Acute Illness

Guideline: Signs and/or symptoms of an acute illness should be promptly identified by caregivers and reported to nursing staff or the person's primary care prescriber. Appropriate medical evaluation and treatment should be instituted according to accepted standards of medical care.

DEFINITIONS:
Medical progress notes: The section of the individual's record where primary care providers document their findings and provide rationale for treatment plans.
Nursing staff: Registered nurses and licensed practical nurses.
Primary care providers: Physicians, nurse practitioners, and physician assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

RATIONALE:
1. People with intellectual and related disabilities deserve the same quality of medical care that exists for the general population.
2. There may be differences in the way acute illnesses present in people with intellectual/ developmental disabilities which may make diagnoses more difficult.
3. Prompt and accurate communication between nursing and primary care providers is essential to the delivery of the best health care for those with acute problems.

EXPECTED OUTCOMES:
1. Change in a person's appearance, activity level, or behavior which may suggest an acute illness should be promptly recognized by caregivers and reported to health personnel. Reported observations and follow-up assessment results should be documented in the nursing notes.
2. After appropriate assessment of the problem, referral to an acute care facility may be necessary. Referral forms should be completed by the primary care provider and include the reason for the referral, adequate health history, and other pertinent information. The rationale for the referral should also be documented in the medical progress notes.
3. If referral to another facility does not occur, appropriate evaluation and medical care should be initiated at the facility. The medical plan of care should be reflected in the medical orders and medical progress notes.
4. Appropriate treatment and monitoring should take place by nurses and primary care providers until problems are resolved. When a situation is resolved, it should be noted in the respective progress notes.
5. Medical and nursing documentation should be clear, concise, and comprehensive.

GENERAL GUIDELINES
1. **Preliminary Evaluation by Nursing Staff**
   a. Direct care staff should respond to verbal complaints, signs and symptoms of illness, or changes in a person's demeanor by reporting them to the appropriate nurse. Coughing, vomiting, significant changes in appetite, unusual lethargy and increased irritability are examples of the conditions that should be reported to the nurse.

Preliminary Evaluation by Nursing Staff cont'd

b. The unit nurse or nursing supervisor should assess the person's condition and and report significant deviations from normal to the primary care provider. These findings and the notification of the primary care provider should be documented in the nursing notes.
c. The nurse should be prepared to discuss the following information when communicating with the primary care provider:
    1. a brief summary of the problem, findings, or concerns
    2. a brief, pertinent summary of the person's health history
    3. findings from nursing assessment, including baseline vital signs, current vital signs, any unusual changes in vital signs or changes in mental condition that have been noted
    4. current medications
    5. any known allergies
    6. current weight
    7. summary of intake and output

2. Response to Communication by Primary Care Provider

a. Some conditions may require immediate hands-on medical evaluation. Some symptoms which could require immediate hands-on evaluation include:
    1. respiratory distress
    2. change in level of consciousness
    3. "stiff neck"
    4. active bleeding from GI, GU, or respiratory tract
    5. severe pain, especially presenting over abdomen or chest
    6. sudden weakness or paralysis of a portion of the body
    7. status epilepticus or cluster seizures
    8. marked point tenderness or rebound tenderness and/or unusual distention of the abdomen
    9. new onset of pain or deformity over bony areas
    10. an irreducible hernia
    11. swallowing of a sharp foreign object
    12. facial asymmetry not previously noted
    13. a significant change in vital signs or difficulty in obtaining them
b. If immediate medical attention is called for, the primary care provider should perform an examination within 15 minutes or order transport to a nearby hospital emergency triage area.
c. Primary care providers must recognize that there are certain differences in many people with intellectual/ developmental disabilities that can alter the way they present with very dangerous health problems. These include but are not limited to:
    1. inability to communicate pain or discomfort effectively.
    2. damaged thermal regulating mechanisms which may cause their body temperatures to be as low as 89º F on a routine basis. For these people, a temperature of 94º F could represent a high fever. Conversely, unexpected hypothermia may also be a symptom of grave concern.
    3. impaired response to pain, especially abdominal pain. A change in the activity level, lethargy, vomiting, or a change in vital signs may be the only indicator of an acute abdomen.

Response to Communication by Primary Care Provider cont'd

4. medications (e.g., Tegretol) that may depress the white blood count. For a person with a usual WBC of 3,000, a WBC of 8,000 may represent leukocytosis in response to a bacterial infection. Records of baseline WBC should be maintained so deviations can be evaluated appropriately.

d. When it is determined by the primary care provider that someone is not in acute distress (e.g., cough, low grade fever, urinary frequency, dysuria, minor vomiting, diarrhea) an evaluation and treatment plan should be established so appropriate care can be provided within the facility.

3. Evaluation of Acute Illness

a. The primary care provider should take an appropriate history from the patient, if possible, and/or from personnel familiar with the acute problem. In the event that the problem arises when the primary care provider is "on-call", the primary care provider may ask specific questions of caregivers on the telephone and summarize pertinent historical information in the individual's record on the next work day.
b. The primary care provider should examine a person with symptoms of acute illness whenever possible. When symptoms occur and the person cannot be seen immediately by the primary care provider, the nurse may provide a verbal report of findings to the primary care provider.
c. The primary care provider may order diagnostic evaluations on either a STAT or next day basis. These may include tests such as cultures, x-rays, and blood chemistries.
d. As soon as possible, the primary care provider should summarize and document a diagnosis or differential diagnosis as well as the medical plan of action.

4. Treatment of Acute Illness

a. Based on assessment information, the primary care provider should institute treatment in accordance with current accepted standards of care.
b. The person's progress should be monitored at appropriate intervals and further diagnostic procedures should be completed if indicated.
c. If the illness does not respond to the initial treatment, appropriate modification in the treatment may be indicated.
d. If the illness has not responded to treatment in the expected period of time, or appears to be worsening, appropriate specialty or acute hospital consultation should be sought.
e. In the event that an illness requires laboratory or x-ray follow-up, the evaluations and tests should be ordered and results evaluated and documented in a timely fashion.
f. When an acute illness subsides, the person should receive routine medical and nursing follow-up.