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# Nurse Assessment:
# *Acute Changes in Condition*

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## Target Audience

Nurse

## Learning Objectives

- Describe normal age-related changes.
- Differentiate chronic versus acute conditions.
- Recognize symptoms and changes in vital signs, physical function, mental function, and body condition that could indicate acute conditions.
- Apply the assessment phase of the nursing process as it relates to managing an acute change in condition.

## Directions

Read through the handout below. Stop and answer questions at the checkpoints.

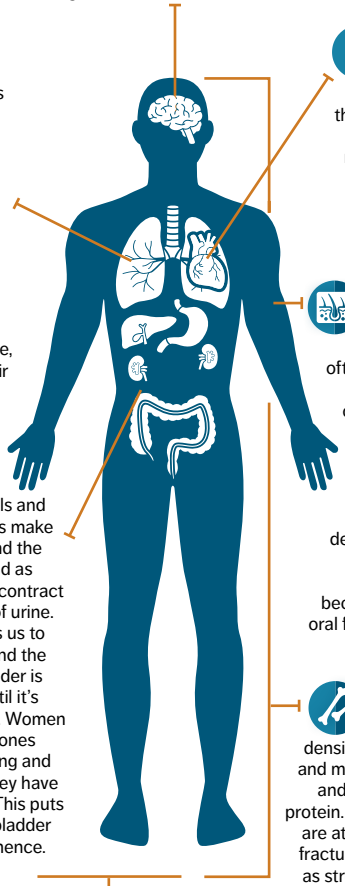
## Age-Related Changes

As we age, there are normal physiological changes that occur that put the geriatric resident at risk for illnesses and injuries. These changes also put the geriatric resident at risk for multiple chronic conditions, making nursing care very complex and dynamic. The nurse must assess subtle changes and work with the medical team to differentiate normal changes of aging from acute changes in condition, both of which can be compounded by the chronic conditions already present.

**Thinking** - The brain and blood flow to the brain change as we age, but it's a myth that confusion or dementia and memory loss are a normal part of aging. Changes in thinking happen because of a disease such as Alzheimer's or damage to the brain such as can happen during a stroke or cerebrovascular accident (CVA).

**Respiratory -** Respiratory muscles weaken; lungs become smaller and flabbier; blood flow decreases; the airway closes early, stopping full exhale short; and the gag and cough reflex aren't as strong. These changes put the elderly at risk for respiratory infections. It also means it takes more energy to breathe, and the exchange of air isn't as effective.

**Cardiovascular** The heart wall and valves in the heart thicken. There are fewer pacemaker cells. This means the heart has to work harder to pump blood and may have difficulty getting the signal telling it to beat.



**Skin -**The skin cells change shape and they don't renew as often. There is decreased moisture, sweat, and oil production. The skin thins and there is a loss of subcutaneous tissue. This puts the elderly at risk for slowed wound healing, development of pressure ulcers, skin tears, and bruises. The skin also becomes dry and requires oral fluids and lotion to help keep it moist.

**Urinary -** There is a decrease in kidney cells and blood flow; the kidneys make more urine at night; and the bladder doesn't expand as much to hold urine or contract as strongly to get rid of urine. The message that tells us to drink isn't as strong, and the message that the bladder is filling up is delayed until it's almost or is totally full. Women have changes in hormones which can cause leaking and make them feel like they have to urinate frequently. This puts the elderly at risk for bladder infections and incontinence.

**Bones & Muscle -** The bones lose their density; reaction times slow; and muscles decrease in size and their ability to process protein. This means the elderly are at risk for falls, as well as fractures. The muscles aren't as strong and don't have the same endurance, or ability to coordinate movement, making it more difficult to do Activities of Daily Living (ADLs).

**Temperature Regulation -** There is a decrease in subcutaneous fat; the ability to sweat and shiver declines; and circulation diminishes. This causes the elderly person to have a lower normal body temperature, and a decreased febrile response when they are sick, meaning they may not have a fever when they are sick or the temperature isn't far above their normal when they do have a fever.

## Checkpoint

**After reading about age-related changes and what they can mean, check if you have cared for residents with the following:**

- ☐ Urgency or stress incontinence?
- ☐ Respiratory infections multiple times a year?
- ☐ Temperature that averages below 98.6?
- ☐ Falls caused by orthostatic hypotension?

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### Acute vs. Chronic

Many residents in your care have chronic conditions. A chronic condition is usually long-term and often incurable. Residents can also have an acute condition. An acute condition has a sudden onset, is short-term, and can be treated and eliminated. See the examples below of acute and chronic conditions.

| Acute | Chronic |
|---|---|
| Delirium | Dementia |
| Pneumonia | Chronic Obstructive Pulmonary Disease (COPD) |
| Acute Heart Failure | Congestive Heart Failure (CHF), High Blood Pressure/ Hypertension (HTN) |
| Urinary Tract Infection (UTI) | Benign Enlarged Prostate |
| Fracture | Arthritis or Osteoporosis |

**Residents have an especially high risk for developing acute conditions because:**

- They already have chronic diseases that make them susceptible to acute conditions.
  - Their body systems have changed with aging and are not as effective at protecting against illness.
  - Due to multiple chronic conditions, residents often take many medications. Medication side effects and interactions are leading contributors for triggering an acute condition change.
  - Recent hospitalizations increase the risk for developing new acute conditions.

***Assess, Don't Assume!***

When a nurse assumes the resident's symptom(s) reported by the CNA are just normal or to be expected because they're old, they have let that assumption stop them from proper assessment. This is not good nursing practice. When there is an acute change occurring, the geriatric resident may have a rapid decline in their condition, even though the signs were very subtle initially. Residents count on you to assess them and identify problems. Your actions ensure they receive proper treatment and avoid unnecessary pain, complications, and hospitalization. Don't let assumptions stop assessment.

**Checkpoint**

As you read, check off any acute changes you have seen in the residents you are caring for.

### *Vital Signs*

- ☐ A rise or drop in their usual temperature. (Keep in mind that many older people have normal body temperatures that are lower than 98.6° F. For a resident who has a normal body temperature of 97° F, a temperature of 99° F could indicate a fever, even though this type of temperature may not cause concern in a younger person.)
- ☐ Blood pressure that was 20 mm Hg lower or higher than normal. (Note that orthostatic hypotension is a systolic blood pressure decrease of at least 20 mm Hg or a diastolic blood pressure decrease of at least 10 mm Hg within three minutes of standing.)
- ☐ Pulse that was lower than 60 or higher than 100 beats per minute or had a change in pulse quality, i.e. thready, weak, rapid, or bounding.
- ☐ Respirations that were fewer than 12 or greater than 20 breaths per minute. Or, if the resident had changes in respiratory effort, such as labored, pursed-lipped breathing, or use of accessory muscles.
- ☐ O2 saturation was less than 90%

### *Physical Function*

- ☐ Reduced functional ability (ADL decline)
- ☐ Unsteady gait
- ☐ Fatigue doing activities that didn't cause fatigue previously

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### *Mental Function*

- ☐ Change in level of consciousness
- ☐ Inappropriate responses or change in speech
- ☐ Inability to follow directions
- ☐ Mood changes and/or agitation, irritability
- ☐ Poor judgment
- ☐ Increased or new confusion
- ☐ Change in interest level for activities

### *Body Condition*

- ☐ Change in skin tone, diaphoretic, furrowed tongue
- ☐ Discoloration, bruising, rashes, or open areas
- ☐ Body parts that do not appear to have their normal shape or movement
- ☐ Edema or change in weight

### *Symptoms*

- ☐ Shortness of breath and/or change in breath sounds
- ☐ Pain
- ☐ Dizziness
- ☐ Numbness or tremors
- ☐ Tightness in chest
- ☐ Nausea or change in eating habits
- ☐ Symptoms of hypoglycemia
- ☐ Cough
- ☐ Change in output

**Checkpoint**

**Would You Assess?** Decide what situations you would and wouldn't assess and mark an X in the corresponding column.

| EXAMPLE | YES, I would assess | NO, I wouldn't assess |
|---|---|---|
| Mr. Brown ate 30% of his breakfast. He usually eats 25-50% of his breakfast. | ☐ | ☐ |
| Mrs. Smith usually loves to attend activities in the morning, but the CNA reports she didn't want to get out of bed this morning. | ☐ | ☐ |
| Mr. Alverez was breathing harder than normal when the CNA helped him walk to the bathroom. | ☐ | ☐ |
| Mr. Jones is always confused, but today it's worse because he can't even find his room. | ☐ | ☐ |
| Ms. Jackson always has edema in her lower legs in the morning, and there is no change in the amount. | ☐ | ☐ |

## Checkpoint Bonus

### Practicing Assessment Skills

**Directions**

*The Staff Development Coordinator or other nurse leader will facilitate this exercise with a group of nurses. Nurses will divide into pairs. One nurse will play the role of the resident experiencing an acute change in condition while the other nurse conducts an assessment. The nurse and "resident" will need to read through their assigned scenario card before starting so they are prepared to play the roles. There are two different scenarios, so each nurse has a turn assessing a "resident." Allow a few minutes for the assessment and for the nurse to document the assessment, then debrief with the group by asking the four Debrief Questions listed below.*

***Debrief Questions***

1. What symptoms did you find during your assessment of the resident?
2. What concerns you about these symptoms and their effect on the resident?
3. Do these symptoms indicate an acute change or a chronic condition?
4. What is one thing you would improve about the narrative note you wrote?

**Scenario #1**

**Resident: Mr./Ms. Washington**

You have pneumonia and you're dehydrated. There are symptoms listed below that you can demonstrate or tell the nurse you have. You may also act out other symptoms that demonstrate symptoms of pneumonia and dehydration. Do NOT tell the nurse you are dehydrated and have pneumonia. The nurse has your vital signs but no other information.

**Symptoms:**

- Vital Signs
  - T 99.9
  - P 102
  - R 23
  - BP 98/56
- You have a fever. Complain of feeling chilled. "It's so cold in here."
- Complain of feeling lightheaded.
- Take shallow rapid breaths.
- Cough.
- Tell your nurse your urine is much darker than usual and your mouth feels very dry.
- Respond to questions as if you are more confused than normal.
- You refuse fluids and have lost your appetite.

FOLD OR CUT HERE

FOLD OR CUT HERE

**Scenario #1**

**Nurse caring for Mr./Ms. Washington**

You're caring for Mr./Ms. Washington and the CNA has reported they are worried and think he/she is sick. It's your job to assess them. You may ask questions, listen to lung sounds, touch them, etc. When you're done with your assessment, write a narrative nurse note describing the assessment findings.

**Resident's Vital Signs:**

- T 99.9
- P 102
- R 23
- BP 98/56

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## Scenario #2

**Resident: Mr./Ms. Hernandez**

You are dehydrated and have the norovirus (very contagious virus and gastroenteritis outbreaks). There are symptoms listed below that you can demonstrate or tell the nurse you have. You may also act out other symptoms that demonstrate symptoms of gastroenteritis. Do NOT tell the nurse you are dehydrated and have the norovirus. The nurse has your vital signs but no other information.

**Symptoms:**

- Vital Signs
  - T 100
  - P 98
  - R 16
  - BP 100/64
- You have a fever. Complain of feeling chilled. "I'm freezing to death."
- Tell your nurse your urine is much darker than usual and your mouth feels very dry.
- Moan and rub your stomach.
- Complain of feeling very nauseated, having diarrhea, and vomiting before the nurse came in the room.

FOLD OR CUT HERE

FOLD OR CUT HERE

## Scenario #2

**Nurse caring for Mr./Ms. Hernandez**

You're caring for Mr./Ms. Hernandez, and the CNA has reported they are worried and think he/she is sick. It's your job to assess them. You may ask questions, listen to lung sounds, touch them, etc. When you're done with your assessment, write a narrative nurse note describing the assessment findings.

**Resident's Vital Signs:**

- T 100
- P 98
- R 16
- BP 100/64

## KNOWLEDGE CHECK QUESTIONS

1. **Which of the following usually characterizes an acute condition?**
   - a. It comes on slowly.
   - b. It is short-term.
   - c. It cannot be eliminated

2. **True or false? Nursing home residents have a low risk of developing acute conditions.**
   - a. a. True
   - a. b. False

3. **Mr. Clark's vital signs usually are 98° F-70-18, BP 124/84. Which of the following vital signs would prompt you to assess Mr. Clark?**
   - a. 98.4° F-74-16, BP 128/84
   - b. 98° F-84-18, BP 118/78
   - c. 98.4° F-80-18, BP 100/60

4. **True or false? Confusion can be a sign of an acute condition in older residents.**
   - a. True
   - b. False

5. **True or false? The many chronic diseases that residents have make them more prone to develop acute conditions.**
   - a. True
   - b. False

6. **The CNA reports that Mrs. Aimes has slurred speech. When the CNA asked her how she felt, she said she was just tired. What is your best action?**
   - a. Tell the CNAs to watch her closely, allow her to get some sleep, and see what she is like at the end of the shift.
   - b. Initiate a nursing assessment.
   - c. Call 911 to have her transferred to the hospital.

7. **The CNA reported Mr. Johnson had a new cough and shortness of breath. What would you assess?**
   - a. Vital signs, including O2 saturation levels.
   - b. Lung sounds and quality of respiratory effort.
   - c. Nothing, because Mr. Johnson has COPD and you would expect him to have difficulty breathing.
   - d. Both a and b

## Checkpoint Answers

### Would You Assess

| EXAMPLE | YES, I would assess | NO, I wouldn't assess |
|---|---|---|
| Mr. Brown ate 30% of his breakfast. He usually eats 25-50% of his breakfast. | | X |
| *You would not assess him because he is eating the amount he normally does.* | | |
| Mrs. Smith usually loves to attend activities in the morning, but the CNA reports she didn't want to get out of bed this morning. | X | |
| *This is a subtle symptom that may indicate something is wrong.* | | |
| Mr. Alverez was breathing harder than normal when the CNA help him walk to the bathroom. | X | |
| *Even though he may usually have some shortness of breath, this subtle change indicates it's worse and you would assess.* | | |
| Mr. Jones is always confused, but today it's worse because he can't even find his room. | X | |
| *Even though he always has confusion, it's worse and may indicate something is wrong.* | | |
| Ms. Jackson always has edema in her lower legs in the morning, and there is no change in the amount. | | X |
| *If the swelling is unchanged from her normal, there is no change or new symptom triggering the need for assessment.* | | |

### KNOWLEDGE CHECK ANSWERS

1. b 2. b 3. c 4. a 5. a 6. b 7. d