Synergy Healthcare Resources
& Solutions Group

Title: Change of Condition: Recognize, Assess, Communicate & Follow up - Transcripts

00:00:03.600 --> 00:00:07.918
Welcome to Change of Condition: Recognize, Assess,
Communicate, and Follow Up.

00:00:08.068 --> 00:00:13.108
This training was developed by Mildred DeCastro and
produced by Synergy Healthcare Resources and Solutions

00:00:13.108 --> 00:00:18.068
Group for the education and professional development
of staff working within our partner skilled nursing

00:00:18.068 --> 00:00:19.295
and long-term care facilities.

00:00:19.445 --> 00:00:24.325
Throughout this training, we will focus on recognizing
a resident’s change from their usual baseline, completing

00:00:24.325 --> 00:00:29.925
an appropriate nursing assessment, determining when
concerns require prompt or immediate escalation, communicating

00:00:29.925 --> 00:00:34.283
relevant clinical information, and following the resident
after interventions have been initiated.

00:00:34.433 --> 00:00:40.993
We will also use SBAR â€” Situation, Background, Assessment,
and Recommendation â€” as a structured communication

00:00:40.993 --> 00:00:46.193
method to help licensed nurses organize important
clinical information when communicating a resident’s

00:00:46.193 --> 00:00:51.476
change in condition to a physician, nurse practitioner,
physician assistant, or other appropriate practitioner.

00:00:51.626 --> 00:00:57.626
Before we begin, an important disclaimer: This educational
program is intended for training purposes and is not

00:00:57.626 --> 00:01:03.546
a substitute for professional clinical judgment, resident-specific
assessment, practitioner orders, facility policies

00:01:03.546 --> 00:01:07.927
and procedures, emergency protocols, or applicable
federal and state requirements.

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:01:08.077 --> 00:01:13.757
The clinical examples, scenarios, forms, and decision points presented in this program are provided for

00:01:13.757 --> 00:01:15.031
educational purposes.

00:01:15.181 --> 00:01:21.341
Individual facilities may use different forms, electronic health record systems, policies, notification procedures,

00:01:21.341 --> 00:01:22.623
or clinical protocols.

00:01:22.773 --> 00:01:28.053
Staff must always follow the policies and procedures of the facility where they are providing care, as

00:01:28.053 --> 00:01:31.283
well as resident-specific orders and their individual scope of practice.

00:01:31.433 --> 00:01:36.713
When a resident appears to be experiencing a medical emergency or significant deterioration, staff should

00:01:36.713 --> 00:01:41.993
follow the facility's emergency response procedures and should not delay necessary care in order to complete

00:01:41.993 --> 00:01:44.065
documentation or an SBAR form.

00:01:44.215 --> 00:01:50.455
The goal of this training is simple: recognize the change, assess the resident, communicate clearly,

00:01:50.455 --> 00:01:54.710
and follow through until the resident's condition and response have been appropriately addressed.

00:01:54.860 --> 00:02:00.224
Let's begin by looking at what we mean when we say a resident has experienced a change in condition.

00:02:04.424 --> 00:02:09.543
By the end of this training, licensed nurses should be able to demonstrate five key behaviors related

00:02:09.543 --> 00:02:12.539
to recognizing and managing a resident change in condition.

00:02:12.689 --> 00:02:17.329
First, you will be able to identify changes from a resident's usual baseline and distinguish findings

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:02:17.329 --> 00:02:21.569
that require urgent attention from those that may
be managed through a non-urgent change-of-condition

00:02:21.569 --> 00:02:22.151
process.

00:02:22.301 --> 00:02:27.661
Second, you will be able to state the notification
actions associated with F580 when a qualifying change

00:02:27.661 --> 00:02:28.768
in condition occurs.

00:02:28.918 --> 00:02:34.598
We will discuss what the federal regulation requires,
who must be notified, and why timely communication

00:02:34.598 --> 00:02:35.176
is important.

00:02:35.326 --> 00:02:42.046
Third, you will demonstrate the use of SBAR: Situation,
Background, Assessment, and Recommendation, to organize

00:02:42.046 --> 00:02:46.808
and communicate pertinent clinical information when
reporting a resident's condition to a practitioner.

00:02:46.958 --> 00:02:51.462
Fourth, you will practice completing the entire change-of-condition
documentation process.

00:02:51.612 --> 00:02:56.732
This includes documenting your assessment findings,
notifications, practitioner orders or interventions,

00:02:56.732 --> 00:02:59.948
the resident's response, and continued monitoring
and follow-up.

00:03:00.098 --> 00:03:04.978
Finally, you will apply the Change of Condition process
to a resident case scenario.

00:03:04.978 --> 00:03:08.887
The goal is not to teach one particular form or electronic
health record.

00:03:09.037 --> 00:03:11.893
Facilities may use different documentation systems.

00:03:12.043 --> 00:03:16.523
Instead, we want you to understand the clinical process

Synergy Healthcare Resources & Solutions Group Copyright Protected

well enough that you can apply it whether your facility

00:03:16.523 --> 00:03:20.112
uses a paper form, or other electronic documentation system.

00:03:20.262 --> 00:03:24.742
As we work through the training, keep one question in mind: What has changed from this resident's usual

00:03:24.742 --> 00:03:27.356
baseline, and what do I need to do about that change?

00:03:27.506 --> 00:03:30.942
We'll begin by defining exactly what we mean by a change in condition.

00:03:35.143 --> 00:03:40.103
Before we can communicate a change in condition, we first have to recognize that something about the resident

00:03:40.103 --> 00:03:40.622
is different.

00:03:40.772 --> 00:03:46.372
In skilled nursing and long-term care, a change in condition does not always mean an emergency.

00:03:46.372 --> 00:03:51.279
A change may be immediate or urgent, or it may be non-immediate but still clinically important.

00:03:51.429 --> 00:03:55.989
An immediate or urgent change may involve an acute or sudden onset with a marked difference from the

00:03:55.989 --> 00:03:57.269
resident's usual condition.

00:03:57.419 --> 00:04:02.830
It may also involve a symptom or condition that is not relieved by measures that have already been prescribed.

00:04:02.980 --> 00:04:08.980
For example, a resident who suddenly develops significant difficulty breathing, becomes unresponsive, develops

00:04:08.980 --> 00:04:14.660
new stroke-like symptoms, or experiences severe symptoms that are not relieved by the current treatment requires

00:04:14.660 --> 00:04:15.878
immediate attention.

00:04:16.028 --> 00:04:18.028

Synergy Healthcare Resources & Solutions Group Copyright Protected

A non-immediate change is different.

00:04:18.028 --> 00:04:22.908
The resident may have a new symptom or a worsening
problem, but the findings do not meet the criteria

00:04:22.908 --> 00:04:24.294
for immediate notification.

00:04:24.444 --> 00:04:28.604
That does not mean we ignore the change or simply
wait until the next shift.

00:04:28.604 --> 00:04:33.744
The resident still requires appropriate nursing assessment,
communication, monitoring, and follow-up.

00:04:33.894 --> 00:04:37.494
The most important concept on this slide is baseline.

00:04:37.494 --> 00:04:40.848
Ask yourself: What is normal for this resident, and
what is different today?

00:04:40.998 --> 00:04:47.718
A blood pressure, respiratory rate, behavior, appetite,
mobility level, or mental status cannot always be

00:04:47.718 --> 00:04:50.937
interpreted by looking at one number or one observation
alone.

00:04:51.087 --> 00:04:55.510
We need to understand the resident's usual condition
and determine whether something has changed.

00:04:55.660 --> 00:04:59.900
For example, a resident who normally walks to the
dining room but suddenly needs extensive assistance

00:04:59.900 --> 00:05:01.906
to transfer has experienced a change.

00:05:02.056 --> 00:05:07.016
A resident who is normally alert and conversational
but is suddenly confused or unusually sleepy has experienced

00:05:07.016 --> 00:05:07.501
a change.

00:05:07.651 --> 00:05:13.491
A resident who normally eats most meals but suddenly
refuses food and fluids may also be showing an early

00:05:13.491 --> 00:05:15.171

Synergy Healthcare Resources & Solutions Group Copyright Protected

change in condition.

00:05:15.171 --> 00:05:17.322
These changes may have many possible causes.

00:05:17.472 --> 00:05:21.392
Our job as licensed nurses is not to assume the diagnosis.

00:05:21.392 --> 00:05:27.152
Our job is to recognize the change, assess the resident,
determine the urgency, and communicate the clinical

00:05:27.152 --> 00:05:28.177
findings appropriately.

00:05:28.327 --> 00:05:32.807
As we continue, we will look more closely at the types
of changes that should trigger a nursing assessment

00:05:32.807 --> 00:05:35.119
and which findings require more immediate attention.

00:05:39.319 --> 00:05:44.279
Now that we have defined a change in condition, let's
connect the clinical process to the federal regulatory

00:05:44.279 --> 00:05:45.799
requirement.

00:05:45.799 --> 00:05:48.189
F580 is Notification of Changes, under Federal Guidance.

00:05:48.339 --> 00:05:53.779
For licensed nurses, the important point is that certain
changes require immediate communication.

00:05:53.779 --> 00:05:56.280
This is more than simply documenting that a change
occurred.

00:05:56.430 --> 00:06:01.770
Think about the process in four parts: inform, consult,
notify, and document.

00:06:01.920 --> 00:06:07.200
First, inform the resident when a qualifying change
occurs, consistent with the resident's condition and

00:06:07.200 --> 00:06:09.026
ability to participate in their care.

00:06:09.176 --> 00:06:14.296
Second, consult with the resident's physician or appropriate
practitioner when the circumstances identified by

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:06:14.296 --> 00:06:15.248
the regulation occur.

00:06:15.398 --> 00:06:20.135
This is where a clear clinical assessment and organized
SBAR communication become important.

00:06:20.285 --> 00:06:25.725
We want to communicate not simply that something
changed, but what changed, when it changed, how

00:06:25.725 --> 00:06:30.919
the resident compares with baseline, our assessment
findings, and what we are requesting or recommending.

00:06:31.069 --> 00:06:36.429
Third, notify the resident representative consistent
with the representative's authority and the applicable

00:06:36.429 --> 00:06:37.389
notification requirements.

00:06:37.389 --> 00:06:37.641
.

00:06:41.841 --> 00:06:43.745
And fourth, document the process.

00:06:43.895 --> 00:06:49.575
The medical record should tell the complete clinical
story: what was identified, what you assessed, who

00:06:49.575 --> 00:06:55.815
was contacted and when, what information was communicated,
what orders or instructions were received, what interventions

00:06:55.815 --> 00:06:58.279
were implemented, and how the resident responded.

00:06:58.429 --> 00:07:04.189
It is also important to understand that F580 does
not mean every minor change automatically falls into

00:07:04.189 --> 00:07:05.662
the same regulatory category.

00:07:05.812 --> 00:07:10.584
The regulation identifies specific circumstances requiring
immediate notification.

00:07:10.734 --> 00:07:16.014
These include certain accidents involving injury with
the potential to require physician intervention, a

00:07:16.014 --> 00:07:21.774

Synergy Healthcare Resources & Solutions Group Copyright Protected

significant change in physical, mental, or psychosocial status, the need to significantly alter treatment,

00:07:21.774 --> 00:07:24.074
and decisions involving transfer or discharge.

00:07:24.224 --> 00:07:27.424
We will look at those circumstances more closely on the next slide.

00:07:27.424 --> 00:07:31.376
The practical takeaway is this: recognizing the change is only the beginning.

00:07:31.526 --> 00:07:36.966
When the change meets the F580 notification criteria, the nurse must make sure the appropriate people are

00:07:36.966 --> 00:07:42.646
informed, the practitioner is consulted, necessary interventions are carried out, and the resident continues

00:07:42.646 --> 00:07:44.006
to be reassessed and followed.

00:07:44.156 --> 00:07:50.316
And remember, the SBAR is the communication method we are using to organize that clinical information.

00:07:50.316 --> 00:07:52.318
F580 is the regulatory notification requirement.

00:07:52.468 --> 00:07:54.868
They are related, but they are not the same thing.

00:07:54.868 --> 00:07:55.057
.

00:07:59.258 --> 00:08:05.658
Now let’s look more closely at the specific circumstances under F580 that require immediate notification.

00:08:05.658 --> 00:08:07.860
First trigger is an accident involving injury.

00:08:08.010 --> 00:08:13.210
If a resident has an accident that results in an injury and that injury has the potential to require physician

00:08:13.210 --> 00:08:15.770
intervention, the notification requirement applies.

00:08:16.125 --> 00:08:18.877
Second is a significant change in the resident’s condition.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:08:19.027 --> 00:08:24.707
This means deterioration in the resident's physical,
mental, or psychosocial status involving a life-threatening

00:08:24.707 --> 00:08:26.503
condition or a clinical complication.

00:08:26.653 --> 00:08:32.333
Remember, that not every change in condition automatically
meets the regulatory definition of a significant change

00:08:32.333 --> 00:08:33.399
under F580.

00:08:33.549 --> 00:08:38.989
A resident can still have a clinically important change
that requires assessment, practitioner communication,

00:08:38.989 --> 00:08:43.591
monitoring, and follow-up even when it does not rise
to this particular regulatory threshold.

00:08:43.741 --> 00:08:46.354
Third is the need to significantly alter treatment.

00:08:46.504 --> 00:08:51.704
This may occur when an existing treatment must be
discontinued because it is causing adverse consequences,

00:08:51.704 --> 00:08:55.246
or when the resident's condition requires the initiation
of a new form of treatment.

00:08:55.396 --> 00:09:00.365
Fourth is a decision to transfer or discharge the
resident, as specified under the regulation.

00:09:00.515 --> 00:09:05.235
When a resident's condition requires transfer to the
emergency department or hospital, the appropriate

00:09:05.235 --> 00:09:09.211
notification process must occur along with the clinical
transfer process.

00:09:09.361 --> 00:09:14.001
From a nursing perspective, there is an important
distinction here: the nurse should not delay assessment

00:09:14.001 --> 00:09:18.916
or emergency intervention while trying to decide whether
an event technically meets an F580 category.

00:09:19.066 --> 00:09:23.386
If the resident is experiencing an emergency, address

Synergy Healthcare Resources & Solutions Group Copyright Protected

the emergency.

00:09:23.386 --> 00:09:28.969
Follow facility procedures, obtain the necessary assistance,
and initiate emergency services when indicated.

00:09:29.119 --> 00:09:32.799
Then make sure the communication and documentation
are complete.

00:09:32.799 --> 00:09:34.799
A useful way to remember this is:

00:09:34.799 --> 00:09:36.479
Accident with injury.

00:09:36.479 --> 00:09:38.399
Significant deterioration.

00:09:38.399 --> 00:09:39.440
Significant treatment change.

00:09:39.670 --> 00:09:40.809
Transfer or discharge.

00:09:40.959 --> 00:09:46.239
When one of these qualifying circumstances occurs,
the nurse needs to recognize the regulatory notification

00:09:46.239 --> 00:09:51.478
obligation and ensure that the resident, practitioner,
and resident representative are informed as required.

00:09:51.628 --> 00:09:57.068
Next, we will separate this regulatory concept of
a significant change from the broader clinical process

00:09:57.068 --> 00:10:01.729
we use every day to identify and manage any meaningful
change from a resident's baseline.

00:10:05.929 --> 00:10:11.209
This distinction is very important because the term
significant change can mean different things depending

00:10:11.209 --> 00:10:12.593
on the process we are discussing.

00:10:12.743 --> 00:10:17.623
On the left is the clinical Change of Condition and
F580 notification process.

00:10:17.623 --> 00:10:21.346
On the right is the MDS Significant Change in Status
Assessment process.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:10:21.496 --> 00:10:25.280
These processes are related to resident care, but
they are not interchangeable.

00:10:25.430 --> 00:10:30.710
A resident can experience a clinically important change
in condition that requires immediate nursing assessment,

00:10:30.710 --> 00:10:36.310
practitioner communication, intervention, and follow-up
without meeting the criteria for an MDS Significant

00:10:36.310 --> 00:10:37.505
Change in Status Assessment.

00:10:37.655 --> 00:10:44.295
For example, a resident may develop a new cough, new
confusion, increased pain, a urinary concern, a fall

00:10:44.295 --> 00:10:47.523
with an injury concern, or a sudden change in blood
glucose.

00:10:47.673 --> 00:10:52.553
The nurse does not wait to determine whether the resident
qualifies for an MDS Significant Change assessment

00:10:52.553 --> 00:10:54.187
before responding to those findings.

00:10:58.387 --> 00:11:02.947
The MDS Significant Change in Status Assessment, on
the other hand, addresses a broader change in the

00:11:02.947 --> 00:11:04.342
resident's overall status.

00:11:04.492 --> 00:11:10.012
It generally involves a major decline or improvement
that is not expected to resolve without intervention,

00:11:10.012 --> 00:11:15.292
affects more than one area of the resident's health
status, and requires interdisciplinary review or revision

00:11:15.292 --> 00:11:16.555
of the resident's care plan.

00:11:16.705 --> 00:11:19.025
So think of these as two different questions.

00:11:19.025 --> 00:11:24.545
The bedside nurse asks: Has something clinically
important changed that requires assessment, intervention,

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:11:24.545 --> 00:11:25.726
or notification now?

00:11:25.876 --> 00:11:31.556
The interdisciplinary and MDS process asks: Has the
resident experienced a significant change in overall

00:11:31.556 --> 00:11:34.874
status that meets the criteria for a Significant Change
in Status Assessment?

00:11:35.024 --> 00:11:39.104
Those determinations do not necessarily happen at
the same time.

00:11:39.104 --> 00:11:43.708
The most important message for the licensed nurse
is the statement at the bottom of this slide:

00:11:43.858 --> 00:11:48.165
Do not wait for an MDS determination before escalating
a clinically important change.

00:11:48.315 --> 00:11:53.675
If you identify a new or worsening condition, assess
the resident, compare the findings with baseline,

00:11:53.675 --> 00:11:59.355
determine the urgency, communicate the change, implement
appropriate interventions or practitioner orders,

00:11:59.355 --> 00:12:00.947
and continue to monitor the resident.

00:12:01.097 --> 00:12:06.697
The MDS and interdisciplinary team can subsequently
determine whether the resident's overall change also

00:12:06.697 --> 00:12:09.944
meets the requirements for a Significant Change in
Status Assessment.

00:12:10.094 --> 00:12:15.294
Next, we'll move from the regulatory distinction back
to the bedside and look at the specific clinical areas

00:12:15.294 --> 00:12:18.825
nurses should assess when determining whether a resident
has changed from baseline.

00:12:23.025 --> 00:12:25.544
Now we move into the bedside recognition process.

00:12:25.694 --> 00:12:30.414

Synergy Healthcare Resources & Solutions Group Copyright Protected

When assessing a possible change in condition, one
of the most important things a nurse can do is compare

00:12:30.414 --> 00:12:32.892
the resident's current findings with their usual baseline.

00:12:33.042 --> 00:12:38.002
A change may occur in one area, or you may see several
changes occurring together.

00:12:38.002 --> 00:12:40.802
Let's look at some of the major clinical areas.

00:12:40.802 --> 00:12:42.609
First, mental and cognitive status.

00:12:42.759 --> 00:12:45.799
Ask: Is the resident more confused than usual?

00:12:45.799 --> 00:12:50.015
Are they unusually sleepy, difficult to arouse, less
responsive, or behaving differently?

00:12:50.165 --> 00:12:55.125
A new change in cognition or level of consciousness
may be one of the earliest signs that something is

00:12:55.125 --> 00:12:56.165
wrong.

00:12:56.165 --> 00:12:58.036
Next is functional status and safety.

00:12:58.186 --> 00:13:03.626
A resident may suddenly become weaker, require more
assistance with transfers, stop walking at their usual

00:13:03.626 --> 00:13:09.425
level, develop a new gait or balance problem, experience
a fall, or develop difficulty swallowing.

00:13:09.575 --> 00:13:14.375
A functional change can be an important clinical finding
even when the resident cannot clearly describe what

00:13:14.375 --> 00:13:15.032
they are feeling.

00:13:15.182 --> 00:13:21.262
For cardiac and respiratory status, look for new chest
symptoms, significant changes in pulse or blood pressure,

00:13:21.262 --> 00:13:26.942
new or worsening edema, shortness of breath, cough,
increased work of breathing, changes in oxygen needs,

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:13:26.942 --> 00:13:28.359
or abnormal lung findings.

00:13:28.509 --> 00:13:34.509
For gastrointestinal and genitourinary status, consider
new vomiting, diarrhea, constipation, abdominal pain

00:13:34.509 --> 00:13:40.816
or distention, decreased urine output, new urinary
symptoms, or concerns involving a catheter or dialysis.

00:13:40.966 --> 00:13:43.446
Skin and wound changes also matter.

00:13:43.446 --> 00:13:49.366
New redness, warmth, drainage, skin breakdown, a new
wound, or deterioration of an existing wound should

00:13:49.366 --> 00:13:51.635
trigger further assessment and appropriate follow-up.

00:13:51.785 --> 00:13:54.641
Finally, look at laboratory and metabolic findings.

00:13:54.791 --> 00:14:00.711
This may include abnormal laboratory results, significant
blood glucose changes, electrolyte abnormalities,

00:14:00.711 --> 00:14:03.684
or findings that may be associated with a medication
or treatment.

00:14:03.834 --> 00:14:07.914
One important point is that we should not look at
these categories in isolation.

00:14:07.914 --> 00:14:10.951
Imagine a resident who is normally alert and ambulates
with assistance.

00:14:11.101 --> 00:14:17.181
Today, the resident is newly confused, requires substantially
more assistance to transfer, is eating poorly, and

00:14:17.181 --> 00:14:18.067
has a new cough.

00:14:18.217 --> 00:14:23.097
Each individual finding is important, but when we
put them together, the overall change becomes even

00:14:23.097 --> 00:14:24.537
more concerning.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:14:24.537 --> 00:14:27.227
This is why knowing the resident's baseline is so important.

00:14:31.427 --> 00:14:36.067
Once you recognize a change in condition, the next step is to prepare the clinical picture before contacting

00:14:36.067 --> 00:14:36.895
the practitioner.

00:14:37.045 --> 00:14:42.485
The goal is not simply to call and say, The resident Doesn't look right, or The resident has a change

00:14:42.485 --> 00:14:47.045
in condition. We want to provide enough relevant information so the practitioner can understand what

00:14:47.045 --> 00:14:50.896
is happening now, how it differs from baseline, and what may be needed next.

00:14:51.046 --> 00:14:56.006
Start by evaluating the resident and completing a focused assessment related to the change you identified.

00:14:56.006 --> 00:14:58.035
Your assessment should match the clinical concern.

00:14:58.185 --> 00:15:03.305
For example, a respiratory change requires a different focused assessment than abdominal pain, a fall, or

00:15:03.305 --> 00:15:04.605
a change in mental status.

00:15:04.755 --> 00:15:09.515
Next, obtain and review the resident's current vital signs and other indicated measurements.

00:15:09.665 --> 00:15:15.985
Depending on the situation, that may include oxygen saturation, blood glucose, pain level, neurological

00:15:15.985 --> 00:15:19.615
findings, intake and output, or other resident-specific information.

00:15:19.765 --> 00:15:23.167
Review the medical record for information that may help explain the change.

00:15:23.317 --> 00:15:30.357
Look at recent progress notes, laboratory and diagnostic

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

results, current orders, medications, and recent treatment

00:15:30.357 --> 00:15:30.863
changes.

00:15:31.013 --> 00:15:37.253
You should also know the resident's relevant diagnoses, allergies, current treatments, and any advance directives

00:15:37.253 --> 00:15:39.825
or care-limiting orders that may affect the plan of care.

00:15:39.975 --> 00:15:43.815
Most importantly, know the resident's baseline and timeline.

00:15:43.815 --> 00:15:48.615
Be prepared to answer: When was the resident last known to be at their usual baseline?

00:15:48.615 --> 00:15:50.134
When was the change first noticed?

00:15:50.284 --> 00:15:52.444
Was the onset sudden or gradual?

00:15:52.444 --> 00:15:55.241
Has the condition improved, remained unchanged, or worsened?

00:15:59.442 --> 00:16:04.642
When you contact the practitioner, you should be prepared to communicate six basic pieces of information:

00:16:04.642 --> 00:16:05.762
What changed.

00:16:05.762 --> 00:16:06.882
When it started.

00:16:06.882 --> 00:16:07.762
What you found.

00:16:07.762 --> 00:16:08.869
What has already been done.

00:16:09.179 --> 00:16:11.579
How the resident responded.

00:16:11.579 --> 00:16:13.259
And what you need next.

00:16:13.259 --> 00:16:17.831
For example, instead of saying, Mrs. Jones is confused,

Synergy Healthcare Resources & Solutions Group Copyright Protected

a stronger report would be:

00:16:17.981 --> 00:16:23.581
Mrs. Jones is normally alert and oriented to person
and place. At 2 this afternoon , the CNA reported

00:16:23.581 --> 00:16:29.261
that she was unusually sleepy and confused. I assessed
her found that her temperature is 101, oxygen saturation

00:16:29.261 --> 00:16:35.021
is 91 percent compared with her usual 95 to 97 percent,
and she has a new productive cough. She is currently

00:16:35.021 --> 00:16:38.937
receiving no antibiotics. I'm calling to report this
change and obtain further direction.

00:16:39.087 --> 00:16:42.140
That gives the practitioner a much clearer clinical
picture.

00:16:42.290 --> 00:16:47.810
However, there is one important exception to the idea
of gathering everything before making the call: do

00:16:47.810 --> 00:16:52.690
not delay emergency care while trying to complete
the form, review the entire chart, or collect every

00:16:52.690 --> 00:16:53.703
piece of information.

00:16:53.853 --> 00:16:59.373
If the resident has a life-threatening change, initiate
the appropriate emergency response first and communicate

00:16:59.373 --> 00:17:01.701
the available information as quickly as possible.

00:17:01.851 --> 00:17:06.571
Once we have gathered the pertinent information, we
need a consistent way to organize it.

00:17:06.571 --> 00:17:07.819
That is where SBAR comes in.

00:17:12.019 --> 00:17:17.138
Once the resident has been assessed and we have gathered
the relevant clinical information, SBAR gives us a

00:17:17.138 --> 00:17:20.807
structured way to communicate that information clearly
and efficiently.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:17:20.957 --> 00:17:26.717
SBAR stands for Situation, Background, Assessment,
and Recommendation or Request.

00:17:26.717 --> 00:17:28.557
Let's walk through each part.

00:17:28.557 --> 00:17:30.237
S is Situation.

00:17:30.237 --> 00:17:32.397
Start with the reason you are calling.

00:17:32.397 --> 00:17:33.252
What has changed?

00:17:33.402 --> 00:17:35.322
When did the change begin?

00:17:35.322 --> 00:17:39.162
Is the resident improving, worsening, or remaining
the same?

00:17:39.162 --> 00:17:41.802
Keep the opening concise and clinically focused.

00:17:41.802 --> 00:17:42.284
For example:

00:17:42.434 --> 00:17:47.714
I'm calling about Mrs. Jones because she has developed
a new change in mental status and respiratory condition.

00:17:47.714 --> 00:17:52.914
She was at her usual baseline this morning, but at
approximately 2 p. m. she became confused and developed

00:17:52.914 --> 00:17:54.090
a productive cough.

00:17:54.240 --> 00:17:59.280
That immediately tells the practitioner who you are
calling about and why you are concerned.

00:17:59.280 --> 00:18:01.120
B is Background.

00:18:01.120 --> 00:18:05.038
Now provide the relevant information the practitioner
needs to understand the situation.

00:18:05.188 --> 00:18:11.348
This may include pertinent diagnoses, recent hospitalization
or clinical events, current medications or antibiotics,

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:18:11.348 --> 00:18:15.474
recent orders, allergies, advance directives, and
the resident's usual baseline.

00:18:15.624 --> 00:18:18.744
Provide the background that helps explain the current
problem.

00:18:18.744 --> 00:18:20.184
A is Assessment.

00:18:20.184 --> 00:18:23.321
This is where you communicate what you actually found
during your nursing assessment.

00:18:23.551 --> 00:18:29.631
Include the pertinent vital signs, physical assessment
findings, mental status, pain, respiratory findings,

00:18:29.631 --> 00:18:34.991
blood glucose, wound findings, intake and output,
or other clinical information related to the resident's

00:18:34.991 --> 00:18:35.430
change.

00:18:35.580 --> 00:18:39.340
You may also communicate your clinical concern based
on those findings.

00:18:39.340 --> 00:18:39.887
For example:

00:18:40.037 --> 00:18:47.877
Her temperature is 101, oxygen saturation is 91 percent
compared with her usual 95 to 97 percent, respiratory

00:18:47.877 --> 00:18:53.397
rate is 26, and she has new coarse breath sounds with
a productive cough. She is also more confused than

00:18:53.397 --> 00:18:54.399
her usual baseline.

00:18:54.549 --> 00:18:59.541
Notice that this is much stronger than simply saying,
I think she has pneumonia.

00:18:59.691 --> 00:19:05.131
We communicate the objective findings and our clinical
concern rather than jumping directly to an unsupported

00:19:05.131 --> 00:19:06.891
diagnosis.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:19:06.891 --> 00:19:09.153
Finally, R is Recommendation or Request.

00:19:09.303 --> 00:19:13.063
This is an important part of SBAR that nurses sometimes
leave out.

00:19:13.063 --> 00:19:16.023
Ask yourself: What do I need from the practitioner?

00:19:16.023 --> 00:19:18.823
Do you need additional monitoring parameters?

00:19:18.823 --> 00:19:19.392
Laboratory testing?

00:19:19.542 --> 00:19:21.142
Diagnostic studies?

00:19:21.142 --> 00:19:23.222
A medication or treatment order?

00:19:23.222 --> 00:19:24.982
A practitioner visit?

00:19:24.982 --> 00:19:27.205
Guidance regarding transfer to a higher level of care?

00:19:27.355 --> 00:19:31.195
Your recommendation does not mean that you are independently
prescribing treatment.

00:19:31.195 --> 00:19:35.923
It means you are clearly communicating what you believe
needs to be addressed or what direction you are requesting.

00:19:36.073 --> 00:19:38.633
One final point is very important:

00:19:38.633 --> 00:19:39.927
SBAR is a communication tool.

00:19:40.077 --> 00:19:45.517
It does not replace the nursing assessment, clinical
judgment, emergency response, practitioner notification

00:19:45.517 --> 00:19:49.121
requirements, resident-representative notification,
or documentation.

00:19:53.322 --> 00:19:57.350
Now that we understand SBAR, let’s look at how it
connects with Change of Condition documentation.

00:19:57.500 --> 00:20:02.700

Synergy Healthcare Resources & Solutions Group Copyright Protected

Every facility may use a different form or electronic
health record, but the essential clinical information

00:20:02.700 --> 00:20:04.380
should tell the same story.

00:20:04.380 --> 00:20:05.871
Start with the Event or Situation.

00:20:06.021 --> 00:20:11.381
Document what changed from the resident's baseline,
when it started, and whether the condition is improving,

00:20:11.381 --> 00:20:13.621
unchanged, or worsening.

00:20:13.621 --> 00:20:15.739
Avoid vague statements like "resident not doing well."

00:20:15.889 --> 00:20:18.929
Instead, describe the actual change.

00:20:18.929 --> 00:20:20.022
Next is the Assessment.

00:20:20.172 --> 00:20:26.092
Document the focused nursing assessment and relevant
findings, such as vital signs, pain, mental or functional

00:20:26.092 --> 00:20:31.532
status, respiratory or neurological findings, skin
concerns, blood glucose, or other information related

00:20:31.532 --> 00:20:32.176
to the change.

00:20:32.326 --> 00:20:35.403
Ask yourself: What did I find when I assessed the
resident?

00:20:35.553 --> 00:20:41.793
The Background provides important context, including
relevant diagnoses, medications, recent events, current

00:20:41.793 --> 00:20:45.816
treatments or orders, allergies, and advance directives
when applicable.

00:20:50.017 --> 00:20:52.257
Next is Communication.

00:20:52.257 --> 00:20:57.137
Document who was notified, when they were notified,
what information was reported, and the practitioner's

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:20:57.137 --> 00:20:58.417
response.

00:20:58.417 --> 00:20:59.920
Avoid simply writing "MD aware."

00:21:00.070 --> 00:21:03.669
The record should show what was communicated and what
happened as a result.

00:21:03.819 --> 00:21:10.539
Then document Orders and Interventions: new orders,
treatments, medication changes, monitoring, labs or

00:21:10.539 --> 00:21:13.419
diagnostics, or transfer when applicable.

00:21:13.419 --> 00:21:14.488
Finally, document Follow-Up.

00:21:14.638 --> 00:21:17.838
Did the resident improve, remain unchanged, or worsen?

00:21:17.838 --> 00:21:20.238
Were the orders implemented and effective?

00:21:20.238 --> 00:21:22.289
Is additional monitoring or reassessment needed?

00:21:22.439 --> 00:21:26.519
Remember, a Change of Condition does not end with
the first phone call.

00:21:26.519 --> 00:21:31.159
If the resident worsens or the intervention is ineffective,
reassess and escalate again.

00:21:31.309 --> 00:21:34.909
Think of the documentation as a simple clinical timeline:

00:21:34.909 --> 00:21:35.869
What changed.

00:21:35.869 --> 00:21:37.069
What did I assess.

00:21:37.069 --> 00:21:38.349
Who did I notify.

00:21:38.349 --> 00:21:39.149
What was done.

00:21:39.149 --> 00:21:40.749
How did the resident respond.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:21:40.749 --> 00:21:41.514
What happens next?

00:21:41.664 --> 00:21:46.424
The form may differ from one facility to another,
but the clinical process remains the same.

00:21:50.624 --> 00:21:55.424
One of the most important things to remember is that
Change of Condition does not end after the practitioner

00:21:55.424 --> 00:21:56.704
is notified.

00:21:56.704 --> 00:22:00.097
The SBAR call and new orders are only part of the
process.

00:22:00.247 --> 00:22:02.487
First, reassess the resident.

00:22:02.487 --> 00:22:06.967
Ask: Is the resident improving, stable, unchanged,
or worsening?

00:22:06.967 --> 00:22:11.126
Focus your reassessment on the original concern and
the resident's response to the intervention.

00:22:11.276 --> 00:22:13.436
Second, implement the plan.

00:22:13.436 --> 00:22:16.236
Carry out the practitioner's orders and nursing interventions.

00:22:16.236 --> 00:22:20.935
This may include medications, treatments, labs, diagnostics,
increased monitoring, or other measures.

00:22:21.085 --> 00:22:26.605
Receiving an order is not enough, the order must be
implemented.

00:22:26.605 --> 00:22:29.645
Third, continue appropriate monitoring.

00:22:29.645 --> 00:22:33.740
Monitoring should be individualized to the resident's
condition, orders, and facility policy.

00:22:33.890 --> 00:22:38.610
A resident with hypoglycemia may need repeat blood
glucose checks, while a resident with respiratory

00:22:38.610 --> 00:22:42.168

Synergy Healthcare Resources & Solutions Group Copyright Protected

symptoms may need repeat respiratory assessments and oxygen saturation.

00:22:42.318 --> 00:22:45.278
Fourth, communicate again when necessary.

00:22:45.278 --> 00:22:51.518
If the resident develops a new finding, worsens, or does not respond as expected, reassess and escalate

00:22:51.518 --> 00:22:51.896
again.

00:22:52.206 --> 00:22:57.326
Saying, "I already called the doctor," is not enough when the resident's condition has changed.

00:22:57.326 --> 00:23:01.543
Make sure the change and required follow-up are also communicated during shift-to-shift handoff.

00:23:01.693 --> 00:23:03.795
Finally, update the plan of care.

00:23:03.945 --> 00:23:09.625
If the resident now has a new ongoing need, treatment, safety measure, or level of assistance, update the

00:23:09.625 --> 00:23:13.244
care plan, Kardex, or other facility communication system as appropriate.

00:23:13.394 --> 00:23:15.554
Remember the sequence:

00:23:15.554 --> 00:23:18.914
Reassess, Implement, Monitor, Communicate, Update

00:23:18.914 --> 00:23:22.034
The question is not simply, "Did we call the practitioner?"

00:23:22.034 --> 00:23:23.135
The more important question is:

00:23:23.285 --> 00:23:26.005
"What happened to the resident after we called?"

00:23:26.005 --> 00:23:27.975
That is what closes the Change of Condition loop.

00:23:32.176 --> 00:23:35.751
Change of Condition management is a continuous clinical process.

00:23:35.901 --> 00:23:41.181

Synergy Healthcare Resources & Solutions Group Copyright Protected

If the resident develops a new finding or begins to
worsen, the nurse must respond to what is happening

00:23:41.181 --> 00:23:44.063
now, even if the practitioner was already notified
earlier.

00:23:44.213 --> 00:23:47.359
The first step is to recognize the new or worsening
finding.

00:23:47.509 --> 00:23:53.909
This might be increasing shortness of breath, a declining
oxygen saturation, new confusion, increasing lethargy,

00:23:53.909 --> 00:23:59.669
worsening pain, abnormal vital signs, new weakness,
decreased responsiveness, or another finding that

00:23:59.669 --> 00:24:01.558
was not present during the previous assessment.

00:24:01.708 --> 00:24:06.428
Once the change is identified, reassess the resident
and compare the current findings with baseline and

00:24:06.428 --> 00:24:07.478
with the previous assessment.

00:24:07.628 --> 00:24:12.268
Ask yourself: What has changed since I last assessed
this resident?

00:24:12.268 --> 00:24:16.556
For example, perhaps the resident initially had a
mild cough and stable vital signs.

00:24:16.706 --> 00:24:23.426
Two hours later, the resident is now breathing rapidly,
has a lower oxygen saturation, and is becoming confused.

00:24:23.426 --> 00:24:25.746
That is no longer the same clinical picture.

00:24:25.746 --> 00:24:27.712
The next step is escalate and notify.

00:24:27.862 --> 00:24:33.222
A previous practitioner notification does not eliminate
the need to notify again when the resident develops

00:24:33.222 --> 00:24:34.840
new or worsening findings.

00:24:34.990 --> 00:24:38.960

Synergy Healthcare Resources & Solutions Group Copyright Protected

When you call back, use SBAR again and make the progression very clear:

00:24:39.110 --> 00:24:45.350
I am calling back regarding Mrs. Jones. When I spoke with you earlier, her oxygen saturation was 94 percent

00:24:45.350 --> 00:24:50.870
and she was alert. She is now increasingly short of breath, her oxygen saturation has decreased to 88

00:24:51.350 --> 00:24:52.694
percent, and she is newly confused.

00:24:53.084 --> 00:24:58.364
That comparison helps the practitioner understand that the resident's condition has progressed.

00:24:58.364 --> 00:25:02.044
Then implement the new orders or interventions and reassess again.

00:25:02.044 --> 00:25:03.595
This creates a clinical cycle:

00:25:03.745 --> 00:25:06.145
Identify the change.

00:25:06.145 --> 00:25:07.105
Reassess.

00:25:07.105 --> 00:25:08.065
Escalate.

00:25:08.065 --> 00:25:09.105
Intervene.

00:25:09.105 --> 00:25:09.561
Reassess again.

00:25:09.711 --> 00:25:15.471
Continue that process until the resident is clinically stable, the condition has been appropriately addressed,

00:25:15.471 --> 00:25:18.848
or the resident has been transferred to a higher level of care when indicated.

00:25:18.998 --> 00:25:21.878
There is also an important safety message on this slide:

00:25:21.878 --> 00:25:27.238
If the resident develops an emergency, do not allow routine Change of Condition procedures or documentation

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:25:27.238 --> 00:25:29.157
to delay necessary emergency care.

00:25:29.307 --> 00:25:31.745
Follow the facility's emergency response procedures.

00:25:31.895 --> 00:25:37.175
Activate emergency medical services when indicated,
provide appropriate nursing interventions within your

00:25:37.175 --> 00:25:42.615
scope, and communicate the resident's condition and
relevant advance directives or care-limiting orders

00:25:42.615 --> 00:25:44.074
according to facility policy.

00:25:44.224 --> 00:25:50.041
Documentation is important, but documentation should
never delay treatment of an emergency.

00:25:50.191 --> 00:25:55.471
After the immediate clinical needs have been addressed,
document the sequence clearly: what changed, your

00:25:55.471 --> 00:26:00.911
reassessment findings, who was notified, when they
were notified, what direction or orders were received,

00:26:00.911 --> 00:26:03.937
what interventions were implemented, and how the resident
responded.

00:26:04.087 --> 00:26:05.607
The key message is:

00:26:05.607 --> 00:26:08.887
Do not let routine follow-up create a false sense
of security.

00:26:08.887 --> 00:26:11.854
If the resident changes again, the clinical process
starts again.

00:26:12.004 --> 00:26:16.244
On the next slide, we'll look more closely at the
documentation needed to show that this entire Change

00:26:16.244 --> 00:26:19.167
of Condition process was completed and followed through.

00:26:20.368 --> 00:26:24.528
Good Change of Condition documentation should
allow someone reviewing the record to follow the clinical

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:26:24.528 --> 00:26:25.847
story from beginning to end.

00:26:25.997 --> 00:26:30.502
Document what changed, when it was identified, and
how it differed from the resident's baseline.

00:26:30.652 --> 00:26:36.572
Include the relevant assessment findings, such as
vital signs, pain, mental status, respiratory findings,

00:26:36.572 --> 00:26:39.870
blood glucose, mobility, or other findings related
to the concern.

00:26:40.180 --> 00:26:46.260
Next, document who was notified, when they were notified,
and what information was reported.

00:26:46.260 --> 00:26:51.038
Include the practitioner's response, any new orders,
and the interventions that were actually implemented.

00:26:51.188 --> 00:26:55.268
Document resident and representative notification
when required.

00:26:55.268 --> 00:26:57.108
Most importantly, document follow-up.

00:26:57.348 --> 00:27:01.508
Was the resident improving, stable, unchanged, or
worsening?

00:27:01.508 --> 00:27:02.752
Were the interventions effective?

00:27:02.902 --> 00:27:07.622
Did the resident require additional assessment or
another practitioner notification?

00:27:07.622 --> 00:27:09.462
Avoid documenting only "MD aware."

00:27:09.862 --> 00:27:12.102
Instead, the record should answer:

00:27:12.102 --> 00:27:12.902
What changed?

00:27:12.902 --> 00:27:13.537
What did I find?

00:27:13.687 --> 00:27:15.207

Synergy Healthcare Resources & Solutions Group Copyright Protected

Who did I notify?

00:27:15.207 --> 00:27:16.807
What was ordered or done?

00:27:16.807 --> 00:27:18.407
How did the resident respond?

00:27:18.407 --> 00:27:23.847
If the resident's condition affects ongoing care,
update the care plan, Kardex, or other staff instructions

00:27:23.847 --> 00:27:24.577
as appropriate.

00:27:24.727 --> 00:27:30.253
Remember: document the complete clinical story but
never delay emergency care to complete documentation.

00:27:34.454 --> 00:27:38.214
Now let's apply the Change of Condition process to
a resident scenario.

00:27:38.214 --> 00:27:40.711
This resident is normally alert and participates in
meals.

00:27:40.861 --> 00:27:46.461
Today, the resident is newly confused, ate very little,
and is more difficult to transfer.

00:27:46.461 --> 00:27:49.580
Those are three changes from baseline and should trigger
further assessment.

00:27:49.730 --> 00:27:52.505
Start with vital signs and a focused nursing assessment.

00:27:52.655 --> 00:27:58.335
Evaluate mental status, strength and mobility, pain,
respiratory status, hydration and intake, bowel and

00:27:58.335 --> 00:28:00.933
bladder status, and any evidence of a fall or injury.

00:28:01.083 --> 00:28:05.723
Complete other resident-specific assessments, such
as blood glucose, when indicated.

00:28:05.723 --> 00:28:09.163
The important point is: do not choose a diagnosis
first.

00:28:09.163 --> 00:28:10.683
Assess the resident first.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:28:10.683 --> 00:28:11.938
Next, review the background.

00:28:12.088 --> 00:28:17.928
Look at recent notes, diagnoses, medications and medication changes, labs, treatments, recent falls or hospital

00:28:17.928 --> 00:28:21.295
visits, new orders, and determine when the resident was last at baseline.

00:28:21.445 --> 00:28:23.685
Then organize the communication using SBAR:

00:28:24.085 --> 00:28:30.085
Situation: "The resident has new confusion, decreased oral intake, and increased difficulty transferring

00:28:30.085 --> 00:28:31.058
compared with baseline."

00:28:31.448 --> 00:28:36.968
Background: Provide the relevant diagnoses, medications, recent events, and usual cognitive and functional

00:28:36.968 --> 00:28:37.501
status.

00:28:37.811 --> 00:28:45.811
Assessment: Report the actual findings, vital signs, mental status, pain, respiratory findings, mobility,

00:28:45.811 --> 00:28:49.934
hydration, blood glucose if indicated, and other pertinent findings.

00:28:50.244 --> 00:28:56.564
Recommendation or Request: Clearly state what is needed from the practitioner, such as additional monitoring,

00:28:56.564 --> 00:28:59.976
labs, diagnostics, treatment, evaluation, or transfer.

00:29:00.126 --> 00:29:03.486
Then implement the plan and continue following the resident.

00:29:03.486 --> 00:29:07.406
If labs or monitoring are ordered, complete them and reassess.

00:29:07.406 --> 00:29:09.326
Is the resident becoming more alert?

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:29:09.326 --> 00:29:10.238
Is intake improving?

00:29:10.388 --> 00:29:12.308
Is the resident still weaker?

00:29:12.308 --> 00:29:13.662
Are the vital signs changing?

00:29:13.812 --> 00:29:19.812
If the resident later becomes increasingly lethargic,
develops a fever, or has a significant change in oxygen

00:29:19.812 --> 00:29:24.679
saturation, that is new clinical information and requires
reassessment and escalation.

00:29:24.829 --> 00:29:28.509
Do not simply document, "MD already notified."

00:29:28.509 --> 00:29:33.869
The lesson from this scenario is simple: several subtle
changes occurring together may represent an important

00:29:33.869 --> 00:29:34.837
Change of Condition.

00:29:34.987 --> 00:29:40.587
Recognize the pattern then Compare with baseline then
Assess and follow up with Communication, Intervene

00:29:40.667 --> 00:29:41.547
and Reassess.

00:29:42.747 --> 00:29:47.307
Let’s look at some other reason you may have to call
a physician or practitioner.

00:29:47.307 --> 00:29:51.106
Remember, a Change of Condition does not always mean
that the resident is having an emergency.

00:29:51.256 --> 00:29:56.216
Sometimes the first sign is simply that something
is different from the resident’s usual baseline.

00:29:56.216 --> 00:29:59.243
A Change of Condition may be a new symptom or clinical
finding.

00:29:59.393 --> 00:30:04.993
Maybe the resident develops a new cough, new pain,
new confusion, new swelling, or another finding that

00:30:04.993 --> 00:30:06.593

Synergy Healthcare Resources & Solutions Group Copyright Protected

was not present before.

00:30:06.593 --> 00:30:09.401
It may also be a worsening of an existing condition
or symptom.

00:30:09.551 --> 00:30:15.855
For example, the resident may already have chronic
shortness of breath, but today it is worse than usual.

00:30:16.005 --> 00:30:21.445
A resident may have chronic pain, but the pain has
suddenly increased or is no longer responding to the

00:30:21.445 --> 00:30:22.402
current treatment.

00:30:22.552 --> 00:30:26.767
We also need to recognize changes that may not initially
appear to be medical emergencies.

00:30:26.917 --> 00:30:33.237
A resident may become more confused, weaker, less
mobile, more dependent with ADLs, unusually agitated

00:30:33.237 --> 00:30:39.637
or withdrawn, eat or drink less than usual, or demonstrate
another meaningful physical, mental, functional, behavioral,

00:30:39.637 --> 00:30:41.371
nutritional, or psychosocial change.

00:30:41.521 --> 00:30:45.573
These changes matter because they may be an early
indication that something is developing.

00:30:45.723 --> 00:30:50.704
Another reason to contact the practitioner is when
a current treatment or intervention is no longer effective.

00:30:50.854 --> 00:30:55.814
For example, pain medication is given but the resident
continues to have significant pain.

00:30:55.814 --> 00:30:58.540
A treatment is being provided but the condition continues
to worsen.

00:30:58.690 --> 00:31:05.075
Or the resident develops a possible medication side
effect or adverse response that requires further evaluation.

00:31:05.225 --> 00:31:10.585
An accident or injury may also require practitioner
notification, particularly when there are new symptoms,

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:31:10.585 --> 00:31:16.266
pain, functional changes, neurological findings, or
the potential for an injury requiring medical intervention.

00:31:16.416 --> 00:31:20.073
And do not forget about abnormal laboratory or diagnostic
results.

00:31:20.223 --> 00:31:25.743
The resident may appear stable, but an abnormal result
may still require nursing assessment, practitioner

00:31:25.743 --> 00:31:28.466
communication, new orders, or additional monitoring.

00:31:28.616 --> 00:31:32.831
This is why we should not limit Change of Condition
recognition to a list of emergencies.

00:31:32.981 --> 00:31:38.501
Instead, develop the habit of asking one simple question: What
is different about this resident today compared with

00:31:38.501 --> 00:31:43.941
the resident's usual baseline? If something is new,
worsening, unexpected, or no longer responding to

00:31:43.941 --> 00:31:48.294
the current plan, assess the resident and determine
what communication and follow-up are needed.

00:31:48.444 --> 00:31:53.724
Some of these changes can be handled through routine
but timely clinical communication.

00:31:53.724 --> 00:31:55.352
Others require immediate attention.

00:31:55.502 --> 00:32:00.309
Next, we are going to look at the specific findings
that should make you think: This cannot wait.

00:32:04.509 --> 00:32:10.428
Now let's look more specifically at clinical changes
that should trigger a Change of Condition evaluation.

00:32:10.428 --> 00:32:13.971
Remember, these findings do not automatically mean
that the resident has an emergency.

00:32:14.121 --> 00:32:18.361
They mean that something has changed and the resident
needs further nursing assessment to determine what

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:32:18.361 --> 00:32:21.321
is happening and how urgently we need to respond.

00:32:21.321 --> 00:32:23.351
First are neurological or cognitive changes.

00:32:23.501 --> 00:32:30.621
This includes new confusion, unusual lethargy, decreased
responsiveness, new weakness, slurred speech, or a

00:32:30.621 --> 00:32:32.127
new change in gait or balance.

00:32:32.277 --> 00:32:36.770
These findings are especially important when they
represent a sudden change from baseline.

00:32:36.920 --> 00:32:42.760
For example, if a resident who is normally alert and
conversational suddenly becomes confused or difficult

00:32:42.760 --> 00:32:47.137
to arouse, that is a significant clinical change that
requires prompt assessment.

00:32:47.287 --> 00:32:51.547
Also remember that neurological changes may first
be noticed by the CNA or RNA.

00:32:51.697 --> 00:32:56.817
They may tell you, She isn't acting like herself,
He is much sleepier today, or She suddenly needs

00:32:56.817 --> 00:33:02.019
more help walking. Those observations should not
be dismissed simply because they are not yet a diagnosis.

00:33:02.169 --> 00:33:04.421
Second are respiratory or cardiac changes.

00:33:04.571 --> 00:33:11.211
Look for new or worsening shortness of breath, cough,
decreased oxygen saturation, increased oxygen needs,

00:33:11.211 --> 00:33:15.380
chest discomfort, edema, or significant changes in
pulse or blood pressure.

00:33:15.530 --> 00:33:18.170
Compare those findings with the resident's baseline.

00:33:18.170 --> 00:33:23.610
A resident who normally uses oxygen is not necessarily
experiencing a Change of Condition simply because

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:33:23.610 --> 00:33:24.946
oxygen is being used.

00:33:25.096 --> 00:33:27.736
The question is: Has something changed?

00:33:27.736 --> 00:33:30.136
Does the resident now require more oxygen?

00:33:30.136 --> 00:33:32.776
Is the oxygen saturation lower than usual?

00:33:32.776 --> 00:33:34.216
Is breathing more difficult?

00:33:34.216 --> 00:33:36.148
Third are signs of possible infection.

00:33:36.298 --> 00:33:42.538
This may include fever, new or worsening respiratory
or urinary symptoms, changes involving a wound, or

00:33:42.538 --> 00:33:44.089
an unexplained acute decline.

00:33:44.239 --> 00:33:48.639
In older adults, infection does not always begin with
a dramatic fever.

00:33:48.639 --> 00:33:55.039
Sometimes the first signs may be new confusion, weakness,
poor intake, decreased function, or a general change

00:33:55.039 --> 00:33:55.825
from baseline.

00:33:55.975 --> 00:34:00.615
This is why we assess the whole resident, rather than
relying on one symptom alone.

00:34:00.615 --> 00:34:03.278
Fourth are gastrointestinal and genitourinary changes.

00:34:03.428 --> 00:34:10.868
New abdominal pain or distention, vomiting, diarrhea,
significant constipation, possible gastrointestinal

00:34:10.868 --> 00:34:17.908
bleeding, painful urination, blood in the urine, decreased
urine output, or another new urinary change may require

00:34:17.908 --> 00:34:20.495
further evaluation and practitioner communication.

00:34:20.645 --> 00:34:25.365

Synergy Healthcare Resources & Solutions Group Copyright Protected

Again, determine what is new and compare it with the resident's usual pattern.

00:34:25.365 --> 00:34:27.100
Fifth are skin and wound changes.

00:34:27.250 --> 00:34:34.930
A new skin alteration, pressure injury, redness, warmth, drainage, odor, increased pain, or worsening of an

00:34:34.930 --> 00:34:38.291
existing wound should trigger nursing assessment and appropriate follow-up.

00:34:38.441 --> 00:34:42.760
A skin change should not simply be documented and left for the wound nurse to see later.

00:34:42.910 --> 00:34:47.550
The nurse who identifies the change should assess it, determine what immediate actions are needed, and

00:34:47.550 --> 00:34:52.750
ensure the appropriate practitioner, wound team, and other parties are notified according to the resident's

00:34:52.750 --> 00:34:54.404
condition and facility process.

00:34:54.554 --> 00:34:58.501
Next, we'll look at several additional changes that should also get the nurse's attention.

00:35:02.702 --> 00:35:07.022
Let's continue with other changes that should trigger a Change of Condition evaluation.

00:35:07.022 --> 00:35:07.729
First is pain.

00:35:08.119 --> 00:35:13.799
New pain, a significant increase in chronic pain, or pain that is no longer responding to the resident's

00:35:13.799 --> 00:35:16.679
current interventions should get our attention.

00:35:16.679 --> 00:35:18.223
Don't only document the pain score.

00:35:18.373 --> 00:35:22.853
Assess where the pain is, when it started, what may have triggered it, whether it is different from the

00:35:22.853 --> 00:35:28.053

Synergy Healthcare Resources & Solutions Group Copyright Protected

resident's usual pain, what interventions have already
been attempted, and whether those interventions were

00:35:28.053 --> 00:35:28.648
effective.

00:35:28.798 --> 00:35:30.958
Second are falls and injuries.

00:35:30.958 --> 00:35:33.802
A fall should prompt assessment even when there is
no obvious injury.

00:35:33.952 --> 00:35:40.352
Look for new pain, swelling, bruising, change in range
of motion, inability to bear weight, neurological

00:35:40.352 --> 00:35:44.575
changes after a possible head injury, or a decline
in the resident's usual function.

00:35:44.725 --> 00:35:47.117
Sometimes the important finding appears after the
fall.

00:35:47.267 --> 00:35:52.707
A resident who could transfer normally before the
fall but is now unable to stand, or who develops increasing

00:35:52.707 --> 00:35:57.634
pain several hours later, has experienced a new change
that requires further evaluation.

00:35:57.784 --> 00:36:00.264
Third is nutrition and hydration.

00:36:00.264 --> 00:36:05.064
Poor intake, signs of dehydration, or a clinically
meaningful change in weight may represent a Change

00:36:05.064 --> 00:36:06.344
of Condition.

00:36:06.344 --> 00:36:07.502
Pay attention to patterns.

00:36:07.652 --> 00:36:13.012
One unfinished meal may not necessarily represent
a significant clinical change, but a resident who

00:36:13.012 --> 00:36:18.292
normally eats well and suddenly begins eating very
little, refusing fluids, becoming weak, or showing

00:36:18.292 --> 00:36:20.388

Synergy Healthcare Resources & Solutions Group Copyright Protected

other signs of decline needs further assessment.

00:36:24.588 --> 00:36:26.701
Fourth is diabetes and blood glucose.

00:36:26.851 --> 00:36:34.051
Hypoglycemia, hyperglycemia, glucose outside the resident's
ordered parameters, or a glucose change accompanied

00:36:34.051 --> 00:36:37.195
by symptoms should trigger appropriate assessment
and intervention.

00:36:37.345 --> 00:36:39.905
Do not focus only on the number.

00:36:39.905 --> 00:36:41.265
Look at the resident.

00:36:41.265 --> 00:36:47.631
Is there sweating, shakiness, confusion, lethargy,
weakness, altered behavior, or another change in condition?

00:36:47.781 --> 00:36:53.461
Follow the resident-specific orders and facility protocol,
and determine whether practitioner notification or

00:36:53.461 --> 00:36:55.781
additional intervention is required.

00:36:55.781 --> 00:36:58.219
Fifth are medication and laboratory concerns.

00:36:58.369 --> 00:37:04.609
A suspected adverse medication effect, a clinically
significant medication problem, or a critical or abnormal

00:37:04.609 --> 00:37:08.783
laboratory or diagnostic result may require Change
of Condition evaluation.

00:37:08.933 --> 00:37:16.053
For example, if a new medication is followed by excessive
sedation, hypotension, bleeding, rash, or another

00:37:16.053 --> 00:37:21.573
concerning change, assess the resident and communicate
the findings rather than simply documenting the possible

00:37:21.573 --> 00:37:22.226
side effect.

00:37:22.376 --> 00:37:27.656
Likewise, when an abnormal laboratory or diagnostic
result is received, connect the result back to the

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:37:27.656 --> 00:37:28.100
resident.

00:37:28.250 --> 00:37:34.170
Assess the resident, review relevant orders and clinical information, and follow the appropriate notification

00:37:34.170 --> 00:37:35.450
process.

00:37:35.450 --> 00:37:37.817
Finally, look at behavior, function, and refusals.

00:37:37.967 --> 00:37:41.067
A new or worsening behavior may be a clinical symptom.

00:37:41.217 --> 00:37:49.457
New agitation, withdrawal, resistance to care, hallucinations, or another significant behavioral change may indicate

00:37:49.457 --> 00:37:54.580
that something has changed medically, environmentally, psychologically, or functionally.

00:37:54.730 --> 00:37:58.143
A decline in mobility or ADL performance is also important.

00:37:58.293 --> 00:38:04.213
If a resident suddenly requires more assistance with transfers, dressing, eating, toileting, or ambulation,

00:38:04.213 --> 00:38:06.664
ask why this resident is functioning differently today.

00:38:06.814 --> 00:38:12.334
Persistent refusal can also become a Change of Condition concern when the refusal may adversely affect the

00:38:12.334 --> 00:38:18.894
resident's health or treatment, for example, repeated refusal of important medications, food, fluids, treatment,

00:38:18.894 --> 00:38:19.805
or necessary care.

00:38:19.955 --> 00:38:22.915
The presence of a change should trigger assessment.

00:38:22.915 --> 00:38:26.770
The resident's findings determine how urgently the situation must be escalated.

00:38:26.920 --> 00:38:32.520
Not every change requires an emergency response, but

Synergy Healthcare Resources & Solutions Group Copyright Protected

every meaningful change deserves the appropriate nursing

00:38:32.520 --> 00:38:33.027
assessment.

00:38:33.177 --> 00:38:37.657
From there, determine whether the resident can be
monitored with routine practitioner communication

00:38:37.657 --> 00:38:41.235
or whether the findings require immediate attention
and notification.

00:38:41.385 --> 00:38:46.585
That is what we will look at next: how to distinguish
a change that requires evaluation from a change that

00:38:46.585 --> 00:38:47.375
cannot wait.

00:38:51.576 --> 00:38:55.176
Now that we have identified the different types of
changes that should trigger a Change of Condition

00:38:55.176 --> 00:38:59.540
evaluation, the next question is: How quickly do we
need to act and communicate?

00:38:59.690 --> 00:39:04.410
This is where we distinguish between an immediate
and a non-immediate change.

00:39:04.410 --> 00:39:05.971
Let’s start with immediate notification.

00:39:06.121 --> 00:39:11.961
Think of an immediate concern as a change that is
acute or sudden in onset and represents a marked change

00:39:11.961 --> 00:39:14.852
from the resident’s usual signs, symptoms, or baseline.

00:39:15.002 --> 00:39:20.602
Immediate notification may also be necessary when
the resident has symptoms, signs, or apparent discomfort

00:39:20.602 --> 00:39:23.407
that are not relieved by measures that have already
been prescribed.

00:39:23.557 --> 00:39:29.246
For example, a resident may have a PRN medication
or an existing intervention for a known condition.

00:39:29.396 --> 00:39:34.436

Synergy Healthcare Resources & Solutions Group Copyright Protected

If that intervention is given appropriately but the
resident continues to experience significant symptoms, or

00:39:34.436 --> 00:39:38.789
the condition continues to worsen, that should prompt
further assessment and escalation.

00:39:38.939 --> 00:39:42.468
The nurse should promptly assess the resident and
communicate the findings to the practitioner.

00:39:42.618 --> 00:39:48.058
If the findings indicate an emergency, follow the
facility's emergency response procedures and do not

00:39:48.058 --> 00:39:52.405
delay necessary care while waiting for a routine callback
or completing documentation.

00:39:56.606 --> 00:39:59.966
Now let's look at non-immediate notification.

00:39:59.966 --> 00:40:03.061
Non-immediate does not mean unimportant, and it does
not mean do nothing.

00:40:03.211 --> 00:40:08.571
It means the resident has a new or worsening symptom
or finding, but based on the current assessment, the

00:40:08.571 --> 00:40:11.639
situation does not meet the immediate criteria at
that time.

00:40:11.789 --> 00:40:14.989
The resident still requires an appropriate nursing
assessment.

00:40:14.989 --> 00:40:19.389
The practitioner should be contacted according to
the resident's clinical needs, practitioner orders,

00:40:19.389 --> 00:40:20.474
and facility policy.

00:40:20.624 --> 00:40:24.944
Any new orders or interventions should be implemented,
and the resident should continue to be monitored and

00:40:24.944 --> 00:40:25.755
reassessed.

00:40:25.905 --> 00:40:32.945
For example, a resident may develop a new mild cough
but remains alert, has stable vital signs, has no

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:40:32.945 --> 00:40:36.772
respiratory distress, and has oxygen saturation consistent with baseline.

00:40:36.922 --> 00:40:42.202
That is still a Change of Condition that needs evaluation and appropriate follow-up, but the current clinical

00:40:42.202 --> 00:40:47.987
picture may be different from a resident who suddenly becomes severely short of breath, hypoxic, and confused.

00:40:48.137 --> 00:40:51.017
The important point is that urgency can change.

00:40:51.017 --> 00:40:53.721
Something that begins as non-immediate can become immediate.

00:40:53.871 --> 00:40:59.311
If that resident with the mild cough later develops fever, increased work of breathing, decreasing oxygen

00:40:59.311 --> 00:41:04.587
saturation, or acute confusion, reassess the resident and escalate based on the new findings.

00:41:04.737 --> 00:41:08.817
So when deciding how urgently to respond, ask yourself:

00:41:08.817 --> 00:41:10.097
Was the change sudden?

00:41:10.097 --> 00:41:12.177
Is it a marked change from baseline?

00:41:12.177 --> 00:41:14.269
Are the symptoms significant or worsening?

00:41:14.419 --> 00:41:17.539
Are prescribed interventions failing to relieve the problem?

00:41:17.539 --> 00:41:20.769
Is the resident showing signs of instability or an emergency?

00:41:20.919 --> 00:41:24.919
The purpose of these categories is not to give the nurse permission to delay care.

00:41:24.919 --> 00:41:29.430
The purpose is to help the nurse prioritize the response based on the resident's actual clinical condition.

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:41:29.580 --> 00:41:36.460
And remember: non-immediate does not mean wait until
tomorrow. It means assess, communicate appropriately,

00:41:36.460 --> 00:41:40.017
monitor, and be prepared to escalate if the resident
changes.

00:41:40.167 --> 00:41:44.567
Next, we'll look at specific clinical findings that
should make the nurse think immediate attention and

00:41:44.567 --> 00:41:45.949
practitioner notification.

00:41:50.149 --> 00:41:55.989
Now let's look at the types of neurological and mental-status
changes that require immediate attention.

00:41:55.989 --> 00:42:00.075
First is an abrupt, significant change in mental status
or level of consciousness.

00:42:00.225 --> 00:42:05.665
If a resident who is normally alert suddenly becomes
confused, extremely lethargic, difficult to arouse,

00:42:05.665 --> 00:42:10.953
or markedly different from their usual cognitive baseline,
this requires prompt assessment and escalation.

00:42:11.103 --> 00:42:15.131
Remember that acute confusion is a clinical finding,
not a diagnosis.

00:42:15.281 --> 00:42:20.961
Do not simply assume that it is dementia, aging, or
just confusion. A sudden mental-status change can

00:42:20.961 --> 00:42:27.201
be associated with many underlying problems, including
infection, hypoxia, abnormal blood glucose, medication

00:42:27.201 --> 00:42:31.651
effects, dehydration, metabolic abnormalities, or
an acute neurological event.

00:42:31.801 --> 00:42:35.961
Second is unresponsiveness, fainting, or loss of consciousness.

00:42:35.961 --> 00:42:38.059
These findings require immediate assessment.

00:42:38.209 --> 00:42:43.809

Synergy Healthcare Resources & Solutions Group Copyright Protected

Evaluate the resident's responsiveness, airway, breathing and circulation, obtain pertinent vital signs when

00:42:43.809 --> 00:42:49.249
appropriate, and follow the facility's emergency-response process based on the resident's condition and advance

00:42:49.249 --> 00:42:49.831
directives.

00:42:49.981 --> 00:42:52.732
Third are new focal neurological findings.

00:42:52.882 --> 00:42:58.722
These may include sudden weakness, particularly weakness affecting one side of the body, facial asymmetry or

00:42:58.722 --> 00:43:03.204
drooping, slurred or abnormal speech, or another new focal neurological deficit.

00:43:03.354 --> 00:43:08.554
When these findings appear suddenly, think about the possibility of an acute neurological event such as

00:43:08.554 --> 00:43:09.077
a stroke.

00:43:13.278 --> 00:43:18.606
Fourth is abrupt dizziness or unsteadiness when it occurs with other focal neurological findings.

00:43:18.756 --> 00:43:24.276
Sudden dizziness or loss of balance accompanied by weakness, facial changes, speech changes, altered

00:43:24.276 --> 00:43:27.963
consciousness, or another neurological deficit is much more concerning.

00:43:28.113 --> 00:43:33.953
Fifth is a head injury accompanied by a change in consciousness, mental status, or neurological findings.

00:43:34.103 --> 00:43:39.623
After a fall or possible head injury, do not focus only on whether you can see an external injury.

00:43:39.623 --> 00:43:43.066
Assess the resident neurologically and compare the findings with baseline.

00:43:43.376 --> 00:43:50.336
New confusion, vomiting, increasing lethargy, loss of consciousness, severe or worsening headache, new

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:43:50.336 --> 00:43:55.116
weakness, or other neurological changes after a head injury require prompt escalation.

00:43:55.266 --> 00:44:01.385
Finally, signs or symptoms suggesting stroke or another acute neurological event require immediate attention.

00:44:01.535 --> 00:44:09.455
Think about sudden changes in face, arm or leg strength, speech, balance, vision, level of consciousness, or

00:44:09.455 --> 00:44:10.881
other neurological function.

00:44:11.031 --> 00:44:14.791
The nurse's role is not to wait until a stroke has been confirmed.

00:44:14.791 --> 00:44:18.786
For sudden and significant neurological change, the nurse should act immediately.

00:44:18.936 --> 00:44:24.856
Persistent or new cognitive change that is not immediately unstable, still assess it, communicate it, and follow

00:44:24.856 --> 00:44:25.136
it.

00:44:25.286 --> 00:44:30.963
In either situation, do not dismiss a change from the resident's neurological or cognitive baseline.

00:44:35.164 --> 00:44:38.565
Now let's look at respiratory changes that require immediate attention.

00:44:38.715 --> 00:44:43.435
Respiratory changes can progress quickly, so when something is different, assess the resident promptly

00:44:43.435 --> 00:44:46.436
and compare the findings with the resident's usual respiratory baseline.

00:44:46.586 --> 00:44:51.866
First is acute respiratory distress or significant new or worsening shortness of breath.

00:44:51.866 --> 00:44:54.906
Look at the resident, not just the oxygen saturation.

00:44:54.906 --> 00:44:56.303

Synergy Healthcare Resources & Solutions Group Copyright Protected

Is the resident struggling to breathe?

00:44:56.453 --> 00:44:59.813
Are they unable to speak normally because of shortness
of breath?

00:44:59.813 --> 00:45:05.173
Are they using accessory muscles, becoming restless
or confused, or showing another sign of respiratory

00:45:05.173 --> 00:45:05.799
distress?

00:45:05.949 --> 00:45:11.534
Second is markedly labored breathing, concerning new
lung findings, or rapid respiratory deterioration.

00:45:11.684 --> 00:45:17.284
A new abnormal lung finding becomes particularly concerning
when it occurs together with changes such as increased

00:45:17.284 --> 00:45:24.002
respiratory effort, fever, hypoxia, altered mental
status, or a decline in the resident's overall condition.

00:45:24.152 --> 00:45:26.632
Third is oxygen saturation.

00:45:26.632 --> 00:45:32.232
The Change of Condition reference used for this training
identifies an oxygen saturation of less than 90 percent

00:45:32.232 --> 00:45:34.322
as an example requiring immediate reporting.

00:45:34.472 --> 00:45:36.792
But we need to use that number appropriately.

00:45:36.792 --> 00:45:40.370
Do not treat 90 percent as a universal standing order
for every resident.

00:45:40.520 --> 00:45:45.083
Some residents may have individualized oxygen parameters
because of their underlying conditions.

00:45:45.233 --> 00:45:51.073
Always consider the resident's baseline, current practitioner
orders, established parameters, symptoms, and overall

00:45:51.073 --> 00:45:52.141
clinical presentation.

00:45:52.291 --> 00:45:59.331
For example, if a resident normally maintains an oxygen

Synergy Healthcare Resources & Solutions Group Copyright Protected

saturation of 95 to 97 percent and suddenly drops

00:45:59.331 --> 00:46:05.091
to 90 or 89 percent with new shortness of breath,
that is a meaningful change even before we consider

00:46:05.091 --> 00:46:06.060
the rest of the assessment.

00:46:06.210 --> 00:46:08.450
Fourth is respiratory rate.

00:46:08.450 --> 00:46:13.410
The reference used for this training identifies a
respiratory rate greater than 28 or less than 10 breaths

00:46:13.410 --> 00:46:16.299
per minute as examples requiring immediate reporting.

00:46:16.449 --> 00:46:19.729
Again, the number should never replace assessment.

00:46:19.729 --> 00:46:22.057
Observe the quality and effort of breathing as well
as the rate.

00:46:22.207 --> 00:46:27.887
Fifth, pay attention when new respiratory symptoms
occur together with fever or other signs of acute

00:46:27.887 --> 00:46:28.927
illness.

00:46:28.927 --> 00:46:32.180
A new cough by itself may require Change of Condition
evaluation.

00:46:32.330 --> 00:46:38.490
But a new cough combined with fever, hypoxia, tachypnea,
increasing weakness, confusion, or other signs of

00:46:38.490 --> 00:46:41.339
deterioration creates a more concerning clinical picture.

00:46:41.489 --> 00:46:46.529
Sixth is an increasing oxygen requirement accompanied
by clinical deterioration.

00:46:46.529 --> 00:46:49.268
This is where comparing to baseline becomes especially
important.

00:46:49.418 --> 00:46:54.410
Suppose a resident normally uses two liters of oxygen
and maintains their expected saturation.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:46:54.560 --> 00:46:59.840
Today, the resident requires more oxygen to maintain
that same saturation and is increasingly short of

00:46:59.840 --> 00:47:00.969
breath or confused.

00:47:01.119 --> 00:47:06.639
The saturation number may look acceptable because
additional oxygen is being provided, but the increasing

00:47:06.639 --> 00:47:10.465
oxygen requirement itself may represent a significant
change from baseline.

00:47:10.615 --> 00:47:14.086
Use resident-specific orders and parameters together
with clinical judgment.

00:47:18.286 --> 00:47:21.850
Now let's move into cardiovascular changes that require
immediate attention.

00:47:22.000 --> 00:47:27.200
As with respiratory changes, the nurse should look
at the entire clinical picture and compare the resident

00:47:27.200 --> 00:47:31.195
with their usual baseline, rather than relying on
a single vital-sign number.

00:47:31.505 --> 00:47:36.407
First, new or abrupt chest pain, pressure, or tightness
requires prompt assessment.

00:47:36.557 --> 00:47:41.757
The resident may not always describe the symptom as
chest pain. They may report heaviness, squeezing,

00:47:41.757 --> 00:47:46.309
burning, pressure, unusual discomfort, or simply say
that something does not feel right.

00:47:46.459 --> 00:47:50.244
In older adults, an acute cardiac event may also present
less typically.

00:47:50.394 --> 00:47:56.234
The resident may develop new shortness of breath,
weakness, nausea, diaphoresis, dizziness, confusion,

00:47:56.234 --> 00:47:58.997
or an unexplained decline rather than classic chest
pain.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:47:59.147 --> 00:48:04.267
Second, pay particular attention when chest symptoms
are not relieved by measures that have already been

00:48:04.267 --> 00:48:04.894
prescribed.

00:48:05.044 --> 00:48:10.244
For example, if a resident has an existing order or
treatment plan for angina and the symptoms continue

00:48:10.244 --> 00:48:16.084
despite following that plan, this represents a significant
concern and requires immediate escalation according

00:48:16.084 --> 00:48:19.847
to the resident's orders, advance directives, and
facility emergency procedures.

00:48:19.997 --> 00:48:22.679
Third, look for symptoms occurring together.

00:48:22.829 --> 00:48:28.349
Chest discomfort becomes even more concerning when
it is accompanied by diaphoresis, shortness of breath,

00:48:28.349 --> 00:48:34.845
altered mental status, weakness, dizziness, cyanosis,
or a significant change in blood pressure or pulse.

00:48:34.995 --> 00:48:39.105
Fourth, assess for signs of impaired circulation or
cardiac decompensation.

00:48:39.255 --> 00:48:46.535
New cyanosis, signs of poor perfusion, an acute circulatory
change, or significant new edema associated with symptoms

00:48:46.535 --> 00:48:51.492
such as shortness of breath or declining function
should trigger immediate assessment and escalation.

00:48:51.642 --> 00:48:54.521
Now let's look at the blood pressure and pulse examples
shown on this slide.

00:48:54.671 --> 00:48:59.631
The Change of Condition reference used for this training
identifies examples for immediate reporting that include

00:48:59.631 --> 00:49:04.751
a systolic blood pressure greater than 200 or less
than 90 millimeters of mercury, a diastolic blood

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:49:04.751 --> 00:49:09.857
pressure greater than 115, or a resting pulse greater
than 100 or less than 50 beats per minute.

00:49:10.007 --> 00:49:14.012
These numbers are reference examples and not universal
standing orders for every resident.

00:49:14.162 --> 00:49:19.122
This is especially important in long-term care because
some residents have established values that are already

00:49:19.122 --> 00:49:20.258
known to their practitioner.

00:49:20.408 --> 00:49:27.848
A resident with chronic hypertension, chronic hypotension,
atrial fibrillation, a pacemaker, or another cardiovascular

00:49:27.848 --> 00:49:31.275
condition may have individualized parameters established
by the practitioner.

00:49:31.425 --> 00:49:36.865
But individualized parameters should never cause us
to ignore a meaningful change from baseline or a symptomatic

00:49:36.865 --> 00:49:37.392
resident.

00:49:41.593 --> 00:49:44.953
Next, let's look at falls, injuries, and acute pain.

00:49:44.953 --> 00:49:47.113
These are common events in skilled nursing.

00:49:47.113 --> 00:49:50.718
First, a fall with a suspected serious injury requires
immediate attention.

00:49:50.868 --> 00:49:55.748
After a fall, do not focus only on whether the resident
has a visible injury.

00:49:55.748 --> 00:49:59.773
Complete an appropriate post-fall assessment and compare
the resident with their pre-fall baseline.

00:49:59.923 --> 00:50:07.843
Look for new pain, swelling, bruising, bleeding, deformity,
decreased range of motion, inability to bear weight,

00:50:07.843 --> 00:50:10.987
difficulty transferring, or a new decline in mobility
or function.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:50:11.137 --> 00:50:15.537
Second, consider the possibility of a fracture or dislocation.

00:50:15.537 --> 00:50:19.055
New hip or groin pain following a fall is particularly concerning.

00:50:19.205 --> 00:50:24.485
A resident who was previously able to stand, transfer, or ambulate but now cannot tolerate weight-bearing

00:50:24.485 --> 00:50:27.947
or has significant pain with movement requires prompt evaluation.

00:50:28.097 --> 00:50:31.937
Remember that an injury is not always immediately obvious.

00:50:31.937 --> 00:50:36.840
A resident may initially have minimal complaints and later develop increasing pain or functional decline.

00:50:36.990 --> 00:50:40.990
That is why ongoing reassessment after a fall is important.

00:50:40.990 --> 00:50:43.364
Third, head injuries require careful assessment.

00:50:43.514 --> 00:50:50.074
A head injury associated with a new neurological or mental-status change, such as confusion, lethargy,

00:50:50.074 --> 00:50:56.874
decreased responsiveness, loss of consciousness, new weakness, vomiting, severe headache, or other neurological

00:50:56.874 --> 00:50:59.361
Findings, requires immediate escalation.

00:50:59.511 --> 00:51:03.751
The nurse should also identify whether the resident is receiving medications that may increase the risk

00:51:03.751 --> 00:51:09.111
of bleeding, such as anticoagulant or antiplatelet therapy, because that information is important when

00:51:09.111 --> 00:51:10.773
communicating the event to the practitioner.

00:51:14.973 --> 00:51:21.133
Fourth, new severe pain or a marked increase in chronic

Synergy Healthcare Resources & Solutions Group Copyright Protected

pain is itself a change in condition.

00:51:21.133 --> 00:51:24.736
Pain may be the first indication of an injury or another acute medical problem.

00:51:24.886 --> 00:51:31.446
Assess the location, intensity, quality, onset, duration, associated symptoms, and what makes the pain better

00:51:31.446 --> 00:51:32.050
or worse.

00:51:32.200 --> 00:51:37.413
Fifth, pay attention to pain or other symptoms that are not relieved by measures already prescribed.

00:51:37.563 --> 00:51:42.363
If the resident received the ordered intervention and continues to have significant pain or the symptoms

00:51:42.363 --> 00:51:46.955
are worsening, reassess the resident and communicate that lack of response to the practitioner.

00:51:47.105 --> 00:51:53.185
Finally, significant uncontrolled bleeding or an injury that may require practitioner intervention requires

00:51:53.185 --> 00:51:54.315
immediate attention.

00:51:54.465 --> 00:51:59.665
Assess the resident, initiate appropriate first-aid or emergency measures within your scope and facility

00:51:59.665 --> 00:52:03.068
policy, and escalate based on the resident's clinical condition.

00:52:03.218 --> 00:52:08.258
One important point: a fall does not become clinically insignificant simply because the initial assessment

00:52:08.258 --> 00:52:13.858
shows no apparent injury. Continue to monitor for delayed symptoms, including new pain, neurological

00:52:13.858 --> 00:52:18.090
changes, decreased mobility, swelling, bruising, or a decline in function.

00:52:18.240 --> 00:52:20.586
The goal is not simply to document the fall.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:52:20.736 --> 00:52:26.976
The goal is to identify injury early, recognize changes
from baseline, communicate promptly, implement appropriate

00:52:26.976 --> 00:52:30.558
interventions, and continue reassessing the resident
for changes that may appear later.

00:52:34.759 --> 00:52:39.718
Now let's look at infection and fever, because infection
in the older adult may not always present the way

00:52:39.718 --> 00:52:40.839
we expect.

00:52:40.839 --> 00:52:43.733
The first thing to remember is that we are not looking
only for a fever.

00:52:43.883 --> 00:52:48.843
We are looking for a change in the resident's overall
clinical condition that may indicate infection.

00:52:48.843 --> 00:52:52.730
In some older adults, these changes may appear before
a significant fever develops.

00:52:52.880 --> 00:52:59.126
First, acute clinical deterioration associated with
a suspected infection requires immediate attention.

00:52:59.276 --> 00:53:04.876
If the resident suddenly looks significantly different
from baseline, complete a focused assessment and obtain

00:53:04.876 --> 00:53:07.484
the appropriate vital signs and clinical information.

00:53:07.634 --> 00:53:12.905
Second, a new fever becomes especially concerning
when it occurs with another significant change.

00:53:13.055 --> 00:53:20.735
For example, fever accompanied by new confusion, respiratory
distress, decreased oxygen saturation, abnormal blood

00:53:20.735 --> 00:53:26.575
pressure, tachycardia, decreased responsiveness, or
a major decline in function requires prompt evaluation

00:53:26.575 --> 00:53:27.533
and escalation.

00:53:27.683 --> 00:53:32.643
Third, consider the possibility of sepsis or systemic

Synergy Healthcare Resources & Solutions Group Copyright Protected

infection.

00:53:32.643 --> 00:53:34.243
Sepsis is not simply an infection.

00:53:34.243 --> 00:53:38.654
It is a potentially life-threatening response to infection
associated with organ dysfunction.

00:53:38.804 --> 00:53:44.244
In the skilled nursing setting, our responsibility
is to recognize deterioration early and escalate the

00:53:44.244 --> 00:53:44.484
change.

00:53:44.852 --> 00:53:50.831
Fourth, evaluate abnormal laboratory or diagnostic
findings in the context of the resident's symptoms.

00:53:50.981 --> 00:53:56.581
An abnormal urinalysis or positive urine culture by
itself does not necessarily establish a symptomatic

00:53:56.581 --> 00:53:57.982
urinary tract infection.

00:53:58.132 --> 00:54:03.492
Look at the resident's symptoms, clinical findings,
baseline, and the overall assessment, and communicate

00:54:03.492 --> 00:54:04.959
those findings to the practitioner.

00:54:05.109 --> 00:54:09.829
Fifth, the Change-of-Condition reference used for
this training identifies a new oral temperature greater

00:54:09.829 --> 00:54:15.269
than 100 degrees Fahrenheit as an example for immediate
reporting, unless the resident is already being treated

00:54:15.269 --> 00:54:17.682
and the condition and temperature are known to the
clinician.

00:54:17.832 --> 00:54:22.952
When communicating a suspected infection using SBAR,
be prepared to report what changed from baseline,

00:54:22.952 --> 00:54:28.632
when it began, current vital signs, mental and functional
status, respiratory findings when applicable, intake

00:54:28.632 --> 00:54:34.072

Synergy Healthcare Resources & Solutions Group Copyright Protected

and hydration, urinary or gastrointestinal symptoms,
skin or wound findings, relevant laboratory results,

00:54:34.072 --> 00:54:38.498
current antibiotics or recent infections, and what
interventions have already been completed.

00:54:38.808 --> 00:54:44.488
Recognize the change, assess the entire clinical picture,
compare it with baseline, communicate the findings

00:54:44.488 --> 00:54:50.397
promptly, implement the practitioner's orders, and
continue reassessing for improvement or further deterioration.

00:54:54.597 --> 00:54:59.957
Next, let’s discuss diabetes and blood glucose changes
that require immediate attention.

00:54:59.957 --> 00:55:03.002
In residents with diabetes, we should never look only
at the glucose number.

00:55:03.152 --> 00:55:09.072
We need to assess the glucose result, the resident’s
symptoms, their usual glucose pattern, current medications,

00:55:09.072 --> 00:55:12.649
meal intake, and the resident-specific parameters
ordered by the practitioner.

00:55:12.799 --> 00:55:17.679
First, a blood glucose result outside the resident’s
ordered parameters, particularly when accompanied

00:55:17.679 --> 00:55:21.042
by concerning symptoms, requires prompt assessment
and follow-up.

00:55:21.192 --> 00:55:24.872
Ask yourself: Is the resident awake and responding
normally?

00:55:24.872 --> 00:55:31.832
Are they confused, shaky, sweaty, weak, dizzy, unusually
sleepy, nauseated, or experiencing another acute change?

00:55:31.832 --> 00:55:32.315
Have they eaten?

00:55:32.465 --> 00:55:35.985
Did they receive insulin or another glucose-lowering
medication?

00:55:35.985 --> 00:55:38.409

Synergy Healthcare Resources & Solutions Group Copyright Protected

Is there a recent medication change or acute illness?

00:55:38.559 --> 00:55:43.064
Hypoglycemia requires particular attention because
the resident can deteriorate quickly.

00:55:43.214 --> 00:55:48.654
A resident with low blood glucose may develop sweating,
trembling, weakness, dizziness, confusion, behavioral

00:55:48.654 --> 00:55:51.840
changes, decreased responsiveness, seizures, or loss
of consciousness.

00:55:51.990 --> 00:55:56.150
Follow the resident's ordered hypoglycemia protocol
immediately.

00:55:56.150 --> 00:56:00.093
Then reassess the blood glucose and the resident's
clinical condition according to that protocol.

00:56:00.243 --> 00:56:05.189
If the hypoglycemia does not respond to the ordered
intervention, that is an escalation point.

00:56:05.339 --> 00:56:10.379
Do not repeatedly treat the number without recognizing
that the resident is failing to respond as expected.

00:56:10.379 --> 00:56:12.479
The same principle applies to hyperglycemia.

00:56:12.629 --> 00:56:18.149
A significantly elevated glucose should prompt assessment
for associated findings such as increased thirst,

00:56:18.149 --> 00:56:25.029
increased urination, dehydration, weakness, altered
mental status, nausea or vomiting, or other evidence

00:56:25.029 --> 00:56:26.550
of clinical deterioration.

00:56:26.700 --> 00:56:31.420
The Change-of-Condition reference used for this training
identifies blood glucose greater than 300 milligrams

00:56:31.580 --> 00:56:37.980
per deciliter and blood glucose less than 70 milligrams
per deciliter in a resident with diabetes as examples

00:56:37.980 --> 00:56:39.076
for immediate reporting.

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:56:39.226 --> 00:56:45.066
These values are reference examples from the Change-of-Condition tool; they are not universal standing orders for every

00:56:45.066 --> 00:56:45.623
resident.

00:56:45.773 --> 00:56:51.293
The resident may have practitioner-established notification parameters that are different, and those resident-specific

00:56:51.293 --> 00:56:52.495
orders should be followed.

00:56:52.645 --> 00:57:00.245
For example: The resident's glucose is 62. The resident is awake but newly confused and diaphoretic. The resident

00:57:00.245 --> 00:57:05.685
received the ordered hypoglycemia intervention. Fifteen minutes later the glucose remains below the ordered

00:57:05.685 --> 00:57:08.121
parameter and the resident remains symptomatic.

00:57:08.271 --> 00:57:12.831
That tells the practitioner not only what the number is, but what is happening to the resident and how

00:57:12.831 --> 00:57:14.529
the resident responded to treatment.

00:57:18.730 --> 00:57:22.890
Next, let’s talk about abnormal laboratory and diagnostic results.

00:57:22.890 --> 00:57:26.520
A change in condition does not always begin with something that we can see at the bedside.

00:57:26.670 --> 00:57:32.030
Sometimes, the first indication of a problem comes from a laboratory result, X-ray, or other diagnostic

00:57:32.030 --> 00:57:32.533
finding.

00:57:32.683 --> 00:57:37.188
When an abnormal result is received, the nurse should not simply document the number or file the report.

00:57:37.338 --> 00:57:43.578
The result needs to be evaluated together with the resident’s current symptoms, diagnosis, usual baseline,

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:57:43.578 --> 00:57:48.657
recent trends, medications, current orders, and any
practitioner-established parameters.

00:57:48.807 --> 00:57:53.847
The Change-of-Condition reference used for this training
provides several examples of laboratory findings that

00:57:53.847 --> 00:57:55.680
may require immediate reporting.

00:57:55.830 --> 00:58:01.830
A low platelet count becomes particularly concerning
if the resident has new bruising, bleeding, petechiae,

00:58:01.830 --> 00:58:03.609
or other evidence of impaired clotting.

00:58:03.759 --> 00:58:08.959
For chemistry results, the reference provides examples
including BUN greater than 60, calcium greater than

00:58:08.959 --> 00:58:15.601
12.5, potassium below 3 or above 6, and sodium below
125 or above 155.

00:58:15.751 --> 00:58:19.559
Significant electrolyte abnormalities can affect multiple
body systems.

00:58:19.709 --> 00:58:25.149
Depending upon the abnormality and the resident's
condition, you may see weakness, confusion, altered

00:58:25.149 --> 00:58:30.460
mental status, cardiac symptoms, changes in level
of consciousness, or other clinical deterioration.

00:58:30.610 --> 00:58:36.290
Again, don't simply report, The potassium is abnormal.
Assess the resident and communicate the number together

00:58:36.290 --> 00:58:37.332
with the clinical picture.

00:58:37.482 --> 00:58:42.362
Other examples in the Change-of-Condition reference
include a drug level above the therapeutic range and

00:58:42.362 --> 00:58:44.065
an INR greater than 6.

00:58:44.215 --> 00:58:49.575
When these types of results are received, review relevant
medications and assess for associated symptoms or

Synergy Healthcare Resources & Solutions Group Copyright Protected

00:58:49.575 --> 00:58:50.935
complications.

00:58:50.935 --> 00:58:54.188
The reference also includes symptomatic abnormal urine testing.

00:58:54.338 --> 00:58:55.964
The word symptomatic is important.

00:58:56.114 --> 00:59:00.674
An abnormal urine result should be interpreted together with the resident's clinical findings rather than

00:59:00.674 --> 00:59:04.461
assuming that an abnormal test by itself establishes a symptomatic infection.

00:59:04.611 --> 00:59:07.490
Diagnostic results can also create a change in condition.

00:59:07.640 --> 00:59:14.040
A new or unexpected finding such as a fracture, pneumonia, or congestive heart failure may require immediate

00:59:14.040 --> 00:59:18.252
practitioner communication and a change in the resident's treatment or monitoring plan.

00:59:18.402 --> 00:59:23.042
One final point is extremely important: the values shown on this slide are reference examples from the

00:59:23.042 --> 00:59:25.298
Change-of-Condition material used for this training.

00:59:25.448 --> 00:59:30.893
They are not universal standing orders and should not be presented as CMS-mandated laboratory thresholds.

00:59:31.043 --> 00:59:37.443
Always follow facility policy, the laboratory's critical-value reporting process, practitioner-established parameters,

00:59:37.443 --> 00:59:38.985
and resident-specific orders.

00:59:42.185 --> 00:59:46.527
We have now reviewed several clinical situations that may require immediate attention.

00:59:46.677 --> 00:59:52.757
Now let’s connect those clinical examples back to the federal regulatory requirement under F580, Notification

Synergy Healthcare Resources & Solutions Group Copyright Protected

Unauthorized reproduction, redistribution, or removal of attribution is prohibited without written permission.

00:59:52.757 --> 00:59:53.654
of Changes.

00:59:53.804 --> 00:59:58.402
F580 identifies four circumstances in which immediate
notification requirements apply.

00:59:58.552 --> 01:00:03.512
The first is an accident involving the resident that
results in an injury and has the potential to require

01:00:03.512 --> 01:00:04.752
physician intervention.

01:00:04.902 --> 01:00:10.022
Notice the wording: it is not limited to an injury
that has already required treatment.

01:00:10.022 --> 01:00:15.037
If the injury has the potential to require physician
intervention, the notification requirement is triggered.

01:00:15.187 --> 01:00:20.547
For example, after a fall, a resident may develop
new hip pain, decreased ability to bear weight, a

01:00:20.547 --> 01:00:23.964
head injury, significant bleeding, or another concerning
finding.

01:00:24.114 --> 01:00:28.561
The nurse should assess the resident and initiate
the appropriate notification and follow-up process.

01:00:28.711 --> 01:00:33.935
The second circumstance is a significant change in
the resident's physical, mental, or psychosocial status.

01:00:34.085 --> 01:00:39.333
This can include deterioration associated with a life-threatening
condition or a clinical complication.

01:00:39.483 --> 01:00:46.123
Examples could include acute respiratory deterioration,
significant neurological change, severe or uncontrolled

01:00:46.123 --> 01:00:49.351
symptoms, or another substantial decline in the resident's
condition.

01:00:49.501 --> 01:00:55.501
Remember, however, that nurses should not wait until
a change becomes severe enough to satisfy a regulatory

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:00:55.501 --> 01:00:59.335
definition before assessing or communicating a clinical concern.

01:00:59.485 --> 01:01:04.925
Earlier in this training, we discussed many changes from baseline that still require nursing assessment

01:01:04.925 --> 01:01:07.066
and appropriate practitioner communication.

01:01:07.216 --> 01:01:10.955
The third circumstance is the need to alter the resident's treatment significantly.

01:01:11.105 --> 01:01:17.585
This may include discontinuing an existing treatment because it is causing adverse consequences or beginning

01:01:17.585 --> 01:01:22.517
a new form of treatment because the resident has developed a new problem or significant change.

01:01:22.667 --> 01:01:27.387
This is an important concept because F580 is not limited to emergencies.

01:01:27.387 --> 01:01:31.294
A significant treatment change can itself create the regulatory notification requirement.

01:01:31.444 --> 01:01:36.900
The fourth circumstance is a decision to transfer or discharge the resident as specified under the regulation.

01:01:37.050 --> 01:01:42.250
When a decision is made to transfer the resident, for example, to an emergency department or hospital, the

01:01:42.250 --> 01:01:44.353
required notification process must occur.

01:01:44.503 --> 01:01:50.183
So what should the nurse remember: When one of these regulatory circumstances occurs, the facility must

01:01:50.183 --> 01:01:52.663
follow the required notification process.

01:01:52.663 --> 01:01:54.673
This brings us back to why we use SBAR.

01:01:54.823 --> 01:02:01.303
F580 tells us when notification is required; SBAR helps us organize the clinical information we communicate.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:02:01.303 --> 01:02:03.043
SBAR itself is not the federal requirement.

01:02:03.193 --> 01:02:08.473
It is the structured communication method we can use
to make that required communication clear, concise,

01:02:08.473 --> 01:02:10.426
clinically meaningful, and complete.

01:02:13.627 --> 01:02:15.387
Now let's put everything together.

01:02:15.387 --> 01:02:20.666
One of the most important concepts from this training
is that Change of Condition, or COC, is the entire

01:02:20.666 --> 01:02:21.707
clinical process.

01:02:21.857 --> 01:02:25.377
SBAR is the communication tool we use within that
process.

01:02:25.377 --> 01:02:27.937
The process begins when a change is identified.

01:02:27.937 --> 01:02:30.448
Maybe the CNA reports that the resident is acting
differently.

01:02:30.598 --> 01:02:36.838
Maybe the nurse notices a new symptom, an abnormal
vital sign, a change in function, an abnormal lab

01:02:36.838 --> 01:02:39.120
result, or a treatment that is no longer effective.

01:02:39.270 --> 01:02:41.910
Once a change is identified, assess the resident.

01:02:41.910 --> 01:02:44.611
Do not simply document the observation and call the
physician.

01:02:44.761 --> 01:02:50.281
Perform the appropriate focused nursing assessment
and obtain the relevant objective findings.

01:02:50.281 --> 01:02:52.551
Next, compare the findings with the resident's baseline.

01:02:52.701 --> 01:02:55.580
Ask yourself: What is different about this resident

Synergy Healthcare Resources & Solutions Group Copyright Protected

today?

01:02:55.730 --> 01:03:02.530
A blood pressure, oxygen saturation, mental status, appetite, mobility level, or behavior may have very

01:03:02.530 --> 01:03:05.901
different significance depending on what is normal for that particular resident.

01:03:06.051 --> 01:03:08.291
Then, determine the urgency.

01:03:08.291 --> 01:03:09.731
Is this an emergency?

01:03:09.731 --> 01:03:12.018
Does it require immediate practitioner notification?

01:03:12.168 --> 01:03:17.439
Or is it a non-immediate change that still requires assessment, communication, monitoring, and follow-up?

01:03:17.589 --> 01:03:23.189
If the resident requires emergency care, do not delay necessary treatment or transfer just to complete the

01:03:23.189 --> 01:03:24.469
SBAR.

01:03:24.469 --> 01:03:26.064
Next, gather the pertinent information.

01:03:26.214 --> 01:03:33.494
Have the resident's vital signs, assessment findings, relevant diagnoses, medications, recent orders, labs,

01:03:33.494 --> 01:03:37.964
recent events, advance directives, and other information related to the change available.

01:03:41.164 --> 01:03:44.284
Now we communicate using SBAR.

01:03:44.284 --> 01:03:46.844
Situation: What is happening right now?

01:03:46.844 --> 01:03:49.407
Background: What does the practitioner need to know about this resident?

01:03:49.557 --> 01:03:54.437
Assessment: What did you assess and what did you find?

01:03:54.437 --> 01:03:57.231

Synergy Healthcare Resources & Solutions Group Copyright Protected

Recommendation or Request: What do you need from the practitioner?

01:03:57.381 --> 01:04:03.301
Do you need an order, additional monitoring, labs, diagnostic testing, a practitioner visit, or consideration

01:04:03.301 --> 01:04:04.341
of transfer?

01:04:04.341 --> 01:04:07.400
Once the practitioner provides direction, the process is not finished.

01:04:07.550 --> 01:04:09.790
Implement the orders and interventions.

01:04:09.790 --> 01:04:15.950
Make sure the treatment, medication, monitoring, diagnostic testing, transfer, or other intervention is actually

01:04:15.950 --> 01:04:16.548
carried out.

01:04:16.698 --> 01:04:20.538
Then monitor, reassess, and document the resident's response.

01:04:20.538 --> 01:04:21.978
Did the resident improve?

01:04:21.978 --> 01:04:22.938
Are they stable?

01:04:22.938 --> 01:04:24.218
Are they unchanged?

01:04:24.218 --> 01:04:25.045
Or are they getting worse?

01:04:25.195 --> 01:04:31.035
Finally, if the resident is worsening or the intervention is ineffective, escalate again.

01:04:31.035 --> 01:04:33.764
A physician notification does not close a change of condition.

01:04:33.914 --> 01:04:38.794
The nurse continues to follow the resident until the clinical concern has been appropriately addressed.

01:04:38.794 --> 01:04:42.554
Think of it this way: COC is a loop, not a phone call.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:04:42.554 --> 01:04:43.114
Recognize.

01:04:43.114 --> 01:04:43.594
Assess.

01:04:43.594 --> 01:04:43.759
Compare.

01:04:43.909 --> 01:04:45.909
Determine urgency.

01:04:45.909 --> 01:04:46.789
Communicate.

01:04:46.789 --> 01:04:47.749
Intervene.

01:04:47.749 --> 01:04:48.709
Reassess.

01:04:48.709 --> 01:04:49.109
Document.

01:04:49.109 --> 01:04:50.782
And escalate again when necessary.

01:04:50.932 --> 01:04:55.732
SBAR helps us communicate clearly during that process,
but the nurse remains responsible for following the

01:04:55.732 --> 01:04:58.664
resident's condition and response after the SBAR is
completed.

01:05:02.865 --> 01:05:07.265
Once you have recognized the change, assessed the
resident, and communicated with the practitioner,

01:05:07.265 --> 01:05:10.945
your documentation needs to tell the complete clinical
story.

01:05:10.945 --> 01:05:12.396
First, document what changed.

01:05:12.546 --> 01:05:18.386
Be specific about what you observed or what was reported,
when it began, and how it is different from the resident's

01:05:18.386 --> 01:05:19.222
usual baseline.

01:05:19.372 --> 01:05:25.612
Avoid vague statements such as resident not doing

Synergy Healthcare Resources & Solutions Group Copyright Protected

Well, or condition changed.

01:05:25.612 --> 01:05:27.267
Second, document your assessment.

01:05:27.497 --> 01:05:32.937
Include the pertinent vital signs, symptoms, pain assessment, cognition or mental status, functional

01:05:32.937 --> 01:05:36.949
changes, intake and output, and the focused assessment findings related to the problem.

01:05:37.099 --> 01:05:41.259
Include relevant laboratory or diagnostic findings when applicable.

01:05:41.259 --> 01:05:45.051
Third, document the background information that is important to understanding the change.

01:05:45.201 --> 01:05:50.881
This may include the resident's diagnosis, recent hospitalization or event, recent orders or treatments,

01:05:50.881 --> 01:05:54.629
medications, allergies, and code status or advance directives when relevant.

01:05:54.779 --> 01:05:57.579
Fourth, document your communication.

01:05:57.579 --> 01:05:58.699
Who did you notify?

01:05:58.699 --> 01:06:00.299
What time did you notify them?

01:06:00.299 --> 01:06:02.139
What information did you report?

01:06:02.139 --> 01:06:04.647
And most importantly, what was the practitioner's response?

01:06:04.797 --> 01:06:09.917
Simply documenting MD aware is not enough to tell the clinical story.

01:06:09.917 --> 01:06:14.689
Document what the practitioner was told and what direction, recommendation, or orders were received.

01:06:14.839 --> 01:06:17.319
Fifth, document the action taken.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:06:17.319 --> 01:06:20.272
If you received new orders, show that those orders
were implemented.

01:06:20.422 --> 01:06:26.582
Document treatments, medications, labs, diagnostic
testing, increased monitoring, transfer, or other

01:06:26.582 --> 01:06:27.862
interventions.

01:06:27.862 --> 01:06:31.278
Also document notification of the resident or responsible
party when required.

01:06:31.428 --> 01:06:33.428
Finally, document the follow-up.

01:06:33.748 --> 01:06:35.748
This is extremely important.

01:06:35.748 --> 01:06:38.228
What happened to the resident after the intervention?

01:06:38.228 --> 01:06:39.908
Did the resident improve?

01:06:39.908 --> 01:06:40.788
Remain stable?

01:06:40.788 --> 01:06:41.668
Stay unchanged?

01:06:41.668 --> 01:06:42.213
Or worsen?

01:06:42.363 --> 01:06:44.283
Was the treatment effective?

01:06:44.283 --> 01:06:45.963
Did you reassess the resident?

01:06:45.963 --> 01:06:48.443
Did you have to call the practitioner again?

01:06:48.443 --> 01:06:52.545
Remember: the first physician notification does not
end the change-of-condition process.

01:06:52.695 --> 01:06:57.792
Your documentation should continue until the resident's
response and appropriate follow-up are evident.

01:06:57.942 --> 01:07:02.502

Synergy Healthcare Resources & Solutions Group Copyright Protected

And although the actual Change of Condition or SBAR
form may look different depending on the facility,

01:07:02.502 --> 01:07:08.422
company, or electronic health record, the clinical
process remains the same: what changed, what you assessed,

01:07:08.422 --> 01:07:11.654
who you notified, what was done, and how the resident
responded.

01:07:15.854 --> 01:07:21.214
As we close, there are four key points I want you
to remember when managing a resident's change in condition.

01:07:21.214 --> 01:07:24.317
First: recognize the change by comparing the resident
to their baseline.

01:07:24.467 --> 01:07:27.507
Do not look only at a number or a single symptom.

01:07:27.507 --> 01:07:31.979
Ask yourself, What is different about this resident
today compared with what is normal for this resident?

01:07:32.129 --> 01:07:39.409
Sometimes the earliest sign of a problem is subtle a
change in behavior, appetite, mobility, cognition,

01:07:39.409 --> 01:07:41.022
or participation in care.

01:07:41.172 --> 01:07:46.692
Second: assess first and gather the information needed
for safe clinical decision-making.

01:07:46.692 --> 01:07:49.613
When a change is identified, complete the appropriate
nursing assessment.

01:07:49.763 --> 01:07:56.003
Obtain pertinent vital signs and focused findings,
review relevant medications, orders, labs, diagnoses,

01:07:56.003 --> 01:07:58.900
and recent events, and determine the urgency of the
situation.

01:07:59.050 --> 01:08:05.610
If it is an emergency, initiate the appropriate emergency
response without delaying necessary care.

01:08:05.610 --> 01:08:08.430
Third: use SBAR to organize your communication.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:08:08.580 --> 01:08:15.540
SBAR helps you clearly explain the Situation, Background,
Assessment, and Recommendation or Request to the practitioner.

01:08:15.540 --> 01:08:19.389
But remember: SBAR is the communication tool it is
not the regulation.

01:08:19.539 --> 01:08:24.819
The applicable regulatory notification requirements,
including F580 when its criteria are met, still have

01:08:24.819 --> 01:08:26.499
to be followed.

01:08:26.499 --> 01:08:27.991
Fourth: document the full loop.

01:08:28.141 --> 01:08:33.661
Your documentation should show the assessment, who
was notified and when, what information was communicated,

01:08:33.661 --> 01:08:38.381
the practitioner's response and orders, what interventions
were implemented, and what happened to the resident

01:08:38.381 --> 01:08:38.834
afterward.

01:08:38.984 --> 01:08:43.384
And this last part is critical: do not stop at MD
notified.

01:08:43.384 --> 01:08:44.744
Reassess the resident.

01:08:44.744 --> 01:08:46.984
Determine whether the intervention was effective.

01:08:46.984 --> 01:08:48.028
Continue the ordered monitoring.

01:08:48.178 --> 01:08:52.898
If the resident is not improving, or if the condition
worsens escalate again.

01:08:52.898 --> 01:08:55.378
So remember the complete process:

01:08:55.378 --> 01:08:56.978
Recognize the change.

01:08:56.978 --> 01:08:57.618
Assess.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:08:57.618 --> 01:08:59.058
Compare to baseline.

01:08:59.058 --> 01:08:59.754
Determine urgency.

01:08:59.904 --> 01:09:01.184
Communicate using SBAR.

01:09:01.744 --> 01:09:03.584
Implement.

01:09:03.584 --> 01:09:04.704
Reassess.

01:09:04.704 --> 01:09:05.184
Document.

01:09:05.184 --> 01:09:07.103
And escalate when necessary.

01:09:07.103 --> 01:09:10.097
Our goal is not simply to complete a Change of Condition
form.

01:09:10.247 --> 01:09:16.167
Our goal is early recognition, timely communication,
appropriate intervention, and safe follow-through

01:09:16.167 --> 01:09:16.749
for the resident.

01:09:20.949 --> 01:09:25.189
This concludes our Change of Condition and SBAR training
for licensed nurses.

01:09:25.189 --> 01:09:29.099
But early recognition of a resident's change in condition
begins with the entire care team.

01:09:29.249 --> 01:09:34.049
Nursing assistants are often the staff members who
spend the most time providing direct care and may

01:09:34.049 --> 01:09:35.982
be the first to notice that something is different.

01:09:36.132 --> 01:09:40.772
Watch for our upcoming Nursing Assistant training
on STOP AND WATCH which focuses on recognizing early

01:09:40.772 --> 01:09:45.003
changes in a resident and promptly reporting those
observations to the licensed nurse.

Synergy Healthcare Resources & Solutions Group Copyright Protected

01:09:45.153 --> 01:09:48.380
And remember, your learning does not end with this presentation.

01:09:48.530 --> 01:09:53.810
Visit our Synergy Intranet Training Hub, where you can access additional case studies, competency checks,

01:09:53.810 --> 01:09:57.203
lesson plans, and training resources to reinforce what you learned today.

01:09:57.353 --> 01:10:03.993
Thank you for participating, and remember: recognize the change, assess the resident, communicate clearly,

01:10:03.993 --> 01:10:05.282
and always follow through.

Synergy Healthcare Resources & Solutions Group Copyright Protected

REFERENCES

1. Centers for Medicare & Medicaid Services. (n.d.). State Operations Manual, Appendix PP: Guidance to Surveyors for Long Term Care Facilities (F580—Notification of Changes; 42 CFR § 483.10(g)(14)). https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
2. Electronic Code of Federal Regulations. (n.d.). 42 CFR § 483.10(g)(14), Notification of changes. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.10
3. University of Florida, Quality and Patient Safety Initiative. (n.d.). SBAR: Situation, Background, Assessment, Recommendation. https://knowledge.qpsi.med.ufl.edu/team-leadership/sbar-communication/
4. Florida Atlantic University. (2011). INTERACT version 3.0: SBAR communication form and progress note [Clinical tool]. https://www.in.gov/health/files/INTERACT_SBAR_Form.pdf
5. INTERACT Program / Florida Atlantic University. (2011). INTERACT: Interventions to Reduce Acute Care Transfers—clinical communication and change-in-condition tools [Program materials]. https://www.in.gov/health/files/INTERACT_SBAR_Form.pdf
6. Source attribution note: INTERACT tools are attributed to Florida Atlantic University. The SBAR communication framework is also described in the University of Florida educational resource. Referencing these resources does not imply endorsement or ownership of their materials by Synergy Healthcare Resources & Solutions Group. Original INTERACT forms may carry separate reuse restrictions.

Synergy Healthcare Resources & Solutions Group Copyright Protected