PURPOSE:
To define assessment parameters for when to report abnormal findings to physicians. Also to ensure compliance with state, federal and accreditations standards.

CONSIDERATIONS:
1. Patient-specific parameters for notifying physician are outlined in the plan of care at the time of admission or resumption of care.
2. A complete set of vital signs must be taken at the start of care but also every 14 days as part of regular protocol. Vital signs include height, weight, blood pressure, temperature, pulse, respirations, and pain. Follow specific guidelines provided by physician to determine reportable findings
3. If there are no parameters provided by the physician, then follow the guidelines as outlined within this procedure.
4. For hospice patients deviations in vital signs are normal. As the focus of care is not treatment but alleviation of pain and other symptoms, changes in vital signs do not need to be reported unless physician has specifically requested it.
5. Home health aides can also be a great resource to determine a change in vital signs. The following findings must be reported to the primary clinician verbally. If the primary clinician is not available for a discussion, the Home Health Aide is to report findings to a Clinical Supervisor. The following list is not all inclusive:
   a. Noted increase shortness of breath.
   b. Noted increase in swelling in feet/ankles/legs.
   c. Change in mental status (i.e. increase in confusion, decrease in alertness).
   d. Change in personality (i.e. noted change in behavior – aggressiveness, giddiness, anger, etc.).
   e. Reports of pain – new onset, increase in pain and pain unrelieved by current treatment.
   f. Any new bruises, skin breakdowns,
   g. Suspected neglect or abuse.

EQUIPMENT:
Blood Pressure Cuff
Stethoscope
Tape Measure
Thermometer
Weight Measurement Scale
Pulse Oximetry device
Pain Assessment tool

PROCEDURE:
1. At time of admission, a baseline height and weight should be recorded. Estimating subsequent heights and weights is permissible unless proper data is required for medication dosing or nutritional evaluation.
2. For clients with a diagnosis of heart failure on the careplan, a weight will be recorded at each visit. Clients are encouraged to record their daily weight. If the client has not taken his/her weight, the agency clinician will weigh the client at the time of the visit. The agency will attempt to find scales for those clients with a diagnosis of heart failure who cannot afford a scale.
3. Pain: Client reports of pain must be assessed and fully documented. Type (surgical, cardiac, respiratory: stabbing, throbbing, radiating), severity (using standardized scale: 1 to 10, Wong-Baker Faces, or FLACC scale), location (site of pain), when does it occur (activity, all the time, at rest), what relieves it (rest, heat, stretching). Any new onset of pain or pain unrelieved by current treatment requires physician notification. Severe Pain is pain over 7-10 on 1 to 10 scale.
4. Laboratory Test Results: Any lab report received by the agency that is flagged by the laboratory as a critical value requires a telephone call to the ordering physician to report the results. Documentation in the patient record reflecting that this has taken place and the outcome is required.
5. Changes in Physical or Mental Condition: Any changes need to be reported to the attending physician. This includes, but not limited to:
   a. Changes in wound – signs/symptoms of infection, necrosis, etc.
   b. Changes in personality, behavior, level of consciousness, etc.
   c. Decrease in mobility, balance, or increase in falling.

AFTER CARE:
1. Document reportable findings in patient’s medical record.
2. Follow-up with physician utilizing SBAR communication tool.
3. Encourage patients and caregivers to record new onset of symptoms
4. Educate patient and caregiver on any follow up items, or how to treat new onset of symptoms.
5. Instruct the patient and caregiver to seek immediate medical attention for emergency reasons.

REFERENCES:
In the absence of client specific physician orders, the following guidelines represent reportable clinical findings:

Prior to notification of the physician when abnormal measurements are obtained the clinician will validate assessment findings which may include retaking the measurement, review previous measurements recordings to identify trends and assess for other signs and symptoms to determine if the abnormal reading is indicative of an early gradual health status change or if it is a rapid change requiring urgent or emergent attention. Consideration should also be given to the patient’s baseline or normal parameters which may or may not fall within the stated guidelines below as a result of health status or disease state.

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Low</th>
<th>High</th>
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<tbody>
<tr>
<td><strong>Temperature</strong></td>
<td>Hypothermia: &lt;95 orally &lt;96 rectally</td>
<td>• &gt;100.5 orally &gt;101.5 rectally</td>
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<td></td>
<td>Mild case assess for signs and symptoms including confusion, lack of coordination, dizziness, nausea or vomiting and fatigue. Signs and symptoms of hypothermia include shivering, clumsiness or lack of coordination, slurred speech or mumbling, stumbling, confusion or difficulty thinking, poor decision making, drowsiness or very low energy, apathy, progressive loss of consciousness, weak pulse and shallow breathing.</td>
<td>Consider the length of time with fever, (trend) symptoms, and response to simple treatments. Assess for signs and symptoms including infection, flushed skin, tachypnea, tachycardia, headache, neurological symptoms: seizures, loss of consciousness, hallucinations, speech difficulties or cognition issues and muscle cramps or weakness.</td>
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<tr>
<td><strong>Pulse</strong></td>
<td>&lt; 60 at rest</td>
<td>&gt; 100 at rest</td>
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<td>Assess for signs and symptoms including near-fainting or fainting (syncope), dizziness, weakness, fatigue, shortness of breath, chest pains, disturbed sleep, confusion or memory, impairment, easily tiring during physical activity.</td>
<td>Assess for signs and symptoms including dizziness, shortness of breath, lightheadedness, heart palpitations, irregular heartbeat, chest pain and fainting (syncope).</td>
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<td><strong>Respirations</strong></td>
<td>&lt;12 at rest</td>
<td>&gt; 24 at rest</td>
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<td>Assess for signs and symptoms including fatigue, weakness, changes in level of consciousness (LOC), cyanosis, diminished breath sounds and ability to move extremities.</td>
<td>Assess for signs and symptoms including dyspnea, a sensation of difficult or uncomfortable breathing or a feeling of not getting enough air.</td>
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<tr>
<td><strong>Blood Pressure</strong></td>
<td>• Systolic: &lt;90 mm Hg sitting • Diastolic: &lt;60 mm Hg sitting</td>
<td>• Systolic: &gt;140-159 mm Hg sitting • Diastolic: &gt;90-99 mm Hg sitting</td>
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<td></td>
<td>Assess for signs and symptoms including dizziness or lightheadedness, fainting (syncope), lack of concentration, blurred vision, nausea, cold, clammy, pale skin, rapid, shallow breathing, fatigue, depression, thirst</td>
<td>Assess for headaches, dizziness and nosebleeds, Consider other conditions including cardiovascular disease, stroke and kidney disease.</td>
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<tr>
<td><strong>Orthostatic Blood Pressure</strong></td>
<td>Changes of &gt; 20mm Hg with posture changes</td>
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<tr>
<td><strong>Pulse Oximetry</strong></td>
<td>&lt;97% for patients without chronic lung disease &lt;92% for patients with respiratory condition or chronic lung disease</td>
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May indicate deterioration/dyspnea or hypoxemia. Assess for signs and symptoms including changes in respiratory rate, shortness of breath, fatigue and confusion.

### Blood sugar readings

<table>
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<tr>
<th>Value</th>
<th>Signs and Symptoms</th>
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<tr>
<td>&lt; 70</td>
<td>Shakiness, weakness, sweatiness, clumsiness, palpitations, hunger, lightheadedness, nervous, confusion, fatigue, anger, tingling around mouth</td>
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<tr>
<td>&gt; 180</td>
<td>Increased thirst, increased hunger, urination frequency, tired/sleepy, blurred vision, sick to stomach, breathing problems</td>
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### Pain

New onset of pain, pain that has changed or pain unrelieved by current treatment.

### Weight gain

Greater than 3 pounds in 48 hours
In heart failure patients, > 2 lbs. overnight or > 5 lbs./week for heart failure patients

Assess for signs and symptoms of volume overload/decomposition such as paroxysmal nocturnal dyspnea, increased SOB, fatigue, edema, abdominal bloating, nausea, vomiting and early satiety.

### Symptoms of dehydration

Loss of water and important blood salts like potassium & sodium. Signs of dehydration include:
- **Mild:** Thirst, Dry lips, Slightly dry mouth membranes
- **Moderate:** Very dry mouth membranes, Sunken eyes, Skin doesn’t bounce back quickly when lightly pinched and released
- **Severe:** All signs of moderate dehydration plus; rapid weak pulse (more than 100 bpm at rest), cold hands & feet, rapid breathing, blue lips, confusion, lethargy, difficult to arouse