Monitoring Residents for Changes in Condition

Learner Workbook

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CHANGE IN CONDITION

A "change in condition" is any change noted to a resident's physical, mental, emotional, or social functioning or any changes in needs. Direct care staff are often the first to observe a change since they are caring for the resident continuously and are often more aware of subtle changes observed. When a resident exhibits a change in condition, it is important to speak with your supervisor and/or nurse on duty. Follow you Community's policy regarding reporting an observed change in condition.

Examples of Changes in Condition

Changes in condition may include, but are not limited to, any of the following:

- Significant behavioral changes, such as depression, anxiety, aggression, or other change
- Changes in wandering or elopement behavior
- Infection
- Pressure sore or other skin changes
- Diarrhea, nausea, vomiting, or other acute condition
- Increase in pain or inability to control pain
- Increase in falls
- Unusual weight gains or losses
- An increase in the severity of a disease or its signs and symptoms of a health condition
- Deterioration in communication or cognitive abilities
- Deterioration in ability to perform activities of daily living

Sometimes a change in condition is not directly observable, but a staff person has an "instinct" that something is wrong or different. Very often theses instinctual feelings are valid and further assessment uncovers a problem in the early stages of development. Always report any concerns you have.

CAUSES OF CHANGES IN CONDITION

Many reasons may cause a change of status in a resident. Below is just a few examples:

- Medication side effects
- Reaction to a new medication
- Result of disease or illness
- Infection, such as a urinary tract infection
- Medical condition such as heart attack, stroke, diabetic/insulin emergency, etc.
- Stress or psychological crisis, such as a recent medical diagnosis, loss of friend or spouse/significant other, family problems, difficult relationship with other resident, etc.
- Cognitive problems due to delirium, dementia or other cognitive disease

Medication Side Effects

Let's look at some of these causes in more detail, including:

- Medication side effects
- Urinary tract infection
- Various conditions that create an increase in falls
- Various conditions that cause delirium

Adverse drug reactions frequently go unnoticed or are misdiagnosed for the following reasons:

- Drug reactions sometimes mimic signs or symptoms of disease (e.g., dementia)
- Symptoms of drug reaction are thought to be caused by an existing medical condition or the onset of a new health problem
- Physical reactions to medication, such as fatigue, falling, or weight loss, may be mistakenly labeled as "normal" aging

There are many physical signs that may be attributed to an adverse drug reaction. These include:

- Fatigue
- Constipation or diarrhea
- Confusion
- Incontinence
- Frequent falls
- Depression
- Weakness or tremors
- Excess drowsiness or dizziness
- Agitation or anxiety
- Decreased sexual behavior

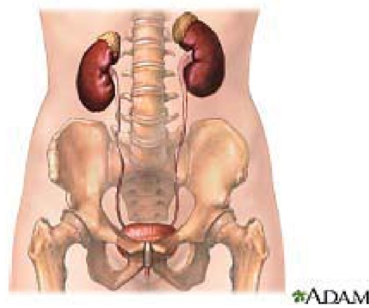
If a resident develops a problem shortly after he/she begins taking a medication, you must alert the physician immediately. Sometimes it takes time for an adverse reaction to occur, so be aware that medication side effects do not always occur immediately.

Two other types of drug reactions are: 1) Drug-drug interactions; and 2) Drug-food interactions.

Drug-drug interactions occur when the effect of one drug is altered by the presence of another drug. One drug might reduce or increase the effects of another drug. Two drugs taken together may produce a new and dangerous interaction. Two similar drugs taken together may produce an effect that is greater than would be expected from taking just one drug. Be aware that over-the-counter medications can interact with prescription drugs or with each other.

Urinary Tract Infection (UTI)

A Urinary tract infection, or UTI, is an infection that can happen anywhere along the urinary tract. Urinary tract infections are caused by germs, usually bacteria that enter the urethra and then the bladder. This can lead to infection most commonly in the bladder itself, which can spread to the kidneys. Women tend to get UTIs more often because their urethra is shorter and closer to the anus than in men.



Among other reasons, the following increase the chances of developing a UTI:

- Diabetes
- Advanced age
- Problems emptying the bladder (urinary retention) because of brain or nerve disorders
- Bowel incontinence
- Any condition that blocks the flow of urine, such as an enlarged prostrate
- Kidney stones
- Staying still (immobile) for a long period of time (for example, if recovering from a hip fracture)

UTIs are fairly common in the elderly population.

The symptoms of a bladder infection include:

- Cloudy or bloody urine, which may have a foul or strong odor
- Low fever (in some people)
- Pain or burning with urination

- Pressure or cramping in the lower abdomen (usually middle or back)
- Strong need to urinate often, even right after the bladder has been emptied

If the infection spreads to the kidneys, symptoms may include:

- **Mental changes or confusion (in the elderly, these symptoms often are the only signs of a UTI)**
- Chills and shaking or night sweats
- Fatigue and a general ill feeling
- Fever above 101 degrees Fahrenheit
- Side, back, or groin pain
- Flushed, warm, or reddened skin
- Nausea and vomiting
- Severe abdominal pain (sometimes)

Mental changes and confusion was highlighted above because of its importance. If you see these changes in condition with an elderly person, always have his/her physician examine the resident to determine the presence of a UTI. Very often mental changes/confusion is misdiagnosed as dementia or a psychiatric problem when it is in fact as a result of an UTI.

Falls

While “falls” themselves are not a cause of a change of condition, the occurrence of falls can indicate one of many underlying changes in condition that are causing the occurrence of the falls.

An increase in falls in the elderly can indicate a change in condition from a variety of causes including:

- Side effects of medications
- Cognitive changes (depression, dementia, delirium)
- Increased weakness
- Vision problems
- Foot or lower leg problems (e.g., arthritis, loss of feeling, swelling, etc.)
- Orthostatic hypotension (low blood pressure that happens when a person stands up from sitting or lying down)
- Serious medical conditions, such as stroke

Whenever a resident falls, or an increase in the number of falls occurs, it is best to have the resident evaluated by his/her physician to explore the cause(s) of the fall.

Delirium

Direct care staff are often familiar with dementia and depression, but delirium is also very common in the elderly. Delirium can occur at any age, but it occurs more commonly in the elderly who have compromised mental status, such as dementia. Delirium has been found in 14-56% of elderly patients who are hospitalized. Percentages are unknown among assisted living residents, but delirium is extremely common among nursing home residents.

Delirium is characterized by a sudden onset of confusion. The clinical hallmarks are decreased attention span and a waxing and waning type of confusion. Unlike most dementias, cognitive function improves when you treat the problem causing the delirium. Even if confusion has become chronic due to a neglected illness, family and caregivers will recall cognitive function rapidly diminishing.

Delirium often is unrecognized or misdiagnosed and commonly is mistaken for dementia, depression, or “normal” confusion in the elderly. Delirium always should be suspected when a rapid deterioration in behavior, cognition, or function occurs, especially in patients who are elderly, demented, or depressed.

The symptoms of delirium may include:

- Clouding of consciousness
- Difficulty maintaining attention or shifting attention
- Disorientation
- Illusions
- Hallucinations
- Fluctuating levels of consciousness

Delirium can be caused by many factors including:

- Medications (most common cause)
- Substances, such as alcohol
- Infections, such as urinary tract infections and pneumonia
- Heart problems
- Malnutrition, anemia, or vitamin deficiencies
- Hypoglycemia, fluid imbalance, or other metabolic causes
- Head injury

Often many factors together are causing the delirium.

Simple conditions like untreated urinary tract infection (UTI), urinary retention, constipation, colds, and undermanaged pain can cause delirium. In fact, almost any medical illness, intoxication, or medication can cause delirium.

Drug interactions and side effect are often missed causes of delirium. Be sure to report any changes in cognitive functioning and personality that emerge after starting a new medication.

The diagnosis of delirium is clinical. No laboratory test can diagnose delirium. Obtaining a thorough history is essential.

Because delirium patients often are confused and unable to provide accurate information, getting a detailed history from family, caregivers, and nursing staff is particularly important. Detailed chart notes can be very helpful for documenting the time and episodes of disorientation, abnormal behavior, and hallucinations.

ESTABLISHING A BASELINE

A baseline must be established for a resident to help the caregiver determine when a resident's condition has changed. A baseline is what is considered "normal" or typical for a particular resident. For example, if Mary's blood pressure normally runs 110/75 that is Mary's baseline blood pressure.

Knowing the resident helps to identify changes over time. Typically, a variety of assessments and information are initially obtained for a resident during the preadmission appraisal. This would form the initial baseline. Over time, a resident's condition may change and be documented. This now forms a new baseline from which to assess a change in condition.

We have a variety of sources from which we get to know our residents and establish a baseline. Let us take a look at some common sources used in most Communities.

Pre-admission assessment

The pre-admission assessment often includes the following sources of information:

- Physician reports
- Reports from family members
- Direct assessments conducted by medical professionals in your Community
- Continue to get to know the resident

1. **Physician's Report**

The physician's report contains a great deal of information about a resident, including the following:

- **Physician impairments, such as:**
    - Auditory or visual impairments
    - Bowel or bladder impairments
    - Use of substances
    - Special dietary needs
    - History of skin
- **Mental conditions, such as:**
    - Confusion/disoriented
    - Inappropriate behavior
    - Aggressive, wandering, sundowning behaviors
    - Ability to communicate needs
    - Depression
- **Capacity for self care, such as:**
    - Ability to self-administer medications
    - Ability for self-care
- **Ability to ambulate independently**

2. Reports from family

Family can often provide a great deal of information and insight about a resident, including the following:

- Family and social history
- Medical and emotional concerns
- Likes/dislikes/preferences
- Triggers for difficult behaviors

3. Direct assessments conducted by Community

Several interventions and a resident appraisal is conducted by the medical professionals in the Community to determine appropriateness of placement and resident needs. The resident appraisal frequently determines:

- Mental and physical needs
- Social needs, interests, and activities
- Functional capabilities
- Services needed
- Resident history, including: (Daily habits and routines, sleeping patterns, eating patterns, voiding patterns)

4. Getting to know the resident

As you spend time with a resident, you learn more of his/her likes/dislikes, daily habits, and typical personality characteristics.

CHECK FOR UNDERSTANDING: MONITORING RESIDENTS FOR CHANG IN CONDITION

It is important to establish a “baseline” from which to determine if a resident has experienced a change in condition.

A. True
B. False

Explain your answer:

DETERMINING A CHANGE IN CONDITION

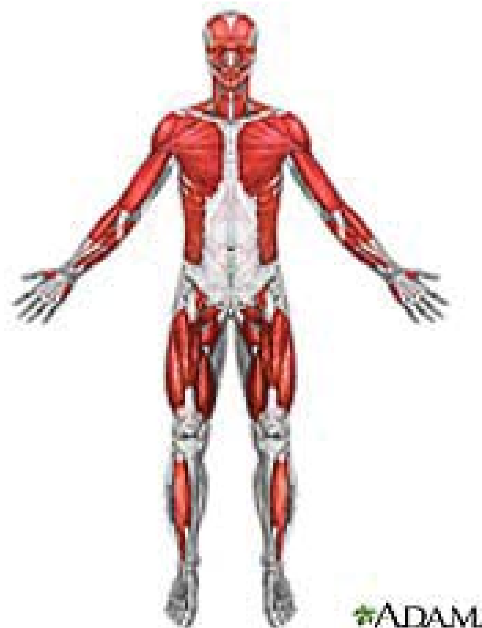
A change of condition may be noted in any physical, mental, emotional, or social functioning or needs.

One of the best ways to approach the observation of a change in condition is to do a head-to-toe assessment. Since physical, mental, and emotional causes are interrelated, one may see a change occur that is due to a seemingly unrelated cause. For example, in the elderly population it is fairly common that an increase in agitation, wandering, and/or forgetfulness may actually be caused by a urinary tract infection.

Observation Assessment

Each day as you care for residents, you naturally observe each of them. Typically you become very sensitive to even very subtle changes that may be demonstrated by a resident.

To assist you in watching for changes, we will highlight some changes to look for when caring for your residents. To simplify to order, we will present the information starting at the head and proceeding down to the toes.



Observing: Head

When monitoring changes in the head, it involves both physical and cognitive changes.

- Physical Changes

Physical changes may involve: slurring of speech; difficulty speaking; drooping of the face, mouth, or eyelids; and/or changes in expression, such as sadness or hyperalertness. Some of these physical changes may be caused by a stroke, depression, diabetic complications, or other causes.

- Cognitive (Mental) Changes

Cognitive changes may involve: memory loss or forgetfulness; confusion; paranoia or other psychotic symptoms; and depression or sadness. Some of these cognitive changes may be caused by medication side effects, stress, emotional concerns, dementia, or other causes.

Observing: Mouth

When monitoring changes in the mouth, it involves both the teeth and gums. Oral changes may involve: redness and swelling of the gums; bleeding of the gum tissue; sores in the mouth; cleanliness of teeth and/or dentures; and/or bad breath (halitosis).

Some of these oral changes may be caused by poor oral hygiene, ill fitting dentures, medication side effects, and a variety of physical conditions.

Observation: Chest

When monitoring changes in the chest, it involves both the heart and the lungs. Changes in the chest area may involve: pain or tightness in the chest; abnormal or increased heart rate; shortness of breath; coughing or wheezing; and/or blood in sputum. Any time you suspect a cardiac or respiratory problem, report it immediately.

Observation: Arms and Hands

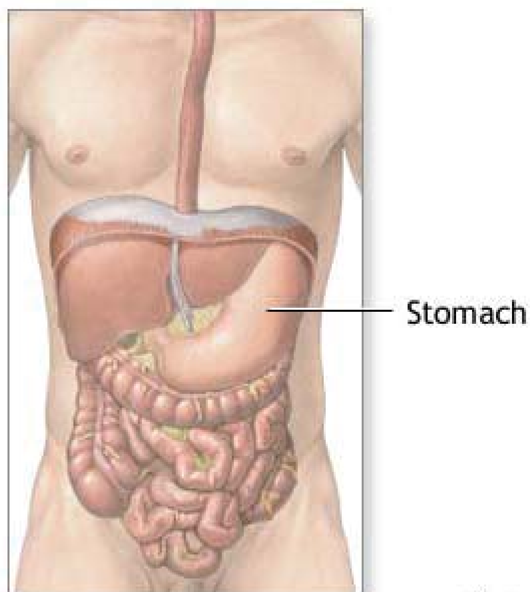
When monitoring changes in the arms and hands, any immediate changes can be an indication of a stroke or heart attack.

Changes in the arms and hands may involve: sudden one-sided weakness (possible stroke); radiating pain down an arm or shoulder (possible heart attack); and/or pain, burning, numbness, and tingling.

Any time you suspect a cardiac problem, report it immediately.

Observation: Abdomen

Changes in the abdomen can be indicative of a wide variety of problems since the abdomen contains most of our internal organs. Changes in the upper abdomen may involve: stomach pain; loss of appetite; nausea; or heartburn. The feeling of heartburn can be a symptom of a cardiac problem, so report it immediately.



Changes in the lower abdomen may involve: diarrhea or loose stools; constipation or hard stools; black or tarry stools (may indicate internal bleeding); hemorrhoids (may cause bleeding); or cramping. Any of these changes should be reported to your supervisor and possibly to the resident's physician.

Observation: Urinary Output

Changes in the urinary output should be observed for changes or other problems. You should observe the resident's urine for:

- Frequency of urination
- Output (excessive amount or minimal amount)
- Urine color (Darker than normal; White or cloudy – possible infection; or red streaks or blood – possible infection.
- Pain or discomfort when urinating

Changes in urinary output can be indicative of physical problems, such as diabetes, or of a urinary tract infection.

Observation: Legs and Feet

Changes in the legs and/or feet can be due to numerous causes. Observe the legs and feet for:

- Weakness
- Pain
- Tingling or burning
- Swelling or puffiness (may be a sign of heart problems)

Changes in the legs and feet can limit mobility and cause other difficulties. If you notice any of these changes listed above, be sure to report it to your supervisor.

Observation: Skin

Changes in the skin are one of the easiest to see. Always look at the resident's skin with assisting a resident with bathing or dressing. When observing the skin, look for:

- Redness
- Sores
- Changes in moles
- Dryness or irritation
- Cuts or skin tears
- Hives or rashes
- Bruises

A major concern for residents in the presence of bed sores (pressure ulcers). Even a slight redness can be indicative of a pressure ulcer. Pressure ulcers are rated ("staged") from Stage I (earliest signs) to Stage IV (most severe). This "staging" should always be done by a licensed medical professional.

Pressure Ulcer Stages

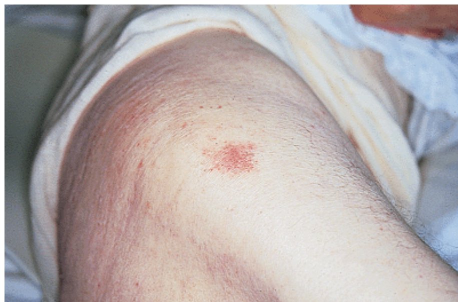
Stage I: A reddened area on the skin that, when pressed, is “nonblanchable” (does not turn white). This indicates that a pressure ulcer is starting to develop.

Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated.

Stage III: The skin breakdown now looks like a crater where there is damage to the tissue below the skin.

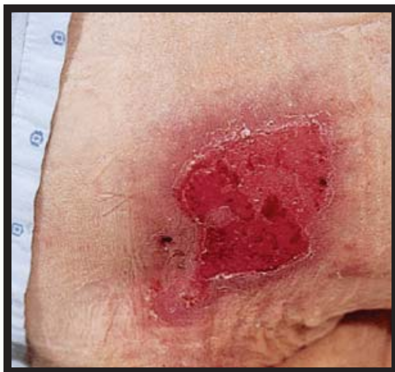
Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes tendons and joints.

Once a pressure ulcer has started, the progression can happen very quickly. To demonstrate the awareness you need to have when observing a resident’s skin, notice the shaded area in the photo of a Stage I pressure ulcer.

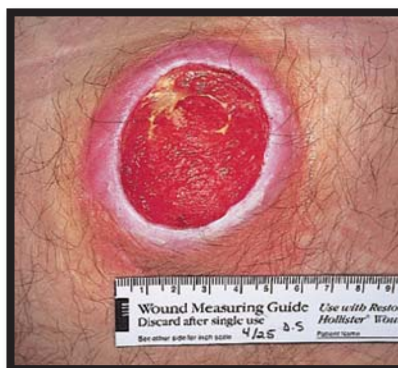


Stage I Pressure Ulcer

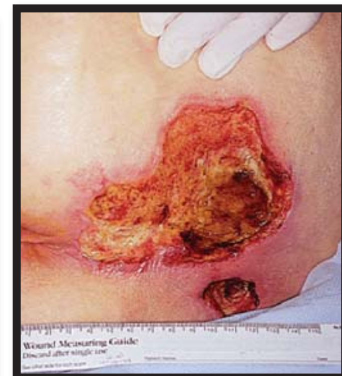
Below are photos of a Stage II, III, and IV pressure ulcers.



Stage II Pressure Ulcer



Stage III Pressure Ulcer



Stage IV Pressure Ulcer

Social Change in Condition

Another change in condition that may be noted with a resident occurs with a change in social functioning.

Some examples of social change in condition include:

- A normally outgoing individual that typically attends numerous activity events during the week becomes withdrawn and prefers to remain in his/her room.
- A typically easy-going resident who begins to initiate conflicts/arguments with other residents.
- A resident who is generally happy alone begins to beg direct care staff and friends to not leave her alone in her room.

Any changes in social functioning are important and should be reported per Community policy.

CHECK FOR UNDERSTANDING: MONITORING RESIDENTS FOR CHANGE IN CONDITION

When observing a resident for a change in condition, it is important to monitor a resident's:

A. Any physical changes, including skin condition
B. Overall attitude and personality, including signs of depression, confusion, anxiety, etc.
C. Both A and B

Explain your answer:

WHAT TO DO IF A CHANGE IN CONDITION IS NOTED

Always follow your Community's policy and procedures for how to report changes in condition.

Generally, if a staff person observes a change in condition, the nurse on duty or supervisor should be alerted. The nurse should perform an assessment. Depending upon the outcome of the assessment, 9-1-1 may be summoned and the resident's physician may be contacted.

If a nurse is not on duty, the med aid will determine if the resident's physician and/or 9-1-1 should be contacted. The resident's family/responsible party is also notified of the change in status.

Hospice

Procedures for reporting a change in condition may be different for persons on hospice. Depending upon the nature of the resident's emergency and the resident's personal preferences, it may be Community policy to contact the hospice nurse rather than calling 9-1-1.

Also, state regulations may vary regarding calling the hospice and/or 9-1-1. Be sure to check with your supervisor for the appropriate actions to take during an emergency with a resident who is on hospice.

When to Call 9-1-1

Below are guidelines of when to call 9-1-1:

- When in doubt, call 9-1-1
- Loss of consciousness
- Difficulty breathing
- Chest pain
- Severe bleeding
- Anytime you suspect a life-threatening emergency

Always follow your Community's policy regarding calling 9-1-1.

When to Report Changes

Any change in condition should be reported to your supervisor and the resident's physician, even if 9-1-1 has been called.

Anytime you report a change in condition to the resident's physician, be sure you receive instructions from the physician on how he/she wishes the reported change in condition to be treated.

Reporting to Family/Responsible Party

As mentioned earlier, the family or responsible party should be updated anytime a change of condition is noted in a resident. However, the family is NOT the first contact in an emergency nor can they give medical advice.

Always follow your Community's policy regarding procedures to follow during both emergency and non-emergency changes observed in a resident's condition.

What to Do If a Change in Conditions is Noted

The change of condition should be documented as appropriate in the resident's chart, and staff should be alerted during a change in shift. The resident should be re-evaluated on a regular basis and the service plan may need to be updated as necessary.

Staff should be familiar with each resident's typical or "baseline" physical, mental, and emotional condition and habits. Staff should also closely observe residents for any change in condition. Any changes seen in a resident should be documented and appropriate staff and health personnel alerted. Always follow your Community's policy and procedures when a change in condition is observed in a resident.