Improving Patient Safety in Long-Term Care Facilities

Module 1.

Detecting Change in a Resident's Condition

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Student Workbook

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Student Workbook

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This student workbook is from the first module of a three-module set of training materials. Module 2 focuses on communicating changes in a resident's condition, and Module 3 covers falls prevention and management. For information on ordering additional copies of this student workbook or other materials in this set, please contact the AHRQ Publications Clearinghouse at 800-358-9295 or ahrqpubs@ahrq.hhs.gov.

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Detecting Change in a Resident's Condition

Student Workbook

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Detecting Change in a Resident's Condition

Student Workbook

Learning Objectives: Knowledge and Performance Objectives

Knowledge Objectives

Participants will learn:

- Why detecting change is important.
- How to get to know a resident's normal (baseline) condition.
- How to watch for change.
- How the Early Warning tool and SBAR tool work.
- How to follow up at the first sign of changew.

Performance Objectives

Participants will be able to:

- Summarize a resident's normal (baseline) condition for other team members.
- Identify whether changes in a resident's condition are important or not important.
- Promote behaviors that improve change detection.
- Use the Early Warning tool and SBAR tool.
- Decide when to report or when to ask for help when observing changes in a resident's condition.

Session 1

NOTES

Introduction

Case Study: Ms. A

Ms. A is a mentally intact 79-year-old frail (in a weakened condition) woman who arrived at the Manor Nursing Center after a hip fracture at home. After a stay at an acute rehabilitation center, she is still not able to manage by herself. Ms. A walks with difficulty with a walker and needs help with daily living activities. Ms. A also has several other medical problems. She has high blood pressure, diabetes, and arthritis. She is also being treated for depression. Her family visits her regularly on weekends. She rarely participates in activities of the Manor Nursing Center; at mealtimes she tends to avoid conversation. Recently she had diarrhea, was incontinent of liquid stool, was placed in adult briefs, and nursing assistants had to change her adult briefs once or twice per shift. She began taking meals in her room. Stool tests showed that she had a bowel infection with *Clostridium difficile.* An antibiotic was started. Even with the antibiotic, her bowel movements continued to be liquid and frequent over the next week, and she was eating less. Her blood pressure had been normal for her at 130/80, but her pulse rate was higher than her usual 70-75 at 90-100. Yesterday, she had a fever of 102.5 and was transferred to the acute hospital, where she was admitted to the Intensive Care Unit.

How did Ms. A get so sick with only diarrhea? What changes might you have noticed about Ms. A? When might you have decided to do something about it? What could you have done?

Key Lessons:

- Learn to notice a change early.
- Not reporting a change can lead to other things going wrong.
- The sooner something is done, the better.

We've all been in difficult situations that might have been avoided if we had noticed a problem early and dealt with it right away, before it got worse. These situations may happen when a person is ill, and even more so if that person is frail. When one thing goes wrong, it seems to lead to another thing going wrong, and that can continue until the person is dangerously ill. So noticing changes that might signal or lead to a serious condition is important. Often, the sooner something is done, the better it is for the person who is ill.

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Role of Nursing Assistants and Licensed Nurses

As nursing assistants and licensed nurses, your role in a long-term nursing center is very important. At home, people know each other well and notice changes in a friend or family member's condition or behavior. In a hospital or clinic, registered nurses, nurse practitioners, and doctors are there almost all the time, and they are trained to look for signs of illness and to be sensitive to changes in a patient. In nursing centers and other types of long-term care, nurse practitioners and doctors are there for much less time.

The providers who most often see the residents are the nursing assistants, and the ones who see them some of the time are the occupational and physical therapists and the licensed nurses. Unit administrators, clerks, and volunteers may also be there. Residents in long-term nursing centers depend on nursing assistants and these other providers to be the ones who notice change.[1] Nursing assistants, in particular, become the eyes, ears, and hands of the care team. Residents depend on you to be alert and interested. They depend on you to talk with your team members so everyone is "tuned-in." They also expect you to respond if something comes up. Nursing assistants are very busy and have many tasks, but detecting change is one of the most important.

Leaders and advocates in nursing center care believe that having the same staff consistently assigned to the same residents leads to better care for the resident and higher staff satisfaction.[2]

Role of Nursing Assistants and Licensed Nurses

- Your role in a long-term nursing center is important.
- Nursing assistants see the residents most often.
- Residents in long-term care depend on nursing assistants to notice changes.
- Nursing assistants are the eyes, ears, and hands of the care team.

[1] Boockvar K, Brodie HD, Lachs M. Nursing assistants detect behavior changes in nursing home residents that precede acute illness: Development and validation of an illness warning instrument. J Am Geriatr Soc. 2000; 48:1086-1091.

[2] Increasing use of consistent assignment. Advancing Excellence in America's Nursing Homes campaign. Available at http://www.nhqualitycampaign.org/files/factsheets/Staff%20Fact%20Sheet%20-%20Consistent%20Assignment.pdf. Accessed January 10, 2012.

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Having consistent assignments is more likely to work when:

- Nursing center leadership educates staff on the benefits of consistent assignment.
- All members of the team participate in meetings about consistent assignment.
- There is a process to ensure that nursing assistants have input when assignments are given, with the goal of having everyone feel that their assignment is fair.
- Care team members meet regularly to discuss how the consistent assignment is working, including reviewing assignments to ensure that relationships with the residents are going well.
- Leadership invites suggestions from team members about improvements.

Detecting Change

- Know the resident's normal (baseline) condition.
- Note the resident's ability to move around.
- Know how the resident does with activities of daily living.
- Know the resident's preferences for activities, eating, and dressing.
- Changes from the resident's normal condition can signal a medical change.

Detecting Change

Know the Resident's Normal (Baseline) Condition

When you first meet residents you are responsible for, you should talk with other members of your team to find out everything you can about the residents. Your coworkers may have learned things you need to know from other care providers or from family members and visitors. This can help you establish what's normal and may be called "baseline" information. Try to stay with each new resident as long as possible, just getting to know him or her, so that changes don't get overlooked because you don't have enough baseline information. Establish a conversational relationship with the resident and family and stay in touch every day you are with the resident so that you are more "tuned in" to how he or she normally is and how long he or she has been at that baseline. A change of shift report is another good way to gather baseline information.

Be sure to note a resident's ability to move around; their usual method for getting from, say, bed to chair; and how they do with activities of daily living. For example, do they need to sit while they are in the shower? It helps to know their preferences for activities, eating, dressing, and so on. Changes from the baseline in a resident's routines or enjoyable parts of the day can signal a medical change. In addition, be aware if the resident seems to be uncomfortable. Many older adults will not be willing to talk about pain or discomfort unless you ask them about their pain. When you learn these important things about residents, make

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sure that you share the information with your coworkers.

Some care providers, such as the float nurse or new hires, don't know all they need to about the residents. Help them out by sharing relevant information and tips.

Recognizing Change

When something about a resident seems to have changed, you should always observe and document the following things:

- Look back at the previous shift notes and make a shift-to-shift comparison.
- Make sure that needed equipment is available – the blood pressure cuff and stethoscope, the pulse oximeter, and the thermometer.
- See if a change occurred in any of the resident's vital signs – blood pressure, pulse rate, breathing rate, and/or temperature.
- Check the resident's records of urination and bowel movements – a quick check by the licensed nurse of the resident's bladder with a physical examination (percussing or tapping over the bladder area to see if it sounds like it is full), or with an ultrasound if one is available, can be very helpful for the resident who has not urinated and may need a catheter. If your nursing center has a hand-held ultrasound, make sure it is present too.

Recognizing Changes

- Do a shift-to-shift comparison.
- Make sure the needed equipment is available.
- See if a change occurred in any other resident's vital signs.
- Check the resident's records of urination and bowel movements.

When you have collected all the information you can, be sure to share it with a licensed nurse. The registered nurse may then decide to do a full assessment by reviewing the resident's condition to see if a different treatment is required.

Registered Nurse's Assessment

Registered nurses should follow prior training when conducting an assessment. This Workbook will not address in detail how registered nurses should assess change.

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However, briefly, the registered nurse will do the following:

- Ask the resident how he or she feels even if the resident is confused or seems to be "out of it."
- Ask the resident how the symptoms began and when.
- Take the resident's vital signs again.
- Perform a general exam and assessment of the resident's level of consciousness or cognitive function and physical function, following the usual methods for resident assessment.
- When the assessment is completed, the registered nurse will organize this information to report the change to the resident's nurse practitioner or doctor, if this is necessary.

Registered Nurse's Assessment

- Ask the resident how he or she feels, even if the resident is confused or seems to be "out of it."
- Ask the resident how and when the symptoms began.
- Take the resident's vital signs again.

Because older people may have a serious illness and the only sign of that illness is some confusion, assessment of confusion is important. Several tools to help with evaluating mental status are included in the MDS[3] and are accurate for nursing center residents (see the Additional Tools and Resources section), including:

- Brief Interview for Mental Status (BIMS), which evaluates the normal (baseline) mental function.
- Modified Confusion Assessment Method (CAM), which is a simple set of questions that help to identify the presence of confusion.
- PHQ-9 detects changes in mood, such as depression or anxiety.

Knowing how to administer each of these instruments is part of the licensed nurse's scope of work and may help to identify changes in mental function that could be a sign of serious illness.

[3] Minimum Data Set 3.0: Brief Interview for Mental Status (BIMS), Items C0299-C0500; Confusion Assessment Method (CAM), Items C1300 and C1600; and the PHQ-9, Item D0200.

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Session 2

Changes That Matter

It's a challenge for nursing assistants and licensed nurses to notice changes that matter because so many things might matter.

We all know from our own lives that it can be hard to know when to react to a possible concern. For example, on the one hand, sometimes we worry too soon that our second sneeze might be a sign of a cold and, on the other hand, sometimes we ignore too long our bad cough and get sinusitis or even pneumonia.

The signs and symptoms of illness in older adults may be mild or different than in younger people. Older people have slower responses and less response to change. Sometimes mild symptoms and behaviors like feeling or acting tired are the only clue to an illness. In a younger person, the same illness would cause a fever or something more recognizable. So, it is important to notice and report changes in a resident sooner than for a younger person.

Things to watch for in residents include physical and non-physical changes. The top 12 changes to watch for are described here.

Top 12 Changes in Residents

Physical Changes	Non-Physical Changes
› Walking	› Demeanor
› Urination and bowel patterns	› Appetite
	› Sleeping
› Skin	› Speech
› Level of weakness	› Confusion or agitation
› Falls	› Resident complaints of pain
› Vital signs	

Physical Changes

1. Walking

A change in walking is important to notice, and there may be many different signs. You may notice the resident has trouble getting started or poor balance. He or she may seem to take smaller or shuffling steps or walk with the feet wider apart. The resident may favor one side more than another. These kinds of changes put the resident at risk for falling and also may signal an underlying problem. The resident may have had a fall and may have a broken bone or have worsening arthritis with increased pain and stiffness. Perhaps a small stroke occurred, or the resident has another new medical problem that is contributing to confusion and unsteadiness. Medications can also make the resident unsteady, lightheaded, or stiff. A more complete assessment is usually needed if a resident's walking changes.

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2. Urination and Bowel Patterns

People can be incontinent of urine for a number of reasons, including medications, infection, and many medical conditions. New urinary incontinence (lack of bladder control) should always be assessed medically. Decreased or absent urination is also important to notice. In addition to dehydration or kidney failure causing decreased urine production, people can retain urine and their bladder can fill and stretch and back up, damaging the kidneys and causing other problems.

Constipation and diarrhea are common among older people and need early attention, both to manage the condition if there is no serious problem, and to detect a problem requiring new treatment. Constipation (slowing of the bowel movements) can worsen over time and progress to serious problems resulting from impaction (stool left in the colon). Sometimes liquid stool can come out around retained stool and appear to be diarrhea, so it is important to check for impaction. Diarrhea (watery, liquid stool) can also be a side effect from a medication, a symptom of a viral illness, or a serious bacterial infection that requires specific treatment.

Physical Changes

- Walking – e.g., how much assistance the resident needs with walking.
- Urination and bowel patterns – e.g., the resident is urinating less frequently.
- Skin – e.g., the resident's skin is puffy.
- Level of weakness – e.g., the resident is having difficulty lifting his or her arm.
- Falls risk– e.g., the resident reaches for objects when in a wheelchair.
- Vital signs – e.g., the resident is breathing faster than normal.

3. Skin

Skin is the largest organ in the body and is usually kept mostly covered to everyone except the nursing assistant. It is very important to notice and report changes in skin. Reddened or darkened skin near a pressure point, or skin breakdown in those areas, can lead to a full pressure ulcer (bed sore) if not responded to promptly. Swollen, puffy, or red skin might be a sign of a skin infection, of a blood clot deep inside, or of excess fluid that needs medical attention. Dry or cracked lips can be a sign of dehydration or of an oral infection such as thrush (yeast). New rashes (bumps, blisters, or red marks) over any part of the body should be reported because they can be a sign of an allergic reaction, another illness needing treatment, or an infection that could be spread to others.

4. Level of Weakness

Weakness can be a symptom of many kinds of illnesses. It can be general weakness (all over the body, fatigue) or local (in just one area of the body). Weakness that comes on suddenly might be a sign of a stroke or a serious medical illness. Weakness that happens gradually could be part of almost any other illness. Small changes in level of weakness that are different from the baseline

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pattern should be noted and followed over time; assessment will depend on where the change is located and how quickly it is changing.

5. Falls Risk

A fall is defined as "involuntarily coming to rest on a lower surface," whether it is an observed and assisted transition to the floor or an unwitnessed event that results in an injury. There are many things that can cause a fall, including things in the environment (like lighting, slippery floors, objects in the way) and things about the person who fell (like medications, medical conditions, and state of mind). Because falls often involve many factors, they should always be reported to determine what changes can be made to keep the resident safe.

6. Vital Signs

Vital signs include temperature, respiratory rate, blood pressure, and pulse rate. Some vital signs are collected using equipment, and some (respiratory rate) are done through observation. Vital signs are measured on a routine basis in nursing homes and help to monitor the resident's status and response to certain therapies. When there is suspicion of clinical change, vital signs must be obtained and should always be compared to baseline vital signs. Sometimes a resident will be observed to have an abnormally high or low respiratory rate, and that will be the first sign of a clinical change that requires further assessment. For example, a high respiratory rate with fever and a high heart rate could signify an infection in the lungs or bloodstream, while a low respiratory rate could be a sign that the person has had too much pain medication.

Non-Physical Changes

Many of the non-physical changes described here may be present when the resident has delirium. Delirium is confusion that comes on suddenly and is related to another condition. Delirium can result in increased activity (hyperactive) or decreased activity (hypoactive).

7. Demeanor (Appearance or Way of Acting)

Illness can affect a person's mood or behavior by changing the way the brain works. This can be caused by a bloodstream infection, a stroke, or simply not doing well with the social setting. A resident may become more withdrawn or passive or not want to get out of bed, socialize with others, or participate in usual activities. He or she may not be as talkative or may seem to be inattentive. Getting clues about what a change in demeanor may mean comes from doing an

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assessment, usually starting with an assessment by the registered nurse. The registered nurse's assessment might include administration of the MDS PHQ-9 (see Additional Tools and resourses section) to compare to previous results.

8. Appetite

Changes in appetite may signify many conditions and should always be reported. Sometimes medications change the way things taste or smell. The sense of taste can also be affected by a cold, chronic sinus congestion, or problems with stomach acid. Dental problems or pain in the mouth may make people not want to eat. Some medical conditions cause people to feel full faster or to feel nauseous all the time. People who are depressed or delirious may lose their appetite. Some people with dementia or confusion may have decreased initiative or interest in food. A more complete assessment, usually starting with assessment by a registered nurse, is needed if a resident loses his or her appetite.

Non-Physical Changes

- Demeanor – e.g., the resident is socializing less than normal.
- Appetite – e.g., the resident is not interested in his or her food.
- Sleeping – e.g., the resident falls asleep in unusual places.
- Speech – e.g., the resident's speech is slurred.
- Confusion or agitation – e.g., the resident is talking a lot more than usual.
- Resident complaints of pain – e.g., the resident grimaces or winces when he or she moves.

9. Sleeping

Poor sleep is a problem for everyone, and residents deserve an assessment to allow them good sleep if at all possible. Changes to watch for include the resident complaining about not feeling rested, falling asleep in unusual settings, and being hard to rouse from sleep. Some residents with dementia or delirium have their sleeping and waking times mixed up, and after being up talking all night, they finally fall asleep in the morning hours. Poor sleep may also be a sign of something else, such as pain, anxiety, or depression. Some residents have difficulty breathing at night due to chronic lung problems, snoring, or pneumonia and may never fall into a deep sleep. Some medications and alcohol at night can also change sleeping patterns and interrupt normal sleep.

10. Speech

Speech problems are noted when residents have newly slurred or garbled speech, problems speaking loudly enough, or problems with chewing or swallowing food. Sometimes they might have problems finding the right words to say. Changes like this that happen suddenly might be related to their medication, or they may signal a stroke. Sometimes residents may simply be sleep-deprived. Usually new difficulties with speech mean that an assessment is needed.

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11. Confusion or Agitation

Older people living in long-term nursing centers are often confused at baseline, but new levels of confusion or delirium can mean many things. Changes to watch for include behaviors such as talking a lot more or less than usual, talking loudly, or talking in ways that don't make sense, as well as refusing or resisting care. Some residents with confusion see or hear things or people that are not there. These changes can mean that the resident is in pain, that medications need adjustment, or that another illness has begun – anything from pneumonia or urosepsis to dehydration or a stroke. A nursing center resident's normal (baseline) mental status is evaluated on admission using the MDS BIMS assessment (see Additional Tools and Resourses), and this baseline can provide helpful information if there is a change. The licensed nurse may assess change using a tool such as the CAM assessment from the MDS, which will provide helpful information. New confusion or delirium should be reported and addressed clinically.

12. Resident Complaints of Pain

Residents know their own body sensations. It may be hard for them to convey that something new is happening or something has gotten worse. But even residents with dementia may be able to express something. Listen to the resident to see if he or she can tell you more about what hurts or feels different or bothersome.

Chronic pain is often due to arthritis or some other condition that is not likely to cause quick changes in the resident's condition. It still needs to be reported and evaluated, but it may be less urgent than new pain. New pain can be a symptom of many things, for example a heart attack, a dangerous weakening in one of the major blood vessels, or a weakening in the bowel wall that has worn through. New pain needs to be brought to the attention of the licensed nurse right away.

Watching for Change

The key to watching for change is to always be watching. But that is hard to do. No one can be perfectly aware all the time, but if we have a good baseline for what is normal, it is almost automatic to notice change. Try to watch residents wherever they are, and not just in specific places or times (such as medication hour), as much of the time as possible. The more comfortable and familiar the relationship with the resident, the easier it is to see change. Check in with residents often, ask how they are, and watch them during their daily living activities.

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Take special care with residents with dementia to get to know their baseline and watch them because changes for these residents can be sudden, and they may not be able to tell you what's wrong.[4]

Always talk with others who provide care for your residents. When you see what might be a change it is especially important to talk with your team members and see if they noticed it and when they think it started.

Here are some examples of how the interdisciplinary team can watch for the Top 12 changes.

Physical changes:

- **Walking –** If the resident needs assistance, watch how much assistance he/she needs with walking. You can watch to see if the resident changes mode of transportation (walking to wheelchair). You can watch the resident when they walk down the hall to see if he/she uses the guard rails more than usual.
- **Urination and bowel problems –** Be sure to notice if the resident is incontinent of urine or stool, or if urination is more frequent, urine smells different, or if bowel movements are rare or change to diarrhea.
- **Skin –** While bathing and dressing the resident, look to see if the resident's skin is discolored or puffy.
- **Level of weakness –** Watch when the resident raises his or her arms while eating, during activities, or while performing personal hygiene to see if the resident has more difficulty than usual.
- **Falls –** Watch the resident when doing things that could result in a fall (e.g., reaching for objects when in a wheelchair).
- **Vital signs –** Record the resident's blood pressure and heart rate and look for any changes in breathing and temperature.

Watching for Change

- The key is to always be watching.
- Residents should be watched wherever they are, as much of the time as possible.
- Check in with residents often.
- Talk with others who provide care for your residents.

[4] Inouye SK, Dyck CH, Alessi CA, et al. Clarifying confusion: The confusion assessment method. A new method for detection of delirium. Ann Intern Med. 1990; 113:941-948.

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Non-physical changes:

- **Demeanor –** Observe the resident to see if he or she socializes less or participates in activities less than usual.
- **Appetite –** Observe the resident during meals (and the tray after meals) to see if the resident is not interested in his or her food.
- **Sleeping –** Observe during the day to see if the resident falls asleep in unusual places.
- **Speech –** Talk to the resident to see if speech is slurred.
- **Confusion or agitation –** Watch the resident for new fidgeting. When approaching the resident to give normal care, ask the resident structured questions to see if he/she talks more or less.
- **Resident complaints of pain –** When transferring a resident or when the resident is moving, look to see if the resident is grimacing or wincing.

What Should Be Reported

What is important enough to report? If you only reported things that turned out to be a problem, you would probably have missed some. If you reported so many things that few turned out to be a problem, over time you might not get the attention you need when it matters.

What is important enough to report?

- For about every three to five reports, one full assessment is done.
- It is more important to report anything that might matter than to get the amount of reported information perfect.

As a general rule, the care team member who reports about three to five changes to the supervising licensed nurse for every one that the registered nurse responds to with a full assessment is probably getting it right. But this is only a "rule of thumb," and it can vary from resident to resident and from day to day, depending on the resident's needs. It also varies from staff member to staff member. In general, the process of reporting should allow each provider level to pick out the most important information from a somewhat larger amount of possibly important information.

It is more important to report anything that might matter than to get the amount of reported information perfect. Experience and training help when deciding on how much to report; team members with less training or less experience should not hesitate to report more rather than less. So, if in doubt, report your concern to your supervisor.

When starting out with a new situation or a new resident, it can be overwhelming to think about how many things can go wrong and how much you have to watch for. But once you're familiar with daily patterns, you'll be aware of the things that happen often and those that are changes.

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Following Up on the First Sign of Changes

Sometimes it is hard to know when a change is really a change and that it should be reported. Here are some things you can do to be confident that you are looking at a real change and also that you are not waiting too long to decide that it is a real change that should be reported.

Shift-to-shift Comparisons

Your nursing center probably has a place to record your resident's blood pressure, urination and bowel information, temperature, activities of daily living, and behaviors. Be sure to use this to record information from your shift, and be sure to read what was written from the shifts before yours so you can make comparisons. Always ask yourself: 'Are there any changes that should be watched or reported?' If you feel there is something that needs to be watched, write it in your shift notes. If you feel something has changed that needs to be reported, do so. You may want to use the Early Warning tool and/or the SBAR tool when reporting a change to the licensed nurse.

How to Follow Up on the First Sign of Changes

- Shift-to-shift comparisons.
- Are there any changes that should be watched for or reported?
- Early Warning tool.
  - Form that nursing assistants can use to write down what they have noticed about a resident's condition.
  - Use the tool anytime a resident has had a change.
- SBAR tool.
  - An abbreviation that helps you to remember how to communicate change.
  - SBAR stands for Situation, Background, Assessment, Recommendation.

Early Warning Tool

The Early Warning tool is a form that nursing assistants and other staff members can use to write down what they have noticed about a resident's condition. It is a brief guide through all of the early changes that can be signs of illness. It is meant to help you communicate about the change with the nurse. The form should be completed any time a resident has had a change by the direct staff member who noticed the change. A link to the Early Warning Tool is provided in the Additional Tools and Resources section of this Workbook.

Take a look, and if you have not used one before, try filling it out, say, for the resident you have taken care of most recently. If any changes are noted on the Early Warning tool, report that to the licensed nurse before the end of your shift.

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The Early Warning tool should not take the place of talking to the nurse, but it can help the nursing assistant remember everything he or she wants to tell the nurse about the resident's change in condition.

SBAR Tool

SBAR is an abbreviation that helps you to remember how to communicate a change. "S" stands for situation, "B" stands for background, "A" stands for assessment, and "R" stands for recommendation. When you see a change, the licensed nurse needs to know about it. After seeing the resident and assessing his or her symptoms or physical function, the licensed nurse can decide if the change is important.

If the resident continues to have a problem and it appears that there was no response to the report or the response didn't help, it's probably important to report the resident's condition again. Sometimes the nursing assistant needs to report the problem again to the licensed nurse. Sometimes the licensed nurse needs to report the problem again to the nurse practitioner or doctor.

This is how SBAR works. Think about the case at the start of this Workbook. Imagine Marli wants to report that Ms. A's diarrhea is not improving after several days of antibiotics. Marli might say to the licensed nurse:

Ms. A's situation is not improving; indeed, her diarrhea seems to be worse. You probably remember the background; she started with this diarrhea just over 2 weeks ago, and the stool sample was sent off, and they started medicines 3 days ago. My best assessment is that you would want to know in case you want to make a recommendation to the doctor.

Notice that Marli used the words "situation," "background," "assessment," and "recommendation" to prompt herself as she was giving the relevant information to the licensed nurse. SBAR is a memory aide that helps us to focus on what we need to do.

Observing and Reporting

- Who is responsible?
- Front-line providers are the eyes and ears of the team.
- Part of helping the team perform best is sharing information.
- Receptionists, occupational therapists, chaplains, volunteers, housekeeping staff, other staff members, and visitors are important observers.

For nursing assistants reporting the detected change, the most important part of SBAR is the situation and background. The assessment and recommendation part is mostly for the registered nurse. This is discussed more in the Student Workbook on 'Communicating Change in a Resident's Condition.'

A link to the SBAR tool is in the Additional Tools and Resources section at the back of this Workbook.

Responsibility for Observation and Reporting

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Team members have to pull their own weight, but they also rely on other team members. Front-line providers are the eyes and ears for the team. Medical personnel have to make decisions based on the information that comes to them through the chain of command, including nursing assistants, licensed nurses, and other staff. Keep this in mind when reporting changes in residents; part of helping the team perform best is sharing information.[5]

Receptionists, clerks, occupational therapists, chaplains, volunteers, and members of the transport, dietary, and housekeeping staff are also important observers. They get to know the residents and should feel encouraged to report changes to a clinical member of the team. Visitors can be very important observers too. If they make any comments about changes, ask them what they see that is different and when it seems to them to have changed.

Creating a Safe Environment

Reporting changes helps keep residents as safe as possible. Residents are safest – protected from harm or injury – when everyone expects to openly report anything that might affect the residents' well-being.

Learning and experience help providers to keep residents safe. Learning and experience involve getting information and seeing how things work, noticing when they aren't working right, understanding how to prevent those things from happening, and knowing how to recover when things do go wrong.

A Safe Environment

- Reporting changes helps keep residents as safe as possible.
- Learning and experience help providers to keep residents safe.
- Open communication among team members helps to keep residents safe.
- Team members must move beyond blaming someone.
- Those who care will speak up.

An experienced care team has seen sick people get well with good care. They have also seen things go wrong in the care system. They have learned how to avoid those situations and to fix them as well as they can.

[5] Haig KM, Sutton S, Whittington J. SBAR: A shared mental model for improving communication between clinicians. Jt Comm J Qual Patient Saf. 2006; 32:167-175.Creating a Safe Environment

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Perhaps most importantly, care team members have learned to communicate openly with each other when something happens that might affect a resident's well-being. This may not be easy if the change seems to be serious. When things go wrong or look as if they are about to (near-misses), we tend to feel embarrassed, and worry that if we report the problem, our job performance could be questioned or we might get punished. And we don't want to get anyone else in trouble. This is particularly true if a supervisor needs to be involved. As a result, things that might affect a resident's safety may go unreported or not be discussed. This puts the resident at risk for a bad outcome.

Not being able to talk about how things did or could go wrong holds back our own learning. Learning is much harder if we can't see what happens when things go wrong for others, or we can't get feedback when it happens to us. Everyone – residents and staff – benefits from an environment that supports discussion and learning from near misses and adverse events.

This teaching session should be a chance for you to talk about reporting change in a way that is safe for you and your colleagues (that is, you should feel confident that no one will blame you and your team) as well as good for the residents. If you feel safe to report change, say so. If you don't, say so; you should be able to feel safe when reporting change.

We all care about the residents in our nursing center. To make sure they stay safe, we have to move beyond blaming anyone, to being able to openly share experiences – good and bad. It is true that you may come across a situation in which a care provider's actions are not well-intended; that person may have to be identified and possibly removed from the setting. But that is very unusual. Usually, when things go wrong it is because a provider was too tired, distracted, didn't know the system, or the communication or teamwork was not smooth. Sometimes systems create "an accident waiting to happen." These kinds of problems can be fixed best if discussion is encouraged by the leadership (or administration), and the care team can work together to figure out a solution.

Remember, caring means speaking up. Residents expect and deserve a safe environment and often cannot speak for themselves, so it is up to members of their care team to speak for them. While that's easier for some of us than others – especially on sensitive matters that we think might cause blame – it's something we all have to learn to do.

Conclusion

In Summary

The ability to detect change in a resident's condition is important because it can prevent illness from getting worse. Nursing staff know the residents best; therefore they are the best qualified to notice when there is a change in a resident's condition. Detecting change depends on all nursing staff (nursing assistants/licensed nurses) being alert to changes and ready to share their observations and respond to the changes.

In order to properly assess a change, it is necessary to know the resident's normal (baseline) condition, assess the change and compare it with the baseline, and know which changes might be signs of illness. When there is a change in condition in an older person, it usually is less obvious than it would be in a younger person, and it could mean many different things.

Changes to watch for include those affecting the way a resident walks, urination and bowel patterns, skin changes, level of weakness, falls, vital signs, demeanor, appetite, sleeping, speech, confusion or agitation, and resident complaints of pain. It may be necessary to report a change repeatedly.

Summing Up:

- Detecting changes can prevent an illness from getting worse.
- Nursing staff know the resident best.
- Nursing staff must be alert to watch for changes.
- The need to share observations and respond to changes is very important.
- Staff must know what's normal for the resident so it can used for comparison when there is a change.
- Staff must know the different changes they need to watch for.

Pearls and Pitfalls

Pearls

1. The best way to detect a change in a nursing center resident is to get to know what is normal for that particular resident.
2. You can learn to be observant, and to make a habit of being "tuned in" to residents.

3. Older people have less response to change, so the signs and symptoms of illness they exhibit may be milder or different from those seen in younger people.
4. A safe environment supports open reporting of resident changes and doesn't find fault with reporters.
5. When in doubt, report a change.

Pitfalls

1. Feeling that it is hard to report a change because someone might be blamed is a barrier to safe care.
2. Forgetting to use reporting tools makes it harder for the care team to be alerted to changes once these are detected.
3. Expecting someone else to take action when change is detected does not help residents stay safe.
4. Assuming someone else knows the resident better or knows more than you can get in the way of your desire to report what you think might be a change.

Additional Tools and Resources

A. Early Warning tool (adapted for long term care settings such as nursing centers) http://www.in.gov/isdh/files/Doc_7_-_Interact_Stop_and_Watch_Tool.pdf. Accessed January 10, 2012.

B. SBAR tool http://www.interact2.net/docs/Communication%20Tools/SBAR_Communication_Tool_and_Progress_Notec.pdf; accessed January 30, 2012.

C. Increasing Use of Consistent Assignment. Advancing Excellence in America's Nursing Homes Campaign. http://www.nhqualitycampaign.org/files/factsheets/Staff%20 Fact%20Sheet%20-%20Consistent%20Assignment.pdf; accessed January 9, 2012.

D. Minimum Data Set 3.0: Brief Interview for Mental Status (BIMS), Items C0200
– C0500; Confusion Assessment Method (CAM), Items C1300 and C1600; and the PHQ-9, Item D0200. https://cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage

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