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CONTINUING EDUCATION LESSON PLAN

Title: Change of Condition: Recognize, Assess, Communicate & Follow Up

Provider: Mildred DeCastro MSN, RFNP, CIC, LNC-Sp for Synergy Healthcare Resources & Solutions Group

Target audience: Licensed nurses working in skilled nursing and long-term care facilities

Type of offering: Asynchronous, self-paced online education

Teaching method: Recorded video presentation, independent transcript reading, detailed-content reading, and scenario-based knowledge assessment

Total Participant Hours for CE Credit: 1.5 contact hours, Knowledge-based pre-test (diagnostic) and post-test (summative), with assigned clinical monograph reading.

Source material: Change of Condition: Recognize, Assess, Communicate & Follow Up — video presentation transcript, approximately 70 minutes, and Article for Change of Condition Clinical Monograph

Official CA BRN Provider Disclosure: Provider approved by the California Board of Registered Nursing, Provider Number **CEP 17462** for **1.5 Contact Hours**.

Refund & Cancellation Policy: Since this self-paced digital course is provided entirely free of charge, there are no refund policies applicable for registration or non-attendance. In the unexpected event that this digital training platform or video becomes unavailable or is discontinued, no monetary compensation will be issued. Users are welcome to re-access and resubmit the form at any time to complete their 1.5 contact hours.

Program Relevance to Nursing Home Setting: The program strengthens participants' (administrator, director of nurses, MDS nurses and RN, LVNs) understanding of early recognition and reporting of changes in resident condition, timely communication with healthcare practitioners and responsible parties, appropriate escalation of care, and accurate documentation. It emphasizes the importance of establishing standardized communication processes, including SBAR, to support timely interventions and continuity of care. Participants will gain knowledge applicable to staff training, supervision, policy implementation, incident review, interdisciplinary coordination, and Quality Assurance and Performance Improvement (QAPI) activities. These principles support identifying gaps in clinical communication, reducing preventable delays in treatment, and promoting resident-centered care across skilled nursing, assisted living, and home- and community-based settings.

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Attendance Verification Method: Attendance and participation for this self-paced online educational program will be verified electronically through Google Forms. Participants must provide their full name, email address, professional license or certification number (if applicable), and facility affiliation; attest to completing the instructional video and required Clinical Monograph reading; complete the course evaluation; and achieve a minimum passing score of 80% on the post-test. Submission timestamps, learner attestations, and assessment results will be recorded in Google Sheets for verification, tracking, and record retention. Certificates of completion will be issued only after all required learning activities and assessment requirements have been successfully completed.

Regulatory applicability: Federal nursing facility notification requirements, including F580, are specifically applicable to Medicare- and Medicaid-certified nursing facilities. HCBS and assisted living administrators should apply the program's clinical communication and resident safety principles in accordance with their respective state licensing requirements, organizational policies, and scope of services.

Course Validity & Document Retention Policy:

- **Credit Expiration Rule:** In compliance with California Board of Registered Nursing (BRN) standards, these **1.5 Contact Hours** are only valid for your immediate, current two-year license renewal cycle. To count toward your renewal, the date of course completion printed on your certificate must fall within the 24 months directly preceding your license expiration date. Credits cannot be rolled over into future renewal cycles.

- **Mandatory 4-Year Retention:** Per California regulatory mandates, both the Continuing Education Provider and the licensed participant are legally required to securely retain and preserve this Certificate of Completion for a **minimum of four (4) years** from the exact date of issuance. This document must be made available if your license is selected for a random compliance audit by the State of California.

Behavioral Objectives

1. Identify a change from a resident's usual baseline and classify findings as immediate/urgent or non-immediate based on the clinical presentation.
2. Identify qualifying F580 notification circumstances and select appropriate resident, practitioner, and representative notification actions.
3. Organize and communicate relevant findings to a practitioner using Situation, Background, Assessment, and Recommendation (SBAR).
4. Describe and sequence complete change-of-condition documentation, including assessment, notifications, orders, interventions, reassessment, resident response, and follow-up.
5. Apply the change-of-condition workflow to a resident case scenario and select appropriate escalation, communication, and follow-through actions.

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Overview

This program prepares licensed nurses to recognize clinically meaningful deviations from resident baseline, assess and prioritize changes, communicate clearly using SBAR, fulfill applicable notification responsibilities under F580, implement and document interventions, and continue monitoring through resolution or appropriate handoff. The presentation distinguishes the clinical change-of-condition process from the MDS Significant Change in Status Assessment process and emphasizes that emergency treatment must not be delayed to complete documentation.

Detailed Content and Instructional Outline

Article Reading Requirement: Change of Condition in Skilled Nursing Facilities: Clinical Recognition, Assessment, SBAR Communication, and Regulatory Follow-Up

1. Introduction, scope, and baseline recognition

Detailed content: Define change in condition; compare observations with resident-specific baseline; consider changes in cognition, breathing, behavior, intake, mobility, and other clinical signs; distinguish urgent from non-immediate findings.

Learning activity: Learner reviews video/transcript introduction and baseline examples; identifies changes in short scenarios.

2. Regulatory notification: CMS F580

Detailed content: Review Notification of Changes, including accident with potential injury requiring physician intervention, significant deterioration, significant alteration in treatment, and transfer/discharge circumstances; distinguish clinical escalation from the regulatory notification threshold; discuss whom to inform/consult/notify and documentation.

Learning activity: Learner reads transcript discussion of F580 and identifies required notification actions.

3. Assessment and prioritization

Detailed content: Perform resident-focused nursing assessment within scope; collect pertinent observations, vital signs, comparison to baseline, relevant history, and other clinical findings; determine urgency and activate emergency response when indicated.

Learning activity: Learner applies assessment priorities to symptoms and change-of-condition examples.

4. Structured SBAR communication

Detailed content: Situation: resident and current concern; Background: baseline and relevant clinical context; Assessment: objective findings and changes; Recommendation: request for evaluation, orders, clarification, or next steps; include read-back/confirmation per facility policy.

Learning activity: Learner constructs an SBAR communication using the video/transcript model.

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5. Orders, interventions, monitoring, and follow-up

Detailed content: Implement practitioner orders and resident-specific interventions; reassess effectiveness; monitor evolving signs and symptoms; escalate if worsening or unresponsive; ensure continuity at shift handoff.

Learning activity: Learner sequences appropriate post-notification actions and follow-up.

6. Documentation of the complete clinical story

Detailed content: Document onset and baseline comparison, focused assessment, notification contacts/times, information shared, practitioner response/orders, interventions, resident response, repeat assessments, and continued follow-up.

Learning activity: Learner identifies omissions in sample documentation and selects complete entries.

7. Clinical application and case scenarios

Detailed content: Apply the full workflow: recognize, assess, determine urgency, communicate, implement, document, and follow through; distinguish emergency actions from routine follow-up and adapt to local facility procedures and electronic records.

Learning activity: Learner completes case-based post-test questions and reflects on workplace application.

Lesson Aids / Instructional Materials

- Recorded video presentation: Change of Condition: Recognize, Assess, Communicate & Follow Up (approximately 70 minutes).
- Complete 73-page video transcript is available as a reference resource. The required 35-minute reading assignment must be a separately identified selection of transcript passages and detailed-content reading totaling approximately 3,850 words; the complete transcript is not designated as a 35-minute reading assignment.
- Detailed-content reading guide aligned with the instructional outline and transcript. Its actual word count must be combined with the required transcript excerpts and recorded before the 35-minute allocation is finalized.
- SBAR communication examples and change-of-condition case scenarios presented in the training.
- Online pre-test and post-test (Google Forms or equivalent platform).
- Access to applicable facility procedures, resident-specific orders, and clinical escalation protocols for workplace application.

Learning Sequence and Time Allocation

Activity	Minutes
Pre-test (diagnostic)	5
Video presentation/Transcript Reading	70

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Clinical Monograph Detailed-content reading	12
Post-test (summative)	23
TOTAL	108 minutes

Independent Reading Time: Calculation and Audit Justification

The Clinical Monograph contains 2,490 words. Using an instructional planning rate of 110 words per minute for dense clinical educational reading, the estimated independent reading time is 22.6 minutes, rounded to 23 minutes.

This calculation provides a documented basis for the reading-time allocation. The reading rate is a planning assumption rather than an officially mandated California BRN standard.

Source Verification: Video Presentation and Accompanying Transcript: The course includes a 70-minute instructional video presentation accompanied by a 73-page written transcript containing approximately 11,287 words. The transcript is provided as a supplementary learning aid that participants may read simultaneously while viewing the video to support comprehension, reinforce key clinical concepts, and review instructional content.

The transcript is not designated as a separate independent reading assignment. Its use is incorporated into the 70-minute video presentation and does not generate additional instructional time or contact hours. Participants may also reference the transcript after viewing the presentation for clarification and review. The Clinical Monograph, containing 2,490 words, is the separately assigned independent reading activity, with its own calculated reading-time allocation.

Audit Evidence and Documentation: Synergy Healthcare Resources & Solutions Group will maintain the following documentation to support the course's instructional time allocation:

1. The 70-minute instructional video and accompanying transcript, which serves as a simultaneous reading and reference aid.
2. The Clinical Monograph containing 2,490 words, designated as the required independent reading assignment.
3. A dated word-count verification and calculation supporting approximately 23 minutes of independent reading, based on an instructional planning rate of 110 words per minute.
4. The course lesson plan identifying instructional activities, teaching methods, learning objectives, and allocated time.
5. Learner participation records, completion attestations, and pre-test and post-test results.

The independent reading-time calculation will be reviewed and updated whenever the Clinical Monograph undergoes substantive revisions.

Evaluation and Completion

Pre-test: Online multiple-choice and scenario-based questions assess baseline understanding. Results are diagnostic and used to identify learning needs.

Post-test: Online multiple-choice and scenario-based questions assess achievement of all five behavioral objectives, including F580, SBAR, assessment priority, documentation, and follow-up.

Suggested completion standard: 80% or higher on the post-test, with retake permitted after content review. This is a proposed course policy, not a requirement established by the supplied transcript.

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Completion evidence: Video/course participation attestation, assigned reading completion, post-test score, learner identity, date, and provider records. Confirm any required CE evaluation and contact-hour calculation under the applicable licensing board/provider rules before awarding credit.

References and Source Attribution

- Synergy Healthcare Resources & Solutions Group. (2026). Change of Condition: Recognize, Assess, Communicate & Follow Up [Video presentation transcript].
- Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP, F580—Notification of Changes.
- 42 CFR § 483.10(g)(14), Notification of changes.
- University of Florida, Quality and Patient Safety Initiative. SBAR: Situation, Background, Assessment, Recommendation.
- Florida Atlantic University. INTERACT Version 3.0: SBAR Communication Form and Progress Note.

Instructional note: The training transcript states that clinical examples are educational and do not replace professional judgment, facility policy, resident-specific orders, or emergency procedures.

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