Nursing Documentation for the Six Qualifying Conditions

CNA Training Slides

NY-RAH Goals

The goal of the **N**ew **Y**ork–**R**educing **A**voidable **H**ospitalizations (NY–RAH) project is to reduce the number of potentially avoidable transfers and hospitalizations

Efficient and effective communication is the cornerstone of the care delivery process

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Objectives

Early identification and recognition of signs and symptoms of any of the six qualifying conditions in nursing facility residents

Documenting complete, consistent, and accurate information in the residents' charts

Reporting findings appropriately via the Stop and Watch, SBAR, **AND** verbal communication

Improve the quality of communication between the staff while improving clinical outcomes for residents

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Objective Information

Objective information: Based on facts

What you see, hear, feel, and smell

Consistency of information, content, and sequence enables the giver and receiver to know what to expect and execute the **BEST** next steps

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Importance of CNA Role

Information presented will assist in enhancing **your practice**

It's about the resident BUT it's also **about you!**

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Importance of CNA Role

CNAs play an **extremely** important role in caring for the residents

You are the first line of defense for your residents

You know the resident's **normal** behavior pattern so you will be able to recognize any early warning signs of a problem the resident may exhibit

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Observation

EYES

- Observe body language
- Skin color
- Breathing pattern
- Facial expression
- Nasal Flaring

NOSE

- Any odor to breath
- Body odor

EARS

- Sneezing
- Coughing
- Raspy breathing
- Crying or moaning
- Wheezing

TOUCH

- Skin temperature
- Skin texture
- Skin moisture
- Pulse

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Document

Document findings on the Stop and Watch tool (paper/kiosk)

Document intake and output

Any other findings as per facility protocol

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Stop and Watch

What is Stop and Watch?

- An early warning documentation tool

What is it for?

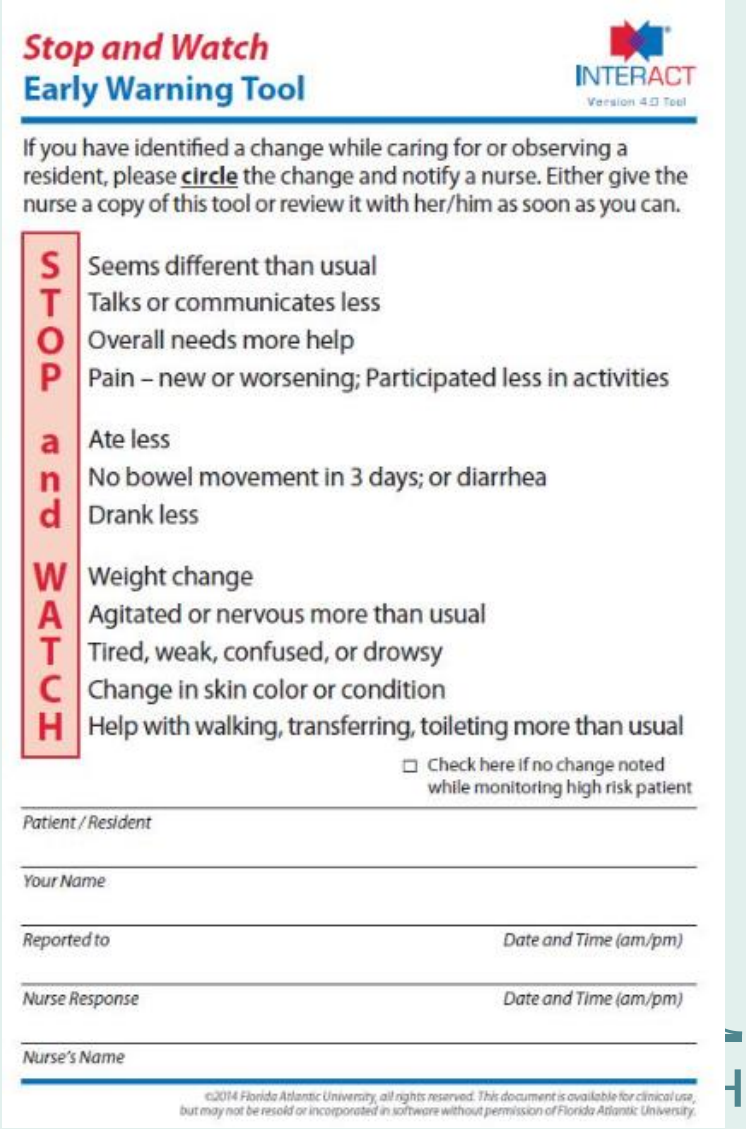
- To document and communicate changes in a residents condition to the nurses

Why is it important?

- Routine monitoring high risk residents

Who can complete it?

- Can be completed by CNAs, all nursing home staff, and family members



Stop and Watch
Early Warning Tool

INTERACT
Version 4.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

NY–RAH Qualifying Conditions

- Congestive Heart Failure (CHF) is a chronic condition in which the heart doesn't pump blood as well as it should

CHF

- Chronic Obstructive Pulmonary Disorder (COPD) is a group of lung diseases that block airflow and make it difficult to breathe
- Asthma is a risk factor for developing COPD

COPD/Asthma

- Pneumonia is an infection that inflames air sacs in one or both lungs, which may fill with fluid

Pneumonia

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NY–RAH Qualifying Conditions

- Dehydration is a condition that results when the body loses more water than it takes in
- This imbalance disrupts the usual levels of salts and sugars present in the blood, which can interfere with the way the body functions

Fluid/ Electrolyte Disorder

- A Urinary Tract Infection (UTI) is an infection in any part of the urinary system, the kidneys, bladder, or urethra

UTI

- Cellulitis is a bacterial infection of the skin and tissues beneath the skin
- Sometimes cellulitis appears in areas where the skin has broken open, such as the skin near ulcers or surgical wounds

Skin Ulcer/Cellulitis

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Respiratory Conditions: CHF, COPD/Asthma, Pneumonia

What to look for when Observing Residents

Food Intake

- Decreased appetite
- Did the resident skip a meal or eat less that 50% of their meal?
- Is this a new pattern?

Breathing

- Difficulty breathing during the meal?
- Are they struggling to breath when they talk?
- Are they having difficulty breathing while walking?
- Do they stop frequently to catch their breath when walking?

Lethargic

- Does the resident appear tired? Sleepy?
- Does the resident have any complaints?
- Do they complain of feeling lightheaded?

Bloating

- Do their shoes feel tight?
- Swollen Ankles?

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What to Report to the Nurse

Appearance

- Behavioral Changes (confused, agitated)
- Nausea, vomiting, or diarrhea
- Pain: facial grimace
- Color of skin: pale, blue or grey to lips, nail bed, tip of nose and ear lobes
- Sweating, chills
- Appears more tired than usual
- Sitting up to breathe
- Doesn't look their usual self

Vital Signs

- Respirations; number of breaths per minute
- Rate: regular or irregular
- Depth: shallow or slow
- Type: labored, mouth breathing, pursing the lips
- Temperature: rectal if able (higher or lower than normal)
- Pulse Oximetry

Pulse

- Rate
- Rhythm regular or irregular

Cough

- Dry
- Productive

Sputum color

- Clear, white, pink, green etc.

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Sample Respiratory Report

Report clear and concise information about the resident to the nurse; the nurse will use your information as the basis for her assessment.

Resident Jones in 407A appears more confused than usual, skin feels warm and has some difficulty breathing.

She has a rectal temperature of 101 F, Respirations are 24 and shallow. She is making noise with every breath. Pulse Ox 91%

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Fluid/Electrolyte Disorder

What to look for when Observing Resident's

Mild Symptoms

- Dryness of the mouth, dry tongue with thick saliva
- Unable to urinate or pass only small amounts of urine; dark or deep yellow urine
- Cramping in limbs
- Decrease appetite
- Headaches
- Inability to sweat
- Crying with few or no tears
- Weakness, not feeling well
- Sleepiness or irritability

Moderate to Severe Symptoms

- Confusion and disorientation
- Bloated stomach
- Rapid but weak pulse
- Dry or sunken eyes with few or no tears
- Wrinkled skin; no elasticity
- Breathing faster than normal
- Recurrent falls
- Fainting

What to Report to the Nurse

Monitor intake and output of fluids

Report and Record

the amount of fluids the resident drank and the amount of food the resident ate	the amount, color, odor of the resident's urine

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Sample Electrolyte Disorder/ Dehydration Report

Report clear and concise information about the resident to the nurse; the nurse will use your information as the basis for her assessment.

Resident Jones in 407A appears more confused than usual, she complained about dizziness on ambulation.

Her lips are dry and cracked and her urine is less than 50 cc, dark with a strong odor.

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UTI

What to look for when Observing Residents

Urinary tract infections (UTIs) are very common among residents

- Some residents may or may not have symptoms
- Some residents may have no pain, no burning, no odor to their urine, no frequency BUT they may have profound changes in behavior
  - Not wanting to get out of bed; sleeping all day
  - Not wanting to eat
  - Behavior which will be considered bizarre for the resident

Not all the symptoms of a UTI have to do with urine!

- Residents may exhibit signs of:
  - AMS, confusion
  - Agitation
  - Hallucinations
  - Other behavior changes
  - Poor motor skills
  - Falling

What to Report to the Nurse

Monitor for

- Painful urination
- Urine that appears cloudy
- Bloody urine
- Strong or foul smelling urine
- Fever
- Night sweats
- Shaking or chills
- Pain in upper abdomen, back or sides
- Change in color or consistency of urine

Report and Record

- the amount of fluids the resident drank and the amount of food the resident ate
- the amount, color, odor of the resident's urine

You can be asked to assist with getting a urine specimen

You will be asked to assist with monitoring the resident's vital signs, especially temperature

Report clear and concise information about the resident to the nurse; the nurse will use your information as the basis for her assessment.

Resident Jones in 407A appears more confused than usual, skin feels warm and urine is dark with a strong odor.

I took Ms. J to the bathroom twice in the last 20 minutes and she made very little urine; she continues to rub her left side and lower left back.

Sample UTI Report

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Skin Ulcer/Cellulitis

What to look for when Observing Residents

For residents who remain in bed for long periods, pressure sores can occur in a number of areas:

- Back or side of the head
- Rims of the ears
- Shoulders or shoulder blades
- Hip bones
- Lower back and tail bones
- Back or side of knees
- Heels, ankles and toes
- Any other areas where equipment can cause pressure; like under the tracheostomy cuff

Residents who use a wheelchair for long periods are more likely to develop a pressure sore on the parts of the body where they rest against the chair like:

- Tailbone or buttocks
- Shoulder blades
- Spine
- Back of arms and legs

Skin Appearance

- Red
- Warm
- Rash
- Sores
- Blisters
- Tears
- New or abnormal lesions
- Foul odor from an existing wound

What to Report to the Nurse

Monitor and Inspect Skin DAILY

- Look for early warning signs showing an issues with the skin
  - Discoloration of the skin (red, purple or blue)
  - Odor from a new or existing wound
  - Torn or swollen skin
  - Warmth
  - Swelling
  - Cracks or calluses

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Sample Skin Ulcer/ Cellulitis Report

Report clear and concise information about the resident to the nurse; the nurse will use your information as the basis for her assessment.

Resident Jones in 407A is sitting in her wheelchair for longer periods than normal; when putting her back to bed I notice she has a purple area to her right buttock.

She also has a superficial skin tear on her right ankle.

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Questions?

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