Significant Condition Change

Significant Condition Change

- A fall resulting in head trauma, excessive pain or possible fracture.
- A 5% weight change in 30 days or 10% change in 6 months.
- Development of a Stage II or greater pressure sore.
- Refusal or inability to consume food or fluids for more than 2-3 shifts.
- A sudden change in mental status including agitation, lethargy, sudden lack of responsiveness or manic behavior.
- Chest pain

SIGNIFICANT CONDITION CHANGES, cont.

- Abrupt onset of edema
- Seizures
- Abrupt onset of shortness of breath
- Change in resident's usual vital signs
- Unusual need for suctioning and/or oxygen
- Diarrhea/Emesis
- Medication Error
- Critical/Abnormal Lab results
- Symptoms of stroke

CMS Regulation

F580

§483.10(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

Regulation, cont.

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is—

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

Regulation, continued

- While the regulatory obligation is not limited to these symptoms, physician notification should occur when a resident experiences symptoms such as chest pain, loss of consciousness, or other signs or symptoms of heart attack or stroke that may signify a significant change.
- Even when a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident.
- If the resident is not capable of making decisions, facility staff must contact the designated resident representative, consistent with his or her authority, to make any required decisions, but the resident must still be told what is happening to him or her.

These are Potential Claims and/or Survey Issues

- Resident develops pressure sores
- Resident requires emergency room treatment or hospitalization and does not receive it or does not receive it in a timely manner.
- Weight loss by a resident without physician and family notification and a change in treatment being provided.
- Unexplained or unexpected death of a resident.
- Fall with Fracture

Dangerous Areas

- NO DOCUMENTATION
  - On pain
  - On lab results
  - On family contact
  - On resident refusal of meds and/or treatments

- ONE ENTRY OF A PROBLEM WITHOUT ANY FOLLOW-UP
  - Mention of a pressure sore
  - Elevated temperature
  - Emesis or diarrhea
  - Level of consciousness change

Audits are Vital!

- Lack of notification to family and/or doctor
- Unclear designation of pressure sore origin
- Lack of Fall documentation
- Lack of follow up from prior shift
- Careplan interventions not followed
- Problems not entered on careplan
- Lack of follow up from outside caregivers or therapy

Use Your EMR to Monitor

- Decide what you want the Dashboard or 24 Hour Report to include
  - Specific Types of New Physician orders
  - High Risk Notes
  - Incidents
  - Incomplete Documentation
  - Missed Documentation
  - New orders for antibiotics
  - New recommendations from RD or Therapy
  - New Admits or Re-admits
  - No BM in 3 days
  - Food Intake below 25% for 3 meals

Who will Monitor

- Decide who is Monitoring
  - The DON
  - Charge Nurses
  - Corporate Nurses
- Decide who is responsible for reviewing and reviewing documentation
- Decide who is responsible for follow-up of:
  - Calls to family/doctors
  - Medical issues mentioned
  - Condition changes

Who does What?

- The DON reviews the 24 hour report or Communication Board on a daily basis. This is the first priority of the day. Pertinent information can be shared in the morning meeting.
- Charge nurses review the same for their unit as part of report.
- The DON or designee follows up with the nursing units on what has been completed at least 2 hours before shift ends.
- Charting is reviewed on random daily basis dependent on severity of issue by the DON or designee
- In depth audits done on falls and pressure sores

What if something is missing?

- An “additional information” note or “Follow up Note to…” can be made
  - Use as an opportunity to put a summary into the record of what has happened, what has been done and the current status.
  - Put the dates and times if known into the body of the note
  - Include comment about doctors and family notifications
  - Allows additional comments from the DON

Keep Your Documentation on Target

- At least monthly
- With resident changes
- After admissions
- After incidents
- Every *shift* for Medicare
- Every shift on residents on Hot Chart or 24 hour report

Charting Do's:

- Chart care at the time you provided it.
- Chart meds as you give them
- Make sure charting reflects care plans
- Be careful transcribing Dr. orders
- Chart resident response to PRN's
- **Chart what issues you told the doctor about**
- **Chart what you called the doctor about and what the response was**

What you write MATTERS

- Note all resident noncompliance.
- Note all family decisions/disagreements.
- Document negative findings. Chart enough so someone reading it two or three years from now will know what you were thinking and why you decided to do, or not to do, a particular intervention.
- Document any discussion of medical orders, and the directions the doctor gave. Record your comments and your actions as a result of the discussion.
- Record only your own observations, actions. If you receive information from another care giver, state the source of the information.

Acute Medical Issues

- Notify the physician immediately if significant changes are noted.
- Inform the family of the change and action taken.
- Document the results of monitoring, interventions, notifications.
- If the resident is on an antibiotics or other therapy, document the condition for which the antibiotics are being given. Avoid entries such as “no side effects to antibiotics.”
- If the resident is not responding to treatment for an acute medical problem within 24 hours, contact the physician.

Chronic Conditions

- Behaviors
- Diabetes
- Pain
- ADL limitations
- Food/Fluid intake issues
- Recurrent infections
- Aspiration
- Constipation

Behavioral Incident Follow-Up

- Be sure the incident is documented fully and is clear and concise.
- Contact the resident physician for new orders, i.e.: possible medication changes. Contact family. Contact state agencies as required.
- If injury, notify police within 2 hours
- Care plan update: Be sure that the dates of changes coincide with the date of the occurrence, encourage family involvement and involvement of any outside agency such as day treatment etc.
- Add to communication board or 24 hour report.

Diabetes: Call the doctor….

- A blood glucose of <60 with signs and symptoms suggestive of hypoglycemia.
- Two or more blood glucose values >250 if this is a new or markedly different situation
- Blood glucose values >300
- Had poor oral intake for two or more days
- Document your questions and doctor's answers
- If you are using sliding scale for multiple times during the week

Pain

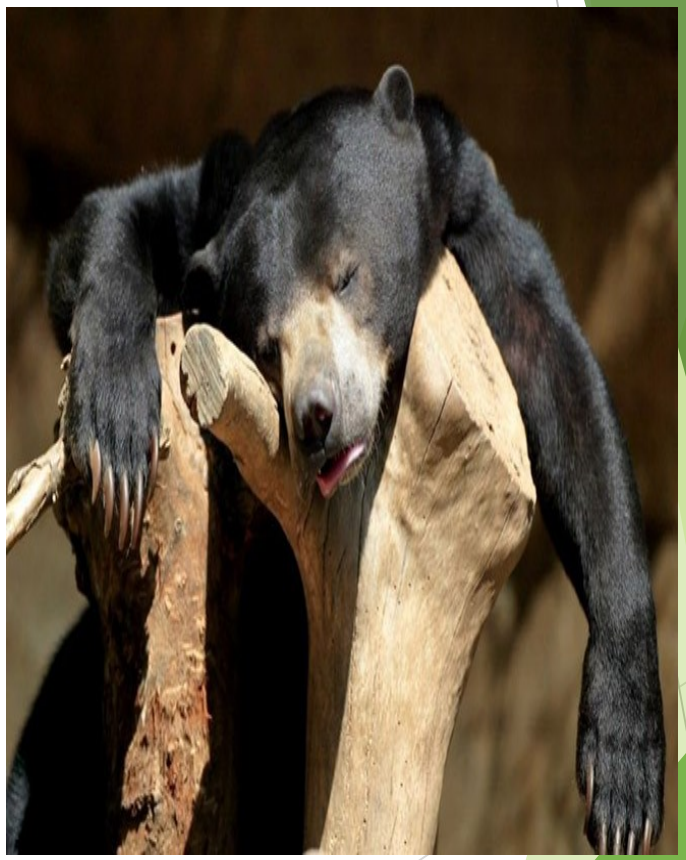
- Nurses need to do a better assessment when a resident complains of pain. Include questions about the type of pain and what makes it worse or better.
- If there is PRN pain medication, interventions other than the medication as the first choice need to be tried and documented.
- Document when the doctor is called about pain and what he/she was told about the pain type/quality
- Be VERY ALERT to any complaints of pain within 5 days of a fall.

Signs of Resident Decline

- Resident asking for more help with dressing
- Resident falling more
- Resident using wheelchair instead of walking
- Resident not eating without set up and frequent encouragement
- Resident not attending level of activities that they usually do

Can Decline be a Significant Change?

- Unusual fatigue for 2 or more days
- Change in LOC within a month of a fall
- Behaviors unusual for a resident with other “usual” behaviors
- Gait changes
- Speaking less



Potential Malnutrition and Dehydration

- Monitor daily for indication of decreased intake. Use the CNA's to provide information. Consider Interact tools if you don't have EMR records.
- When water is refilled in rooms, it needs to be reported to nurse if a large amount remains
- All workers in the dining room need to be mindful of resident consumption.
- Persons recording food intake need method of alerting charge nurse for intake less than 25%.
- Weight changes of more than 2 pounds should be checked.
- Consider baseline BUN levels

Sepsis

To be diagnosed with sepsis, you must exhibit at least two of the following symptoms:

- Fever above 101.3 F (38.5 C) or below 95 F (35 C)
- Heart rate higher than 90 beats a minute
- Respiratory rate higher than 20 breaths a minute
- Probable or confirmed infection
- Altered white blood cell count (>12,000 cells/mm 3 , <4,000 cells/mm 3
- Altered tissue perfusion (such as hypotension, decreased urine output, and decreased skin perfusion)
- Impaired coagulation (such as decreased platelets and petechiae)

Infection to Sepsis

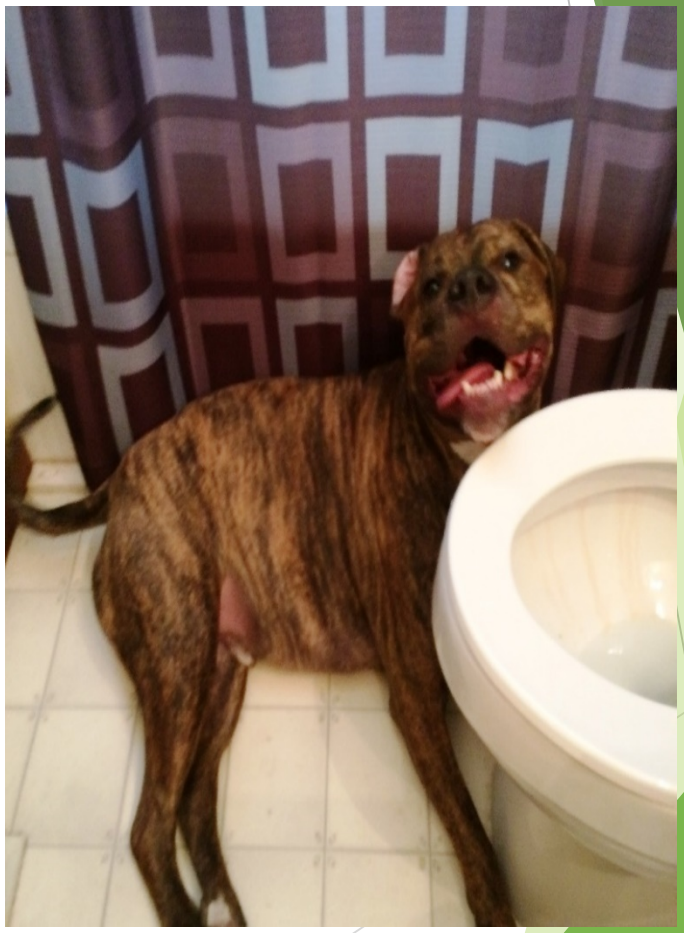
- Wounds that become infected.
- Chest congestion that becomes pneumonia
- Cellulitis that is untreated or undertreated
- UTI out of control.

Aspiration Risk

- Hold annual inservices on recognizing signs of aspiration and the Heimlich Maneuver. Include Dietary staff
- Nurse should be in dining area for all meals
- Speech Therapy must have communication method to inform nursing of any residents that they have concerns about
- Potential aspiration risk needs to be discussed AND documented with physician, resident and family.
- If the resident refuses downgrade in diet, use an Informed Refusal which is updated quarterly and as needed.
- Document all episodes of choking, coughing
- Difficulty breathing or noisy breathing
- Inability to cough forcefully
- Skin, lips and nails turning blue or dusky

Constipation

- Residents without a BM in 3 days require follow up.
- Nurses need to be checked to ensure that they know how to listen for bowel sounds and document it.
- Aides need inservice on how important it is to monitor for constipation or change in bowel movements. Include information on changes in color and consistency of stool.
- If PRN meds are given there must be method of reminders to follow up on effectiveness.



Stroke

Knowing the warning signs of a stroke is important because you can act quickly. If you call 9-1-1 immediately, you can reduce the effects of a stroke and possibly save a life. The warning signs of a stroke are:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body;
- Sudden confusion, trouble speaking or understanding;
- Sudden trouble seeing in one or both eyes;
- Sudden trouble walking, dizziness, loss of balance or coordination; and
- Sudden severe headache with no known cause.

FAST is an easy way to remember what to do if you suspect a stroke is occurring.

- **F**ace – Ask the person to smile. Does one side of the face droop?
- **A**rms – Ask the person to raise both arms. Does one arm drift downward?
- **S**peech – Ask the person to repeat a simple phrase. Is their speech slurred or strange?
- **T**ime – If you observe any of these signs, call 9-1-1 immediately.

Bee Careful

It is very hard to defend that the standard of care wasn't breached when there is no documentation that you called the doctor in a timely manner.

Policies

- Policies are separate from Procedures
- Do you need one on everything that may be done for or with a resident?
- Have you read them lately?
- How old are they?
- Which ones do staff have to read?
- Which ones do staff have to know?

Inservice vs. Meetings

- Inservices should contain only the educational items covered and who the audience was.
- Sign in sheets need to be maintained with the above information.
- Keep for 2 years.
- Nursing/CNA meetings must be completely separate from inservices
- If you want to keep a record of meetings do it on separate paper from the inservice

Interact Stop and Watch

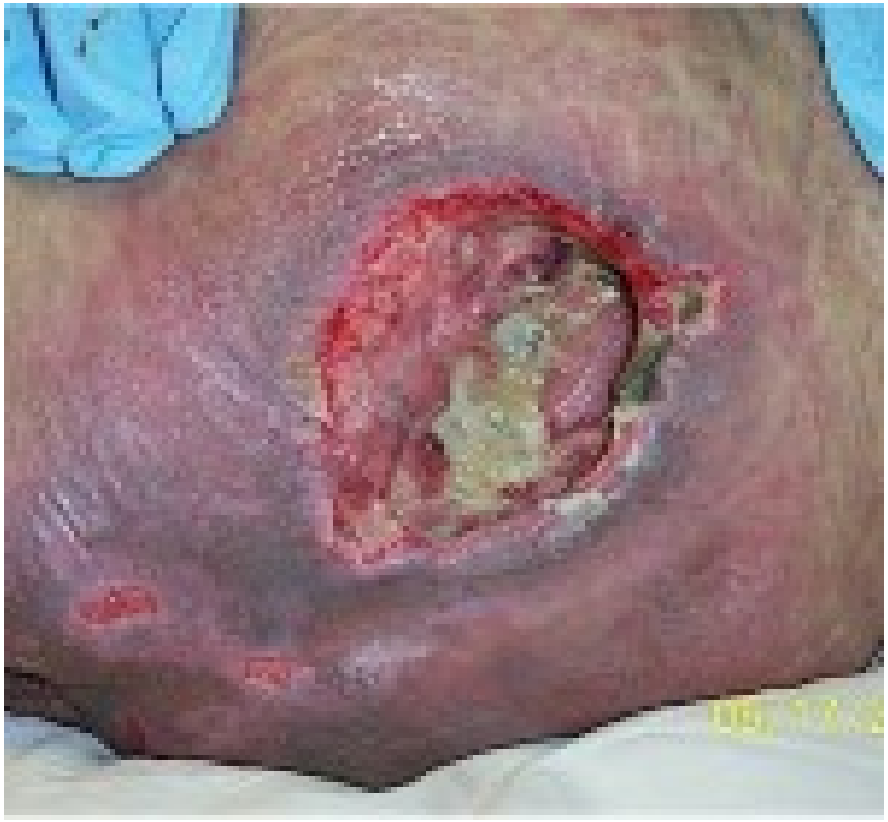
Stop and Watch

Early Warning Tool

- If you have identified a change while caring for or observing a
- resident, please **circle** the change and notify a nurse. Either give the
- nurse a copy of this tool or review it with her/him as soon as you can.
- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities
- Ate less
- No bowel movement in 3 days; or
- diarrhea
- Drank less
- Weight change
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- Help with walking, transferring, toileting more than usual

- *Patient / Resident*
- *Your Name*
- *Reported to Date and Time (am/pm)*
- *Nurse Response Date and Time (am/pm)*
- *Nurse's Name*

Pressure Sores

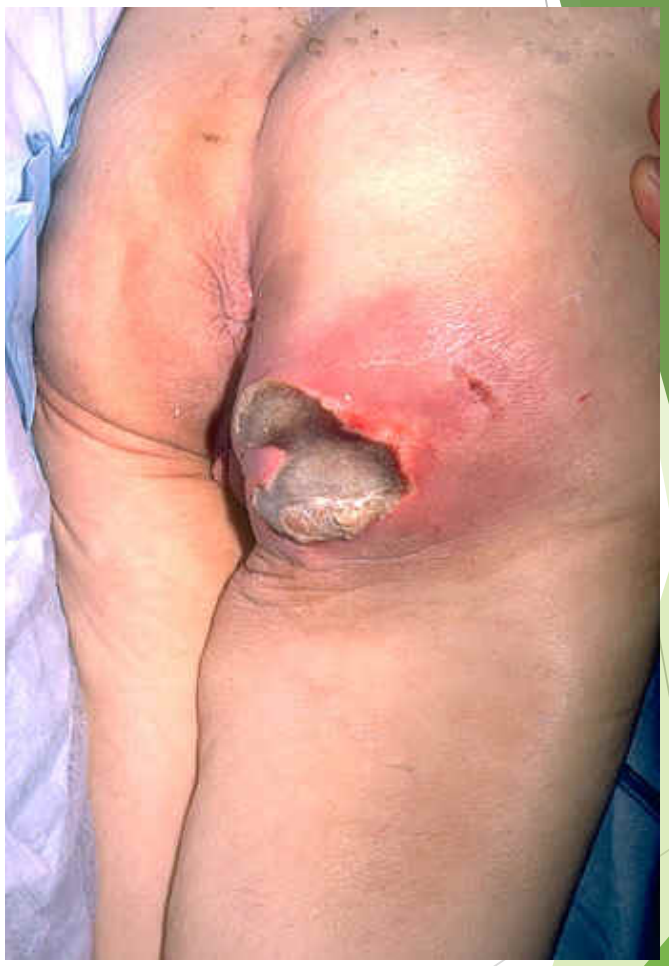


Unavoidable Pressure Sore

"Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

Pressure Sore Documentation

- At admission
- Risk Assessments
- MDS
- Weekly
- With Changes
- At transfer
- At discharge



Pressure Sore Documentation

Physician orders

- Specific wound cleaning and treatments.

Progress notes

- Include treatment done and how wound looks

Care plans

- Don’t put specific treatment orders; refer to the POS or TAR. Do enter preventative items (see the MDS)

Weekly Notes

- Measurements, wound description and response to treatment

Pressure Sore Documentation, cont.

Minimum Data Set

- Mark the list of preventative measures taken

Resident assessment protocol summaries

- Incorporate factors making the areas clinically unavoidable.

Transfer records

- Clearly document skin condition on transfer from your facility.

Internal documents

- The Plaintiff will use your written policies and procedures when trying a pressure sore case.

RD documentation monthly

- **Nutritional supplements**
- **Resident likes/dislikes**
- **Fluid intake**

Protein Intake is Crucial

FALLS

Post Fall Documentation

- Position of Resident
- Last observed
- First Aid provided
- Assessment of resident
- What environmental issues existed if any
- Statement from Resident

Fall Careplan

- Don’t put in entries that talk about the future. (i.e., “Will have assessment done for PT”)
- Do date all interventions when added or discontinued
- Don’t add too many at one time
- Write a care plan note at least quarterly after the meeting
- Use it as an opportunity to tell the story of the past 3 months
- Include information about family and resident compliance and involvement
- Explain any decisions to keep the same interventions without changing them.

In Conclusion

- Provide inservices on Significant Condition change for both nurses and aides
- Set EMR parameters to ensure that Communication Boards accurately reflect important information
- Perform audits to ensure follow up is complete
- Calls to the doctor must include documentation on what the doctor was told.
- Consider using an SBAR
- Documentation must include what the doctor told you
- Documentation must include what you told the resident and family