PALTmed
POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

know-it-all™

WHEN YOU'RE CALLED

Diagnosing System

Essential clinical data exchange:

A GUIDE FOR ATTENDING PRACTITIONERS ON CHANGE OF CONDITION

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☐ ABDOMINAL PAIN, DISTENSION, AND / OR DISCOMFORT

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal evaluation including tenderness, pain, bulging, distension upon palpation, and bowel sounds upon auscultation
- Digital rectal evaluation, including any tenderness, mass, or hard stool
- If vomiting, describe contents, quantity, and presence of blood, check hemoccult
- Type of pain (dull, sharp, stabbing, burning, and to rate their pain on scale (including whether pain is consistent or intermittent)
- Note alleviating factors or aggravating factors

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of symptoms
- Current medications, including any recent changes
- Recent food and fluid intake patterns, including any recent changes
- Current diet (regular, restricted, etc.)
- All current diagnoses
- Any recent lab or diagnostic test results
- History of related gastrointestinal conditions (prior surgery, history of peptic ulcers, diverticulitis, etc.)
- Approximate frequency of bowel movements, last bowel movement and any associated problems

DRILL IT DOWN

- Any viral infection in facility?
- And change in mental status (lethargic)?
- Any fever?
- Any diarrhea / constipations?
- If on a SNF Med A stay, why? (e.g. post-op recovery)
- Radiology (X-ray, US)
- Recent bowel history
- Nausea / vomiting?
- Bowel sounds
- Abdominal tenderness to palpation
- Describe location and type, radiation
- Vital signs
- LABS: CBC, CMP, UA, C&S

ABDOMINAL PAIN (cont'd)

DRILL IT DOWN (cont'd)

- Evaluate hydration status, (signs and symptoms of dehydration; postural pulse difference – increase from lying down to sitting or standing of 30 beats per minute or more, tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased confusion)
- Oral intake?

DIAGNOSES TO CONSIDER:

- Constipation (#1)
- UTI (#2)
- GERD (#3)
- Abdominal wall hernia
- Appendicitis
- Ascites
- Geriatric caveat – frail seniors exhibit vomiting and lethargy as a sign and symptom of pneumonia
- Infectious diverticulitis
- Obstruction / ileus
- Pancreatitis / Gall stones / Peptic ulcer disease
- Renal stones
- Scrotal pain – consider prostatitis / strangulated hernia

SEND OR KEEP?

Transfer to ER if: hemodynamically unstable (tachycardia, tachypnea), ileus, abdominal exam shows signs and symptoms of peritonitis (guarding, rigidity, rebound tenderness), fever with vomiting, change in mental status (lethargic), vomiting not relieved with antiemetics, tarry black stools, hypotensive (systolic blood pressure less than 90), concerned with obstruction, positive X-ray for obstruction, patient does not have a "do not transfer" order.
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1).

ABDOMINAL PAIN (cont'd)

WHAT DO I DO?

- Constipation – rectal treatment (enema, suppository, etc.); oral treatment (magnesium hydroxide suspension, senna, sorbitol, prune juice, polyethylene glycol laxative)
- Antibiotics
- Symptomatic treatment of emesis
- Consider bowel rest and antiemetics if needed
- Avoid pain medications if possible — may mask pain
- Treat dehydration / fluid imbalance – IV fluids / clysis / salty snack and favorite beverage (dependent on level of imbalance / dehydration)

FOLLOW UP:

Within first 24 hours:

If the patient's X-ray shows fecal impaction, make sure that patient has bowel movement. Check on patient's hydration status, X-ray and labs. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Antibiotics if indicated.

Next business day:

Check the labs, manage pain, manage symptoms, and look for worsening or improvement of symptoms. Make next treatment/ management decisions based on this information.

Next scheduled visit:

Follow up and make decisions on whether or not to continue any medications started for this recent problem, especially for peptic ulcer. If peptic ulcer disease suspected and patient has ongoing epigastric discomfort, do stool for *Pylori* antigen.

☐ ABRASION (SEE ALSO RASH)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Description of abrasion (size, location, etc.)
- Whether significant bleeding or pain is present at the abrasion site
- If reporting a complication of an existing abrasion, any signs of infection or significant bleeding
- Description of skin condition around the abrasion (normal, reddened, swollen, tender, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Date and circumstances of onset (how abrasion occurred, if known)
- All current medications, including any recent changes, especially anticoagulants, prednisone, and other medications associated with thin or fragile skin
- Whether individual has history of fragile skin or recurrent skin tears
- Results of any interventions thus far

DRILL IT DOWN

- Description of abrasion (shape, bleeding, pain, gaping, depth, redness, swelling)
- Can the facility stop the bleeding or does the patient require sutures?
- S/S of cellulitis (redness, warmth, swelling, and pain in the involved tissues redness that spreads to adjacent skin)
- Is it traumatic?
- Any evidence of infection (erythema, streaks, local adenopathy)?
- Review medication especially blood thinners – such as coumadin, dipyrimadole, ASA, antiplatelet drugs (e.g. clopidogrel), etc.
- Check tetanus status
- Incident report to investigate cause of abrasion

ABRASION (cont'd)

DIAGNOSES TO CONSIDER:

- Pressure or environment related – fall, scratched self (e.g. when itching), accidents (e.g. bump into wall while in wheel chair), activity
- Shearing forces – transferring, pulling or pushing, aggressive behavior
- Trauma – self-induced or environment-related

SEND OR KEEP?

Transfer to ER if: laceration is deep (exposing tendons, bone or with uncontrolled bleeding) needing sutures.
Keep in facility if: the abrasion is superficial and can be treated in the facility.

WHAT DO I DO?

- Superficial – clean and dry area. Nonstick gauze and antibiotic cream. Hold in place with gauze* bandage roll
- Minimal bleeding – pressure and nonstick gauze. Hold in place with gauze* bandage roll
- Moderate to heavy bleeding – local pressure and gauze* bandage roll to stop bleed
- Avoid thin transparent polyurethane membrane film dressings (i.e., tegaderm) in patients with fragile skin
- With skin tears, attempt wound closure strips to pull skin back if possible
- Oral antibiotics with signs of systemic infection
- Consider tetanus or Tdap vaccination (vaccination more than 10 years ago)
- Consider upper extremity sleeve or elbow pads to protect fragile skin
- Trim fingernails if self-induced abrasion
- Evaluate if positive for pruritus (see Rash section)

**avoid tape and adhesive bandages on frail elder's skin.*

ABRASION (cont'd)

FOLLOW UP:

Within first 24 hours:

Check for continued bleeding, pain, erythema, signs of infection.

Next business day:

Any new swelling, gaping of wound, slough, signs of infection. Intervene appropriately based on symptomology. Antibiotics if indicated.

Next scheduled visit:

Check for pain, erythema, gaping of wound, healing of abrasion, any new abrasions.

☐ AGITATION OR BEHAVIORAL DISTURBANCE (SEE ALSO CONFUSION, MEMORY LOSS)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Lung and abdomen evaluation
- Details of the behavioral problem (onset, frequency, duration, nature, etc.)
- Neurological evaluation, including details of mood, orientation, and level of consciousness
- Any signs suggesting possible infection
- Any significant changes in bowel and bladder function
- Any evidence of head trauma or other recent injury
- Evaluation of any pain (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity
- Food and fluid intake patterns over previous week
- Full description of behavior compared to usual behavior
- Any recent history of injury or fall
- All current medications, including any recent changes
- History of any psychiatric disorders
- All current medical diagnoses
- Any recent lab or diagnostic test results, especially BMP (Basic Metabolic Profile)
- Recent blood sugar trends, if patient is diabetic

DRILL IT DOWN

- If on a SNF Med A stay, why? (e.g. post-op recovery?)
- Is this new or a pattern?
- Is this behavior provoked or unprovoked? If new — stronger possibility provoked
- At risk of hurting self or others?
- Review behavior charting log
- Any history of sundowning?
- Recent hospitalization

AGITATION (cont'd)

DRILL IT DOWN (cont'd)

- Recent removal of indwelling catheter?
- What environmental options have been tried – redirection (food, massage), decrease or increase stimulus, provide craft / activity, take to bed for a nap, etc.?
- Recent medication changes – trial of decrease in psychiatric medications (i.e. GDR)?
- Infectious disease work up?
- LABS – indicated (per history): CBC, BMP, medication levels, urine culture, pulse oximetry, X-rays

DIAGNOSES TO CONSIDER:

If new, look for medical causes

Environmental (#1 cause)

- Recent change in routine, room, or staff for patient
- Too much noise / sensory deprivation or overload
- Change of room

Physical

- Bathing, toileting, or other ADLs needs not being met
- Loss of sleep, altered sleep cycle (putting someone to bed / getting up that is contrary to circadian rhythm)

Medical

- Cardiovascular, metabolic encephalopathy (renal, hepatic)
- Constipation / impaction
- Delirium
- Electrolyte imbalance (increased Ca, decreased Na), hypoxia, hypercarbia / hypercopnia, hypotension, severe anemia
- Indwelling catheter
- Medications (anticholinergics, benzodiazepines, opioids, steroids, cardiac / arrhythmic medications)
- Pain
- UTI / infection / urinary retention (nurse must palpate abdomen for enlarged bladder)

AGITATION (cont'd)

SEND OR KEEP?

Transfer to ER if: patient is at risk to hurt self or others and needs one on one supervision and family / responsible party unable to provide OR patient needs emergency psychiatric evaluation.
Keep in facility if: non-emergent and facility can meet patient's needs (see Appendix 1).

WHAT DO I DO?

- Environmental redirection (#1 intervention)
- Treat underlying medical cause if acutely new
- Medication review
- Consider delirium
- Mental health consultation

FOLLOW UP:

Within first 24 hours:
Follow up labs, other investigations, and manage appropriately.

Next business day:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:
Evaluate cognition, mood, medications, care plan review, hearing aids, glasses, dentures, nutrition, functional status and schedule family meeting if appropriate.

☐ AMBULATION, ALTERED (SEE ALSO FALLS, GAIT DISTURBANCE)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details of current ambulatory capability, gait, and balance
- Extremities and musculoskeletal evaluation, including evidence of deformity, pain, altered range of motion, etc. of lower extremities
- Any changes in mental status and level of consciousness
- Evidence of recent injury to lower extremities
- Ability to ambulate with assistive devices

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of symptoms
- Usual (baseline) ambulatory capabilities
- All current medical diagnoses
- All current medications, including any recent changes
- History of any episodes of falling, injury, or other events affecting ambulation

DRILL IT DOWN

- Medication review – especially for antiarrhythmics, anticholinergics, antidepressants, antidiabetic agents, antiepileptics, antihypertensives, antiparkinsonian agents, antipsychotics, benzodiazepines, diuretics, opioid analgesics, sedative hypnotics, urinary antispasmodic agents, vasodilators.
- If on a SNF Med A stay, why? (e.g. rehab)
- Physical therapy / occupational therapy already?
- Do they use assistance devices?
- Vital signs – include orthostatic BP evaluation
- Joint pain – stiffness, swelling, heat, redness, limitation of movement
- Muscle pain – cramps, weakness
- Bone – deformity, pain, trauma

AMBULATION, ALTERED (cont'd)

DIAGNOSES TO CONSIDER:

Common causes of falls / altered ambulation / gait disturbances

- Deconditioning / poor endurance
- Environmental – slippery surfaces, poor lighting / glare, trip over clutter, poor fitting footwear, etc.
- Fear of falling (status post fall)
- Fracture – hip, vertebral (e.g. osteoporotic spontaneous fracture)
- Hemiplegia
- Lower extremity weakness
- Medication adverse reaction / side effect
- Needs assistance device
- Orthostatic hypotension
- Pain
- Peripheral neuropathy

Other causes

- CVA
- Electrolyte imbalance
- Hypoxia
- Intoxication – alcohol, drugs, medications (benzodiazepines, antipsychotics, anticholinergics, alpha blockers)
- Parkinson's disease
- Spinal cord compression
- Visual impairment

SEND OR KEEP?

Transfer to ER if: concerned with possible fracture, CVA, spinal cord compression (if advance directives suggest surgical / aggressive treatment or patient safety impaired).
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1) or if order for do not transfer is in place.

AMBULATION, ALTERED (cont'd)

WHAT DO I DO?

- Review the situational / surroundings of the fall
- Provide adaptive equipment
- Change / taper / medications if cause
- R/O orthostatic hypotension
- Symptom management if cause is stiffness and swelling of joints, limitation of movement, pain, etc.
- Consider physical therapy / occupational therapy consultation
- Order appropriate diagnostic services (e.g. X-rays) if injury suspected
- Consider vitamin D and calcium supplementation – to improve muscle and bone strength

FOLLOW UP:

Within first 24 hours:

Ensure safety of the patient, address medication changes, new infections, electrolyte imbalance, mange pain. Order any necessary emergent labs.

Next 24 hours:

Follow up on intervention(s). Make next treatment/management decisions based on response to initial interventions and any lab results if ordered. Order labs (25 OH vitamin D, Vit B12, Hgb, electrolytes, BUN, creatinine) if recent results not on chart.

Next scheduled visit:

Check labs (25 OH vitamin D), PT/OT recommendations, educate family members, review care plan. Follow-up on last interventions to see if adjustments are needed.

☐ APPETITE, DIMINISHED (SEE ALSO ABDOMINAL PAIN, CONFUSION, SODIUM ABNORMAL)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Signs of change in mental status, mood, behavior, orientation, or alertness
- Signs of dehydration or fluid and electrolyte imbalance
- Abdominal evaluation, especially for bowel sounds, tenderness, pain, or distension
- Any signs of infection
- Any nausea and vomiting
- Mouth / throat, teeth / gums evaluation, especially condition of teeth and gums, mouth pain, throat or tongue swelling, or discomfort

MEDICAL HISTORY

- Patient's age and sex
- Details of individual's appetite and food and fluid intake patterns over previous week, compared to usual (baseline)
- All current medications, including any recent changes, especially medications known to cause anorexia
- Current diet (regular, mechanical soft, etc.) including any restrictions and any recent changes
- Any recent history of mouth or throat pain, nausea or vomiting, abdominal pain, heartburn, or indigestion
- Any recent changes in bowel pattern (constipation, diarrhea, etc.)
- Recent history of changes in mood, behavior
- Any current dietary supplements
- All current diagnoses
- Any recent lab or diagnostic test results

APPETITE, DIMINISHED (cont'd)

DRILL IT DOWN

- Diet intake, adequate caloric intake?
- Is the weight measurement accurate?
- Is there weight loss with anorexia?
- Documentation of weight loss? Rapid, progressive? (over 5 lbs in 30 days or over 10 lbs in 6 months)
- High energy output – such as wandering?
- Review of last history and physical exam
- LABS: TSH, CBC with differential, Complete Metabolic Profile, pre-albumin, albumin (any drug levels – e.g. Digoxin, Dilantin)
- Simplified Nutrition Assessment Questionnaire (SNAQ)
- Evaluate appetite and dietary intake

DIAGNOSES TO CONSIDER:

Most common causes

- Cognitive impairment
- Constipation
- Depression
- Difficulty chewing or swallowing (dental health, decreased salivation)
- Dysphagia
- Medication side effects / adverse reactions (most common offenders – digoxin, ACE inhibitors, SSRI, dilantin, metformin, theophylline, warfarin)
- Restricted diet, "therapeutic diets"

Other causes

- Cachexia
- Cancer
- Cardiac causes
- Constipation
- Diabetes mellitus
- Infection (especially chronic infections)

APPETITE, DIMINISHED (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Mental health disorders
- Olfactory sensory deficit
- Patient newly requires feeding assistance
- Thyroid disease
- Urinary retention

**Geriatric caveat – acute onset anorexia with lethargy – such as missing breakfast and going to bed – can be an early sign of pneumonia*

SEND OR KEEP?

Keep in facility always: Reversible causes identified and amenable to correction in facility. Not all weight loss is correctable and is often a sign of impending mortality.

WHAT DO I DO?

- Liberalize diet (if possible cater to patient's preference – socialization, palatability, meal presentation, person centered care plan for meals, dietary supplements, enhanced foods, etc.)
- Remove, substitute, or lower offending medications
- Treat constipation
- Maintain fluid intake
- Consider treating for depression
- Consider megace 800mg daily only if cancer or HIV cachexia (because of side effect of edema and increased deep vein thrombosis risk)
- Consider dental evaluation and management
- Consider psychiatry consult if depression refractory

APPETITE, DIMINISHED (cont'd)

FOLLOW UP:

Check pre albumin / albumin if not on chart. Order a dietary consultation (but do not rely on dietary supplements until you have come in and performed a differential diagnosis).

Next business day:

Come into facility to perform a differential diagnosis, check for change in routines, look for reversible and modifiable factors.

Next scheduled visit:

Change care plan, educate family about futility of feeding tubes with advanced dementia and the importance of advanced directives

☐ BACK PAIN

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Signs of swelling, bruising, fracture or deformity of back, spine, hips, or pelvis
- Pain evaluation (location, nature, severity, etc. Does it change with activities)
- Movement of, and sensation in, lower extremities
- Range of motion of hips and knees, compared to usual baseline

MEDICAL HISTORY

- Patient's age and sex
- Any history of back surgery, spinal cord injury, urinary tract infections, pneumonia and other respiratory infections, cardiovascular disease, or diabetes
- Attempted symptom management to date
- All current diagnoses
- History of any recent falls, injuries, or recent back surgeries
- Level of mobility (ambulatory, bed-bound or chair-bound, etc.)
- All current medications, including any recent changes
- Any recent lab or diagnostic test results, especially BMP (Basic Metabolic Profile)
- Recent blood sugar trends, if patient is diabetic

DRILL IT DOWN

- Is the pain new?
- History if cancer
- If on a SNF Med A stay, why? (e.g. rehab?)

BACK PAIN (cont'd)

DRILL IT DOWN (cont'd)

- Detailed history (Red flags: trauma, saddle area numbness, increased pain with cough and straining, worse pain at night / rest, bowel and bladder dysfunction – fecal incontinence or urinary retention, weight loss)
- Duration of pain
- Any associated neurological deficits
- What makes it better / worse?
- Recent radiographic imaging
- Recent urinalysis
- Recent CBC with differential, ESR, CRP (elevated in osteomyelitis, abscess, metastases)

DIAGNOSES TO CONSIDER:

- Abdominal aortic aneurysm
- Arthritis
- Chronic pain flare from recent hospitalization / deconditioning
- Compression fracture (history of osteoporosis) primary vs. secondary (such as metastatic disease)
- Herpes zoster
- Myofascial pain
- Nephrolithiasis
- Nerve compression (radiculopathy)
- Sacroiliac joint dysfunction
- Spinal Stenosis
- Trauma (fall)

SEND OR KEEP?

Transfer to ER if: presented with symptoms of sepsis (hemodynamic instability), abdominal aortic aneurysm, cord compression, cauda equina syndrome, concern for bone metastasis causing cord or nerve compression.
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1).

BACK PAIN (cont'd)

WHAT DO I DO?

- Order diagnostic tests (imaging, labs) as appropriate
- Pain medications (include order for laxatives with narcotics)
- Calcium and vitamin D prophylaxis
- Calcitonin for compression fractures for 4-8 weeks
- Heat or ice
- Massage range of motion, pain modulates, TENS unit
- Consider PT consult
- Consider transfer assistance; use of assistive devices
- Encourage normal activity (after practitioner assessment)
- Consider capsaicin cream (wear gloves with application)

FOLLOW UP:

Within first 24 hours:

Check on patient's X-ray and labs. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next business day:

If there is no neurologic manifestation refer to neurosurgery or orthopedics (spinal stenosis, nerve impingement, bowel or bladder dysfunction, pain management). Follow up on effectiveness on interventions.

Next scheduled visit:

Most patient's improve in 4-6 weeks, Educate proper biomechanics, physical activity. Follow up on effectiveness on interventions.

☐ BEHAVIOR, CHANGE

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological, behavioral, and cognitive evaluations including any significant changes in level of consciousness, function, mood, cognition, and behavior
- Any signs of respiratory distress, O2 sats.
- Signs of nausea and vomiting
- Blood sugar level (finger stick)
- Signs of fluid imbalance
- Any signs or symptoms of acute infection (fever, chills, changes in urinary pattern, etc.)
- Signs of bruising or other injury
- Pain evaluation (location, nature, severity, etc.)
- Evaluate and collect details of mood, behavior, orientation, and alertness

MEDICAL HISTORY

- All current medications, including any recent changes
- Any history of acute or chronic psychiatric disorders
- Details of the change (onset, duration, and fluctuation) compared to usual baseline
- Results of any screening evaluation such as BIMS and Mini-Cog
- Current status of bowel and bladder function
- Any recent history of fall, head trauma injury
- Findings from previous neurologic or psychiatric consultations
- All current diagnoses
- Any recent lab or diagnostic test results, including blood sugar, if patient is a diabetic

DRILL IT DOWN

- Ask the nurse to explain the behavior in detail and with descriptive wording:
  - How is it effecting themselves and others?
  - How is the behavior "different" than normal?
  - What preceded the behavior?

BEHAVIOR, CHANGE (cont'd)

DRILL IT DOWN (cont'd)

- Continence / toileting issues
- Current diagnoses
- Review medication
- Pain assessment – especially nondescript signs and symptoms of pain
- Recent intake – food and fluid
- Recent sleep patterns
- Vital signs

DIAGNOSES TO CONSIDER:

Common diagnoses

- Boredom vs. over-stimulated
- Delirium
- Dementia
- Depression
- Environmental issues
- Mood lability / frontal signs
- Pain
- Psychosis
- Sleep-wake cycle reversal
- Toileting
- Thirst / hunger

SEND OR KEEP?

Transfer to ER if: behavior escalates where patient is a danger to themselves or others.
Keep in facility if: all other issues.

WHAT DO I DO?

Ordering a UA is NOT the answer to behavioral problems.
Medications are not first-line treatments. The more defined the problem, the more likely the intervention will work.

- Identify / address provoked stimuli
  - ADLs – dressing, grooming, bathing
  - Noise
  - Boredom vs. over-stimuli
  - Change of shift

BEHAVIOR, CHANGE (cont'd)

WHAT DO I DO? (cont'd)

- New caregiver
- Change of routine
- Roommate issues

- Consider appropriate pharmacological management if necessary (e.g. depression, dementia, psychosis, sleep-wake reversal, etc.)
- Make environmental changes
- Toileting
  - Assess for differential diagnosis for underlying incontinence (if incontinent)
  - Consider toileting on awakening and bedtime and pre- and post-meals instead of toileting every 2-3 hours
  - Consider scheduled voiding 1-2 times at night (older adults usually void 1-2 times per night)
- Pain
  - Most pain meds must be dosed every 4 hours for continuous pain control
  - Consider scheduling pain meds in patients with dementia – even just acetaminophen (no more than 3 grams / day)

FOLLOW UP:

Within first 24 hours:
Intervene appropriately based on symptomology and any abnormal test results and patient's advanced directives.

In 7 – 10 days:
Make next treatment / management decisions based on response to initial interventions and any lab and / or radiology results if ordered.

Next routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ BLISTERS (SEE ALSO RASH)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Skin evaluation, including location (localized or diffuse), size, appearance (vesicles, pustules, bullae, etc.), number (single or multiple), and any underlying redness or exudate
- Pain evaluation (location, nature, severity, etc.)
- Any signs of secondary bacterial infection

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, rate of appearance of new blisters, etc.
- Medical history, including history of autoimmune disorders or skin rashes
- All current diagnoses
- Any allergies to food, medications, detergents, etc.
- All current medications, including any recent changes
- Current treatments

DRILL IT DOWN

- History of lesions
- Recument lesions (lips)
- Location: dermatomal – zoster, lower extremity edema, heels, mucosal involvement
- Distribution
- Type of lesion

DIAGNOSES TO CONSIDER:

- Bullous pemphigoid
- Drug reaction
- Eczema
- Friction (also self-induced)
- Herpes simplex
- Herpes zoster
- Impetigo
- Sunburn, 2nd degree
- Venous stasis

BLISTERS (cont'd)

SEND OR KEEP?

Transfer to ER if: pain unresponsive to oral medications and needs continuous IV pain medications, immunocompromised patients that may need reverse type isolation, Steven Johnson syndrome involving major areas of the body, drug reaction with hemodynamic compromise.
Keep in facility if: drug reactions, bullous pemphigoid, herpes simplex, eczema, impetigo, folliculitis, sunburns. Non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Isolation if zoster
- Ophthalmology consult if there is eye or tip of nose (V2) involvement
- Antiviral drugs (penciclovir for oral lesions, acyclovir, valacyclovir)
- Local care to decrease itching
- Float heels / pressure relief
- Compression stockings if associated with lower extremity edema

FOLLOW UP:

Within first 24 hours:
Isolation if appropriate, pain management, antivirals, hydration. Intervene appropriately based on symptom control, diagnoses.

Next business day:
Secondary infection evaluation. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:
With recurrent lesions consider oral antiviral daily. Follow-up on last interventions to see if adjustments are needed.

☐ BLOOD PRESSURE (HIGH OR LOW)

	Systolic	Diastolic
***High** Blood Pressure		
Stage 1	140 – 150	90 – 99
Stage 2	160 or higher	100 or higher
***Low** Blood Pressure	90 or below	60 or below

*Mayo Clinic definition for elderly.

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, including orthostatic BP taken while lying, sitting and standing, if feasible
- Any associated signs of related neurological or cardiac decline including altered level of consciousness, significant new neurological abnormalities, cardiac rate or rhythm disturbances
- Any associated signs of hemorrhage, including bleeding, bruising, and tenderness
- Pain evaluation
- Headache, facial flushing, nose bleed, and fatigue (hypertension)
- Tachycardia, weak or thready pulse, weakness, dizziness, confusion, or cool, pale, dusky or cyanotic skin (hypotension)

MEDICAL HISTORY

- Patient's age and sex
- Usual BP patterns over time, including any correlation with medication adjustments
- Any associated symptoms of related neurological or cardiac decline including chest pain, dizziness, lightheadedness, blurred vision, headache, weakness or fatigue, difficulty breathing, palpitations, nausea, vomiting, or dark or bloody stools
- Any changes in color or output of urine
- All current medications, including any recent changes; especially any antihypertensive or cardiac medications
- Recent or current history of chest pain, head trauma, persistent headache, change in level of consciousness, dizziness, and diaphoresis
- All current diagnoses

BLOOD PRESSURE (cont'd)

DRILL IT DOWN

- Was this a sudden and rapid development of extremely high blood pressure (malignant hypertension — send to ER)?
- Hydration status
- New or change in BP medications
- Associated symptoms – chest pain, dizziness, lightheadedness, blurred vision, headache, weakness, or fatigue, difficulty breathing, palpitations, nausea, vomiting, or dark or bloody stools
- LABS: CBC, BMP
- Chest radiographs
- UA

DIAGNOSES TO CONSIDER:

High Blood Pressure (↑BP)

- Common causes
  - CHF (fluid overload)
  - CVA (acute)
  - Incorrect cuff size
  - Medication non-adherence or recent change
  - Medication side effects (steroids, NSAIDS, rebound of clonidine effect)
  - Pain (uncontrolled)
- Other causes
  - Anxiety
  - Cardiac disease
  - Medication (excess or non-compliance)
  - Renal failure

Low Blood Pressure (↓ BP)

- Abrupt cessation or decrease of chronic steroids (adrenal crisis)
- Bleeding / Anemia
- Cardiac disease
- Hypovolemia (including over-diuresis)
- Infection (Sepsis)
- Medication side effect
- Paraplegia

BLOOD PRESSURE (cont'd)

SEND OR KEEP?

Transfer to ER if: patients presenting with hypertensive crisis, sepsis, volume loss due to bleeding, severe volume loss due to vomiting and or diarrhea, inadequate intake when systolic blood pressure is less than 90, anaphylaxis, hypo adrenal shock or unresponsiveness. Malignant hypertension is a medical emergency and has to be managed in ER promptly.
Keep in facility if: BP changes are tolerated and are caused by medication excess, hypovolemia, infections, anxiety, or if non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Maintain hydration – push oral fluids
- IV fluids or clysis if appropriate
- Change / adjust blood pressure medication
- Determine hypertension urgency / emergency
- Review labs and medications

FOLLOW UP:

Within first 24 hours:
Evaluate patient clinical situation and treat appropriate underlying cause.

Next business day:
Patients should be followed up within 24 hours with review of labs, and regular measurement of blood pressure.

Next scheduled visit:
Make sure to adjust treatment / management plan if needed and treat underlying etiology.

☐ BRUISE

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Description of bruise
- Pain evaluation (location, nature, severity, etc.)
- Injury evaluation (any associated bleeding, deformity, swelling, etc.)
- Evidence of a recent fall

MEDICAL HISTORY

- Patient's age and sex
- All current medications, including any recent changes; especially anticoagulants, NSAIDs, salicylates and other platelet inhibitors
- Behavior over last 48 hours (especially whether patient has movement disorder or aggressive behavior)
- Any history of tendency to easy bruising
- All current diagnoses
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Detailed description (type, size, color, any exudates, odor, peri wound tissue, undermining, etc.)
- Review of medication – especially anticoagulants and antithrombotics, SSRIs, steroids, depakote, NSAIDS, etc.
- Concern for hematoma – symptomatic anemia
- Accidental vs. person to person trauma
- Risks for easy bleeding
- CBC and clotting factor assay
- Consider possible staff or patient to patient abuse
- Trauma
- Incident report to investigate cause of bruise

BRUISE (cont'd)

DIAGNOSES TO CONSIDER:

- Medications – anticoagulants, antithrombotics
- Thrombocytopenia
- Trauma accident – self-induced vs. environmental vs. fall

SEND OR KEEP?

Transfer to ER if: patient on warfarin with profuse bleeding, infected bruise with sepsis AND cannot be treated in facility (e.g. requires IV antibiotics and facility does not do IVs), large bruises with suspected bleeding in to internal organs, presenting with severe anemia and hypotension.
Keep in facility if: uncomplicated bruises.

WHAT DO I DO?

- Encourage proper transferring of patients for routine care if the causation
- Trimmed nails for direct care givers
- Consider discontinuing of anticoagulants and antithrombotics
- Protective garments – sleeves, elbow pads
- Local care

FOLLOW UP:

Within 1 – 2 days:
Make next treatment / management decisions based on response to initial interventions. May be done by phone.

☐ BURNS

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Mental status
- Location and detailed description of burn(s)
- Signs of infection (purulent drainage, foul odor, redness or swelling, etc.) at or around burn site
- Pain evaluation (location, nature, severity, etc.)
- Any other injuries sustained at time of burn

MEDICAL HISTORY

- Patient's age and sex
- Detailed description of how burn occurred, especially if new
- Results of burn treatments to date
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Determine the extent of burns, depth of burns (1st, 2nd, 3rd degree) and cause

DIAGNOSES TO CONSIDER:

- Chemical burn
- Cold burns (frost bite)
- Electrical injury
- Radiation burns
- Sunburn (see Blisters section)
- Thermal burn (i.e. hot liquid spill)

BURNS (cont'd)

SEND OR KEEP?

Transfer to ER if: patient presents suspected inhalational injury, has moderate to severe burns, circumferential burns, electric burns, hand, face, eye or genital involvement.
Keep in facility if: 1st degree and superficial 2nd degree burns (i.e. blisters), small scalds, mild frost bite, and mild chemical burns.

WHAT DO I DO?

- If small (less than the size of a fifty cent piece or 3 cm) immerse in cool water, cover with antibiotic ointment or silver sulfadiazine cream, and dry sterile dressing
- Leave blisters intact
- Pain management
- Avoid friction to the area
- Monitor hydration
- Can apply cool water to site up to 24 hours

FOLLOW UP:

Next business day:
Check for secondary infection, monitor hydration, pain management. Intervene appropriately based on symptomology.

☐ CHEST PAIN, PRESSURE OR TIGHTNESS (SEE ALSO ABDOMINAL PAIN, DYSPNEA, NAUSEA AND VOMITING)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, including changes such as increased/decreased pulse rate and rhythm, blood pressure, and respiratory rate
- Heart and lung evaluation, including any rales, wheezes, rhonchi, labored breathing, jugular vein distension, and peripheral edema
- Abdominal evaluation for epigastric discomfort to palpation
- Pain evaluation including quality (tightness or heaviness, pressure, radiating, localized, or vague discomfort), onset and duration of the pain, and precipitating, aggravating (such as increased pain with movement or touch), and relieving factors
- Evidence of musculoskeletal pain
- Signs of dizziness, palpitations, nausea, or indigestion, cyanosis
- Skin (cool and clammy, diaphoretic)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and intensity of symptoms
- If chronic, comparison of current to usual symptoms
- Relieving factors (such as antacids or nitroglycerin, position changes, etc.)
- All current medications, including any recent changes
- Related history of cardiac or GI problems
- All current diagnoses
- Recent lab or diagnostic test results, including EKG results, if available

CHEST PAIN (cont'd)

DRILL IT DOWN

Is the pain life threatening or non-life threatening? (Patients should be transferred to the ER when cardiac cause of chest pain has been established, if they do not have a do not transfer order)

- Advanced directive, allow natural death, or code status
- If on a SNF Med A stay, why? (e.g. post hip / knee replacement)
- Check history and diagnoses sheet for cardio and pulmonary disorders?
- Pain reproducible with touch or movement?
- Vital signs – including O2 sats.
- Does Nitroglycerin relieve the pain?
- LABS: CBC, BMP

DIAGNOSES TO CONSIDER:

Cardiac causes

- Acute coronary syndrome—MI / unstable angina
- Pericarditis – more severe pain lying down, feels better sitting up, worse when take a deep breath – can occur S/P CABG

Gastrointestinal causes

- Cough-induced rib pain
- GERD
- Medication induced esophagitis (Fosamax, ASA, potassium, MSAIDS, Ca channel blockers)

Pulmonary causes

- Cough-induced rib pain
- Pneumonia / pleurisy
- Pneumothorax
- Pulmonary embolus – sudden shortness of breath, chest pain associated with taking a deep breath

Musculoskeletal causes

- Costochrondritis
- Musculoskeletal pain
- Skin and sensory nerves (e.g. herpes zoster)

CHEST PAIN (cont'd)

SEND OR KEEP?

Transfer to ER if: concerned about acute coronary syndromes, aortic dissection, pulmonary embolus, pneumothorax, and are consistent with advanced directives.
Keep in facility if: multiple comorbid conditions for cardiac disease, herpes zoster, if advance directives state DNI (do not hospitalize), keep in observation in the facility. Also if non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- If suspicion for CAD/MI – CALL 911 – EMS if consistent with goals of care and are consistent with advanced directives
- Portable chest X-ray if suspect pneumonia / pleurisy
- Order appropriate labs
- Treatment of dyspepsia
- Cardiologist referral if indicated

FOLLOW UP:

First 24 hours:
Come into facility to perform physical and differential diagnosis. Treat and manage according to findings. Follow up labs and manage appropriately.

Next business day:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Check labs, medication review.

Next scheduled visit:
Stratify risk for cardiac disease, update code status, update advance directives and goals of care, medication review. Follow-up on last interventions to see if adjustments are needed.

☐ CONFUSION (SEE ALSO AGITATION OR BEHAVIORAL DISTURBANCE, MEMORY LOSS, SODIUM ABNORMAL)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological evaluation, including any signs of motor weakness, facial weakness, lethargy, or significant change in function
- Any signs of respiratory distress, O2 sats.
- Signs of nausea and vomiting
- Blood sugar level (finger stick)
- Signs of fluid imbalance
- Any signs or symptoms of acute infection (fever, chills, changes in urinary pattern, etc.)
- Signs of bruising or other injury
- Pain evaluation (location, nature, severity, etc.)
- Evaluate and collect details of mood, behavior, orientation, and alertness

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency of problem
- Food and fluid intake patterns over previous week
- Full description of behavior compared to usual behavior
- All current medications, including any recent changes
- Any history of acute or chronic psychiatric disorders
- Current status of bowel and bladder function
- Any recent history of fall, head trauma injury
- Findings from previous neurologic or psychiatric consultations
- All current diagnoses
- Any recent lab or diagnostic test results, including blood sugar, if patient is a diabetic

CONFUSION (cont'd)

DRILL IT DOWN

- Medication history
- If on a SNF Med A stay, why? (e.g. recent surgery, suspect delirium)
- Finger stick glucose check, if diabetic
- Any new focal neurological findings – CVA
- S/S of infection
- LABS: CBC, BMP, UA
- Urine toxicology screen (consider only if you feel patient is abusing drugs; send them to ER for urine drug screen and alert DON)

DIAGNOSES TO CONSIDER:

- Advancing dementia
- Arrhythmias
- CHF
- Constipation / urinary retention
- CVA
- Delirium (lethargy, change in MS)
- Dehydration / electrolyte imbalance
- Hypoglycemia (if diabetic)
- Hypotension
- Hypoxia
- Infection (UTI, pneumonia, sepsis)
- Medication S/E
  - Anticholinergics
  - Coumadin
  - Digoxin
  - Dilantin
  - Isosorbide
  - Lasix
  - Lithium toxicity

CONFUSION (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Nifedipine
- Ranitidine
- Theophylline
- Medication changes, recent
- Pain (especially in persons with dementia)
- Sleep loss, change in environment / sensory deprivation or overload
- Sundowning (persons with dementia)

SEND OR KEEP?

Transfer to ER if: patient is unresponsive, new focal neurologic finding.
Keep in facility if: dehydration / fluid electrolyte imbalance and can be managed in facility, pain, medication side effect, and all other non-emergent conditions / situations.

WHAT DO I DO?

- Confusion assessment method (CAM score of 3 out of 4 equals delirium)
- Check for dehydration, infection, malnutrition, sensory impairments, cognitive impairment, mood disorders, substance abuse
- Medication review
- Reorientation to time, place, person
- Request stimulating activities
- Correct sleep deprivation
- Correct for vision and hearing
- Ensure adequate hydration
- Support culture change, home like environment, minimize noise, consistent assignment, etc.

CONFUSION (cont'd)

FOLLOW UP:

In 24 hours:

Follow-up on any intervention / any test results. Come in to facility to perform a differential diagnosis, if needed.

Next business day:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ CONVULSIONS OR SEIZURES

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological evaluation, including any evidence of significant change in level of consciousness
- Details (location, duration, severity, and recurrence, etc.) of any seizure activity, including localized or generalized motor activity, bowel or bladder incontinence, or behavioral changes
- Details of any injury or complications associated with the convulsion or seizure

MEDICAL HISTORY

- Patient's age and sex
- Any history of seizure disorder or actual seizure activity
- All current medications, including any recent changes, particularly medications associated with increased seizure risk
- All current diagnoses
- Date and time of any recent or current seizure activity
- Comparison of any current seizure activity related to usual patterns
- Related and recent lab or diagnostic test results, especially BMP, calcium, and anticonvulsant blood levels

DRILL IT DOWN

- New seizure or known seizure history? (first time seizure will normally need ER evaluation)
- Review medications – new / recent changes?
- Recent falls / head trauma?
- Anticoagulation treatment?
- Check O2 sats. (R/O hypoxia)
- Consider urine drug screen
- Check blood sugar (R/O hypoglycemia)
- LABS: CBC, UA, CMP, seizure medication drug level

CONVULSIONS OR SEIZURES (cont'd)

DIAGNOSES TO CONSIDER:

- Breakthrough seizure while on antiseizure drugs
- CVA
- Delirium
- Head trauma
- Hypoglycemia
- Infection (lowers threshold for seizures)
- New seizure disorder
- Sleep disorders
- Subdural
- TIA

SEND OR KEEP?

Transfer to ER if: seizure due to hypoxia or hypoglycemia, persistent mental changes, arrhythmias, alcohol withdrawal, acute head trauma, status epilepticus, first seizure, post-seizure new focal deficit, if head CT or MRI of brain required.
Keep in facility if: history of seizure disorder and etiology of breakthrough seizure identified and is treatable at facility.

WHAT DO I DO?

- ABC – Airway, breathing, circulation
- Order appropriate labs
- Consider reloading patient with seizure medications while labs are pending
- Remove potential drug interactions causing lowered seizure threshold (e.g. wellbutrin, cipro, seroquel, etc.)

CONVULSIONS OR SEIZURES (cont'd)

FOLLOW UP:

In 24 hours:

Come in to facility to perform a differential diagnosis. Intervene appropriately based on symptomology and test results and patient's advanced directives.

Next business day or within next few days:

(dependent on circumstances): refer to neurology for seizure management or persistent mental status changes over 24 hours. Follow-up on last interventions to see if adjustments are needed.

☐ COUGH

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Head, mouth / throat, teeth / gums evaluations, including signs of swollen tongue, inflamed throat, dental or periodontal disease, nasal congestion or drainage, or sinus tenderness
- Detailed description of cough (dry, hacking, productive)
- Description of sputum, if productive
- Respiratory evaluation, including dyspnea, wheezing, rales – rhonchi, use of accessory muscles, any cyanosis
- Pain with cough
- O2 sats.
- Any signs related to the gastrointestinal (GI) tract, such as epigastric discomfort, or abdominal pain

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, exacerbating and relieving factors
- Any symptoms related to nasal congestion, postnasal drip, sore throat, etc.
- Whether cough has any relation to meals (if cough occurs several hours after eating, etc.)
- Whether cough is associated with patient's position (worse when lying down, etc.)
- Whether cough is persistent or intermittent, or is disturbing sleep
- Any recent history of pneumonia, bronchitis, tracheitis, or sinusitis
- Last meal intake (aspiration)
- History of aspirations?
- Any history of smoking
- Does cough improve upon exposure to cold air?
- All current medications, including any recent changes; especially medications associated with cough such as ACE inhibitors
- All current diagnoses
- Any recent labs (CBC, electrolytes) and diagnostic tests

COUGH (cont'd)

DRILL IT DOWN

- Review current medications
- Any change in color of sputum?
- Is cough keeping patient up at night?
- Any orthopnea? (SOB with lying down)
- Associated fever, SOB, chest pain, or oral intake
- Lung exam
- Is there a build of ear wax? (dry and unproductive cough is a sign of impacted ear wax)
- Recent chest radiography

DIAGNOSES TO CONSIDER:

- Aspiration
- Cardiac
- COPD exacerbation vs. chronic cough
- Foreign body
- Infectious (pneumonia, bronchitis, viral URI)
- Medication reaction – ACE inhibitors
- OTO – cough reflex (i.e. cerumen impaction)
- Post-nasal drip
- Silent GERD
- Smoker's cough
- Sputum color change
  - White – cold, viral, bronchitis
  - Yellow / green – bacterial infection
  - Rust – TB, pneumococcal pneumonia
  - Pink / frothy – pulmonary edema

COUGH (cont'd)

SEND OR KEEP?

Transfer to ER if: cough due to massive aspiration, pneumonia with hypotension.
Keep in facility if: cough due to reflux, medication, aspiration, asthma, post nasal drip, smokers cough, COPD exacerbation, non-emergent situation and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Change medication if causing cough
- Symptomatic treatment – such as cough drops or cough syrup (put stop date with order)
- Swallowing evaluation if associated with aspiration
- Treatment of underlying conditions
- Encourage smoking cessation
- Order appropriate labs, radiologic tests

FOLLOW UP:

Within 72 hours:
Check intervention. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

☐ DEPRESSED MOOD (SEE ALSO SUICIDE POTENTIAL IF SUICIDAL IDEATION IS PRESENT)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological, behavioral, and cognitive evaluations including affect, level of consciousness, responsiveness, or cognitive function
- Any signs of lethargy, confusion, apathy, weakness
- Pain evaluation (location, nature, severity, etc.)
- Any actions by the patient that could reflect an effort to injure or kill himself / herself
- Results of depression screening (PHQ-9 score)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of signs and symptoms, including crying, sleeplessness, or anorexia
- Level of activities of daily living (ADLs) performance
- Extent of socialization and participation in activities
- All current medications, including any recent changes; especially those known to cause depression, or suicidal ideation
- All current diagnoses
- Recent or current medical, psychological or social episodes related to grief or loss, such as death of a family member
- Any statements by the patient that could reflect patient desire or plan to injure or kill himself / herself
- Any recent psychiatric consults or treatments

DEPRESSED MOOD (cont'd)

DRILL IT DOWN

- Recent MI / CVA?
- Recent onset or chronic or seasonal?
- Recent weight loss / gain, slowed thoughts, speech, appetite changes?
- Access suicidal risk
- LABS: CBC, thyroid screen, UA, urine tox screen

DIAGNOSES TO CONSIDER:

- Adjustment disorder (#1)
- Major Depression (#2)
- Cancer
- Dementia-related apathy
- Medication side-effects – such as betablockers, cloridine
- Normal grief reaction
- Pain
- Post-stroke or post-MI depression

SEND OR KEEP?

Transfer to ER if: patient has suicidal / homicidal ideations with a plan.
Keep in facility if: outpatients follow up can be recommended if organic causes are ruled out or treated, if the patient is not in danger to self or others.

DEPRESSED MOOD (cont'd)

WHAT DO I DO?

- Transfer to mental health hospital or geriatric psych unit if risk to self and others
- Close observation
- Consider treatment of dementia if dementia-related apathy
- Treatment of pain
- Adjustment of antidepressant medications
- Psychiatry consult / counseling in facility, light therapy, exercise and increased activities

FOLLOW UP:

Next scheduled visit 1 – 7 days:

Intervene appropriately based on symptomology, abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions.

☐ DIABETES, POORLY CONTROLLED

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Any symptoms of a current acute illness including infection (urinary, skin / wound, respiratory, etc.) or an unstable chronic condition
- Significant changes in function, level of consciousness, orientation, mood and cognition

MEDICAL HISTORY

- Patient's age and sex
- Patient's blood sugars over past week compared to usual trend over recent months
- Onset and duration of any blood sugar changes
- Changes in food and fluid intake and urine output over the past week
- All current medications, including any recent changes
- All current diagnoses
- Doses and times of most recent anti-hyperglycemic medication given (oral or insulin)
- Recent lab or diagnostic test results
- Results of finger stick blood sugar, if available, including average daily glucose levels
- Recent or current changes in dietary intake; for example, family started bringing in food
- Any current skin breakdown
- Presence of neuropathy
- Baseline A1c
- Any new infection

DIABETES, POORLY CONTROLLED (cont'd)

DRILL IT DOWN

- Medication review (antipsychotic agents — both first- and second-generation, β-Adrenergic agonists, Ca channel blockers, glucocorticoids, estrogens, levodopa, megestrol acetate, nicotinic acid, opiates, phenytoin, protease inhibitors, thiazides, furosemide and thyroid hormone)
- Review recent meal intake
- Accucheck records for over 1 week to check trend
- Check medical record for the following medical conditions that can cause hyperglycemia (acute infections; obesity, metabolic syndrome, diseases of the pancreas (e.g. pancreatitis, pancreatic trauma, pancreatectomy, pancreatic cancer, hemochromatosis); endocrine diseases (e.g. Cushing's syndrome, hyperthyroidism, acromegaly, glucagonoma, pheochromocytoma, aldosteronoma); genetic defects of beta cell function or insulin action; other genetic syndromes (e.g. Down's syndrome, Klinefelter's syndrome, Friedreich's ataxia, Huntington's chorea, myotonic dystrophy)
- LABS: fasting or random (casual) blood glucose test, lipid levels, urine for the presence of proteinuria
- Assess renal function (glomerular filtration rate)

DIAGNOSES TO CONSIDER:

- Inappropriate accuchecks — such as immediately after eating
- Acute infection
- Dietary indiscretion
- Medication non-adherence
- Medication induced (steroids, antipsychotics, thiazides, dilantin, beta agonists)

If the following conditions are present, evaluate to determine if problem is caused by diabetes or by another medical condition:

- Charcot joint
- Congestive heart failure (CHF)

DIABETES, POORLY CONTROLLED (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Coronary artery disease (CAD)
- Delayed wound healing
- Foot ulcers
- Hyperlipidemia
- Hypertension (especially nocturnal hypertension)
- Neuropathic pain (deep, gnawing pain)
- Oral infections, severe caries, and periodontal disease
- Orthostatic hypotension, dysautonomia
- Peripheral arterial disease
- Proteinuria (in the absence of infection) and renal insufficiency
- Tingling, burning, numbness in extremities (peripheral neuropathy)
- Urinary incontinence
- Urinary retention or frequent urinary tract infections
- Vomiting, diarrhea, constipation (gastroparesis)
- Weight loss

SEND OR KEEP?

Transfer to ER if: BS over 400 and lethargic, change in mental status.
Keep in facility if: response with oral medications, insulin or treating precipitating etiology.

WHAT DO I DO?

- Adjust oral meds or long acting insulin
- Sliding scale insulin should be individualized and used acutely for one week maximum
- Reduce or discontinue offending agents
- Encourage medication adherence

DIABETES, POORLY CONTROLLED (cont'd)

WHAT DO I DO? (cont'd)

- Prescribe liberalized diet and adjust treatment rather than adhere to ADA therapeutic diet
- Treat underlying hyperglycemic trigger such as infection
- If patient refusing medications, then discuss goals of care

FOLLOW UP:

Next scheduled visit 1 – 7 days:

Review blood glucose checks in one week and continue to adjust / evaluate intervention. If on sliding scale, calculate average daily glucose and switch to basal / basal – bolus regime.

☐ DIARRHEA

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially lying, sitting, and standing blood pressure (if obtainable) and pulse
- Abdominal evaluation, including presence of abdominal pain, tenderness, distension, guarding
- Detailed description of bowel movements, including quantity, frequency, consistency (loose, soft, watery, etc.), severity, contents (blood, pus, mucus), etc.
- If there has been continuous oozing of liquid stool (paradoxical diarrhea) perform a digital rectal evaluation to check for pain, tenderness, mass, or presence of hard, dry stool in the rectum
- Any change in mental status, function, mood, behavior, or level of consciousness

MORE

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of signs and symptoms
- Any GI symptoms including bloating, gas, cramping, fecal urgency, or constipation alternating with diarrhea
- Any changes in nutritional intake (spicy foods, high fiber foods, caffeine, etc.)
- All current medications, including any recent changes, especially recent or current antibiotic therapy and medications that are known to affect bowel motility
- All current diagnoses, especially history of upper or lower gastrointestinal (GI) medical conditions, history of bowel obstructions, or of irritable bowel syndrome
- Recent lab (electrolytes) or diagnostic test results

MORE

DIARRHEA (cont'd)

INFORMATION YOU SHOULD GET FROM THE NURSE (cont'd)

PHYSICAL DATA

- Signs of possible fluid volume depletion or dehydration (postural pulse difference — increase from lying down to sitting or standing of 30 beats per minute or more, tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased confusion, fever)

MEDICAL HISTORY

DRILL IT DOWN

- History: sick contacts, recent (less than 60 days) antibiotic use
- Associated symptoms? – nausea vomiting, abdominal pain, fever, black tarry stools, rectal bleeding
- Duration?
- R/O impaction
- Hydration status, orthostatic hypotension
- LABS: BNP, CBC, stool examination including *C-diff* toxin, stool cultures
- Recent antibiotic use, recent exposure, bloody diarrhea, fever

DIAGNOSES TO CONSIDER:

- *C. Difficile* colitis
- Drugs – laxatives, colchicines, metformin or antibiotics or PPI
- Fecal impaction
- Food contamination / intolerance
- Ischemic colitis
- Lactose intolerance

DIARRHEA (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Malabsorption
- Viral syndrome (G.I. bug)

SEND OR KEEP?

Transfer to ER if: hemodynamically unstable, systemic toxicity, fever greater than 100.4°F, blood in diarrhea, severe abdominal pain.
Keep in facility if: hemodynamically stable, identifiable reversible cause, tolerating oral fluids / IV fluids, uncomplicated C. Difficile colitis.

WHAT DO I DO?

- Stop / hold laxatives
- Provide rehydration and replacement of important electrolytes and calories, usually accomplished with oral fluids – consider IV or SQ clysis if needed
- BRAT diet — avoid milk, all fruit juices, coffee, alcohol, fatty or fried foods until diarrhea has resolved
- Supportive treatment
- Consider probiotics
- Anti-diarrhea medications only if diarrhea is not due to infectious cause or absence of fever and limit duration to a few days
- Antibiotics only if indicated (for infectious diarrhea)
- Order any labs if needed

DIARRHEA (cont'd)

FOLLOW UP:

Within 72 hours:

Evaluate intervention(s). Adjust if needed.

Next scheduled visit in 1-7 days.

Reassess the patient's bowel pattern and discontinue any short term treatment if the pattern returned to normal. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ DIZZINESS / LIGHTHEADEDNESS

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially lying, sitting, and standing blood pressure (if obtainable) and pulse
- Neurological evaluation, evaluate for weakness, confusion, blurred or double vision
- Description of effort to stand and ambulate, including whether the individual staggers or tends to fall to one side or another
- Any significant changes in function, mood, behavior, cognition, or level of consciousness
- Signs of vertigo (inspect external ear for signs of redness, drainage, swelling, etc.)
- General appearance. Fidgeting and eyelid twitching
- Blood sugar level

MEDICAL HISTORY

- Patient's age and sex
- Detailed description of the symptoms (lightheaded-ness vs. vertigo, nausea, vomiting, etc.)
- Onset, duration, frequency, and severity of signs and symptoms; things that make it better or worse (turning head, lying down, standing up, etc.)
- All current medications, including any recent changes
- All current diagnoses
- Recent lab or diagnostic test results
- Fluid intake over past week

DRILL IT DOWN

- Last history and physical report
- Duration
- Ask for lateralization of symptoms, aggravating and relieving factors, any intermittent or continuous, hearing loss, syncope, head ache, tinnitus, vertigo

DIZZINESS / LIGHTHEADEDNESS (cont'd)

DRILL IT DOWN (cont'd)

- Any past medical history of CHF, COPD, diabetes, CVA
- Medication review
- Ear examination – fluid behind eardrum, cerumen impaction
- LABS: CBC, BMP

DIAGNOSES TO CONSIDER:

Common diagnoses

- Lightheadedness – R/O low BP
- Vertigo – R/O benign paroxysmal positional vertigo (BPPV)
- Unsteady balance – evaluate gait and balance (see Falls / Ambulation section)
- Foggy thinking – evaluate for dementia / cognitive loss

Other diagnoses

- Anemia
- Anxiety / depression
- Brain stem CVA / CNS masses
- Cardiovascular disease (ischemia, valvular problems, arrhythmias)
- Drug side effects
- Inner ear pathology
- Orthostatic hypotension / volume depletion / dehydration

SEND OR KEEP?

Transfer to ER if: arrhythmias, CVA, intractable vomiting, gait abnormality, central vertigo, new focal neurologic deficits, new onset hearing loss.
Keep in facility if: inner ear pathology, anemia, hypoglycemia, anxiety / depression, non-emergent and facility can meet patient needs (see Appendix 1).

DIZZINESS / LIGHTHEADEDNESS (cont'd)

WHAT DO I DO?

- Medication review
- Dix-Hall pike test – if positive for BPPV – vestibular rehabilitation
- Treat underlying cause
- Hydration
- Orthostatic hypotension evaluation
- Focal neuro findings and neuro imaging
- Romberg and cerebellar function tests
- Cardiac exam and EKG
- Vestibular function tests

FOLLOW UP:

Next scheduled visit in 1-7 days.

Intervene appropriately based on symptomology, abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions.

☐ DRUG LEVELS (SERUM) ELEVATED OR TOXIC

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Any signs of side effects related to the higher than the therapeutic level related to that particular drug (for example, unsteady gait in someone with antiepileptic toxicity or bleeding in someone on anticoagulants with an elevated Prothrombin Time / INR)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of signs and symptoms
- Current and previous lab or diagnostic test results in relation to current and previous dosages
- All current medications, including OTC, herbals
- All current diagnoses

DRILL IT DOWN

- Any recent change or new medication
- Associated symptoms, any change in MS?
- Any hemolysis or blood draws?
- Does the patient have ESRO – dialysis and did they miss it?

DIAGNOSES TO CONSIDER:

If on any of the following, order levels as appropriate:

- Amiodarone
- Carbamazepine
- Digoxin
- Dilantin
- Lithium
- Phenobarbital
- Phenytoin
- Potassium
- Theophylline
- Valproic Acid
- Vancomycin
- Warfarin

DRUG LEVELS (SERUM) ELEVATED OR TOXIC (cont'd)

SEND OR KEEP?

Transfer to ER if: presented with acute toxicity – loss of consciousness, arrhythmias, or respiratory distress. If severe hyperkalemia (K greater than 6) – need EKG to evaluate peak T wave changes.
Keep in facility if: for mild elevated drug level keep in the facility and monitor vitals and mental status.

WHAT DO I DO?

- Think of drug-drug, drug-disease, or drug-nutrient interactions on medication review
- Dose adjustment based on drug level
- Dose adjustment specifically for renal and hepatic disorders and for low albumin
- Symptomatic support
- Assess indication of medication
- If missed dialysis, consider sodium polystyrene sulfonate oral 15-60 gm for severe hyperkalemia
- Check frequency of labs
- Order next drug level as appropriate

FOLLOW UP:

Next business day:

Make next treatment / management decisions based on response to initial interventions and recent drug level results if ordered.

☐ DYSPNEA (ALSO ASTHMA, COPD EXACERBATION, SOB) (SEE ALSO CHEST PAIN, EDEMA, EKG ABNORMAL)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, including changes such as increased / decreased pulse rate and rhythm, blood pressure, and respiratory rate and rhythm
- Heart and lung evaluation including rales, wheezes, rhonchi, and labored breathing, cough, pursed lip breathing, O2 sats.
- Signs of cyanosis, molting
- Abdominal evaluation for epigastric tenderness
- Pain evaluation including quality (tightness or heaviness, pressure, vague discomfort, etc.), onset and duration of the pain, and precipitating factors
- Presence of ascites or edema of extremities or face
- Description of symptoms (occur with activity or rest, constant or intermittent, began suddenly or gradually)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and intensity of symptoms
- If chronic, comparison of current to usual symptoms
- Relieving factors (such as antacids or nitroglycerin, oxygen administration, position changes, etc.)
- Aggravating factors
- All current medications
- Related history of cardiac or GI problems, recent trauma, smoking
- All current diagnoses, especially those related to cardiac and pulmonary conditions
- Any recent lab or diagnostic test results, including EKG results, if available

DYSPNEA (cont'd)

DRILL IT DOWN

- Code status (#1)
- If on a SNF Med A stay, why? (e.g. rehab?)
- Recent history and physical exam
- Any underlying pulmonary disease
- Report on associated symptoms (pale / ash appearance, diaphoresis, pursed lip breathing, tripod sitting etc.)?
- Any lung function tests
- Imaging of the chest – plain radiographs
- LABS: CBC, BMP, BUN / creatinine, liver function tests

DIAGNOSES TO CONSIDER:

- Angina (unstable)
- Anemia
- Anxiety and panic attacks
- Arrhythmia
- Asthma
- Congestive heart failure
- COPD exacerbation
- Foreign body aspiration
- Interstitial lung disease
- MI
- Pulmonary embolism
- Pleural effusion
- Pneumothorax
- Pulmonary edema
- Pulmonary tumors
- Vocal cord dysfunction

SEND OR KEEP?

Transfer to ER if: hypoxia with fatigue, needs mechanical ventilation, pulmonary edema, unstable angina, MI, SOB and mental status change, unable to maintain O2 sats., severe respiratory distress, impending respiratory arrest, if interventions do not improve respiratory status.
Keep in facility if: interstitial lung disease, congestive heart failure, anemia, anxiety or panic attacks, if intervention improves respiratory status.

DYSPNEA (cont'd)

WHAT DO I DO?

- Treat underlying causes
- Bronchodilators
- Antibiotics to treat infections
- Anxiolytics for psychogenic causes
- Steroids
- Order lung function tests, pulmonary radiographic imaging
- Order onsite spirometry if available to facility
- Ventilation (O2)
- EKG, echocardiogram, cardiac enzymes, cardiac imaging
- Send for surgical intervention if needed and does not conflict with advanced directives

FOLLOW UP:

Within first 24 hours:

If patient was sent to ER and sent back to facility follow up within 24 hours: Check respiratory rate, chest X-ray, O2 sats., mental status (as compared to base line). If no ER visit intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit 1 – 7 days:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ EARACHE

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Pain evaluation (location, nature, severity, etc.) of both external and internal ear
- Does the earache worsen when patient changes positions?
- Any difficulty swallowing, hoarseness, neck pain, or pain when opens mouth?
- Presence of bleeding or discharge from the ear canal
- Current ability to hear sounds and voices, compared to usual
- Any ringing, swishing or other noise in ears, any dizziness?
- Inspect external ear for redness, drainage, swelling or deformity

MEDICAL HISTORY

- Patient's age and sex
- Onset, nature, duration, frequency, and severity of symptoms
- Any recent trauma or ear injury, any discomfort associated with itching
- Has showering triggered ear discomfort?
- Any recent cold or problems with eyes, mouth, teeth, jaw, sinuses, or throat
- History of partial or total hearing loss in one or both ears
- All current medications, including any recent changes
- Any current or recent treatments related to the ear
- Use of hearing device
- Any changes in gait or balance

DRILL IT DOWN

- Recent Q-tip or fingers in ear canal
- Ask nurse to look with otoscope if one available
- Fever

EARACHE (cont'd)

DIAGNOSES TO CONSIDER:

- Cerumen impaction (#1)
- Otitis externa (#2)
- Otitis media with effusion or tympanic membrane perforation (#3)
- Dental disorders
- Foreign body
- Malignant otitis externa – rare but occurs in uncontrolled DM-2
- Referred pain from pharynx area
- Tympanic membrane perforation

SEND OR KEEP?

Transfer to ER if: malignant otitis externa – high mortality rate and requires urgent ENT consultation and admission for IV antibiotics.
Keep in facility if: otitis externa and media.

WHAT DO I DO?

- Otitis media: amoxicillin
- Visual inspection and with otoscope
- Otitis externa: pain control, topical antimicrobials for 10 days, hydrocortisone ear drops
- Pain control
- Consider ENT if patient is persistent or cholestoma with associated hearing loss
- Common impaction – carbamide peroxide drops for seven days then ear irrigation
- LABS (if appropriate): CBC if suspect infection, culture if drainage

EARACHE (cont'd)

FOLLOW UP:

First 24 hours:

Intervene appropriately based on symptomology and abnormal test results.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed.

☐ EDEMA

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Respiratory evaluation (including SOB, frothy sputum, rales rhonchi, wheezing) and cardiac evaluation
- Location, extent (for example, ankle, up to mid-calf, etc.), and nature (for example, pitting or non-pitting) of edema
- Does the edema move throughout the day (for example from upper extremities to the lower extremities)?
- Is the edema worse in the morning or throughout the day? Is it affected by position changes? Is it accompanied by shortness of breath?
- Measurement and comparison of circumference of edematous area (if location of edema permits) at same level from day to day
- If patient is bed ridden evaluate the back, sacrum, and hips for dependent edema
- Evaluate skin temperature, palpate peripheral pulses, note whether feet and hands are cold
- Signs of pain, tenderness, warmth, or redness in edematous area(s)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, progression, of symptoms
- Current weight, compared to usual, including any recent changes, including how rapidly weight changes from day to day
- Patient's activity level, including percentage of time each day spent sitting, walking, and lying down, if known
- Recent or previous history of edema, heart failure, renal failure, phlebitis, venous stasis
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

EDEMA (cont'd)

DRILL IT DOWN

- If on a SNF Med A stay, why? (e.g. knee replacement?)
- Recent PICC line use?
- Evidence of new renal failure (decreased urine output, SOB, fatigue, confusion, nausea)
- New onset CHF or decompensating CHF
- Is Edema dependent or stasis?
- Recent labs TSH, BMP, albumin, digoxin level (if on digoxin)
- Liver function tests
- Ultrasound

DIAGNOSES TO CONSIDER:

- Medications side effects are the #1 diagnosis to consider: gabapentin, pramipexole minoxidil, diazoxide, megace, thiazolidinedione's, Ca channel blockers (particularly nifedipine), nonsteroidal antiinflammatory drugs, fludrocortisone, estrogens
- Angioedema
- CHF
- Dependent edema venous insufficiency / stasis
- Deep vein thrombosis
- Hypoalbuminemia (albumin equal to or less than 2) – malnutrition
- Lymphedema
- Malignancy (bulky abdominal masses)
- Nephrotic syndrome / renal failure
- Trauma (large hematoma)
- Thyroid disease (myxedema)
- Cirrhosis
- Recent PICC line use

EDEMA (cont'd)

SEND OR KEEP?

Transfer to ER if: patient presents deep vein thrombosis, CHF (new or severe exacerbation), lymphatic obstruction, acute renal failure, angioedema (unless in opposition of advanced directives).
Keep in facility if: CHF with good ejection fraction, nephrotic syndrome, hypoalbuminemia, thyroid disease, liver disease, malignancy without complication.

WHAT DO I DO?

- Leg elevation and compression stockings
- Unilateral LE/UE edema – R/O deep vein thrombosis – order doppler imaging of lower extremities (if edema unilateral and especially if thigh – not calf – edema)
- Anticoagulation if deep vein thrombosis
- Diuretics as indicated for CHF
- Improve nutrition – especially high protein intake
- Stop offending medication or decrease dosage
- Order labs (if not done recently): TSH, BMP, albumin, digoxin level (if on digoxin)

FOLLOW UP:

In 24 hours:
Follow-up on last interventions to see if adjustments are needed. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit in 1 – 7 days:
Intervene appropriately and timely based on symptomology, diagnosis, abnormal test results and patient's advanced directives.

☐ EKG, ABNORMAL (SEE ALSO CHEST PAIN, DIZZINESS, DYSPNEA)

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, including pulse rate and rhythm
- Heart and lung evaluation, including any rales, wheezes, rhonchi, labored breathing, jugular vein distension, and peripheral edema
- Any signs of acute illness

MEDICAL HISTORY

- Patient's age and sex
- Any symptoms such as palpitations, chest pain, skipped beats, lightheadedness, dizziness, or dyspnea
- Results of current EKG and change from last EKG if available
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Why was the EKG done?
- What did previous EKG show?
- Was the EKG done with symptoms or after resolution of symptoms?
- Recent labs: CBC, urine toxicology screen, BMP, cardiac enzymes
- Recent echocardiography, chest radiography.

DIAGNOSES TO CONSIDER:

- Acute MI
- Atrial fibrillation
- Electrolyte abnormalities
- "Normal" for this patient
- Medication effect
- Other arrhythmias
- Pulmonary hypertension

EKG, ABNORMAL (cont'd)

SEND OR KEEP?

Transfer to ER if: patient presents new EKG changes consistent with MI, arrhythmias, pulmonary hypertension with dyspnea, pulmonary edema, pericarditis, atrial fibrillation with RVR (rapid ventricular response) (Rate over 150 per minute).
Keep in facility if: mild electrolyte abnormalities, medication side effects, non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Depends on what the EKG shows – i.e. concern for MI – send to ER for evaluation if consistent with advance directives and goals of care
- Rate control
- Correction of electrolyte abnormalities
- Medication review
- Order echocardiography, chest radiography if needed
- Order labs: CBC, urine toxicology screen, BMP, cardiac enzymes if not done recently

FOLLOW UP:

In 24 hours:

Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

☐ EYE INJURIES (FOREIGN BODIES, CHEMICAL BURNS, CONTUSIONS, ETC.)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Eye evaluation, especially detailed description of injured area including location (sclera, conjunctiva, lid, etc.) and related findings (discharge, bleeding, drainage, etc.)
- Pain evaluation (location, nature, severity, etc.)
- Visual acuity and change in vision compared to usual

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, and precipitating factors
- Any treatments administered so far
- Symptoms of eye pain (blurred or double vision, loss of vision, etc.)
- History of glaucoma, cataract, retinal detachment

DRILL IT DOWN

- History of photophobia?
- Change in vision, tearing, redness, sensation of foreign body, conjunctiva injection
- Check for ocular movements of eye
- Any foreign body?
- Is eyelid inflamed (blepharitis)?
- Is lower lid turned outwards (ectropion)?
- Is lower lid turned inward (entropion)?
- Which part of the eye is red – white?

EYE INJURIES (cont'd)

DIAGNOSES TO CONSIDER:

- "RED EYE"
  - Blepharitis
  - Conjunctivitis
  - Corneal abrasion
  - Corneal edema
  - Dry eye syndrome
  - Ectropion / endopion
- Accidental injury to iris and lens due to penetrating objects
- Chemical injury (acid, alkali, and other substances due to accidental exposure in severely demented patients)
- Conjunctiva laceration
- Corneal injury (foreign body, laceration)
- Laceration to the lids due to fall
- Orbital fracture secondary to fall

Uncommon (yet serious) diagnoses

- Globe ruptures
- Hyphema (blood in artery or chamber)
- Acute angle glaucoma

SEND OR KEEP?

Transfer to ER if: globe of the eye is involved, chemical injury to eye(s), urgent Ophthalmology consultation needed (e.g. for red fixed pupil – acute glaucoma, sudden vision loss, hyphema, lacerations, herpetic corneal lesion, or photophobia).
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Eyelid exam to look for foreign body
- Flush or irrigation of eye in normal saline
- Eye shield for corneal injuries, control pain, antiemetic, topical ophthalmic antibiotics

EYE INJURIES (cont'd)

WHAT DO I DO? (cont'd)

- Ophthalmology consult
- Never prescribe topical anesthetics or topical steroids
- Consider optometry (in-house) evaluation ASAP
- Flourescein strip for corneal tears (not available at all facilities)
- Ocular exam with using topical anesthetic in the eyes (not available at all facilities)

FOLLOW UP:

In 24 hours:

Intervene appropriately based on symptomology and diagnosis. Assess the extent of eye damage.

☐ FAINTING (SYNCOPAL EPISODE)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially pulse rate and rhythm, orthostatic blood pressure, and O2 sats.
- Neurological evaluation, including signs of seizure activity (tongue biting, incontinence, postictal confusion, etc.) and duration of loss of consciousness
- Signs of injury if patient fell during fainting episode
- Any significant changes in mood, behavior, or cognition
- Blood glucose (finger stick)

MEDICAL HISTORY

- Patient's age and sex
- Details of the episode (onset, duration, whether sitting or standing, any nausea, sweating, any muscle spasms, incontinence, etc.)
- Any history of similar episodes
- All current diagnoses
- Any recent lab or diagnostic test results
- All current medications, including any recent changes; especially those associated with dizziness, hypotension, altered heart rate / rhythm, or lethargy

DRILL IT DOWN

- Review medications – many cause orthostatic hypotension – antipsychotics, trazodone, tricyclic antidepressants, and especially diuretics
- Associated with exertion?
- Associated symptoms with syncope (red flags: syncope while supine, cardiac symptoms, incontinence, prolonged change in consciousness, tongue biting and trauma after syncope may be indicative of lack of warning signs)
- New focal neurological findings?

FAINTING (cont'd)

DRILL IT DOWN (cont'd)

- Fingerstick blood sugar check
- Pain evaluation
- Recent labs, BMP, CBC

DIAGNOSES TO CONSIDER:

- Anxiety/panic attack
- Cardiac – arrthymias, orthostatic hypotension, hypertrophic cardiomyopathy, severe aortic stenosis, or carotid artery stenosis
- CAD (history of)
- Hypoglycemia
- Hypovolemia
- Neurologic – seizure, CVA / TIA
- Pulmonary embolism (PE)
- Vasovaga – on toilet (defecation or urination)
- Vertigo

SEND OR KEEP?

Transfer to ER if: the patient is identified with "true" syncope — seniors have high risk for cardiogenic etiologies — (e.g. age over 60 and history of CAD), chest pain with syncope, first episode of syncope without a known cause, young patients presenting with exertional syncope.
Keep in facility if: non-syncope, (e.g. presyncope or lightheadedness), hypoglycemia, anxiety, vertigo, panic attack, etc., and facility can meet patient needs (see Appendix 1).

FAINTING (cont'd)

WHAT DO I DO?

- Order EKG, cardiac imaging
- Order labs (if none recent): BMP, CBC
- Treat underlying cause

FOLLOW UP:

In 1 – 7 days:

Visit timing dependent on diagnosis. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed.

☐ FALLS (SEE ALSO FRACTURE AND DISLOCATIONS, EKG ABNORMAL, FAINTING)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially orthostatic blood pressure and pulse
- Signs of injury, especially fracture or head injury
- Neuro evaluation if head injury or unwitnessed fall
- If diabetic, blood glucose (finger stick)
- Evidence of joint deformity or change in normal range of motion, weight bearing, etc.
- Any changes in cognition or level of consciousness
- Evidence of localized weakness, poor coordination, impaired balance, abnormal gait
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Frequency and number of falls since last physician visit
- Precipitating factors (dizziness, fainting, environmental factors, etc.) and details of circumstances of the fall
- All current medications, including any recent changes especially those associated with dizziness, hypotension, or lethargy
- New balance problems
- All current diagnoses
- Any recent lab (especially Hct /Hgb, vit D level, TSH, T4) or diagnostic test results

DRILL IT DOWN

- Complete history and physical
- Review all medication and see if patient is on any blood thinners
- Injury from the fall – head injury, fracture, laceration, bruising

FALLS (cont'd)

DRILL IT DOWN (cont'd)

- Indications for head CT – anything newly abnormal on neurological exam, change in mental status
- Check recent labs: CBC, BUN, Ca, Mg, blood glucose, thyroid function, folate, vitamin B12, vitamin D, blood levels of ethanol and current medications

DIAGNOSES TO CONSIDER:

- Alcohol intoxication
- Anemia
- CVA
- Delirium
- Diabetes (hypoglycemia)
- Difficulty with gait, balance and coordination
- Environmental hazards
- Infections
- Medication side effect (and polypharmacy)
  - Antiarrhythmics
  - Anticholinergics
  - Antidepressants (tricyclics, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors)
  - Antidiabetic agents
  - Antiepileptics
  - Antihypertensives
  - Antiparkinsonian agents
  - Antipsychotic medications (typical and atypical)
  - Benzodiazepines (both short acting and long acting)
  - Cholinesterase inhibitors
  - Diuretics
  - Opioid analgesics
  - Sedative hypnotics
  - Urinary antispasmodic agents
  - Vasodilators
- Musculoskeletal pain
- Neuropathy
- Orthostatic hypotension
- Osteoporotic spontaneous fracture
- Parkinson's disease
- Poor nutrition / vitamin deficiencies (B12, D)
- Recent addition of medications or side effects of medications
- Urge incontinence (hurrying to bathroom)
- Visual impairment

FALLS (cont'd)

SEND OR KEEP?

Transfer to ER if: intractable pain, CVA, fracture (especially open), joint displacement.
Keep in facility if: medication side effects, poor nutrition, visual impairment, non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Order a post fall evaluation (obtain relevant history regarding the circumstances)
- Order to monitor for bruising over next 24 hours – especially in patients on blood thinners
- Order to monitor for functional deficits over next 72 hours (e.g. patient sustained hairline fracture that completely breaks with weight bearing)
- Order to monitor and report any changes in mental status over next 48 hours (e.g. subdural hematoma) if witnessed fall or head was hit during fall with no immediate apparent injury
- Order a gait and balance evaluation (nursing staff can perform)
- Consider PT / OT evaluation if fall was functional in nature
- Encourage physical training and muscle strengthening exercises
- Reduce risk of injury with falling (interventions such as hip protectors, mats, assistive devices),
- Supervise toileting if urge incontinence is involved or fall was from commode
- Vitamin D supplementation
- Remove offending medications or lower dosage
- Order halter monitoring for recurrent syncope of unknown etiology
- Order labs: CBC, BMP, BUN, Ca, Mg, blood glucose, thyroid function, folate, vitamin B12, vitamin D, blood levels of ethanol and current medications for toxicity
- X-ray if concern for fracture
- Address fear of falling

FALLS (cont'd)

FOLLOW UP:

In 1 – 7 days:

If multiple etiologies are suspected, come in to facility to perform a differential diagnosis. Evaluate the patient's drug regimen carefully to identify medications that may be precipitating falls. Titrate and adjust medications as appropriate. Treat related factors (D3 deficiency, anemia, diabetic complications, etc.). If caused by UI, assess underlying cause of UI and treat causative factors).

Next scheduled visit:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ FEVER

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Fever patterns (continuous, intermittent, etc.)
- Any signs of alternating fever and rigors (shaking, chills, fatigue, or pain), diaphoresis
- Signs of inflammation or infection at specific locations (joints, lungs, skin, etc.)
- Any significant cardiac, lung, or abdominal findings, headache, muscle aches, clinical signs of dehydration (postural pulse difference — increase from lying down to sitting or standing of 30 beats per minute or more, tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased confusion, fever), loss of appetite

MEDICAL HISTORY

- Patient's age and sex
- Onset (gradual or sudden) and frequency (intermittent or continuous)
- Whether and when any antipyretics or antibiotics are ordered or have been administered
- All current medications, including any recent changes
- All current diagnoses
- Any recent lab or diagnostic test results
- Food and fluid intake patterns over past week

DRILL IT DOWN

- Confirm that it's a fever – increase in temperature of equal to or greater than 2°F (1.1°C) from baseline
- Change in mental status – lethargic?
- Associated symptoms (cough, dyspnea, dysuria, increased urinary frequency, etc.)
- Is patient on antibiotics and if so why?

FEVER (cont'd)

DRILL IT DOWN (cont'd)

- If on a SNF Med A stay, why? (e.g. rehab?)
- Immunocompromised?
- Is there a facility or community viral syndrome? (other patients with similar symptoms?)
- Vital signs including O2 sats.
- Lung assessment, abdomen assessment
- Recent labs: CBC with differential, CMP, UA, chest X-ray, urine culture

DIAGNOSES TO CONSIDER:

- Common infection – UTI, pneumonia and other respiratory tract infections, soft-tissue infections, gastroenteritis, infectious diarrhea, viral syndrome (e.g. Norwalk virus) – infections can be bacterial, Viral, fungal, parasitic, and aspirational
- Cardiovascular diseases – MI, thrombophlebitis, PE
- Dialysis – line sepsis, endocarditis
- Drug fever, tissue injury, hematoma
- Gastrointestinal – inflammatory bowel disease, hepatitis (alcoholic, granulomatous)
- Heat stroke, malignant hyperthermia due to drugs
- Uncommon infections – drug fever, cholangitis, post-op surgery (abscess, deep vein thrombosis / PE)
- Wound – infection / cellulitis or sepsis

SEND OR KEEP?

Transfer to ER if: fever over 102°F with dramatic change of mental status, fever over 104°F, signs of sepsis with hemodynamic instability (low BP especially), immunocompromised patients or patient, or recent surgeries – R/O abscess (the patient's reason for SNF rehab), and is consistent with patient's advanced directives.

FEVER (cont'd)

SEND OR KEEP? (cont'd)

Keep in facility if: fever under 102 °F and responding to antibiotics and antipyretics. Most fevers can be treated in facility if source identified and hemodynamically stable – with positive oral intake, usual mental status or mild change in mental status, good hydration or mild hydration deficits that can be addressed in facility. Basically non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Antipyretics (Acetaminophen 325-650mg) every 4h (Maximum of 3000mg per day). Ensure staff monitor's temperature and reports back to you if temperature is not reduced by second dose. Put stop date of 72 hours with this order.
- Order labs (if appropriate): CBC with differential, CMP, UA, chest X-ray, urine culture
- Address hydration needs – oral vs. IV/SQ clysis depending on hydration needs
- Order temperature to be taken every 24 hours (and other related vital signs). Ask results to be reported to you as appropriate based on severity of increased temperature.
- Antibiotics depending on the severity and progression of illness and fever source (be aware of the importance of antibiotic stewardship)

FOLLOW UP:

Within next 24 hours:

Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

In 1 – 7 days:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ FRACTURES AND DISLOCATIONS

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Musculoskeletal and extremities evaluation, including any changes in range of motion, deformity, swelling, bruising, bleeding etc.
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- History of past fractures
- History of osteoporosis
- Description of incident leading to fracture or dislocation
- What has been done to manage the situation so far
- All current diagnoses
- All current medication, including any recent changes
- Any recent lab test or X-ray results
- History of long-term steroid use

DRILL IT DOWN

- Detailed history: type of injury, direction of force, immobilization efforts done after injury
- Injuries to tendons, any open wounds, swelling around the injured site, fever, bony crepitus, range of motion around the joints
- What has been done for pain control so far and results?
- Incident report (How did injury occur?)
- Evaluate for neurovascular compromise – pulses, capillary refill, sensation

DIAGNOSES TO CONSIDER:

- Cause of fracture — spontaneous, trauma, stress-related, pathologic, osteoporosis
- History of:
  - Steroid use
  - End stage renal disease
  - Cancer (with bone metastasis)

FRACTURES AND DISLOCATIONS (cont'd)

SEND OR KEEP?

Transfer to ER if: requires urgent diagnosis and treatment (radiographic tests and orthopedic consultation are performed in ER), open fractures, neurovascular compromise, uncontrollable hemorrhage, intractable pain, or need immediate orthopedic consult.
Keep in facility if: fracture that can be treated with splint or other immobilization devices without orthopedic consult or patient at end-of-life and / or has a "do not transfer" order.

WHAT DO I DO?

- Pain control
- Order X-rays of the affected area (2 views)
- Splint and immobilize (rest, ice, compression, elevation)
- Buddy splinting or taping of digits
- Order neurovascular checks (pulses, capillary refill, sensation)
- Treatment for osteoporosis
- Instruct the nursing staff to send the patient to ER (unless in contradiction with advanced directives) if the patient reports decreased sensation, intractable pain or nurse notices impaired circulation.

FOLLOW UP:

In 24 hours:
(If patient does not go to ER) intervene appropriately based on symptomology and results of radiology report(s) and patient's advanced directives.

In 1 – 7 days:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ GAIT DISTURBANCE

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Musculoskeletal and neurological evaluations, including signs of muscle weakness, paralysis, joint deformity, poor coordination, impaired balance, impaired sensation in lower extremities, or change in normal range of motion of lower extremities
- Signs or complaints of pain on weight bearing or while ambulating
- Signs or complaints of pain to lower extremities when non-weight bearing
- Whether individual tends to lean or fall to one side, backwards, or forwards
- Mental changes or change in speech pattern

MEDICAL HISTORY

- Patient's age and sex
- Onset (gradual to acute), duration, frequency, and severity of gait problem
- Any history of head trauma, or fall
- Aggravating factors that worsen the gait
- Diagnosis of neuropathy
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Any new focal neurological findings – including mental status changes?
- Is the gait disorder abrupt / significant change or gradual / persistent?
- Set of orthostatic vitals
- Any pain (especially back / hip / knees)?
- Recent orthopedic surgeries?
- Recent labs: CBC with differential, serum electrolytes with Ca, Mg, and phosphates, blood glucose (if diabetic), drug levels (if indicated)

GAIT DISTURBANCE (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Medication side effect or toxicity
- Orthostatic hypotension
- Lower extremity weakness / deconditioning / poor endurance
- Environmental problems / obstacles
- Sensory problems – vision, peripheral neuropathy, etc.

Neurogenic causes
- Weakness
- Spasticity
- Cerebellar ataxia
- Vestibular dysfunction
- Frontal lobe dysfunction

Non-Neurologic causes
- Visual loss
- Orthopedic disorders
- Rheumatologic disorders
- Pain
- Side effects of drugs
- Cardiorespiratory problems

SEND OR KEEP?

Transfer to ER if: abrupt onset or with slurred speech or change in mental status, or other new and focal neurological findings. If suspected diagnosis require urgent radiologic tests.
Keep in facility if: gradually progressive or persistent gait problems differing from usual pattern.

GAIT DISTURBANCE (cont'd)

WHAT DO I DO?

- Review medications and adjust accordingly
- For neuro-imaging transfer the patient to an institution with imaging capabilities
- Consider physical therapy to improve LE weakness and balance
- Consider OT consult
- Offer alternatives for mobilization (orthotic, prosthetic, and assistive devices) to improve balance and better control
- Order routine labs: CBC with differential, serum electrolytes with Ca, Mg, and phosphates, blood glucose (if diabetic), drug levels (if indicated)

FOLLOW UP:

Within 24 hours:

Come in to facility to perform a differential diagnosis, if needed.

Next scheduled visit:

Check for improvement in balance and postural control with assistance offering devices (if needed).

☐ GLUCOSE, ABNORMAL (HYPERGLYCEMIA / HYPOGLYCEMIA)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Signs of changes in cognition, level of consciousness, function, or responsiveness
- Signs of localized or systemic infection
- Blood sugar (finger stick) results

MEDICAL HISTORY

- Patient's age and sex
- Verify existing diagnosis of diabetes, hyperglycemia, hypoglycemia, glucose intolerance, etc.
- Any recent lab or diagnostic test results, including blood glucose (finger stick) or serum glucose results
- If patient is diabetic, details of last dose of oral hypoglycemic medications or insulin
- Patient's usual patterns of blood sugars and / or HbA1c
- Food and fluid intake patterns over past week
- Current diagnoses, medications and medication changes
- Recent history of nausea, vomiting or diarrhea

DRILL IT DOWN

- Inquire about the facility's hypoglycemic protocol (if facility does not use "rule of 15", recommend it. See page 93.)
- Recent oral intake
- What diabetic medications given including SSI in past 24 hours?
- What are patient's usual blood sugars and recent HgA1c if available?
- Is there a diagnosis of diabetes – Type 1 or 2?
- Current mental status – can they eat / drink at this time?

GLUCOSE, ABNORMAL (cont'd)

DRILL IT DOWN (cont'd)

- Any other hypoglycemic symptoms? (shakes, change MS, diaphoresis, nausea, etc.)
- Associated hypoglycemic symptoms? (altered level of consciousness, altered behavior, confusion or disorientation, fall, generalized weakness, hunger, irritability, pallor)
- Associated hyperglycemic symptoms? (blurred vision, new or increased confusion, lethargy, polydipsia, polyphagia, recent weight loss, new or worsening incontinence, fruity breath odor)
- Recent labs: serum electrolytes, CBC, BUN / creatinine, LFT's, UA, chest X-ray, TSH, urine drug screen, blood alcohol level, CT scan of head

DIAGNOSES TO CONSIDER:

- Undiagnosed or undertreated diabetes (#1)

Common diagnosis – **hypoglycemia**

- Diabetic medications (oral or insulin) with recent change or oral intake / diet or worsening renal function

Less likely diagnosis

- Infection – sepsis (usually change MS, lethargic as well)

Uncommon diagnosis

- Progressive cirrhosis, alcohol use

Other diagnoses – **hyperglycemia**

- Diseases of the pancreas
- Endocrine diseases (e.g. Cushing's syndrome, hyperthyroidism)
- Genetic defects of beta cell function or insulin action
- Infections
- Metabolic syndrome
- Obesity
- Other genetic syndromes (e.g. Down's syndrome, Huntington's chorea)

GLUCOSE, ABNORMAL (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

Other general diagnoses

- Alcohol intoxication
- CNS disorder (CVA, seizure)
- Depression
- Hepatic failure
- Hypothyroidism
- Malignancies
- Medication side effect
  - Medications that may cause *hyperglycemia* — antipsychotic agents, adrenergic agonists, Ca channel blockers, glucocorticoids, estrogens, levodopa, megestrol acetate, nicotinic acid, opiates, phenytoin, protease inhibitors, thiazides, furosemide, thyroid hormone

SEND OR KEEP?

Transfer to ER if: unable to elevate BS over 60 or unable to decrease BS under 400, mental status change persistent despite normal level BS, sulfonylurea over dose, sepsis. Uncontrollable high BS and has one or more of the following additional symptoms: abdominal pain, fever, hypotension, lethargy or confusion, or respiratory distress.
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1).

GLUCOSE, ABNORMAL (cont'd)

WHAT DO I DO?

- Repeat fingerstick blood glucose (confirmation)
- Order STAT serum glucose, if available in facility
- Hypoglycemia – if PEG or oral:
  1. Give 15 g of glucose or carbohydrate, which is equivalent to any one of the following:
     - 1/2 cup juice
     - 1/2 cup apple sauce
     - 1 cup milk
     - 1 tube glucose gel
     - 3 glucose tablets

     "The Rule of 15"
  2. Wait 15 minutes
  3. Recheck blood glucose levels – if level is still below the target, give another 15 g of glucose or carbohydrate
- Adjust oral medication / insulin with additional accuchecks accordingly
- Labs to assess systemic cause of hypoglycemia / hyperglycemia
- Remove offending medications or reduce dosage

FOLLOW UP:

In 24 hours:

Follow up with phone call to check on last 24 hours of finger stick blood glucose checks and any stat labs if ordered.

Routine visit:

To review blood glucose levels, oral / PEG intake / current diet, change in medications or dose adjustments. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ HEADACHE

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Pain evaluation (location, character, duration, severity, etc.)
- Any significant changes in function, behavior, cognition, or level of consciousness including speech pattern and signs of facial drooping
- Nausea or vomiting, stiff neck
- Significant changes in vision, hearing, or smell
- Signs of sinus tenderness by percussion
- Neurological evaluation

MEDICAL HISTORY

- Patient's age and sex
- Onset, location, frequency, and severity of symptoms, including precipitating and relieving factors
- Any history of headaches and any changes in frequency, intensity or pattern
- Response to any analgesics or other interventions
- Any recent fall or injury
- All current diagnoses
- All current medications, including any recent changes

DRILL IT DOWN

- History of onset (thunder-clap, minutes, hours, or days)
- Severity (are they debilitated?)
- Associated symptoms including nausea, emesis, vision changes, change MS, fever, increased BP, poor fluid intake, sinus pressure
- Recent falls / head trauma
- Recent URI?
- Medication list and recent changes (less than 72 hrs.)
- Any relief with patient's PRN analgesics?

HEADACHE (cont'd)

DRILL IT DOWN (cont'd)

- Any **new** focal neurological findings? (e.g. unsteady gait, muscular rigidity, expressive aphasia, seizures, changes in personality, sensory impairments, impairment of tactile sensation, hallucinations, memory disturbances and impairments, loss of ability to comprehend music or language, inability to make a decision, apathy, problems involving balance and coordination)
- Recent labs: CMP, CBC, ESR

DIAGNOSES TO CONSIDER:

Common diagnoses
- Medication side effects / ADEs (nitrates, Ca channel blockers, etc.)
- Medication toxicity
- Medication withdrawal / dependency (NSAIDS, etc.)
- Mild fluid / electrolyte imbalance
- Tension headaches (usually patient has had prior tension headaches)

Uncommon diagnoses
- Hypertensive urgency / crisis
- Intracranial mass
- Subdural hematoma
- Temporal arteritis
- Meningitis

Other diagnoses
- Head trauma
- Hypertension
- Migraines
- Sinus infection / pressure

HEADACHE (cont'd)

SEND OR KEEP?

Transfer to ER if: severe headache associated with BP over 210/115, abrupt onset (thunder-clap), any NEW focal neurological findings, high fever, stiff neck, persistent vomiting with inability to tolerate oral intake and facility does not do clysis or IVs.
Keep in facility if: non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Analgesics
- Antibiotics if consistent with sinus infection
- Treatment of high blood pressure, if BP under 210/115 and elevation persistent after pain resolves
- LABS: CMP, CBC, ESR, if indicated

FOLLOW UP:

In 24 hours:
Reassess if persistent and unresponsive to standard analgesics.
Routine visit:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ HEAD INJURIES

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- General condition and appearance
- Neurological evaluation, including any significant changes in function, behavior, cognition, or level of consciousness, dizziness, nausea, irritability, slurred speech, slow to answer questions
- Head, eye, ear, nose evaluations, including significant changes in vision, hearing, or smell
- Any signs of neck, eye, or facial injury
- Pain evaluation (location, character, duration, and severity)

MEDICAL HISTORY

- Patient's age and sex
- Description of how injury occurred
- How situation has been managed so far?
- All current medications, including any recent changes
- All current diagnoses
- Any recent lab or diagnostic test results
- Any recent falls or injuries

DRILL IT DOWN

- New neurological symptoms including – behavior, cognition, dizziness, nausea, irritability, slurred speech, new focal weakness, changes in the eye (see Headache section – new focal neurological findings)
- Exam of face and head for signs of trauma including lacerations
- What is level of consciousness?

HEAD INJURIES (cont'd)

DIAGNOSES TO CONSIDER:

Most common diagnoses
- Abrasions
- Contusions

Less common but crucial diagnoses
- Concussion
- Fractures
- Intracranial hemorrhage / subdural hematomas

Other diagnoses
- Altered mental status (drugs, alcohol, hypoglycemia, seizures)
- Anoxic encephalopathy
- Cervical spondylitis and cord injury
- Laceration
- Skull fracture
- Subarachnoid hemorrhage
- Subdural hemorrhage

SEND OR KEEP?

Transfer to ER if: post-injury vomiting, amnesia, seizures, alcohol use, possible facial or skull fracture, systolic blood pressure of less than 90, decreased mental status, penetrating trauma, new focal neurological findings, laceration requiring sutures, any eye involvement.
Keep in facility if: most common diagnoses such as simple laceration that does not need sutures, or non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Order neuro checks / monitoring as per LTC facility policy
- Supportive care
- Local care of laceration or facial trauma in facility

HEAD INJURIES (cont'd)

FOLLOW UP:

Within 24 hours:

(or sooner): check on the patient's neurological status. Make emergent decisions if the patient requires surgery or if the patient's neurological status is deteriorating.

Routine visit:

Make next treatment / management decisions based on response to initial interventions and any lab results / radiology tests if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ HEARING LOSS (ACUTE)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Check ear canal for cerumen
- Check ear for drainage in both ears. (If there is drainage, what is the color and consistency?)
- Check the external ear for inflammation and foreign bodies
- Significant changes in hearing from baseline (compare one ear to the other)
- Evaluate to see if loss is unilateral or bilateral, continuous or intermittent
- Evaluate for pain. (Is it unilateral or bilateral? Continuous or intermittent? In one or both ears?)
- Evaluate for ringing, buzzing, hissing or other noises in one or both ears
- Evaluate for dizziness
- If patient wears a hearing aid, evaluate for damage, blockage, or poor battery

MEDICAL HISTORY

- Patient's age and sex
- Onset (anywhere from a gradual progressive decline to an abrupt sudden loss)
- Duration, frequency, and severity of signs and symptoms
- History of recent respiratory infections, head trauma, and/or recent falls
- All current diagnoses
- All current medications, including any recent changes, especially medications that may cause ototoxicity

HEARING LOSS (cont'd)

DRILL IT DOWN

- Validate that hearing aids are functioning (#1)
- Any association with ear pain, trauma, fever?
- Medication review (there are more than 200 known ototoxic medications)
- Otoscope evaluation (if available in LTC facility)

DIAGNOSES TO CONSIDER:

Common diagnoses

- Cerumen impaction (#1)
- Malfunctioning hearing aid (#2)
- Eustachian tube dysfunction (associated with URI) (#3)
- Ear infection
- Otitis media / trauma / otosclerosis
- Ototoxic medications – aminoglycosides, loop diuretics, NSAIDS, cisplatin
- Recent sinus
- Tumors

Less likely diagnoses

- Otitis media
- Foreign object
- Bell's Palsy / Horner's Syndrome
- Meniere's disease
- Paget's disease

SEND OR KEEP?

Transfer to ER if: traumatic hearing loss, abrupt onset, known foreign body in canal that's refractory to ear irrigation removal.
Keep in facility if: due to cerumen or foreign body that can be easily removed and other reversible causes that can be handled in the facility.

HEARING LOSS (cont'd)

WHAT DO I DO?

- Cerumen removal (carbamide peroxide drop, ear irrigation)
- ENT referral (if indicated)
- Audiology evaluation (if indicated) – Hearing Handicap Inventory in the Elderly Screening (HHIE-S)
- Antibiotics for ear infection

FOLLOW UP:

Next 24 hours:

Check on patient (may be by phone) to see how initial interventions have worked. Intervene appropriately based on any continued symptomology.

Next scheduled visit:

If hearing loss is chronic, ask if the hearing loss is associated with decline in activities of daily living, socialization, and ability to live independently. It is important to have both hearing aids worn and functional to get maximum improvement in hearing.

☐ HEMATOCRIT / HEMOGLOBIN, ABNORMAL

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Signs of bleeding. Note where bleeding is seen if visible. Note color and consistency (bright red blood, brown or coffee ground in color)
- Check pupils for dilatation and reaction to light
- If Hct/Hgb is below normal range (anemia), evaluate for signs related to anemia, such as increased heart rate, shortness of breath, palpitations, fatigue, and exercise intolerance,
- If Hct/Hgb is above normal range, evaluate for signs of hydration deficits, headache, dizziness, or change in level of consciousness

MEDICAL HISTORY

- Patient's age and sex
- Recent lab or diagnostic test results, especially previously recorded hematocrit, hemoglobin, serum iron, serum potassium ferritin, transferrin saturation, and renal function (BUN, Creatinine)
- Check for GFR < 60mL/min, if Hct/Hgb is less than 12 g/dl in a female and less than 13 g/dl in a male
- Any history of cancer chemotherapy, gastrointestinal (GI) or urinary bleeding, or other bleeding or clotting disorders
- Recent and current food and fluid intake
- All current diagnoses, including cancer, bone marrow failure and renal disease
- All current medications, including any recent changes, especially those associated with bone marrow suppression or increased bleeding risk

HEMATOCRIT / HEMOGLOBIN (cont'd)

DRILL IT DOWN

- Past Hct/Hgb?
- Recent PRBC transfusions?
- Past history – PUD, GI bleeds, abdominal surgeries, diverticulosis, bright-red blood per rectum (BRBPR)
- Orthostatic vitals (BP + HR)
- Associated symptoms – fatigue, lightheadedness, pallor, hypotension, shortness of breath, tachycardia, chest pain, worsening CHF, edema, or signs of bleeding
- Recent lab studies including: CBC, iron panel, ferritin, B12, folate, renal function, PT/INR (if indicated)
- Medication review – blood thinners, OTC / herbals, vit E, ginseng, Ginkgo, garlic, NSAIDS, ASA, etc.

DIAGNOSES TO CONSIDER:

- Anemia of chronic or renal disease
- B12 of folate deficiency
- Blood loss
- Iron deficiency
- Lack of production including bone marrow disorder
- Malignancy

SEND OR KEEP?

Transfer to ER if: patient is symptomatic (orthostatic hypotensive, tachycardic, change in mental status or LOC) with Hb less than 8, active blood loss, unstable vital signs, Hb less than 10 if symptomatic WITH history of cardiac disease (CAD, CHF), and consistent with patient's advanced directives.
Keep in facility if: asymptomatic, chronic and progressive, out-patient transfusion preferred, Hb less than 10 and awaiting lab results, OR non-emergent and facility can meet patient needs (see Appendix 1).

HEMATOCRIT / HEMOGLOBIN (cont'd)

WHAT DO I DO?

- Ferrous sulfate – 325mg per day for 90 days if iron deficiency anemia
- Order lab studies including: CBC, iron panel, ferritin, B12, folate, renal function (estimated GFR), PT/INR (if indicated)
- Consider GI evaluation — if iron deficiency anemia and not due to recent surgery (i.e., post-op anemia), or history of GI bleeds, ulcers
- Reassess blood thinner indications
- Monitor vitals
- Monitor Hct/Hgb as indicated
- Consider hematology evaluation (output)
- Consider erythropoietin stimulating agent (if indicated)

FOLLOW UP:

Next scheduled visit (dependent on what type of anemia – anywhere from 1 day to 2 weeks):

Follow up Hct/Hgb. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ HEMATURIA

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal evaluation
- Any signs of bleeding at other sites, including vaginal bleeding in women
- Signs of trauma to urethra or external genitalia
- Quantity, color, clarity of urine (note any clots)
- Pain evaluation (location, nature, severity, etc.)
- Rectal evaluation

MEDICAL HISTORY

- Patient's age and sex
- Onset of blood in urine. Did it vary in severity between voiding?
- Any recent abdominal or flank trauma
- History of recent urinary catheterization
- All current diagnoses
- Any history of kidney failure, bladder or kidney tumors, or glomerulonephritis
- All current medications, including any recent changes; especially medications associated with nephritis and anticoagulants
- Recent lab (urinalysis, hemoglobin level and hematocrit) or diagnostic test results
- How has situation been managed so far?

DRILL IT DOWN

- Gross or micro-hematuria?
- History of current or recent catheterization
- Medication review – use of anticoagulants, BPH medications
- Associated symptoms – abdominal pain, flank pain, dysuria, fever, nocturia, dribbling, hesitancy, weight loss, renal disease including family history of renal disease, CVA, tenderness, palpable mass in abdomen, other bleeding sites

HEMATURIA (cont'd)

DRILL IT DOWN (cont'd)

- Recent urinalysis with microscopy and / or urine culture

DIAGNOSES TO CONSIDER:

Common diagnoses – **gross hematuria**

- Indwelling catheter (irritation, trauma, or pulling)
- Trauma to urethra
- If not from indwelling catheter
  - Women – vaginal bleeding, UTI, cystitis
  - Men – UTI, BPH

Less likely diagnoses

- Nephrolithiasis
- Bladder or urological cancer
- Coagulopathy (elevated INR)

Common diagnoses – **microhematuria**

- Erroneous lab result
- UTI, cystitis
- BPH

Less likely diagnoses

- Nephrolithiasis
- Bladder or urological cancer
- Coagulopathy
- Glomerulonephritis

SEND OR KEEP?

Transfer to ER if: for additional testing such as renal US, KUB X-ray, CT spinal for stone evaluation or urgent urology consult (if requested or indicated), hemodynamic instability, gross hematuria with pain, other signs of bleeding at other sites.
Keep in facility if: nephrolithiasis, benign prostatic hyperplasia, UTI, cancer, and on hospice or palliative care services with a "no hospitalization intervention".

HEMATURIA (cont'd)

WHAT DO I DO?

- Order urinalysis with microscopy and urine culture (if micro-albuminuria)
- Antibiotics for UTI (if indicated)
- Treat BPH (if indicated)
- Pain control and hydration for kidney stones, if diagnosed
- Urology consult (if indicated) for cancer, BPH (out-patient)
- Voiding monitoring

FOLLOW UP:

Within next 24 hours if:

Gross hematuria and persistent despite intentions. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

In 1 – 7 days if:

There is HTN and proteinuria, ensure patient is on ACE inhibitor. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Routine visit:

Follow-up on last interventions to see if adjustments are needed. Hematuria due to urinary catheter needs repeat urine analysis in 2 – 3 weeks. Episodic hematuria needs follow up every 3 months for 1 year and yearly for 3 years and as needed.

☐ HEMOPTYSIS (COUGHING UP BLOOD)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Amount of blood and whether mixed with mucous, contains clots, etc.
- Respiratory rate and rhythm
- Heart and lung evaluations, including rales, wheezes, rhonchi, and labored breathing
- Evaluate nose, mouth, and pharynx for sources of bleeding and confirm origin of bleeding and whether blood is being coughed, vomited or is coming from nose
- O2 sats.

MEDICAL HISTORY

- Patient's age and sex
- All current diagnoses
- How has situation been managed so far?
- Onset, frequency, and duration of symptoms
- Any history of chronic lung disease or chronic sinusitis, bleeding disorders, or smoking or tobacco use
- Any recent lab (CBC, coagulation studies, sputum culture, and smear) or chest or sinus X-ray results)
- Any recent history of pneumonia, bronchitis, upper respiratory infection, acute sinusitis
- All current medications, especially anticoagulants use, including any recent changes

DRILL IT DOWN

- Recent surgeries / hospitalization / deep vein thrombosis?
- Medication review – anticoagulants
- PPD smoking history?
- Recent chest X-ray (availability of and accessibility of mobile chest X-ray)
- Gross hemoptysis vs. blood-tinged?

HEMOPTYSIS (cont'd)

DRILL IT DOWN (cont'd)

- Associated symptoms – SOB, chest pain, pain, cough, upper respiratory infection
- Vital signs and pulse ox
- Recent labs: CBC, PT/INR

DIAGNOSES TO CONSIDER:

Common diagnoses
- Acute bronchitis
- Epistaxis (from nasal source)
- Acute pneumonia

Less likely diagnoses
- Anticoagulants
- Pulmonary embolism
- Lung cancer
- TB

Rare diagnoses
- Massive pulmonary edema
- Lung abscess
- Disseminated intravascular coagulation (DIC)

SEND OR KEEP?

Transfer to ER if: patient has massive hemoptysis, hemodynamic instability, concerned for pulmonary embolism – chest pain, SOB, hypoxia, tachypnea.
Keep in facility if: lung cancer when family elects no further intervention, bronchitis, epistaxis, normal chest X-ray with normal vitals, non-emergent and facility can meet patient needs (see Appendix 1).

HEMOPTYSIS (cont'd)

WHAT DO I DO?

- Acute bronchitis: symptomatic management
- Pneumonia: appropriate antibiotic (1st dose now – ask what is available in ER kit vs. what can be delivered to facility later)
- Consider pulmonary evaluation (outpatient)
- Consider outpatient CT chest if chest X-ray suspicions for lung CA or (positive) KISK factors
- Oxygen, if sats. below 90%
- Order labs: CBC, PT/INR (if indicated)

FOLLOW UP:

Within next 24 hours:

Follow-up on chest X-ray. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions.

Within 1 – 7 days:

Follow-up on last interventions to see if adjustments are needed.

☐ HYPOTHERMIA

Rare event – usually a sequelae from cold exposure – improper dress, elopement, poor judgment / safety awareness – can occur however if the weather is not that cold

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological evaluation, including significant changes in level of consciousness, function, mood, or behavior
- O2 sats.
- Evidence of systemic infection (sepsis)
- Any signs associated with hypothyroidism (sluggishness, change in mental status, etc.)
- Evaluate extremities (color, temperature, sensation, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration of symptoms
- Any recent prolonged exposure to cold
- Recent lab or diagnostic test results, especially thyroid function tests
- All current diagnoses
- All current medications, including any recent changes

DRILL IT DOWN

- Level of consciousness
- Recent severe trauma – head injury, burns
- Comorbid conditions such as heart failure, pulmonary infection, or endocrine disorders (increases risk of poor outcomes)
- Medication review – especially tranquilizers, sedatives, hypnotics, or antipsychotics disorders (increases risk of poor outcomes)
- Recent thyroid function tests – if mild and chronic low temp
- Hydration status
- Evidence of systemic infection
- Incident report (if indicated)

HYPOTHERMIA (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Cold exposure
- Sepsis
- Chronic + mild-hypothyroidism

Other diagnoses
- Severe trauma – especially brain injury or burns
- Prolonged muscle inactivity

SEND OR KEEP?

Transfer to ER if: moderate-severe hypothermia (below 30°C – 86°F), hypothermia with change in mental status, lethargy, sepsis, trauma (CNS injury, burn), slow heart rate, shallow respirations, loss of consciousness.
Keep in facility if: no change in mental status and normal vitals, facility can meet patient's needs.

WHAT DO I DO?

- Passive rewarming for hemodynamically stable patients (Heat packs placed under the arms and on the chest, neck, and groin. Do not warm the arms and legs directly. Do not apply heating pads or heating blankets. Don't rub arms and legs.)
- Order staff to monitor respirations
- Order thyroid function tests – if mild and chronic low temp

FOLLOW UP:

Within first 24 hours:

Follow-up by phone to check on patient's status. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ INCONTINENCE OF URINE OR STOOL, INCREASED SEVERITY OR NEW ONSET

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal evaluation
- Significant changes in level of consciousness, function, mood, or behavior
- Rectal evaluation, including masses, weakened (loose) rectal muscles, pain, or hard stool on digital rectal evaluation (especially if oozing liquid stool)
- Signs of bladder distension or tenderness to palpation
- Males: swelling, bleeding or penis pain
- If urinary incontinence, post-void residual
- Determine whether indwelling urinary catheter is present and draining freely. Determine if an indwelling catheter was removed recently
- Pain evaluation (location, nature, severity, etc.) Pain / burning on urination?
- Feelings of urgency
- Frequency of urination
- Color and consistency of urine and stool

MEDICAL HISTORY

- Patient's age and sex
- Comparison of current symptoms to usual pattern
- If urinary incontinence, usual voiding patterns
- If fecal incontinence, usual pattern of bowel function and bowel movements
- All current diagnoses
- All current medications, including any recent changes; especially medications that may affect bowel and bladder function
- Recent lab (urinalysis or stool studies) or diagnostic test results
- Changes in food or fluid intake pattern

INCONTINENCE (cont'd)

DRILL IT DOWN

- Medication review – especially antihistamines and other anticholinergics, narcotic analgesics, diuretics
- Recent removal of indwelling catheter
- Recent post void residual measurement of urinary volume
- Associated symptoms of UTI (at least 3 of the following) – dysuria, hematuria, fever, flank or suprapubic pain or tenderness, changes in characteristic in urine, changes in mental status
- Recent labs: BMP, serum calcium, serum glucose, BUN, UA and culture

DIAGNOSES TO CONSIDER:

- Acute UI
  - Fecal impaction / severe constipation (usually causes urgency)
  - BPH (male)
  - Delirium
  - Functional – "can't get to the toilet in time"
  - Hyperglycemia (BS more than 200) in diabetes mellitus Type-2
  - Medication effects – antihistamines and other anticholinergics, narcotic analgesics, diuretics
  - Medication effects on BPH – anticholinergic pseudoephedrine, OTC cold meds
  - Restricted mobility
  - UTI
- UI – Physical
  - Atrophic vaginitis
  - Bladder irritants (e.g. excessive intake of caffeinated beverages)
  - Bladder or prostate cancer
  - Hypercalcemia
  - Hyperglycemia

INCONTINENCE (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Recent removal of urinary catheter
- Recent surgery or acute medical illness
- Urethral stricture
- Uterine prolapse

- UI – Functional
  - Arthritis of the knees, hips, or spine
  - Dementia
  - Inadequate access to toilet, restrictive clothing, use of physical restraints
  - Parkinson's disease and other degenerative neurological conditions
  - Stroke
  - Visual disturbances

SEND OR KEEP?

Transfer to ER if: suspect patient has *Cauda Equina* syndrome – evidenced by acute urinary retention, stool incontinence with saddle parathesia (this requires an urgent evaluation), if lethargic with change in mental status and suspect sepsis, if severe fecal impaction is confirmed with X-ray and onsite intervention is not successful.
Keep in facility if: incontinence can be managed in the facility. Assessing causation of UI may take some time on the part of the practitioner. However, once causation is discovered a treatment / management plan is usually possible at the facility level.

WHAT DO I DO?

- Perform differential diagnosis exam to assess causation of incontinence – urges, stress, overflow, functional, transient, mixed
- Physical exam (abdominal exam for bladder distention)

INCONTINENCE (cont'd)

WHAT DO I DO? (cont'd)

- Order mobile ultrasound (if indicated and available)
- Order mobile abdominal X-ray of fecal impaction suspected as cause (confirmation)
- Order PVR testing
- Order urinalysis and / or culture if systemic signs of infection present
- Order labs: BMP, serum calcium, serum glucose, BUN
- Antibiotics for UTI (if indicated)
- Indwelling catheter for urinary retention (if high PVR 200 – 400mL)
- Treat the underlying cause (e.g. order appropriate pharmacology to type of incontinence)
- Urology consult (if indicated)

FOLLOW UP:

1 – 7 days after initial call:

Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to any initial interventions.

Next routine visit or medically necessary visit:

Follow-up on last interventions to see if adjustments are needed.

☐ ITCHING (PRURITUS)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details of skin condition, including evidence of dryness, fragility, redness, rash, hives, blisters, etc.
- Signs of complications from scratching, such as excoriations or secondary infection

MEDICAL HISTORY

- Patient's age and sex
- Onset, frequency, severity, intensity, location, and duration of symptoms
- Evaluate to see if there is relationship to activities (physical exertion, bathing, applying make up, or the use of perfumes, creams, soaps, etc)
- All current medications, including any recent changes, especially medications associated with dry skin, itching, or causing pain
- All current diagnoses
- All current allergies
- Response to any recent interventions
- Recent lab (CBC, erythrocyte sedimentation rate, protein electrophoreses) or diagnostic test results

DRILL IT DOWN

- Recent drugs changes
- Any signs of scabies or lice
- Evidence of scratching – for chronic pruritus
- Skin description – complete exam of skin, dryness, fragility, redness, rash, hives, blisters
- Recent labs: CBC with differential, TSH and UA, CMP

ITCHING (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Dry skin
- Intertriginous – candidiasis (yeast infection in skin folds)
- Chronic edema – stasis dermatitis
- Unilateral dermatone – herpes zoster (usually with pain)
- Allergic reaction

Less common diagnoses
- Secondary infection (cellulitis) can be itching and painful with other symptoms – erythema and warmth
- Scabies (severe pruritus, usually with exposure)
- Bullous pemphigoid
- Stasis dermatitis
- Contact dermatitis
- Lice
- Allergic reaction to drugs (antidepressants, aspirin, opiates, etc.)
- Diabetes mellitus, hepatobiliary disease, thyroid disease, uremia, ESRD, heart disease

Uncommon diagnoses and with chronic pruritus
- Abdominal and CNS malignancies
- Iron deficiency anemia
- Leukemia
- Lymphomas
- Polycythemia vera

SEND OR KEEP?

Transfer to ER if: pruritus is first sign of more severe, life threatening allergic reaction.
Keep in facility if: case can be managed in the facility or as outpatient / dermatology referral.

ITCHING (cont'd)

WHAT DO I DO?

- Consider lab evaluation for chronic pruritus
- Eliminate or treat underlying etiology
- Isolate for scabies / lice until treated
- Topical moisturizing agents – know what your facility stocks and use accordingly twice daily and PRN
- Topical antipruritic lotions (calamine, hydrocortisone, or more potent topical steroids) for less than 2 weeks (Be sure to write stop date with order.)
- Oral antihistamines (like loratadine) – monitor for urinary retention and utilize for 72 hours or less to alleviate acute symptoms (avoid hydroxyzine and diphenhydramine as they can cause confusion / delirium)
- Order lab: CBC with differential, TSH and UA, CMP (if not recent)

FOLLOW UP:

In 1 week:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed.

☐ LACERATION

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details of wound (location, depth, degree of bleeding, etc.)
- If on extremities, evaluate pulses and parts distal to (beyond) the wound site for involvement (joints, nerves, tendons, etc.)
- Evaluate severity of situation and identify whether sutures may be required
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- How laceration was obtained, if known
- Management of the condition so far
- All current diagnoses
- All current medications, especially those that may affect bleeding or clotting
- Tetanus toxoid vaccination history, if known

DRILL IT DOWN

- How did laceration occur?
- Is there a need for sutures?
- Wound characteristics – time since wound occurred, length, depth, shape, location, scar formation from previous wounds, foreign body in wound, and distal neurovascular symptoms
- What can be done in the facility (sterile adhesive strip skin closures)?
- Control of bleeding
- Facility's policies on wound care

DIAGNOSES TO CONSIDER:

- Bite wound
- Crush wound
- Foreign body
- Laceration

LACERATION (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Open fracture
- Puncture wound

SEND OR KEEP?

Transfer to ER if: laceration requires sutures, laceration involves the eye, open joint fracture, extensive facial wounds, involvement of neurovascular bundle and loss of significant skin surface area, uncontrolled bleeding, altered mental status changes.
Keep in facility if: can be treated / managed in facility.

WHAT DO I DO?

- Consider tetanus toxoid or Tdap
- Consider pain management
- Skin tear
- Replace epidermal flap over wound
- Secure with sterile adhesive strip skin closuress
- If epidermal skin flap is lost – use of flexible high glycerine gel or similar product, or bacitracin and non-stick gauze (if available); keep non-stick gauze in place with gauze roll; goal is to keep area moist
- If thin transparent film dressing utilized, monitor skin flap when removing so not to worsen skin tear with removal of dressing and change thin transparent film dressing once a week and as needed
- Consider antibiotics for bite, infected, and closed fist wounds
- Puncture wounds may require exploration
- Order nursing staff to call if signs of infection

FOLLOW UP:

Routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ MEDICATION ERROR OR ADVERSE DRUG EVENT

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Evaluate for signs of significant side effects related to the medication, especially any medications with high potential for significant toxic side effects

MEDICAL HISTORY

- Patient's age and sex
- Details of the medication error
- All other current medications, including any recent changes
- All current diagnoses

DRILL IT DOWN

- What was medication error? – too high dose, omitted, or wrong med given, wrong time, one time drug given again, wrong route, etc.
- Ask for list of all medications, any recent changes in medications, OTC medications
- List of all diagnoses – including any renal or liver dysfunction
- Any change in condition in base line status
- **Potential ADEs noted with medications:** anorexia, anxiety, ataxia, constipation, delirium, diarrhea, dizziness, forgetfulness, gait disturbance, hallucinations, insomnia, lethargy, memory impairment, nausea and vomiting, new onset of confusion, restlessness, sedation, skin rash, syncope, tremor, unexplained falls and trauma, vertigo, weight loss
- Recent labs: creatinine clearance, liver function studies

DIAGNOSES TO CONSIDER:

- Chronic kidney disease
- Drug interactions
- Error in self-administration in ALF/ALC (assisted living facility/ community)
- Liver disease

MEDICATION ERROR (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Nurse administration error
- Pharmaceutical error – wrong drug
- Polypharmacy

SEND OR KEEP?

Transfer to ER if: ADEs cause hemodynamic instability, severe change in mental status from baseline.
Keep in facility if: patient asymptomatic with stable vitals or non-emergent ADE that can be handled in facility (see Appendix 1).

WHAT DO I DO?

- Assess impact of medication error
- Consider pharmacy or poison control for assistance
- Hold all the medication with an ADE in context
- Treat appropriately for ADEs
- Small doses (Go low, Go slow)
- Pay attention to drug related geriatric syndromes causing impairments – malnutrition, constipation, urinary incontinence, cognitive impairment, depression
- Order labs: BMP, drug levels

FOLLOW UP:

1 – 7 days:
Review and adjust medications as appropriate to reduce ADEs. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Routine Visit:
Review medication list. Follow-up on last interventions to see if adjustments are needed.

☐ MEMORY LOSS (SEE ALSO AGITATION OR BEHAVIORAL DISTURBANCE, CONFUSION)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological, behavioral, and cognitive evaluations including any significant changes in level of consciousness, function, mood, cognition, and behavior
- Any changes in movement or sensation

MEDICAL HISTORY

- Patient's age and sex
- Details of the change (onset, duration, and fluctuation) compared to usual baseline
- Results of any screening evaluation such as Mini-Cog (see reverse side)
- All current diagnoses
- All current medications, including any recent changes, especially those with potential to cause lethargy or confusion
- Recent falls or trauma

DRILL IT DOWN

- What is the patient's baseline status and how are they different today?
- Any evidence of agitation (ask nurse to describe how agitation "presents" itself) – disruptive behavior, hallucinations, insomnia or mood disorders
- Medication review – any new medication initiated recently, or changes made to medication regimen?
- Any recent fall or fall with head trauma?
- Review course of memory loss, level of consciousness, hydration status, most recent BIMS, PHQ-9
- History of alcohol use
- Recent labs: CBC, CMP, UA, chest X-ray, drug levels

MEMORY LOSS (cont'd)

DIAGNOSES TO CONSIDER:

- Acute memory loss
  - Medication side effects or toxicities
  - Delirium (infection, electrolyte imbalance, dehydration, etc.)
  - Uncommon – late sequelae (less than one week of head trauma: could be subdural hematoma)
- Newly admitted and undiagnosed or undertreated:
  - Alzheimer's dementia
  - B12 deficiency
  - Diabetes
  - Frontotemporal dementia
  - Hypothyroidism
  - Lewy body dementia
  - Mixed dementia
  - Vascular dementia
  - Normal Pressure Hydrocephalus (uncommon)
  - Picks Disease (uncommon)
  - Neurosyphilis (rare)

SEND OR KEEP?

Transfer to ER if: agitation and memory loss is acute and is causing harm to self and / or others, change in mental status with fever (over 102°F) or new positive focal neurologic findings.
Keep in facility if: chronic cause (memory can be evaluated and followed up at facility). If acute etiology and non-emergent and can be identified and treated at facility level.

WHAT DO I DO?

- Identify potentially reversible causes and manage appropriately
- If diagnosis of moderate to severe Alzheimer's dementia confirmed, consider starting acetylcholinesterase inhibitors and NMDA antagonists

MEMORY LOSS (cont'd)

WHAT DO I DO? (cont'd):

- Consider antidepressants for treatment of anxiety / depression, insomnia, pain, anorexia
- Atypical antipsychotics may be prescribed to treat **confirmed** psychosis (patient shows psychotic features – e.g. delusions, hallucinations, paranoia – to support a decision to prescribe antipsychotic agents). Treatment of psychosis also should include identifying and treating underlying causes, ensuring safety, and supporting the patient's physical functioning. All patients with psychotic symptoms should receive environmental and supportive interventions with the use of antipsychotics.
- Treat underlying cause of delirium.
- Non pharmacological management – includes calm environment, positive communication, involvement in activities, improve social skills, music, gardening, pet therapy, massage, encouraging patient to perform their own ADLs and IADLs to help boost self-confidence, promote independence and sense of purpose.
- Order lab: CBC, CMP, UA, consider chest X-ray and urine C&S (if appropriate), drug levels (if warranted)

FOLLOW UP:

1 – 7 days:
May be done by phone. Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ NAUSEA AND VOMITING (SEE ALSO ABDOMINAL PAIN, APPETITE DIMINISHED)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal evaluation, including bowel sounds, distension, and tenderness
- Rectal evaluation, including pain or tenderness, masses or hard stool in rectum (if signs of constipation or fecal impaction)
- Presence of blood (gross or occult) or undigested food in vomitus
- Description of vomitus (color, amount)
- Inspect for jaundice and bruises

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, intensity, frequency, precipitating and alleviating factors
- Any history of similar symptoms
- Any significant history of gastrointestinal (GI) disorders (weight loss, recent abdominal pain, anorexia)
- Food and fluid intake patterns over past week
- Bowel movement frequency and patterns over past week
- All current medications, including any recent changes, especially those associated with nausea, anorexia and esophageal or gastric irritation
- All current diagnoses
- Any recent lab or diagnostic test results
- Recent fall or trauma, especially head trauma

DRILL IT DOWN

- Hydration status
- Are there any other patients in the facility with the same symptoms?
- Are there signs of obstruction on the abdominal evaluation?

NAUSEA AND VOMITING (cont'd)

DRILL IT DOWN (cont'd)

- Medication changes – medications that could treat or cause esophageal or gastric irritation
- Recent falls – head trauma
- Description of vomitus – color, amount, consistent with recently ingested food, relation of emesis to food / liquid consumption, any "coffee ground" material
- New jaundice
- Recent labs: BMP, CBC, UA / culture, chest X-ray / abdominal X-ray

DIAGNOSES TO CONSIDER:

Common diagnoses

- Acute viral gastroenteritis
- Gastroparesis
- GERD
- Medication side effects – antibiotics, bisphosphonates, digoxin, iron, metformin, narcotics, NSAIDS, etc.
- Medication toxicities – digoxin, dilantin, valproic acid
- Severe constipation

Other diagnoses

- Food poisoning
- Gallstones
- Gastric and duodenal ulcers, gastric outlet obstruction
- GI cancer
- Hypercalcemia
- Kidney stones
- Liver failure
- Metabolic – diabetic ketoacidosis, hyponatremia
- Neurological – any etiology that increased intracranial pressure
- Uremia
- UTI

**FYI – in frail seniors – sometimes an early symptom of pneumonia is vomiting*

NAUSEA AND VOMITING (cont'd)

SEND OR KEEP?

Transfer to ER if: altered mental status after head injury, abdominal pain with signs of hollow viscus perforation, diabetic ketoacidosis, obstruction of small and large bowels or presents with acute abdomen requiring surgical intervention, severe dehydration.
Keep in facility if: dyspepsia, UTI, non-perforated GU/DU if constipation, kidney stones, GI malignancy, acid reflux, medication side effect, viral gastroenteritis, dehydration or electrolyte imbalance and facility can hydrate, non-emergent and facility can manage (see Appendix 1).

WHAT DO I DO?

- Consider bowel rest with IV/SQ clysis
- Antiemetic's PO or suppository – be aware of anticholinergic / antiparkinsonian side-effects
- Monitor for dehydration, use supplemental hydration if viral GI symptoms (if possible in facility), and monitor for 24-48 hours
- Treat constipation
- Restart PPI if nausea and vomiting starts shortly after medication discontinuation
- Order labs: BMP, CBC, UA / culture, chest X-ray / abdominal X-ray

FOLLOW UP:

In 1 – 3 days:
May be done by phone, dependent on underlying causation. Come in to facility to perform a differential diagnosis or medically necessary visit, if needed. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives. Make next treatment / management decisions based on response to initial interventions.

In 7 – 14 days:
Follow-up on last interventions to see if adjustments are needed.

☐ NOCTURIA

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal evaluation, including suprapubic distension or tenderness to palpation
- Any local or systemic signs of UTI (pain or burning on urination, difficulty initiating a urine stream)
- Inspect the urinary meatus
- Rectal evaluation, including any masses, pain, or hard stool (Nocturia can be caused by benign prostatic hyperplasia, prostate cancer, chronic renal failure and other conditions leading to masses, pain, hard stool, and constipation)
- Post-void residual amount
- Characteristics of urine (color, clarity, etc.)
- Signs of symptomatic infection – Fever >38°C = >100.4°F or chills, new or increased burning pain on urination, new flank or suprapubic pain or tenderness, changes in character of urine, worsening mental function

MEDICAL HISTORY

- Patient's age and sex
- History of urinary abnormalities or difficulties
- Changes in usual pattern or volume of fluid intake
- Changes in weight
- Onset, duration, severity, and changes from usual pattern
- Alleviating factors
- All current medications, including any recent changes, especially those associated with increased urination or altered urinary tract function
- All current diagnoses
- Any recent lab (serum BUN, creatinine, electrolytes) or diagnostic test results

NOCTURIA (cont'd)

DRILL IT DOWN

- Local or systemic signs of UTI (fever greater than 100.4°F or 2.4°F above baseline and new or worsening symptoms in at least one of the following – costovertebral angle tenderness, frequency, gross hematuria, suprapubic pain, urgency, urinary incontinence), or if the patient complains of painful urination, it is reasonable to consider a UTI

DIAGNOSES TO CONSIDER:

Common diagnoses

- Noctural polyuria
  - CHF
  - Diabetes mellitus type 2 (BS consistently over 200)
  - Excessive fluid intake
- Urge incontinence
  - Continuation of frequent voids over 8 times per day from day into night
- BPH
- Medications – e.g. diuretics after 3pm, beta blockers
- Obstructive sleep apnea

Other diagnoses

- Chronic renal failure
- Constipation, fecal impaction
- Decreased bladder capacity – bladder outlet obstruction, neurogenic bladder
- Depression
- Diabetes insipidus
- Extrinsic bladder compression – uterine fibroids, radiation induced fibrosis, pelvic neoplasms
- Heart failure
- Hypercalcemia
- Hyperglycemia
- Intake of caffeine, alcohol, or too high fluid intake prior to bed

NOCTURIA (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Psychological factors – anxiety
- Prostate cancer
- UTI

** Nocturia often has multifactorial underlying causes*

SEND OR KEEP?

Transfer to ER if: the patient's vital signs are unstable, critical diagnostic tests are not available in the facility in the required time period, symptoms accompanied by fever 2.4°F above baseline with mental status change. In patients with UTI, complications such as renal obstruction, sepsis, unstable pulse or blood pressure, or serious illness, combined with uncertain diagnosis, may warrant a hospital transfer, however, with nocturia, transfer usually is not necessary.
Keep in facility if: cause can be managed appropriately at facility level (majority of time). Refer to urologist as needed.

WHAT DO I DO?

- Abdominal exam for enlarged bladder
- Clear fecal impaction
- Cystoscopy if indicated
- Perform a digital rectal examination for check of prostate and rectal masses
- Limit fluid intake before bed
- Manage psychogenic causes
- Pelvic and abdominal exam for extrinsic causes
- Treat constipation with laxatives
- Treat underlying disease
- Order a nursing digital rectal evaluation if fecal impaction suspected; if stool sound in rectal vault, order abdominal X-ray to confirm
- Order labs: glucose, UA, PSA, ultrasound of renal system
- Order biopsy of the prostatic gland if CA is suspected

NOCTURIA (cont'd)

FOLLOW UP:

1 – 7 days:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ NOSEBLEED

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details of bleed (quantity, continuous, or intermittent, clots, etc.)
- Any signs of facial or nasal injury
- Inspect under fingernails for possible mechanical cause

MEDICAL HISTORY

- Patient's age and sex
- Any history of similar episodes or trauma
- Onset, duration, frequency, and any related factors (nose picking, high blood pressure, dry air, etc.)
- Severity and ease / means of controlling bleeding.
- All current medications, including any recent changes, especially those that affect bleeding or clotting
- All current diagnoses
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Can nasal bleeding being controlled?
- How much bleeding – teaspoonful or tablespoon, etc.?
- Medication review – is the patient on blood thinners?
- Recent fall?
- Is there a visible facial or nasal injury?
- Is the patient hypertensive?
- Have they been vigorously blowing their nose or "picking" their nose?
- Recent labs: CBC, BMP, clotting profile with PT/PTT
- Determine if bleeding anterior (common and easily visualized) or posterior (occurs from both nares, blood seen in posterior pharynx)

NOSEBLEED (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Local trauma
- Dry, irritated mucosa

Less likely diagnoses
- Elevated INR
- Severe hypertension, bleeding disorder (cirrhosis, leukemia)

Other diagnoses
- Allergic rhinitis
- Foreign body
- Hypertension
- Infection
- Trauma
- Medications (warfarin and other anticoagulants)
- Tumor

SEND OR KEEP?

Transfer to ER if: poorly controlled epistaxis with hemodynamic instability, posterior epistaxis, leukemia, bleeding disorder, PT/INR elevated with uncontrollable bleeding or if surgical intervention needed.
Keep in facility if: bleeding is controlled and hemodynamically stable.

WHAT DO I DO?

- Hold direct pressure for about 10 minutes and repeat (intranasal phenylephrine if available)
- Reassess anticoagulation
- Consider packing of anterior nostrils (if anterior packing done, order specific monitoring for complications like sinusitis, otitis media, cardiac arrhythmia, necrosis of mucosa, and hypoxia), counsel patient about picking nose
- Consider saline spray for dry, irritated mucosa
- Order Labs: CBC, BMP, clotting profile with PT/PTT if appropriate
- Treat hypertension

NOSEBLEED (cont'd)

FOLLOW UP:

1 – 7 days:

If anterior packing – follow-up visit. Patients who had anterior packing should be seen in 2 – 3 days to look for complications like sinusitis, otitis media, cardiac arrhythmia, necrosis of mucosa, hypoxia. Otherwise, make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Routine visit:

Follow-up on last interventions to see if adjustments are needed.

☐ POTASSIUM (K+), ABNORMAL (HYPOKALEMIA / HYPERKALEMIA)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially pulse rate and rhythm
- If **potassium** level is **low**, are there any signs of muscle weakness, cramps, fatigue and confusion
- If **potassium** level is **high**, any signs of numbness and tingling of extremities, palpitations, fatigue, and weakness

MEDICAL HISTORY

- Patient's age and sex
- Any recent lab or diagnostic test results, including serum electrolytes, BUN, and creatinine results, compared to previous results
- History or current diagnosis of acid-base disturbance (alkalosis or acidosis)
- Recent or current symptoms of significant vomiting, diarrhea, or poor dietary intake
- All current medications, including any recent changes, especially potassium supplements, ACE inhibitors and diuretics and lanoxin
- All current diagnoses

DRILL IT DOWN

- Hypokalemia (LOW K+)
  - Signs and symptoms: severe weakness, cramps, hyporeflexiaileus, arrhythmias, hypotension, rhabdomyolysis
  - Medication review – determine if patient is taking digoxin
  - Recent labs: CBC, BMP, serum Mg, serum phosphates, serum glucose
- Hyperkalemia (HIGH K+)
  - Recheck if hemolyzed specimen
  - Discontinue medications causing elevated K+
  - EKG to evaluate for peaked T waves
  - Recent labs – electrolytes (Ca, Mg, PO4), BUN / creatinine

POTASSIUM (K+), ABNORMAL (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses – **hypokalemia**
- Medications – diuretics
- K+ loss via GI – recent significant vomiting or diarrhea
- Hypomagnesaemia

Common diagnoses – **hyperkalemia**
- Lab error – hemolysis
- Medications – K+ supplements, ACE inhibitors, spironolactones
- Acute or chronic renal failure

Other causes / diagnoses
- Acid-base disturbance
- Dietary excess
- Hypothyroidism
- Infections
- Rhabdomyolysis, hemolysis, periodic paralysis
- Pseudo hyperkalemia due to hemolysis
- Steroid myopathy

SEND OR KEEP?

Transfer to ER if: severe hypokalemia (less than 2.5 mEq/L), K less than 3.0 with cardiac symptoms or EKG changes OR severe hyperkalemia (6.5-7.5 mEq/L), K 6.0-6.5 with EKG changes. (Unless patient has a do not transfer order.)
Keep in facility if: asymptomatic residents without EKG changes manage expectantly. Missed dialysis appointment – consider sodium polystyrene sulfonate 60gm PO once and inform the dialysis center.

WHAT DO I DO?

Hypokalemia
- Treat underlying potassium deficiency
- Replete potassium and magnesium hydrate if needed

POTASSIUM (K+), ABNORMAL (cont'd)

WHAT DO I DO? (cont'd):

Hyperkalemia

- Discontinue offending medication
- Consider sodium polystyrene sulfonate orally
- Consider loop diuretics
- Order repeat potassium level
- Order magnesium level and replace if necessary

FOLLOW UP:

1 – 7 days:

Follow-up on ordered lab tests and intervene accordingly.

Next scheduled visit:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ PRESSURE ULCERS

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Skin evaluation, including detailed description of pressure ulcer (anatomical location, size, depth, color of the wound and surrounding tissue, description of any drainage, and staging)
- Pain evaluation (location, nature, severity, etc.), including ability to sense and react to pain and discomfort
- Presence and strength of peripheral pulses when lower extremity ulcers are present
- Degree of immobility, presence of contractors, and presence of urinary or fecal incontinence

MEDICAL HISTORY

- Patient's age and sex
- History of previous pressure ulcers, healed or unhealed
- Current treatments, including pressure offloading devices and effectiveness of those treatments
- All current diagnoses, especially peripheral vascular disease, diabetes, urinary or fecal incontinence, and anorexia or weight loss
- All current medications
- Current weight, diet, and nutritional status
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Is it getting better or worse?
- Does it require debridement?
- Presence of peripheral pulses, if lower extremity ulcer present
- Degree of immobility, presence of contractures, presence of urinary or fecal incontinence
- What is currently being done for pressure prevention?
- Dietary intake – adequate?
- Is the resident septic?

PRESSURE ULCERS (cont'd)

DIAGNOSES TO CONSIDER:

- Staging of ulcer (see Appendix 2)

SEND OR KEEP?

Transfer to ER if: the patient has signs of septic infected pressure ulcer(s) (hypotension, fever over 102°F change in level of consciousness, fever, surrounding cellulitis or abscess, or suspicion of osteomyelitis) and you feel that starting of antibiotics in facility will not manage the infection quickly enough.
Keep in facility if: no signs and symptoms of urgent systemic infection.

WHAT DO I DO?

Not all open skin lesions are pressure ulcers. The attending practitioner will need to diagnose type of lesion first. For example, non-pressure ulcer lesions could be: arterial ulcers; diabetic foot ulcers; excoriations / rashes; post-surgical sites; self-indicted wounds; venous stasis ulcers

- Assess for risk factors – comorbid conditions (e.g. diabetes, renal disease, thyroid disease); drugs that may affect ulcer healing (e.g. steroids); exposure of skin to fecal incontinence; history of a healed Stage III or IV pressure ulcer; impaired diffuse or localized blood flow (e.g. generalized atherosclerosis, lower-extremity arterial insufficiency); impaired or decreased mobility and functional ability; increase in friction or shear; moderate to severe cognitive impairment; organ failure, refusal of some aspects of care and treatment; calorie and protein undernutrition, malnutrition, and hydration deficits
- Do additional pressure reduction devices need to be ordered – bed, wheelchair cushion, off-loading for heels, splints?
- Look to see if the wound is infected – odor, increased pain, wound is getting worse, erythema, purulent drainage

PRESSURE ULCERS (cont'd)

WHAT DO I DO? (cont'd):

- Familiarize yourself with the list of wound care products available to the facility
  - i.e. hydrocolloid, hydrogel – solid and liquid, collagenase, silver products, calcium alginate, zinc oxide
- Ask if the facility has or has access to a certified wound care expert
- Pain control for dressing changes if needed
- Importance of keeping wound clean – maintenance of bowel and urine by occlusive dressings, frequent changes. (Indwelling catheters to heal sacral wounds are not universally recommended but may be appropriate in some patients.)
- Order labs: CBC, creatinine, erythrocyte sedimentation rate (if infection or anemia suspected)

FOLLOW UP:

24 – 48 hours of first assessment:
Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Bi-weekly if no certified wound care nurse or wound not healing as expected:
Make next treatment / management decisions based on response to initial interventions.

Routine visits for monitoring:
Follow-up on last interventions to see if adjustments are needed.

☐ PULSE, ABNORMAL (SEE ALSO CHEST PAIN, DIZZINESS, DYSPNEA, EKG ABNORMAL, POTASSIUM ABNORMAL)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially detailed evaluation of pulse rate, rhythm and blood pressure
- If pulse is absent or weak, palpate the remaining arterial pulses to distinguish between localized or generalized loss / weakness. Assess for pain in the area pulse is absent. Evaluate the limb for color and temperature
- Heart and lung evaluations
- Evaluate for related findings including alteration in consciousness, chest pain, diaphoresis, dyspnea, fever, and blood loss
- O2 sats.

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration and severity of any associated symptoms including dizziness, loss of consciousness, anxiety, chest pain, diaphoresis, shortness of breath and blood loss
- Any history of cardiac arrhythmias
- Presence of a pacemaker and whether it is functioning
- All current diagnoses
- All current medications, including any recent changes, especially those known to affect cardiac rhythm and rate such as antiarrhythmics or Ca channel blockers
- History of dietary intake that could affect heart rate (such as caffeine)
- Any recent lab or diagnostic test results
- Change in food and / or fluid intake
- Presence of nausea, vomiting, diarrhea

PULSE, ABNORMAL (cont'd)

DRILL IT DOWN

- Irregular, high heart rate / low heart rate
  - Is there a pacemaker in place and functioning?
  - Medication review
  - Diet – more or less caffeine than usual?
  - Signs of dehydration
  - O2 sats.
  - Is there an EKG – can it be scanned and emailed or faxed to you for review?
- High heart rate
  - Move patient to calm environment, and re-check pulse manually
  - Any accompanying symptoms – chest pain, SOB, dizziness, change in LOC, diaphoresis?
  - Any precipitating factors – pain, physical activity, anxiety, caffeine?
  - History of palpitations? Atrial fibrillation?
- Slow heart rate
  - Check pulse manually
  - Check vitals
  - Any accompanying symptoms – fatigue, chest pain, SOB, dizziness / change in LOC, etc.?
  - Cardiac medications – beta blockers, digoxin, Ca channel blockers, anti-arrhythmic agents (sotalol, amiodarone)

DIAGNOSES TO CONSIDER:

- Angina
- Atrial fibrillation
- Bradycardia
- Tachycardia

SEND OR KEEP?

Transfer to ER if: heart rate (HR) greater than 150, HR 100-150 with symptoms, HR less than 55 with symptoms, other vital signs abnormal with irregular pulse, may be septic, EKG is indicated and needed urgently, pulse on one side is absent (e.g. one foot is cold without a palpable pulse while other foot is warm with a palpable pulse).

PULSE, ABNORMAL (cont'd)

SEND OR KEEP? (cont'd)

Keep in facility if: HR less than 150 and patient is asymptomatic and can tolerate symptoms, HR less than 55 with no symptoms.

WHAT DO I DO?

- HR less than 55 and no accompanying symptomology, order monitoring and to notify you if rate decreases and or if patient presents with symptoms
- HR 100 – 150 with no symptoms order monitoring and to notify you if rate increases and or if patient presents with symptoms
- Reassess medications and remove or reduce offending medications
- Order mobile EKG, if warranted and available
- Order labs: chest X-ray to detect pulmonary disease, quantify cardiac size and assess pulmonary congestion; echocardiogram will quantify left ventricular function and may detect valvular abnormalities, ventricular hypertrophy, or evidence of pericardial effusion; blood tests that may be helpful for identifying precipitating factors for AF include thyroid-stimulating hormone to detect hyperthyroidism or hypothyroidism, CBC to detect anemia or polycythemia, a CMP to search for electrolyte abnormalities or evidence of renal or hepatic dysfunction

FOLLOW UP:

Next 24 hours:
Intervene appropriately based on symptomology and any abnormal test results and patient's advanced directives.

In 7 – 10 days:
Make next treatment / management decisions based on response to initial interventions and any lab and / or radiology results if ordered.

Next routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ PUNCTURE WOUNDS

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Describe wound depth, location, amount of any drainage or bleeding, and other characteristics
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- How has situation been managed so far?
- All current medications, including any recent changes
- All current diagnoses
- Tetanus toxoid vaccination history, if known
- How puncture wound occurred, if known?

DRILL IT DOWN

- How did the wound occur?
- What has been done to control the bleeding?
- What can be done in the facility? What are the facility wound care policies?
- Wound characteristics – time since wound occurred, length, depth, shape, location, tension, tetanus status, tendon function, scar formation from previous wounds and distal neurovascular symptoms
- Is there a need for sutures, staples, skin glue?

DIAGNOSES TO CONSIDER:

- Laceration
- Crush wound
- Bite wound
- Puncture wound
- Foreign body
- Open fracture

PUNCTURE WOUNDS (cont'd)

SEND OR KEEP?

Transfer to ER if: puncture wound in head, neck, chest, or stomach, wound is bleeding profusely, unable to remove the object from the wound, signs of decreased blood flow at or near a puncture wound, loss of function at or near the puncture wound, immediate and large amount of swelling and bruising at or near a puncture wound.
Keep in facility if: can be treated / managed in facility.

WHAT DO I DO?

- Control bleeding – allow wound to bleed freely, but if bleeding is heavy, apply pressure until it stops
- Explore the wound for foreign bodies – if you believe there are foreign bodies, order an X-ray (an X-ray can reveal metal pieces but send out for CT scan for wood or plastic pieces)
- Debride devitalized dead tissue
- Order wound care – use bacitracin and non-stick gauze (if available); keep non-stick gauze in place with gauze roll; goal is to keep area clean and moist
- Consider tetanus toxoid or Tdap
- Consider pain management
- Order nursing staff to notify you if signs of infection

FOLLOW UP:

In 48 hours:
Call to see if signs of infection are present.
In 7 – 10 days:
Call to see if wound is healing without complications.
Next scheduled visit:
Follow up to see if wound has healed without complications.

☐ RASH (SEE ALSO BLISTERS)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Skin evaluation, including detailed description of location (diffuse or localized), whether the rash or blisters are discrete or confluent (run together), presence of erythema or other discoloration, associated blistering *(bullae, pustules, vesicles), and whether the rash is flat or raised
- Other details of skin condition, including evidence of dryness, fragility, redness, blisters, etc.
- Signs of complications from scratching, such as excoriation
- Evaluate for signs of allergic reaction, such as urticaria (hives)

MEDICAL HISTORY

- Patient's age and sex
- All current medications, including any recent changes
- History of allergies (food, medications, etc.)
- History of other (similar or different) skin rashes or allergic reactions
- Any changes in lotions, perfumes, soaps, etc.
- All current diagnoses
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Onset and evolution of symptoms
- Type and distribution of rash, symptomatology (fever, pruritus)
- Signs of allergic reaction (hives)
- Rash contacts? (scabies)
- Any prior treatment?
- Current or recent antibiotic use?
- Is rash painful?

RASH (cont'd)

DRILL IT DOWN (cont'd)

- Characterization of rash — what does it look like?
  - Bullae – more than one bulla – bulla is a blister more than 0.5cm with thin walls that is full of fluid
  - Macule – flat non palpable change in skin color smaller than 1.0cm
  - Nodule – elevated solid mass, deeper and firmer than papule 0.5 to 2.0cm (such as a wart)
  - Papule – palpable solid elevation smaller than 0.5cm
  - Ulcer – deep loss of skin surface that may extend to the dermis and frequently bleeds and scars
  - Vesicle – elevation of skin filled with serous fluid smaller than 0.5cm
  - Wheal – irregularly shaped, elevated area or superficial localized edema, varies in size (hive, mosquito bite)

DIAGNOSES TO CONSIDER:

Most common diagnosis
- Dry skin (xerosis)

Common diagnoses
- Drug reaction
- Neurodermatitis – seen in dementia

Rare diagnoses
- Autoimmune disorders
- Connective tissue disorder
- Toxin mediated desquamative rashes (Steven Johnson Syndrome)

Other diagnoses
- Eczema
- Infections / febrile rash / shingles / folliculits
- Infestations (scabies)
- Miliria – **not a rash** – chronic white creamy papules on face and arms
- Skin malignancy – **not a rash** – mole or skin lesions with central ulceration and rolled edges
- Urticaria (hives)
- Psoriasis

RASH (cont'd)

SEND OR KEEP?

Transfer to ER if: sepsis with hemodynamic compromise, infected rashes needing IV antibiotics, immune compromised state.
Keep in facility if: all other non-emergent causes.

WHAT DO I DO?

- Treat the underlying cause
- Isolate patients with scabies and treat accordingly
- Consider topical steroids and moisturizing lotions
- Antibiotics / antivirals / antiparasitics as appropriate with underlying cause
- Consider dermatology consult
- Discontinue or reduce offending medication

FOLLOW UP:

As soon as possible:
If you don't get a good sense of the rash diagnosis from the nurse, you would want to see the rash yourself.

In 7 – 10 days:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ RESPIRATORY RATE, ABNORMAL (SEE ALSO CHEST PAIN, EDEMA, EKG ABNORMAL)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, especially respiratory rate and rhythm
- Heart and lung evaluations, including presence of rales, wheezes, rhonchi or absent breath sounds, dyspnea or respiratory distress
- Whether individual is struggling to breathe and/or using accessory muscles to help breathe
- Related signs, including cough or sputum production
- Evaluate level of consciousness, orientation
- Evaluate skin for color, temperature (cool, clammy, etc.)

MEDICAL HISTORY

- Patient's age and sex
- How has situation been managed so far?
- Onset, severity and duration
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results, including pulse oximetry results and findings of acid-base disturbance (acidosis, alkalosis)

DRILL IT DOWN

- Medication review
- Past medical history
- History of chronic lung disease – COPD, emphysema
- CXR if available
- EKG if available
- Is this acute or chronic?
- Evidence of new cough, sputum production, fever or other signs of infection
- Other symptoms – anxiety, unable to lie down, fever, low blood pressure

RESPIRATORY RATE, ABNORMAL (cont'd)

DRILL IT DOWN (cont'd)

- Are they in respiratory distress – SOB, diaphoresis, brief fragmented speech, retractions, cyanosis / dusky?
- Evidence of CHF – edema, rales
- Evidence of MI
- Vitals include O2 sats.

DIAGNOSES TO CONSIDER:

Common diagnoses
- COPD exacerbation
- Respiratory infection / pneumonia

Other diagnoses
- Cancer of lung and pleura
- Asthma
- Cardiac-CHF / MI / arrhythmias
- Hypoxia
- Anemia
- Medication (side effects and / or ADEs)
- PE

Rare diagnoses
- Acute anaphylaxis
- Carbon monoxide poisoning
- Sarcoidosis, Wegener's Granulomatosis

SEND OR KEEP?

Transfer to ER if: associated with respiratory distress (COPD exacerbation, flash pulmonary edema), or signs of hemodynamic instability (sepsis, MI, pulmonary embolism), or severe change of mental status, tachypnea (more than 28/minutes) with labored respirations, secondary to acute infection, chronic lung disease, acute exacerbation causing hypoxia, presence of high-risk comorbid conditions (e.g. cardiac arrhythmia, congestive heart failure, diabetes mellitus, pneumonia, renal or liver failure).

RESPIRATORY RATE, ABNORMAL (cont'd)

SEND OR KEEP? (cont'd)

Keep in facility if: there is an identifiable source of increased respiratory rate and can be controlled / corrected at facility level, hypoxia can be corrected with supplemental oxygen, patient has a "do not transfer" order.

WHAT DO I DO?

- Supplemental oxygen
- Anxiolytics / bronchodilators
- Order CBC, chem panel
- Order portable spirometry if appropriate and available
- Treat the underlying cause
- Review medications and discontinue offending agents
- Antibiotics to control infection
- Morphine sublingual or PO every 2 hours to help air hunger in palliative care patients

FOLLOW UP:

In 24 hours:
May be done by phone. Follow-up on patient's respiratory rate and other vital signs, intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

In 1-7 days:
Make next treatment / management decisions based on response to initial interventions.

Next routine visit:
Follow-up on last interventions to see if adjustments are needed.

☐ SEIZURE ACTIVITY OR CONVULSIONS

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details (location, duration, severity, recurrence, etc.) of any seizure activity, including localized or generalized motor activity, bowel or bladder incontinence, behavioral changes, loss of consciousness
- Details of any injury or complications associated with the seizure activity
- Any signs and symptoms associated with any medical conditions related to the patient's seizure disorder (muscle twitching due to hypocalcemia, etc.)
- Neurologic evaluation after seizure activity

MEDICAL HISTORY

- Patient's age and sex
- Any history of seizure disorder or seizure activity
- Any recent history of head injury, fall, trauma, fever, headache, periods of confusion
- All current medications, including any recent changes, particularly medications associated with increased seizure risk
- All current diagnoses
- Date and time of any recent or current seizure activity
- Comparison of current seizure activity related to usual patterns
- Recent lab or diagnostic test results, especially BMP, calcium and anticonvulsant blood levels

DRILL IT DOWN

- Detailed history and physical
- LABS: electrolytes, serum glucose, CBC, BUN / creatinine, ESR, LFT's, CK, RPR, urinalysis
- Urine and blood drug toxicology screen
- Antiepileptic drug levels in patients taking anticonvulsants
- Lumbar puncture
- CT scan of head without contrast
- EKG
- MRI of the brain

SEIZURE ACTIVITY (cont'd)

DIAGNOSES TO CONSIDER:

- Arrhythmia
- Breakthrough seizure while on antiseizure drugs
- CVA
- Delirium
- Dementia (usually moderate to late stage)
- Drug overdose / toxicity
- Epilepsy
- Head trauma
- Hypoglycemia
- Hyperventilation syndrome
- Infection (lowers threshold for seizures)
- Metabolic encephalopathy
- Migraines
- New seizure disorder
- Sleep disorders
- Subdural
- Syncope
- TIA
- Trauma

SEND OR KEEP?

Transfer to ER if: seizures due to hypoxia, hypoglycemia, persistent mental status changes, arrhythmias, alcohol withdrawal, acute head trauma, and status epilepticus.
Keep in facility if: dementia, sleep disorders, accidental drug ingestion with normal vitals, can be handled at facility level, patient has a "do not transfer" order.

WHAT DO I DO?

- ABC: airway, breathing and circulation
- Supplemental oxygen, pulse oximetry
- Treat the underlying systemic cause
- Neurology consult if appropriate
- Order appropriate labs
- Consider reloading patient with seizure medications while labs are pending
- Remove potential drug interactions causing lowered seizure threshold (wellbutrin, cipro, seroquel, etc.)

SEIZURE ACTIVITY (cont'd)

FOLLOW UP:

In 24 hours:

Come in to facility to perform a differential diagnosis. Intervene appropriately based on symptomology and test results and patient's advanced directives.

Next business day or within next few days (dependent on circumstances):

Referral to neurology for seizure management or persistent mental status changes over 24 hours. Follow-up on last interventions to see if adjustments are needed.

☐ SLEEP DISTURBANCE

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Any significant changes in function, mood, cognition, and behavior
- Observations related to the individual's efforts to sleep (restlessness, apnea episodes, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Details of the problem (frequency, severity, precipitating and relieving factors, whether individual is having difficulty falling asleep, difficulty staying asleep, or early morning awakening)
- When the individual usually goes to bed or falls asleep
- Any change from usual or customary pattern for this patient
- Any history of insomnia, sleep apnea or other sleep disorders
- All current medications, including any recent changes, especially those associated with sleep disturbances
- All current diagnoses
- Environmental factors (room by nurses station, etc.)
- Effectiveness of any current or previous interventions
- Possible contributing factors such as caffeine intake or afternoon nap
- Social issues such as the death of a loved one or depression

SLEEP DISTURBANCE (cont'd)

DRILL IT DOWN

- Acute vs. chronic?
- Any past treatment for insomnia?
- Determine difficulty falling asleep, staying asleep, early morning awakening (sleep diary by staff – quietly check resident each hour and document)
- Snoring +/- arousals?
- Medication review including times of treatments and medication dosing

DIAGNOSES TO CONSIDER:

Common diagnoses

- Improper sleep habits / hygiene – especially daytime napping and staff interruptions (e.g. vitals, meds, assessments, change briefs / turning, etc.)
- Depression and/or anxiety
- Nocturia
- Medication – steroids, phenytoin, amiodarone, amiodarone, paroxetine, antipsychotics, omeprazole, anticonvulsants, atorvastatin, ramipril, beta blockers and levodopa (which can cause nightmares)
- Pain
- OSA (obstructive sleep apnea)
- True insomnia (~10%)

Other diagnoses

- Caffeine at night
- Comorbid conditions that exacerbate insomnia – orthopnea, nocturia, Parkinson's, GERD
- Nightmares, hallucinations
- Restless leg syndrome
- Sleep apnea, narcolepsy

SLEEP DISTURBANCE (cont'd)

SEND OR KEEP?

Transfer to ER if: patient is psychotic, acutely or severely depressed with suicidal tendencies.
Keep in facility: most causes treated conservatively working with nursing staff and family.

WHAT DO I DO?

- Sleep hygiene education, cognitive behavioral therapy, warm milk (#1)
- Monitor environmental factors – noise, light, smells, awakening for continence checks, bed positioning by staff (#2)
- Increase exercise / activities daily
- Allow patient flexibility in time to go to bed / get up; avoid day time catnapping
- Depression and anxiety (remeron may be helpful – sedating at doses less than equal to 30mg)
- Light therapy to regulate sleep wake cycle dysfunction
- Chaplain / counseling if recent emotional loss (e.g. death of spouse)
- Control of blood sugars – nighttime urination, hypo or hyperglycemia
- Consider medications: Trazadone or Ambien (avoid benzodiazepine use, avoid hypnotics if possible due to potential side effects)
- Refer for sleep study if suspect OSA (for dx and CPAP / BPAP titration)

FOLLOW UP:

In 1-7 days:
May follow-up by phone. Make next treatment / management decisions based on response to initial interventions.
Next scheduled visit:
Follow-up on last interventions to see if adjustments are needed.

☐ SODIUM, ABNORMAL (HYPONATREMIA / HYPERNATREMIA)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Signs of significant changes in mental status, function, behavior, or level of consciousness
- If Na level is **high,** evaluate for signs of agitated type behavior, behavioral disturbance, diminished appetite, confusion, altered level of consciousness, alterations in urine output, and conditions associated with fluid loss such as vomiting or diarrhea
- If Na level is **low,** evaluate for signs of complications including confusion, altered level of consciousness, anorexia, convulsions, signs of conditions associated with fluid loss including vomiting, diarrhea, sweating and fever, and signs of shift of body fluids such as edema and ascites

MEDICAL HISTORY

- Patient's age and sex
- Any recent lab test results, especially BUN, creatinine, serum osmolality, electrolytes, urine osmolality and urine spot sodium, and previous test results for comparison
- All current diagnoses
- All current medications, including any recent changes, especially diuretics, ACE inhibitors, and other medications containing sodium, or associated with sodium retention, or disturbances in renal function, or fluid electrolyte balance
- Any symptoms of conditions causing fluid excess or loss
- Diet, especially any salt or fluid restrictions
- Patterns and amounts of food and fluid intake over past week

DRILL IT DOWN

- Assess volume status – signs of both fluid overload and dehydration (#1)
- Medication review – diuretic effect with potassium retention from concurrent CRI, antipsychotics, depakote, SSRIs, NSAIDS, etc. (#2)

SODIUM, ABNORMAL (cont'd)

DRILL IT DOWN (cont'd)

- Compare sodium level to past labs
- Recent labs: CBC, CMP, plasma and urine electrolytes, plasma and urine osmolality, serum glucose, serum protein and lipids, liver function studies, BUN / creatinine, urine Na+, TSH followed by T3 and T4

DIAGNOSES TO CONSIDER:

Common diagnoses – **Hyponatremia** (an acute drop is more significant than a slowly progressive drop)

- A sodium level of 120 – 130 mEq/L could lead to confusion, altered mental status, lethargy
- A sodium level of less less than 120 mEq/L could lead to seizures, coma, delirium, death
- Euvolemi – SIADH, medication side effect, renal failure, fluid overload, CHF, cimbosis, nephrotic syndrome
- Hypertonic – hyperglycemia, hypertonic fluid infusions
- Hypotonic
  - Hypervolemic – cirrhosis, CHF, nephrosis
  - Isovolemic – SIADH, renal failure, hypothyroidism, psychogenic polydipsia, drugs (diuretics, ACE inhibitors, SSRI, opiates, chlorpropamide, cytotoxics, carbamazepine)
  - Hypovolemic – vomiting, diarrhea, burns, pancreatitis, Addison's disease, renal tubular acidosis and renal losses through diuretics
- Isotonic – hyperlipidemia, hyperprotienemia

Common diagnoses – **Hypernatremia**

- Hypovolemia / dehydration
- IV fluids (normal saline use)

SODIUM, ABNORMAL (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

Other diagnoses – **Hypernatremia**

- Diabetes insipidus
  - Central DI: characterized by decreased secretion of antidiuretic hormone, that results in polyuria and polydipsia by diminishing the patient's ability to concentrate urine
  - Nephrogenic DI: characterized by a decrease in the ability to concentrate urine due to resistance to antidiuretic hormone action in the kidney
- Increased H2O loss – vomiting, diarrhea, sweating, fever, diuretics, burns, alcohol, osmotic diuresis due to hyperglycemia, drugs (lithium, phenytoin), thyrotoxicosis, hyperthermia, adrenal or renal failure
- Decreases H2O intake – impaired thirst, poor oral intake in elderly (coma, CVA, ventilated patients)
- Increased Na+ – sodium bicarbonate administration, hypertonic saline, renal salt retention (e.g. mineralocorticoid excess, Conn's, Cushing's)

SEND OR KEEP?

Transfer to ER if: severe hyponatremia (less than 120 mEq/L) or any Na level with change in mental status or seizures, CNS symptoms.

If: severe hypernatremia (greater than 158 mEq/L), hypotension, decreased urine output, lethargy, coma, confusion, seizures with mental status changes (symptoms begin when: osmolarity greater than 350; irritability and ataxia when greater than 375; lethargy, coma, and seizures greater than 400).

Keep in facility if: mild hyponatremia without change in mental status and the facility has the ability to check sodium appropriately (greater than 120 mEq/L), non-emergent and facility can meet patient needs (see Appendix 1).

If: mild hypernatremia without change in mental status and stable vitals, non-emergent and facility can meet patient needs (see Appendix 1).

SODIUM, ABNORMAL (cont'd)

WHAT DO I DO?

Hyponatremia

- Order labs: plasma and urine electrolytes, plasma and urine osmolality, serum glucose, serum protein and lipids, BUN / creatinine, urine Na+
- Run IV fluids (if facility has ability)
  - Treat severe hyponatremia (less than 120 mEq/L) with 3% saline at 25 – 100 mL/hr
  - For hypotonic and hypovolemic hyponatremia – administer 0.9% normal saline
- For isotonic and hypertonic hyponatremia – correct glucose, lipids and protein abnormalities
- For hypotonic, isovolemic hyponatremia – restrict fluids and loop diuretic
- For hypotonic and hypervolemic hyponatremia – restrict Na+ and water and administer loop diuretic

Hypernatremia

- Order labs: CMP, CBC, serum osmolarity, urine Na+, urine osmolarity, liver function tests, TSH followed by T3 and T4
- Encourage oral fluids – usually patients need 3 – 4 liters for rehydration
- Run IV fluids (if facility has ability) – treat emergently with IV fluids
  - Free water deficit has to be replaced, so alternate normal saline with 5% dextrose solutions – most patients will have sodium corrected to normal before fully being hydrated
  - Serum Na+ should be reduced by no more than 10 – 15 mEq/L per day
  - Isovolemic hypernatremia – replace fluid with 5% Dextrose water
  - Hypovolemic hypernatremia – replace fluid with NSS
  - Hypervolemic hypernatremia – administer 5% Dextrose water and loop diuretics

SODIUM, ABNORMAL (cont'd)

FOLLOW UP:

Within 24 hours:

Follow-up on labs and make next treatment decisions based on results.

In 1 – 7 days (based on diagnosis):

Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. Follow-up on last interventions to see if adjustments are needed.

☐ SORE THROAT (SEE ALSO SWALLOWING DIFFICULTY)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Mouth / throat and teeth / gums evaluations, including details of sore throat (location, nature, severity, etc.)
- Signs of oral / dental problems and difficulty swallowing
- Any associated signs such as rhinorrhea, sinus congestion, hoarseness, fever, ear pain, or dysphagia
- Any signs of respiratory distress
- Any signs of dyspepsia, indigestion, or gastroesophageal reflux

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration and severity of symptoms
- All current diagnoses
- All current medications, including any recent changes
- Recent or current history of gastroesophageal reflux disease, dyspepsia, gastritis, peptic ulcer disease, pharyngitis, dental or periodontal disease
- Use of oxygen
- Effectiveness of any recent interventions (humidification of inspired air, change in room temperature, hot beverages, throat lozenges, etc.)
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Any other patients in facility with same symptoms?
- Onset
- Associated symptoms – rash, fever, hypotension, cough, post nasal drip, sinus tenderness
- Hoarseness or cough symptoms if viral syndrome
- Recent labs: CBC, BMP

SORE THROAT (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Viral URI
- Viral pharyngitis
- Post-nasal drip
- Oral candidiasis
- GERD

Other diagnoses
- Aphthous ulcers (canker sore)
- Glossitis
- Infection – viral / bacterial
- Pharyngitis
- Severe reflux
- Sinusitis
- Xerostomia

Uncommon diagnoses
- Cervical spine pain
- Thyroiditis

SEND OR KEEP?

Transfer to ER if: sore throat with any respiratory distress, stridor, drooling (functional dysphagia secondary to mass), evaluation, tonsillar / peritonsillar abscess needing urgent ENT evaluation.
Keep in facility if: stable.

WHAT DO I DO?

- Symptomatic relief with fluids, chloroseptic spray, throat lozenges as needed (less than 1 week duration)
- Treat pain with acetaminophen 325mg 1 – 2 tablets every 6 hours (for less than 1 week duration and do not exceed 3gms per day)
- Anti-inflammatory agents and oral anesthetics
- If bacterial (pharyngitis) use penicillin, if penicillin allergy use azithromycin (500mg PO for 3 days)
- Treat underlying cause

FOLLOW UP:

1 – 7 days:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered. May be done by phone.

☐ SPEECH, ABNORMAL

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological evaluation, including changes in mental status and level of consciousness, facial weakness / drooping
- Mouth / throat and teeth / gum evaluation, including mouth or tongue pain, swelling or ulcers, and missing teeth

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, severity, and scope of abnormality, intermittent or constant
- History of stroke or other neurological disorders, oropharyngeal diseases or surgery, or tumors of mouth, face, tongue, or throat
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Review medication list for potential side effects that increase confusion
- Onset (acute or chronic), duration, associated symptoms, drooling of saliva, focal or lateralizing signs, new behaviors, alcohol use
- Pulse oximetry
- Recent labs: CBC BMP, UA

DIAGNOSES TO CONSIDER:

- Acute dysarthria (slurred speech) – suspect CVA/TIA
- Gradual / chronic
  - medication side effect
  - progression of disease – prior CVA, Parkinson's, dementia

SPEECH, ABNORMAL (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Alcohol excess
- Cardiac arrhythmias
- Edentulousness (toothless)
- Electrolyte disturbances
- Ill-fitting dentures
- Medication adverse event
- Metabolic encephalopathy
- Myasthenia gravis
- Parkinson's disease
- Recent surgery in HEENT area
- Swallowing problems
- Stroke / cerebellar disease
- Tumors of mouth, face, throat, or tongue

SEND OR KEEP?

Transfer to ER if: abrupt change in speech with or without other focal neurological deficits, TIA/CVA diagnosis, if the patient is having impending stroke or TIA, dangerous medication error or overdose.
Keep in facility if: stable patient with normal vitals.

WHAT DO I DO?

- Treat underlying condition appropriately – hydrate patient, remove or adjust offending medications, have patient avoid alcohol, control hypertension and modify the risk factors for stroke (lipids, glucose), get dentures that fit, etc.
- Order EKG if appropriate
- Order labs: CBC BMP, UA, if appropriate
- Send out for CT scan of brain (non-contrast)

SPEECH, ABNORMAL (cont'd)

FOLLOW UP:

1 – 7 days:
Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

7 – 14 days (dependent on diagnosis):
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:
Follow-up on last interventions to see if adjustments are needed.

☐ SPRAINS / STRAINS

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Musculoskeletal and extremities evaluation, including signs of swelling, deformity, bruising, discoloration
- Change in active or passive range of motion to affected part
- Ability to bear weight, if lower extremity involved
- Pain evaluation (location, nature, severity, etc.)
- Signs of injury to other body areas

MEDICAL HISTORY

- Patient's age and sex
- How the injury occurred, if known
- Status of injury compared to earlier (if not new)
- How situation has been managed so far (ice, elevation, compression, etc.)
- All current medications, including any recent changes
- All current diagnoses
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Determine mechanism of injury
- Which joint(s)?
- Extent of injury?
  - ROM?
  - Can patient bear weight?
  - Deformity / swelling / bruising / discoloration / crepitus?

DIAGNOSES TO CONSIDER:

- In General :
  - 1° sprain – strained ligament
  - 2° sprain – partially torn ligament
  - 3° sprain – complete torn ligament (at risk for associated avulsion fracture – this is an unstable joint)

SPRAINS / STRAINS (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Acute osteoarthritis
- Dislocation
- Fall
- Gout
- Elder abuse
- Muscle hematoma
- Osteomyelitis
- Rheumatoid arthritis
- Septic arthritis

SEND OR KEEP?

Transfer to ER if: abnormal neurovascular signs, any potential fracture or 3° sprain (for orthopedic consult in ER), instability of joint.
Keep in facility if: 1° or 2° sprain with normal neurovascular examination

WHAT DO I DO?

- Have nurse examine pulses, capillary refill, sensation (neurovascular signs)
- R/O fracture by clinical examination
- Order X-ray if needed (especially if patient cannot bear weight)
- RICE – rest, ice, compression, elevate (ice for more than 24 hours to decrease swelling)
- Consider physical therapy consult
- Immobilization
- NSAIDS / analgesics for pain control

FOLLOW UP:

1 – 7 days:
May be done by phone. Check on pain control and neurovascular signs.
Next scheduled visit:
Follow-up on last interventions to see if adjustments are needed.

☐ SUICIDE POTENTIAL

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Current mood and affect
- Neurological, behavioral, and cognitive evaluations
- Current behavior or statements by the patient indicating active efforts or desire to inflict self-harm

MEDICAL HISTORY

- Patient's age and sex
- All current diagnoses, especially those related to psychiatric disorders and previous suicide attempts
- Any documented statements by the patient indicating a detailed plan for suicide or about wanting to die, but without a specific plan or threat
- Patterns or change in frequency or extent of discussions about suicide or of wanting to die
- Any recent history of personal loss (for example, death of spouse)
- All current diagnoses
- All current medications, including any recent changes, especially antidepressants or medications that may cause central nervous system depression
- Recent lab or diagnostic test results
- Any findings from recent or previous psychiatric consultations
- Any hoarding of medications
- What measures are in place to prevent self-harm?

SUICIDE POTENTIAL (cont'd)

DRILL IT DOWN

- History – include medical disorders, toxicity, comorbidity
- Last MDS 3.0 PHQ-9 Screen
- Recent labs: urine and blood toxicology screen

RISK FACTORS:

- Suicide ideation (#1)
- Plan – is there a plan? (answering yes to the PHQ question does not show the plan) (#2)
- Accessibility (lack of) to support systems
- Age, sex and race
- Adverse childhood experiences
- Alcohol and substance abuse history
- Antidepressants
- Any preparations and previous attempts
- Disconnectedness and lack of rapport
- Family history and genetics
- Health (poor)
- History of previous suicide attempts or threats
- Hoarding of medications
- Hopelessness and impulsivity
- Lethality of plan
- Likelihood of rescue
- Marital status
- Means of plan execution
- Occupation
- Psychiatric disorders
- Sense of hopelessness
- Strength and intent to carry out suicidal thoughts

SUICIDE POTENTIAL (cont'd)

SEND OR KEEP?

Transfer to ER if: imminent suicide plan to execute self, imminent danger to other residents, overdose of substances with altered mental status or hemodynamic instability, chance for delayed toxicity with substances with multi-organ failure.
Keep in facility if: severe depression with no suicide thoughts or plans.

WHAT DO I DO?

- Determine if they require urgent acute psychiatrist care (ER) (#1)
- Write order for staff to follow facility suicidal ideation policies / protocols, "suicide watch", 15 minute checks, etc.
- Contact patient contact (close family member, etc.) for involvement / commitment to support / help
- Ask about accessibility to lethal means
- Be aggressive in treatment
- Ensure safety
- Chaplain to see patient timely if possible / accepted
- Manage underlying factors
- Cognitive behavioral therapy to prevent suicidal behavior
- Treatment of depression
- Psychiatry consult

FOLLOW UP:

Next scheduled visit:

Regular patient follow up and contact, ensure adequate support system to be in place as suicide risk increases weeks after the patient is discharged and feels lack of support, educate the family members regarding the need of support system.

☐ SWALLOWING DIFFICULTY (DYSPHAGIA)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Any signs of impaired ability to eat, chew, or swallow, including trouble chewing food, coughing or choking while swallowing food or fluids, excessive accumulations of saliva, and difficulty or inability to swallow bolus of food
- Neurological evaluation, including any signs of facial paralysis, speech difficulties (dysarthria), facial weakness, mouth drooping, swelling or impaired mobility of tongue, impaired or absent gag reflex
- Any evidence of loose, decayed, or broken teeth
- Condition of gums, tongue, mouth, and throat, including redness, swelling, ulcers, white patches, discoloration, and bleeding
- Signs of tooth, gum, mouth, or throat pain and its effects on oral intake

MEDICAL HISTORY

- Patient's age and sex
- Details of symptom history, including onset, duration, frequency, severity, precipitating and relieving factors
- History of stroke, other chronic or acute neurological conditions
- Diseases of mouth, teeth, gums, throat, or esophagus, gastroesophageal reflux disease
- History of aspiration
- Diagnosis / history of pneumonia
- All current diagnoses
- All current medications, including any recent changes, especially those associated with dysphagia, lethargy, confusion, impaired salivation, loss of taste, anorexia, or gastroesophageal irritation
- Any recent lab or diagnostic test results
- Type of diet

SWALLOWING DIFFICULTY (cont'd)

DRILL IT DOWN

- Detailed history – intermittent or progressive, duration and course
- Medication history
- Is there any substernal pain or heart burn?
- Is the dysphagia due to solids or liquids, aspiration, weight loss, nasal regurgitation, wheezing?
- Neurological evaluation – suggestions of acute CVA – facial paralysis, speech changes, mouth drooping, change in mobility of tongue, impaired or absent gag reflex
- History of radiation / caustic injury or cancer of the esophagus

DIAGNOSES TO CONSIDER:

- Progressive dementia* (#1)
- Post-CVA deficit* (#2)

**dry mouth and ill-fitting dentures worsen patient's ability to compensate*

- GERD
- Esphageal dysphagia – sensation of food stuck in esophagus
- Solids and liquids
  - Sporadic: esophageal spasm – common
  - Progressive: achalazia, sclerodemia – rare
- Solids only or solids then liquid progression
  - Progressive
    - GERD (#1)
    - Peptic stricture (#2)
    - Esophageal cancer (#3)
  - Sporadic: esophageal ring / web – less likely
- Achalasia
- CVA
- Diabetic neuropathy
- Dermatopolymyositis
- Lower esophageal sphincter (LES) hypertension
- Multiple sclerosis or ALS

SWALLOWING DIFFICULTY (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

- Myasthenia gravis
- Obstruction (e.g. food bolus, tumor, stricture)
- Parkinson's disease
- Severe esophagitis
- Sjogren's syndrome
- Xerostomia

SEND OR KEEP?

Transfer to ER if: acute dysphagia is mechanical obstruction / food impaction, severe systemic illness, unstable vitals, risk of aspiration, CVA with severe weight loss and does not conflict with advanced directives, myasthenia Gravis, achalasia, severe esophagitis, diffuse esophageal spasm.
Keep in facility if: chronic dysphagia and / or outpatient evaluation indicated.

WHAT DO I DO?

- Cardiac causes have to be ruled out if chest pain is present
- Modify consistency of diet if needed
- Review of care goals / living will / advance directives and consult with patient and family
- Treat underlying or reversible causes
- Protect airway if risk of aspiration is present
- Adequate hydration through IV fluids, modify diet as needed
- Medication adjustment
- Speech therapy evaluation if needed
- Plan for alternative needs of nutrition if dysphagia is irreversible and does not conflict with advanced directives
- Order bedside barium swallow

SWALLOWING DIFFICULTY (cont'd)

WHAT DO I DO? (cont'd):

- Order outpatient tests if needed and not in conflict with advanced directives:
  - Endoscopy
  - Esophageal manometry
  - CNS imaging
  - Plain radiographs of neck, chest

FOLLOW UP:

1 – 7 days (dependent on diagnosis):
Follow-up for malnutrition, hydration status, weight loss and aspiration pneumonia. Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit:
Follow-up on last interventions to see if adjustments are needed.

☐ TOOTHACHE

✓ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Teeth / gums evaluation, including evidence of loose, decayed, or broken teeth
- Condition of gums, tongue, mouth, and throat, including redness, swelling, ulcers, white patches, discoloration, and bleeding
- Condition of jaw
- Signs of tooth, gum, mouth, or throat pain and its effects on oral intake
- Any signs of sinus congestion or tenderness

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of symptoms
- Any history of chronic or acute sinusitis
- Effectiveness of any interventions so far
- All current diagnoses
- All current medications, including any recent changes
- Names of personal dentist or dentists that consult for the facility
- Current diet consistency, changes in food and / or fluid intake, any weight loss

DRILL IT DOWN

- Medication review – especially anticoagulant use
- Check on oral hygiene, daily brushing, missing teeth, sensitivity, sweet foods intake
- Does a dentist come to the facility? How often?
- Fitting, cleanliness, and integrity of dentures
- Evidence of active infection – temperature, swelling, purulent drainage
- Ask about tetanus status
- Recent labs: CBC with ESR

TOOTHACHE (cont'd)

DIAGNOSES TO CONSIDER:

- Common Diagnoses
  - Ill-fitting dentures (more than 10% weight loss can cause gum reabsorption)
  - Abnormal tooth – broken or carries
  - Periodontal abscess / infection
- Consider referred pain sources – sinusitis
- Dentoalveolar abscess
- Gingivitis / periodontitis
- Jaw necrosis, osteonecrosis of jaw
- Oral candidiasis usually sore throat or painful swallow
- Post extraction osteitis
- Sinus infection
- Submandibular abscess
- Surgical procedure complication
- Trauma – teeth abrasion, dental fracture
- Trigeminal neuralgia

SEND OR KEEP?

Transfer to ER if: periodontal abscess with respiratory compromise, orbital cellulitis, dental avulsions, tooth subluxations, tooth avulsion – **depending on patient and POA desire to keep tooth.** (Best scenario is immediate placement in socket and follow-up ER – dental emergency (tooth will survive if not more than one hour). Usually — tooth needs to be placed immediately in cold milk and then the container / baggie placed in ice (tooth can survive for a few hours). DO NOT rinse tooth or clean it. If avulsed tooth is a choking hazard, do not place back in socket.)

Keep in facility if: avulsed tooth not to be kept, oral candidiasis, trigeminal neuralgia, gingivitis and periodontitis responding to antibiotics.

TOOTHACHE (cont'd)

WHAT DO I DO?

- Have nurse inspect teeth integrity (if possible) and report back to you
- Have nurse remove dentures and inspect gum line and report back to you
- Consider antibiotics for active abscess / other infection – usually PCN / amoxicillin
- Pain relief with ice, NSAIDS, or narcotics
- Modification of diet until resident can be seen by dentist
- Orders / care plan for future dental care
- Dental referral
- Order labs: CBC with ESR if needed

FOLLOW UP:

1 – 7 days:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed. If dental consult was order, ensure it took place.

☐ URINARY HESITANCY OR RETENTION

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Abdominal, rectal, and genitalia evaluations, including signs of suprapubic tenderness, bladder distension, incontinence, dribbling, or difficulty urinating, (in males, any signs of enlarged or painful prostate on rectal evaluation, swollen or painful penis, swelling or pain of testicles, inspect urinary meatus for inflammation, discharge, and other abnormalities)
- Urine color, clarity, and presence of gross or microscopic hematuria
- Quantity (in cc's) of any post-void residual urine
- Signs of symptomatic infection — Fever (>38C = >100.4F) or chills, new or increased burning pain on urination, new flank or suprapubic pain or tenderness, changes in character of urine, worsening mental function

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, nature, and severity of symptoms
- Any progressive, abrupt or marked change, or decrease in urinary output, or increase in post-void residual urine > 300cc
- All current diagnoses
- All current medications, including any recent changes; especially medications associated with alteration in urinary function or urinary retention
- Any recent lab or diagnostic test results, especially related to renal function

URINARY HESITANCY OR RETENTION (cont'd)

DRILL IT DOWN

- Confirm recent voiding history
- Medication review – especially for anticholinergic medications
- Review bowel history
- Abdominal evaluation for bladder enlargement
- Post void residual volume measurement
- Recent labs: urinalysis, serum BUN, creatinine, electrolytes, serum blood glucose, PSA

DIAGNOSES TO CONSIDER:

Common diagnoses

- BPH with obstruction
- Pharmacologic agents – anticholinergics, antiarrhythmics, antihistamines, antihypertensives, narcotics
- Recent bed rest for acute illness
- Recent placement of indwelling catheter
- Severe constipation / impaction (usually causes urgency)
- UTI / prostatitis

Less likely diagnoses

- Acute renal failure
- Anuria / oliguria (severe dehydration)
- Intravascular volume depletion
- Neurogenic causes (CVA, CVD, diabetes mellitus)
- Obstruction – bladder calculi, bladder cancer
- Prostate cancer

Rare diagnoses

- Autonomic neuropathy
- Cauda equina syndrome
- Guillain-Barre syndrome
- Multiple sclerosis
- Pelvic trauma
- Spinal cord trauma

URINARY HESITANCY OR RETENTION (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

Men:
- Balanitis
- Trauma – penis fracture

Women:
- Obstruction – cystocele, uterine prolapse, uterine leiomyoma
- Acute vulvovaginitis, vaginal pemphigus

SEND OR KEEP?

Transfer to ER if: acute renal failure, surgical drainage, fracture of penis, severe volume or electrolyte disturbances, post obstructive diuresis, difficulty in catheter placement, hematuria with clots causing urinary obstruction, severe pain.
Keep in facility if: BPH, acute vulvovaginitis, intravascular volume depletion, constipation, obstruction relieved with urinary catheter placement and facility can meet patient's needs (see Appendix 1).

WHAT DO I DO?

- Catheterization – indwelling urethral catheter or intermittent straight cath if PVR greater than 200 – 400; post void residual (greater than 200 ml) implies bladder emptying dysfunction
- Order UA / urine culture (specimen can be from PVR cath)
- Rectal examination (by practitioner – nurses cannot do an examination)
- Correction of hydration (if present)
- Treatment for constipation if that is the cause
- Antibiotics to treat urinary tract infection (Typically E-box has antibiotics available for use while awaiting pharmacy's delivery.)
- Remove or reduce offending medications

URINARY HESITANCY OR RETENTION (cont'd)

WHAT DO I DO? (cont'd):

- Order outpatient imaging studies – renal and bladder ultrasonography, pelvic ultrasonography, CT abdomen and pelvis, retrograde cystourethrography, urodynamic studies
- Order labs: urinalysis, serum BUN, creatinine, electrolytes, serum blood glucose, PSA
- Order urology consult if needed

FOLLOW UP:

1 – 7 days:

Check serum electrolytes, indwelling catheter need, complications such as acute renal failure, transient gross hematuria and post obstructive diuresis, make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed.

☐ VAGINAL DISCHARGE

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Detailed description of discharge (color, amount, odor, consistency, etc.)
- Evaluation of exterior genitalia for redness, edema and excoriation
- Any associated symptoms, such as dysuria and perineal pruritis, and burning
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age
- Onset, duration, frequency, and severity of symptoms
- Any recent history of sexual activity
- Any previous history of vaginal discharge, infections, tumors, or other conditions
- All current medications, including any recent changes or recent antibiotic use
- All current diagnoses
- Any recent lab or diagnostic test result

DRILL IT DOWN

- Medication list – especially antibiotics
- Type of discharge, odor, associated burning or itching
- Associated symptoms?
- History should include:
  - Pain in the back, abdomen, or pelvis
  - Change in sexual partner – are they having sex / new partner?
  - Menstrual history – are they post-menopausal or recent vaginal bleeding?
- Hygiene regarding use of tampons and female vaginal lubricants, baths, soaps, douches, quality of self-bathing / shower (especially with dementia patient)

VAGINAL DISCHARGE (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Atrophic vaginitis (usually pruritis with discharge symptoms)
- Bacterial vaginosis
- Candidiasis
- Irritants and allergans (wet briefs, OTC rinses, douches, creams, soaps)
- Recurrent or relapsing infection

Less likely diagnoses
- Cervical and vaginal lesions
- Cervicitis
- Desquamative inflammatory vaginitis
- Foreign object
- STDs (trichomonas)
- Vesicovaginal, vesicorectal, rectovaginal fistulas

Rare diagnoses
- *Streptococcal vulvovaginitis*

SEND OR KEEP?

Transfer to ER if: sepsis with hemodynamic instability, new vesicovaginal, vesicorectal, rectovaginal fistula, vaginal discharge secondary to sexual abuse.
Keep in facility if: treatable infection, all other causes.

WHAT DO I DO?

- Topical estrogen replacement for atrophic vaginitis
- Vaginal lubricants
- Treat underlying infection

VAGINAL DISCHARGE (cont'd)

WHAT DO I DO? (cont'd):

- Consider gynecologist referral if unable to perform adequate exam in facility
- Vaginal yeast infection
  - Miconazole 2% cream intravaginally for 7 days
  - Fluconazole 150mg once – monitor in liver patients, and drug interactions
- Bacterial vaginosis
  - Metronidazole 500mg bid for 7 days (no alcohol with concomitant use)
  - Metronidazole 0.75% 5g intravaginally daily for 7 days or
  - Clindamycin 2% vaginal cream 5mg intravaginally for 7 days
- Notify and treat the partner if STD is confirmed
- Pelvic examination
- Order labs: CBC, UA, urine culture if needed
- Ultrasound of the abdomen including the pelvis (see if facility has access to mobile sonography)
- Diagnostic studies (may not be able to have done in LTC facility)
  - Vaginal PH
  - Microscopy
  - Vaginal culture
  - Cervical culture
  - Serological tests

FOLLOW UP:

1 – 7 days:

Do pelvic exam, assess need for yogurt, probiotics, long term topical estrogens, intervene appropriately based on symptomology and abnormal test results.

Next scheduled visit:

Make next treatment / management decisions based on response to initial interventions and any test results if ordered.

☐ VISION, PARTIAL OR COMPLETE LOSS

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological and eye evaluation, including pupil size, shape, and reaction to light
- Any signs of eye redness, pain, discharge, cataracts, aversion to light (photophobia), corneal changes

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency and severity of symptoms (decreased ability to read or watch television, full or partial loss of visual field in one or both eyes, etc.)
- Is visual loss transient or persistent?
- Recent history of facial or eye trauma
- Whether individual wears corrective lenses and whether they are used
- Date and results of most recent eye evaluation
- All current diagnoses, especially history of glaucoma or cataracts
- All current medications, including any recent changes, especially medications associated with blurred or double vision
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Medication list – antiarrhythmia drugs, antimalarial drugs, corticosteroids, erectile dysfunction drugs, phenothiazines, tamoxifen, tamsulosin, etc.

VISION (cont'd)

DRILL IT DOWN (cont'd)

- Do they wear contact lenses?
- Recent eye surgery?
- History of vascular disease?
- Recent trauma to eye?
- Onset
- Laterality
- Any associated symptoms (e.g. pain, redness)

DIAGNOSES TO CONSIDER:

Common diagnosis – **worsening vision**

- Cataracts
- Corneal abrasion
- DM retinopathy progression (if diabetes type 2)
- Foreign body
- Glaucoma
- Herpetic keratitis
- Muscular degeneration progression (#1 cause of blindness)
- Presbyopia progression
- Retinal tear

Loss of vision – **unilateral, painless**

- Acute maculopathy
- Ischemic optic neuropathy
- Lens dislocation
- Multiple sclerosis
- Optic nerve injury
- Papilledema
- Radiation (photo keratitis)
- Retinal artery occlusion
- Retinal detachment
- Retinal vein occlusion
- Vitreous hemorrhage

VISION (cont'd)

DIAGNOSES TO CONSIDER (cont'd):

Loss of vision – **unilateral, painful**

- Anterior uveitis
- Corneal abrasion
- Endophthalmitis
- Hyphema
- Keratitis
- Optic neuritis
- Temporal arteritis

Loss of vision – **bilateral, painless**

- Anatomic, structural disorders – keratoconus, glaucoma, optic atrophy, optic neuritis, retinitis proliferans, retinitis pigmentosa, cortical blindness, myopia malignant type
- Homonymous field loss – chiasmal or retrochiasmal etiology
- Metabolic or toxic – hyperglycemia, methanol toxicity, ethylene glycol

SEND OR KEEP?

Transfer to ER if: acute transient or persistent vision loss (over 24 hours) is an ophthalmic emergency and should be referred to ER or ophthalmology specialist ASAP for appropriate examination / treatment. Immediate treatment is required for, acute central retinal artery occlusion, intraocular pressure greater than 40 mm Hg with eye pain, vision loss in the setting of suspected giant cell arteritis. **Emergent referral is required for** infectious keratitis, endophthalmitis, hyphema, retinal detachment.

Keep in facility if: urgent referral (within 24 to 48 hours) for non-infectious uveitis, vitreous hemorrhage, acute maculopathy, central retinal vein occlusion, optic neuritis.

WHAT DO I DO?

- CVA work up and treatment
- Physical examination — the eye examination should include the following elements:

VISION (cont'd)

WHAT DO I DO? (cont'd):

- General inspection – noting erythema, tearing, light sensitivity
- Visual acuity – to be tested with glasses, one eye at a time
- Evaluation of extraocular movement
- Confrontation visual fields
- Pupils – symmetry, reactivity to light, pupillary reflex
- Fluorescein application (if available)
- Ophthalmoscopic examination
- Testing afferent pupillary defect

- Order head CT outpatient if needed
- Order labs: CBC with ESR
- High dose systemic steroids for temporal arteritis
- Send for surgical repair of retinal detachment if cause
- Treat pain with analgesics

FOLLOW UP:

Within 1 week:

If no ophthalmology or ER evaluation. Make next treatment / management decisions based on response to initial interventions and any test results if ordered.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed.

☐ VOMITING BLOOD (HEMATEMESIS)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs, including BP standing, sitting and lying (if obtainable)
- Abdominal evaluation, including signs of abdominal or epigastric tenderness, pain, or abdominal distension
- Whether blood is being vomited or coughed up (hemoptysis)
- Estimated quantity (in cc's) of any blood loss
- Contents of vomitus (color of any bright red blood or blood clots, presence of "coffee ground like substance", etc.)
- Pain evaluation (location, nature, severity, etc.)
- Evaluate for black or tarry stools
- Inspect the mucous membranes, nasopharynx and skin for signs of bleeding.

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of signs and symptoms
- History of gastric or esophageal bleeding, ulceration, erosion, or tumor
- Is hematemesis preceded by nausea, flatulence, diarrhea or weakness?
- Effectiveness of any management of situation so far
- All current diagnoses
- All current medications, including any recent changes, especially anticoagulants, NSAIDs, salicylates, osteoporosis medications
- Any recent lab or diagnostic test results

DRILL IT DOWN

- Medication list – especially anticoagulants, NSAIDs, salicylates, biphosphonates
- Past med history – especially GI cancer, cirrhosis (varices)
- Volume of blood vomited

VOMITING BLOOD (cont'd)

DRILL IT DOWN (cont'd)

- Blood – streaked vs. bright – red vs. coffee-grind?
- Mental status – lethargic?
- Associated symptoms – fever, abdominal pain, epistaxis, multiple and prior retching leading to hematemesis, bleeding in the stools?
- Advance directives
- Vital with orthostatic reading

DIAGNOSES TO CONSIDER:

Common diagnoses

- Arteriovenous malformations (AVM)
- Erosive gastritis (usually medication induced)
- Mallory-Weiss tear
- Medication induced – NSAIDs, warfarin, etc.
- Peptic ulcer disease (PUD)
- Varices

Less likely diagnoses

- Epistaxis source
- Esophageal / gastric cancer

Uncommon diagnoses

- Aortoenteric fistulas
- Hemobilia
- Upper gastrointestinal tumors

SEND OR KEEP?

Transfer to ER if: urgent GI evaluation is needed, diagnosis is needed via EGD, massive bleed with hemodynamic instability.
Keep in facility if: resident has a do not transfer order, situation is non-emergent and facility can handle needs.

VOMITING BLOOD (cont'd)

WHAT DO I DO?

- If the patient is stable evaluate for the cause of bleed
- Hydration to prevent renal complications and to maintain volume status
- Order labs: CBC with differential, serum electrolytes, BUN, creatinine, serum Ca, serum Mg
- Order stool for occult blood
- Make the patient NPO if absolutely needed
- GI consultation
- Remove or reduce offending medication

FOLLOW UP:

Next business day:

Check vitals and volume status, monitor Hct/Hgb. Intervene appropriately based on symptomology and any abnormal test results and patient's advanced directives.

Next scheduled visit:

Follow-up on last interventions to see if adjustments are needed. Look for potential risk of rebleed.

☐ WBC COUNT, ELEVATED (LEUKOCYTOSIS)

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Any signs of acute illness, inflammation or infection

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of any associated symptoms
- Any recent loss of blood, weight loss, severe emotional distress, recent tissue damage
- Any recent or previous history of bone marrow disorders, leukemia, or other causes of leukocytosis
- Any lab or diagnostic test results, including current and previous WBC count and differential
- All current diagnoses
- All current medications, including any recent changes

DRILL IT DOWN

- Review medications
- Past med history – any recent infections, any bleeding, fatigue, anorexia, weight loss
- Associated symptoms – change in mental status, lethargy, fever, URI / cough, weight loss, dysuria / new UI, diarrhea?
- Signs and symptoms of secondary infection – shingles, pneumococcus, meningococcus, TB, fungal
- Recent CBC with differential (lymphocytosis)
- Vitals including O2 sats.

WBC COUNT, ELEVATED (cont'd)

DIAGNOSES TO CONSIDER:

Common diagnoses
- Infection – bacterial or viral
- Malignancies – leukemia, CML, myeloproliferative disorders
- Medication side effects – glucocorticoids, lithium, lithium toxicity, phenytoin, allopurinol

Other diagnosis
- Post-seizure

Rare diagnosis
- Polymyalgia rheumatica, giant cell arteritis

SEND OR KEEP?

Transfer to ER if: new extreme leucocytosis, sepsis, hemodynamic instability.
Keep in facility if: known and treatable etiologies, patient has a do not transfer order or at end-of-life.

WHAT DO I DO?

Treat underlying cause appropriately
- Antibiotics / antifungals / antivirals for infections
- History and physical – lymphadenopathy, hepatosplenomegaly
- Remove offending medications
- Steroids for PMR/GCA
- Order CBC with differential (lymphocytosis)
- Order appropriate cultures if suspect infection
- Referral to hemoncologist if suspect of malignancy

FOLLOW UP:

1 – 7 days:
Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ WEAKNESS, GENERAL

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Neurological and musculoskeletal evaluations, including overall condition and function, and whether weakness is localized or generalized
- Signs of easy fatigue, poor endurance, lethargy, poor coordination, confusion, or loss of muscle strength
- Details of patient symptoms including easy fatigue, poor endurance, loss of coordination, lethargy, apathy, or weakness (loss of muscle strength)
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of signs and symptoms
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results
- Changes in food and / or fluid intake, any weight loss

DRILL IT DOWN

- Medication review
- Recent intake of food and fluid
- History of blood loss or anemia
- Recent labs: CBC with differential, serum electrolytes, serum Ca, Mg and phosphate, blood glucose, urine drug screen, blood and urine cultures, serum T3 and T4 with TSH, volume status, rheumatoid factor assay, ESR

WEAKNESS, GENERAL (cont'd)

DIAGNOSES TO CONSIDER:

Most common diagnoses
- Infection
- Medication side effects
- Metabolic disorders
- Stroke / TIA
- Vitamin D deficiency

Life threatening diagnoses
- Acute coronary syndrome
- Adrenal insufficiency
- Carbon monoxide poisoning
- Sepsis

Other diagnoses
- Anemia
- Dehydration or hypovolemia
- Hypothyroidism
- Presyncope
- Rheumatologic disease
- Polymyalgia rheumatica

SEND OR KEEP?

Transfer to ER if: sepsis, carbon monoxide poisoning, adrenal failure, acute coronary syndrome.
Keep in facility if: hypothyroidism, infection, dehydration, anemia, medication side effects, presyncope, all other non-emergent conditions and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Treat the underlying cause
- Antibiotics for infection
- Correct dehydration
- Treat hypothyroidism

WEAKNESS, GENERAL (cont'd)

WHAT DO I DO? (cont'd):

- Supplement with vitamin D
- Assess for underlying cause of anemia and treat
- Remove or reduce offending medication
- Order labs: CBC with differential, serum electrolytes, serum Ca, serum Mg and phosphate, blood glucose, urine drug screen, blood and urine cultures, serum T3 and T4 with TSH, volume status, rheumatoid factor assay, ESR

FOLLOW UP:

1 – 7 days:

Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Next scheduled visit:

Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.

☐ WEAKNESS OR PARALYSIS, ARM OR LEG

INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Details of the impairment (location, severity, etc.)
- Any associated complications (contracture, deformity, pain, etc.)
- Neurological evaluation, including any impairments of sensation, temperature, position sense, and any alterations in consciousness or function
- Pain evaluation (location, nature, severity, etc.)
- Signs of injury, head trauma, etc.

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, intensity and progression of paralysis
- History of the event or underlying cause(s) (stroke, recent fall, injury, etc.), if known
- Any associated symptoms such as fevers, headaches, vision disturbances, nausea and vomiting, muscle pain or weakness, fatigue
- Aggravating factors such as activity, pain, stress
- All current diagnoses
- All current medications, including any recent changes
- Patient's description of sensation, pain, use of extremity, etc.
- Any recent lab or diagnostic test results

WHAT DO I ASK FOR?

- Determine if the weakness is life threatening or not?
- Important questions to be asked when assessing unilateral weakness
  - Is there presence of cortical signs (unable to talk, neglecting a portion of the body, memory loss)?

WEAKNESS OR PARALYSIS (cont'd)

WHAT DO I ASK FOR? (cont'd)

- Is there facial weakness?
- Are groups of muscles involved?
- Is the weakness associated with peripheral nerve involvement?

- Important questions to be asked when bilateral weakness is assessed
  - Is there a change in mental status?
  - Are any extremities involved?
  - Is there a sensory deficit?
  - Is there involvement of bladder?
  - Which group of muscles are involved? Proximal or distal?
  - Is there associated weakness of tongue muscles, facial and jaw muscles, inability to speak?
  - Is the degree of weakness consistent?

DIAGNOSES TO CONSIDER:

Unilateral weakness
- Ischemic stroke
- Intracerebral hemorrhage
- Subarachnoid hemorrhage

Bilateral weakness
- Brainstem stroke
- Muscle disease
- Neuromuscular junction disease
- Peripheral nerve disease
- Spinal cord disease

Focal findings
- Calcium disorders
- Hypoglycemia
- Magnesium and phosphate disorders
- Potassium disorders

**Also multiple sclerosis and hemiplegic migraine and postictal paralysis may be considered*

WEAKNESS OR PARALYSIS (cont'd)

SEND OR KEEP?

Transfer to ER if: life threatening (stabilize the patient and transfer the patient to ER for further management), ischemic stroke, intracranial bleed, subarachnoid hemorrhage, brain stem stroke spinal cord disease, for neurological imaging.
Keep in facility if: hypoglycemia, potassium disorders, calcium, magnesium and phosphate disorders, non-emergent and facility can meet patient needs (see Appendix 1).

WHAT DO I DO?

- Determine if it is unilateral or bilateral?
- Investigate for the causes of unilateral and bilateral weakness
- Order labs: CBC with differential, serum electrolytes, serum Ca, serum Mg and phosphate, blood glucose, CSF culture and cell count
- Nasogastric tubing if the patient is unable to swallow to prevent regurgitation
- Foley catheter for neurogenic bladder
- Neurologist referral

FOLLOW UP:

1 – 7 days:
Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.
7 – 14 days:
Make next treatment / management decisions based on response to initial interventions and any lab results if ordered.
Next scheduled visit:
Follow-up on last interventions to see if adjustments are needed.

☐ WOUNDS, NEW OR NON-HEALING AND/OR WORSENING (SEE ALSO PRESSURE ULCERS, RASH)

✔ INFORMATION YOU SHOULD GET FROM THE NURSE

PHYSICAL DATA

- Vital signs
- Skin evaluation, including description of wound size, color, depth, odor, tunneling, sinus tract, etc.
- Other factors that help differentiate type and cause of wound (decreased pulses in extremities, evidence of venous stasis, recent surgery or trauma to area, etc.)
- Identify drainage, necrotic tissue or slough and eschar associated with wound
- Identify signs of infection (redness, swelling, edema, pain, bogginess, etc.) around the wound
- Pain evaluation (location, nature, severity, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Any existing wounds in other locations
- History of previous wounds in same or other locations
- Any history of venous stasis, arterial insufficiency, peripheral vascular disease, or diabetic neuropathy
- All current diagnoses
- All current medications, including any recent changes
- History of present wound(s), including onset, duration, progress in healing, etc.
- Any recent lab or diagnostic test results
- Changes in food and / or fluid intake or weight loss
- Non-healing wounds. Current orders for treatment and recent changes. What has been tried that didn't work previously?

WHAT DO I ASK FOR?

- List of medications that can complicate healing – steroids, etc.
- Detailed description of wound – anatomical location, size, depth, color of the wound and surrounding tissue, description of any drainage

WOUNDS (cont'd)

WHAT DO I ASK FOR? (cont'd)

- Presence of peripheral pulses if lower extremity ulcer present
- Degree of immobility, presence of contractures, presence of urinary or fecal incontinence
- Dietary intake – adequate?
- Is the resident septic?
- Determine the cause of the wound
- Look for any foreign body and remove it if found
- Type of wound – pressure, arterial, venous, or traumatic
- Any signs of wound infection or potential sepsis

DIAGNOSES TO CONSIDER:

- Arterial ulcer
- Cancer
- Chronic malnutrition
- Diabetes mellitus ulcer
- Elder abuse
- Excoriation
- Infection
- Post-surgical site wound
- Self-inflicted wound
- Trauma / pressure
- Venous ulcer
- Xerosis

SEND OR KEEP?

Transfer to ER if: sepsis with hemodynamic instability, osteomyelitis with draining wounds, ischemic arterial ulcer with impending gangrene.
Keep in facility if: venous ulcer, trauma, chronic malnutrition, skin graft for healing wound with large surface.

WOUNDS (cont'd)

WHAT DO I DO?

The attending practitioner will need to diagnose type of lesion first. For example non-pressure ulcer lesions could be: arterial ulcers; diabetic foot ulcers; excoriations / rashes; post-surgical sites; self-indicted wounds; venous stasis ulcers.

- Assess for risk factors – comorbid conditions (e.g. diabetes, renal disease, thyroid disease); drugs that may affect ulcer healing (e.g. steroids); exposure of skin to fecal incontinence; history of a healed Stage III or IV pressure ulcer; impaired diffuse or localized blood flow (e.g. generalized atherosclerosis, lower-extremity arterial insufficiency); impaired or decreased mobility and functional ability; increase in friction or shear; moderate to severe cognitive impairment; organ failure, refusal of some aspects of care and treatment; calorie and protein undernutrition, malnutrition, and hydration deficits
  - Look to see if the wound is infected – odor, increased pain, wound is getting worse, erythema, purulent drainage
  - Familiarize yourself with the list of wound care products available to the facility
    - i.e. hydrocolloid, hydrogel – solid and liquid, collagenase, silver products, calcium alginate, zinc oxide
  - Ask if the facility has or has access to a certified wound care expert
- Pain control for dressing changes if needed
- Order labs: CBC, creatinine, erythrocyte sedimentation rate (if infection or anemia suspected)
- X-ray if needed
- Tetanus immunization (or Tdap)
- Patient training and counseling for modifiable risk factors (e.g. quit smoking)
- Antibiotics – oral (mild infection); systemic (bacteremia, osteomyelitis, sepsis, severe cellulitis); topical (exudative wound for more than 2-4 weeks)
- Wound culture / biopsy for non-healing ulcer more than 2 weeks

WOUNDS (cont'd)

WHAT DO I DO? (cont'd):

- Educate families, patients and caregivers on wounds. Develop care plan consistent with patient goals to enhance function and quality of life
- Relieve pressure around bony prominences, positioning devices, head end should not be more than 30 degrees
- Wound care consult if facility has a dedicated wound care service if non healing or worsening
- Always remember that wound healing is best in moist environment
- Manage arterial, venous, diabetic ulcers appropriately
- No debridement of ankle wounds due to pressure

FOLLOW UP:

24 – 48 hours for first assessment:
Intervene appropriately based on symptomology and abnormal test results and patient's advanced directives.

Bi-weekly if no certified wound care nurse or wound not healing as expected:
Make next treatment / management decisions based on response to initial interventions.

Routine visits for monitoring:
Follow-up on last interventions to see if adjustments are needed.

APPENDIX 1

QUESTIONS TO ASK TO SEE IF FACILITY CAN MEET PATIENT'S NEEDS

- Does the facility have the ability to do diagnostic testing?
  - ☐ Mobile stat EKG (within 4-6 hrs.)
  - ☐ Mobile stat X-ray (within 4-6 hrs.)
  - ☐ Bladder ultrasound
  - ☐ Mobile cardiac echo
  - ☐ Bedside spirometry

- Does the facility have NP Services and if so how often?
  - ☐ 7 day/wk. visits
  - ☐ 5 day/wk. visits
  - ☐ 1-2x/wk. visits

- Does the facility have nursing services available?
  - ☐ O2 sats. monitoring by Pulse Ox
  - ☐ Neurological checks

- Does the facility have the following interventions available?
  - ☐ On site dialysis
  - ☐ G/J, NG tube feeding
  - ☐ Hypodermoclysis
  - ☐ IV capabilities (either start and manage at the facility or have access to an infusion service)
  - ☐ IV antibiotics
  - ☐ Nebulizer treatments
  - ☐ NG tube insertion
  - ☐ O2 management
  - ☐ PICC insertion (either start at the facility or have access to an infusion service)
  - ☐ PICC management
  - ☐ Suction q2hr
  - ☐ Tracheostomy management
  - ☐ Vent management
  - ☐ Other

APPENDIX 1 (cont'd)

- Does the facility have the ability to do Emergency Interventions?
  - ☐ CPR — basic only
  - ☐ Other
- How long does it take to get mediations from the pharmacy?
- What medications are available in interim box while I wait for medication to come from pharmacy?
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____

APPENDIX 2

STAGES OF PRESSURE ULCERS
National Pressure Ulcer Advisory Panel, 2007

Suspected deep tissue injury
Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear*. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark ulcer bed. The ulcer may further evolve and become covered by thin eschar*. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Stage I
Intact skin with nonblanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

Stage II
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed, without slough*. May also present as an intact or open/ruptured serum-filled blister.
Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration* or excoriation.

**Bruising indicates suspected deep tissue injury*

APPENDIX 2 (cont'd)

Stage III
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining* and tunneling*.
Further description: The depth of a Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone / tendon is not visible or directly palpable.

Stage IV
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often include undermining and tunneling.
Further description: The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 ulcers can extend into muscle and / or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone / tendon is visible or directly palpable.

Unstageable
Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and / or eschar (tan, brown or black) in the ulcer bed.
Further description: Until enough slough and / or eschar is removed to expose the base of the ulcer, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema* or fluctuance*) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.