How Well Do You Know Your Residents?

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Recognition and Assessment

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Introduction

Our residents never stay the same, just like ourselves. We all have our ups and downs but how do we know when to sound the alarm??

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Acute Change of Condition (ACOC)

Definition

An Acute Change of Condition is a sudden clinical change from the resident's baseline including cognition, behavioral, or functional decline.

ACOC may happen abruptly, over several hours or days.

Without intervention it may result in further complications or even death.

Goals of Identification

To recognize the change, identify the signs/symptoms, severity and potential cause.

To enable staff to evaluate the resident and manage at the facility avoiding a transfer to the hospital.

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Identification of Resident Risk Factors

- Learn resident's baseline utilizing all sources of information: resident, family, medical records (hospital records, discharge summary), and staff
- Identify pre-existing conditions, prior complications, and any adverse events occurring during the most recent hospitalization

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5

Pre-existing Conditions

- Cardiac: MI, CHF, atrial fibrillation, CVA, HTN
- Respiratory: COPD, asthma
- Infectious: pneumonia, UTI, sepsis, fever
- Metabolic: delirium, dehydration, weight loss/malnutrition, hypo/hyperglycemia
- Functional: fractures, falls, impairment of one, or more ADLs

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6

Specific Conditions with Associated ACOC Risks

- CHF: acute dyspnea, pulmonary edema
- Acute MI: Dysrhythmia, DVT/PE
- Diabetes: hypoglycemia, fluid/electrolyte imbalance
- CVA, TIA: acute bleeding, from anticoagulation therapy, recurrent stroke
- Neurogenic bladder, urinary retention: UTI
- COPD: acute dyspnea, upper/lower respiratory infections
- Fractures: pulmonary embolism, venous thrombosis
- New medications: falls, delirium (mental status change)

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Top 12 Changes in Residents

Physical	Non-Physical
- Walking - Urination and bowel patterns - Skin - Level of weakness - Falls - Vital Signs	- Demeanor (Appearance or way of acting) - Appetite - Sleeping - Speech - Confusion of agitation - Complaints of pain

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Triggering Situations

Immediate	• As soon as possible given the situation
Non-immediate	• Usually within 1 business day

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Facility Policy

- Must know who is always covering
- Must know how they are to reach them
- Should have a triage system to ensure timely notification without undue physician burden
- Should have policies that let nurses know what is expected in communication with physicians
- Ideally should review via QA

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Identifying Potential Risk Factors

What is their baseline by reviewing all available sources of information including the resident, family, medical record and staff

Identify pre-existing conditions, prior complications and any adverse events since the most recent hospitalization

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Additional Risk Factors

Possible Pre-existing Conditions

- Cardiac: MI, CHF, Atrial fibrillation, CVA, HTN
- Respiratory: COPD, asthma
- Infectious: pneumonia, UTI, sepsis, fever
- Metabolic: delirium, dehydration, weight loss/malnutrition hypo/hyperglycemia
- Functional: Fracture, falls, impairment of one or more ADLs

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Specific Conditions with Associated ACOC Risks

CHF: acute dyspnea, pulmonary edema
Acute MI, Dysrhythmia, DVT/PE
Diabetes, hypoglycemia, fluid/electrolyte imbalance
CVA, TIA, acute bleeding form anticoagulation therapy, recurrent stroke
Neurogenic bladder, urinary retention, UTI
COPD, acute dyspnea, embolism, venous thrombosis
New medication: falls, delirium, (mental status change)

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Physical Changes

Walking: change in level of assistance or balance	Level of weakness: fatigue, difficulty in raising arm or leg	Urination and bowel patterns: new changes
Fall risk: repeated falls, out of character	Skin: swollen, dry/cracked, red, itching, bleeding	Vital signs: breathing faster, fever

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Non-Physical Changes

COMPLAINTS OF PAIN

CONFUSION OR AGITATION

SPEECH

DEMEANOR

APPETITE

SLEEPING

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Purpose

To provide licensed nursing staff general guidelines for situations under which physicians should be notified.

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COMMUNICATION

Depends on…

- Individual physician preferences
- Use of physician extenders

Telecommunication capabilities

- Fax
- Pager
- Office phone
- Exchange number
- Smartphone
- Cellphone

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WHY DISCUSS PHYSICIAN NOTIFICATION

- Patients in NH are often unstable
- Physicians aren't always on site
- Physicians depend on timely and accurate communication from the NH staff
- Physician practice styles vary
- Little consistency in logistics/understanding
- Medico-legal risk
- Issues must be triaged

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Physician Preferences

- Must be understood for each practitioner, documented for all nurses to see
- Evening/weekend/holiday coverage
- Covering physicians must abide by policy
- Facility policy/attending physician agreement helpful
- All contact information should be available to the DON/Charge nurse

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Physician Extenders

- Can improve communication
- Triage system should be understood re: routine, urgent, emergent
- Hours/days of coverage must be understood and clearly documented
- Communication means must be understood
- Facility policy may be helpful

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Assessment

The nurse should not hesitate to contact the physician at any time for a problem which in their judgment requires immediate medical attention.

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Facility Policy

- Must know who is covering
- Must know how to reach them
- Should have a triage system to ensure timely notification without undue physician burden
- Ideally should review the process via QA

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Be Prepared

To Fax or Not To Fax

- Fax protocols are commonly misunderstood
- Legally, faxes are answered within 1 business day (up to 2.5 days on weekend)
- No such thing as an urgent fax UNLESS physician is notified/proper arrangements made AND documented
- Faxes are only for routine matters

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Be Prepared

Assessment should include…

- Vital signs
- Major diagnosis
- Allergies
- Current pertinent medication
- Relevant physical findings
- Action already taken
- Presence of advanced directives, CPR status

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Get Your Act Together

1. Obtain and organize resident information before calling
2. Save several non-immediate items for one call and coordinate calls with the other nurses who may also need the MD
3. Anticipate the questions the physician might ask and have the answers ready

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Implementation

The nurse, the facility, and the resident should be identified to the physician. If the physician is on call physician, also identify the resident's attending physician.

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Triaging Situation

Immediate	As soon as possible given the situation
Non-Immediate	Usually within 1 business day

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Planning

If the physician needs to return your call, be available when the call is returned.

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PLANNING

Obtain and organize resident information before calling

Present the data in a logical manner

Consider AMDA's "Know it all before you call" toolkit

https://paltc.org/?q=product-store/know-it-all%E2%84%A2-paltc-assisted-living-settings-series

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TO FAX OR NOT TO FAX.....

Fax protocols are commonly misunderstood

Legally, faxes are answered within 1 business day (up to 2.5 days on weekends)

No such thing as an urgent fax UNLESS physician is notified/prior arrangements made AND documented

Faxes are only for routine matters

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ASSESSMENT

The nurse should not hesitate to contact the physician at any time for a problem that, in their judgment, requires immediate medical attention.

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PLANNING

Before the physician is contacted, the nurse MUST be prepared with the following information:

- Vital signs
- Major diagnosis
- Allergies
- Current pertinent medication
- Relevant physical findings
- What have you done already
- Presence of advanced directives, CPR status

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PLANNING

Obtain and organize	Obtain and organize resident information before calling
Save	Save several non-immediate items for one call and coordinate calls with other nurses who may also need to speak with the physician
Anticipate	Anticipate the questions the physician might ask and have the answers ready

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PLANNING

If the physician needs to return your call, be available when the call is returned.

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IMPLEMENTATION

Attempts to notify the physician should take place in the following order:

- Attending physician
- Alternate or on-call physician
- Medical Director
- For situations requiring immediate action, use best clinical judgment

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IMPLEMENTATION

The nurse, the facility, and the resident should be identified to the physician. If the physician is on call physician, also identify the resident's attending physician.

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IMPLEMENTATION

Present the data in a logical manner

- Consider AMDA's "Know it all before you call" toolkit

Consider the SBAR tool

- Situation
- Background
- Assessment
- Recommendation

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IMPLEMENTATION

Inform the physician of the services available in the facility vs automatic transfer of resident to the ER →

Examples

- IV therapy
- Emergency medications
- 24-hour mobile imaging, pharmacy, lab
- Consultation services: (e.g., dermatology, psychiatry, ophthalmology, and dentistry)

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IMPLEMENTATION

The resident's interested family members or legal representative should be notified of significant change in resident's status unless resident has specified otherwise.

39

OUTCOME

Monitor and reassess resident's status and response to interventions

The physician should develop a working diagnosis and guide the nursing staff in what to expect, what to monitor, and when to re-contact the physician if the resident's progress deviates from the anticipated or expected course

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Specific Conditions

The following are general guidelines for notifying physicians regarding specific conditions.

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Alteration in Mental Status

IMMEDIATE	NON-IMMEDIATE WITHIN NEXT OFFICE DAY
• Abrupt change in mental status	• Gradual change in mentation

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Bleeding

Immediate	Non-Immediate (within next office day)

• Uncontrolled or repeat episode within 24 hours
  • Prolonged nosebleed, bloody emesis, bloody stools not from hemorrhoids, profuse vaginal bleeding, gross bloody urine
	• Controlled
	  • No further episodes
	  • Bleeding from hemorrhoids
	  • Minor hematuria

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Chest Pain

Immediate	Non-Immediate (within next office day)
• New onset • Recurrent onset not relieved in 20 min. by previously ordered NTGx3 • Chest pain accompanied by change in VS • Diaphoresis • N/V or SOB	• Known history chest pain with increase in frequency or episodes

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Diarrhea

Immediate	Non-immediate (within next office day)
• Acute onset of multiple stools with change in VS (e.g., temp .> 101) or mental status changes	• Persistent loose stools with stable VS

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Edema

Immediate	Non-immediate (Within next office day)
• Abrupt onset in one leg • Abrupt onset with tenderness and redness • Acute shortness of breath	• Known history of edema with progressive unilateral or bilateral increase • Gradual progressive edema with weight gain

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Emesis

Immediate	Non-immediate (Within next office day)
• Bloody or coffee grounds • Repeat episodes • Pain • Associated with change in VS	• Persistent loose stools with stable VS

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47

Edema

Immediate	Non-immediate (Within next office day)
• Abrupt onset in one leg • Abrupt onset with tenderness and redness • Acute shortness of breath	• Known history of edema with progressive unilateral or bilateral increase • Gradually progressive edema with weight gain

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Enteral Feeding Tube

Immediate	Non-immediate (within next office day)
• If removed and unable to immediately replace	• Intolerance to feeding • Leakage around G-tube stoma site

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Falls

Immediate	Non-immediate (within next office day)

• Obvious deformity
  • Shortening of lower extremity w/rotation
• Hip pain with palpation or inability to walk
• Head injury
• Abnormal neuro status
• New onset of confusion
• Laceration with uncontrolled bleeding
	• No bleeding
	• No injury
	• Minor injury
	  • Skin tear, bruise, etc.
	• Increase frequency of falls in a 24-72 hour period
	• An isolated explainable fall

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Family Request

Immediate	Non-immediate (Within next office day)
• Requesting or demanding to speak to a physician now	• Persistent, recurrent concern that may need physician attention

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Medication Errors

Immediate	Non-immediate (Within next office day)
• Significant error • Resident is symptomatic due to the error	• Non-significant medication error • No symptoms

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Pressure Sores

Immediate	Non-immediate (Within next office day)
• Stage II, III, IV, receiving no treatment and no treatment protocol available to cover condition	• New stage I • Any stage when current treatment is not effective

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Seizures

Immediate	Non-immediate (Within next office day)
• New onset • Status epilepticus	• Self-limited with known history and on antiseizure medication

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Shortness of Breath

Immediate	Non-immediate (within next office day)
• Acute onset or with chest pain • Change in VS • Labored breathing • Ashen or dusky appearance • Cyanosis	• Partial relief with previously ordered treatment (o2, inhalers) • Recurrent episodes but now more frequent

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Skin Rash

Immediate	Non-immediate (within next office day)
• Significant urticaria with face and neck swelling • Rash with a new medication • Dyspnea	• Generalized urticaria without symptoms • Localized • No other symptoms • Recurrent

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Vital Signs

Immediate	Non-immediate (Within next office day)
• Systolic BP: >200 or <90	• Diastolic BP routinely >90
• Diastolic BP: >115	• Resting pulse: >120 on repeat exam
• Resting pulse: >130 ,<55*	
• Respirations: >28. <`0*	
• Oral temp:>101	
• Rectal temp:>102	

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Weight Gain

Immediate	Non-immediate (Within next office day)
	• 5% in 30 days • 7.5% in 90 days • Over 10% in 180 days

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Laboratory Values

Immediate	Non-immediate (Within next office day)
ANY PANIC LEVEL* *Unless values are consistently at this level and the physician is aware	

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CBC (Complete Blood Count)

Immediate	Non-immediate (Within next office day)
• WBC> 1200* with change of condition or fever *Unless values are consistently at this level and the physician is aware	• WBC> 10,000 without symptoms or fever

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Chemistry

Immediate	Non-immediate (Within next office day)

• BUN:>60*
• Potassium (K) <3.0 >6.0
• Sodium (NA) <125 >155
• Glucose
  • >300 in Diabetic (W/OS/S)
  • >430 in Diabetic w/s/s
  • <70 in diabetic
  • < 50 in anyone
 	
*Unless values are consistently at this level & the physician is aware
	• Glucose consistently > 200
	• Glycosated Hb: any value
	• Albumin: any value
	• Billirubin: any value
	• Cholesterol: any value
	• Triglycerides: any value

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Drug Levels

Immediate	Non-immediate (Within next office day)
• Dilantin (phenytoin) >25mcg/ml (hold next dose) • Lanoxin >2.2 (hold next dose) Levels above therapeutic range in any drug, hold next dose	• Any normal value unless resident is clinically toxic

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PROTIME

IMMEDIATE	NON-IMMEDIATE (WITHIN NEXT OFFICE DAY)

• PT
  • INR > 6 (hold Coumadin)
	• PT
	  • INR 4-6 (hold Coumadin)

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URINALYSIS

IMMEDIATE	NON-IMMEDIATE (WITHIN NEXT OFFICE DAY)
• WBCs >10 with symptoms: fever, burning, pain, altered mental status	• WBCs < or >10, no symptoms

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Urine Culture

Immediate	Non-Immediate (Within next office day)
• >100,000 colony count *with* symptoms	• >100,000 colony count *without* symptoms

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X-Ray

Immediate	Non-Immediate (Within next office day)
• New or suspected finding, such as fracture or pneumonia	• Old or long-standing finding, no change

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DOCUMENTATION

Document in the nurses' notes:

- All attempts to contact the physician
- All attempts to notify family/legal representative
- Physician response
- Physician orders
- Resident status and response

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DOCUMENTATION

If the resident remains at the facility and a change in condition has occurred…

- Update the care plan!
- Alert the MDS coordinator that a change has occurred

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DOCUMENTATION

If the resident is transferred to the hospital…

- Complete transfer form
- Send a copy of the most recent:
  - H and P
  - Progress note
  - Advanced directive
  - Medication list
  - Diagnosis list
  - Pertinent lab and x-ray reports

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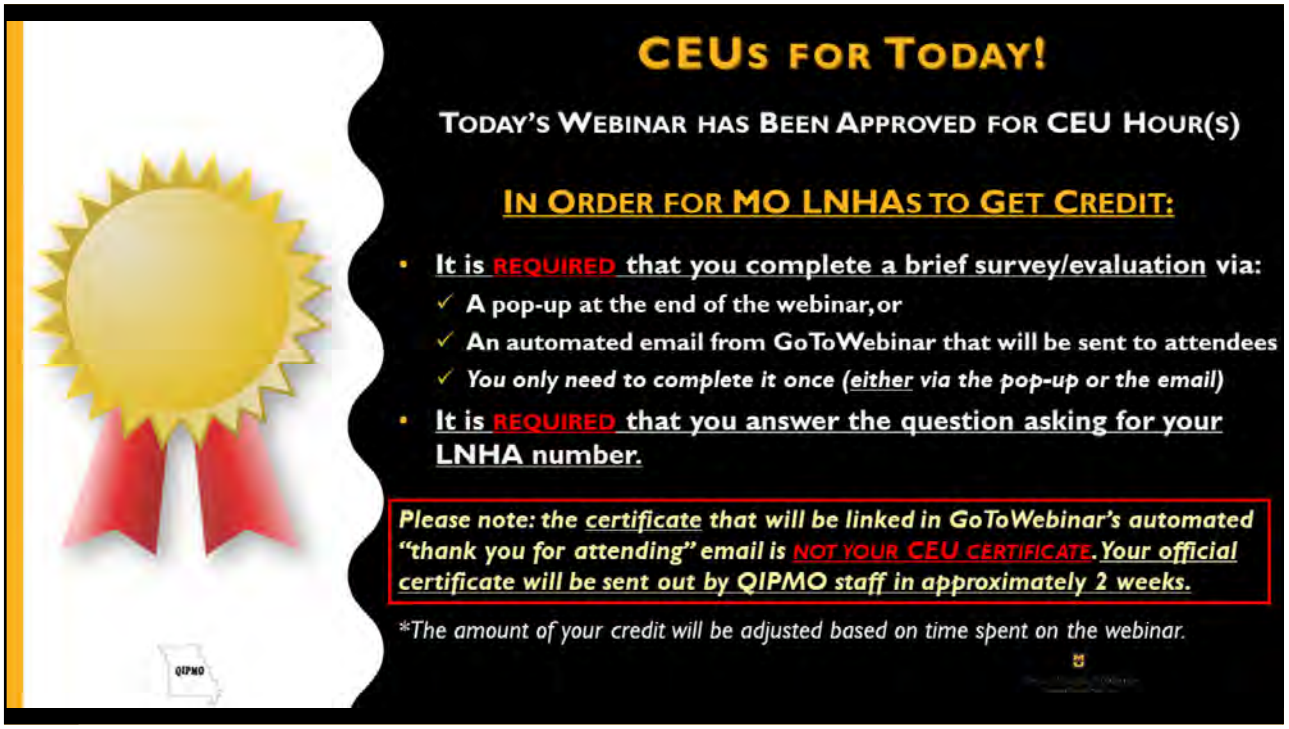

70

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This follow-up email was sent to 129 attendees.

We hope you enjoyed our webinar.

Please send your questions, comments and feedback to: musonqipmo@missouri.edu.

Please take the following survey:

QIPMO Webinar Survey

Your certificate is available here:

My Certificate

This is *NOT* your CEU certificate!! It's just a participation certificate that 's automatically sent out by GoToWebinar.

71

72

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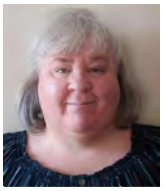

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73

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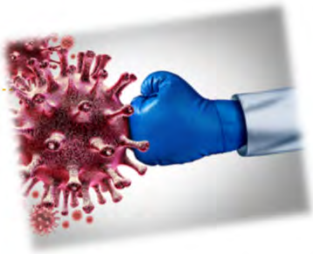

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74

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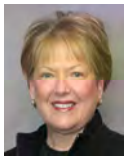

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75