IN THE KNOW

...developing **top-notch** CNAs, one inservice at a time

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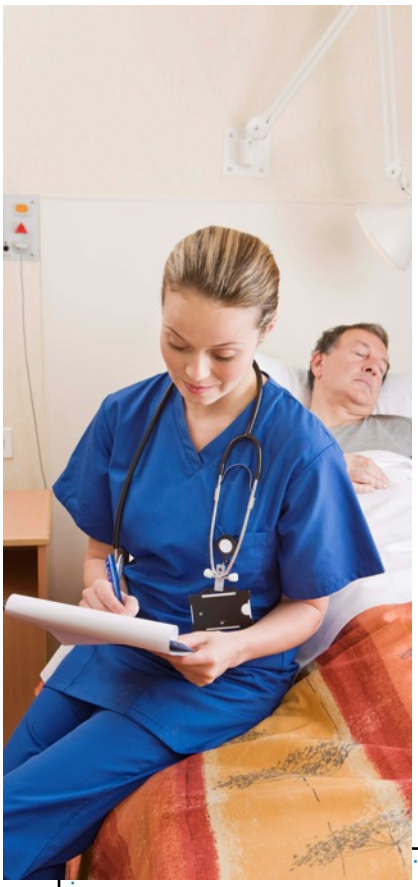

A Client Care Module:

RECOGNIZING & REPORTING ABNORMAL OBSERVATIONS

IN THE KNOW

Developing Top-Notch CNAs, One Inservice at a Time

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A Client Care Module:

Recognizing & Reporting Abnormal Observations

SAVING CARRIE JANE...

Carrie Jane is an 83 year old woman with a collection of health problems. She has diabetes, high blood pressure, and a permanent colostomy. In addition, she just had hip replacement surgery. You are assigned to care for her during her rehabilitation.

On your first visit with Carrie Jane, you observe a slightly overweight woman with a good understanding of her diabetes and high blood pressure. She eats a healthy diet, takes her medications as prescribed and is able to manage her diseases effectively.

One week later, Carrie Jane has lost some weight without trying, her energy level is low, her blood sugar level stays high throughout the day, and you notice a reddened, sore area on the top of her foot where the shoe rubs.

You report what you observe right away. The nurse and a dietitian arrive to assess Carrie Jane's diet and medication. A special wound nurse is assigned to prevent the pressure sore on Carrie's foot from progressing.

Your careful observation and reporting have set in motion the intervention needed to keep Carrie Jane healthy while under your care.

Without your careful attention, Carrie Jane's unintentional weight loss would have continued, her elevated blood sugar would have further damaged her body and the pressure sore that was developing could have progressed to a dangerous wound that may have only been resolved by amputation.

One of the primary roles of the nursing assistant is to collect and communicate information. That information is collected by observing clients and communicated by reporting to the nurse and/or documenting in the client's chart.

Keep reading to learn more about recognizing and reporting abnormal observations. This important role ensures the best possible outcome for your client when changes or new developments occur.

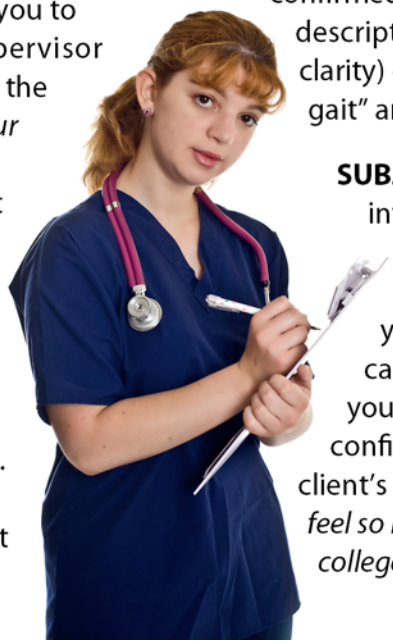
WHO, WHAT, WHEN AND HOW?

UNDERSTANDING PRIORITY LEVELS

You make observations about clients all day long. But, how do you know *what*, *when*, and *how* to report what you see?

Throughout this inservice, you will read about all sorts of abnormal observations. In order to help you decide the best course of action to take with each observation, they will be grouped according the following priority levels:

- **URGENT:** When you observe something abnormal that falls under this category, you must **STOP** what you are doing and **REPORT** to a nurse or your supervisor right away. Urgent abnormal observations are those that are ***immediately life-threatening.*** They include the ABC's (airway, breathing and circulation problems) and abnormal vital signs.
- **IMPORTANT:** This category contains abnormal signs and symptoms that require you to **REPORT** to the nurse or your supervisor and **RECORD** your observations in the chart *as soon as you complete your task with the client*. This category includes signs and symptoms that require intervention but are *not* immediately life-threatening.
- **SIGNIFICANT:** This third category are those signs and symptoms that should be **RECORDED** in detail in the chart. There is no urgency but these abnormal observations should not be ignored.



A FEW TERMS TO KNOW

TO OBSERVE: This involves paying close attention to the client and the surroundings while gathering information through your eyes, ears, nose and sense of touch.

TO REPORT: Contacting a nurse or supervisor to verbally describe any *urgent* or *important* observations. If your job requires you to document, your report should always be followed by a detailed entry in the client chart indicating what was observed, the date and time of the observation and who the observation was reported to (including full name and title).

TO RECORD: Writing a detailed account of the observation in the client's medical chart.

OBJECTIVE OBSERVATIONS: Information that can be seen, heard, smelled, felt or measured and confirmed by another person. Vital signs, a description of urine (including amount, color and clarity) or reporting that your client has a "shuffling gait" are all examples of objective observations.

SUBJECTIVE OBSERVATIONS: Pieces of information that cannot be (or were not) observed. They are based on something reported to you by the client. For example, your client reports feeling sad or lonely. You cannot see, hear, smell or feel the feelings yourself. . . and there is no way to measure or confirm the information. So, you report the client's exact words in the chart: "Client states, *'I feel so lonely since my granddaughter went off to college and can't visit as often.'*"

WHAT'S NEW?

Grab your favorite highlighter! As you read through this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your supervisor and co-workers!

FOCUS ON VITAL SIGNS

Vital signs (temperature, pulse, respirations and blood pressure) measure how the vital organs of the body are functioning. Vital organs sustain life. Without properly functioning vital organs (heart, lungs, brain), life would end.

Your workplace may have a specific policy in place to follow for handling abnormal vitals. Ask your supervisor for this policy. If no policy is in place, here are some general guidelines:

PRIORITY LEVEL: URGENT!

Consider all abnormal vital signs urgent and report immediately to the nurse or supervisor.

NORMAL FINDINGS	ABNORMAL FINDINGS
TEMPERATURE: 97.6°-99.6° F or 36.5°-37.5° C (oral) ***Note:*** Temperatures are usually lowest in the morning and highest in the afternoon. Older adults tend to have lower temperatures than other age groups. Exercise can cause temperature to increase temporarily.	**Greater than 100.2°F** **(***Many organizations consider a temperature greater than 100.2°F or 37.8°C to be a fever.)* **Less than 97.2°F** *(A low temp may be normal for your older client, but anything less than 97.2°F or 36.2°C may be a sign of hypothermia.)* Know your workplace ranges.
PULSE: 60-100 beats per minute Regular rhythm, easy to find and count.	**Greater than 100 or less than 60** **Irregular Rhythm** **Bounding** *(forceful)* **Thready** *(weak)*
RESPIRATIONS: 12-20 respirations per minute. Regular rhythm, effortless, quiet.	**Greater than 20 or less than 12.** **Shortness of Breath.** **Retractions** *(skin pulling in at neck and ribs on inspiration)* **Coughing.** **Noisy** *(raspy or wheezing)*
BLOOD PRESSURE: 100-139 Systolic *(top number)* 60-89 Diastolic *(bottom number)*	**Hypertension** *(high BP)* **Hypotension** *(low BP)* **Orthostatic Hypotension** *(a drop in blood pressure when changing from a sitting to a standing position)*

THINK about it!

What do you do when your client has abnormal vital signs?

- If your client is in *immediate* distress (no breathing, no pulse), ***call for help***! DO NOT LEAVE THE CLIENT ALONE.
  - Start CPR (unless a DNR or "do not resuscitate" order is in place).
  - Continue CPR until help arrives.
- If you feel the abnormal vital sign does not match how your client appears . . . then ***recheck*** the measurement to ***confirm*** your initial observation.
- Ask a co-worker to check the client if you are having trouble getting a measurement.
- Use different equipment or take a manual measurement if it seems your equipment may be giving a false reading.
- ***Report*** the abnormal value to the nurse or supervisor right away. Then, ***record*** the value in the chart along with the date, time, name and title of the person to whom you reported.

FOCUS ON PAIN

Pain is considered the *5th vital sign*. This means it is just as important to know your client's pain level as it is to know respirations or heart rate.

Use your workplace guidelines for gathering information about pain. If no guidelines are in place—use the 10 point scale or the "FACES" scale pictured on this page. Ask your client to rate his pain on a scale of 1 to 10 with "0" being no pain and "10" being the worst pain ever.

- Client's who are nonverbal may show pain in other ways like wincing, frowning, crying, or holding the painful area.

Every client has the right to pain relieving measures.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS

NO PAIN

Many older adults mistakenly believe that some degree of pain is a normal part of getting older. Others may fear becoming addicted to pain medication.

- It's important to teach clients that pain is not normal and can usually be relieved.

Remember, pain is **subjective**. This means pain is *whatever your client says it is.*

"Pain is inevitable. Suffering is optional."

~ Anonymous

"Pain is such an uncomfortable feeling that even a tiny amount of it is enough to ruin every enjoyment."

~Will Rogers

ABNORMAL FINDINGS

Joint Pain *(may also observe swelling or decreased range of motion)*

Muscle Pain *(especially after a fall, accident or new exercise routine)*

Abdominal Pain *(may be accompanied by nausea, vomiting or diarrhea; make note of any swelling or bulging areas and check vitals)*

Non Verbal Pain Cues:

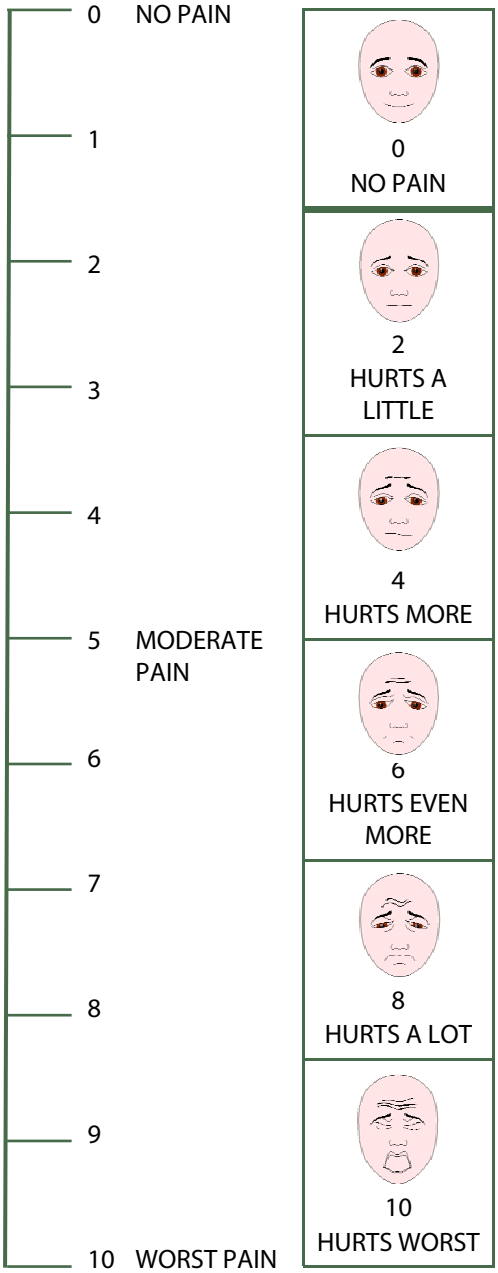
- **Guarding** *(protecting the painful area)*
- **Grimacing** *(frowning)*
- **Moaning**
- **Agitation or Restlessness**
- **Diaphoresis** *(excessive sweating)*
- **Change in vital signs**

Chronic Pain *(Clients who have lived with pain for a long time may work very hard to try to NOT show pain.) Some signs your client suffers chronic pain are:*

- **Rubbing or Bracing**
- **Decreased Activity**
- **Sighing**

PAIN scales

Pain Assessment Tools



FOCUS ON MENTAL STATUS

Mental status is the measure of how well your client functions emotionally, intellectually and socially.

Keep in mind, you are observing for any ***change*** from what is *"normal"* for your client. If you have a client with Alzheimer's who is routinely confused and shows impaired judgment, you will not need to report this right away as you would in a client who does not usually have these symptoms.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
APPEARANCE Posture is erect. Dressed and groomed appropriately for weather. Smooth, even body movements.	**Hunched or Stooped** **Curled up in bed** **Disheveled** *(untidy or messy)* **Restless or fidgety movements**
LEVEL OF CONSCIOUSNESS Awake, alert and aware of your presence in the room.	**Confused** *(slow to respond)* **Lethargic** *(difficult to arouse)* **Coma** *(unable to arouse)*
MOOD Should be appropriate to client's place and condition. Cooperative.	**Flat** *(lacks emotional expression)* **Depressed** *(sad, tearful)* **Anxious** *(worried, nervous)* **Irritable** *(easily angered, annoyed)*
ORIENTATION Aware of ***time*** (day, date, year), ***place*** (present location) and ***person*** (knows own name).	**Disoriented** *(Your client may become confused about the date, but under normal circumstances, should know where and who he is.)*
THOUGHT PROCESSES Conversations make sense. Logical and rational.	**Illogical** *(Ideas are disconnected and run together.)* **Blocking** *(stops in the middle of a thought)*
PERCEPTION Aware of reality.	**Hallucinations** *(sees or hears things that are not really there)*

THINK about it!

WHEN IS MEMORY A PROBLEM?

Normal aging changes the way the brain stores and recalls information.

It's ***normal*** if your elderly client forgets the name of someone she just met or where she put her purse.

It's ***not normal*** when memory affects activities of daily living. For example, your client suddenly has trouble remembering how to get dressed or find her way around a familiar place.

Normal memory loss doesn't get much worse over time. Dementia gets worse over a short period of time.

- ***Be sure to report any abnormal memory problems affecting your client.***

An elderly man was telling his friend about a new restaurant he and his wife recently visited.

"The food and service were great!" he said.

His friend asked, *"What's the name of the place?"*

"Gee, I don't remember," he said, *"What do you call the long stemmed flower people give on special occasions?"*

"You mean a rose?" asked his friend.

"That's it!" he exclaimed and turned to his wife and asked, *"Rose, what's the name of that restaurant we went to the other day?"*

FOCUS ON NUTRITION

Nutrition is about more than just eating! It's about providing the right *type* and right *amount* of fuel to support the day-to-day needs of each individual.

Nutrition can be affected by emotions, illness, chemotherapy and radiation, culture and economics. In addition, nutritional needs change with age and activity level.

One size does not fit all when it comes to "normal" nutrition. However, below you will find a few observations that might be clues that something is abnormal.

PRIORITY LEVEL: SIGNIFICANT!

RECORD *observations in detail in the chart, if required. Most symptoms of abnormal nutrition* ***can*** *be corrected and* ***should not*** *be*

NORMAL FINDINGS	ABNORMAL FINDINGS
WEIGHT Normal weight for height and age.	**Obese** *(increases BP & blood sugar, hinders mobility, damages joints, and causes many other problems)* **Underweight** *(fuel reserves may be depleted, may lack energy, unable to fight infection or heal wounds)* **Unintentional weight loss** *(a weight loss of 5% or more of body weight over a 30 day period)*
PHYSICAL APPEARANCE Skin is smooth. Eyes are clear and shiny. Tongue is moist, not swollen. Muscles have good tone and strength.	**Skin is dry and flaky** **Eyes are dry, dull, sunken, may be red with sores on the edges** **Tongue is pale, or beefy red, swollen or painful** **Muscle wasting** *(weakness)*
APPETITE Consumes an appropriate amount of food for age and activity level.	**Anorexia** *(unable or unwilling to eat; may be related to medication, illness, pain or emotional problems)* **Overeating** *(eats in response to stress, emotions or boredom)*

CONNECT it now!

Apply what you know

You are caring for a 78 year old woman who is diabetic and receiving radiation treatment for breast cancer.

- You know she has to eat at specific times to regulate her blood sugar. But, the cancer treatments make her nauseated and unable to eat.
- She has lost six pounds in the last week. She also has signs of depression.
- How can you help? ***Think of three creative solutions*** to help with mood, appetite and unintentional weight loss.
- ***Share your ideas with your co-workers and supervisor.***

He who takes medicine but neglects his diet wastes the skill of his doctors.

~ Chinese proverb

FOCUS ON ELIMINATION

Many older adults mistakenly believe that incontinence, constipation and hemorrhoids are just part of normal aging. . . but, it's just not true. These are things that can usually be treated or prevented with proper and timely intervention.

Be sure ***YOU*** know what's normal and what's not so you can help your clients understand their bodies a little better. . . and to help you recognize and report any abnormal elimination observations so intervention can be started.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
URINE OUTPUT Amount: 1200-1400ml per day. Color: Clear to dark yellow. Odor: Light "nutty" odor. No pain or burning. Consistent bladder control.	**Less than 1200ml** *(may be dehydrated or not drinking enough)* **More than 1500ml output** *(may be seen in diabetics or clients on diuretics—"water pills"* **Dark amber urine** *(dehydration)* **Dark red or brown** *(may contain blood)* **Foul Odor** *(may indicate infection)* **Pain or burning with urination** *(may indicate infection)* **New or worsening incontinence** *(may indicate infection)*
BOWEL ELIMINATION Amount: ***Once a day*** . . . but it can be normal to go up to ***3 times a day*** or as little as ***once every 3 days***. Shape: Formed, firm. Color: Light to dark brown. No pain or straining.	**Diarrhea** *(frequent, watery stools)* **Constipation** *(no BM in more than 3 days)* **Fecal Impaction** *(Stool forms a large hard ball that client is unable to pass naturally. Watery leakage and cramping pain are common.)* **White or Yellow Stool (***may be a problem with absorption)* **Black or Red Stool** *(blood in stool)* **Pain or Straining** *(may need to increase fluids or fiber in diet)*

Thinking outside the box!

Working with clients in the home often requires coming up with creative solutions to uncommon problems.

- **THE PROBLEM:** You are caring for a 76 year old man who lives alone but just needs help with personal hygiene, cooking and cleaning.
- When you arrive at his house on this day you find a box of laxative pills sitting out on the bathroom counter. You ask him if he has had trouble having a bowel movement. He replies that he normally has a BM every day but didn't have one yesterday so he thought he should take two or three laxative pills.
- **WHAT YOU KNOW:** You know it can be normal for people to go as long as 3 days without a BM. It depends on diet and activity level. You also know overuse or misuse of laxatives can be harmful.
- **GET CREATIVE**: Think of **3 creative solutions** you might suggest to your client to keep him from overusing laxatives in the future.
- **TALK ABOUT IT:** Share your ideas with your co-workers and supervisor and find out how they would solve the problem.

FOCUS ON SKIN

Skin is an organ just like the heart and lungs. In fact, skin is the largest organ of the human body. And, just like you wouldn't ignore an abnormal heart rate or abnormal respirations, you shouldn't ignore wounds, rashes, redness, pain, swelling or other problems with your client's skin.

Any break in the skin, whether it is a cut, tear, burn or pressure ulcer, leaves the body vulnerable to infection. Infections in older or ill clients can be deadly.

PRIORITY LEVEL: IMPORTANT!

Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care.

NORMAL FINDINGS	ABNORMAL FINDINGS
COLOR Should be consistent with genetic background. Varies from pinkish to dark brown. May have yellow or olive undertones.	**Pallor or Ashen Gray** *(looks like a "loss of color;" can be a sign of anemia or shock)* **Widespread Redness** **Cyanosis** *(blue colored skin)*
TEMPERATURE Skin should feel warm, with hands and feet slightly cooler.	**Hypothermia** *(temp less than 97.2°F)* **Hyperthermia** *(temp greater than 100.2°F)*
MOISTURE Normal perspiration in response to activity or environment.	**Diaphoresis** *(extreme sweating, soaking though clothing and bedding)* **Dehydration** *(eyes, nose, mouth and lips look dry and sticky)*
BRUISING No bruising, or normal bruising from occasional bumps.	**Multiple Bruises** *(many bruises in multiple stages of healing may indicate abuse)* **Bruises on face, chest or abdomen**
PRESSURE SORES No signs of pressure sores.	**Pressure Sore present** *(Know the early signs of a pressure sore—see "Stages of Pressure Ulcers to the right. Recognize and report early so treatment can be started.)*

STAGES OF PRESSURE ULCERS

Early signs of a pressure sore may be pale skin or slightly reddened skin over a bony area.

The client may complain of pain, burning, or tingling.

Stage 1: The skin over a bony area is intact but pink or slightly reddened.

- In the dark skin client, skin may appear ashen.
- The client may sense slight itching or mild tenderness.

Stage 2: The skin is red and swollen.

- There will either be a blister or an open area.

Stage 3: The area begins to look like a crater.

- The sore will extend deeper into the skin.

Stage 4: The sore extends deep into the fat, muscle, or bone.

- There may be a thick black scab, called eschar, which is actually dead skin.

FOCUS ON FAMILY AND RELATIONSHIPS

Families come in all shapes and sizes and defining a family as healthy and functional is difficult and subjective. However, there are a few "red flags" or abnormal observations you can be aware of that—when properly reported—may actually prevent needless harm or suffering for your client.

It's important to understand that if you *observe or suspect* your client is being ***abused*** . . . you have an obligation to report that abuse right away. You should get yourself and your client out of harm's way as soon as possible.

PRIORITY LEVEL: SIGNIFICANT!

RECORD *observations in detail in the chart, if required. Personal relationships* ***can*** *be difficult to deal with but* ***should not*** *be ignored.*

NORMAL FINDINGS	ABNORMAL FINDINGS
HEALTHY, FUNCTIONING FAMILY • Power roles are equal, there is respect and trust. • Conversations can be playful and humorous. • Family members listen to each other. • The family is able to admit when help is needed and seeks professional support. • The client is connected to the larger community. Knows neighbors, attends church, has friends other than family members.	**Dictatorship** *(One caregiver is making all the decisions without input from the client or other family members.)* **Fear or Anxiety** *(The client becomes frightened, fearful, tearful or withdrawn around certain family members.)* **Anger** *(Every family has a history— and grudges can be held for a long time. But anger can lead to violence or other destructive behavior and should be addressed by a professional.)* **Suspicion** *(Your client may feel suspicious of certain family members. It's important to explore whether this suspicion is rational or irrational.)* **Substance Abuse** *(Any substance abuse by your client or other family member in the home can lead to dangerous, destructive or harmful behavior.)* **Isolation** *(Clients and families who do not reach out to friends, the community or professionals when needed will become isolated.)*

5 KEY points

Key Points to Remember

1. It's not enough to just know what is normal or abnormal. You also have to know what's normal for **YOUR** client.
2. Recognizing abnormal signs is only half of the story. Knowing *who, what, and when* to report your observations is the key!
3. You should always have a pen and paper in your pocket to write down important pieces of information. This will make reporting easier.
4. A verbal report should be factual. It should not contain your opinion. Try to use *objective* information as much as possible.
5. Always document the *date* and *time* in addition to the *name* and *title* of the person to whom you reported.

"A family is a unit composed not only of children but of men, women, an occasional animal...and the common cold.

~Ogden Nash

"Families are like fudge—mostly sweet with just a few nuts."

~ Anonymous

FINAL TIPS ON ABNORMAL OBSERVATIONS

SOME ADDITIONAL ABNORMAL OBSERVATIONS

- **Cold or flu Symptoms:** Report any fever, chills, congestion, drainage from eyes or nose, or cough so treatment can be started right away before symptoms worsen.
- **Trouble Sleeping:** Report if your client has trouble *falling* asleep or *staying* asleep. Insomnia is a common side effect of many medications and can often be corrected.
- **Problems with routine ADL's:** You should notice and report if your client is having new or increasing difficulty with activities of daily living. The level of care may need to be increased.
- **Changes in vision or hearing:** Let your supervisor know if your client has any new or worsening vision or hearing problems. Often a trip to the eye or ear doctor is all that is needed.
- **Change in ability to ambulate:** Be sure to report and document if your client is unable to ambulate safely. A physical therapist or new assistive equipment may be needed.
- **New symptoms of one sided weakness:** One sided weakness is a sign of a stroke. Report this immediately so treatment can be started and damage can be minimized.

FINAL TIPS FOR REPORTING ABNORMAL OBSERVATIONS

- Always carry a pen and paper in your pocket to write down important pieces of information. This will make reporting easier.
- When giving a verbal report to the nurse or your supervisor, be sure to use the client's full name, room number and even bed number (if applicable) to correctly identify the client.
- Be factual in your reporting. Use objective information as much as possible. Remember, objective information is measurable and can be confirmed. It is not an opinion or a judgment.
- If documentation is required for CNAs at your workplace, document your observations in the client's chart . . . even if you've given a verbal report to the nurse. Be sure to document the date and time of the observation in addition to the name and title of the person to whom you reported.

Now that you've read this inservice on abnormal observations, take a moment to jot down a couple of things you learned that you didn't know before.