CARE GIVER GUIDES

For Residential Aged Care












Residential aged care Integration Programme

Waitemata District Health Board **www.wdhb-agedcare.co.nz**

Residential aged care Integration Programme

Waitemata District Health Board
Te Wai Awhina

Welcome to the Care Giver Guides for Residential Aged Care

The Care Giver Guides were developed by the Residential Aged Care Integration Programme Work Group which included Care Givers, the Waitemata DHB Gerontology Nursing Service, and leaders and clinicians working in residential aged care.

They have been reviewed by senior nurses across New Zealand and discussed in care giver focus groups.

We are delighted to offer these guides to Care Givers to support them in their practice.

The Care Giver Guides are designed to:

* **Prompt care givers to look for early warning signs of deterioration in residents' health**
* **Document their concerns clearly**
* **Report their concerns to the Registered Nurse**
* **Provide evidence based interventions for care givers**

The Care Giver Guides are to be used as a guide only. They do not replace Registered Nurse oversight and intervention; instead they enable the Registered Nurse to provide early intervention for residents.

Janet Parker RN, NP
Gerontology Nurse Practitioner
Specialised Services for Older Adults
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Cover: Photographs of some of the many Care Givers often unseen but a vital part of the work force in Waitemata DHB Residential Aged Care

DELIRIUM, DEPRESSION & DEMENTIA

RECORD / REPORT / ACTION

DELIRIUM—Onset sudden—fluctuates over 24 hours and is reversible

Definition: *A medical illness that can be treated with the expectation that the patient will recover.*

Symptoms:

- Change in behaviour
- Confusion
- Anger
- Anxiety
- Aggression
- Disorientation
- Restlessness
- Hallucinations
- Sleep disruption

Causes of Delirium

- Infection: urinary tract, chest, skin or other infection
- Low blood sugar levels
- Dehydration
- Constipation
- Pain
- Tiredness
- Change of environment
- Stroke or other diseases of the brain
- Medication—side effects
- Medical illness

What to do:

- Take temperature, pulse, respirations, blood pressure
- Check blood sugar levels
- Test urine
- Check bowel record
- Encourage fluids and record
- Quiet environment
- Calm and reassure resident
- Ensure safety—prevent falls
- Note any signs of pain

DEPRESSION—Onset gradual—duration up to 2 years

Definition: *A common mental condition that presents with depressed mood, loss of interest or pleasure.*

Symptoms:

- Irritable
- Crying
- Loss of interest
- Tiredness
- Poor concentration
- Hopelessness
- Not speaking
- Fearful
- Anxious
- Sad
- Withdrawn
- Suicidal thoughts
- Weight loss or gain
- Sleep changes

Causes of Depression

Depression can have many causes:

- Genetic / family history
- Psychological
- Social
- Physical illness
- Loss of independence
- Grief

What to do:

- Monitor and record food and fluid intake
- Listen
- Encourage resident to talk
- Spend time with the resident
- Report urgently if patient has suicidal thoughts or is self harming
- If resident unwell see ‘Delirium’

DEMENTIA—Deterioration over months or years—ongoing

Definition: *A disease of the brain which is progressive and affects memory and thinking.*

Symptoms:

- Memory loss
- Disorientation to time, place, or person
- Forgetting to eat and drink
- Forgetting how to wash or dress
- Difficulty performing familiar tasks:
  - using the toilet
  - washing and dressing
  - using fork and knife
- Changes in mood and behaviour
- Changes in personality
- Language problems:
  - using the wrong words
  - not able to speak
  - unable to understand

Causes of Dementia

- Alzheimer’s disease
- Stroke
- Parkinson’s disease
- Lewy body dementia
- Alcoholic dementia
- Vascular dementia
- Frontal lobe dementia

What to do:

- Respect and know individual needs
- Call the resident by name and approach in clear view
- Orientate to time, date and place
- Consistent daily routines
- Keep the environment calm and quiet
- Use simple instructions
- Repeat requests in a clear and simple manner
- Do not argue
- Stay calm if resident becomes agitated or aggressive
- Monitor food and fluid intake
- Follow management plan for behavioural problems
- Ensure safety/security of resident

PROMPTS

- Have I recorded all behavioural changes or problems
- Have I reported the family’s concerns
- What is the care giver follow up plan after reporting this to the RN
- Have the family been notified
- Have I completed all forms and notes and reported concerns to the RN

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DELIRIUM, DEPRESSION & DEMENTIA

FALLS, FRACTURES & INCIDENTS

Don't panic - stop and assess

Collapse

Residents who are suddenly unresponsive should receive emergency care unless clearly documented otherwise

A IRWAY

- Head tilt and chin lift to open airway

B REATHING

- Rate
- Depth
- Rhythm

C IRCULATION

- Pulse
- Blood pressure
- Colour

What to do

- Recovery position
- Capillary glucose
- Is an ambulance required

*Recovery position

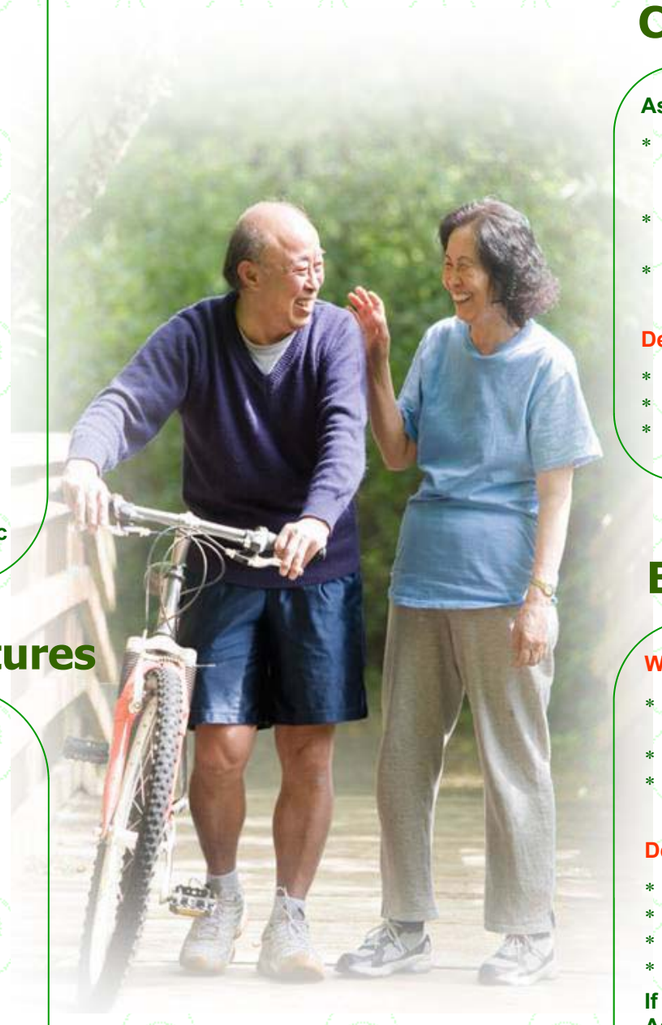
Describe:

- What happened before the collapse
- Any warning signs or symptoms
- Any incontinence, injury, pain, confusion etc

Call the RN immediately for Help!

If there is no RN call for an ambulance for the following:

- Severe breathlessness OR new chest pain
- Unconscious, drowsy or confused
- Severe bleeding
- Ongoing choking with distress
- Collapse
- Major burn
- Suspected fracture



Head

DROWSY OR CONFUSED

What to do

- Blood pressure, pulse, respirations, temperature

Describe:

- Changes to level of consciousness or alertness
- How it occurred e.g. knock to head during fall
- Other injuries e.g. bruising to chin
- Any warning signs or symptoms

Choking

Ask "ARE YOU CHOKING"

- If resident unable to respond notify RN and call ambulance (if trained give quick upward abdominal thrusts)
- If resident able to respond position upright and observe closely until no longer in distress
- Do not give resident food or drink until cleared by RN, GP or paramedic

Describe:

- Cause of choking e.g. food product
- Length of episode
- Recovery

Falls or suspected fractures

Do not move resident until notified by RN, GP or paramedics

Check for:

- Bruising or swelling
- Exposed bone
- Deformity of limb—shortness or abnormal position

What to do

- Blood pressure, pulse, respiratory rate
- Someone stays with the resident to:
  - comfort and calm
  - monitor bruising, swelling, pain, deformity and position
- Bleeding or skin tear? (See Care Giver guide "SKIN")
- Conscious or unconscious (see Head)

Describe:

- What happened
- Witnessed or unwitnessed
- Conscious or unconscious

Bleeding & skin tear

What to do

- Apply direct pressure until bleeding stopped: at least for 5 minutes, longer if required
- For skin tear see "SKIN"
- Apply clean non-stick cover and if required pressure dressing

Describe:

- What happened
- Approximately how much blood loss
- How long to stop bleeding
- Size, appearance and site of wound

If they are on an anticoagulant e.g. Warfarin, Aspirin, check the wound for evidence of further bleeding regularly

Burn

What to do e.g. cold water for at least 10 minutes

- Dress with clean non-stick covering

Describe:

- How it occurred
- Size appearance and site of burn

PROMPTS

- Are the residents and staff safe
- Does someone need to stay with the resident
- Have the family been notified
- Have I filled in an incident form
- Have I completed all forms and notes and reported to the RN
- What is the care giver follow up plan after reporting this to the RN
- Have I followed the policy for:
  - Getting help
  - Falls and suspected fractures
  - Bleeding and skin tears
  - Cardiac and/or respiratory arrest
  - Shock
  - Basic observations

Bruising

What to do

- Elevation if appropriate
- Cold compress (don't rub)
- Pain relief

Describe:

- How it occurred
- Size, appearance and site of bruise

If they are on an anticoagulant e.g. Warfarin, Aspirin, check the wound for evidence of further bleeding regularly

REPORT / RECORD / ACTION

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FALLS, FRACTURES & INCIDENTS

INTAKE & OUTPUT

Caregivers have the greatest opportunity to look, find and report

INTAKE

Hydration

- Changes to drinking habits
- Very thirsty
- Refusing to drink
- Leaving drinks unfinished
- Unable to reach or hold cup
- Difficulty swallowing
- Coughing/choking when drinking

Nutrition

- Changes to usual eating habits e.g. eating only desserts
- Slower to eat
- Holding food in the mouth
- Refusing to eat
- Leaving food on the plate
- Difficulty chewing food
- Difficulty swallowing food

OUTPUT

Stomach

- Vomiting or nausea
- Heartburn or abdomen pain

Bladder

- Not passing urine
- Dry pad
- No urine in bag
- New urgency
- Frequency passing urine? How often
- Change in amount
- Change in appearance
- Change in odour (smell)
- Pain passing urine or other pain

Bowels

- Change to usual bowel habits
- Last bowel motion 3 or more days ago
- Straining
- Dry and hard motions
- Change in bowel motion e.g. black, pale, blood, mucous
- Pain or discomfort on bowel movement

Behavioural Changes

- Frowning or grimacing
- Taking dentures out
- Spitting food or fluids out
- Needing help to eat or drink
- Loss of interest or mood change
- Change in behaviour e.g. increase in confusion, irritability, decreased level of function
- Holding or rubbing of abdomen
- Refusing medication

Ongoing Observations

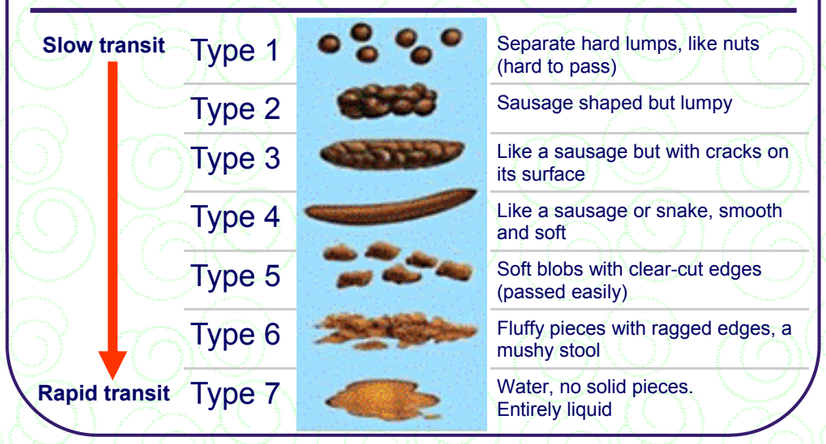
- Dry lips, tongue or mouth
- Other changes to lips, tongue or mouth
- Are they wearing dentures. Do they fit
- Are the dentures comfortable?
- Thickened, increased or coloured secretions
- Weight loss or gain
- Resident hot, flushed or cold to touch
- Changes to usual appearance of the body

PROMPTS

- **Have I checked the resident's mouth**
- **Have I accurately written up the resident's fluid balance chart, bowel chart**
- **Have I checked the care plan and progress notes**
- **Have I completed accurately all forms and notes and reported concerns to the RN**
- **What is the care giver follow up plan after reporting these to the RN**
- **Have I reported the family's concerns**
- **Have the family been notified**

STOOL FORM CORELATES TO INTESTINAL TRANSIT TIME

BRISTOL STOOL CHART



PAIN

RECORD / REPORT / ACTION | **Ask the resident about their pain**

ALERT

* **Behaviour changes may be due to pain**
* **People with dementia DO feel pain**

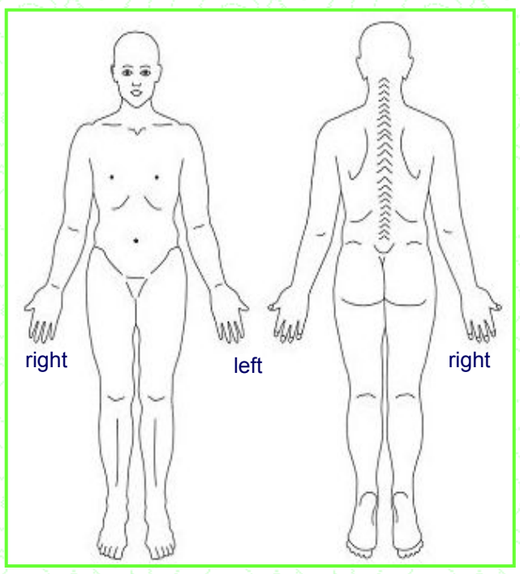
If **acute chest pain** or other new acute pain notify the RN immediately
Other **acute pain** see Care Giver guide "Vital Organs"

Tell me about your pain—*where is it?*
Get the resident to show you on their body
Ask family members about previous pain problems

Dementia or non verbal residents

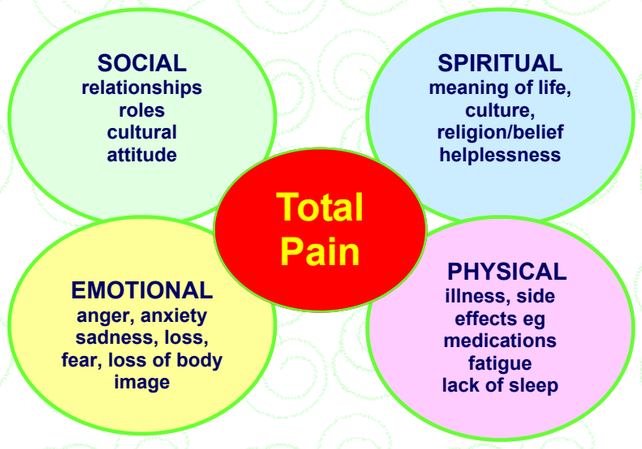
* **Vocalisation:** whimpering, groaning, crying
* **Facial expression:** looking tense, frowning, grimacing or looking frightened
* **Change in body language:** fidgeting, rocking, guarding part of the body, withdrawn
* **Behavioural change:** increased confusion, refusing to eat, alteration in usual patterns
* **Physiological change:** temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
* **Physical changes:** skin tears, pressure areas, arthritis, contractures, previous injuries

Numbness	○
Pins & Needles	●
Aches	X
Cramping	□
Burning	▲
Stabbing	+



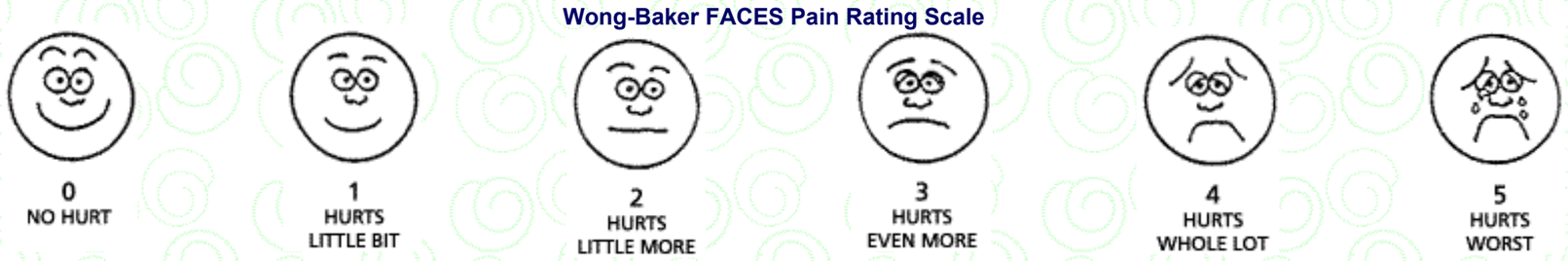
Suggestions for words that describe pain:

* Shooting
* Stabbing
* Sharp cramping
* Gnawing
* Hot/burning
* Throbbing
* Aching
* Pulling
* Heavy
* Tender
* Tight
* Splitting
* Tiring/exhausting
* Sickening
* Fearful
* Punishing
* Nauseating



0 = no hurt
1 = hurts just a little
2 = hurts a little bit more
3 = hurts even more
4 = hurts a whole lot more
5 = hurts worst as you can imagine
(don't have to be crying to feel this much pain)

Wong-Baker FACES Pain Rating Scale



From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Paediatric Nursing, ed. 7, St. Louis, 2005, Mosby p.1259. Used with permission. Copyright Mosby

COMFORT MEASURES

Has the resident been prescribed pain relief?

YES

Has this been given?

NO

Arrange for this to be given as charted and documented

Check after 30 minutes to see if it is working

YES

YES WORKING → **Document and reassess resident every 2 hours**

NO NOT WORKING → **Document and have resident re-assessed by RN/GP**

OTHER MEASURES THAT MAY HELP RELIEVE PAIN

- ✓ Supportive talk
- ✓ Gentle touch
- ✓ Music
- ✓ Soft lighting
- ✓ Decreased noise
- ✓ Massage (check with the RN)
- ✓ Reminiscing
- ✓ Repositioning
- ✓ Soothing activities
- ✓ Prayer and spiritual support
- ✓ Listening, and conversation
- ✓ Favourite food or drinks
- ✓ A walk
- ✓ Family involvement
- ✓ Warm or cold packs, if agreed by the nurse
- ✓ Help with personal cleanliness

PROMPTS

* Have I checked the care plan and progress notes
* Have I completed all forms and notes and reported concerns to the RN
* What is the care giver follow up plan after reporting this to the RN
* Does someone need to stay with the resident
* Have I reported the family's concerns
* Have the family been notified

SKIN

Caregivers have the greatest opportunity to look, find and report

General

Any changes in skin:

* Colour e.g. red, white, purple
* Hot or cold
* Dryness, leaking, moisture or sweaty
* Scaling or itching
* Bruises or rash
* Swellings, lumps, blisters or bites
* Moles and freckles
* Cracking or broken skin
* Unable to turn, move or walk

Check:

* Hair, ears, eyes, nose, mouth and nails
* Skin folds: breast and groin
* Feet: toes and nails

PROMPT

* *Cleansing—hygiene to be individualised*
* *Hydrating—with effective moisturisation*
* *Replenishing—hydration and nutrition*
* *Protecting against injury—moving & handling*

Skin Care

* Follow skin integrity assessment care plan e.g. Waterlow, Bradens and Norton
* Appropriate pressure relieving mattress and seating
* Review hydration and nutrition

Moving & Handling tips

Appropriate moving and handling such as:

* *Gentle hands*
* *Lifting devices*
* *Regular turns and positioning*
* *Arm and leg protection*
* *Safe use of equipment and in clean working order*
* *Follow policy for "Falls Prevention"*

New skin tear

Stop bleeding and clean

Tissue alignment—edges together—strip if needed

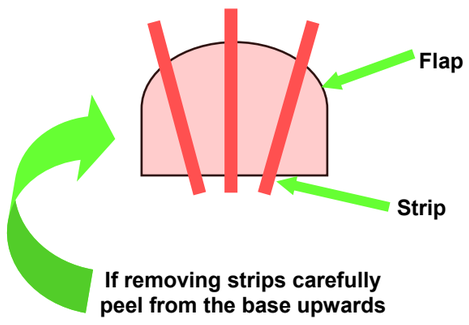
Assess and dress: pressure dressing, clean non stick covering

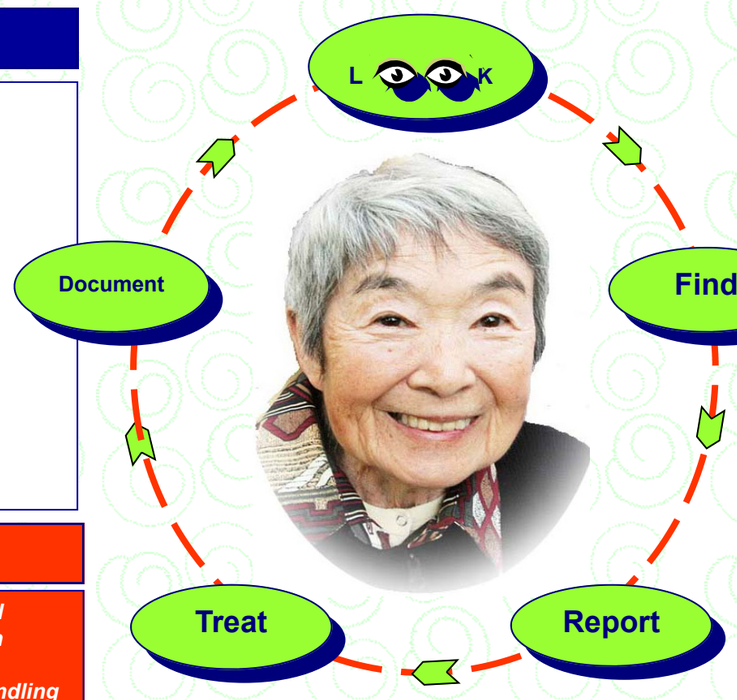
Review and re-assess 24—48 hours by RN

Document notes/handover, incident form and care plan

SKIN CLOSURE STRIPS

* Strip only required if there is a flap
* Do not put on with tension / force
* Strips stay intact until falling off





Remember!!!

Standard precautions

Is the resident in isolation?

* Shower the resident last
* Top to toe hygiene
* Gown and glove and mask
* Dispose of linen correctly
* Follow policy for cleaning equipment
* Wash your hands

Your own hand hygiene

Wash hands for 15-20 seconds with soap and warm running water and dry thoroughly

OR

Alcohol rub for unsoiled hands

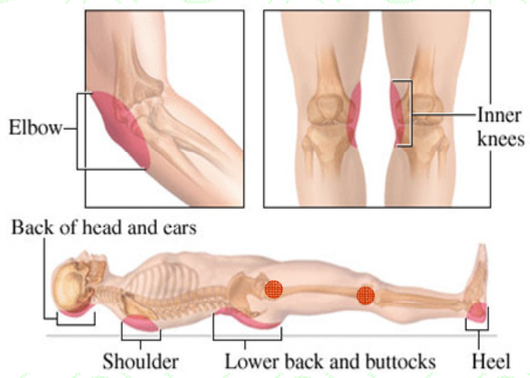
* Have the family been notified?
* What is the care giver follow up plan after reporting this to the RN?

Wound care

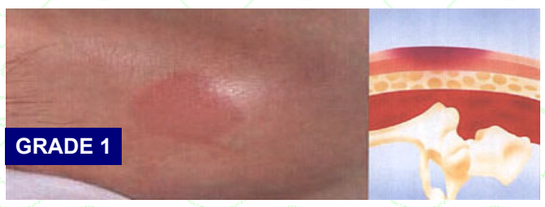
Check the care plan

1. Keep the dressing dry as needed
2. Remove dressing safely and gently
3. Report changes and progress
4. Replace the dressing promptly
5. Document

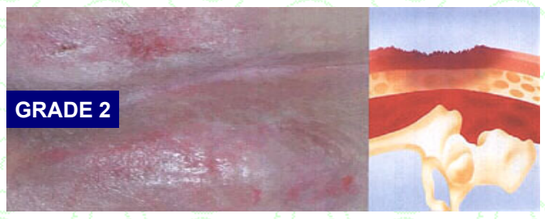
Pressure Points Check each shift



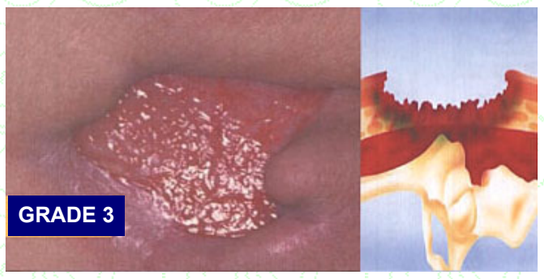
Report to RN



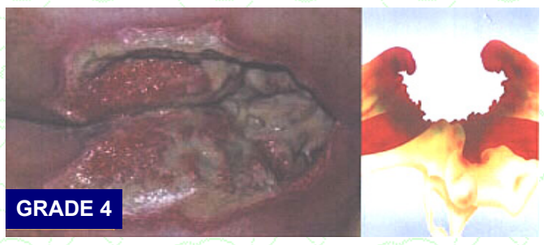
Skin is not broken but is red or discoloured. The redness or change in colour does not fade within 30 minutes after pressure is removed.



The epidermis (top layer) is broken creating a shallow, open sore. May or may not leak.



Ulceration progresses beyond the dermis to subcutaneous tissue (2nd layer). Redness remains around edges. Hardening of tissue or leakage can occur.



Ulceration progresses to deeper layers and can extend down to the bone. Usually lots of dead tissue and leakage occurs.

RECORD / REPORT / ACTION

VITAL ORGANS

REPORT / RECORD / ACTION

Brain

New or increased:
Seizures, partial or total

CHANGES TO:

Level of alertness:
* Drowsy
* Confusion
* Seeing or hearing things that are not real

Behaviour:
* Agitation
* Getting lost / wandering
* Withdrawn
* Aggressive
* Irritable / refusing care
* Tiredness

Function:
* ADLs
* Weakness
* Speech
* Swallowing
* Mobility

Face or body:
Facial expression; weakness of arm or leg
One sided facial droop
Paralysis or loss of function

Stomach

New or increased:
* Pain: type, where, severity e.g. burning
* Swallowing problems
* Thirst or hunger
* Indigestion
* Belching
* Nausea
* Vomiting

Changes to:
* Breath e.g. ketones (nail polish smell)
* Appetite

Heart

New or increased:
* Pain or discomfort e.g. tightness, heaviness, pressure of aching
* Palpitations
* Dizziness when standing up
* Irregular pulse

Complaints of pain or discomfort in:
* Chest / jaw / left arm
* Upper abdomen, radiating
(see RN Care Guides p8)

What treatment has been given?

Sexual Organs

New or increased:
* Pain
* Discharge (colour)
* Offensive smell
* Blood
* Prolapse
* Itching
* Swelling

Bladder & Kidneys

* Concentrated smelly urine
* Difficulty / pain passing urine
* Frequency of urine
* Little or no urine
* Changes to odour e.g. ketones (nail polish smell)

Is a sample needed? Dipstick urine

See Care Giver guide "Intake & Output"

Lung

New or increased:
* Breathlessness at rest or on exertion
* Cough or wheeze
* Noise on breathing
* Pain on breathing

Sputum:
* Colour
* Consistency
* Smell
* Blood
* Amount

CHANGES TO BREATHING PATTERN:
* Rapid or fast
* Shallow
* Deep
* Unusual
* Slow

Bowel

New or increased:
* Bloating or distension
* Black bowel motions
* Diarrhoea
* Constipation
* Pain passing motion
* Prolapse / haemorrhoids / piles
* Bleeding

Is a sample needed?

See Care Giver guide "Intake & Output"

Skin

Changes:
* Dusky, blue, discoloured
* Pale or cold
* Clammy, sweaty
* Swollen
* Painful to touch
* Lips
* Swelling of feet, ankles sacrum

New or increased:
* Fluid leakage
* Rash, breaks, redness
* Skin tear

See Care Giver guide "Skin"

General

Weight loss or gain

PROMPTS

* Have I checked the care plan and progress notes
* Have I reported the family's concerns
* Have I followed the advanced care plan
* Have I written / recorded accurately all forms and notes to the RN
* What is the follow up plan after reporting this to the RN
* Have the family been notified

CALL THE RN FOR HELP!

If there is no RN call an ambulance:
* Unconscious, drowsy or confused
* Collapse
* New or severe seizure
* Severe bleeding
* New or severe vomiting or passing of blood
* Ongoing choking with distress
* New or severe chest pain
* New or severe breathlessness
* You suspect a stroke

INTAKE & OUTPUT

Caregivers have the greatest opportunity to look, find and report

INTAKE

Hydration

- Changes to drinking habits
- Very thirsty
- Refusing to drink
- Leaving drinks unfinished
- Unable to reach or hold cup
- Difficulty swallowing
- Coughing/choking when drinking

Nutrition

- Changes to usual eating habits e.g. eating only desserts
- Slower to eat
- Holding food in the mouth
- Refusing to eat
- Leaving food on the plate
- Difficulty chewing food
- Difficulty swallowing food

OUTPUT

Stomach

- Vomiting or nausea
- Heartburn or abdomen pain

Bladder

- Not passing urine
- Dry pad
- No urine in bag
- New urgency
- Frequency passing urine? How often
- Change in amount
- Change in appearance
- Change in odour (smell)
- Pain passing urine or other pain

Bowels

- Change to usual bowel habits
- Last bowel motion 3 or more days ago
- Straining
- Dry and hard motions
- Change in bowel motion e.g. black, pale, blood, mucous
- Pain or discomfort on bowel movement

Behavioural Changes

- Frowning or grimacing
- Taking dentures out
- Spitting food or fluids out
- Needing help to eat or drink
- Loss of interest or mood change
- Change in behaviour e.g. increase in confusion, irritability, decreased level of function
- Holding or rubbing of abdomen
- Refusing medication

Ongoing Observations

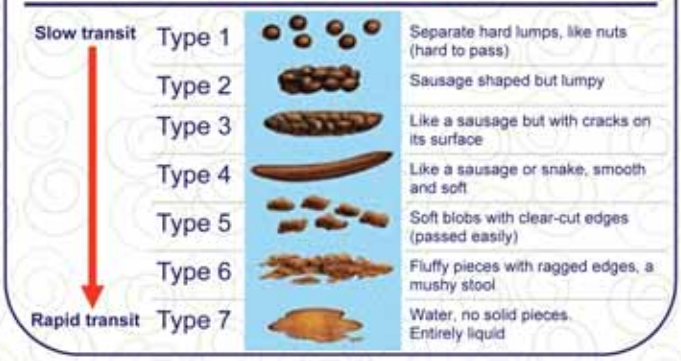
- Dry lips, tongue or mouth
- Other changes to lips, tongue or mouth
- Are they wearing dentures. Do they fit
- Are the dentures comfortable?
- Thickened, increased or coloured secretions
- Weight loss or gain
- Resident hot, flushed or cold to touch
- Changes to usual appearance of the body

PROMPTS

- **Have I checked the resident's mouth**
- **Have I accurately written up the resident's fluid balance chart, bowel chart**
- **Have I checked the care plan and progress notes**
- **Have I completed accurately all forms and notes and reported concerns to the RN**
- **What is the care giver follow up plan after reporting these to the RN**
- **Have I reported the family's concerns**
- **Have the family been notified**

STOOL FORM CORELATES TO INTESTINAL TRANSIT TIME

BRISTOL STOOL CHART



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