later, at work. Attention should be paid to the concerns of adolescents with chronic health conditions about absenteeism resulting from medical care. The Adolescent Health Survey in British Columbia found that youth living with a chronic health condition often had problems with school attendance, vocational planning, economic support and physical activity, to the point that they had a 30 per cent reduction in school attendance compared with their healthy peers. Physicians and other health professionals can help students explain their medical problems to teachers, either by phone or by providing them with literature.

Parents may need help in arriving at realistic expectations for their adolescent. Some may continue to expect achievement beyond the teen's abilities, while others may have settled for goals much below their adolescent's potential. Prevocational skills training can be introduced in junior high school. A realistic, meaningful goal improves quality of life: the adolescent, family and health care professional can work together to formulate this goal and devise strategies to achieve it.

**Physical appearance.** All adolescents are self-conscious about their physical appearance and pubertal development. Concerns about delayed puberty and physical abnormalities may be heightened in adolescents with chronic conditions. It is important for the professional to anticipate these issues and address them early in a manner appropriate to the teen's developmental age.

While minor physical changes, such as body odour, may concern adolescents, they may also be seen as concrete evidence of maturation. A physician who points out these changes, discusses the adolescent's sexual maturity rating or undertakes a bone age measurement to establish any growth delay can reassure adolescents with chronic conditions who are concerned about their physical development. Delays in growth and development may be due to nutritional factors that can be corrected or to medication that can be modified. Maturation delays caused by disease may respond to hormonal treatment.

## The practical approach to care

**Age limits and office practice.** The goals of providing health care to youths with chronic health conditions should include the following:

- optimal medical control
- adolescent involvement in management of the health condition
- adolescent and family understanding of the condition
- acknowledgement of personal potential for activity, education, recreation and functioning
- completion of adolescent developmental tasks
- the attainment of self-esteem and self-confidence
- the acknowledgement of personal potential for a vocation or career

Legal and ethical issues are another important aspect of adolescent health care. Health care providers are encouraged to be knowledgeable about legal regulations in their local area. These aspects of adolescent health care include consent to treatment, confidentiality and competency.

**Networking.** Health care professionals are encouraged to be informed about groups, organizations and websites that can provide physical and emotional support to patients and their families. In particular, physicians should facilitate families' access to public

health nurses, lay groups, home health providers, social service agencies and educators. Physicians should also strive to foster broader community responsibility for the chronically ill by becoming community educators and advocates.

**Education.** Educating adolescents about their disease has three measurable beneficial effects:

- they learn how to avoid situations that exacerbate their condition
- they learn how to minimize the severity of an exacerbation
- they learn self-care skills to minimize the daily effects of their illness

## Recommendations

The CPS makes the following recommendations for the care of the adolescent with chronic conditions and special health care needs. Health care professionals ...

- must encourage adolescents to develop the highest level of independence based on a realistic and objective evaluation of their abilities and limitations.
- must encourage parents to strike a balance between parental supervision and increased control of care by the adolescent.
- must help parents to recognize and accept safe forms of self-expression because adolescents often achieve autonomy by engaging in behaviours that parents may perceive as dangerous.
- must question adolescents about their relationships with peers and advise them on any problems to ensure that they develop and maintain friendships.
- must help teachers understand the condition of the adolescent and facilitate integration into the school program. Also, professionals must help parents to have realistic academic expectations for their adolescent with a chronic condition.
- must be knowledgeable about legal regulations and aspects of consent and confidentiality in their province, especially when dealing with adolescents with chronic conditions.
- must be informed about organizations

that can provide support to adolescents and their families.

- must foster broader community responsibility for the chronically ill and be community educators and advocates.

In particular,

- physicians must assess issues related to pain control in adolescents with certain chronic conditions, such as sickle cell anemia, juvenile idiopathic arthritis and neuromuscular conditions, in which pain may be underestimated and not treated appropriately.
- physicians must facilitate the adolescents' and their families' access to needed services in the community.
- paediatricians must be flexible when deciding when to transfer adolescents to adult facilities and must take their developmental age into consideration, ensuring that the transition to an adult facility or new health professional is continuous, comprehensive and coordinated both to minimize disability and to promote appropriate use of health care services. Discussions about transition should start between the ages of 10 and 12 years.
- the adolescent must be involved in decision-making regarding treatment or referral. To do so, the health care professionals must also educate the adolescent about his or her condition.

For health care professionals, caring for adolescents with chronic conditions and special health care needs can be interesting and rewarding. Professionals have more impact on their progression into adulthood than on patients seen less frequently and in less intense situations. The opportunity to have an effect on the life of these adolescents is invaluable, as are the lessons that professionals learn from them.

*References are available in the original source document.*

*Adapted from the position statement "Care of adolescents with chronic conditions," which appeared in Paediatrics and Child Health, Vol. 11., No. 1, produced by the Canadian Paediatric Society. For a full copy of the statement, please visit [www.cps.ca/english/statements/AM/ah06-01.htm](http://www.cps.ca/english/statements/AM/ah06-01.htm).*

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"Fitting the bariatric client: Seating and mobility prescription considerations"  
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# Measuring fall program outcomes: The importance of statistics and analysis

By Pat Quigley, PhD, MPH, ARNP, CRRN, FAAN; Julia Neily, RN, MS, MPH; Mary Watson, MSN, ARNP, BC; Marilyn Wright, BSN, RNC; and Karen Strobel, RN, MSN.

Fall-related injuries are a serious health issue for the aged population. Nurses make a major contribution to patient safety by assessing risk and designing patient-specific interventions that reduce the risk of falls. Knowledge of fall prevention program deployment and evaluation using statistical analysis can help nurses design and test the effectiveness of fall prevention programs.

## Recording incidents

Health care organizations rely on incident reports for counting the frequency of falls and collecting fall-related data. When a fall occurs in a health care organization, an incident report is completed to record the occurrence and the circumstances surrounding a fall.

Many facilities (Veterans' Affairs [VA] and non-VA) use an incident report form, specifically designed to collect data based on evidence about factors contributing to fall occurrences. For example, these data might include time of day, location, activity, orthostasis and incontinence. From data analysis, one can determine the type of fall, such as accidental, anticipated physiological, and unanticipated physiological fall and severity of injury (i.e., minor, moderate or major/severe). Analysis of data enables clinicians, administrators and risk managers to profile their patients' level of fall risk and the actual factors contributing to the fall, as well as to identify overall patterns and trends surrounding fall occurrence.

## Collecting data

When analyzing the effectiveness of fall prevention programs, rates of both fall incidence and severity of injury should be included. Each rate is needed to monitor the effectiveness of interventions for a specific population in a specific clinical setting. For example, in acute care and long-term care settings, restraint use has been reduced to improve patient freedom and reduce restraint-related injury and death. In response to restraint reduction, increased falls were anticipated. Systematic data analysis helps nurses to test this assumption.

Rates can be measured in many ways:

**Fall rates.** Fall rates can be analyzed at either the individual unit or overall facility level.

**Repeat fall rates.** An elevated fall rate may be due to one patient who has fallen several times. Repeat fallers may account for a large percentage of falls within a single clinical unit of an organization. Thus, we recommend a sub-analysis of the fall data to determine what percent of the falls are second, third, fourth or more falls. These repeat fall frequencies are needed to determine the effectiveness of interventions.

**Injury rates.** The injury rate reports how many injuries occurred per 100 falls. It is important to separate the injuries based on severity. We suggest measuring both major and minor injuries rates. As an example of injury rates, a facility has had 80 falls in the last month. Of the 80 falls, five resulted in a minor injury such as an abrasion, hematoma not requiring medical attention; three falls resulted in a major injury, such as a hip fracture; and the remainder resulted in no injury.

Injury analysis by severity levels enables clinical and administrative staff to profile both patient vulnerability and safety program effectiveness. For example, if 80 per cent of patients who sustain lateral falls fracture their hips, one would suspect a large prevalence of osteoporosis. If one unit exceeds other units on their monthly fall rates and has higher injury rates, one would target that unit for evaluation and intervention.

In addition to tracking injury and injury severity rates, another performance indicator is the number of days between major injuries. Increases in the length of time between major injuries are yet another indicator of program effectiveness.

## Presenting information

Visual presentation of falls data is an effective method for summarizing and presenting

outcomes and trends over time. Run charts and control charts are two tools that allow for the evaluation of a program's effectiveness as well as the identification of influential factors on program outcomes.

**Run charts.** Run charts visually display plotted data over time. Their usefulness in analyzing data is enhanced by the ability to annotate the chart with narrative comments on the graph about when and what actions were implemented to reduce patient falls. This chart helps to put the data display into context for the viewer, such as the staff nurses on the unit.



Data analysis enables ... managers to profile their patients' level of fall risk and the actual factors contributing to the fall.

**Control charts.** Control charts are a specific kind of run chart intended to assess the amount of variation within a specified measurement range referred to as upper and lower limits of performance and quality control. A control chart used for fall rates could include the fall rate (number of falls per 1,000 bed days of care) plotted by month for the unit.

## Developing a program

Following is a case study of the development and implementation of a fall prevention program, using control charts to evaluate its effectiveness and share the outcomes with staff.

The program was developed for three long-term care units representing 160 beds in a rural 400-bed Veterans Administration Medical Center that provides acute medicine, psychiatry, intermediate medicine and long-term care. The nursing staff working in an interdisciplinary team lowered the average fall rate by 54 per cent on the pilot unit and 27 per cent on all three units combined during the implementation phase.

Prior to the fall prevention program, a comprehensive, coordinated approach to fall prevention did not exist, as each unit worked in isolation on its own fall prevention program. Nursing staff assessed patients' risk for falling

with a “home grown” risk scale, the incident reporting system was cumbersome and lengthy, and periodic audits suggested that falls were under reported.

To address these problems, a Process Action Team (PAT) was formed and conducted comprehensive data analysis to assess the current nature and scope of falls occurring on the long-term care units. The team members analyzed medical record data related to the location, severity, time of day, and frequency of falls, and identified residents with multiple falls. Based on their analysis, the team concluded that fall “prevention” efforts had been reactive (i.e., initiated after a fall occurred) and recommended the development of a coordinated proactive fall prevention program. Specific components of the recommended program included

- establishing an interdisciplinary falls workgroup
- developing an interdisciplinary fall prevention program policy
- implementing a reliable and valid fall-risk-screening tool
- establishing a near miss and hazard reporting system
- establishing electronic documentation tools that would provide useful data for continuing process improvements
- developing a formulary of medications associated with falls which can also be used as a staff education tool
- establishing fall safety-specific environmental rounds
- increasing staff education and awareness of fall risk, screening, and intervention.

The falls workgroup was immediately established under the PAT’s direction and developed a strategic plan to implement and evaluate the impact of the above actions. For implementation and evaluation, the workgroup used the Plan-Do-Study-Act (PDSA) cycle of planned change. This four-part, action-oriented cycle for improvement enables a group to examine barriers to and facilitators of an intervention and assess its outcome before moving to the next step of a plan. Before implementing any new intervention on a large scale, a small scale test of changes enables a workgroup to test one action at a time and modify the intervention to fit the environment at the unit level.

The key interventions accomplished during the implementation phase were as follows: standardization of a fall definition; selection

of a valid and reliable fall-risk-screening tool; establishment of a hospital-wide fall prevention program policy; development of electronic medical record fall risk assessment and care plan documentation tools; redesign of the fall incident reporting system; stratification of patient fall risk identification levels and system of communication; and development of patient education fall prevention materials. Additionally, interdisciplinary environmental rounds were implemented for patient safety and fall prevention. The environmental rounds involved staff members from throughout the facility conducting unit surveys with a goal to reduce environmental hazards and provide lessons learned as a part of staff education.

Progress made during each phase of deployment and system change was celebrated through a recognition program. Thus, the workgroup’s successes were an integral part of the medical centre’s staff recognition program. Another key intervention, medication reviews, were initiated to heighten the awareness of side effects that may increase fall risk and are now done routinely for patients with frequent falls.

Lastly, a key intervention was implemented to address communication gaps in the information collected about a fall and reporting the fall occurrence among disciplines. Since these fall-related information are an integral part of the fall prevention program, a unit-based fall data and communication tracking sheet was developed to monitor fall specific data and is available to all providers directly responsible for the care of the residents. This new process is considered an administrative intervention to fill gaps in the program and thus can be tracked to measure the program’s impact.

As a result of this sheet, anyone on the unit can visually see a patient who fell, and where the staff are in the communication process about the fall occurrence and revising the plan of care to prevent a repeat occurrence. This sheet visually displays fall occurrences for nurses and physicians on a unit, and any staff member can easily view the unit’s most recent falls. Also, staff can easily view a resident who experienced multiple falls and track when all elements of the post fall care plan

were completed. This type of information complements a control chart, because this sheet provides information about the single fall, whereas a control chart uses averaged data about monthly fall rates.

The team achieved its patient safety goals by reducing the residents’ fall rate and severity of fall-related injury. Comparing the assessment phase to the implementation phase, the overall rate of falls decreased 54 per cent (from 9.75 to 4.49 falls per month). This accomplishment is even more significant because it was achieved while concurrently eliminating restraints use as a fall prevention measure. The team has since used falls data to internally compare ongoing progress in patient safety.

### Meaningful results

Protecting patients from falls and fall-related injuries requires shared responsibility among health care providers, administrators and risk managers. Yet, data analysis using only general fall rates lacks the specificity needed to profile the effectiveness of fall risk reduction programs and injury prevention methods.

Data management, analysis, and reporting for systematic analysis of patient, unit and organizational factors illustrate the vital components of program evaluation needed for understanding the effectiveness of patient safety programs. The above case study has results that are meaningful to patients, clinicians, administrators and policy makers.

Falls can be prevented, and the severity of fall-related injuries can be minimized. As showcased in the aforementioned example, quality managers, nurse managers, and staff are integrating charts and graphs—familiar to researchers—into program evaluation at the point of care. The case study demonstrates effective means for tracking additional outcomes in fall prevention programs.

*References, sample charts and an additional case study are available in the original source document.*

*Adapted with permission from “Measuring fall program outcomes.” Online Journal of Issues in Nursing, Vol. 12, Iss. 2. Full article is available online at [www.nursingworld.org/ojin](http://www.nursingworld.org/ojin).*

Aided by statistical analysis, nursing staff ... lowered the average fall rate by 54 per cent on the pilot unit and 27 per cent on all three units combined during the implementation phase.

# Equipment round-up: New and innovative rehab products

By Linda Norton, BSc OT, OT Reg (Ont)

Fall is the time when manufacturers in the rehab and home health care industry launch their latest and greatest products. This year, as in other years, I've visited a number of shows across the country to discover the most innovative products shown in the exhibit halls. Here are the new (and not so new) products that I found the most interesting.

Of course, not every product I list is appropriate for every client, which is why a holistic assessment is needed to determine what equipment would work best for each client. This list, however, does provide you with some additional options that may be helpful for your clients.

## Wheelchairs and wheelchair accessories

**Centre-mount footrests for bariatric clients** ([www.motionconcepts.ca](http://www.motionconcepts.ca), [www.pdgmobility.com](http://www.pdgmobility.com)). One of the problems faced by clinicians in the past is that footrests were mounted in line and off the side of the wheelchair frame. This left clients whose feet were in midline either unsupported or struggling with a foot board. With a centre-mounted foot platform, the client's legs are supported closer to midline, and the wheelchair's overall turning radius may be decreased.

**Amy Systems power tilt system** ([www.amysystems.com](http://www.amysystems.com)). New this year, this power tilt and/or recline system has been redesigned both in terms of aesthetics and functionality. This system can be retrofitted to most bases and, depending on the base, have a seat to floor height as low as 16 inches. The power elevating leg rest actuator is located on the chair rather than on the leg rest, making the leg rest easy to remove and put back on the chair and relatively light weight. Standard weight capacity ranges from 300 to 400 lbs but can be customized to 650lbs and 32" in depth.

**TDX SP** ([www.invacare.com](http://www.invacare.com)). This centre-wheel-drive power wheelchair has been redesigned to improve the chair's style and performance. The tilt system on this wheel-

chair allows for 55 degrees of tilt (weight capacity of 300 lbs), enabling users to shift their weight to help manage pressure and prevent pressure ulcers.

**Quantum Litestream XF** ([www.pridemobility.com](http://www.pridemobility.com)). This new manual wheelchair from Quantum has a dual cross brace, tab-style cross brace mount and recessed upholstery rails between the side frames to make this folding chair propel and respond just like a rigid chair. The footrests swing in under the seat and out to the side, so they can be easily moved out of the way for transfers. And if you remove the footrests, they will balance and stand on the footplate, making them easy to reach. As well, the front flush-mounted casters clear up space for clients who foot propel.

**Co-pilot** ([www.permobil.com](http://www.permobil.com)). This device, which is compatible with Permobil, resembles a pair of stroller handles that have been mounted on the back of a power wheelchair. There is a mechanism on these handles that engages the motors to assist a caregiver in pushing the power wheelchair. When testing this product, I was amazed at how easy it was to push the chair. Using the mechanism is intuitive and makes pushing the power wheelchair just like pushing a manual one, which means less training is needed for a caregiver than when driving an attendant control. The Co-pilot is ideal in situations where the client requires occasional assistance with mobility or where the caregiver frequently pushes the power chair. Finding funding for this product may be a challenge, but it is certainly worth exploring.

## Seating

**Merlin Proximity Sensor** ([www.therohogroup.com](http://www.therohogroup.com)). Have you ever had a client ask this question: "How do I know my cushion is inflated correctly and not leaking?" Well, Merlin now provides the answers to these questions. This proximity sensor is placed under the Roho Cushion. Once the client sits on the cushion, the sensor is set to remember that client's inflation level. If the level changes,

an audible alert is sounded. This device may help users and care providers use the cushion correctly as well as bring their attention to leaks or other issues.

**Jay 3 back support** ([www.sunrisemedical.com](http://www.sunrisemedical.com)). Sunrise medical has redesigned their back support to offer more options in contour. Now, the therapist can specify the depth of contour, support position, support size and backrest width. Hardware comes in either a standard configuration with 1.5 inches of depth adjustment or extended with three inches of depth adjustment. This variety of options will enable therapists to customize the fit of the back for more clients rather than having to move to custom molded solutions.

**Vicair cushion**. Although not a new product, this cushion may be helpful to manage pressure for clients with cushion maintenance challenges. The Vicair cushion contains small individual pockets that can be added and removed based on the client's needs.

## Transfer devices

**Ergo Sheets** ([www.waverleyglen.com](http://www.waverleyglen.com)). The ability to get a sling under a client without turning them in bed and the ability to get a sling behind a client in a wheelchair without leaning them forward are the most useful techniques I have learned this year. This pair of silicone nylon sheets are equipped with handles along the side to assist the caregiver with repositioning a client in bed. "Unfolding" the ergo sheets under the client in bed allows the sheets to be positioned under the client, without rolling. The sling can then easily slide between the two sheets. The manufacturer tells me that that a video will be available shortly to help clinicians learn this technique.

## Bathroom equipment

**Big John Toilet Seat and Support** ([www.bigjohntoileseat.com](http://www.bigjohntoileseat.com)). This device is aimed at better accommodating bariatric clients within washroom facilities. A new seat fits both round and elongated bowls and provides

a larger seating surface. The support fits on the front of wall-mounted toilets and can increase the weight capacity to 1,000 lbs, providing a safer and more secure environment for the patient.

**Sanibag.** While this is not a new product, The Sanibag is one that can be helpful. The liners contain a substance that neutralizes odour and solidifies the waste, making cleaning the commodes much easier. This product would likely be appreciated by the client who uses a bedside commode.

**Z Raz commode.** For clients who need individualized support or pressure management

when using a commode, the Z Raz is a great option. By filling out a detailed order form, the therapist can select a variety of options such as the type of seat. The adjustable axle allows the position of the rear wheel to be changed, which will help facilitate a client's ability to propel the commode.

### Vehicles

**Permalock ([www.permobile.com](http://www.permobile.com)).** Permobile has developed a new wheelchair securement system for vans. One of the features that makes this product helpful is the retractable pin on the wheelchair. The user can retract this pin when not in the van, thus increasing the clearance for the wheelchair. This means

that clients can continue going over rougher terrain without worrying about damaging their van tie-down system.

The products mentioned above are just a synopsis of some of the more interesting products available from manufacturers. When you attend presentations and exhibits, take the time to explore, ask questions and listen carefully. The more products that you see and learn about today, the more options you will have to offer your clients tomorrow.

*Linda Norton, BSc OT, OT Reg (Ont.), is the Rehabilitation Education Coordinator with Shoppers Home Health Care in Toronto, ON.*

## Linda's corner

*Linda Norton, Rehabilitation Education Co-ordinator at Shoppers Home Health Care, answers your seating and mobility-related questions.*

**Q** I get overwhelmed when I browse through exhibit halls filled with equipment. Although I look at many products, I'm not sure I retain the information I need. Any suggestions?

**A** Exhibit halls and conferences can be overwhelming. To get the most out of your experience, reflect on your learning needs before you go:

- What issues or clinical situations in your practice do you find are the most difficult to resolve?
- What types of equipment do your clients need (e.g., manual wheelchairs, power wheelchairs, ambulation aids, assistive devices)?
- What equipment features (e.g., easy to operate, lightweight, manoeuvrable) are helpful or not helpful to clients on your current caseload?
- What gaps in your knowledge base could be filled by information from the conference or exhibit you are about to attend?

Reflecting on your learning needs and current caseload will make it easier to identify which workshops and which manufacturers will be most helpful.

While there, don't expect to remember everything you see. When going through the exhibits, take the time to reflect on the equipment features that may be helpful to your clients. And take notes on the product literature itself; this way, your notes will be with the manufacturer's information for easy reference. Finally, keep a file of literature, perhaps

organized by product type, that you can flip through later while exploring options for your clients.

**Q** I have a very active client with paraplegia who experiences recurrent breakdown over her sacrum. She transfers well, and I can not identify any friction or shearing. I have also looked at every surface that she sits or lies on. What else should I consider?

**A** Optimizing a treatment plan for clients with recurrent pressure ulcers requires that the professional and client work together and become detectives. The first question to consider is "what is the client doing differently (activity, surface, location, etc.) at the time the pressure ulcer develops?" Also, is there a pattern to ulcer development? Examples may include a longer trip, an overnight stay at a hotel or cottage, and so on.

If nothing comes to mind, examine the client's daily routine at home. Go through each activity and the equipment the client is using. You may find that he or she is using a surface that was missed during the assessments. For example, I had evaluated one client who had a pressure ulcer over his left hip. I looked at all the surfaces in his home—or so I thought. Although his nutrition, transfers, dressings, and so on had been examined, his wound was not improving. I then decided to examine his routine. During this examination, he took me to his garage where his car was parked. Due to the garage set up, the car was parked so that he transferred into it on the passenger side, then slid over (on his left hip) to the driver's side. This manoeuvre was likely causing some of the trauma to his wound. In this case, modifying the car transfer helped to decrease the trauma to the wound.



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# Intelligent homes: Helping older adults stay independent

By Carolyn Lovas

As the Canadian population ages, the number of people affected by Alzheimer's disease and other dementias is expected to increase dramatically. It is estimated that by the year 2031, more than 750,000 Canadians will have Alzheimer's or a related dementia. Researchers at the Toronto Rehabilitation Institute (Toronto Rehab) in Ontario are leading the way in the development of intelligent, self-adaptive technologies that will enable older adults with cognitive impairments to safely remain in their homes.



## Aging in place

"Often when a person gets moderate to severe levels of impairment, they are taken out of their home and put into a care facility," says lead scientist Dr. Alex Mihailidis, a mechanical and biomedical engineer and researcher at Toronto Rehab. "We are using artificial intelligence to support aging-in-place so that people can remain in their homes for as long as possible."

Dr. Mihailidis and his research team at the Intelligent Assistive Technology and Systems Lab, a Toronto Rehab and University of Toronto joint venture, have developed home-based computer systems that use artificial intelligence to promote independence and ensure the safety of older people living at home who might experience memory loss, confusion or other cognitive problems as a result of Alzheimer's disease or stroke.

Alzheimer's disease and other related dementias often affect a person's ability to perform daily personal care activities, such as

proper toileting. Dr. Mihailidis and his team have developed a "talking" bathroom outfitted with a computer screen that gives video and verbal cues to assist with handwashing.

## Asking for help

The team has also developed a personal emergency response system that can detect when a person has fallen and call for help. Using ceiling-mounted cameras in the house, pictures are fed to the computer system, which analyses the images to determine the position of the occupant and whether or not a fall has occurred. A voice recognition system will then ask the occupant if they need help.

"Often we hear of cases where an individual has fallen and is found three days later lying on the bathroom or kitchen floor. When this happens, their chances of survival and recovery are drastically reduced," says Dr. Mihailidis. "Our emergency response system will ensure they get the help they need immediately."

## Learning and adapting

It is the ability of an intelligent system to monitor a person and situation, take into account probabilities and statistics, and come up with a course of action that distinguishes an intelligent home from a smart home, according to Dr. Mihailidis. "Smart homes respond to pre-programmed requests but cannot learn and adapt. Our systems use computer algorithms that act more like a human in terms of rational thought and decision-making. They actually learn and adapt to a person's needs."

Toronto Rehab researchers are the first to test home-based artificial intelligence systems in clinical trials. One study found that subjects' ability to complete hand-washing steps without help from a caregiver increased by approximately 25 per cent when a computer prompting system was employed. Another study showed that the team's emergency response system detected 77 per cent of falls staged in the lab.

"Our systems are not intended to replace professional or family caregivers. However, the results from our studies show that the use of artificial intelligence in a home can provide safety and security and enhance the quality of life for older adults who would like to remain in their homes as they age," says Dr. Mihailidis.

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**Preventing injuries** *continued from cover*  
events such as assaults by patients, slips, trips and falls. As well, MSDs occur from non-patient-related health care jobs or tasks, such as maintenance work.

Jessica Tullar, a PhD student of Amick's, had been researching interventions in nursing homes and was surprised to find few studies in this area. Tullar is at the University of Texas School of Public Health in Houston, Texas.

The scope of the systematic review initially focused on nursing homes and long-term care facilities. "Because there was not much research on long-term care facilities, we chose to look at all health care facilities," says Tullar, a co-author of the review. "The tasks of these workers are similar across health care facilities." Until now, there has been only one systematic review on injury prevention for patient lifting, but no one has reviewed the broad spectrum of programs in health care settings.

### Canadian-U.S. review team

A joint Canadian-U.S. team was assembled to conduct the review, including reviewers from the Institute and from the University of Texas. The team addressed the following research question: "Do occupational safety and health interventions in health care settings have an effect on musculoskeletal health status?"

To answer this question, the reviewers followed a set of systematic steps. First, they identified more than 8,400 possible articles of interest in their search of various databases. These studies had been published in journals in which independent scientists peer-reviewed the research. The reviewers identified 40 studies that had information relevant to their research question. After assessing the quality of each study, reviewers found 16 studies whose quality was sufficient to give them confidence in the findings.

From these 16 studies, the review team concluded there was moderate evidence that prevention programs had a positive effect on workers' musculoskeletal health in health care settings. Moderate evidence meant at least two studies of medium-high quality agreed on the same findings.

### Two "practices to consider"

Reviewers also found moderate evidence for two specific programs. "Because the evidence wasn't strong, these should be taken as 'practices to consider' rather than 'best practices' or policy

recommendations," says Shelley Brewer, an author and doctoral student of Amick's at the University of Texas.

One practice to consider was patient handling interventions with the following three components:

- a policy change at the worksite, such as a zero-lift policy
- the purchase and implementation of new patient-handling equipment, such as overhead lifts or floor lifts
- training on the new equipment and on patient handling

Two out of three studies on this three-part intervention showed positive effects. In one study, the intervention reduced lost or restricted workdays, injury rates and workers' compensation rates. In the second study, there was a reduction in low-back and shoulder pain reported by workers. The third study showed no effects.

Another practice to consider was exercise training. All six studies on exercise training—including aerobic and/or strength programs—showed positive health effects. These training programs were targeted at health care workers who had already experienced pain. Four studies described their exercise programs as general "physical fitness" or "calisthenics" programs. Two studies looked at exercises that specifically improved strength or endurance.

In all studies, there were positive health effects. Workers reported a decline in pain symptoms, including reductions in the frequency, intensity and duration of their pain.

### Stakeholders part of review

An important part of the review was to include stakeholders from relevant fields to provide feedback on various aspects of the review.

Representatives from hospitals, nursing homes, government agencies, professional associations, insurance companies and lift manufacturing companies were invited to meetings at the start of the review and at the end, to hear results.

Anne Duffy, provincial ergonomist with Ontario's Ministry of Labour, who participated in the review process, says that it helped her as a non-researcher to understand the importance of systematic reviews. However, she admits that she was surprised that there were so few studies of high quality. "One message is that more work needs to be done." Why did so many studies not make the quality cut-off point? There were a number of reasons. They included the way studies were designed, the reporting of statistics, and how the final results were reported.

"The systematic review process teaches researchers what information they need to include when they're writing about their own studies," says Tullar. "If, as a researcher, you don't say exactly what you did, you can't get credit for it." Another important message from the review is that the current state of research has limited high quality evidence on the effectiveness of MSD prevention programs.

"We are frustrated that we are unable to make stronger recommendations," says Amick. "The overwhelming message from our review is that more high quality research must be produced, and we consider this a priority."

*Adapted from "Preventing injury in health care workers," which appeared in At Work, issue 48, produced by the Institute for Work & Health. For a full copy of the review, visit [www.iwh.on.ca](http://www.iwh.on.ca).*

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### Programs have a positive effect

Overall, the systematic review found moderate evidence that occupational safety and health prevention programs have a positive effect on workers' musculoskeletal (MSK) health status in health care settings.

Moderate evidence means at least two studies of medium-high or high quality agree on the same findings. There is also moderate evidence that the following two interventions had a positive effect:

1. Patient handling with the following three components:
  - a policy change at the worksite, such as zero-lift policies
  - the purchase and implementation of new patient-handling equipment, such as overhead lifts or floor lifts
  - training on the new equipment and on patient handling
2. Exercise training programs with aerobics or strength training or both.

## Compassion fatigue *continued from cover*

things are at in your life. Make a list of all the demands on your time and energy (work, family, home, health, volunteering, and so on). Make the list as detailed as you can. For example, under the work category, list the main stressors you see (such as number of clients, amount of paperwork, or difficult boss, etc.).

Once you have the list, take a look at it. What stands out? What is making your plate too full? What would you like to change most? A counsellor or coach can help you with this exercise.

**2. Start a self-care idea collection.** This can be fun, and you can do it with friends and at work.

*With friends:* Interview three friends on their favourite self-care strategies. Start making a list even if they are not ideas that you would do or are able to afford at the moment. Something new might emerge that you had not yet thought of.

*At work:* Start a contest for the best self-care idea of the week or have a “self-care board” where people post their favourite ideas. You could have a “five minutes of self-care” at each staff meeting, where someone is in charge of bringing a new idea each week.

Once you have a long list, pick three ideas that you like. Make a commitment to implement these in your life within the next month.

**3. Rebalance your workload.** Do you work straight through lunch? Do you spend week-ends running errands and catching up on your week? Can you think of simple ways to take mini breaks during a work day? This could simply be that you close your door (if you have a door) and listen to 10 minutes of your favourite music during lunch. A friend of mine has a nap on her yoga mat at work during lunch break.

Make sure you do one nourishing activity each day. This could be having a 30-minute bath with no one bothering you, going out to a

movie, or taking 10 minutes to sit and relax. Take time when you can, and make the most of it.

**4. Ask for help.** Here is a home-based example: Have you ever taught a four-year-old how to make a sandwich? How long would it take you to make the same one? Yes, you would likely make it in far less time and cause far less mess in the kitchen, but at the end of the day, that four year old will grow into a helpful 10 year old, and one day, you won't have to supervise the sandwich making anymore. Are there things that you can let others do their own way?

**5. Have a transition from work to home.** Do you have a transition between work and home? Do you have a 20-minute walk home through a beautiful park or are you stuck in traffic for two hours? Do you walk in the door to find your kids fighting?

Helpers have told us that one of their best strategies involved a transition ritual of some kind: putting on cozy clothes when getting home and mindfully putting their work clothes away, having a 10-minute quiet period to shift gears, or going for a run. What is your transition ritual?

**6. Learn to say no (or yes) more often.** Are you the person who ends up on all the committees at work? Do you volunteer in the helping field as well as work in it? Being the source of all help for all people can be draining. Are you able to set limits? If not, this is something that needs exploring, perhaps with a counsellor. Can you think of one thing you could do to say no a bit more often?

Conversely, maybe you have stopped saying yes to all requests, because you are feeling so burned out. Have you stopped saying yes to friends and to new opportunities?

Take a moment to reflect: do you need to learn to say no or yes more often?

**7. Assess your trauma inputs.** Do you work with clients who have experienced trauma? Do

you read about, see photos of, and are exposed to difficult stories and images at work?

Take a trauma input survey of a typical day in your life. Starting at home, what does your day begin with? Watching morning news on TV? Listening to the radio or reading the paper? Note how many disturbing images and difficult stories you come across. Now look at your work. Not counting direct client work, how many difficult stories do you hear?

In a nutshell, there is a lot of extra trauma input outside of client work that we do not necessarily need to absorb or to hear about. We can create a “trauma filter” to protect ourselves from this extraneous material.

**8. Exercise.** Do you exercise regularly? Can you think of three small ways to increase your physical activity? One busy counselling service hired a yoga instructor to come once a week to their office and everyone chipped in their \$10 and did yoga together at lunch. Another agency said that they had created a walking club, and that a group of helpers walked outside for 30 minutes three times a week.

### One small change

You may not notice it right away, but making one small change to your daily routine can have tremendous results in the long term. For example, imagine if you started walking up two flights a stairs per day instead of using the elevator, what might happen after three months? Would you feel healthier or better about yourself?

Compassion fatigue can have serious consequences. Fortunately, you can take steps to manage it and control it. By doing so, you'll be helping yourself in order to continue helping others.

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