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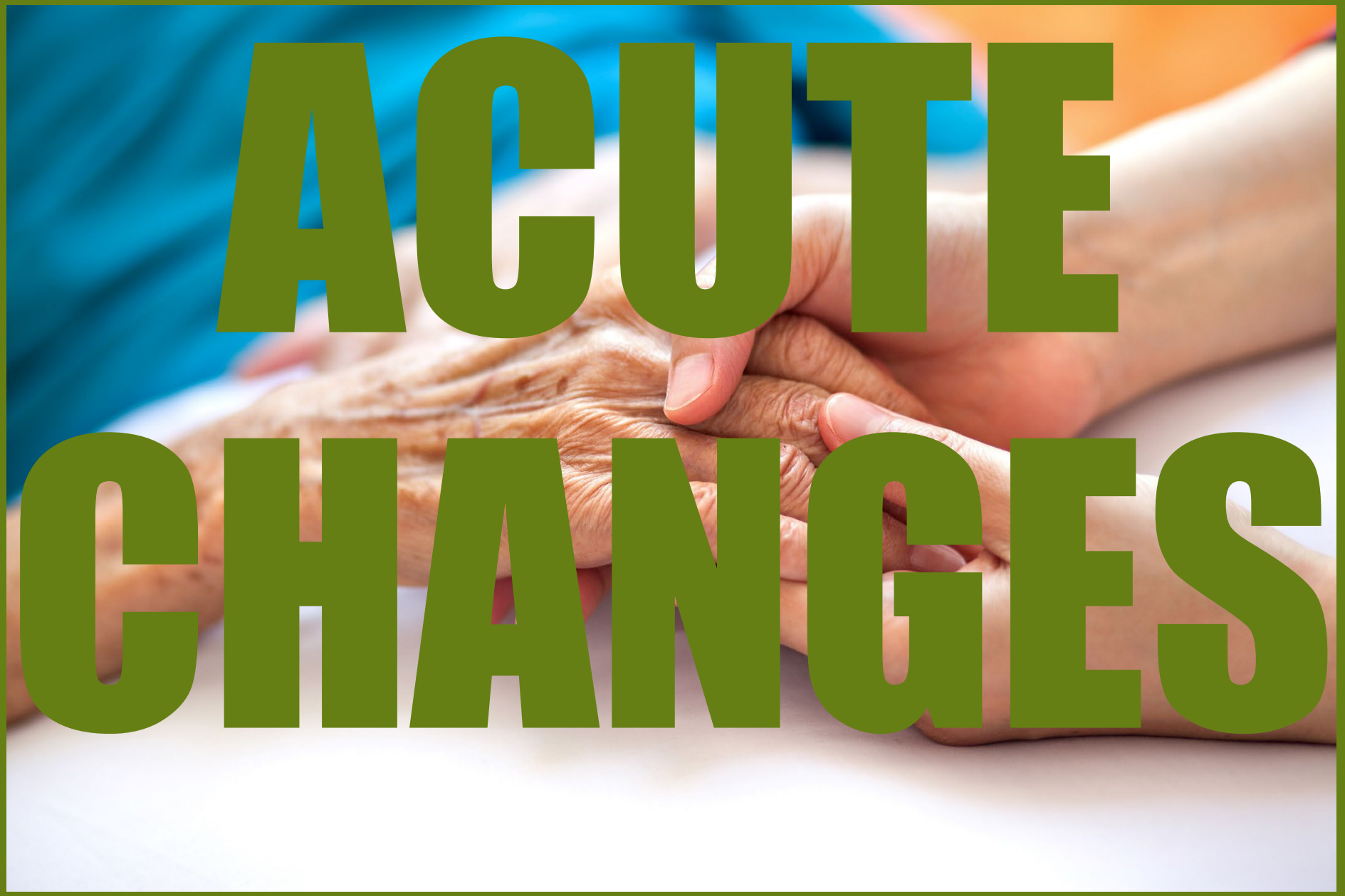
NURSING SUPERVISOR

RECOGNIZING CHANGES IN BODILY FUNCTIONS THAT SHOULD BE REPORTED TO THE SUPERVISOR IMMEDIATELY

OBSERVING, REPORTING AND DOCUMENTING CLIENT STATUS AND THE CARE OR SERVICES PROVIDED, INCLUDING IN FUNCTIONAL ABILITY AND MENTAL STATUS DEMONSTRATED BY THE CLIENT


ACUTE
CHANGES

CAREGIVERS ROLE

- As a professional caregiver, you are the eyes and ears for families, other healthcare professionals and an advocate for your client
- Your role is especially important as you are helping to ease the worries of families who cannot provide full-time care for their loved ones by ensuring someone is there for their loved one when they are away
- Your role is also pertinent for the family members who are juggling care for their own children and aging parents simultaneously
- A professional caregiver's training and supervision are essential for identifying problems in vulnerable elders before they become larger and even potentially life threatening issues

- Our immune system becomes weaker as we age
- As we age, various health conditions may arise, both acute and chronic – it is vital to recognize acute changes to prevent complications
- Acute changes are sudden changes in health condition that requires assessment and treatment promptly to prevent complications. They may be a sign of a new or worsening underlying issue, ex:
  - Urinary Tract Infection or UTI
  - Progression of cognitive decline
  - Depression
  - Increased risk for falls

ACUTE CHANGES

REMEMBER

NOT ALL *ACUTE* CHANGES PRESENT THEMSELVES THE SAME, BUT SOME KEY INDICATORS MAY HELP TO IDENTIFY THESE CHANGES THAT SOMETHING IS *NOT RIGHT*

- Mood swings
- Changes in eating habits
- Weight fluctuations
- Hallucinations
- Physical injuries
- Sudden partial or complete weakness

BE FAST

STROKE

Learn the signs of heart attack

Chest discomfort

Sweating

Upper body discomfort

Nausea

Shortness of breath

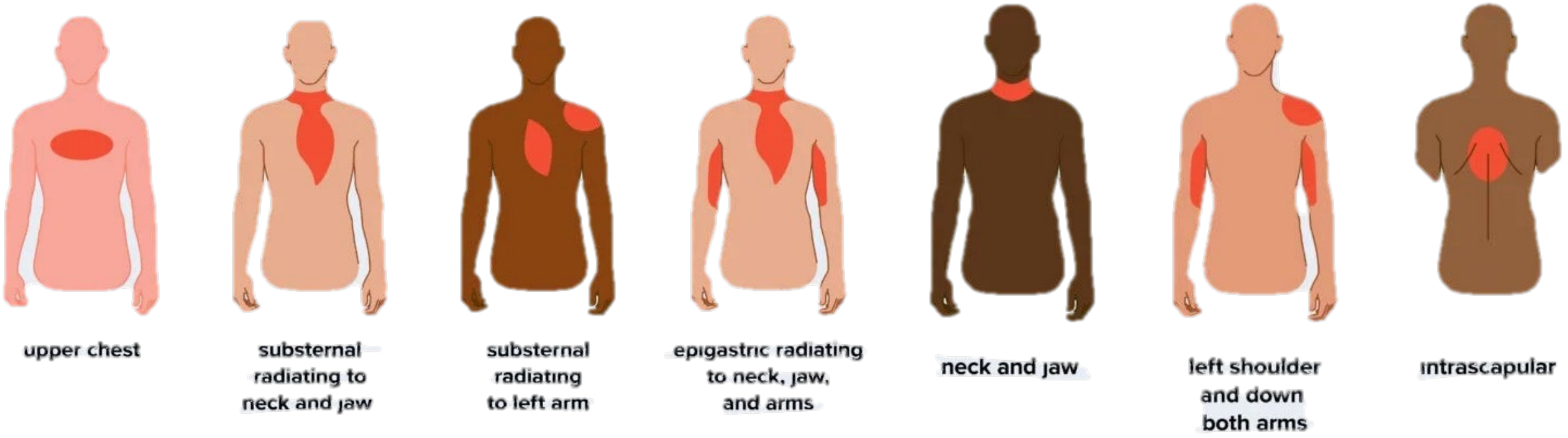
Light-headedness

If you experience any of these signs, call 9-1-1 immediately.

heartandstroke.ca/heartsigns

Heart&Stroke™

HEART ATTACK



WHERE IS HEART ATTACK PAIN

CAREGIVER RESPONSIBILITY

- Both skilled and unskilled in-home caregivers are responsible and equipped with elder care training, especially education regarding signs to look for that may alert in sudden change of health status
- An attentive caregiver who knows their client well and can detected sudden changes can save a life, and responsibility to report include:
  - Detecting a new behavior or condition changes
  - When to alert their supervisor
  - When to inform a senior's family members of the changes and how they will be addressed
  - When to call 911
- Even if an elder client has not experienced any changes in their condition, their family and care coordinator should routinely be updated on the elder client health condition and care. Care coordinators and supervisors routinely review their record and assess their health and functional status to see if any modifications should be made to their care plan

- You make observations about clients all day long. You may worked with them for few days or few months and know their baseline. Once observing and noting a change in their health or having a concern regarding their health, when should you report it and to whom? In order to best decide how to report your observations, they will be grouped according to the following priority levels:

URGENT

IMPORTANT

SIGNIFICANT

- We will discuss in the next few slides this categories in more details

UNDERSTANDING PRIORITY LEVEL

▪ YOU MUST STOP WHAT YOU ARE DOING AND REPORT TO YOUR SUPERVISOR IMMEDIATELY OR CALL 911!

- You observe an abnormal finding that urges immediate medical attention
- An actions or observation cause harm
- Accidental harm or injury, such as falls
- Life threatening abnormal findings
- ABC's abnormal observations
  - Airway
  - Breathing
  - Circulation
- Abnormal vital signs
  - Very high blood pressure >180/100
  - Critical temperatures or fevers >101F
  - Any other abnormal vital signs
  - Note only family members or a visiting nurse may check vital signs

URGENT

- This observations and findings require you to record your observations and report them to your supervisor promptly for proper intervention to take place
- May be done as soon as you finish completing your current task
- Includes signs and symptoms that require an intervention but are not an immediate life threatening situation
- Examples include:
  - Loss of appetite
  - Weakness and fatigue
  - Fevers
  - Nausea and/or vomiting
  - Inability to sleep
- Report can be done to the supervisor and family members. Remember that supervisor must always be notified, and family members will be notified by supervisors

IMPORTANT

- This third category is for observations that are not life-threatening and do not require immediate or quick response, but still need to be noted and recorded
- Signs and symptoms that should be recorded in details in the client chart record
- There is no urgency but these abnormal observations should not be ignored
- Examples include:
  - Forgetting to change the linens
  - Changes in preferences for specific foods
  - If client is alone for prolonged period of time or has no family or friends

SIGNIFICANT

A FEW THINGS TO KNOW

TO OBSERVE

- Paying close attention to the client and the surroundings while gathering information through some or all of the 5 senses: eyes, ears, nose, touch, taste.

TO REPORT

- Contacting a supervisor to verbally describe any urgent, important or significant observations. Documentation is done in writing and stored in the client record
- Your report should always be followed by a detailed entry in the client chart indicating what was observed, the date and time of the observation, and who reported the observations (including full name and title)
- **If it wasn't documented – it didn't happen! Everything MUST be documented**

TO RECORD

- Writing and verbal explanation of the observation. A detailed account of the observations in the client's plan of care is dated, including who reported it, and who accepted the report
- Follow up interventions or actions taken following the report
- Any resolutions of the reported information

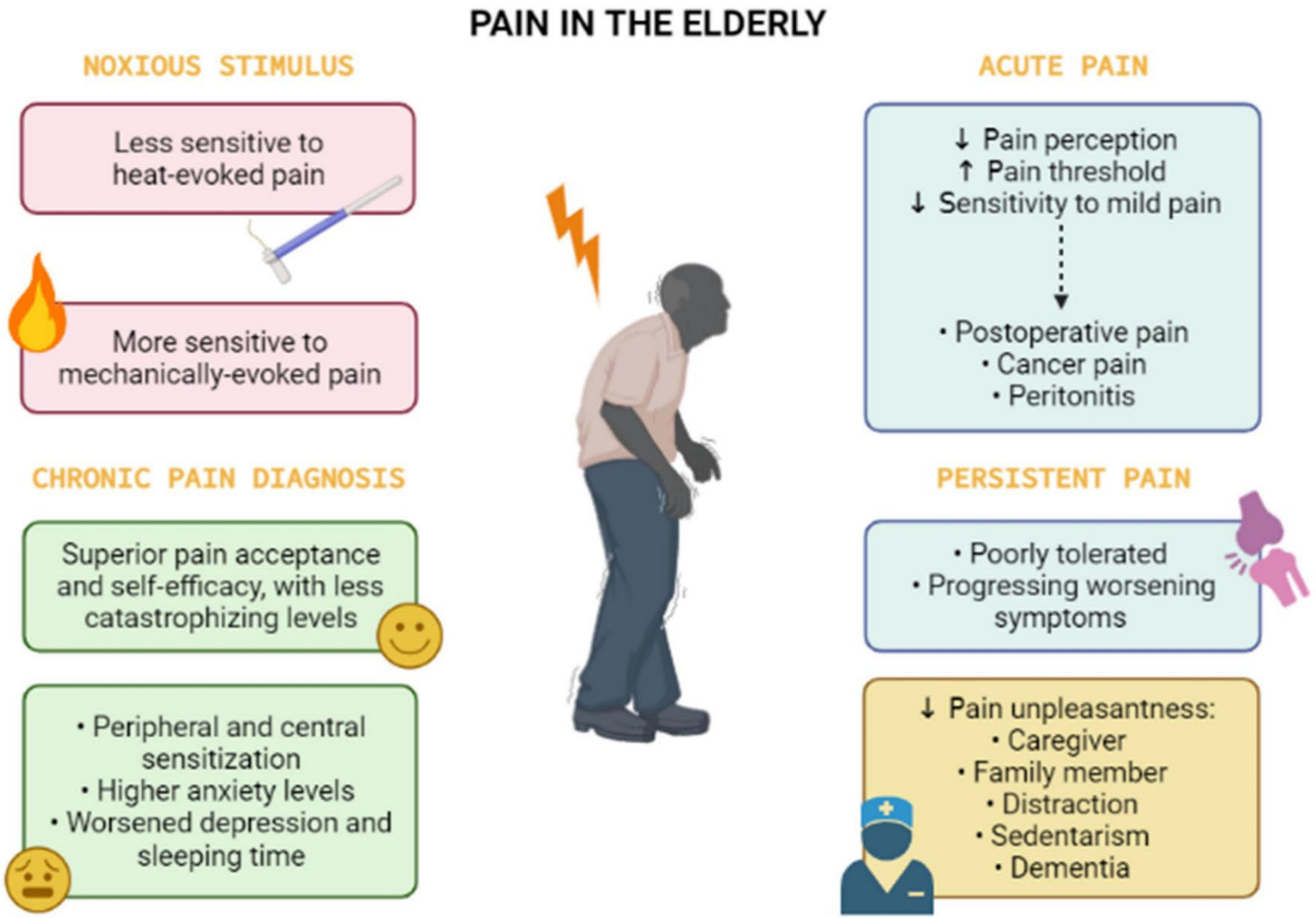
OBJECTIVE VS SUBJECTIVE

OBJECTIVE OBSERVATIONS

- Information that can be seen, heard, smelled, felt or measured and confirmed by another person
- Vital signs
- A description of urine (including amount, color and clarity)
- Reporting that client has a “shuffling gait”
  - A type of gait (walking) characterized by dragging one's feet along or without lifting the feet fully from the ground

SUBJECTIVE OBSERVATIONS

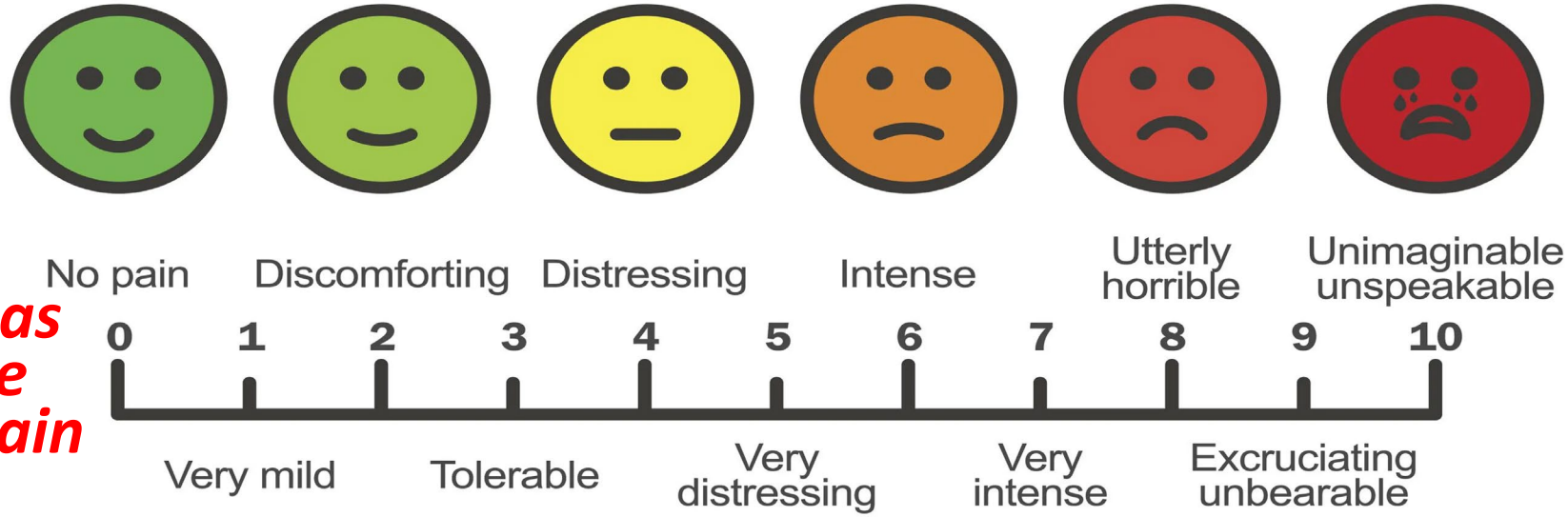
- Pieces of information that cannot be (or were not) observed
- They are based on something reported to you by the client or your suspicions
- Your client reports feeling sad or lonely
  - You cannot see, hear, smell or feel the feelings yourself. . . and there is no way to measure or confirm the information
  - You report the client’s exact words in the chart: “Client states, ‘I feel so lonely since my children moved to another state”



UNDERSTADNING PAIN IN THE ELDERLY

PRIORITY LEVEL: IMPORTANT!

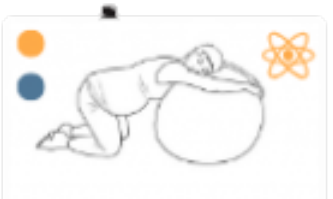
- Pain is considered the 5th vital sign (blood pressure, heart rate, temperature, breathing)
- It is just as important to know of your client's pain level as it is to know how they are breathing or if their blood pressure is too high
- Currently, at European Service we do not have a specific guidelines for pain scale, but you may use the 10 point scale or the "FACES" scale pictured here. Ask your client to rate their pain on a scale of 1 to 10 with "0" being no pain and "10" being the worst pain ever
- If pain is significant or unrelieved, it must be reported and client may need to be evaluated by a medical professional
- Clients who are nonverbal may express pain in other ways, such as wincing, frowning, crying or holding on to the painful area



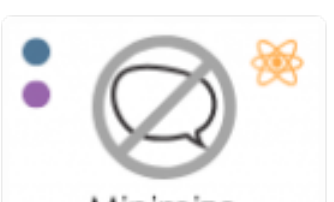
Every client has the right to be pain free and pain relieving measures

PAIN

support person



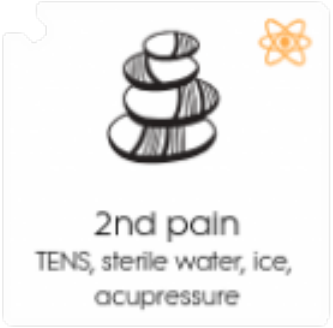
-Mobility-
change positions



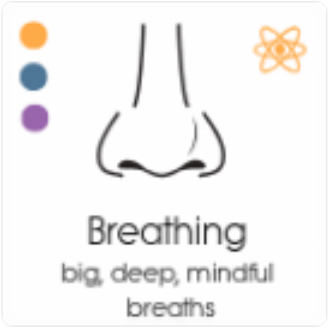
Minimize
talking &
interruptions

Hypnosis
or guided
meditation

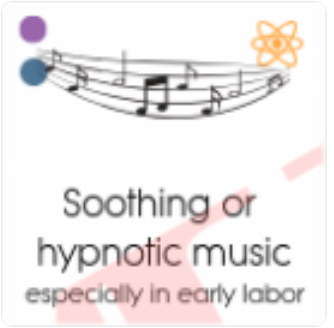
Shower
Tub/Pool



2nd pain
TENS, sterile water, ice,
acupressure



Breathing
big, deep, mindful
breaths



Soothing or
hypnotic music
especially in early labor

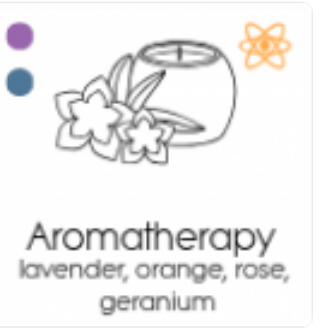
-Massage-
Light (tickly) or firm
pressure

Mindfulness/
Non-focused
awareness

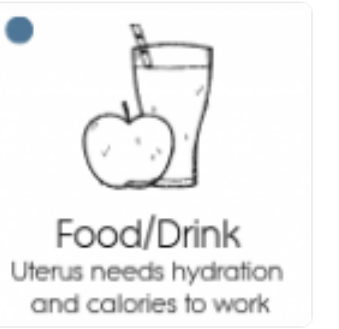
Low Lights

hip/tailbone
massage, press

Cool/Hot



Aromatherapy
lavender, orange, rose,
geranium



Food/Drink
Uterus needs hydration
and calories to work

NON PHARMACOLOGICAL PAIN MANAGEMENT

- Heat
- Cold
- Massage
- Relaxation / Visualization
- TENS Unit
- Aromatherapy
- Wearable Therapies
- Music Therapy
- Physical Therapy
- Exercise / Movement
- Structured Support
- Yoga
- Repositioning
- Distraction
- Guided meditation
- Shower / Bath
- Acupuncture
- Foods / Beverages

NON PHARMACOLOGICAL PAIN MANAGEMENT

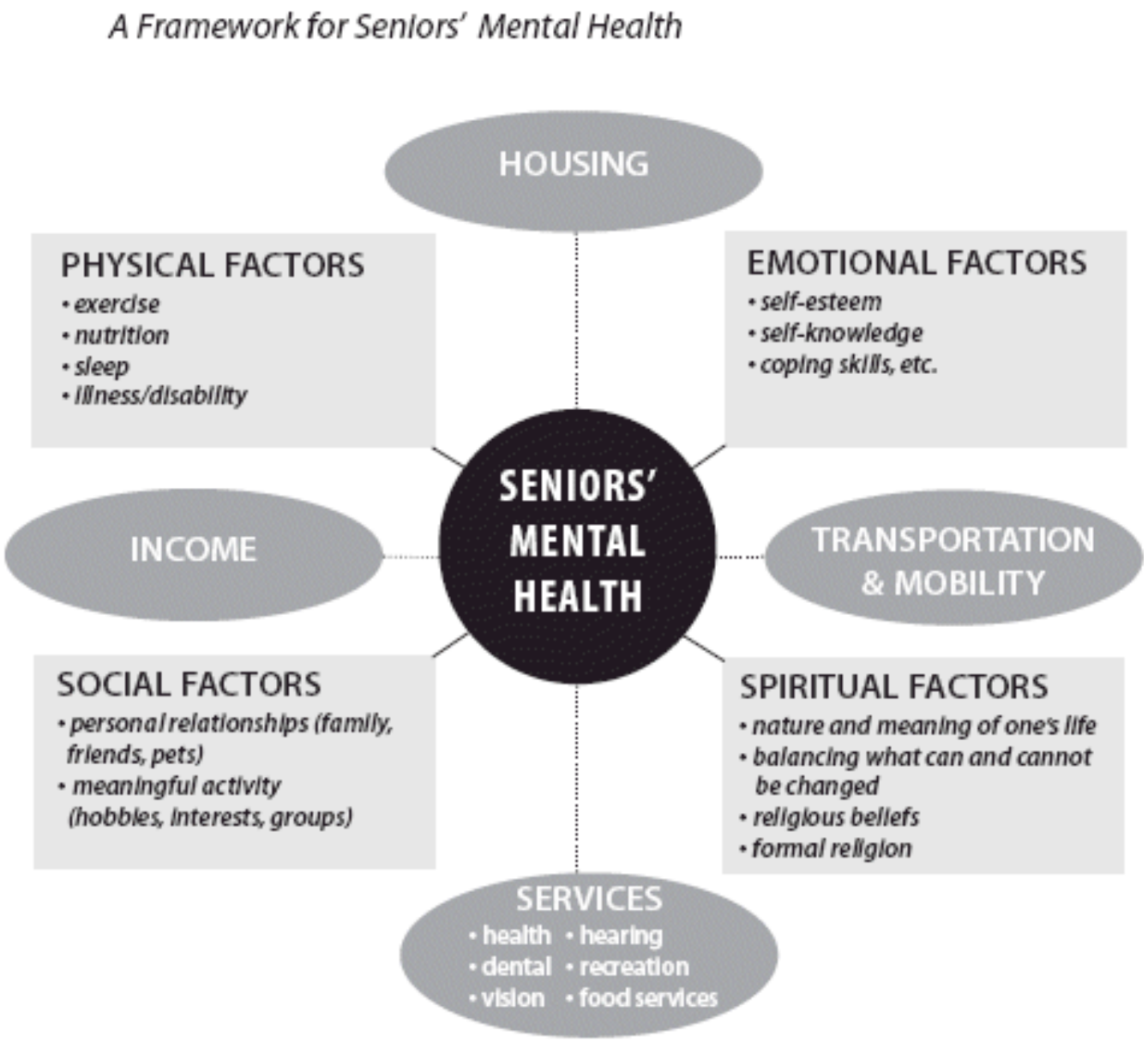
NORMAL VS ABNORMAL FINDINGS: PAIN

NORMAL FINDING

- Many older adults mistakenly believe that some degree of pain is a normal part of getting older
- Some may fear becoming addicted to pain medication
- It is important to understand that pain is ***not*** normal and can be usually relieved
- Remember, pain is *subjective*. This means pain is whatever your client says it is

ABNORMAL FINDING

- **Joint Pain**: may also observe swelling or decreased range of motion.
- **Muscle Pain**: especially after a fall, accident, or new exercise routine
- **Abdominal Pain**: maybe accompanied by nausea, vomiting or diarrhea; make note of any swelling or bulging areas
- **Non-Verbal Pain Cues**:
  - Guarding (protecting the painful area)
  - Grimacing (frowning)
  - Moaning
  - Agitation or Restlessness
  - Diaphoresis (excessive sweating)
  - Change in Vital Signs
- **Chronic Pain**: clients who have lived with pain for a long time may work very hard to try to not show pain. Some signs your clients suffers from chronic pain are:
  - Rubbing or Bracing
  - Decreased Activity
  - Sighing



MENTAL STATUS

PRIORITY LEVEL: IMPORTANT!

MENTAL STATUS

- Mental status is the measure of how well your client *functions* and *feels emotionally*, *intellectually* and *socially*
- **Keep in mind, <u>you</u> are observing for *any* change from what is "<u>normal</u>" from your client**
- If you have a client with Alzheimer's who is routinely confused and shows impaired judgment, you will not need to report this right away as you would in a client who does not usually have these symptoms. However, be vigilant and observe for changes in behavior that may warrant decline in mental status
- Report your observations to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of visit or care
- Examples:
  - Lack of sleep or inability to sleep
  - Lack of appetite
  - Aloofness
  - Isolation
  - Weakness
  - Increased confusion

PRIORITY: IMPORTANT!

TIPS TO ENSURE MENTAL HEALTH OF ELDERLY DURING PANDEMIC

Reconnect with family or ask them to share their life experiences with children

Perform routine exercises together like yoga, meditation etc.

Revisit old memories through pictures and videos

Suggest them to read spiritual books

Look for hobbies that interest them

	NORMAL FINDINGS	ABNORMAL FINDINGS
APPEARANCE	**Posture** is erect **Dressed** and **groomed** appropriately for weather **Smooth**, **even body movements**	**Hunched** or **stopped** **Curled** up in bed **Disheveled** (untidy and messy) **Restless** and fidgety movements
LEVEL OF CONSCIOUSNESS	**Awake**, **alert** and **aware** of their surroundings and your presence	**Confused** (slow to respond or irrational responses) **Lethargic** (difficult to stimulate) **Coma** (unable to wake up)
MOOD	**Appropriate** to client's place and circumstances **Cooperative** **Pleasant** **Calm**	**Flat** (lacks emotional expression) **Depressed** (sad, tearful) **Anxious** (worried, nervous) **Irritable** (easily angered, annoyed)
ORIENTATION	**Alert and aware of time** (date, day, year), **place** (current location), **person** (who they are, own name), and **purpose** (who you are, why you are here, what's going on)	**DISORIENTED** Client becomes confused about the date or purpose and what is going on, whereas under normal circumstances they would be fully aware
THOUGH TPROCESS	**Conversations make sense** **Logical** and **rational**	**Illogical** (ideas are disconnected and run together) **Blocking** (stops in the middle of a thought)
PERCEPTION	**Aware of reality**	**HALLUCINATIONS** Sees, hears or feels things that are not really there

NORMAL VS ABNORMAL FINDINGS

Why and When would Memory be an issue?

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

- Memory changes can be a sign of aging, medication interaction, or be an underlying symptom of a condition that needs medical attention and intervention

- It's **normal** if your elderly client forgets the name of someone she just met or where she put her purse
- It is **not normal** when memory affects activities of daily living

- For example: your client suddenly has trouble remembering how to get dressed or find her way around a familiar place
  - Normal memory loss doesn't get much worse over time
  - Dementia gets worse over a short period of time

***Be sure to report any Abnormal memory problems affecting your client**

THINK ABOUT IT

Nutrition is about more than just eating!

It's about providing the **right TYPE** and the **right AMOUNT** of *fuel* to support the day-to-day needs of each individual

Nutrition can be affected by *emotions, illness, chemotherapy* and *radiation, culture* and *economics*

Nutritional needs *change* with age and activity level

One size **does not** fit all when it come to "***normal***" nutrition

As an attentive caregiver, you should **RECORD** observations in detail in the chart regarding your client nutrition, if required. Most symptoms of abnormal nutrition can be corrected and **should not** be ignored

FOCUS ON NUTRITON

PRIORITY LEVEL: SIGNIFICANT

MyPlate for Older Adults

A healthy AND balanced diet helps improve energy levels, improve overall body health and mood

Fruits & Vegetables

Whole fruits and vegetables are rich in important nutrients and fiber. Choose fruits and vegetables with deeply colored flesh. Choose canned varieties that are packed in their own juices or low sodium.

Healthy Oils

Liquid vegetable oils and soft margarines provide important fatty acids and some fat-soluble vitamins.

Herbs & Spices

Use a variety of herbs and spices to enhance flavor of foods and reduce the need to add salt.

Fluids

Drink plenty of fluids. Fluids can come from water, tea, coffee, soups, and fruits and vegetables. Be cautious of any fluid restrictions.

Grains

Whole grain and fortified foods are good source of fiber and B vitamins

Dairy

Fat-free and low-fat milk, cheeses and yogurts provide protein, calcium and other important nutrients, including gut health and help maintain bone mineral density.

Protein

Protein rich foods provide many important nutrients including building strength and improving the healing process in the body during recovery. Choose a variety including nuts, beans, fish, lean meat and poultry.

FOCUS ON NUTRITION

PRIORITY LEVEL: SIGNIFICANT

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

NORMAL VS ABNORMAL FINDINGS: NUTRITION

FOCUS ON ELIMINATION

PRIORITY LEVEL:

IMPORTANT

Many older adults mistakenly believe that incontinence, constipation and hemorrhoids are just part of normal aging. . . ***BUT THAT IS NOT TRUE!***

These are things that can usually be treated or prevented with proper and timely intervention

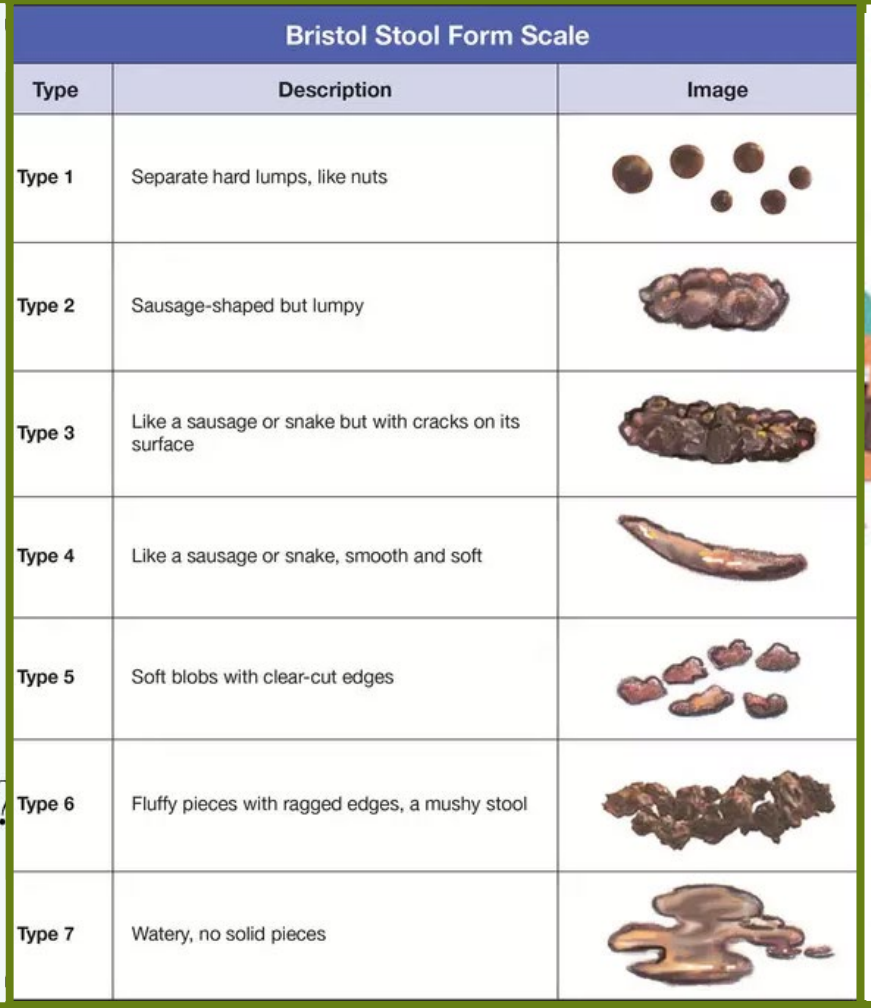
It is *important* that **YOU** know what's **normal** and wh **not** so you can help your clients understand the bodies a little better

Knowing what to look out for and how to recognize changes in your client elimination habits may help you recognize and report any **abnormal** observations thus start intervention promptly

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

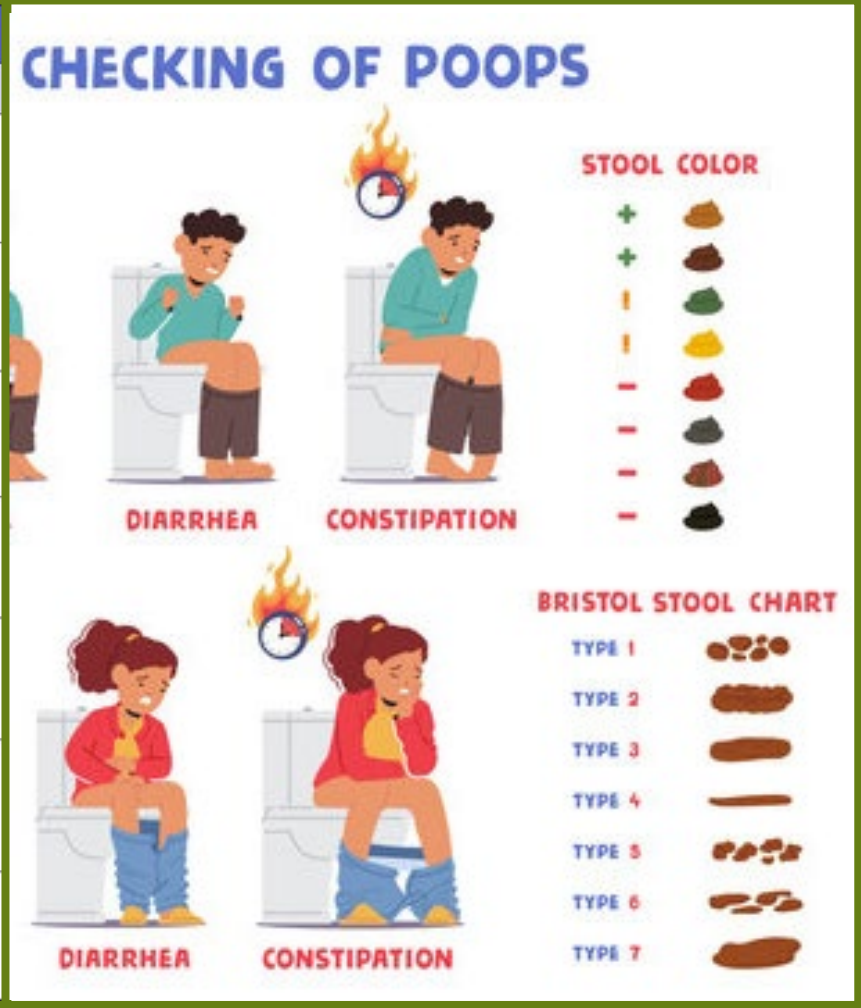
	NORMAL FINDINGS	ABNORMAL FINDINGS
URINE OUTPUT	**AMOUNT**: **1200-1400ml per day** **COLOR**: **clear** to **dark yellow** **ODOR**: light "nutty" odor **No pain or burning** **Consistent bladder control**	**AMOUNT**: **less than 1200ml** (may be due to dehydration, not drinking enough liquids, or a medical condition); **more than 1500ml** (may be due to overhydration, diabetes, or clients taking diuretics – 'water pills', or other medical condition) **COLOR**: **dark amber** (dehydration); **dark red** or **brown** (blood in the urine) **ODOR**: **foul** odor (infection) **Pain or burning** with urination (infection or dehydration) **Incontinence**
BOWEL OUTPUT	**AMOUNT**: **once a day**, but can be normal up to x3 times a day or as little **as once every 3 days** **SHAPE**: **formed**, **firm**, **soft** **COLOR**: **light** to **dark brown** **No pain or straining** **Consistent bowel control**	**AMOUNT**: **Diarrhea** (frequent, watery stools); **Constipation** (no BM in more than 3 days); **Fecal I****mpaction** (stool forms a large and hard ball that client is unable to pass naturally. Watery leakage and cramping pain is common) **COLOR**: **white** or **yellow** stool (absorption issue, needs to be addressed by doctor); **black** or **red** stool (blood in stool) **Pain** or **straining** (may need to increase fluids or fiber in diet) **Incontinence**

NORMAL VS ABNORMAL FINDINGS: ELIMINATION



Bristol Stool Form Scale

Type	Description	Image
Type 1	Separate hard lumps, like nuts	
Type 2	Sausage-shaped but lumpy	
Type 3	Like a sausage or snake but with cracks on its surface	
Type 4	Like a sausage or snake, smooth and soft	
Type 5	Soft blobs with clear-cut edges	
Type 6	Fluffy pieces with ragged edges, a mushy stool	
Type 7	Watery, no solid pieces	



NORMAL AND ABNORMAL SIGNS

URINE AND BOWEL OUTPUT

FOCUS ON SKIN

PRIORITY LEVEL: IMPORTANT!

- Skin is an organ just like the heart and the lungs

In fact, skin is the largest organ of the human body!

- Just like you wouldn't ignore an abnormal heart rate or abnormal respirations, you shouldn't ignore skin abnormalities:
  - **Wounds**
  - **Rashes**
  - **Redness**
  - **Pain**
  - **Swelling**
  - **Bruising**
  - **Discoloration**
  - **Skin tears**
  - **Other new or unusual problems with the skin**

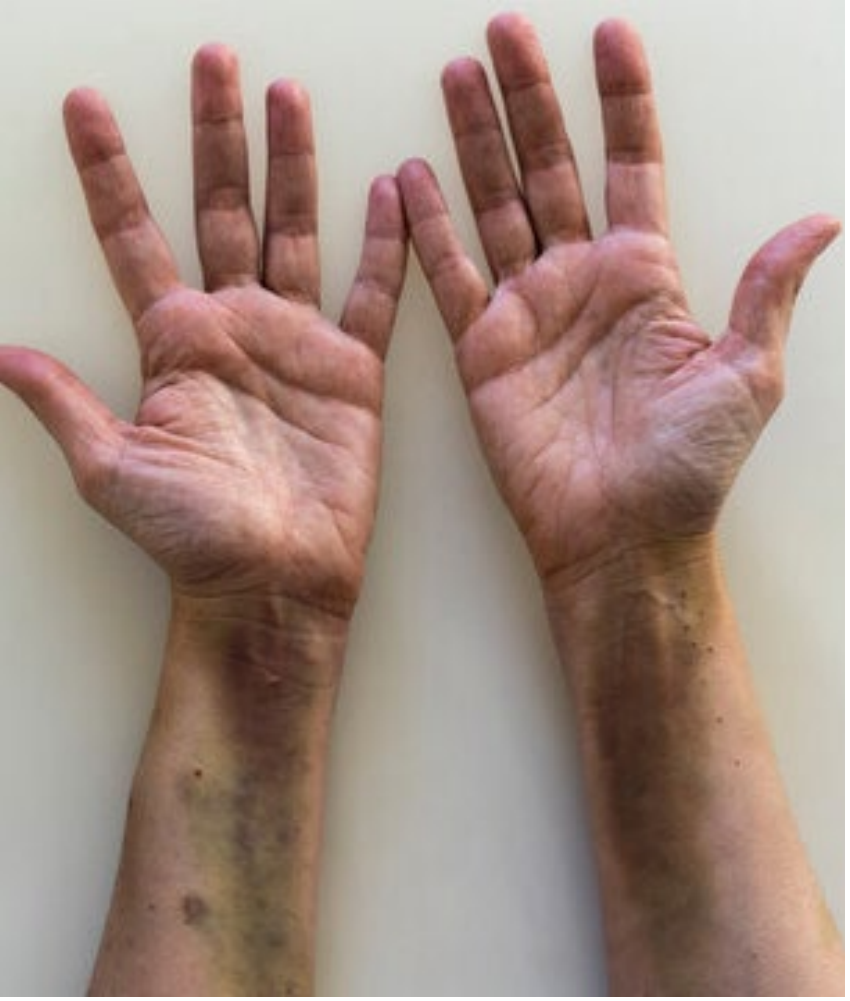
- Any break in the skin, whether it is a cut, tear, burn or pressure ulcer, leaves the body *vulnerable to infection*
- Infection in the elderly, immunocompromised or ill clients can be **DEADLY**
- **Report your observations** to the nurse or supervisor and, if required, make a detailed note in the client's chart upon completion of care

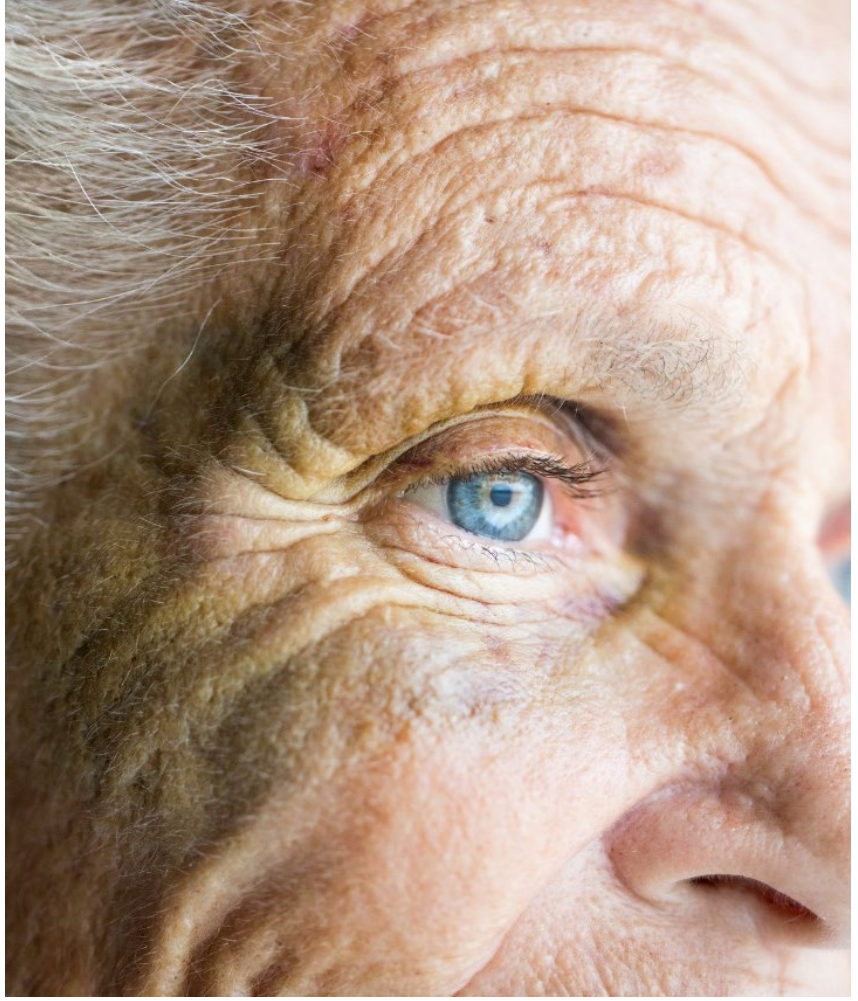
FOCUS ON SKIN

PRIORITY LEVEL: IMPORTANT!

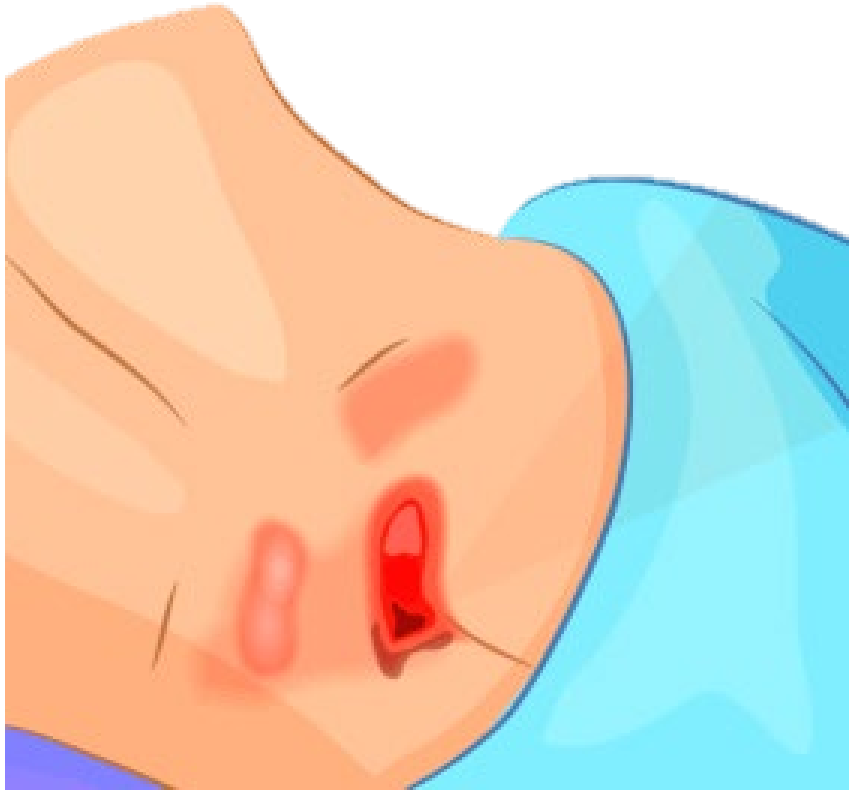
	NORMAL FINDING	ABNORMAL FINDING
COLOR	**Consistent with genetic background** Varies from pinkish to dark brown May have yellow or olive undertones	**Pallor** or **ashen gray** ("loss of color"; can be a sign of blood loss, anemia or shock) **Widespread redness** **Cyanosis** (blue colored skin; can be a sign of shock, lack of oxygen or poor circulation)
TEMPERATURE	Feels **warm** Hands and feet slightly cooler	**Hypothermia** (temperature less than 97.2F) **Hyperthermia** (temperature greater than 104F)
MOISTURE	**Normal perspiration** in response to activity or environment	**Diaphoresis** (extreme sweating, soaking through clothing and bedding) **Dehydration** (eyes, nose, mouth, lips look and steaky, cracking)
BRUISING	**No bruising or unusual skin discoloration** Normal or small bruising from occasional bumps and heals appropriately	**Multiple bruises** (many bruises in multiple stages of healing may indicate ***abuse*** and **must be reported**) **Bruises on face, chest or abdomen, pelvic area, arms or legs**
PRESSURE SORES	**No signs of pressure sores**, redness or pain	**Pressure sores present** (recognize early stages of a pressure sore and **report** them; redness, pain, tenderness, skin pealing)

NORMAL FINDING VS ABNORMAL FINDING: SKIN





PRESSURE SORE INJURY



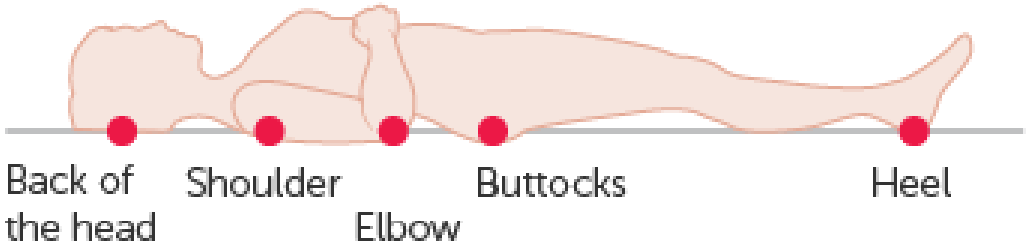
STOP ELDER ABUSE AND NEGLECT

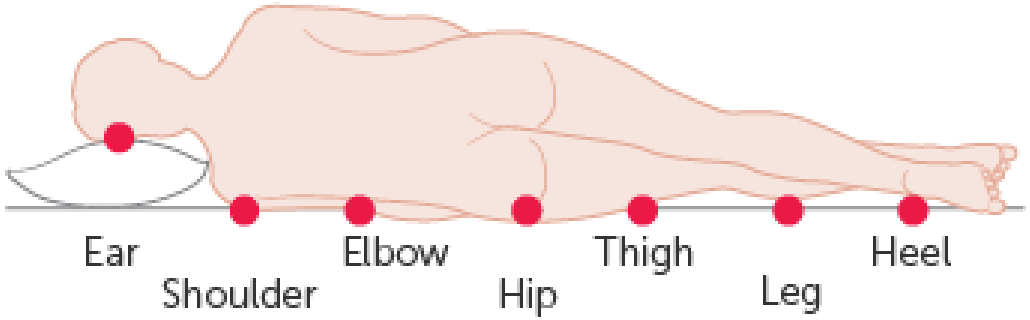
MULTIPE BRUISES IN VARIOUS STAGES OF HEALING MAY BE A SIGN OF ABUSE – YOU MUST REPORT IT!!!

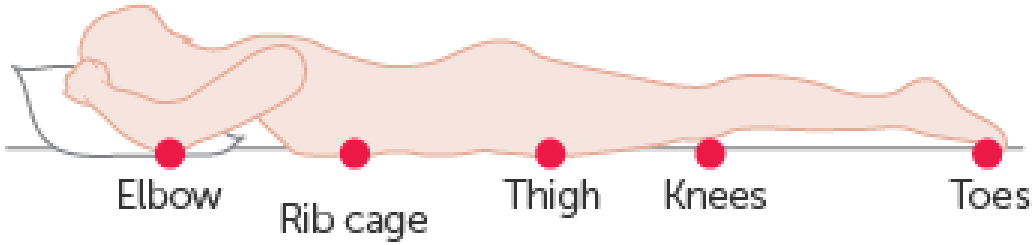
REPORT SUSPICION OR OBSERVATION OF PRESSURE SORE INJURY!!!

STAGES OF PRESSURE SORES

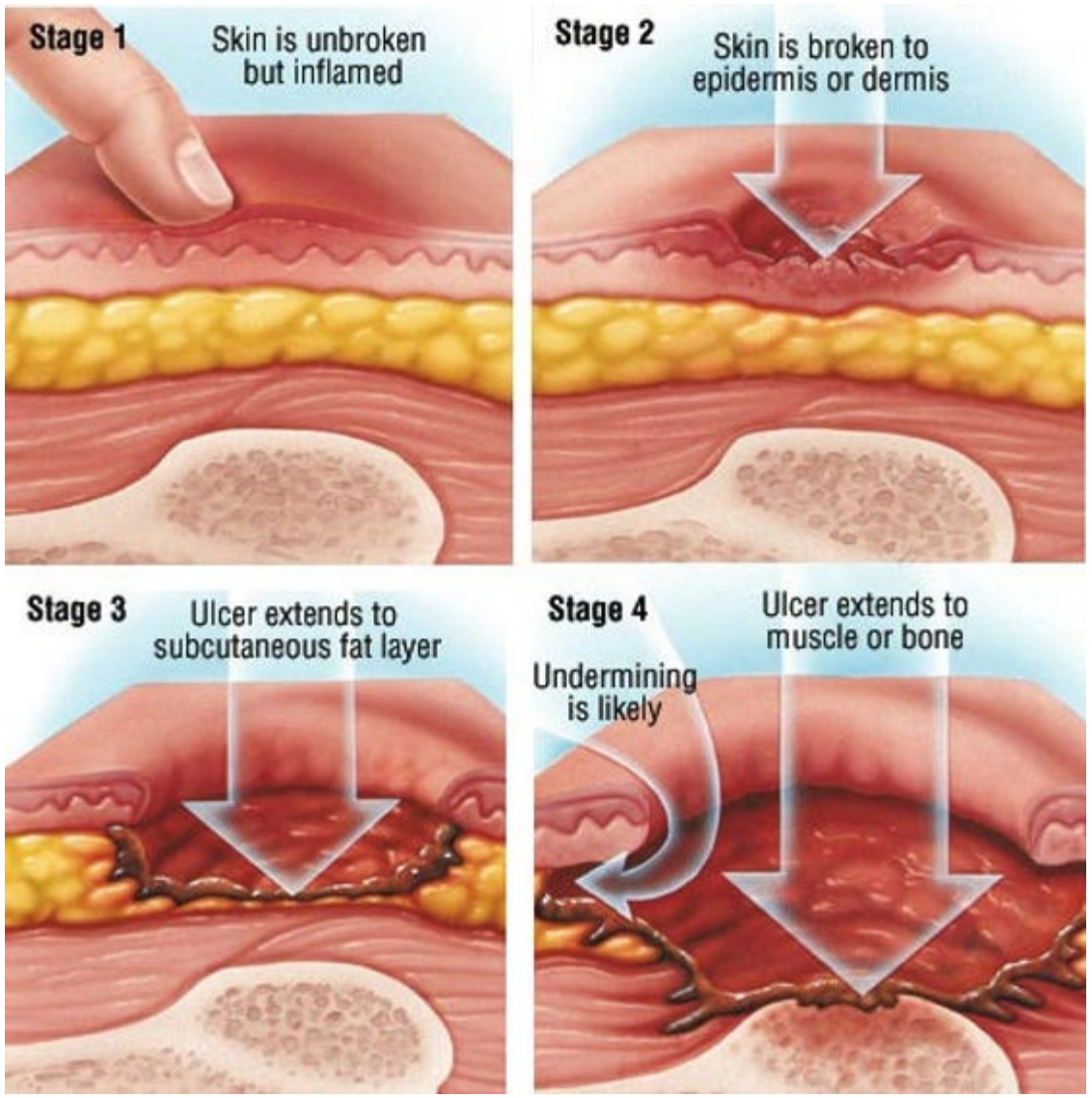
- Early recognition or pressure sores is vitals to stop it from progressing. Your observations are VITAL and must be reported to prevent complications
- Early signs include pale skin or slightly reddened area over a bony area
- Client may complain of pain, tenderness, burning, or tingling
- **<u>Prevention is KEY!</u>** Ensure to *keep moving*! If client is in the *chair*, they need to *shift* their position from *side to side every 15 minutes*! If they are in bed, they *must* be repositioned *every 1-2 hours*!







- **STAGE 1**
  - Skin over bony area is **intact** but **pink** or slightly **reddened**
  - May be **painful** or **tender**, **tingly** or **sore** to touch
  - In ***darker skin*** it may appear **ashen**
  - May complain of slight **itching** or mild **tenderness**
- **STAGE 2**
  - Skin is **red** and **swollen**
  - **Blister** or an **open area** may be noted
  - **Painful** and sore
- **STAGE 3**
  - Area begins to look like a **crater**
  - Area is **open and sore**, **painful** at the surface
  - Opening will extend **deeper into the skin**
  - May see **skin** and **muscle** tissue or **fat**
- **STAGE 4**
  - Sore is extended **very deep** into the tissue, including **muscle**, **fat** and/or **bone**
  - There may be thick dark scabs called **eschar** – this is dead tissue
  - There may be **no complains of pain** anymore



STAGES OF PRESSURE SORE / BEDSORES

pressure ulcer prevention

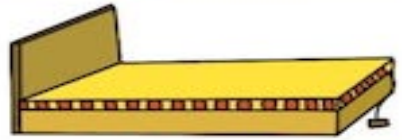
Soniasparkles.com

S — Surface

Mattress type can relieve pressure

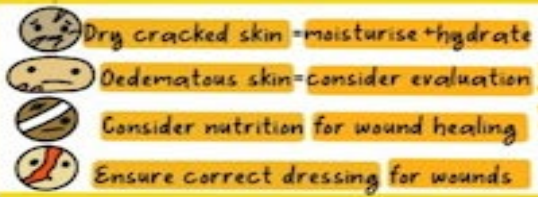
Check cushions relieve pressure

Check equipment integrity



Use specialist equipment

S — Skin inspection



Early inspection = early detection

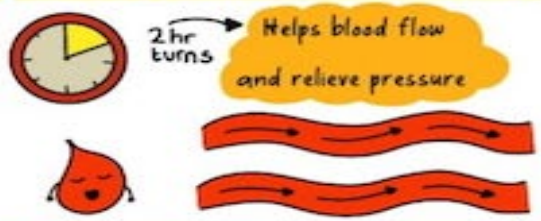
Carry out full daily skin inspection

Educate on early signs of pressure damage

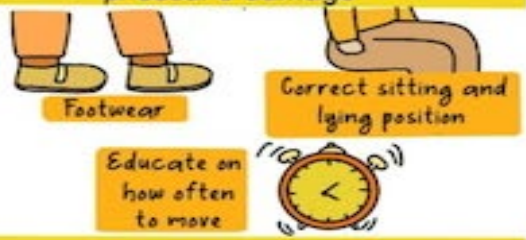
Check vulnerable areas

K — Keep moving

Keep moving to prevent pressure damage



Change positions every 2 hours



Encourage independent movement

Promote gentle exercise

I — Incontinence/ moisture

Barrier creams seal out wetness

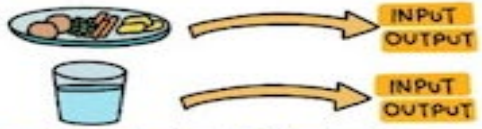
Prevent moist weakened skin

Continence wipes for personal use

Emollients prevent skin dehydration

N — Nutrition/ hydration

Healthy diet speeds up healing process



Monitor food & fluid intake - consider Dietician

Complete MUST assessment

Weight extreme increases risk

FOCUS ON FAMILY AND RELATIONS

PRIORITY LEVEL: SIGNIFICANT!

- Families come in all shapes and sizes and defining a family as *healthy* and *functional* is difficult and **subjective**. However, there are a few "*red flags*" or *abnormal observations* you can be aware of that— when properly reported—may actually prevent needless harm or suffering for your client
- It's important to understand that if you **OBSERVE** or **SUSPECT** your client is being **ABUSED**, you have an **obligation to report** that abuse right away
- You should get yourself and your client out of harm's way as soon as possible, if situation becomes dangerous
- **RECORD** your observations in detail in the chart, if required. Personal relationships can be difficult to deal with but **should not be ignored**

PRIORITY LEVEL: SIGNIFICANT

FAMILY AND RELATIONS

NORMAL VS ABNORMAL FINDINGS: FAMILY

NORMAL FINDING	ABNORMAL FINDING
HEALTHY, FUNCTIONAL FAMILY AND SUPPORT • Power roles are **equal**, there is respect and trust • **Conversations** can be playful and humorous • Family members **listen to each other** • The family is able to **admit when help is needed** and seeks professional support • The client is **connected** to the larger community • Client keeps in touch with neighbors, attend church and have friends and other family members they **keep in touch** with **regularly** • Client has a **good support system** within their community	**DICTATORSHIP** • One caregiver is making all the decisions without others input or consideration **FEAR OR ANXIETY** • The client becomes frightened, fearful, tearful or withdrawn around certain members of the family **ANGER** • Every family has a history and grudges can be held for a long time • Anger leads to violence or other destructive behavior – it should be address by a professional **SUSPICIONS** • Your client may feel suspicious of certain family member or person. Its important to explore whether this suspicion is rational or irrational **SUBSTANCE ABUSE** • Any substance abuse by your client or other family member in the house can lead to dangerous, destructive or harmful behavior and must be reported **ISOLATION** • Clients and family members who do not reach out to friends, community, or other family members or professionals when needed will become isolated






5 KEY TAKEAWAY POINTS TO REMEMBER

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

5 KEY TAKEAWAY POINTS TO REMEMBER

FINAL TIPS: SOME ADDITION ABNORMAL OBSERVATIONS

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

THANK YOU FOR ALL YOU DO!
QUESTIONS?