When time is of the essence: early recognition of acute change of condition in long-term care

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Course description

• According to AMDA, an acute change of condition is a clinically important change from a resident’s well-established and documented baseline in physical, cognitive, behavioral or functional domains. Without early recognition and intervention, an acute change of condition can result in resident injury or death.

• This webinar is designed to initiate engagement of long-term care frontline and nursing staff in understanding the benefits of early recognition and intervention and provide tools that can be easily incorporated into daily skilled nursing facility and assisted living workflows.

Objectives

• Upon completion of this webinar, participants will be able to:
  – Recognize the impact of early recognition and intervention of acute change of condition on resident outcomes.
  – Identify frontline strategies to recognize a change of condition and communicate those findings as early as possible.
  – Discuss nursing competencies needed to assess and communicate with physicians concerning a resident’s acute change of condition.
  – Analyze resident outcomes to improve care processes related to acute change of condition.
Background

• Triple Aim (from the Affordable Care Act)
  – Excellent patient experience
  – Excellent quality measures
  – Cost containment
• Med-PAC report
• Office of Inspector General reports
• Governmental focus on re-hospitalizations

A focus on re-hospitalizations

• According to the Institute for Healthcare Improvement (IHI), “there are about 5 million hospital readmissions annually.”
  – 1/3 occur within 90 days of discharge
  – 46% could be prevented
• Estimated: 15%-25% of all Medicare hospitalizations are re-hospitalizations. This translates to $15 billion annually in Medicare spending

Re-hospitalization defined

• Definition of readmission: “…patients who are discharged from acute care hospital and are hospitalized again within 30 days of discharge.”
• Re-hospitalizations are:
  • Unanticipated
  • Unscheduled
  • Clinically related to the initial admission
  • Can be readmitted to a different hospital – not just original hospital
  • Bounce-back
  • New term: complicated or complex transition
  • Frequent flyers

Acello, Barbara. Ending Hospital Readmissions: A Blueprint for SNF’s. HCPro © March 2011
Conditions monitored by CMS

- Per Patient Protection and Affordable Care Act (PPACA)
  - Heart attack
  - Pneumonia
  - Heart failure
  - COPD
  - Joint replacement
  - Soon to be: Urosepsis
- CMS not paying for readmissions within 24 hours of discharge
- Medicare will “recover” payments for unnecessary readmissions within 30 days of discharge if the patient has one of the above conditions

What is a “change in condition?”
When to report to the MD/NP/PA

- Immediate notification
  - Any symptom, sign or apparent discomfort that is:
    - SUDDEN in onset
    - A MARKED CHANGE (e.g., more severe) in relation to usual symptoms and signs
    - UNRELIEVED by measures already prescribed

Sources:
AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long Term Care Setting, 2003

Impact of not noting early signs of a change in condition

- Mismanagement of co-morbid conditions
- Transition risk factors
- Re-hospitalizations
- Unnecessary emergency room visits
- Transfer trauma
- Death
- Dissatisfied customers and partners
- Loss of referral sources
Strategies for early recognition

• Consistent staffing so staff can “know” the normal condition, behavior, appetite, pain of the residents you serve
• Patient/caregiver engagement in disease management – knowing key warning signs
• Identification of facility capacity followed by training and competency testing of staff

Strategies for early recognition

• Simulation training of predictable change in condition
• Having clear parameters for individual residents with co-morbid conditions and for post-operative patients
• Have a formal process for recognition of change in condition and track through quality management processes

Prepare for what is expected

• Know your facility capacity for acuity
• Have a formal process of recognizing change in condition
• Training and simulation on predictable change in condition situations
Prepare for what is expected

- Engage the patient in co-morbid condition warning signs
- Track through quality management and root cause analysis processes

Prepare for what is expected

- Most common medical conditions (non-surgical) causing re-hospitalization:
  - Heart failure
  - Acute myocardial infarction
  - Pneumonia
  - COPD
  - Psychosis
  - GI problems
  - Electrolyte imbalance
  - Sepsis

Prepare for what is expected

- Most common surgical causes for re-hospitalizations:
  - Cardiac stent placement
  - Percutaneous transluminal coronary angioplasty
  - Coronary artery bypass graft surgery (heart)
  - Major hip or knee surgery
  - Vascular surgery
  - Major bowel surgery
  - Other hip or femur surgery
Prepare for what is expected

• What contributes to re-hospitalization that affects LTC?
  – Shorter length of stay
  – Weekend exodus from LTC to hospital
  – Primary physician not available/on-call
  – Physician reluctant to write orders
  – No medical assessment on site on weekend
  – Fewer diagnostic tests available in facility

Prepare for what is expected

• What contributes to re-hospitalization that affects LTC?
  – Nursing staff are stretched
  – Critical lab levels
  – Communication/coordination problems between facility and hospital
  – Staff not trained or qualified to address the problem
  – Lack of advance directive planning

Prepare for what is expected

• Risk factors for re-hospitalization: polypharmacy
  – People >65 consume more medications than any other age group
  – 15% of population is >65
  – 30% of all prescriptions and 40% of OTC drugs are used by them
• Risk of adverse events increases with number of medications:
  • 2 drugs = 6% increase in risk of adverse events
  • 6 drugs = 80% increase in risk of adverse events
  • 8 drugs = 100% increase in risk of adverse events
Prepare for what is expected

- Risk factors for re-hospitalization: polypharmacy
  - Adverse drug events rank 5th among the top preventable health threats to elderly (after congestive heart failure, breast cancer, hypertension, and pneumonia)
  - Drug interactions are a leading cause of adverse drug events

  Acello, Barbara "Ending Hospital Readmissions: A Blueprint for SNF’s" HCPro March 2011

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Prepare for what is expected

- Most common day of the week to discharge from a hospital is Friday

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Prepare for what is expected

- Temporary care plan upon admission
  - “Resident is at risk for re-hospitalization related to the risk factors of …”
- Share early warning signs of new admissions with staff
- Medication reconciliation
  - Review high-risk drugs (e.g., anti-coagulants, NSAIDs)
Co-morbid condition management

– Diabetes
  • Proper technique for monitoring blood glucose
  • Knowing the high/low parameters of blood glucose
  • Know visible signs and symptoms of high/low blood glucose
  • Know what to do when it is identified
  • Notifications
    – MD/NP
    – Family
  • Documentation
  • Re-assessment of the situation

Co-morbid condition management

– Congestive heart failure
  • Proper technique for obtaining daily weights
    – Same time of day
    – Same scale
    – Same w/c – watch for add-ons or missing pedals
    – Recheck abnormal weights
  • Know the high/low parameters – typically a weight gain of 3 pounds in a day or 5 pounds in a week
  • Know visible signs and symptoms such as edema or labored breathing

Co-morbid condition management

– Congestive heart failure (continued)
  • Know what to do when signs and/or symptoms are identified
  • Make notifications
    – MD/NP
    – Family
  • Follow orders / instructions
  • Document situation and actions
  • Re-assessment of the situation
Co-morbid condition management

– End stage renal disease
  • Proper technique for obtaining daily weights
    – Same time of day
    – Same scale
    – Same w/c – watch for add-ons or missing pedals
    – Recheck abnormal weights
  • Know and encourage compliance to fluid restrictions and diet
  • Know emergency protocols for shunt bleeding

– End stage renal disease (continued)
  • Know what to do when signs and/or symptoms, such as confusion, are identified
  • Make notifications
    – MD/NP
    – Family
    – Dialysis provider
  • Follow orders / instructions
  • Document situation and actions
  • Re-assessment of the situation

Co-morbid condition management

– Urinary tract infection - urosepsis
  • Proper technique for obtaining testing
  • Know the signs and symptoms
  • Confusion, change in behavior, weakness, fever, pain on urination, cloudy urine and/or sediment in urine
  • Know what to do when signs and/or symptoms are identified
Co-morbid condition management

– Urinary tract infection – urosepsis (continued)
  • Make notifications
    – MD/NP
    – Family
  • Follow orders / instructions
  • Document situation and actions
  • Re-assessment of the situation

Have a formal process for early recognition of change in condition

What is a “change in condition”? When to report to the MD/NP/PA

• Immediate notification
  – Any symptom, sign or apparent discomfort that is:
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Sources:
AMHSA Clinical Practice Guideline – Acute Changes in Condition in the Long Term Care Setting 2003.
Stop and watch
Interact 3.0

- Early warning tool for unlicensed assistive personnel (UAP) such as: CNA, NAR, HHA, PCA, paid feeding assistant, etc.

  - If you have identified an important change while caring for a patient today, please circle the change and discuss it with the charge nurse

Stop and watch
Interact 3.0

- Seems different than usual
- Talks or communicates less than usual
- Overall needs more help than usual
- Participated in activities less than usual

Stop and watch
Interact 3.0

- Ate less than usual (not because of dislike of food)
- No bowel movement, or diarrhea
- Drank less than usual
Stop and watch  Interact 3.0

• Weight change
• Agitated or nervous more than usual
• Tired, weak, confused, or drowsy
• Change in skin color or condition
• Help with walking, transferring, toileting more than usual

Once a “change in condition” is suspected or identified

When to report to the MD/NP/PA

• Vital signs
  – Report WHY vital signs were taken
• Laboratory tests/diagnostic procedures
  – Report WHY the test or procedure was done
• Signs and symptoms
  – A-Z
Prepare to contact the MD/NP/PA

- SBAR physician/NP/PA communication and progress note for new symptoms, signs and other changes in condition

SBAR

Before calling MD/NP/PA:
- **Evaluate the resident** and complete the SBAR form
- **Check vital signs**: blood pressure, pulse, respiratory rate, temperature, pulse oximetry, and/or finger stick glucose if indicated
- **Review chart**: recent progress notes, labs, orders

SBAR

Before calling MD/NP/PA:
- **Review relevant INTERACT care path or acute change in condition file card**
- **Have relevant information available when reporting** (i.e., resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)
SBAR

• SITUATION
  – The symptom/sign/change I'm calling about is:
  – This started:
  – This has gotten worse/better/stayed the same since it started
  – Things that make the condition worse are:
  – Things that make the condition better are:
  – Other things that have occurred with this change are:

SBAR

• BACKGROUND
  – Primary diagnosis and/or reason resident is at the nursing home
  – Pertinent history (e.g., recent falls, fever, decreased intake, pain, shortness of breath, other)
  – Vital signs (T-P-R-B/P)
  – Pulse oximetry/oxygen level
  – Change in function or mobility

SBAR

• BACKGROUND
  – Medication changes or new orders in the last two weeks
  – Mental status changes (e.g., confusion/agitation/lethargy):
  – GI/GU changes (e.g., nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)
SBAR

• BACKGROUND
  – Pain level/location:
  – Change in intake/hydration
  – Change in skin or wound status
  – Labs
  – Advance directives (full code, DNR, DNI, DNH, other, not documented)
  – Allergies
  – Any other data

SBAR

• ASSESSMENT (RN)
  – RN: What do you think is going on with the resident? (e.g., cardiac, infection, respiratory, urinary, dehydration, mental status change)
    • I think the problem may be …
    OR
    • I am not sure of what the problem is, but there has been an acute change in condition.

SBAR

• or APPEARANCE (LPN)
  – LPN: The resident appears … (e.g., short of breath, in pain, more confused)
  – Focused assessment within set parameters
**SBAR**

- **REQUEST**
  - I suggest or request (check all that apply):
    - Provider visit
    - Lab work, x-rays, EKG, other tests
    - IV or SC fluids
    - Monitor vital signs and observe
    - Change in current orders
    - New orders
    - Transfer to the hospital
    - Other

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**Tools for monitoring for change in condition**

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**Per Dr. Ouslander,**

“All INTERACT tools MUST be implemented”

- Admission to LTC home
- Medication reconciliation
- Advance care planning
- *Early warning tool*
- *Care paths*
- *Acute change in condition file cards*
- *SBAR*
Per Dr. Ouslander, “All INTERACT tools MUST be implemented”

- Hospital communication tools
- Transfer checklist envelope
- Transfer data list
- Hospitalization rate tracking
- Quality improvement tool for review of acute transfers

Care paths

- Symptoms of UTI
- Dehydration
- Symptoms of CHF
- GI Symptoms
- Shortness of breath
- Symptoms of lower respiratory infection
- Behavior
- Fever
- Mental status change

Capacities and competencies

Nursing assistants / unlicensed personnel:
- Tools: “Stop and Watch”
- Report signs of change to a nurse

Competencies needed:
- Know your patients/residents
- Know “why” you do routine tasks for patients with certain diagnoses
- Know key warning signs
Competencies
Nursing assistants / unlicensed personnel:
• Competencies needed:
  – Know key warning signs
  – For example, pain:
    • (Immediate) new severe pain, or marked increase in chronic pain
    • (Non-immediate) increase in frequency or severity of pain

Competencies
Nursing assistants / unlicensed personnel:
• Competencies needed:
  – Know key warning signs
  – For example, rash:
    • (Immediate) resident on a new medication or one known to cause an allergic reaction
    • (Non-immediate) recent onset of localized or diffuse pruritic rash, or any rash accompanied by other systematic symptoms

Outcomes of early recognition
• Patient/family engagement and satisfaction
• Positive trends in quality metrics
• Referral of choice – health systems will want to partner with your facility

• Most importantly:  It is the right thing to do for those we serve!
Monitoring early recognition of change in condition

- Do you perform a root cause analysis through Quality Council on ALL re-hospitalizations, including ER visits?
- Do you communicate the result with staff and provide system changes to improve that area of care?

Summary of strategies

- Utilize consistent staffing practices and good human resource management
- Select a standardized, evidence-based process to follow to recognize and assess potential change in condition (such as INTERACT, AMDA Clinical Practice Guidelines)
- Train staff on the early warning signs for change in condition, and reward staff / teams for early recognition

Summary of strategies

- Engage patients with education on early warning signs for their conditions
- Provide simulation training to practice skill competencies and critical thinking before an emergency change in condition / know the facility capacity for types of patients
- Debrief after events to capture process improvements or resources needed
Resources

- INTERACT website:  
  www.interact2.net
- American Medical Directors Association:  
  www.amda.com

Questions