The Society
For Post-Acute And
Long-Term
Care Medicine™

know-it-all™

BEFORE YOU CALL

Data Collection System

in Post-Acute/Long-Term Care
and Assisted Living Settings

Essential clinical data collection:
A GUIDE FOR NURSES ON REPORTING
CHANGE OF CONDITION

DISCLAIMER:

These cards are intended for use by qualified licensed nurses to guide the nurse in the resident evaluation and data collection process. The advice for data collection and evaluation described on these cards are offered as guidelines and the applicability and usefulness of such will depend upon the symptoms presented in a given case and the individual practitioner's level of experience, education, and judgment. These cards do not instruct—and are not intended to instruct—a user about how to treat any medical condition. The information on these cards is not intended and should not be construed as a substitute for a practitioner's medical advice. AMDA—The Society for Post-Acute and Long-Term Care Medicine expressly disclaims responsibility for any adverse effects or consequences resulting from the use of any of the advice presented or discussed on these cards. AMDA—The Society for Post-Acute and Long-Term Care Medicine shall not be liable for any damages whatsoever resulting from use of these data collection cards.

How to Use These Cards:

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These data collection cards are intended to **assist nursing staff evaluate residents and collect data before notifying a practitioner regarding changes of condition in nursing facility residents as well as residents residing in assisted living (AL) settings.** As acuity increases in the assisted living resident population, this data collection system will allow the practitioner to receive more complete, clinically important information about both the AL and nursing facility resident to facilitate clinical decision-making. **These cards are not intended to be used as a first aid manual or to advise the user on how to manage any of the conditions.**

Studies show practitioners value a complete and accurate history more than any other factor (for example physical exam and labs) to help them diagnose and manage residents appropriately. Using these cards will help improve communication between practitioners and the licensed nurse, ultimately improving resident care. Medical directors, directors of nursing, and staff educators may want to use the card content as an educational tool to train staff regarding change of condition issues.

When presenting a resident's condition to the practitioner, "introduce" the resident and tell a story about their problem. Do not assume the practitioner knows this resident well or can recall important details. Just as you, the nurse, have to review the resident's medical history to get a complete picture of the resident, help the practitioner to do likewise.

For example, when a call is made to the practitioner regarding an individual with abdominal distension who is complaining of abdominal pain, the presentation to the physician should go something like this:

"This is an 89-year-old female presenting with abdominal distension, who is also complaining of mild nausea and abdominal pain which she describes as "cramping." There have been no changes in the past week in her appetite, diet, or medications. Her last bowel movement was 4 days ago. She was given 4 ounces of prune juice on the second day of having no bowel movement, 2 Senekot tablets at bedtime on the third day of no bowel movement per facility protocol, and a Dulcolax suppository this morning per protocol with no results. Her abdomen is mildly distended, but there is no local pain or tenderness to palpation. Bowel sounds are present but sluggish. Digital rectal exam reveals no stool in the lower rectum, and no rectal tenderness. Her vital signs are within normal limits. Here are her current medications . . . she has no known allergies."

Now let's look at a resident with the same symptoms of abdominal pain and distention whose presentation is as follows:

"This is an 89-year-old female presenting with abdominal distension and complaining of sharp stabbing pains in the abdomen. There is severe pain upon palpation of the epigastric region. She has a history of a duodenal ulcer. She had a large tarry bowel movement at the time of examination. Her BP is 100/60, compared to her normal 140/90. Pulse is rapid but regular at 100. Respirations are elevated to 30 per minute. Temperature is 99.0F. Bowel sounds are hyperactive. Resident was recently started on Coumadin 5 mg. daily to treat a DVT. She is also on Aspirin 81 mg. daily for her history of coronary artery disease. She has had no changes to her diet or her dietary intake. She has an allergy to iodine."

As you can see, the symptoms of abdominal pain and distension are present in both cases, however the information provided by the nurse using these data cards clearly differentiates a *non-emergency from an emergency case.*

The conditions are listed alphabetically, along with the suggested evaluation and other information that pertains to reporting that condition or symptom to a practitioner.

Index:

continued

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ ABDOMINAL PAIN, DISTENSION, AND/OR DISCOMFORT

PHYSICAL DATA

- Vital signs
- 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
- If vomiting, describe contents, quantity, and presence of blood, check hemoccult
- Abdominal evaluation including tenderness, pain, bulging, distension upon palpation, and bowel sounds upon auscultation
- Digital rectal evaluation, including any tenderness, mass, or hard stool

MEDICAL HISTORY

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

Abdominal pain, distension, and/or discomfort

ABDOMINAL EVALUATION

Listen: Auscultation of the abdomen needs to be completed before palpation. You want to listen before you touch, because sometimes touching the stomach can stimulate "noises". Listen for bowel sounds to see if they are active and audible in all four quadrants. Place the bell of the stethoscope lightly over each of the four quadrants. Ask the patient not to talk. Listen until you hear repeated gurgling or bubbling sounds once in each quadrant. Describe sounds as normal, hyperactive, hypoactive, absent. It may take about 5 minutes to hear bowel sounds.

Look: Inspection is the visual evaluation of the abdomen. Look for changes to the abdomen such as distension, bruising, rashes, color, scars, pulsations, symmetry. If you notice bruising look at patient's record to see if she/he is receiving heparin or insulin injections. Scars reveal evidence of past surgery or trauma.

Feel: Palpation is touching the area. Lightly palpate over each of the four abdominal quadrants. Note if the abdomen is soft or firm. Look for tenderness and/or pain, muscle rigidity, warmth, superficial masses, and watch patient's facial expressions during palpation.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ ABRASION (SEE ALSO 'RASH')

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 (warm, normal, reddened, swollen, tender, purulence, 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, aspirin, 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

Abrasion

ABRASION EVALUATION

Include the following when describing an abrasion:

- Exact location (forehead, wrist, forearm, hand, knee, ankle, etc.)
- Size (width, length, depth) in mm or cm
- Duration (how long has it been there?)
- Drainage (color, odor, amount)
- Does it feel tender?
- Is it warm to touch?
- Is there swelling?
- Is the area reddened?
- Complaints of pain, tightness, itching, or other symptoms

Investigate origin of abrasion and document nursing measures to decrease chances of this occurring again. Update the resident's care plan in "real time".

Check on status of last tetanus shot. Notify practitioner of when last tetanus shot was given if available.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

PHYSICAL DATA

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

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

Agitation or behavioral disturbance

The term "agitation" is commonly used to describe symptoms. Instead of using the word "agitation" by itself, describe the behavior using words to show what the behavior is exhibiting such as irritability, restlessness, aggression, screaming, rummaging, resistance to care, disinhibition, and wandering. Be very specific when reporting the behavior to the practitioner. Try to recall the situation preceding the behavior.

You will need to play detective and find the source of the "agitated" behavior. "Agitation" can result from frustration of having an impairment, or the difficulty of making progress in recovering from illness, injury, hypoxia, or hypoglycemia.

Certain medications may cause behavior changes such as antiarrhythmic agents, anticholinergic agents (and medications with anticholinergic effects or side effects), anticonvulsants, antidepressant, antiemetics, antihistamines/ decongestants, antihypertensive agents, antineoplastic agents, antimanic agents, anti-Parkinson's agents, antipsychotics, anxiolytics, corticosteroids, muscle relaxants, opioids, sedatives/sleep medications.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **AMBULATION, ALTERED (SEE ALSO 'FALL', 'GAIT DISTURBANCE')**

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 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, 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

Ambulation, altered

AMBULATION EVALUATION

During the evaluation of the **Musculoskeletal System,** the nurse needs to use his/her skills of inspection and observation such as: Recognizing problems with gait and Range of Motion (ROM), reporting any problems noted in ROM or muscle strength, and taking precautions during ROM exercises to avoid forcing a joint beyond the patient's current ROM.

Joints: Pain, stiffness, swelling, heat, redness, limitation of movement. **Muscles:** Pain, cramps, weakness. **Bones:** Deformity, pain, trauma (fractures, sprains, dislocations). This evaluation is important when a patient reports pain, loss of sensation, or impairment of joint and/or muscle function.

Examples of a Functional Evaluation. How to start: Place the person's leg flat on the bed. Put one hand under the ankle and your other hand under the knee. Straighten the leg and return it to a flat position on the bed after each movement.

- Hip and knee bends. Slowly bend the hip and knee up toward the chest as much as possible (flexion). Slide your hand out from under the knee and toward the upper thigh. Do this to help the knee bend completely.
- Leg movement, side to side. Move the leg out to the outer side as far as possible (abduction). Then return the leg to the middle and cross it over the other leg (adduction).
- Leg rotation, in and out. With the leg flat on the bed, roll the leg toward the middle so the big toe touches the bed (internal rotation). Roll the leg outward so the little toe touches the bed (external rotation).
- Knee rotation, in and out. Bend the person's knee so the bottom of the foot is flat on the bed. Roll the leg inward as far as possible. Try to touch the bed with the big toe. Roll the leg outward as far as possible. Try to touch the bed with the little toe.
- Check if patient leaning to one side or if one extremity is weak.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ APPETITE, DIMINISHED (SEE ALSO 'ABDOMINAL PAIN', 'CONFUSION', 'SODIUM, DEFICIT OR EXCESS')

PHYSICAL DATA

- Vital signs
- Signs of change in mental status, mood, behavior, orientation, or alertness
- Signs of dehydration or fluid and electrolyte imbalance
- Any nausea and vomiting
- Abdominal evaluation, especially for bowel sounds, tenderness, pain, or distension
- Any signs of infection
- 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
- Any current dietary supplements
- 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
- All current diagnoses
- Any recent lab or diagnostic test results

Appetite, diminished

POOR APPETITE EVALUATION

Oral Evaluation

- Look for number and condition of teeth, especially pairs of teeth, in chewing position
- Pain and discomfort due to partial plates or dentures that do not fit properly
- Blisters on the tongue or floor of mouth
- Dry, chapped, or blisters on or around lips
- Swollen or bleeding gums
- White or red patches, bleeding, or ulcers on tissue inside cheeks of mouth
- Foul odor (possibly due to tooth decay)

Mini-Nutritional Assessment (MNA) is a simple, reliable tool for assessing nutritional status in elderly people. It comprises 18 items in four sections. The MNA was shown to be 98% accurate when compared with a comprehensive nutritional assessment that included food records and laboratory tests. The MNA can be obtained at http://www.nursingcenter.com/pdf.asp?AID=770859 (or tool indicated by facility).

Abdominal Evaluation. Listen for bowel sounds to see if they are active and audible in all four quadrants. Lightly palpate over each of the four abdominal quadrants. Note if the abdomen is soft or firm. Look for tenderness, muscle rigidity, warmth, superficial masses and watch patient's facial expressions during palpation. Check for hard stool in the rectum if the resident has not had a bowel movement according to facility policy.

COLLECT IT ALL BEFORE YOU CALL:

☐ ASTHMA (SEE ALSO 'DYSPNEA')

PHYSICAL DATA

- Vital signs, including detailed description of respiratory rate, effort, and rhythm
- Pulse oximetry results (current and previous)
- Lung evaluation, listen especially for wheezing, rales, rhonchi, look for the use of accessory muscles to breathe, and prolonged expiration
- Any sputum production (including consistency and color)
- Level of consciousness

MEDICAL HISTORY

- Onset, duration, frequency, and severity of symptoms
- What has been done so far to manage the situation
- All current medications, including any recent changes
- Precipitating and relieving factors
- Whether patient is using oxygen (O2), and what are O2 settings
- Pulse oximetry results (current and previous)
- All current diagnoses
- Any recent lab or diagnostic test

Asthma

When listening to sounds of the lungs you want to place your stethoscope over the following areas:
Right Upper Lobe ..... Left Upper Lobe
Right Middle Lobe..... Anterior Chest
Right Lower Lobe ..... Left Lower Lobe

Listen

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhoncus.

Look

- Resident is unable to speak at all or cannot speak in sentences because of shortness of breath.
- Breathing patterns such as Cheyne-stokes, hyperventilation.
- Observe the resident for signs of cyanosis, molting, etc.

*See Pulse Oximetry reference card.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **BACK, INJURIES AND PAIN (SEE ALSO 'EVALUATION OF PAIN')**

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 or movement)
- 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
- History of any recent falls, injuries, or recent back surgeries
- 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
- Level of mobility (ambulatory, bed-bound or chair-bound, etc.)
- All current diagnoses
- All current medications, including any recent changes
- Attempted symptom management to date

Back, injuries and pain

BACK INJURY/PAIN EVALUATION

Listen for words from the elderly patient such as discomfort, hurting, or aching rather than use the specific word *pain.* Not everyone uses the word 'pain' to describe pain.

Look: Important information is obtained simply from watching the patient's pattern of movement.

- Observe gait and standing/sitting balance
- Observe lower extremity joint function
- Observe ability to use ambulatory assistive devices (cane, walker, etc.) and modify as indicated
- Observe activity tolerance
- Observe for significant changes in activity

Provide staff with a clear, written procedure that describes what to do when a patient falls.

*See Pain Evaluation reference card.
*See Evaluation of Musculoskeletal System (back of card 4).

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ BLISTERS (SEE ALSO 'RASH')

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

Blisters

BLISTER EVALUATION

A blister is a local swelling of the skin that contains watery fluid. There are many conditions that may result in blisters such as: cold sores, impetigo, shingles, eczema, chicken pox, bullous pemphigoid (which is more common in the elderly), sunburn.

It is important to describe the following:

- Are they located over the entire body?
- Are they cropped together in one location of the body?
- Are they located in an area prone to friction or shearing?
- Are they painful?
- Does the patient have an elevated temperature?
- Does the patient have a history/diagnosis of a blister forming condition in the past?
- Has the patient had past history of chicken pox/ shingles?
- Is there drainage (color & consistency)?

Vesicle: A vesicle of the skin, containing watery matter or serum < 5mm.
Pustules: Swelling of the skin filled with pus.
Bulla: Blister more than 5 mm (about 3/16 inch) in diameter with thin walls that is full of fluid.

If one of the herpes viruses are suspected (such as varicella) evaluate all areas of the body including armpit, groin, joints, abdomen, mouth, neck.

A clinical diagnosis must be made promptly in case isolation is required and employee health measures need to be put in place.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ BLOOD PRESSURE, HIGH OR LOW

PHYSICAL DATA

- Vital signs, including orthostatic BP (more important if low) 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
- Recent or current history of chest pain, head trauma, persistent headache, change in level of consciousness, dizziness, and diaphoresis
- All current medications, including any recent changes; especially any antihypertensive or cardiac medications
- All current diagnoses
- Any changes in color or output of urine

Blood pressure, high or low

BLOOD PRESSURE EVALUATION

Special attention must be made to selection of size of BP cuff in older adults, especially frail older adults, because they have decreased or lost upper body mass.

Classification of Blood Pressure (ACC/AHA)

Normal:	Less than 120/80 mm Hg
Elevated:	Systolic between 120-129 mm Hg *and* diastolic less than 80 mm Hg
Stage 1:	Systolic between 130-139 mm Hg *or* diastolic between 80-89 mm Hg
Stage 2:	Systolic at least 140 mm Hg *or* diastolic at least 90 mm Hg

Examples of Common Mistakes in Blood Pressure Measurement

Error	Effect
Bladder or cuff too wide	False low reading
Bladder or cuff too narrow/too short	False high reading
Cuff wrapped too loosely/unevenly	False high reading
Deflating cuff too slowly	False high diastolic reading
Deflating cuff too quickly	False low systolic/false high diastolic reading
Arm below heart level	False high reading
Arm above heart level	False low reading
Arm not supported	False high reading
Stethoscope that fits poorly	False low systolic/false high diastolic reading
Stethoscope applied too firmly	False low diastolic reading
Inflating too slowly	False high diastolic reading
Repeating evaluations too quickly	False low systolic reading
Inaccurate inflation level	False low systolic reading

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **BRUISE**

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

Bruise

BRUISE DESCRIPTORS

Stage 1: Pinkish red color that can be very tender to touch
Stage 2: Blue or purplish color
Stage 3: Greenish color
Stage 4: Brown or yellowish color

Bruises change colors over time in a fairly predictable pattern. This makes it possible to estimate when an injury occurred by the color of the bruise. Initially, a bruise will be reddish, the color of the blood under the skin. After one to two days, the red blood cells begin to break down, and the bruise will darken to a blue or purplish color. This fades to green at about day six. Around the eighth or ninth day, the skin over the bruised area will have a brown or yellowish appearance. It is important to note the color of a bruise so you can look back and try to figure out **when** it occurred, and perhaps try and figure out **what** may have happened.

Signs of skin breakdown or infection around the bruised area include streaks of redness, pus or other drainage, or fever.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **BURNS**

PHYSICAL DATA

- Vital signs
- Mental status
- Location, size, 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

Burns

DESCRIPTION OF FIRST, SECOND, AND THIRD DEGREE BURNS

Extent or Degree	Evaluation of Extent
First Degree	• Pink to red, slight edema, which subsides quickly • Pain may last up to 48 hrs.; relieved by cooling • Sunburn is a typical example
Second Degree (partial thickness)	**Superficial:** • Pink or red; blisters (vesicles) form; weeping, edematous, and elastic • Superficial layers of skin are destroyed; would be moist and painful • Hair does not pull out easily **Deep dermal:** • Mottled white and red; edematous reddened areas blanch on pressure • May be yellowish, but soft and elastic – may or may not be sensitive to touch; sensitive to cold air • Hair pulls out easily
Third Degree	• Destruction of epithelial cells – epidermis and dermis destroyed • Reddened areas do not blanch with pressure • Not painful; inelastic; coloration varies from waxy white to brown; leathery devitalized tissue is called eschar • Destruction of epithelium, fat, muscles and bone

✔ COLLECT IT ALL BEFORE YOU CALL:

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

PHYSICAL DATA

- Vital signs, including changes such as increased/decreased pulse rate and rhythm, blood pressure, and respiratory rate
- 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
- Heart and lung evaluation, including any rales, wheezes, rhonchi, labored breathing, jugular vein distension, and peripheral edema
- Abdominal evaluation for epigastric discomfort to palpation
- Signs of dizziness, palpitations, nausea, or indigestion, cyanosis
- Skin (cool and clammy, diaphoretic)
- Evidence of musculoskeletal pain

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, pressure, or tightness

After the initial interventions, additional information regarding chest pain can be obtained by performing a heart and lung evaluation.

Listen to the heart for rate, rhythm and to see if there is a murmur. A murmur is a gentle blowing, swooshing sound that can be heard on the chest wall with a stethoscope. Look for a new irregularity of rhythm.

When listening to sounds of the lungs you want to listen for:

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhonchi.

Look to see if the resident is short of breath or has an unusual breathing pattern or is cyanotic.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **COMMUNICABLE DISEASE NOTIFICATION**

PHYSICAL DATA

- Vital signs
- Any findings on evaluation of known or suspected site of infection
- Evidence of sources of potential spread (for example, fecal incontinence, open wounds that cannot be contained, etc.)

MEDICAL HISTORY

- Patient's age and sex
- Background on communicable disease (when acquired, current and previous treatment, whether acute or chronic, recurrent, colonization only, etc.)
- Recent lab results (cultures, serology tests, chest x-ray, etc.)
- All current diagnoses
- Status of the infection in the patient, including response to any treatments
- Infection control precautions in use such as isolation, if any
- Document transition from another care site

Communicable diseases

Since person-to-person spread can play a significant role in the spread of some enteric pathogens, hand hygiene is a critical element of any outbreak prevention and control strategy.

***Wash Your Hands The Right Way:**
When washing hands with soap and water:

- Wet your hands with clean running water and apply soap. Use warm water if it is available.
- Rub hands together to make a lather and scrub all surfaces.
- Continue rubbing hands for 15-20 seconds. Need a timer? Imagine singing "Happy Birthday" twice through to a friend.
- Rinse hands well under running water.
- Dry your hands using a paper towel or air dryer. Use a dry paper towel to turn off the faucet or use the back of your hands.
- Always use soap and water if your hands are visibly dirty.

https://www.cdc.gov./infectioncontrol/basics/standard-precautions.html

https://www.cdc.gov/handwashing/when-how-handwashing.html

*This is an example of a recommended handwashing protocol. Always follow facility policy.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ CONFUSION (SEE ALSO 'AGITATION OR BEHAVIORAL DISTURBANCE', 'CONSCIOUSNESS, ALTERED', 'MEMORY LOSS', 'SODIUM, DEFICIT OR EXCESS')

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 Sat.
- Signs of nausea and vomiting
- Blood sugar level (finger stick) — hypoglycemia or extreme hyperglycemia
- 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

A commonly used instrument, the Confusion Assessment Method (CAM) is based on consideration of 11 different issues that lead to answers to the following questions:

- Is the change in mental status acute and does it fluctuate throughout the course of the day?
- Does the patient have difficulty focusing attention?
- Is the patient's speech disorganized or incoherent?
- Is the patient's level of consciousness altered?

The CAM Tool:
http://consultgerirn.org/uploads/File/trythis/try_this_13.pdf

*See Neurological Evaluation (back of card 37).

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ CONSCIOUSNESS, ALTERED (SEE ALSO 'CONFUSION')

PHYSICAL DATA

- Vital signs
- Neurological evaluation including any evidence of motor weakness, facial weakness, lethargy, or significant change in function
- Signs or symptoms of acute infection (fever, chills, etc.)
- Description of current bowel and bladder function
- Any signs of bruising or other injury
- Pain evaluation of head (location, nature, severity, etc.)
- Evaluate and collect details of recent mood, behavior, orientation, and alertness
- Blood glucose level
- O2 Sat.

MEDICAL HISTORY

- Patient's age and sex
- All current medications, including any recent changes
- Any history of acute or chronic psychiatric disorders
- Any recent history of fall, head trauma, or injury
- All current diagnoses
- Any recent lab or diagnostic test results, including blood sugar if patient is a diabetic
- Findings from previous neurologic or psychiatric consultations

Consciousness, altered

CONSCIOUSNESS, ALTERED EVALUATION

- Evaluate whether resident can follow simple commands and move extremities
- Ask resident name, date/time, place
- Evaluate the appropriateness of the verbal responses
- Evaluate clarity of speech

Observe change in level of consciousness such as:

- Alert: awake and responds appropriately
- Lethargic: very sleepy, but arouses to stimulation
- Stuperous: not completely alert, but responds to pain
- Comatose: is completely unresponsive to stimuli

Glasgow Coma Scale (GCS) is a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial, as well as subsequent evaluation.

GCS:
http://www.strokecenter.org/trials/scales/glasgow_coma.pdf

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **CONSULTATION REPORTS**

PHYSICAL DATA

- Any significant observations and findings related to the condition or problem for which the consultation was ordered

MEDICAL HISTORY

- Patient's age and sex
- Pertinent history related to the problem or reason for which consultation was ordered
- Key contents of consultant's report
- Determine if consultant recommends immediate or urgent action or change in patient management of problem

Consultation reports

When reporting the consultation report to the practitioner, the information should contain (at a minimum):

- Name of consultant and specialty
- Reason for consultation
- Report of findings

If the patient is going out for an appointment or consultation, it is recommended you send with the patient the most recent lab results, diagnostic tests, and progress notes from practitioner. This is important for consistency in information transfer with transitions of care.

COLLECT IT ALL BEFORE YOU CALL:

☐ CONVULSIONS OR SEIZURES

PHYSICAL DATA

- Vital signs, O2 Sat., blood glucose level
- 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, magnesium, and anticonvulsant blood levels

Convulsions or seizures

Nonspecific Clues That Suggest the Presence of Convulsion/Seizures:

One or more of the following clues may indicate the presence of seizures (although no single clue indicates with certainty that seizures are present). In patients with moderate to severe communication problems (aphasia, cognitive impairment, language barriers, etc.), it is important to observe and document these nonspecific clues and to seek further evaluation for possible seizures if any clues are observed. These symptoms usually last a very short time (such as 2 minutes) during a seizure although some symptoms may last for up to a week after a seizure.

Become a Seizure Detective:
Altered mental state
Disorientation
Disrobing
Dizziness
Falls
Language change (slurred speech)
Lapse of consciousness
Memory disturbance
Unexplained confusion
Unresponsive staring off into the distance
Wandering

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ COUGH

PHYSICAL DATA

- Vital signs
- O2 Sat.
- 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
- Chest pain with cough
- 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)
- Hx 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

Description of sputum:

- White or mucoid sputum is often seen with common colds, viral infections, or bronchitis
- Yellow or green sputum is often associated with bacterial infections
- Blood in the sputum is associated with more serious conditions
- Rust colored sputum is associated with tuberculosis or pneumococcal pneumonia
- Pink frothy sputum may be indicative of pulmonary edema

Listen to lung sounds:

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhonchi.

✓ COLLECT IT ALL BEFORE YOU CALL:

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

PHYSICAL DATA

- Vital signs
- Loss of weight
- Neurological, behavioral, and cognitive evaluations including affect, level of consciousness, and responsiveness
- 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

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 or psychological consults or treatments

Depressed mood

***Symptoms of Depression:**

- Depressed mood most of the day, almost every day
- Diminished interest or pleasure in most activities, most of the time
- Thoughts of death or suicide
- Difficulty making decisions
- Feelings of helplessness, worthlessness, or hopelessness
- Inappropriate feelings of guilt
- Psychomotor agitation or retardation not attributable to other causes
- Social withdrawal, avoidance of social interactions, or going out
- Appetite change
- Morning sluggishness and lack of energy that improves markedly later in the day
- Change in ability to think or concentrate
- Change in activities of daily living (ADLs)
- Family history of mood disorders
- Fatigue or loss of energy, worse than baseline
- Insomnia or hypersomnia nearly every day
- Increased complaints of pain
- Preoccupation with poor health or physical limitations
- Weight loss or gain

Geriatric Depression Scale (GDS):
http://www.stanford.edu/~yesavage/GDS.english.long.html

Cornell Scale for Depression in Dementia (CSDD):
https://www.psychcongress.com/saundras-corner/scales-screeners/depression/cornell-scale-depression-dementia-csdd

*See section D of the MDS 3.0- PHQ-9.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ DIABETES, POORLY CONTROLLED

PHYSICAL DATA

- Vital signs and current blood glucose
- 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 glucose trends 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, insulin, or other injectables)
- Recent lab or diagnostic test results
- Recent or current changes in dietary intake; for example, family started bringing in food
- Any current skin breakdown
- Baseline A1c

Diabetes, poorly controlled

Possible Symptoms and Signs of Hypoglycemia in the Frail Elderly

- Altered behavior and mental function
- Altered level of consciousness (drowsiness, lethargy, etc.)
- Confusion or disorientation
- Falls
- Generalized weakness
- Hallucinations
- Hunger
- Irritability
- Poor concentration and coordination
- Pallor

Possible Symptoms and Signs of Hyperglycemia in the Frail Elderly

- Blurred vision
- New or increasing confusion
- Lethargy
- Polydipsia, polyphagia
- Weight loss
- Polyuria or worsening incontinence
- Fruity breath odor

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ DIARRHEA

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, bowel sounds
- 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, or level of consciousness
- Signs of possible fluid volume depletion or dehydration (postural pulse difference — increase from lying down to sitting or standing of 20 beats per minute or more, tachycardia, rapid weight loss, cracked lips, thirst, new onset or increased fall in systolic by > 20 mmHg or fall in diastolic by > 10 mmHg, confusion or fever)

MEDICAL HISTORY

- Patient's age and sex
- 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, hx of bowel obstructions, or of irritable bowel syndrome
- Recent lab (electrolytes) or diagnostic test results

Diarrhea

ABDOMINAL EVALUATION

Look: Look for changes to the abdomen such as distension. Look at the skin for moisture, skin or discoloration.

Listen: Listen for bowel sounds to see if they are active and audible in all four quadrants. Place the bell of the stethoscope lightly over each of the four quadrants. Describe sounds as normal, hyperactive, hypoactive, absent. It may take about 2 minutes to hear bowel sounds.

Feel: Lightly palpate over each of the four abdominal quadrants. Note if the abdomen is soft or firm. Look for tenderness, muscle rigidity, warmth, and watch patient's facial expressions during palpation.

Infection control measures such as hand washing is extremely important to decrease the spread of infectious diarrhea. Examples of infectious diarrhea are:

- C. difficile is known as a major cause of nosocomial diarrhea and most common infectious cause of acute diarrhea in nursing homes. *Clostridium difficile* is shed in feces. Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the *Clostridium difficile* spores. *Clostridium difficile* spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item.
- Noroviruses are highly contagious, resulting in illness 24 to 48 hours after exposure, and are spread by the fecal to oral route of contaminated water and food.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ DIZZINESS/LIGHTHEADEDNESS

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 (lightheadedness versus 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, recent changes
- All current diagnoses
- Recent lab or diagnostic test results
- Fluid intake over past week, vomiting, diarrhea, polyuria

Dizziness/lightheadedness

True vertigo, a sensation of rotational movement, may indicate a disorder called 'benign positional vertigo', a sudden sensation of spinning usually when moving the head, and infections or disorders of the inner ear.

Lightheadedness may reflect cardiovascular problems, hyperventilation, orthostatic hypertension, drug side effect, anxiety, or depression.

When evaluating someone with dizziness or lightheadedness, you may want to perform a neurological evaluation and heart evaluation:

- Observe for changes in level of consciousness
- Listen to the heart for rate, rhythm and to see if there is a murmur. Murmurs common in elderly
- Observe for problems with gait
- Report problems with changes in pupils
- Observe changes in facial symmetry: ask the patient to puff out cheeks, smile, frown
- Observing arms and legs for weakness
- Observe for changes in speech such as inability to speak, difficulty speaking, and inappropriate answers

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **DRUG LEVELS (SERUM), ELEVATED OR TOXIC**

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), or confusion, nausea, vomiting with elevated digoxin levels

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 and recent dose changes
- All current diagnoses

Drug levels (serum), elevated or toxic

Drug levels you may wish to monitor are below. Fill in the panic level as defined by your medical director, lab, or corporate policy etc. in the spaces below.

Term	Definition
Acetaminophen	_____
Carbamazepine	_____
Digoxin (Lanoxin) (ng/ML)	_____
Dilantin therapeutic level (mcg/mL)	_____
Lithium	_____
Phenobarbital	_____
Phenytoin (dilantin)	_____
Potassium (mEq/L)	_____
Theophylline	_____
Valproic Acid	_____
*INR	_____

*While an INR is not a drug level, its monitoring is important enough to list here.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ DYSPNEA (SEE ALSO 'CHEST PAIN', 'EKG, ABNORMAL', 'EDEMA')

PHYSICAL DATA

- Vital signs, including changes such as increased/decreased pulse rate and rhythm, blood pressure, and respiratory rate and effort
- Heart and lung evaluation including rales, wheezes, rhonchi, and labored breathing, cough, pursed lip breathing, O2 Sat.
- Signs of cyanosis, mottled skin
- Description of symptoms (occur with activity or rest, constant or intermittent, began suddenly or gradually)
- 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

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, including EKG and chest x-ray results, if available

Dyspnea

Dyspnea Evaluation includes:
Listening to the heart for rate, rhythm and to see if there is a murmur. A murmur is a gentle blowing; swooshing sound that can be heard on the chest wall with a stethoscope.

Listening to sounds of the lungs, you want to listen for:

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhonchus.

Paroxysmal Nocturnal Dyspnea (PND) occurs with heart failure while lying down.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ EARACHE

PHYSICAL DATA

- Vital signs
- Pain evaluation (location, nature, severity, etc.) of both external and internal ear if otoscope is available
- 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 symptoms 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

Earache

EAR EVALUATION

Some further questions to ask the patient during an evaluation of earache:

- Location of the earache – Does the earache/ pain feel close to the outside of the ear or deeper in the canal?
- Does the pain come and go or is it constant?
- Is the pain dull, aching, stabbing, or sharp?

Discharge from the ear suggests infection. For example:

- External otitis – purulent, sanguineous, or watery discharge.
- *Pseudomonas* and *staphylococcus aureus* can cause severe aggressive otitis externa in patients with diabetes ('malignant otitis externa')
- Acute otitis media with †perforation – purulent discharge.
- Cholesteatoma – dirty yellow gray discharge, foul odor (cholesteatoma – destructive and expanding growth consisting of keratinizing squamous epithelium in the middle ear and/or mastoid process).

†Typically with perforation the patient will experience ear pain first which stops with a popping sensation, then the drainage occurs.

*See Hearing Loss Evaluation (back of card 38).

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ EDEMA

PHYSICAL DATA

- Vital signs, O2 Sat., current weight
- 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) with upright posture
- 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 bedridden evaluate the lower 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, chronic liver disease, phlebitis, venous stasis, DVT
- All current diagnoses
- All current medications, including any recent changes
- Any recent lab or diagnostic test results

Edema

If pitting is present in the extremities, you can grade it using the following scale:

1+ Mild pitting, slight indentation, no perceptible swelling of the leg.
2+ Moderate pitting, indentation subsides rapidly.
3+ Deep pitting, indentation remains for a short time, leg looks swollen.
4+ Very deep pitting, indentation lasts a long time, leg is very swollen.

Summary Checklist: Peripheral Vascular Evaluation

- Inspect lower and upper extremities for color, size, any lesions, open areas, edema, varicose veins
- Palpate temperature of feet and legs
- Palpate pulses (radial, brachial, femoral, popliteal, pedal)
- Examine for unilateral swelling

Abnormal buildup of fluid in the ankles, feet, and legs is called **peripheral edema.**

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

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, especially electrolytes and magnesium

Electrocardiogram (EKG), abnormal

Evaluate patient for chest pain.
After the initial interventions, additional information can be obtained by performing a heart and lung evaluation. **Listen** to the heart for rate, rhythm and to see if there is a murmur. Evaluate if chest pain is relieved by leaning forward or worse with deep inspiration.

Evaluate patient for lung sounds:
When listening to sounds of the lungs you want to listen for;

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhonchi.

Look to see if the resident is short of breath or has an unusual breathing pattern. Look for cyanosis, edema and clubbing.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

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
- Extraocular movements — can look up, down, right and left

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

Eye injuries

Evaluation of the eyes without injury:

- Eyeballs are aligned normally in their sockets
- Eyebrows are present bilaterally and move symmetrically
- Eyelids and lashes (skin is intact without redness, swelling, discharge or lesions)
- Sclera is white
- The iris appears flat with a round regular shape
- The pupils appear round, regular, equal, reactive to light and accommodation
- Extraocular movements are normal

Test for accommodation by asking the person to focus on a distant object. This process dilates the pupils. Then have the person shift their gaze to a near object such as your finger and the pupils will constrict.

Record the normal responses by using **PERRLA (**Pupils Equal Round Reactive to Light and Accommodation).

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ FAINTING (SYNCOPAL EPISODE)

PHYSICAL DATA

- Vital signs, especially pulse rate and rhythm, orthostatic blood pressure, blood glucose, and O2 Sat.
- 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 function, 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, heat exposure, 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

Fainting (syncopal episode)

Syncope is a brief loss of consciousness caused by a temporary deficiency of oxygen in the brain. Ask patient:

- Describe what you felt before you fainted?
- Did you feel the room spinning? (objective vertigo)
- Did you feel like you were spinning (subjective vertigo)
- If this has happened on more than one occasion:
  - When did you begin to notice this?
  - Does it occur a certain time of day?
  - Does it occur after taking certain medications?
  - How often does it occur?

Observe for:

- Changes in level of consciousness
- Problems with gait
- Problems with changes in pupils
- Changes in facial symmetry: ask the patient to puff out cheeks, smile, frown
- Weakness in arms and legs
- Changes in speech such as inability to speak, difficulty speaking, or inappropriate answers

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

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 (esp. hct/hgb, vit D level, TSH, T4), or diagnostic test results

Falls

Evaluation to include:

- Evaluate for possible injuries (especially to the head, neck, spine and extremities) such as pain, swelling, bruising, lacerations, decreased mobility or range of motion (if evaluation shows problems, find corresponding evaluation card and perform evaluation).

Observe for:

- Changes in level of consciousness
- Problems with gait
- Changes in pupils
- Changes in facial symmetry: ask the patient to puff out cheeks, smile, frown

Start critical thinking:

- Residents who are taking anti-coagulants or have conditions such as osteoporosis have the potential to have a serious consequence of falling. Observe carefully for those consequences.
- Describe what you saw and be objective (for example what position was the resident in when found).
- How hard did they fall (for example momentum of the fall)?
- What events occurred or did the patient complain of anything before the fall?
- What environmental hazards were present
- It is not uncommon to have delayed problems after a fall. The problems may occur within several days after the fall, occasionally they can occur several weeks later. Symptomatic intracranial bleeding and fractures may occur days to weeks after an actual fall.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **FEVER**

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

Fever

FEVER EVALUATION

Evaluation of a patient with a fever may include: (not all inclusive)

- How long has the temperature been elevated?
- Is the resident currently being monitored and/ or treated for an infection?
- Is the resident eating and drinking as usual?
- Is the resident tube fed? Any recent choking spells?
- Is there cough, sputum, dysuria, suprapubic tenderness, swollen joints, infected pressure ulcer
- Have any nursing measures or medications for fever (such as acetaminophen) been given?
- Are there any recent (within past week) lab values available?
- What medications is the resident currently taking?
- Is the resident on dialysis?
- Is the resident allergic to any medications?
- Are other residents currently being treated for febrile illnesses?

It is extremely important to know the patient's baseline temperature. A temperature of 99.5 could be a fever for someone whose baseline temperature is 97.0.

COLLECT IT ALL BEFORE YOU CALL:

☐ **FRACTURES AND DISLOCATIONS (IF RELATED TO A FALL, SEE 'FALL')**

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 or rheumatoid arthritis
- 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 anticoagulants and any recent changes in medication
- Any recent lab test or x-ray results
- Long-term steroid use

Fractures and dislocations

Evaluation to include:

- Evaluate for injuries (especially to the head, neck, spine and extremities) such as pain, swelling, bruising, lacerations, decreased mobility or range of motion (if evaluation shows problems, find corresponding evaluation card and perform evaluation).

Definitions:

- A fracture is a disruption or break in the continuity of the structure of a bone. Traumatic injuries account for the majority of fractures, although some fractures are secondary to a disease process (pathologic fractures) such as a spontaneous fracture due to severe osteoporosis.
- A dislocation is the displacement of a body part, especially the temporary displacement of a bone from its normal position.

  Follow facility Policy and Procedures for managing a patient with a fracture or dislocation.

***See Pain Evaluation reference card.**
***See Evaluation of Musculoskeletal System (back of card 4).**

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ GAIT DISTURBANCE

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
- Signs of intoxication

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

Gait disturbance

MUSCULOSKELETAL EVALUATION

During the evaluation of the **Musculoskeletal System**, the nurse needs to use his/her skills of inspection and observation such as: Recognizing problems with gait and Range of Motion (ROM), reporting any problems noted in ROM or muscle strength, and taking precautions during ROM exercises to avoid forcing a joint beyond the patient's current ROM.

Joints: Pain, stiffness, swelling, heat, redness, limitation of movement. **Muscles:** Pain, cramps, weakness. **Bones:** Deformity, pain, trauma (fractures, sprains, dislocations). This evaluation is important when a patient reports pain, loss of sensation, or impairment of joint and/or muscle function.

Examples of a Functional Evaluation. How to start: Place the person's leg flat on the bed. Put one hand under the ankle and your other hand under the knee. Straighten the leg and return it to a flat position on the bed after each movement.

- **Hip and knee bends.** Slowly bend the hip and knee up toward the chest as much as possible (flexion). Slide your hand out from under the knee and toward the upper thigh. Do this to help the knee bend completely.
- **Leg movement,** side to side. Move the leg out to the outer side as far as possible (abduction). Then return the leg to the middle and cross it over the other leg (adduction).
- **Leg rotation,** in and out. With the leg flat on the bed, roll the leg toward the middle so the big toe touches the bed (internal rotation). Roll the leg outward so the little toe touches the bed (external rotation).
- **Knee rotation,** in and out. Bend the person's knee so the bottom of the foot is flat on the bed. Roll the leg inward as far as possible. Try to touch the bed with the big toe. Roll the leg outward as far as possible. Try to touch the bed with the little toe.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ GLOMERULAR FILTRATION RATE (GFR) LESS THAN 60

PHYSICAL DATA

- Vital signs
- Abdominal evaluation, including suprapubic region for signs of distended or tender bladder
- Any signs of fatigue (tiredness), anorexia, shortness of breath, dizziness, especially when standing up
- Any signs of possible infection
- Signs of increased potassium level
- Intake and output data (watch for decreased urine production)
- Any changes in mental status
- Description of edema if present
- With signs of falls (bruising, pain, change in gait, etc.) check hemoglobin

MEDICAL HISTORY

- Patient's age and sex
- All current diagnoses, especially hypertension and diabetes
- All current medications, including any recent changes, especially diuretics, ACE inhibitors, nonsteroidal anti-inflammatory drugs (NSAIDs), antibiotics, or concentrated protein supplements
- History of kidney disease or renal failure or dialysis
- Any recent vomiting, diarrhea, or history of gastrointestinal (GI) bleeding
- Any recent changes in characteristics of urine
- Any recent weight loss or gain
- Any recent infection or fever
- Any recent surgery or acute illnesses
- Any recent increase in itchy/dry skin
- Eating and drinking patterns over previous week
- Recent lab or diagnostic test results, especially basic metabolic profile (BMP, BUN and GFR, creatinine, electrolytes, glucose)
- Trends of previous BUN and creatinine, and GFR results

Glomerular filtration rate (GFR) less than 60

Since **anemia** occurs commonly with **chronic renal disease,** obtain a hemoglobin/hematocrit. Anemia has many negative effects on older adults including fatigue, shortness of breath, dizziness, cognitive problems, irregular heartbeat, can lead to falls and much more.

Chronic kidney disease is defined as either kidney damage or GFR <60 mL/min/1.73 m2 for ≥ 3 months. CKD is the permanent loss of some kidney function. This happens when the tiny filters in the kidneys called glomeruli are damaged. Diabetes and high blood pressure are two major causes of CKD.

Acute Renal Failure
This is when renal failure happens very quickly. Injuries, major blood loss, and some reactions to medicines can cause acute renal failure.

Understanding lab values related to GFR and kidney disease
Serum Creatinine: Creatinine is a substance produced by the muscles and is excreted in the urine. It causes decrease if low muscle mass exists.
Glomerular Filtration Rate (GFR): Your GFR is a calculation that estimates the amount of kidney function present.
Blood Urea Nitrogen (BUN): BUN is a byproduct of protein metabolism and is excreted in the urine.
Hemoglobin: Hemoglobin is the part of red blood cells that carries oxygen from your lungs to all parts of your body.

National Kidney Foundation, Inc. Kidney Disease Outcomes Quality Initiative Clinical Practice Guidelines and Clinical Practice Recommendations for Anemia in Chronic Kidney Disease. New York: 2006.
http://www.kidney.org/professionals/kdoqi/guidelines_anemia/

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ GLUCOSE, ABNORMAL (SEE ALSO 'DIABETES, POORLY CONTROLLED')

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, insulin, or other injectable agents
- Patient's usual patterns of blood sugars and/or HbA1c
- Food and fluid intake patterns over past week (e.g., missed meals, excessive carbohydrates)
- Current diagnoses, medications and medication changes
- Recent history of nausea, vomiting or diarrhea

Glucose, abnormal

Possible Symptoms and Signs of Hypoglycemia in the Frail Elderly

- Altered behavior and mental function
- Altered level of consciousness (drowsiness, lethargy, etc.)
- Confusion or disorientation
- Falls
- Generalized weakness
- Hallucinations
- Hunger
- Irritability
- Poor concentration and coordination
- Pallor

Possible Symptoms and Signs of Hyperglycemia in the Frail Elderly

- Blurred vision
- New or increasing confusion
- Lethargy
- Polydipsia, polyphagia
- Weight loss
- Worsening incontinence
- Fruity breath odor

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **HEADACHE**

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
- Signs of severe dental infection

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

Headache

After the initial interventions, additional information regarding pain can be obtained by using the mnemonic **PQRST.**

P - Provoked or palliative: ask the patient what she/he did when the pain began, ask the patient if she/he knows what caused the pain.
Q - Quality: provide a description of the pain (throbbing, burning, stabbing, etc.), document the patient's description of the pain.
R - Radiation and area of pain: does the pain radiate anywhere, if so where (top of head, side of head, neck, back of head, sinus area), where did the pain begin, have the patient point to the area where it started and the areas it radiates.
S - Severity of pain: use a pain scale the facility uses to describe and rate the pain.
T - Time: ask the patient what time the pain began (minutes, hours, days, etc.).

Evaluate neurologic system by:

- Observing changes in level of consciousness
- Recognizing problems with gait
- Reporting any problems with changes in pupils (PERRLA)
- Recognizing changes in facial symmetry
- Recognizing changes such as drooling, coughing, or clearing throat after eating or drinking
- Observing arms and legs for weakness
- Observe for changes in speech such as inability to speak, difficulty speaking, and inappropriate answers
- Check both temples for tenderness (possible temporal arteritis)

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **HEAD INJURIES**

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, smell, or bleeding)
- 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 antiplatelet or anticoagulant medications and any recent changes in medication
- All current diagnoses
- Any recent lab or diagnostic test results
- Any recent falls or injuries

Head injuries

NEUROLOGICAL EVALUATION

Observe residents for examples of signs of possible neurological impairment (not all inclusive):

- Change in alertness, level of consciousness
- Pupil change in size or response
- Trouble speaking or understanding others who are speaking
- Problems with eyesight, including decreased vision, double vision, or total loss of vision
- Muscle weakness in the face, arm, or leg (usually just one side)
- Numbness or tingling on one side of the body
- Sensation changes that affect touch and the ability to feel pain, pressure, different temperatures, or other stimuli
- Loss of coordination
- Loss of balance, trouble walking
- Changes in personality, mood, or emotion
- Confusion or loss of memory
- Difficulty swallowing
- Difficulty writing or reading
- Dizziness or abnormal sensation of movement (vertigo)
- Lack of control over the bladder or bowels

Check for obvious injuries of the scalp, including lacerations, abrasions, bruising.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ HEARING LOSS

PHYSICAL DATA

- Vital signs
- Check ear canal for cerumen if otoscope available
- 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 function

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

HEARING LOSS EVALUATION

After the initial interventions, additional information regarding hearing loss can be obtained by checking for:

- Evidence of trauma
- Pain with or without touch
- Wax build up
- Patient talking louder
- Patient turning head toward you when you speak
- Patient requesting you to speak louder
- Lack of response to a loud noise
- Inappropriate answers when otherwise cognitively intact

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ HEMATOCRIT (HCT)/HEMOGLOBIN (HGB), ABNORMAL

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)
- 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, snoring, 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, MCV, 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, renal disease, iron deficiency, GI disorders
- All current medications, including any recent changes, especially those associated with bone marrow suppression or increased bleeding risk

Hematocrit (Hct)/hemoglobin (Hgb), abnormal

The World Health Organization defines anemia as hemoglobin of less than 12 g/dL in women and less than 13 g/dL in men.

Symptoms of anemia may include:

- Changes in cognitive status
- Chronic infections
- Decline in ADL function
- Falls
- Fatigue
- Headache
- Increase in heart rate
- Insomnia
- Loss of appetite, weight loss
- Nutritional problems
- Palpitations
- Shortness of breath

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ HEMATURIA

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), diagnostic test results, elevated INR, low platelets
- How has situation been managed so far

Hematuria

Common non-specific symptoms of a urinary tract infection in the elderly include:

- Unexplained deterioration of physical function
- Change in mental status
- New or worsening cognitive impairment, increasing confusion
- Abnormal or a change in vital signs

Listen to patient for complaints of back pain as this may be a sign of kidney problem.

A urinalysis may detect hematuria and clinically significant pyuria, but otherwise is likely to have limited utility as a screening test because of the high prevalence of asymptomatic bacteriuria in the long-term care population.

After the initial interventions, additional information regarding hematuria may be found by performing a physical evaluation:

- Tenderness over the flank or back suggests a blocked kidney from a stone or an infected kidney
- Abrasions or black-and-blue marks over the flank or back suggest recent trauma to the urinary tract
- Tenderness or soreness over the lower abdomen may be from a bladder infection
- A mass or fullness felt in the lower abdomen suggests a distended bladder and the hematuria may be due to pathology of the bladder or prostate
- A tender prostate can mean a prostate infection is present

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ HEMOPTYSIS (COUGHING UP BLOOD)

PHYSICAL DATA

- Vital signs
- Amount of blood and whether mixed with mucous, contains clots, etc.
- Respiratory rate, rhythm, and effort
- 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 Sat.

MEDICAL HISTORY

- Patient's age and sex
- All current diagnoses
- Onset, frequency, and duration of symptoms
- How has situation been managed so far
- 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

Hemoptysis (coughing up blood)

When a patient is coughing up blood or vomiting blood, stabilizing the patient is the most important step. Often times the terms hemoptysis and hematemesis are confused with one another because both involve bleeding. Therefore, "Where is it from" is the question that needs to be answered.

Differences between hematemesis and hemoptysis

Vomiting blood (hematemesis)	**Coughing blood** (hemoptysis)
GI TRACT	RESPIRATORY TRACT
Dark red or brown	Bright red
In clumps	Foamy, runny
Mixed with food	Mixed with mucous
Abdominal discomfort, pain	Chest pain, warmth or gurgling over the chest
Nausea, retching before and after episode	Persistent cough

Hemoptysis Evaluation

- Save all specimens from the patient to show to the clinician.
- Check tuberculosis screening results and chest x-ray results if available.
- Perform lung, abdominal, throat, and mouth evaluation.

COLLECT IT ALL BEFORE YOU CALL:

☐ **HYPOTHERMIA**

PHYSICAL DATA

- Vital signs
- Neurological evaluation, including significant changes in level of consciousness, function, mood, or behavior
- O2 Sat.
- 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

Hypothermia

Hypothermia occurs when your body temperature drops below normal, causing the circulatory, respiratory, and nervous systems to slow down.

Signs and symptoms may include:

- Tachycardia and hypertension
- Cold, pale skin
- Bradycardia if severe
- Confusion
- Cyanotic nail beds, lips
- Discomfort at temperatures higher than normal/usual
- Feeling cold, shivering
- Low energy
- Memory loss
- Respiratory distress or slow respirations if severe hypothermia
- Signs and/or symptoms of infection
- Unable to think or pay attention
- Weak pulse

Observe the patient carefully for shock, such as what may result from urinary sepsis. This is an acute medical emergency.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

PHYSICAL DATA

Urine Incontinence

- Vital signs
- Abdominal evaluation
- Significant change in LOC, function, mood, or behavior
- Signs of bladder distension or tenderness to palpation
- Males: swelling, bleeding, or penile discomfort
- 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

Stool Incontinence

- Vital signs
- Abdominal evaluation
- Significant change in LOC, function, mood, or behavior
- Rectal evaluation, including masses, weakened anal sphincter muscles
- Pain or hard stool on digital rectal evaluation (especially if oozing liquid stool)
- Color and consistency of 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, including diabetes, neurological disorder and pelvic trauma
- 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 of urine or stool, increased severity or new onset

Urinary Incontinence - The following should be determined:

- changes in mental status
- complaints of burning, pain, bloody urine, abnormal temperature, frequency
- duration (recent onset or chronic)
- frequency (occasional episodes or always present)
- presence of abdominal distension
- presence of constipation or impaction
- time of medications (diuretics) given for fluid retention or psychotropics

Fecal Incontinence - The following should be determined:

- duration (recent onset versus chronic)
- frequency (occasional episode or always present)
- fecal urgency
- presence of chronic constipation or fecal impaction (especially if oozing of stool)
- recent antibiotic usage
- severity (soiling by liquid stools only or gross incontinence of solid stools)
- Loss or decreased sensation of anus or perineum

COLLECT IT ALL BEFORE YOU CALL:

☐ ITCHING (PRURITUS)

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
- Look for jaundice

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 especially liver or renal disease
- All current allergies
- Response to any recent interventions
- Recent lab (CBC, erythrocyte sedimentation rate, protein electrophoreses, CMP) or diagnostic test results

Itching

ITCHING EVALUATION

Itching can be a sign of a mild allergic reaction. However, anaphylaxis is a sudden and severe allergic reaction that occurs within minutes of exposure. Immediate medical attention is needed for this condition. It can get worse very fast and lead to death within 15 minutes if treatment is not received.

Evaluation of itching may include interviewing the resident about onset of itching, allergies, location, pain, patterns of behavior that precipitate itching such as anxiety, environmental factors, soaps, detergents, skin products and past history of skin disorders, exposure to someone who has contracted scabies, lice, etc. Ask other patients if they are itching as well.

Common causes of itching are:

- Allergic reactions
- Eczema (dermatitis)
- Dry skin
- Insect bites and stings
- Irritating chemicals
- Parasites, such as scabies, lice
- Rashes
- Reaction to medicines, food (seafood, fruit, etc.)
- Chronic liver or kidney disease

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ **LAB REPORTS, ABNORMAL**

PHYSICAL DATA

- Vital signs
- Any signs and symptoms related to the condition or risk for which the test was obtained

MEDICAL HISTORY

- Patient's age and sex
- Reason test(s) was obtained (new onset of symptoms or condition change, routine monitoring of a risk or condition, or to monitor medication effects or blood level)
- Urgency of acting on results. For example, the call to the practitioner could be considered urgent if test(s) were ordered stat or results were given as "panic" levels
- Any history of recent or current illness or condition changes
- Related previous lab or diagnostic test results for comparison
- All current diagnoses
- All current medications, including any recent changes

Lab reports, abnormal

Below you will find some **examples** of "normal" blood levels for medications and electrolytes. Fill in the blanks of what the facility's medical director feels is important for the facility to have on this card.

Lab	Result	Lab	Result
Albumin (g/dl)	3.5 – 5.0	_____	_____
BUN	8 – 20	_____	_____
Creatinine	0.5 – 1.5	_____	_____
Digoxin (Lanoxin) (ng/ML)	0.5 – 2.0	_____	_____
Dilantin therapeutic level (mcg/mL)	10 – 20	_____	_____
Glucose fasting	70 – 110	_____	_____
INR std. therapy	2 – 3	_____	_____
Prealbumin (mg/dL)	17 – 40	_____	_____
Potassium (mEq/L)	3.5 – 5.0	_____	_____
Sodium (mEq/L)	135 – 145	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **LACERATION**

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

Laceration

Lacerations - also called tears, are separating wounds that produce ragged edges.
Skin tears are reported as a common occurrence in the elderly. Long term steroid use, chronic sun exposure and numerous age-related changes increase the fragility of the skin.

Describe the skin tear in detail for the practitioner:

- **Linear Category I** skin tear has the epidermis and dermis layers separated in an incision-like lesion.
- **Flap-Type Category I** skin tear is characterized by an epidermal flap that covers the dermis, and the wound edges are within 1 mm width of separation.
- **Category II** skin tear is subdivided as scant tissue loss with 25% or less of the epidermal flap missing, and the moderate-to-large subcategory has more than a 25% loss of epidermal flap.
- **Category III** skin tear occurs with the loss of the epidermal skin flap. This is the most severe type.

The Payne-Martin classification for skin tears as described above clearly describes the categories and subcategories of skin tears based on severity of the tear and the loss of epidermal tissue.

For picture descriptive see:
http://www.medscape.com/viewarticle/531999_2
(NOTE: login required for Medscape access)

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ MEDICATION ERROR

PHYSICAL DATA

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

MEDICAL HISTORY

- Patient's age and sex
- Details of the medication error (dosing, timing, omission, etc.)
- All other current medications, including any recent changes
- All current diagnoses

Medication error

Common symptoms of adverse drug reactions in older persons include but are not limited to:

- Anorexia
- Anxiety
- Ataxia or abnormal movement of extremities
- Constipation
- Delirium
- Diarrhea
- Dizziness
- Forgetfulness
- Gait disturbance
- Hallucinations
- Increased "agitated" type behavior
- Insomnia or sleep disturbance
- Lethargy
- Memory impairment
- Nausea and vomiting
- New or worsening cognitive decline
- New onset of confusion
- Restlessness
- Sedation
- Skin rash
- Syncope
- Tremor
- Unexplained falls and trauma
- Vertigo
- Weight loss

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

PHYSICAL DATA

- Vital signs
- Brief 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
- Recent infection or decompensation of a chronic condition (e.g., HF, COPD)
- Recent lab tests (e.g., CBC, TSH, BMP, B12 levels)
- New onset of neurological deficit

Memory loss

Memory is the ability or process of reproducing or recalling what has been learned or retained.

- **Short term memory** is the primary or active memory. The amount of information that is stored is limited and it is stored for a limited amount of time.
- **Long term memory** stores an unlimited amount of information indefinitely.

*Evaluation of a patient's memory ability may be detected by using the following:

The Mini-Cog is a tool composed of three item recall and the Clock Drawing Test (CDT).

Information and instruction on the Mini-Cog tool:
http://mini-cog.com/wp-content/uploads/2015/12/Universal-Mini-Cog-Form-011916.pdf

**Follow facility protocol*

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

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

Nausea and vomiting

During the evaluation of nausea and vomiting, interview the patient for relationships between other factors and the occurrence of the nausea and vomiting. For instance, could the nausea and/or vomiting occur after a particular medication is given or immediately or shortly after mealtime. Inquire about patient's bowel movements (nausea can occur due to constipation, etc.).

Perform an Abdominal Evaluation:
Look: Look for changes to the abdomen such as distension.
Listen: Listen for bowel sounds to see if there are active and audible in all four quadrants. Place the bell of the stethoscope lightly over each of the four quadrants. Describe sounds as normal, hyperactive, hypoactive, absent. This may take time to evaluate.
Feel: Lightly palpate over each of the four abdominal quadrants. Note if the abdomen is soft or firm. Look for patient to react and give clues to tenderness, feel for muscle rigidity, warmth, and watch patient's facial expressions during palpation.

If constipated, perform a Rectal Evaluation:
Feel the anal area and rectal walls for pain or tenderness. Check for hard stool in the rectum. Sometimes liquid stool seeps around a fecal impaction and appears as an oozing of mucous like diarrhea stool.

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ NOCTURIA

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 also 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, timing 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 glucose) or diagnostic test results

Nocturia

Nocturia is the need to get up during the night in order to urinate. Its occurrence is more frequent in the elderly. Nocturia could result simply from too much liquid intake before going to bed (usually the case in the young) or it could be a symptom of a larger problem, such as sleep apnea, hyperparathyroidism, chronic renal failure, urinary incontinence, bladder infection, interstitial cystitis, diabetes, heart failure, benign prostatic hyperplasia, ureteral pelvic junction obstruction, or prostate cancer.

Urinary tract infections (UTI) in the elderly patient can sometimes be difficult to detect. Common symptoms are painful and difficult urination, frequency, and new onset incontinence. An older adult may not have a fever but have a temperature below normal instead. Hypothermia is an important sign of sepsis in the elderly.

Common **non-specific** symptoms of a UTI in an older adult include:

- Agitated behavioral symptoms
- Anorexia
- Change in cognition, increasing confusion
- Change (deterioration) in physical function, unexplained
- Change in vital signs
- Delirium
- Falls
- Lethargy

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ NOSEBLEED (EPISTAXIS)

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 anticoagulants or antiplatelet agents (e.g., aspirin)
- All current diagnoses
- Any recent lab or diagnostic test results

Nosebleed

NOSEBLEED EVALUATION

Look

- At color of blood - red or brown?
- How much bleeding - a teaspoonful or tablespoon?
- Bleeding from one nostril or both?
- Has the patient been vigorously blowing their nose?
- For signs of trauma
- To see if patient is using over the counter nasal medications which may cause nosebleeds or alert you that the patient may be having a problem with allergies, etc.
- Under the fingernails to see if the patient may be digging at their nose

Listen

Ask the patient

- If she/he had nosebleeds in the past
- If they know what caused the nose bleed
- What they may have done to relieve them in the past

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ POTASSIUM (K+), ABNORMAL

PHYSICAL DATA

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

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

Potassium, abnormal

Potassium is essential for the maintenance of important processes in the body including cardiac, smooth and skeletal muscle function, acid base balance, gastric secretions, renal function, protein and carbohydrate metabolism.

Side effects of **Hypokalemia:** (can be mild to severe)

- Anorexia, nausea, and vomiting
- Arrhythmias (weak, irregular pulse, hypotension)
- Cardiac arrest
- Constipation, ileus
- Dizziness, mental confusion
- EKG abnormalities
- Muscle aches and cramps
- Muscle or respiratory paralysis
- Weakness

Side effects of **Hyperkalemia:** (can be mild to severe)

- Malaise
- Muscle weakness
- Palpitations

Side effects of hyperkalemia with acute renal failure:

- Oliguria (urine output less than 400mL/day), anuria (urine output less than 50 mL/day)

Side effects of hyperkalemia with Potassium chloride overdose:

- Muscle weakness, including frank skeletal muscle and diaphragm paralysis, cardiac arrhythmias, and ECG changes

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ PRESSURE ULCERS

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
- Ability to turn self, bed or chair mobility
- Current weight, diet, and nutritional status
- Any recent lab or diagnostic test results

Pressure ulcers

TABLE 1 OF 3

Definition	MDS – Pressure Ulcer†	NPUAP – Pressure Injury
Pressure ulcer/ pressure injury	A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear* and/or friction*.	A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate*, nutrition, perfusion, comorbidities and condition of the soft tissue.
Stage 1 pressure ulcer/injury	An observable, pressure-related alteration of intact skin, whose indicators as compared with an adjacent or opposite area of the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.	Intact skin with a localized area of non-blanchable erythema*, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate DTPI.
Stage 2 pressure ulcer/injury	Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough*. May also present as an intact or open/ruptured blister.	Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or rupture serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue*, slough and eschar* are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (e.g., incontinence associated dermatitis), intertriginous dermatitis, medical adhesive related skin injury, or traumatic wounds (e.g., skin tears, burns, abrasions).

* http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrations/

Pressure ulcers

TABLE 2 OF 3

Definition	MDS – Pressure Ulcer†	NPUAP – Pressure Injury
Stage 3 pressure ulcer/injury	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining* or tunneling*.	Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue* and epibole (rolled out edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage, and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Stage 4 pressure ulcer/injury	Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often incudes undermining and tunneling.	Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining, and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
Deep-tissue pressure injury	Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared with adjacent tissue.	Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Pressure ulcers

TABLE 3 OF 3

Definition	MDS – Pressure Ulcer†	NPUAP – Pressure Injury
Unstageable pressure injury	‡	Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance*) on an ischemic limb or the heel(s) should not be removed.
Medical-device–related pressure injury	‡	This describes the etiology of the injury. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.
Mucosal-membrane pressure injury	‡	Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Because of the anatomy of the tissue, these injuries cannot be staged.

DTPI: deep-tissue pressure injury; MDS: Minimum Data Set

† Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, because CMS has adapted the NPUAP guidelines for MDS purposes, the MDS definitions do not correlate perfectly with each stage as described by NPUAP. ***For this reason, the NPUAP definitions cannot be used to code the MDS. Follow the instructions in the MDS manual to code the MDS.***

‡ MDS does not define these terms

✔ **COLLECT IT ALL BEFORE YOU CALL:**

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

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 of pulse. 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 Sat.

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, calcium channel blockers or beta blockers
- History of dietary intake that could affect heart rate (such as caffeine)
- Any recent lab or diagnostic test results (e.g., digoxin level, TSH)
- Change in food and/or fluid intake
- Presence of nausea, vomiting, diarrhea

Pulse, abnormal

PULSE EVALUATION

When evaluating pulses, it is important to obtain information about the pulse which includes the rate, rhythm, and strength (weak or bounding).

After the initial interventions with a patient with an abnormal pulse, additional information can be obtained by performing a heart and lung evaluation.

Listen to the heart for rate, rhythm, and to see if there is a murmur. A murmur is a gentle blowing, swooshing sound that can be heard on the chest wall with a stethoscope.

Listen to the sounds of the lungs for:

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup) and best heard over the trachea.
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably a rhonchi.

Look to see if the resident is short of breath or has an unusual breathing pattern.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **PUNCTURE WOUNDS**

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 puncture wound occurred, if known
- How has situation been managed so far
- All current medications, including any recent changes
- All current diagnoses
- Tetanus toxoid vaccination history, if known

Puncture wounds

Punctures: Deep, narrow wounds produced by sharp objects such as nails, knives, and broken glass. A puncture wound will be greater in its length, therefore there is usually little bleeding around the outside of the wound and more bleeding inside, causing discoloration.

PUNCTURE WOUND EVALUATION

Visually examine the wound and try to confirm what caused the event, even if the resident is cognitively impaired. Evaluate the extent of the wound and what effect it has had on the patient's well-being (damage to the nervous system or skeletal system, etc.).

The following pose serious health risks and may require immediate action:

- A puncture wound in the head, neck, chest, or stomach
- A puncture wound that is bleeding profusely
- Where you are unable to remove an object from the wound
- The patient has signs of decreased blood flow at or near a puncture wound
- The patient has loss of function at or near the puncture wound
- The patient has immediate and a large amount of swelling and bruising at or near a puncture wound

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ RASH (SEE ALSO 'BLISTERS')

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

***See back of card**

Rash

Types of lesions:

Bullae: More than one bulla, a bulla being a blister more than 5 mm (about 3/16 inch) in diameter with thin walls that is full of fluid

Macule: Flat, non palpable change in skin color, smaller than 1.0 cm

Nodule: Elevated, solid mass, deeper and firmer than papule, 0.5 to 2.0 (such as 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 (such as venous stasis ulcer)

Vesicle: Elevation of skin filled with serous fluid (such as herpes simplex, chicken pox), smaller than 0.5 cm

Wheal: Irregularly shaped, elevated area or superficial localized edema, varies in size (such as hive, mosquito bite)

Description should include:

- Onset
- Location
- Duration
- If it is tender to touch
- Redness
- If it is elevated and if it is fluid filled (with pink, red, clear, yellow fluid)
- If there is a "crust"

✓ COLLECT IT ALL BEFORE YOU CALL:

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

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, agitation, anxiety, pain
- Evaluate skin for color, temperature (cool, clammy, cyanosis, mottled skin, 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 narcotics, hypnotics and psychotropics including any recent changes in medication
- Any recent lab or diagnostic test results, including pulse oximetry results and findings of acid-base disturbance (acidosis, alkalosis)

Respiratory rate, abnormal

Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, prolonged expirations, audible respirations, gasping for air at rest, trouble speaking (only able to say a few words before taking a breath), and use of shoulder and other accessory muscles to breathe.
Ask the resident if shortness of breath occurs when he or she engages in certain activities. Listen to patient reports, such as being out of breath when performing ALDs or lying down. Observe if their shortness of breath is causing them to limit their activities.

Look

- Rate (What is the respiratory rate?)
- Lips (Are the lips cyanotic?)
- Overall skin color and temperature (What is the patient's overall skin color? Are they pale, pinkish, bluish, flushed? Are they cool or clammy, etc.?)
- Is the patient unable to speak at all or cannot speak in sentences because of shortness of breath?
- Observe the breathing patterns such as Cheyne-stokes, hyperventilation, irregular, rapid, slow, shallow, deep, gasping, etc.

Listen

- Crackles: These are high pitched, discontinuous sounds similar to the sound produced by rubbing your hair between your fingers (also known as **Rales**).
- Wheezes: These are generally high pitched and "musical" in quality. **Stridor** is an inspiratory wheeze associated with upper airway obstruction (croup).
- Rhonchi: These often have a "snoring" or "gurgling" quality. Any extra sound that is not a crackle or a wheeze is probably rhonchi.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ SEIZURE ACTIVITY OR CONVULSIONS

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, hypoglycemia, 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
- Comparison of current seizure activity related to usual patterns
- Recent lab or diagnostic test results, especially BMP, glucose, Magnesium, Calcium and anticonvulsant blood levels

Seizure activity or convulsions

When a patient is experiencing a seizure, the primary consideration is to protect the patient from harm.

Nonspecific Clues that Suggest the Presence of Seizures:
One or more of the following clues may indicate the presence of seizures (although no single clue indicates with certainty that seizures are present). In patients with moderate to severe communication problems (aphasia, cognitive impairment, language barriers, etc.) it is important to observe and document these nonspecific clues and to contact the practitioner to seek further evaluation for possible seizures if any clues are observed. These symptoms usually last a very short time during a seizure; some symptoms may last for up to a week after a seizure.

Become a Seizure Detective:
Altered mental state
Disorientation
Disrobing
Dizziness
Falls
Language change (such as slurred speech)
Lapse of consciousness
Memory disturbance
Unexplained confusion
Unresponsive staring off into the distance
Wandering

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **SLEEP DISTURBANCE**

PHYSICAL DATA

- Vital signs
- Any significant changes in function, mood, energy level, 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 including COPD, heart failure, depression, chronic pain
- Environmental factors (room by nurses station, etc.)
- Effectiveness of any current or previous interventions
- Possible contributing factors such as caffeine intake or excessive daytime napping
- Social issues such as the death of a loved one or depression

Sleep disturbance

Signs and Symptoms That May Indicate the Presence of a Sleep Disorder

Nighttime Signs and Symptoms

- Apneic episodes and arousal snort
- Frequent awakenings
- Noticeable snoring or uneven breathing patterns
- Periodic, jerking limb movements during sleep or while lying awake in bed
- Vocalization (talking in sleep)
- Wandering

Daytime Signs and Symptoms

- Abnormal behavior in patients with dementia (agitation, hostility, combativeness, etc.)
- Complaints related to patient not sleeping (by roommate or family member)
- Early-morning agitation, confusion, or headache
- Excessive daytime sleepiness or napping
- Falls or frequent accidents
- Functional decline
- Hypersomnia with functional impairment
- Impaired cognition or mental acuity
- Reduced alertness
- Reduced intake of food and fluids due to excessive sleepiness
- Reduced participation in activities
- Uncontrolled hypertension

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ **SODIUM (NA) DEFICIT (HYPONATREMIA) OR EXCESS (HYPERNATREMIA) (SEE ALSO 'AGITATION OR BEHAVIORAL DISTURBANCE', 'APPETITE, DIMINISHED', 'CONFUSION', 'CONSCIOUSNESS, ALTERED', 'CONVULSIONS', 'DIARRHEA', 'LAB REPORTS, ABNORMAL', 'NAUSEA AND VOMITING')**

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, diarrhea, or fever
- 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, antidepressants, psychotropics 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

***See back of card**

Sodium deficit or excess

Hypernatremia	(*high NA level greater than 145 mEq/L)
Hyponatremia	(*low NA level specifically below 135 mEq/L)

Hyponatremia Signs & Symptoms:
Coma
Confusion
Drowsiness
Headache
Loss of consciousness
Nausea
Restless
Seizures
Stupor

Hypernatremia Signs & Symptoms:
Coma
Confusion
Neuromuscular excitability
Seizures
Thirst
Venous thrombosis

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ SORE THROAT (SEE ALSO 'SWALLOWING DIFFICULTY')

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 dyspnea
- 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

Sore throat

A sore throat can be an acute upper respiratory tract infection due to other causes such as acid reflux, or oral irritation that affects the respiratory mucosa of the throat.

Using a light, observe the oval, rough surfaced tonsils. Their color should be the same pink as the oral mucosa and the surface normally is covered with indentations or crypts. With an acute infection tonsils (if the patient still has them) are bright red, swollen and may have exudate or large white spots. Note any foul breath odor. Examine the tongue for bilateral furrowing.

Observe the mouth and neck for swelling, the throat for edema and redness. Look to see if the patient is drooling, which can be a sign of a significant sore throat (not wanting to swallow).

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **SPEECH, ABNORMAL**

PHYSICAL DATA

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

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, severity, and scope of abnormality, intermittent or constant
- History of stroke or other neurological disorders, dysphagia, 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

Speech, abnormal

During the evaluation of speech include the following:

- Observe changes in facial symmetry (ask the patient to puff out cheeks, smile, frown, and raise eyebrows). Facial expressions should be symmetrical.
- Observe changes which could be a swallowing problem such as drooling, pocketing food, slow eating, gulping, coughing or clearing throat after eating or drinking, wet voice, complaints of food sticking in throat.
- Observe changes in speech, such as inability to speak, difficulty speaking, inappropriate answers, inability to comprehend.

Problems with swallowing may also occur due to problems in the mouth such as:

- Condition of teeth, especially pairs of teeth in chewing position
- Pain and discomfort due to partial plates or dentures that do not fit properly
- Dry, sticky, red tissue or blisters on the tongue or floor of mouth
- Dry, chapped, or blisters on or around lips
- Swollen or bleeding gums
- White or red patches, bleeding or ulcers on tissue inside cheeks of mouth
- Foul odor (possibly due to tooth decay)

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **SPLINTERS/SLIVERS**

PHYSICAL DATA

- Description of the site of injury
- Pain evaluation (location, nature, severity, etc.)
- Signs of localized bleeding, infection, erythema, or purulent drainage

MEDICAL HISTORY

- Patient's age and sex
- How the injury occurred
- Date of last tetanus shot, if known
- Whether entire splinter/sliver was removed
- Effectiveness of any treatments so far

Splinters/slivers

Check to see when patient received last tetanus shot.

When evaluating a patient with a splinter describe the following:

- Any reddened area
- Any swelling
- Any tenderness
- Drainage (color, odor, amount)
- Duration (How long has it been there?)
- Exact location
- Is it warm to touch
- Size (width, length, depth) in mm or cm

It is important to find the environmental location where the patient received the splinter and repair the area to avoid this occurrence from happening again.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **SPRAINS/STRAINS**

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, or any anticoagulants in use
- All current diagnoses
- Any recent lab or diagnostic test results

Sprains/strains

Sprain: an injury that affects the ligaments, thick bands of cartilage that attach bone to bone. Bruising, swelling, instability, and painful movement are common symptoms experienced after a sprain occurs.

Strain: an injury that affects the muscle fibers. Pain, weakness, and muscle spasms are common symptoms experienced after a strain occurs.

After the initial evaluation (musculoskeletal), additional information regarding pain can be obtained by using the mnemonic **PQRST.**

P - Provoked or palliative: ask the patient what she/he did when the pain began, ask the patient if she/he knows what caused the pain.
Q - Quality: provide a description of the pain (throbbing, burning, stabbing, etc.), document the patient's description of the pain.
R - Radiation and area of pain: does the pain radiate anywhere, if so where (top of head, side of head, neck, back of head, sinus area), where did the pain begin, have the patient point to the area where it started and the areas it radiates.
S - Severity of pain: use a pain scale the facility uses to describe and rate the pain.
T - Time: ask the patient what time the pain began (minutes, hours, days, etc.).

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ **SUICIDE, POTENTIAL**

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 or refusal of medications
- What measures are in place to prevent self-harm

Suicide, potential

Suicide risk increases with the severity of depression. The risk is highest among white males aged 80 or older. The next highest risk group is white males between ages 65 and 80.

Suicide Warning Signs:

- Preoccupation with death
- A plan is present and a lethal means available (prescription drugs, sharp object, etc.)
- Preoccupied with thoughts of impending death or suicide
- Statements of hopelessness, helplessness, or worthlessness
- Suddenly happy and calmer after depressive symptoms
- Expresses despair, hopelessness, pessimism about future
- Making arrangements or getting affairs in order
- Giving things away

Report and document the presence and severity of any signs and symptoms of depression in the patient's record. Whoever is designated for this task should be capable of describing and documenting findings (mood, affect, function, etc.) objectively, accurately, and in sufficient detail. Distinguish description from premature diagnosis (for example, do not make statements such as "the resident acts depressed" but instead clarify the behavior such as "the resident has been crying on and off throughout the day but will not verbally state why").

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ SWALLOWING DIFFICULTY

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

When evaluating a patient for swallowing, look for:

- Changes such as drooling, pocketing food, slow eating, gulping, coughing or clearing throat after eating or drinking, wet voice, complaints of food sticking in throat
- Changes in speech such as inability to speak, difficulty speaking, inappropriate answers
- Weakness of facial muscles

Problems with swallowing may also occur due to problems in the mouth such as:

- Condition of teeth, especially pairs of teeth in chewing position
- Pain and discomfort due to partial plates or dentures that do not fit properly
- Dry, sticky, red tissue or blisters on the tongue or floor of mouth
- Dry, chapped, or blisters on or around lips
- Swollen or bleeding gums
- White or red patches, bleeding or ulcers on tissue inside cheeks of mouth
- Foul odor (possibly due to tooth decay)

In addition, evaluate for a sore throat if patient complaining of same.

*See Sore Throat card (card 62).

COLLECT IT ALL BEFORE YOU CALL:

☐ **TOOTHACHE**

PHYSICAL DATA

- Vital signs
- Teeth/gums evaluation, including evidence of loose, decayed, broken teeth, or exposed roots
- 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

Toothache

Possible causes for a toothache are periodontal disease, tooth grinding, cavities, dental abscesses, tooth fracture, sinus infection.

Evaluate the patient for:

- Pain
- Antibiotic therapy before a dental procedure in the past
- Date of the last dental examination
- Problems with their sinuses
- Elevated or abnormal temperature
- Changes to food and fluid intake, weight loss

Oral Evaluation

- Look for number and condition of teeth, especially pairs of teeth in chewing position
- Pain and discomfort due to partial plates or dentures that do not fit properly
- Dry, sticky, red tissue, or blisters on the tongue or floor of mouth
- Dry, chapped, or blisters on or around lips
- Swollen or bleeding gums
- White or red patches, bleeding, or ulcers on tissue inside cheeks of mouth
- Foul odor (possibly due to tooth decay)

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ URINARY HESITANCY OR RETENTION

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 (by urine dipstick)
- Quantity (in cc's) of any post-void residual urine if possible
- 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

When urinary retention is suspected a post-void residual (PVR) test may be helpful. The test should be performed within a few minutes after a continent or incontinent void. Preferably, the volume of the void should be measured, but if it is an incontinent void, the amount of incontinence (i.e., small, moderate, large) should be recorded, along with the PVR volume. A residual volume that is not measured within a few minutes after a void is not helpful.

Common Risk Factors for Urinary Retention:

- Anticholinergic medications, narcotic analgesics, and other drugs that interfere with bladder emptying
- Diabetes with autonomic uropathy
- Male sex, due to an increased prevalence of BPH, possibly resulting in bladder outlet obstruction, in men aged >50
- Neurologic diseases
- Paraplegia/quadriplegia
- Recent anesthesia
- Recent bed rest for acute illness
- Trauma/pain (such as pelvic fractures)
- Recent placement of indwelling catheter
- Uterine prolapse

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ VAGINAL BLEEDING

PHYSICAL DATA

- Vital signs
- Approximate amount of the blood loss (in cc's)
- Whether clots are present
- Evaluate vaginal and rectal areas for evidence of source of bleeding (clarify whether it is rectal or vaginal)
- Evaluate the area for vaginal discharge and evaluate the appearance of the labia
- Presence of any gross or microscopic hematuria
- Pain evaluation (location, nature, severity, etc.)
- Description of blood, color (bright red or dark)
- Presence of itching, burning, or pain in the vaginal area

MEDICAL HISTORY

- Patient's age
- Determine if individual still has menstrual periods or is sexually active
- Onset, duration, frequency, and severity of signs and symptoms
- Any history of problems or diagnoses related to the reproductive tract or gastrointestinal tract, including infections and tumors
- Effectiveness of any treatments rendered so far
- All current diagnoses
- All current medications, including any recent changes, especially anticoagulants, estrogens, megestrol, or medications that affect bleeding or clotting
- Any recent lab or diagnostic test results

Vaginal bleeding

- Any vaginal bleeding in a postmenopausal woman is abnormal and requires that the source of bleeding be identified.
- Approximately 1/3 of cases are caused by premalignant or malignant cervical or endometrial lesions.
- Benign causes of bleeding include fragile mucosa associated with atrophic vaginitis, urethral caruncle (a small elevation of the mucous membrane around the vaginal opening), trauma caused by sexual activity, cervical erosions, endometrial polyps, and endometrial hyperplasia.
- Estrogen replacement therapy can also produce vaginal bleeding.

COLLECT IT ALL BEFORE YOU CALL:

☐ VAGINAL DISCHARGE

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

Vaginal discharge

Common Vaginal Discharges in the Elderly:

- **Atrophic vaginitis** is believed to be the most common cause of vaginal discharge in an elderly woman who is not currently being treated with corticosteroids or antibiotics. Discharge associated with atrophic vaginitis may be initially misdiagnosed as a yeast infection. This type of discharge does not have a foul odor.
- **Bacterial vaginosis** is more common in elderly women than in those who are younger. The thinning of the vaginal mucosa makes it easier for bacteria to enter the sub-epithelial tissues. Organisms such as *Gardnerella Vaginalis* may be detected in association with malodorous vaginal discharge. Vulvar itching and a malodorous yellow-green vaginal discharge are hallmarks of trichomoniasis.

COLLECT IT ALL BEFORE YOU CALL:

☐ VISION, PARTIAL OR COMPLETE LOSS

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
- Is visual loss associated with headache
- Determine if individual wears corrective lenses and if 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

Vision, partial or complete loss

Evaluation of the eyes without injury:

- Eyeballs are aligned normally in their sockets
- Eyebrows are present bilaterally and move symmetrically
- Eyelids and lashes (skin is intact without redness, swelling, discharge or lesions)
- Sclera is white
- The iris appears flat with a round regular shape
- The pupils appear round, regular, equal

Test for accommodation by asking the person to focus on a distant object. This process dilates the pupils. Then have the person shift their gaze to a near object such as your finger and the pupils will constrict. Record the normal responses by using **PERRLA** (Pupils Equal Round Reactive to Light and Accommodation). Test for ability to perceive movement, count fingers and recognize faces.

Common causes of loss of vision include blockage of the blood supply to the retina, diabetes, disorders that damage the optic nerve, glaucoma, cataracts, macular degeneration, and injuries. Sometimes loss of vision can incur with eye infections. Occasionally, complete or partial loss of vision occurs temporarily. A temporary loss of vision can be caused by a transient ischemic attack (sometimes called a mini stroke) or temporal arteritis.

✓ COLLECT IT ALL BEFORE YOU CALL:

☐ VOMITING BLOOD (HEMATEMESIS)

PHYSICAL DATA

- Vital signs, including BP lying, sitting and standing
- 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, tumor, or chronic liver disease
- Is hematemesis preceded by nausea, 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

Vomiting blood (hematemesis)

When a patient is coughing up blood or vomiting blood, stabilizing the patient is the most important step. Often times the terms hematemesis and hemoptysis are confused with one another because both involve bleeding. Therefore, "Where is it from" is the question that needs to be answered.

Differences between hematemesis and hemoptysis

Vomiting blood (hematemesis)	**Coughing blood** (hemoptysis)
GI TRACT	RESPIRATORY TRACT
Dark red or brown	Bright red
In clumps	Foamy, runny
Mixed with food	Mixed with mucous
Abdominal discomfort, pain	Chest pain, warmth or gurgling over the chest
Nausea, retching before and after episode	Persistent cough

Hematemesis Evaluation

- Save all specimens from the patient to show to the practitioner.
- Perform lung, abdominal, throat, and mouth evaluation.
- Check if patient is on blood thinning medications, including aspirin.

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ WALKING, DIFFICULTY

PHYSICAL DATA

- Vital signs
- Musculoskeletal and extremities evaluations, including gait, decreased range of motion, deformities, swelling, muscle atrophy, pain, weakness
- Neurological evaluation, including balance, sensation, and movement of lower extremities
- Any signs of changes in mental status and level of consciousness
- Pain evaluation (location, nature, severity, etc.)
- Any signs of recent injury
- Is weakness present and if so, is weakness localized or general
- Is weakness sudden or gradual
- What degree of loss of strength is present
- Aggravating factors such as activity, pain, edema, acute illness

MEDICAL HISTORY

- Patient's age and sex
- Onset, duration, frequency, and severity of symptoms related to walking, such as pain with ambulation
- Any history of ambulation problems
- All current diagnoses
- All current medications, including any recent changes
- If related to injury, how and when injury occurred, if known
- Any recent lab or diagnostic test results

Walking, difficulty

During the evaluation, the nurse needs to use her/his skills of inspection and observation such as:

- Recognizing problems with gait, strength, balance, and range of motion - ROM (take precautions during ROM exercises to avoid forcing a joint beyond the patient's current ROM).
- Observe for signs of pain such as facial grimacing, guarding, fearful facial expressions, grinding of teeth, etc.
- Report any problems noted in ROM or muscle strength.

Observe walking difficulty. Watch the patient rise from a chair without using his/her arms, walk several paces (allow patient to use assistive devices that they normally use), and return to sitting—stand by in case of fall risk. Report findings, complaints/observations of pain, loss of sensation, or impairment of joint and/or muscle function to practitioner.

Things to look for:
Joints: Pain, stiffness, swelling, heat, redness, limitation of movement
Muscles: Pain, cramps, weakness, or tremulousness
Bones: Deformity, pain, trauma (fractures, sprains, dislocations)

✔ **COLLECT IT ALL BEFORE YOU CALL:**

☐ WBC (WHITE BLOOD CELL) COUNT, ELEVATED (LEUKOCYTOSIS)

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 steroids and any recent changes

WBC (white blood cell) count, elevated (leukocytosis)

A WBC count greater than 14,000 cells/mm3, or a left shift (percent band neutrophils greater than 6% or total band neutrophil count greater than 1500/mm3) is consistent with a bacterial infection with or without fever.

Common Infections Affecting Patients of LTC Facilities:

- Urinary tract
- Respiratory system
- Skin and soft tissues, especially in the presence of wounds/pressure ulcers
- Gastrointestinal
- Bacteremia

Patients of LTC facilities may have **typical or atypical** presentations of infection. Some **typical** findings of a systemic infection are fever, fatigue, generalized weakness, cough and yellow sputum (respiratory infection), heat, redness, purulence and skin breakdown (infected wound), and erythema and purulence of the eye (conjunctivitis).

Some **atypical** manifestations of a systemic infection may include a change in mental status or cognitive function, change in appetite, fatigue, lethargy, or a decline in physical function.

COLLECT IT ALL BEFORE YOU CALL:

☐ WEAKNESS, GENERAL

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 or decline in function
- 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 thyroid medication changes
- Any recent lab (e.g., anemia, renal dysfunction, diabetes) or diagnostic test results
- Changes in food and/or fluid intake, any weight loss

Weakness, general

WEAKNESS, GENERAL, EVALUATION

Look: Look at the patient and describe what has changed to show the patient is weak. Is there a change in what the patient can do for themselves?

Listen: Listen to what the patient states the reasons why she/he feels weaker (not able to tolerate exercise, unable to attend activities because difficult to walk to the activity, etc.)

Feel: Is one side of the patient's body weaker than the other (when squeezing the patient's hands, is one side weaker than the other, etc.)

*See Neurological Evaluation (back of card 37).
*See Evaluation of Musculoskeletal System (back of card 4).

✔ COLLECT IT ALL BEFORE YOU CALL:

☐ WEAKNESS OR PARALYSIS, ARM OR LEG

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
- Change in speech or facial weakness
- 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, back pain
- 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

Weakness or paralysis, arm or leg

WEAKNESS OR PARALYSIS, ARM OR LEG, EVALUATION

Look: Look at the patient and describe what has changed to show the patient is weak. Is there a change in what the patient can do for themselves?

Listen: Listen to what the patient states the reasons why she/he feels weaker (not able to tolerate exercise, unable to attend activities because difficult to walk to the activity, etc.)

Feel: Is one side of the patient's body weaker than the other (when squeezing the patient's hands, is one side weaker than the other, etc.)

*See Neurological Evaluation (back of card 37).

✔ COLLECT IT ALL BEFORE YOU CALL:

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

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

Wounds, new or non-healing, and/or worsening

Wound: an injury to living tissue (especially an injury involving a cut or break in the skin)

Accurate evaluation is key to all aspects of wound care and serves as a baseline for subsequent evaluations. The initial wound evaluation (whatever the type) should have documentation on the:

- Location
- Shape
- Size
- Symptoms of possible infection if present (redness, fever, swelling, purulent drainage)
- Pain (if present)

If the wound is a pressure ulcer, see pressure ulcer evaluation.

References

Pain Evaluation

Be a Pain Detective:

- Frowning, grimacing, fearful facial expressions, grinding of teeth
- Bracing, guarding, rubbing
- Fidgeting, increasing or recurring restlessness
- Striking out, increasing or recurring agitation
- Sighing, groaning, crying, breathing heavily
- Decreasing activity levels from usual
- Resisting certain movements during care
- Change in gait or behavior
- Decline of function from usual levels

Almost all patients in the LTC setting have predisposing factors for the development of chronic, noncancer pain.

- Ask the patient to rate the intensity of his or her pain, using either a numerical score or a verbal or visual descriptor that is appropriate for and preferred by the patient.
- Ask about key characteristics of the pain (duration, frequency, location, onset, pattern, radiation, etc.) and for words that describe its qualities (aching, burning, throbbing, etc.).
- Note factors that make the pain better or worse.
- Observe how the pain is affecting the patient's mood, ADLs, sleep, and selected quality-of-life measures (participation in hobbies, visiting with family, etc.).
- Review the effectiveness of specific drugs and other treatments used in the past to treat pain.

References

Pulse Oximetry

Pulse oximetry should be performed only if staff are trained and skilled in the use of the instrument and in the correct interpretation of results. The results of pulse oximetry must be considered in light of the patient's overall status, including disease severity, expressed preferences, and life expectancy.

Signs of hypoxemia include headache, somnolence, confusion, dusky color, shortness of breath, dyspnea, anxiety, and restlessness.

Gerontological considerations:

- Identification of an acceptable probe site is important in the elderly patient due to conditions such as peripheral vascular disease, anemia, and cold induced vasoconstriction.
- Monitoring skin under sensor site due to tissue fragility and decreased elasticity caused by aging.

Suggestions to assist with placement of the probe:

- Do not attach probe to an area that is edematous or skin integrity is compromised.
- Do not place sensor on same extremity where BP cuff is placed because blood flow to finger will be temporarily interrupted.

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The National Association of Directors of Nurses Administration in Long Term Care (NADONA/LTC)

The Society
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