Long-Term Care Survey Alert

STAFF DEVELOPMENT: Sharpen Your 'Illness Identification' Skills

Hint: Suspicion is your friend when evaluating common Sx.

Sometimes a common symptom such as a headache or nosebleed is a simple problem -- and other times it can herald a life-threatening crisis. And being able to tell the difference requires first and foremost the right mindset for viewing the problem at the outset.

You have to "consciously alter your index of suspicion and believe that all changes are 'something'" until proven otherwise, says **Cheryl Field, MSN, RN,** who worked in acute care before becoming a long-term care nursing and rehab expert. Thus, the nurse notes not just that the resident has a headache but asks: "What could this headache mean or what might be causing it?" Of course, not all headaches equate to strokes, says Field, a consultant with **LTCQ Inc**. in Lexington, MA. "But the nurse who responds to every headache with a complete assessment" keeping the "worst" in mind will identify stroke-related neurological changes faster, says Field.

By the same token, not all nosebleeds indicate "unstable Coumadin control," Field adds. But keeping that possibility in mind for a patient on the anticoagulant "takes the nurse down a complete assessment path" that results in early detection of problems so the physician can intervene.

Do Frequent Rounds

A second rule in assessing acute changes: You have to know the baseline in order to detect a subtle difference. Thus, licensed nurses who do frequent rounds on residents during the shift have a better chance of detecting changes, advises **Lyn Ketelsen, RN, MBA,** a consultant with the **Studer Group** in Gulf Breeze, FL. "You get to know the resident emotionally and physiologically so you can, for instance, notice that a nonverbal resident is grimacing more," which could indicate he's in pain. Nurses who encourage CNAs to report their observations that the resident has had even a subtle change are more likely to get early "red flags" to do further assessment, Ketelson adds.

Get your info in a row: As part of an assessment of a resident's change in status or somatic complaint, "obtain current vital signs and compare these to the baseline of the resident," advises Field. Also "review current medications, including any recent changes in medication regime" that could be causing the change (for more information, see the article in this issue under CARE PLANNING). You can also complete "at risk" tools that the facility uses for falls, pressure ulcers, elopement risk, etc, she adds. "These tools not only can help you identify a change but they provide a best-practice guide for new nurses" to tap advanced assessment skills, notes Field.