Team Essentials for Preventing Acute Deterioration
Reference Guide for Learners
Version 1.0 March 2016
Prepared by the Baycrest Centre for Learning, Research and Innovation in Long Term Care as part of

Team Essentials: Leading Practices for Long-Term Care.

This reference guide supports learners who have participated in the 1-day module on

Team Essentials for Preventing Acute Deterioration.

For more information, please contact the Lead Interprofessional Educator:
Jennifer Reguindin at jreguindin@baycrest.org

Prepared by:
Jennifer Reguindin BScN MScN RN GNC(c)

Reviewers (alphabetically):
Faith Boutcher MN RN
David Conn MB BCh BAO FRCP
Shoshana Helfenbaum MSW RSW
Paul Katz MD
Monika Keri BScN MScN RN
Joyce Kuang BKin
Raquel Meyer PhD RN
Maria Nelson BScN RN GNC(c) ABA(c) CPMHN(c)

Disclaimer: This reference guide is not binding for users. It neither constitutes a liability nor a discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor Baycrest Geriatric Centre give any guarantee as to the accuracy of the information contained in the guide, nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omissions in the contents of this work. Any reference throughout the guide to specific products as examples does not imply endorsement of any of these products.

Supported with funding from the Government of Ontario.
The views expressed are the views of the authors and do not necessarily reflect those of the Province.

© 2016 Baycrest Geriatric Centre. For individual use only.
## CONTENTS

**Foreword** ................................................................................................................................. 4

**Introduction** ............................................................................................................................... 4

**Core Frameworks** ..................................................................................................................... 6

  - The 3Rs Clinical Framework .................................................................................................. 6
  - SBAR Reporting Framework ............................................................................................... 7

**Abbreviations** ............................................................................................................................ 8

### A. BASELINE ............................................................................................................................ 9

**Health History** ......................................................................................................................... 9

**Social & Family History** .......................................................................................................... 10

**Personhood** ............................................................................................................................. 10

**Continuous Monitoring or Trending** ...................................................................................... 10

### B. RECOGNIZE .......................................................................................................................... 11

**Objective Observation** ........................................................................................................... 11

**Common Conditions** .............................................................................................................. 11

  1. Delirium ................................................................................................................................ 12
  2. Dehydration........................................................................................................................... 13
  3. Urinary Tract Infection ........................................................................................................ 14
  4. Respiratory Infection ........................................................................................................... 15
  5. Chronic Obstructive Pulmonary Disease (COPD) Exacerbation ........................................ 16
  6. Septicemia .......................................................................................................................... 17
  7. Decompensated Heart Failure ............................................................................................ 18
  8. Myocardial Infarction (Heart Attack) .................................................................................. 19
  9. Ischemic Stroke .................................................................................................................... 20
  10. Diabetes: Hypoglycemia ...................................................................................................... 21
  10. Diabetes: Hyperglycemia ...................................................................................................... 22

**Prioritize** .................................................................................................................................. 23

**A Note on Risk** ......................................................................................................................... 25

**Basic Information for Any New Situation** .............................................................................. 26

### C. REFLECT ............................................................................................................................... 27

**Critical Thinking: Considerations with Any Change** .............................................................. 27

**Which Systems are Affected?** ................................................................................................. 28

  1. Safety .................................................................................................................................. 30
  2. Neurological – Head, Nerves, & Pain .................................................................................. 31
  3. Mood & Behaviour ............................................................................................................. 34
  4. Sensory – Eyes, Nose, Ears, Tongue .................................................................................. 36
FOREWORD

Introduction

This reference guide was designed for staff and student healthcare providers who have participated in Team Essentials – Leading Practices for Long-Term Care: Preventing Acute Deterioration. The purpose is to help long-term care healthcare providers recognize, prioritize, reflect and respond to acute changes in the health status of residents. Being more attuned to the changing needs of frail elders will improve the care provided and the resident-provider relationship.

Some elderly residents have atypical signs or presentations of deterioration. To assist in identifying early acute changes, this reference guide includes signs and symptoms of common conditions that may lead to the transfer of elderly residents from long-term care to acute care emergency departments. This list of conditions is specific to the geriatric population. The reference guide is based on current best and clinical practice guidelines.

The Sensory Observation System (SOS) was created to help healthcare providers and students recognize, prioritize and respond to subtle and acute changes in the health status of elderly residents. The SOS consists of a head-to-toe assessment whereby senses (i.e., sight, touch, hearing and smell) are used to identify observations and assessments which are grouped by system. It provides a systematic checklist to use when observing and assessing physical, cognitive, emotional and functional changes in residents, in order to prevent worsening of their condition.

The reference guide includes examples of:

- Which systems may need to be considered
- What information may need to be included
- How the reporting term “OK” can be used by a team in a way that supports objective, specific and concrete observations and reporting

The SOS requires baseline knowledge of the resident and is used with a 3Rs clinical framework. The 3Rs ask the healthcare provider to: Recognize, Reflect and Respond. Each step is based on professional readiness and accountability. Figure 1 below depicts this process:
All healthcare providers need to develop an understanding of the resident’s background and relevant information in order to establish a baseline for future observations. Ensuring that the resident is safe in his or her environment is always essential when observing or assessing a resident, but when a change in health status is recognized, SOS is used systematically from head-to-toe starting with the neurological system and ending with integumentary system. If the changes are localized to a system, SOS guides clinicians to perform a focused system assessment. Finally, function, which is a great indicator of an elderly resident’s health condition, is incorporated into the report to complete a picture of the resident’s situation.
Core Frameworks

This module incorporates a clinical framework and a reporting framework.

The 3Rs Clinical Framework

Recognize: the signs, symptoms, risk and priority
Reflect: knowledge, observations and assessments
Respond: pharmacological, non-pharmacological or relational interventions and reporting

The 3Rs is a foundational clinical framework for healthcare providers to use in the face of any clinical situation – whether it is responding to an acute emergency, understanding a resident’s responsive behaviours or interacting with a concerned family. This framework is sequential, whereby healthcare providers are encouraged to first recognize and understand the situation, then to reflect upon their observations and finally, to respond appropriately.

Step 1 is to Recognize by:

i. Observing and assessing the change(s) based on risk and priority
ii. Identifying what may have triggered change(s).
iii. Identifying safety concerns that affect the resident and others.

Step 2 is to Reflect on:

i. The resident's known background and history to form a baseline.
ii. Systematic changes which may be connected to the original concern.
iii. The resident's function to create a fuller picture of the resident's current situation and overall health condition.

Step 3 is to Respond by:

i. Providing appropriate interventions (pharmacological, non-pharmacological, relational).
ii. Describing the effectiveness of actions taken.
iii. Determining if further clinical diagnostic testing is needed.
iv. Reporting situation, background, actions and recommendations to the team.
SBAR Reporting Framework

**Situation** – concern, risk/urgency
**Background** – baseline, observations/assessment
**Action** (unregulated & regulated staff) – intervention, outcomes
**Assessment** (regulated staff) – ruled out, overall picture
**Recommendation/Request**

The SBAR is a structured communication tool that is used to communicate any resident or family concerns between team members. It has been tailored to allow personal support workers in long-term care to share their knowledge, interventions and requests with the team. SBAR offers healthcare providers a thorough, systematic and effective way of providing accurate information to the care team and beyond. This framework allows information to be shared clearly and comprehensively in a short amount of time, thus making it critical for urgent and emergency concerns. However, because clear communication is necessary for efficient teamwork, SBAR is also suitable for non-urgent situations (e.g., action needed within hours, team rounds).
### Abbreviations

The following abbreviations are used in this Reference Guide.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADLs</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>3Rs</td>
<td>Recognize, Reflect and Respond</td>
</tr>
<tr>
<td>BM</td>
<td>Bowel Movement</td>
</tr>
<tr>
<td>Ca&lt;sup&gt;2+&lt;/sup&gt;</td>
<td>Calcium</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>Fe&lt;sup&gt;+&lt;/sup&gt;</td>
<td>Iron</td>
</tr>
<tr>
<td>GERD</td>
<td>Gastroesophageal Reflux Disease</td>
</tr>
<tr>
<td>IADLs</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>kg</td>
<td>Kilograms</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Consciousness</td>
</tr>
<tr>
<td>PSW</td>
<td>Personal Support Worker</td>
</tr>
<tr>
<td>SBAR</td>
<td>Situation, Background, Action/Assessment, Request/Request</td>
</tr>
<tr>
<td>SOS</td>
<td>Sensory Observation System</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>VS</td>
<td>Vital Signs</td>
</tr>
</tbody>
</table>

In this reference guide, the term ‘resident’ is used (instead of client or patient) to reflect the population living in long-term care (i.e., persons who ‘reside’ in long-term care homes).
A. BASELINE

In order to identify changes in a resident, there must be an initial reference point for comparison. This reference point is referred to as the resident’s baseline. To establish a baseline, healthcare providers must understand the resident’s background, health history and social history and must obtain relevant information about the resident using a head-to-toe approach. All time spent with a resident is an opportunity to build on or confirm baseline knowledge. The longer a healthcare provider knows a resident, the more comprehensive baseline knowledge.

*How do you get to know your resident?*

*What do you need to know?*

**Health History**

*Health history information is needed to establish baseline knowledge of your resident. Knowing this information will allow you to anticipate what may go wrong when the health of the resident deteriorates or what conditions may develop in the future. It also allows healthcare providers to understand the goals of care that the healthcare team sets for the resident.*

Questions to consider are:

- What is the **primary diagnosis**?
- What is the **past medical history**?
  - Are the changes being reported relevant to the primary diagnosis or to past medical history?
- Does the resident have any allergies?
- What is the resident’s **code status**?
- Is there an advanced care plan?
- What are the resident’s treatments and **therapies**?
  - Are there any recent changes?
  - Is it relevant to the advanced care plan?
- What is written in the kardex? Is it up to date?
- What is the care plan for this resident?
Social & Family History

Social and family history can help healthcare providers to understand the resident’s current or past environment. Some resident responses and interactions may be more easily understood in the context of this information.

Questions to consider are:

- Is there a relevant family practice or tradition that is important to the resident?
- What stories do your colleagues, family members, volunteers or visitors share about the resident that are significant to the care you are giving?

Personhood

For residents with cognitive decline or impairment such as Alzheimer’s Dementia, knowing the story of the resident is key to creating solutions or interventions to many behaviours and psychological symptoms; also known as “responsive behaviours”.

Questions to consider are:

- Who was the resident before they came to the nursing home? What makes them tick?
  - What are their interests, needs, abilities and skills?
  - What are the resident’s culture, childhood, work life and education?
  - Are there any relevant or important stories or events?
  - Can you engage the resident in any activities based on this knowledge?
- What would allow you to relate well with the resident?
  - How do you present yourself when relating with the resident?
- Are there techniques that are relevant to caring for the resident?
- Are there environmental factors that the resident prefers?
- What is the resident able to do for him or herself?

Continuous Monitoring or Trending

Remember that the longer a healthcare provider knows the resident, the more the healthcare provider will have developed a comprehensive baseline. Any time spent with a resident is an opportunity for the healthcare provider to add to or confirm baseline knowledge of the resident. Each healthcare provider should consider the trends observed in their own practice and by the team.

Consider what you know about the resident, from your baseline observations vs. over time.

Is there a trend?

Report any change.
B. RECOGNIZE

This section will cover:

- Recognizing and describing specific concerns objectively
- Prioritizing new changes

All healthcare providers must be skilled in recognizing changes in resident condition. Communicating this knowledge in a concise and specific manner is essential. In order to develop this skill, this section describes the presentation of acute deterioration related to several conditions in the geriatric population. Also, prioritization of these new changes will be discussed. Signs and symptoms that are localized (system-specific or easily identifiable towards a body system) and general (non-localized) will be covered.

Objective Observation

It is important to maintain objectivity when noting signs and symptoms in order to plan and implement interventions. The Sensory Observation System (SOS) developed for Team Essentials can guide healthcare providers in determining the best method of assessment and encourages systematic observation. Based on the senses, SOS directs the healthcare provider to:

- Look and see
- Listen and hear
- Touch and feel
- Smell
- And consider further knowledge gathered

Common Conditions

Listed below are ten common conditions that may lead to an acute change in a resident’s condition. Note that deterioration of chronic conditions in the frail elderly may present very differently compared to the general population. Thus, the signs and symptoms listed below are specific to the elderly population. Many resources were used to compile these signs and symptoms. In particular, practice guidelines from the former American Medical Directors Association (now The Society for Post-Acute and Long-Term Care Medicine) were followed and information from various sources was then added to complete the list (see References).

As a note, behavioural changes, mental status changes and change in functional status may be cues to delirium, dementia or depression. Further assessment and intervention will only happen if changes are recognized, prioritized and shared with the team.
1. Delirium

Delirium is sudden change or acute disturbance of consciousness. A resident with delirium may show signs such as reduced ability to focus, organize thoughts, or shift attention that may not be accounted for by a pre-existing cognitive impairment like dementia. Most conditions that will be discussed may have signs of a mental status change and appear as confusion but there are different types of delirium to consider. Note that if there is a change from baseline behaviour, this may be related to a change in condition that needs to be addressed.

**Signs of Delirium**

- Sudden onset or change in behaviour, symptoms come and go and is a change from baseline
- Change in mental status or cognition (organizing information, planning, sequencing, perception, memory, language)
  - Inattention, no focus
  - Easily distracted
    - Disorganized thinking
    - Disorientation (confusion)
- Altered level of consciousness
- Memory impairment (long-term and short-term memory problems)
- Psychomotor changes or ADL function
- Visuospatial problems (less able to see and understand the world around them)
- Perceptual disturbances
  - Reports of feeling “cloudy”
  - Labile (always changing) affect

**Hyperactive-Hyperalert Delirium**

- Sleep/wake cycle disturbance (most common)
- Agitation, restlessness
- Paranoid
- Delusions or hallucinations
- Hyperreactivity
- Speech incoherence

**Hypoactive-Hypolert Delirium**

- Decreased level of consciousness and lethargy
- Sluggish
- Inactive or few spontaneous movements
- Apathetic
- Quiet, responds slowly to questions
- Loss of facial reaction

**Mixed Delirium**

- Shows and changes between hyper- and hypo- signs
2. **Dehydration**

Elderly residents who are dehydrated are at higher risk for delirium and infection. Age-related changes, some disease processes and medications also affect how water is retained or eliminated.

**General Signs & Symptoms**

- Change in:
  - ADL function or engagement in activities
  - Intake of food or fluids
  - Mental status (increasing confusion and/or lethargy)
  - Skin temperature
  - General malaise
- Dizziness
- Fall or deterioration in balance or gait

**Other Signs & Symptoms**

- Constipation
- Decreased urine output
- Postural hypotension
- Postural pulse difference
- Tachycardia
- Weight loss (3-5 pounds in a 24-hour time frame)
- Elevated body temperature
3. **Urinary Tract Infection**

Urinary tract infections (UTIs) are common in long-term care residents. Although localized symptoms allow for easier recognition and assessment, at times general signs are seen first.

**General Signs & Symptoms**

- Change in:
  - ADL function or engagement in activities
  - Intake of food or fluids
  - Mental status (increasing confusion and/or lethargy)
  - Skin temperature and/or color
  - Sleep pattern
  - Vital signs
  - Increased or excessive perspiration
  - General malaise
- Dizziness
- Nausea and/or vomiting
- Fall or deterioration in balance or gait
- Fever or hypothermia
- Generalized pain, myalgia

**Localized Signs & Symptoms**

- Suprapubic or flank pain or tenderness
- Painful urination
- Gross hematuria
- Foul smelling urine
- Change in continence level (e.g., urgency or functional)
4. **Respiratory Infection**

Recognizing respiratory signs is very helpful when addressing respiratory infections. Keep in mind the differences in signs based on the location of infection.

**General Signs & Symptoms**

- Change in:
  - ADL function or engagement in activities
  - Intake of food or fluids
  - Mental status (increasing confusion and/or lethargy)
  - Skin temperature and/or color
  - Sleep pattern
  - Vital signs
    - *Tachypnea with or without shortness of breath*
  - Increased or excessive perspiration
  - General malaise
- Dizziness
- Nausea and/or vomiting
- Fall or deterioration in balance or gait
- Fever or hypothermia
- Generalized pain, myalgia

**Localized Signs & Symptoms**

**Pneumonia**

- Tachypnea
- Unlike the general population, coughing may be mild and without copious, purulent sputum, especially in dehydrated elderly residents

**Upper Respiratory Infections**

- Congestion
- Sore throat
- Nasal purulence

**Lower Respiratory Infections**

- Increasing and/or productive cough
- Shortness of breath
- Adventitious lung sounds
5. **Chronic Obstructive Pulmonary Disease (COPD) Exacerbation**

Residents with COPD may have acute exacerbation of the disease and if not treated early enough may lead to a transfer to acute care services.

**General Signs & Symptoms**

- Change in:
  - Mental status (increasing confusion and/or lethargy)
  - Behavioural changes (irritability and anxiety)
  - ADL function or engagement in activities
  - Sleeping pattern (chronic change or observed change over a prolonged period)
  - Intake of food or fluids
  - Vital signs
    - Oxygen saturation < 88%
    - Respiration > 28 breaths per minute
    - Fever
  - Peripheral edema

**Acute Changes Likely When**

- Dyspnea is present
- Increased cough
- Increased sputum production, change in color or thickness
- Chest tightness
- Wheezing
- Accessory muscle use
6. **Septicemia**

The frail elderly with multiple comorbidities, decreased immunity, dehydration and other risk factors have a higher chance to develop an inflammatory body response. These signs may be missed if the diagnosis is not expected (Nasa et al., 2012).

**General Signs & Symptoms**

- Change in:
  - ADL function or engagement in activities
  - Intake of food or fluids
  - Mental status (increasing confusion and/or lethargy)
  - Skin temperature and/or color
  - Sleep pattern
  - Vital signs
  - Increased or excessive perspiration
  - General malaise
- Dizziness
- Nausea and/or vomiting
- Fall or deterioration in balance or gait
- Fever or hypothermia
- Generalized pain, myalgia

**Fever, Infections & the Elderly**

- The febrile response is usually blunted in the elderly. However, using this guideline may indicate fever in the elderly (AMDA, 2011):
  - Increase in temperature of equal to or greater than 1.1 °C from baseline
  - 2 or more measurements of oral temperature equal to or greater than 37.2 °C
  - Single measurement of temperature equal to or greater than 37.8 °C
7. ** Decompensated Heart Failure**

A gradual onset of signs and symptoms of heart failure may lead to emergency transfers and hospitalizations.

**General Signs & Symptoms**

- Change in:
  - ADL function or engagement in activities
  - Intake of food or fluids
  - Mental status (increasing confusion and/or lethargy)
  - Skin temperature and/or color
  - Vital signs
  - General malaise (lethargic, less active, weakness)
  - Nocturia or nocturnal incontinence
  - Sleep disturbance
  - Increased potential for falls
  - New or increasing edema
    - Lower-extremity swelling

**Localized Signs & Symptoms**

- New or increasing edema
  - Sacral edema for bedbound residents
  - Abdominal swelling
- Increased shortness of breath with or without exertion
- Dyspnea (less likely if patient is sedentary)
- Unexplained cough
- Sudden night time dyspnea (difficulty breathing) during sleep
- Orthopnea (breathing comfortably only when standing or sitting up)
- Unexpected and sudden weight gain (example is 2 kgs over 3 days)
8. **Myocardial Infarction (Heart Attack)**

Signs and symptoms of a heart attack may present as “atypical”, which means the classic signs of chest pain that healthcare providers wait for may not be present.

**General Signs & Symptoms**

- Change in mental status (increasing confusion and/or change in level of consciousness - syncope)
- Fatigue or weakness
- Dizziness
- Generalized pain, myalgia
- Increased or excessive perspiration, cold sweats

**Common Manifestations**

- Dyspnea
- Upper abdominal distress
- Syncope
- Vomiting
- Chest pain
9. Ischemic Stroke

There is a higher incidence of stroke in the elderly population and knowing these signs may allow a healthcare provider to recognize a change.

**Acute Stroke**

- Sudden confusion, difficulty speaking (slurred), or difficulty understanding speech
- Sudden difficulty seeing out of one eye
- Sudden difficulty walking, severe dizziness, or loss of balance or coordination
- Sudden numbness or weakness of face, arm, leg – confined to one side of the body
- Sudden severe headache with no other readily identifiable cause

**Subtle or Non-Specific Signs of Ischemic Stroke**

- Dramatic decline in muscle strength, speech, or level of consciousness
- Decline in function
- Difficulty judging distance or depth
- Difficulty recognizing or paying attention to one side of the body
- Difficulty with new learning
- Impulsiveness or poor planning
- Poor judgment
- Poor safety awareness
- Short attention span
- Change in mental status (increasing confusion and/or lethargy)
10. Diabetes: Hypoglycemia

The elderly population present differently when blood glucose levels decrease. The neuroglycopenic symptoms listed below are more common changes in the elderly as opposed to the neurogenic symptoms that the younger diabetic population may present with (Clayton et al., 2013).

**Neuroglycopenic Symptoms***

- Change in mental status (cognition, increasing confusion and/or delirium)
- Difficulty speaking
- Weak, drowsy, lethargic
- Change in psychomotor skills or function
- Lack of coordination
- Dizziness (increased potential for falls)
- Headache
- Vision changes

*Neuroglycopenic symptoms are more common in the elderly.*

**Neurogenic Symptoms**

- Trembling
- Palpitations
- Sweating
- Anxiety
- Hunger
- Nausea
- Tingling

*Asymptomatic hypoglycemia occurs in the frail older resident.*
10. Diabetes: Hyperglycemia

Undiagnosed diabetes leads to further complications (AMDA, 2010b).

**General Signs & Symptoms**

- Change in mental status (new or increasing confusion or delirium)
- Weak, drowsy, lethargic
- Blurred vision
- Worsening incontinence
- Fruity breath odour
- Thirstier than usual
- Hungrier than usual
**Prioritize**

Prioritizing changes makes good use of team resources, time and interventions. Knowing the resident’s baseline, making observations and conducting assessments are necessary to prioritize a change as an emergency, urgent or non-urgent. Prioritizing concerns determines how quickly to respond to a concern. A stoplight system of red, yellow and green can be used to help visually flag the priority (Table 1).

<table>
<thead>
<tr>
<th>Priority Level</th>
<th>Response Time</th>
<th>Stoplight Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Address Immediately</td>
<td>Red</td>
</tr>
<tr>
<td>Urgent</td>
<td>Address Within 1 Hour</td>
<td>Yellow</td>
</tr>
<tr>
<td>Non-Urgent</td>
<td>Address Within Hours</td>
<td>Green</td>
</tr>
</tbody>
</table>

**Table 1. Prioritization of Concerns**

*Emergency concerns need to be addressed immediately to preserve life (or limb).* For example, when a resident presents with new signs of facial drooping, one-sided limb weakness and slurred speech, these would be considered signs of an Ischemic Stroke and call for an immediate transfer.

*Urgent concerns need to be addressed within 1 hour.* This prioritization refers to situations where a resident’s status will not improve or will deteriorate if further interventions are not provided. For example, consider a resident who continues to be short of breath upon exertion but remains on room air with no oxygen support and only non-pharmacological interventions have been used. If oxygen saturation of greater than 92% there are other interventions that could be used to ensure the resident remains stable like applying oxygen by nasal prongs or giving medication. This is considered urgent because the resident saturation may not improve if further interventions are not provided.
Figure 2 provides examples of emergency and urgent concerns by system.

<table>
<thead>
<tr>
<th>System</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological</td>
<td>Sudden change in LOC, Weakness on one side or seizure</td>
</tr>
<tr>
<td>Mood &amp; Behaviour</td>
<td>Sudden behaviour change</td>
</tr>
<tr>
<td>Sensory</td>
<td>Sudden eye pain</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>New/unrelieved chest pain, tightness, pressure, discomfort with known cardiac condition, Hemodynamically unstable</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Sudden or increased effort to breathe at rest, Respiration rate &gt;28, Obstruction</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Rapid onset of abdominal pain or distention, Sudden weight gain</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Bleeding significantly</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Dramatic decline in muscle strength, Falls</td>
</tr>
<tr>
<td>Integumentary</td>
<td>Skin looks gray or blue compared to earlier appearance</td>
</tr>
<tr>
<td>Function</td>
<td>Sudden decline in function compared to earlier status</td>
</tr>
<tr>
<td>Safety</td>
<td>Fall with fracture</td>
</tr>
</tbody>
</table>

**Figure 2. Emergency and Urgent Concerns by System**
A non-urgent concern needs to be addressed within hours. Note: A non-urgent concern is still an important concern (for example, you may take hours to further observe, assess, intervene and evaluate the change). Prioritizing a concern as non-urgent allows the care team time to gather more information and to come up with appropriate interventions. In some cases, non-urgent concerns may escalate if not addressed in a timely manner. For example, when a stage 1 pressure ulcer is recognized and reported, the team then has time to assess the new sore, identify contributing factors that led to the pressure sore and intervene as appropriate. Figure 3 identifies some examples of non-urgent concerns by system (note: this is not a fully inclusive list).

Figure 3. Non-Urgent Concerns by System

If the baseline established for the resident is known, then determining the priority of concerns is clear. If the resident baseline is not known, a nurse should perform a head-to-toe assessment or focused assessment (system specific assessment) to determine the priority.

A Note on Risk

Risk assessment of behaviors is necessary to keep residents and staff safe. It must be noted though that some acute changes of conditions present as a sudden change in behavior. In this case, the sudden change must cue a clinician into the urgency of the situation or a possible delirium. In some instances, these changes in behavior may be seen as a responsive behavior due to dementia if a resident has this comorbidity. If so, further assessment must be done by the team especially if new behaviours appear.
Basic Information for Any New Situation

Table 2 can help organize communication about a concern and make it specific. Having this information right at hand helps the healthcare provider highlight critical signs or symptoms and decide what additional information is needed. See Appendix A for the full worksheet.

<table>
<thead>
<tr>
<th>Table 2. RECOGNIZE: Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong>: What change requires the most attention?</td>
</tr>
<tr>
<td><strong>Priority</strong>: Non-urgent, urgent or emergent</td>
</tr>
<tr>
<td><strong>Risk</strong>: Low, slight, moderate, high, potential to escalate</td>
</tr>
<tr>
<td><strong>Trigger/Antecedent</strong>: What happened prior?</td>
</tr>
</tbody>
</table>

After reviewing Table 2, healthcare providers are encourage to practice using it with past clinical situations experienced.
C. REFLECT

This section will cover:

- Thinking critically to compare the resident’s current status to background and baseline
- Thinking critically to identify the potential source of the changes observed
- Organizing signs and symptoms observed in a systematic manner

Critical Thinking: Considerations with Any Change

Drawing on the knowledge of the resident and his/her background and baseline, makes an important difference in the care provided and allows healthcare providers to build a professional relationship that is resident-centred.

When observing a change, consider:

1. Vital Signs (VS)
   a) Are there significant changes in VS compared to the baseline?
   b) If any of the VS are in the range listed in Table 3 below, act immediately, as the resident may be hemodynamically compromised. If this is the case, the situation may be prioritized as urgent or emergency.
   c) With no change in VS, a healthcare provider has time to gather more data and the situation may be prioritized as non-urgent.

<table>
<thead>
<tr>
<th>Table 3. Critical Vital Sign Changes in the Elderly</th>
</tr>
</thead>
</table>
| TEMPERATURE | • 37.8°C or 100.0°F  
|             | • > or equal to 1.1°C from baseline  
|             | • 2 or more measurements of oral temperature = or >37.2°C  |
| BLOOD PRESSURE | Systolic: < 90 mmHg or > 200 mmHg  |
| HEART RATE | < 50bpm or >100 bpm  |
| RESPIRATORY RATE | <10/min or >28/min  |
| OXYGEN SATURATION | <90% (less than 88%, if COPD) or a 3% decrease from baseline  |
| BLOOD GLUCOSE | <3.9mmol or >16.6mmol  |

2. Is it delirium or delirium on dementia? Remember, there are numerous sources for delirium in elderly residents.
   a) Are basic needs being met?
      • Unmet needs may include: lack of food, lack of fluids, inability to void or defecate, lack of sleep, presence of pain, or inability to breathe comfortably.
      • For example, a change in appetite may trigger hypoglycemia if food is not consumed but diabetic medications are provided to the resident.

3. Is this a change due to disease progression or a new disease?
   • Some diseases have complications as it progresses. Also decompensations or deteriorations happen in diseases such as heart failure or chronic obstructive pulmonary disorders.
4. What other systems are affected or affecting the resident? Localized signs and symptoms may affect other systems.
5. What is relevant about the change? Other considerations? Are there changes to treatment plans, medications, any recent transfers or stressors?
6. Is it an increase in frailty or an age-related change?

**Which Systems are Affected?**

If a system is affected, you will find a signs and symptoms that can be grouped together. Organizing observations by system may be helpful when working or communicating with the resident and the team. The following section describes relevant information for each system in terms of:

- Age-related changes
- Systematic observations that healthcare providers may observe when working with the elderly
- Examples of observations that require urgent attention
- Examples of observations according to systems

Each system is reviewed as listed in figure 4 below:

*Figure 4. Review of the Descriptions of Each System*
With any changes to the resident, ask and consider, and then document and communicate:

- What is the change?
  - Be objective and specific
  - PSWs: What do you see, hear, smell, and feel that is different?

Nurses: What relevant systems are affected?

A sample head-to-toe report is found in Appendix B.
1. **Safety**

**Look & See**

- What does your safety environmental scan show?
- Call bell in reach? Side rails up?
  - Non-slip shoes on resident?
- Bed is low/near the ground?
- Does the head of the bed facilitate better breathing and prevent skin breakdown?
- Environment suited to reduce behaviours?
- Feels like home?
- How is the lighting?
- Any excessive noise that may irritate the resident?
- Bed/chair alarms on and working?
- Restraints used?
- Hip protectors on?
- Could team offer more support for the resident’s memory?

**Non-Urgent Concern (Act within Hours)**

- Reaction new to the environment
- Reaction to sounds and loud environment
- Reaction to warmth or coolness of environment
- Reaction to new staff working with him or her

**Some Safety Observations**

- Unable to follow safety precautions
- Falling frequently
2. **Neurological – Head, Nerves, & Pain**

**Age-Related Changes**

- Less blood flow to brain leads to a decline in executive function – e.g., planning, attention and problem solving abilities.
- Smaller and less brain size and neurons leads to slower speed of thinking, poorer short-term memory, and a need for more time to reason things out.
- Slower nerve impulse (sensory and motor) changes movement and motor control.
- Slower movements, are not as balanced or coordinated.
- Bone thinning of the spine leads to less bones structure and may increase pressure to the spinal cord and may lead to decreased response to stimuli and a need for a longer reaction time.
- Harder to choose words.
- More memory distraction.
- Less able to regulate heat.
- Less likely to show signs of elevated temperature typical of fevers when having an infection.

**Look & See**

- Level of consciousness?
- Alert.
- Drowsy – lethargic, more tired or sleepier than usual.
- Confused - disoriented to person, time, place, altered perception.
- Drowsy and responding only to strong touch and verbal stimulation – stuporous.
- Not rousable and not responding - comatose.
- Mental responsiveness and orientation (name, time, place and purpose)?
- Face even from left to right?

**Listen & Hear**

- What is the resident saying?
  - Cognition - memory, recall, and identification.
  - Complete and organized thoughts, understandable.
  - No change in how the resident speaks.
  - No word finding difficulty finding.
  - Is there a positive or a negative theme?
  - Has sound judgment.

**Touch & Feel**

- Does not show new or sudden weakness.
- No reports of numbness to face, arm, trunk and/or leg.
- Equal strength and movement from both left and right limbs.
Ask & Consider Further

- If there is pain present, consider the following:
  - Is it new or chronic?
  - What started it?
  - Where is the pain?
  - How long has the area been painful?
  - How much pain is the resident in?
  - What is the pain quality?
  - What treatment worked before?
- Does the resident report any dizziness or lightheadedness?
- If there are changes to energy levels:
  - How many hours of sleep has the resident had?
  - Was it enough for the resident to feel rested?
- If the resident is non-verbal and/or cognitively impaired, consider history of painful chronic disease and observe for:
  - Decreased interaction
  - Decreased food intake
  - Rocking movements
  - Grimacing
  - Negative language used
  - Physical or verbal aggression
  - Increased irritability
  - Breathing faster
- Consider if there are physical changes related to pain and observe the following:
  - Gait
  - Posture
  - Appetite
  - Sleep patterns
  - Elevated BP
  - Increased respirations
  - Diaphoresis
- Note the use of restraints and consider if there is a continued need for them

Urgent Concern (Act within 1 Hour)

- Sudden change in level of consciousness – reduction in level of consciousness for example, from alert to stuporous or non-responsive
- Sudden confusion
- Sudden change in speech – slurring or garbled speech
- Sudden numbness limited to 1 side
- New facial droop
- New onset seizure
• Suicidal or homicidal thoughts

**Non-Urgent Concern (Act within Hours)**
• Change in sleeping pattern
• Worsening pain
• New change in cognition
• Decreased energy level—more lethargic, tired, weak, faint
• Decrease in responsiveness
• Chronic pain

**Some Neurological Observations**
• Decreased alertness
• Disoriented or confused
• Pain present
• Insomnia (not sleeping)
• Fatigue
3. **Mood & Behaviour**

**Age-Related Changes**
- Less neurotransmitters and catecholamines that help with brain function such as cognition and emotion
- Poor sleep leads to an increased risk of major depression, memory problem and fewer social interactions
- Lethargy and hypo-alertness are **NOT NORMAL in older adults with dementia**

**Look & See**
- Observe the resident’s affect (non-verbal reaction to environment)
- Interactions with visitors, family, caregivers and staff
  - Positive or negative interaction?
  - Increased or decreased in quantity and/or quality?
- Involvement in programs and activities
  - Is it more or less often than before?
  - Signs of boredom?
  - Is there any unexpected behaviour during care?
- Is the resident hyperactive, more withdrawn (hypoactive) or resistant to care?

**Listen & Hear**
- Interactions with visitors, family, caregiver and staff
  - Positive or negative theme when speaking?

**Ask & Consider Further**
- What is the resident’s mood (what does resident say s/he is feeling)?
  - Is there a change?
- Is there a presence or worsening of new responsive behaviours?

**Is it: Delirium? Depression? Dementia?**
- Who is the behaviour affecting (staff, other residents, family)?
- What is the behaviour and why might it be happening?
- What happened beforehand?
  - What were the specific actions of the resident?
- Describe and quantify
  - What or whom is around the resident at the time of the behaviour?
  - What is the resident saying?
  - When is this happening?
- During the day or at night?
- When is this NOT happening?
  - What can you do about it?
  - Has this behaviour occurred before?
• Which techniques were used? Which techniques were effective? Which techniques were ineffective?
• How long has this behaviour been happening?
  • Are there safety issues for staff, other residents, visitors, etc.?
  • Is there a behaviour that is now “normalized”?

**Urgent Concern (Act within 1 Hour)**

• New delusions, paranoia, hallucinations
• Violence or destructive tendencies to self and/or others
• Suicidal or homicidal ideation present with or without a plan

**Non-Urgent Concern (Act within Hours)**

• New onset behaviour or personality change or a significant change in behaviour:
  • Resisting or refusing care
  • Refusing to get up or move; staying in the same place
  • More withdrawn/sad or talking more than usual, negative themes
• New or increased confusion/disorientation; delusions or hallucinations; severe depressed mood

**Some Behaviour Observations**

• Increased motor activity or verbalization
• Decreased interactions and participation
• More withdrawn or more active than usual
4. Sensory – Eyes, Nose, Ears, Tongue

Age-Related Changes

Eyes

- Lens less flexible, which leads to decreased ability to focus on close objects (presbyopia) and less able to adjust to changes in bright lighting (glare prevents seeing clearly)
- Poorer night vision
- Less sensitive cornea and conjunctiva
- Less tear production
- Less able to see colour differences
- Cholesterol deposit lead to visual haziness

Ears

- Outer ear enlargement
- More ear wax impaction
- Less elastic ear canal
- Thinning and stiffening of the tympanic membrane
- Less able to recognize speech
- Less able to hear higher tones
- Less able to follow conversations
- Slower brain processes of auditory information
- Inner ear structure – changes in vestibular system lead to more dizziness and falling

Nose

- Less smell leads to less taste, which may lead to decreased appetite
- Less able to identify odours
- Higher chance of nose bleeds

Tongue

- Less taste
- Less saliva production

Look & See

Vision

- Visual aids used – glasses, etc.?
- Trouble seeing surroundings?
- Blurred vision

With Hearing Aids

- Comfortable fit
- Batteries changed recently
Listen & Hear

Hearing Deficits
- Resident is responding to you

Ability to Communicate
- Verbal or non-verbal

Ask & Consider Further

Vision
- When was vision last checked and followed up on?
- Seeing double?
- Can’t see the same: decreased, blurry or lost vision?
- New decreased or lost vision?
- Any strain to see out of 1 eye?
- Severe eye pain present?

Touch
- Are there known tactile/touch risk issues?
- Is there a loss of tactile sensation?

Urgent Concern (Act within 1 Hour)
- Sudden change in vision (example, sudden change in visual fields or sudden inability to see out of one eye)
- Severe ear pain and bleeding or discharge from ear canal
- Fast onset of hearing loss

Non-Urgent Concern (act within hours)
- Seeing halos
- Increasing glare from lights
- Experiencing eye pain
- Can’t see the same: new vision loss
- Can’t hear, smell or taste the same

Some Sensory Observations
- Can’t see, hear or taste the same
5. **Respiratory – Breathing & Lungs**

**Age-Related Changes**
- Stiffer chest wall and less lung muscle strength and elasticity
- Decreased gas exchange
- Drier mucus membranes
- Decreased cough reflex leads to less ability to clear mucus/foreign matter and an increased risk of infection and spasm of airway
- Easier to lose breath when working harder than normal, which leads to less to tolerate exercise

**Look & See**
- Depth
  - Deep or shallow
- Rhythm
  - Regular or not
- Respiratory rate
  - Fast or slow
- Mouth breather
- Discomfort when breathing
- Any increased effort to breathe at rest or with activities
- New or worsening shortness of breath only with activity
- Increased need for more pillows to sleep in bed or a need to sit up to sleep

**Listen & Hear**
- Wheezing
- Coughing
- Sneezing
- Congestion

**Ask & Consider Further**
- Is there a new cough?
  - How much and how often is the resident coughing?
  - What is the colour and quantity of sputum?

**Urgent Concern (Act within 1 Hour)**
- Struggling to breathe
- Short of breath at rest
- Coughing up copious amounts of blood
- Sudden or increased effort to breathe at rest

**Non-Urgent Concern (Act within Hours)**
- Shortness of breath with activity or a change in breathing pattern
• Irregular or breathing fast
• Slow breath recovery after an activity – e.g., ADLs or walking
• New increased sputum production
• New or worsened cough, wheezing
• Sore throat

Some Respiratory Observations

• Increased work of breathing at rest or during activities
• New cough
6. Cardiovascular – Heart & Circulation

Age-Related Changes

- Thicker heart muscles, stiffer arteries and heart valves, thicker arterial walls and more fat around the heart lead to **more work for the heart**
- Less blood flow lead to cool arms, hands, legs and feet
- Decreased number of white blood cells and decreased immune response resulting in higher risk of infections
- Lower maximum heart rate during exercise and a high risk of heart rhythm changes
- Less cardiac reserve leads to more tiredness, shortness of breath and slower recovery from higher heart rate – e.g., after exercise
- Higher risk for a drop in blood pressure when changing positions (postural hypotension) – e.g. Switching from laying down to sitting or sitting to standing

Look & See

- Observe the overall colour of the resident
- DIAPHORETIC – sweating too much
- Edema or swelling
  - Where?
  - Legs, arms, sacrum, face, eyes and/or scrotum
  - How much?
  - Compare from left to right?
- If subcutaneous lines are in use:
  - Where is it located?
  - What does the skin look like at the insertion site?
  - Is the dressing holding up?

Touch & Feel

- Is the resident warm to touch?
  - Temperature – new fever?
- Axilla drier than usual

Ask & Consider Further

- Does the resident report:
  - Palpitations
  - Chest pain, chest tightness, pressure, discomfort and/or unusual sweating (diaphoresis)?
    - Location of discomfort: neck, jaw, shoulder, arms, back and/or abdomen?

  Some describe chest pressure as the sensation that “someone is sitting on my chest”

- If needed, are the compression stockings on?
**Urgent Concern (Act within 1 Hour)**

- New or unrelieved chest pain, discomfort, pressure, heaviness or tightness with known cardiac concerns
- Sudden edema in only 1 leg with tenderness and redness
- More than 5 lbs. weight gain in 3 days
- No able to feel or sense touch in swollen legs

**Non-Urgent Concern (Act within Hours)**

- Signs of dehydration:
  - Increasingly tired, sleepy, dry axilla
- Signs of fever
- Worsening edema in arms, legs, abdomen, sacrum or genitalia
- Unable to sleeping laying down flat
- Unable to stand without severe dizziness

**Some Cardiovascular Observations**

- Chest pain or heaviness
- Edema
- Irregular heartbeats
- Dizzy
- Bleeding
- Fatigued
7. **Integumentary – Skin & Touch**

**Age-Related Changes**

- Drier, more scaly and wrinkled
- Less subcutaneous fat (under the skin) leads to less ability to stretch, and decrease skin integrity
- More visceral fat (deep)
- Less able to sweat
- Thinning and shrinking of the top layer of skin (epidermis) leads to slower healing
- Fewer nerve cells leads to less ability to feel and sense
- Less contact between dermis and epidermis (skin layers) lead to less nutrients exchange
- Thinner scalp, pubic and axilla hair; also changes in colours
- Higher risk of infection, trauma, cancerous lesions, and pressure ulcers
- Thicker nasal and ear hair
- More facial hair in women
- Nails thicker, grow slower, become brittle and yellowed
  - Increased risk of splitting and infections of the nails due to less blood supply to nails

**Look & See**

- Colour of skin
  - Pale, pink, yellow, flushed or bluish
- Dry or DIAPHORETIC (excessive sweating)
- Colour of legs
  - Pale, red, mottled
- If there are wounds:
  - Is it a pressure ulcer? Rash? Hives? Blisters?
  - Boggy and/or red areas?
  - Is there any hardened skin around?
  - Any new changes to existing wounds?
  - Where is it?
  - Is there pain due to the wound?
  - How large is the area or wound?
  - What does it look like?
    - Red, yellow, black
    - Wet or dry
  - If there is drainage, what is its:
    - Quantity
    - Colour
  - What does the skin around the wound (PERIWOUND) look like?
  - Is there a dressing on it?
    - Dry and intact?
    - How often is it changed?
• Observe for:
  • Redness over pressure spots that does not blanch when touched
  • Visible scars
  • Bruises
  • Skin tears
  • New changes to moles

**Touch & Feel**

• Warmth of skin
• Drier or more clammy than usual

**Smell**

• Any unusual smell to resident’s wound?

**Ask & Consider Further**

• Are there positioning plans?
• Is there use of special mattress or specialize cushions?
• Presence of pressure sores depends on:
  • The ability to feel pressure-related changes
  • How often skin is wet
  • How often resident gets up and/or does physical activity
  • How much resident is eating and drinking
  • The risk of rubbing on a surface when being lifted or boosted

**Urgent Concern (Act within 1 Hour)**

• Wound from a fall or trauma with significant bleeding
• Colour of skin – gray or blue

**Non-Urgent Concern (Act within Hours)**

• Some signs of dehydration
  • Tired or sleepy, dry skin, poor turgor in central locations (late sign)
• Redness on and around pressure areas that don’t blanche when touched
• A larger or worsening pressure ulcer or existing wound
• A new skin tear
• A lump that is felt in the breast area
• Changes in skin colour – blue or yellow
• Signs of chills
• Showing excessive moisture due to incontinence
• Diaphoresis – excessive sweating
Some Integumentary Observations

- Axilla drier than usual
- Wounds larger and/or more drainage
- Warm to touch
- New reddened areas
8. Gastrointestinal – Mouth, Digestion & Elimination

Age-Related Changes

- Less able to taste
- Diminished thirst drive
- Less calories needed but same nutritional needs
- Teeth sockets wearing away and decreasing gums leads to tooth loss
- Risk of chewing problems contributing to poor nutrition
- Decreased strength of chewing muscles
- Thinner mucus lining in the mouth (less protection) leads to dry mouth
- Weaker mucosal barrier lead to more risk of infection
- Swallowing muscles are less effective leading to risk of swallowing difficulty (dysphagia)
- Weaker peristalsis and weaker esophageal sphincters lead to GERD (heartburn)
- Change in ability to absorb nutrients (Ca^{2+}, Fe^{2+}) and medications leads to further considerations for pharmacological interventions
- Higher risk of adverse drug reactions due to decrease in liver size, blood flow and cardiac reserve
- Less able to digest starch
- Less bile production leads to less tolerance for fats
- Less able to feel the need to defecate BUT **constipation is NOT normal**
- Risk of fecal incontinence with disease (not when resident is healthy)

Look & See

- Nutrition
  - Appetite (meals and snacks)
  - Appropriate diet and texture
  - Able to eat independently
  - Drinking enough
  - Intake is the same as usual
- Oral condition
  - Condition of membranes in the mouth, lips and tongue
    - See if appearance is dry or moist, and pink or covered in white
  - Teeth (own or dentures)
    - Dentures fit comfortably
- Appearance of abdomen
  - Not unusually bloated (DISTENDED)
  - Rounded
  - Flat
- If there is nausea or vomiting:
  - How much, how often and what is vomited?
- Elimination
  - Size and quality of stool
• No change in frequency, size, type and consistency of bowel movement
• Ostomy: stoma, appliance, skin, effluent

**Touch & Feel**

• Pain is present when touching abdomen

**Listen & Hear**

• Voice is clear and there are no changes such as gurgling or wet voice
• If there is a concern with swallowing
  • Coughing before, during or after swallowing
  • Pocketing food in mouth when eating
  • Choking concerns are addressed
• More flatus (gas)

**Smell**

• No unusual smell to resident’s breath (e.g., fruity odour)
• No unusual smell to resident’s BM

**Ask & Consider Further**

• Nutrition:
  • Too much salt or sugar or fat intake?
  • Indigestion
• Appearance:
  • Sudden distention of abdomen?
  • Unexpected weight gain or loss?
• Any sudden onset of abdominal pain or cramps?
• If there is a feeding tube, consider:
  • Location
  • Placement of the tube
  • Amount of feeds
  • Type of feeds ordered
  • Volume and rate of feeds
• If resident is diabetic:
  • How often do they have signs of hypoglycemia or hyperglycemia?
• When was the date of last bowel movement?
  • Is a bowel routine needed?
  • Are laxatives used?
  • Change in frequency, size, type and consistency of the bowel movement?
• Change to the continence level?
• Toileting plan? How often?
• Any unplanned weight loss or weight gain in the last month or quarter to consider?
• Need Registered Dietitian or Speech Language Pathology assessment?
Urgent Concern (Act within 1 Hour)

- Rapid weight gain or weight loss (example 2 kg over 3 days)
- Coffee ground-like or bloody emesis
- Rapid onset of abdominal pain, distention, weight gain and rigid stomach, with or without vomiting, but with known constipation
- Choking during meals

Non-Urgent Concern (Act within Hours)

- Change in appetite or intake pattern – decreased oral intake over past 24-48 hours
- Dry mouth, lips and tongue
- Reporting denture pain or a burning sensation in mouth
- Nausea and/or episodes of vomiting
- Swallowing difficulty: coughing, wet voice, voice changes when eating; pocketing food in mouth
- Blood in stool (without history of hemorrhoids)
- Acute onset of diarrhea or multiple episodes
- Change in stool pattern (frequency, size, type and consistency of BM)
- New constipation or no BM for 3 days (start planning intervention)
- Abdominal pain or any sign of pain when abdomen is touched, bloating
- Weight loss or gain – 5% over last 30 days or 10% over last 6 months?

Some Gastrointestinal Observations

- Not eating or drinking
- Nausea and/or vomiting
- Pain or stomach tenderness
- No BM or watery BM
9. **Genitourinary—Renal & Elimination**

**Age-Related Changes**

- **Kidneys**
  - Decreased kidney size, less blood flow and function leads to lesser ability to clear body of drugs and toxic substances, resulting in higher risk of electrolyte imbalance
  - Leaves body in a more acidic environment
  - Lead to more risk of kidney injury and significant reactions from drugs
  - Higher risk of water retention in body (in heart failure)
  - Higher risk of dehydration
- **Bladder**
  - Less elastic, has less muscle tone and less capacity
  - Bladder volume decreases from 500-600 ml to 150-250 ml
  - More urine left in bladder after voiding
  - More night time urine produced and need to void (nocturia and polyuria) — higher risk of urinary urgency

  _Incontinence is NOT a normal finding_

- **In females**
  - Shorter urethra in women lead to a higher risk of UTI
  - Remember the relationship between UTI and increased potential for falls
  - Decreased estrogen lead to tissue shrinkage and less lubricating secretions
- **In males**
  - Prostate enlargement, testicular shrinkage, less sperm count and decreased testosterone
  - Larger prostate in men compresses the urethra and leads to difficulty or painful voiding

**Look & See**

- Method of urination
  - Spontaneous
    - Continent or incontinent
    - If incontinent, check size and fit of incontinence prevention tool
  - Foley catheter
  - Condom catheter
  - Suprapubic catheter
  - A leg bag is attached with catheters
- The resident is not ANURIC (does not void)
- No dialysis needed
- Frequency of resident’s voiding
  - Frequency does not increase at night
- No urgency, pain when voiding or straining to void
- Quality of urine
  - Amount
  - Colour
  - Odour
  - Clear
  - No signs of blood in the urine

**Smell**
- No unusual smell to resident’s urine

**Ask & Consider Further**
- If there is a change to continence level, is there a toileting plan?
- Is there:
  - Vaginal discharge or bleeding?
  - Itchiness to pubic area?
  - Burning on urination?
  - Blood in urine?
- Is there any history of:
  - UTI?
  - Urinary retention?

**Urgent Concern (Act within 1 Hour)**
- Bleeding significantly from vagina

**Non-Urgent Concern (Act within Hours)**
- Blood in urine or more sediments in urine
- Change in urination pattern (urgency, frequency or continence level)
- Foul smelling or concentrated urine
- Reporting pain or difficulty when voiding
- Pain in lower abdomen, flank
- Less urine output than usual

**Some Genitourinary Observations**
- Incontinence
- Pain when voiding
- Frequency and/or urgency of voiding
- Unusual smell
- Not voiding
10. Musculoskeletal – Muscles & Bones

**Age-Related Changes**

- Less muscle mass and coordination (sarcopenia) leads to weakness and poor exercise tolerance
  - Leads to less strength
  - Leads to higher risk of disability, falls and unstable gait
- Less cartilage-forming cells leads to more joint damage
- Less lean body mass, more fat and less able to absorb calcium leads to bone thinning
- Bone loss in women and men (after peak mass at ages 30 to 35 years) leading to higher risk of fractures and/or osteoporosis
- Less ligament and tendon strength, elasticity and flexibility
- Cartilage erodes and leads to changes in how resident stands and his/her height; range of motion limited, more joint instability, higher risk of osteoarthritis, less flexibility and less mobility

**Look & See**

- If the resident has resident fallen before:
  - Any changes in balance and gait, weight bearing, transfer, ambulation, and posture?
    - Any dramatic or ongoing decline in muscle strength?
  - How often are these falls?
  - Is the resident able to weight bear?
  - Are transfers or mobility aids needed and within reach?
- Movement
  - No change in exercise or activity tolerance
  - No shuffling when walking
  - No tremors, rigidity
  - Coordinated movement
  - Observe feet and toenails to see if there is anything that may cause pain

**Touch & Feel**

- Compare limb strength from left to right
  - Limbs equal in strength
- No 1-sided weakness to face, arm, truck and/or leg
- Joints moving normally for the resident
- No evidence of pain on movement or at rest
- No increase in rigidity or decrease in coordination
- No changes to muscle tone
- No odd bumps on the joints

**Ask & Consider Further**

- Is the resident part of a:
  - Physiotherapy program?
• Occupation Therapy program?
• Exercise/cardiac rehabilitation program?
• Could this resident benefit from more range of motion or joint loading exercises – active/passive?
• Are hip protectors on for high risk fallers who have a history of frequent falls?
  • Is there a falls prevention plan in place?
• If the resident is on bed rest, is there a positioning schedule?

_Urgent Concern (Act within 1 Hour)_

• New onset one-sided weakness (face, arm, trunk, leg) – unequal limb strength
• Fall with obvious broken bones or known blood thinner use
• Dramatic decline in muscle strength

_Non-Urgent Concern (Act within Hours)_

• Change in balance, weight bearing, transfer, ambulation, postural ability or gait
• Change when walking, moving or joint range of motion
• Increased weakness, tremors or rigidity
• Decreased exercise/activity tolerance
• Repeatedly falling
• Known unequal limb strength from left to right

_Some Musculoskeletal Observations_

• Pain
• Stiffer when moved or moving
• Weaker strength
• New or increasing tremors or rigidity
• Falling (new or frequent)
11. Function – ADLs, IADLs, Programs & Roles

Age-Related Changes

- Function is a resident’s ability to carry out his/her activities of daily living (ADLs), instrumental activities of daily living (IADLs) and roles
- Increased engagement in ADLs prevents excess disability
- Providing an agenda for the day or task breakdowns with cue cards leads to better engagement and positive benefits
- Ensure activities and roles are based on the assessment of resident’s needs, interest, skills and ability

Ask & Consider Further

- Is there a sudden decline in function?
- Is there a decrease in tolerance for one or more activities?
- Is the resident participating more or less than usual?
- What is the resident’s ability to do an ADL independently? (capacity)
  - E.g., Toileting, feeding, dressing, grooming, teeth brushing, ambulation and bathing
  - Will you be able to support the resident with a task breakdown?
  - Is there a change in the level of assistance required for the activities?
- What is the resident’s capacity for IADLs?
  - E.g., Shopping, meal planning and preparation, housekeeping, laundry, transit, financial management, using a telephone, medication management and driving
- What Therapeutic Recreation programs does the resident enjoy?

Urgent Concern (Act within 1 Hour)

- Sudden decline in function – ADLs, activity or engaging with others

Non-Urgent Concern (Act within Hours)

- Showing signs of boredom or loneliness
- Hesitation to do a simple task
- Refusing programs or activities
- Showing a steady decline in function (ADLs) and requiring increasing help
- Decreased exercise or activity intolerance

Some Observations about Function

- Not able to function in ADLs as before
- Not participating in activities as per usual
Systems Observed (Look & See) by Task

Some healthcare providers have deemed that a systematic head-to-toe observation is not always feasible unless time is set aside. This section categorizes some systems that may be observed during an activity of daily living when a healthcare provider is continuously monitoring the resident and using these instances to build up on or confirm baseline knowledge of the resident.

<table>
<thead>
<tr>
<th>Table 4. Summary of Systems Observed by Activity of Daily Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Bathing</td>
</tr>
<tr>
<td>Feeding</td>
</tr>
<tr>
<td>Dressing</td>
</tr>
<tr>
<td>Oral Care</td>
</tr>
<tr>
<td>Toileting</td>
</tr>
<tr>
<td>Ambulation</td>
</tr>
<tr>
<td>Transfers</td>
</tr>
<tr>
<td>Activities</td>
</tr>
<tr>
<td>Periodic Checks</td>
</tr>
</tbody>
</table>

Remember that if a resident is able to speak and respond, then healthcare provider is able to collect more information to trend and observe the systems. This will lead to a comprehensive definition of what is “ok” for a resident (See Appendix C: What Does “OK” Mean? for sample descriptions of an “OK” system).
Considerations: Using SOS as a Reflective Checklist

Table 5 can be used as a reflective checklist to put together what is known about the resident. Remember to prioritize the affected system and act on it based on your knowledge, skill, judgment and scope of practice as a healthcare provider. Please see Appendix A for the full worksheet.

<table>
<thead>
<tr>
<th>Background &amp; Baseline (vs. Current Presentation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal and medical history:</td>
</tr>
<tr>
<td>Basic needs (intake, sleep, toileting, pain):</td>
</tr>
</tbody>
</table>

**Sensory Observation System**

Which system(s) are affected? How? Local? Systemic?

- Safety/Environment:
- Vital Signs:
- Neurological:
- Mood, Affect or Behaviour:
- Respiratory:
- Cardiovascular:
- Gastrointestinal:
- Genitourinary:
- Musculoskeletal:
- Integumentary:
- Function:
D. RESPOND

This section will cover:
- Initiating appropriate actions and assessments
- Highlighting needs, requests or recommendations to the team
- Reporting systematically with SBAR
- Planning for follow up

When encountering a resident with a change in condition, the healthcare provider must support the resident to their best of ability in the moment so that the resident can be safe, supported and receive appropriate interventions according to the care plan or level of care. Responding to a resident’s change, in the moment, requires a few considerations, especially if the first observer is alone. If alone, consider the following:

- Is the resident safe and comfortable before setting out to find a co-worker or equipment?
- What resources are available here/now?
- Are there medications ordered for this specific event? If not know, does the nurse know?
- Are there medical directives, policies, or orders that outline the diagnostics and laboratory testing required?
- Is there an advanced care plan that is documented that will prevent or guide further interventions?

Actions in the Moment

If providing a non-pharmacological intervention, consider the following:

- **Interventions – What was done?**
  - Here are some examples:
    - If a resident is not waking up, was verbal communication or light touch tried?
    - If a resident is short of breath, are they safe and sitting? Were deep breathing exercises tried?
  - How many times was the intervention tried?
  - For how long?

_The number of attempts and duration of attempts are valuable pieces of information that may contribute to the plan of care for a resident and should be shared with the team._

- **Outcome of Intervention (Consequences) – Did it work?**
  - Effective: concern modified or stopped
  - Ineffective: concern accelerated or continued

_Sharing the outcome of the intervention will be useful as the team changes or builds new interventions based on the information shared._

- Was there a noticeable trigger, antecedent or unmet need?
Clinical interventions may vary between a medical condition and a concern based on a responsive behavior.

Consider these questions:

- Is it an acute change due to a medical condition OR a delirium? Think about:
  - Medication, supplementary oxygen, increased VS checks, blood work, diagnostic testing, consults or further observations by the team
  - Assess the need for transfer to acute care or further interventions
- Is there a known responsive behaviour due to dementia or depression?
  - If yes, attempt the following non-pharmacological interventions: distract, engage in activity, assist, redirect, instruct verbally, re-approach and monitor; if pharmacological intervention, monitor
  - Consider milieu management

Critical Sign or Symptom – Personal Support Staff

When a PSW identifies multiple concerns, signs, or symptoms of a change in condition, it is imperative to be precise and concise when reporting these changes to the registered staff. Highlighting the priority of the change as non-urgent, urgent or an emergency will help registered staff pay attention to your concern.

If multiple concerns are present, use Figure 2 to highlight and report observations to a nurse. This may assist in the nurse’s further clinical assessment and intervention. If there is more than one emergent or urgent change, list these systematically from head-to-toe, if possible. An example: A resident is coughing, breathing fast, has repetitive vocalizations about not being able to breathe and appears anxious. The critical sign of breathing fast and the symptom of repetitive vocalization about not being able to breathe should be reported first.

A carefully established baseline offers a clearer description of what changes are present in a resident.

Critical Care Path – Nursing Staff

After a registered nurse or physician completes an assessment, a critical care path may be determined. All the initial observations, prioritizations and interventions (pharmacological, non-pharmacological, relational) made by the team lead to this determination.

After careful consideration of the change, identification of a care path provides guidance on how a resident should be monitored and future monitoring and interventions that may be required as well as may set the parameters for transfers to acute care emergency as needed.

For example, a new concern of a cough may lead to a respiratory infection, an exacerbation of chronic obstructive pulmonary disorder or a decompensation of a congestive heart failure. Therefore, careful assessment and evaluation are the keys to ensuring that the correct interventions are implemented by the team.
**Sharing Actions & Assessments**

Table 6 can help organize communication about specific actions or interventions taken and the resulting outcomes. Nurses should provide an overall assessment of the potential critical care path. Please see Appendix A for the full worksheet.

**Table 6. RESPOND: Action, Safety & Assessment**

<table>
<thead>
<tr>
<th>Interventions (Pharmacological or Non-Pharmacological)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Number of trials</td>
</tr>
<tr>
<td>- Duration of intervention</td>
</tr>
<tr>
<td>- Outcome (effective or ineffective)</td>
</tr>
</tbody>
</table>

**Nursing Assessment:**

“I have ruled out …” (basic needs, delirium or other system change);  
“I think the problem may be …”

---

**Asking for or Recommending What is Needed**

Table 7 can help organize communication about any recommendations or requests. It helps you to be specific about what the resident needs or what you need to help the resident. Please see Appendix A for the full worksheet.

**Table 7. RESPOND: Recommendation/Request**

<table>
<thead>
<tr>
<th>PSW:</th>
</tr>
</thead>
</table>
| “I recommend …” (specific action, non-pharm interventions, further observation, monitoring and/or referrals);  
“Can I ask you to ... / What can I do in the next ___ minutes/hour?” |

<table>
<thead>
<tr>
<th>Nursing:</th>
</tr>
</thead>
</table>
| “I recommend …” (non-pharm or pharm interventions, labs, consults, further assessment, review of medication side effects, monitoring and/or transfer);  
“Can I ask you to ...?” (specific action) |
SBAR & Asking for Help: What to Include in Your Report

There are probably times when you ask for help, but you don’t get the response you desire. As a healthcare provider, many elements need to be communicated concisely to help team members gain insight into your knowledge of the resident. The SBAR communication tool has been tailored to assist healthcare providers in long-term care in reporting to the team.

SBAR stands for:

- **Situation** – concern, risk/urgency
- **Background** – baseline, observations/assessment
- **Action** (unregulated & regulated staff) – intervention, outcomes
- **Assessment** (regulated staff) – ruled out, overall picture
- **Recommendation/Request**

**Introduction**

When communicating with a new team member, be sure to introduce yourself. This will help avoid confusion in the beginning. If on the phone, let the team member know where you work so they can identify your specific location.

**Situation**

Always highlight the reason for the call according to *priority*, followed by specifics about the concern. This will paint the picture for the other team member. Stating the priority helps team members to manage their time and workload. If you were able to determine or observe what triggered the new concern, then share this too. In short, let the team member know the main concern and whether it is an emergency, urgent or non-urgent?

**Background**

Share what you know in a systematic way using SOS. Pull together information from what you and the team have observed and/or assessed and consider trends and relevant information. This is where systematic observations or assessments and accurate prioritization are relevant. Comparing what is known from baseline to how the resident is presenting now helps to figure out the next steps. Preparing this ahead of time increases team efficiency and quality of care for the resident.

Always consider if basic needs are being met (e.g., eating, drinking, sleeping, toileting, oxygen, no presence of pain). Pain is a common concern for the elderly. So with respect to basic needs, consider if the resident is experiencing any pain, pressure, or discomfort that can be relieved without medications.

*Pain is a commonly missed change that leads to complications, such as delirium.*
**Action & Nursing Assessment**

When you ask for help, always highlight some of the actions that you have done based on the signs or symptoms that you’ve observed. Let the other team member(s) know if it was effective, so there is no duplication of efforts.

Nurses should also communicate their overall assessment of the situation, which is the critical care path, to ensure that the care provided is consistent and the goals of care are clear with the team. PSWs are encouraged to share the critical sign or symptom observed.

**Recommendations & Requests**

It is always helpful for the other team member to understand why you need his or her help. In emergency or urgent cases, relating what you need from your team also speeds up the process of achieving quality care for the resident.

Consider the interventions listed below and your scope of practice. What clinical actions could another member of the team assist, ordering, perform or evaluate?

- **Acute change** due to a medical condition OR a delirium?
  - Medication, supplementary oxygen, increased VS checks, blood work, diagnostic testing, consults or further observations by the team
  - Transfer to acute care
- **Responsive behavior** due to dementia or depression?
  - Non-pharmacological interventions: distract, engage in activity, assist, redirect, instruct verbally, re-approach and monitor
  - Milieu management, medications and monitoring, further consultation, organized assessments and observations
Table 8 summarizes the elements to be included in an SBAR report for acute deterioration.

### Table 8. SBAR for Acute Deterioration in the Elderly

<table>
<thead>
<tr>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, Position, Location, Resident</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Situation (Recognize)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation: What change requires the most attention?</td>
</tr>
<tr>
<td>Priority: Non-urgent, urgent or emergent</td>
</tr>
<tr>
<td>Risk: Low, slight, moderate, high, potential to escalate</td>
</tr>
<tr>
<td>Trigger/Antecedent: What happened prior?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background (Reflect)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background &amp; Baseline (vs. Current Presentation)</td>
</tr>
<tr>
<td>• Personal and medical history</td>
</tr>
<tr>
<td>• Basic needs (example, intake, sleep, toileting, pain)</td>
</tr>
<tr>
<td>Sensory Observation System</td>
</tr>
<tr>
<td>• Which system(s) are affected? How? Local? Systemic?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action, Safety &amp; Assessment (Respond)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions (Pharmacological or Non-Pharmacological)</td>
</tr>
<tr>
<td>• Number of trials</td>
</tr>
<tr>
<td>• Duration of intervention</td>
</tr>
<tr>
<td>• Outcome (effective or ineffective)</td>
</tr>
</tbody>
</table>

Nursing Assessment:
“"I have ruled out …” (basic needs, delirium or other system change);
“"I think the problem may be …”

<table>
<thead>
<tr>
<th>Recommendation / Request (Respond)</th>
</tr>
</thead>
</table>
| PSW: "I recommend …" (specific action, non-pharm interventions, further observation, monitoring and/or referrals);
“Can I ask you to … / What can I do in the next ___ minutes/hour?”|

Nursing:
“"I recommend …” (non-pharm or pharm interventions, labs, consults, further assessment, review of medication side effects, monitoring and/or transfer);
“Can I ask you to …?” (specific action)
# APPENDIX A: SBAR WORK SHEETS

## PSW Worksheet

<table>
<thead>
<tr>
<th>PSW</th>
<th>Introduction</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name, Position, Location, Resident</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S</th>
<th>Situation (Recognize)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Current Concern</strong>: What change requires the most attention?</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Priority</strong>: Non-urgent, urgent or emergency?</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Risk</strong>: Low, slight, moderate, high, potential to escalate</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Trigger/Antecedent</strong>: What happened prior?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Background (Reflect)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Background &amp; Baseline</strong> (vs. Current Presentation)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Personal and medical history</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Basic needs (intake, sleep, toileting, pain)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sensory Observation System</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Which system(s) are affected?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- How? Local? Systemic?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Safety &amp; Environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Neurological</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Mood &amp; Behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Sensory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Respiratory</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Integumentary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Genitourinary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Function (ADL &amp; IADLs)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th>Action &amp; Safety (Respond)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Interventions</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Number of trials</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Duration of intervention</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outcome of intervention</strong> (consequence)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Effective: concern modified or stopped</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ineffective: concern accelerated or continued</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R</th>
<th>Recommendation / Request (Respond)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>“I recommend ...”</strong> (specific action, non-pharm interventions, further observation, monitoring and/or referrals)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>“Can I ask you to ...”</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>“What can I do in the next _____ min/hr?”</strong></td>
<td></td>
</tr>
</tbody>
</table>

© 2016 Baycrest Geriatric Centre.
**Nurse Worksheet**

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name, Position, Location, Resident</td>
</tr>
</tbody>
</table>

**Situation (Recognize)**

<table>
<thead>
<tr>
<th></th>
<th>Current Concern: What change requires the most attention?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Priority: Non-urgent, urgent or emergency?</td>
</tr>
<tr>
<td></td>
<td>Risk: Low, slight, moderate, high, potential to escalate</td>
</tr>
<tr>
<td></td>
<td>Trigger/Antecedent: What happened prior?</td>
</tr>
</tbody>
</table>

**Background (Reflect)**

<table>
<thead>
<tr>
<th></th>
<th>Background &amp; Baseline (vs. Current Presentation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Personal and medical history</td>
</tr>
<tr>
<td></td>
<td>- Basic needs (intake, sleep, toileting, pain)</td>
</tr>
<tr>
<td></td>
<td>Sensory Observation System</td>
</tr>
<tr>
<td></td>
<td>Which system(s) are affected?</td>
</tr>
<tr>
<td></td>
<td>How? Local? Systemic?</td>
</tr>
<tr>
<td></td>
<td>- Safety &amp; Environment</td>
</tr>
<tr>
<td></td>
<td>- Neurological</td>
</tr>
<tr>
<td></td>
<td>- Mood &amp; Behaviour</td>
</tr>
<tr>
<td></td>
<td>- Sensory</td>
</tr>
<tr>
<td></td>
<td>- Respiratory</td>
</tr>
<tr>
<td></td>
<td>- Cardiovascular</td>
</tr>
<tr>
<td></td>
<td>- Integumentary</td>
</tr>
<tr>
<td></td>
<td>- Gastrointestinal</td>
</tr>
<tr>
<td></td>
<td>- Genitourinary</td>
</tr>
<tr>
<td></td>
<td>- Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td>- Function (ADL&amp;IADLs)</td>
</tr>
</tbody>
</table>

**Action & Safety (Respond)**

<table>
<thead>
<tr>
<th></th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of trials &amp; duration</td>
</tr>
<tr>
<td></td>
<td>Outcome of intervention (consequence)</td>
</tr>
<tr>
<td></td>
<td>Effective: behaviour modified or stopped</td>
</tr>
<tr>
<td></td>
<td>Ineffective: behaviour accelerated or continued</td>
</tr>
</tbody>
</table>

**Nursing Assessment (Respond)**

<table>
<thead>
<tr>
<th></th>
<th>“I have ruled out ...” (basic needs, delirium or other body system change, deterioration of a chronic condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“I think the problem may be ________.”</td>
</tr>
</tbody>
</table>

**Recommendation / Request (Respond)**

<table>
<thead>
<tr>
<th></th>
<th>“I recommend ...” (non-pharm or pham interventions, labs, consults, further assessment, review of medication side effects, monitoring, and/or transfer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Can I ask you to ... ?” (specific action)</td>
</tr>
</tbody>
</table>

© 2016 Baycrest Geriatric Centre.
APPENDIX B: HEAD-TO-TOE REPORT EXAMPLE

Remember: Look up, down and around

The following examples are based on a case study shown during the education day. The first example is listed in a systemic reporting approach and the second is arranged in a sensory observation approach. In both types of reports, descriptions written in **bold blue** represent a sign or symptom that a healthcare provider might report to the team.

Situation Description:
When it was time for activities, Mr. Smith was lethargic with negative affect and interaction with staff. Resident declined participating in his usual programs and reports being uninterested in them. He is more withdrawn than usual.

Patient Background:
Mr. Smith is an 85-year old resident, who likes to eat and attend sing-a-long activities. He is usually pleasant and his wife visits regularly in the evenings.

| Table 9. Comparison of the Systematic Reporting and Sensory Observation Reporting Approaches |
|-----------------------------------------------|-----------------------------------------------|
| **Systematic Reporting Approach** | **Sensory Observation Reporting Approach** |
| Safety | Look & See: (Neuro, Mood, Sensory, Respiratory, CV, Integumentary, GI, GU, MSK, Safety) |
| Resident sitting in armchair with no safety issues noted. | • Awake, _lethargic_ but converses appropriately. Non-verbal signs of pain not present but resident was not asked verbally. |
| **Neurological/ Psychological** | • **Negative in his affect and is interacting more negatively with staff.** |
| Awake, _lethargic_, but converses appropriately. Face is even from left to right. Complete and organized thoughts, understandable but has negative theme. Unable to observe limb strength. The resident was not asked verbally if he was in pain, but no non-verbal signs of pain were present. | • Regular breathing. No noted discomfort with breathing. |
| **Mood & Behaviour** | • No edema observed. Not diaphoretic. |
| **Negative affect observed. Negative interaction with staff. Resident declines to participate in the programs he usually attends.** No restlessness but more withdrawn than usual. | • Skin pink. No wounds seen at this time. |
| **Sensory** | • Resident sitting in chair. Able to turn his head from side to side with no noted discomfort. |
| He does not wear glasses or hearing aids. He can hear | • Resident sitting in armchair with no safety issues noted. |

**Listen & Hear: (Neuro, Sensory, Resp, GI)**
• Complete and organized thoughts, understandable but has a negative theme.
well. No known tactile risk issues.

**Respiratory**
Regular breathing. No noted discomfort. No cough.

**Cardiovascular**
No edema observed. No subcutaneous lines. Not diaphoretic. Unable to feel warmth of skin at this time.

**Skin**
Skin pink. No noted wounds at this time. No excessive sweating noted.

**Gastrointestinal**
Unable to observe oral mucosa, teeth, abdomen or elimination.

**Genitourinary**
Unable to observe elimination at this time.

**Musculoskeletal**
Resident sitting in chair. Able to turn his head from side to side with no noted discomfort.

**Function: ADLs, IADLs, Programs, and Roles**
Resident is reporting that he is not interested in his usual activity at this time.

**Smell: (Integumentary, GI, GU)**
- Unable to smell

**Touch & Feel: (Neuro, Sensory, CV, Integumentary, GI, MSK)**
- Unable to test limb strength.
- Unable to feel warmth of skin at this time.

**Consider Further: (Neurological, Respiratory, Cardiac, Skin, Sensory, Musculoskeletal, Gastrointestinal, Genitourinary, Mood/Behaviour, Safety, ADLs)**

Also, Mr. Smith...
- Declines to participate in the programs he usually attends.
- Is reporting that he is not interested in his usual activities at this time.

The systematic approach gathers all observable data under a system and the sensory observation reporting allows for multiple systems observation grouped under how the resident was observed.
APPENDIX C: WHAT DOES “OK” MEAN?

It is helpful for healthcare teams to establish normal baseline functioning of residents as a reference point for reporting that they are “OK.” This allows caregivers to prioritize changes in residents as they occur. Below, one such list of normal baseline functioning by system is suggested for a general resident population. It is important that the team agrees on the meaning of “OK” and normal baseline functioning.

Neurological, Mood, Senses, Musculoskeletal & Function

- Awake, alert, converses appropriately
- Speaks in complete and organized thoughts
- No behavioural or psychological symptoms of dementia observed
- Positive affect, no sad mood reported
- Using glasses, hearing aid, and mobility aids appropriately and safely
- Moves without difficulty or discomfort
- Equal limb strength from left to right
- Steady gait
- No dizziness when moving
- Non-verbal signs of pain not observed, no pain reported
- No change in ADL level
- Engaging in activities as per usual

Respiratory

- Breathing on room air
- Equal rise and fall of chest
- No cough or wheezing heard
- No increased work of breathing observed

Cardiovascular & Integumentary

- No change in skin color
- No new swelling to arms, legs, abdomen
- Denies chest pain, pressure or discomfort
- No wounds, skin tears, pressure ulcers, bruises
- No excessive sweating

Gastrointestinal & Genitourinary

- No change in appetite
- Mouth clear, no observed sores
- Eating by mouth and taking in 100% of offered food and drinks
- Abdomen not swollen; soft when touched
- Passing flatus; last bowel movement less than 3 days ago
- No changes to continence level
- Toileting routine effective


