**Significant Change in Condition: Identifying/Documenting**

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**Issues with Change of Condition**

- Regulatory requirements
- Identification of change of condition
- Communication of change of condition
- Common pitfalls
- Assessment for change of condition

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**Regulatory Language**

- “Significant change” is a decline or improvement in a resident's status that:
  - will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, is not “self limiting” (decline only)
  - impacts on more than one area of the resident’s health status,
  - and requires interdisciplinary review and/or revision of the care plan

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**Significant Change vs. Significant Error**

- A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS. A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

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**Criteria for Temporary Change**

- Reassessment not required
- Transient changes must be
  - noted in clinical record and
  - necessary clinical interventions implemented.
- Condition expected to return to baseline within short period of time – e.g., 1-2 weeks.
SCSA is appropriate when:

- There is a determination that a significant change (either improvement or decline) in a resident’s condition from his/her baseline has occurred as indicated by comparison of the resident’s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
- The resident’s condition is not expected to return to baseline within two weeks.

SCSA is required when:

- When a resident enrolls in a hospice program.
- When a resident receiving hospice services decides to discontinue those services.

Assessment Reference Date

- Facility may take up to 14 days to determine whether criteria are met (pg. 2-20)
- ARD must be less than or equal to 14 days after IDT’s determination that the criteria are met. (determination date + 14 days). (pg 2-22)

Guidelines for Determination

- NOT AN EXHAUSTIVE LIST
- Final decision based on the judgment of the IDT
- Key is Documentation
  - It is a significant change or
  - It is not a significant change

SCSA is appropriate when:

- Resident who goes in and out of the hospital on a relatively frequent basis
  - pg 2-21
### Decline in two or more of the following:

- Resident’s decision-making changes;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
- Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;  
- Resident’s incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
- Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status;
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
- Overall deterioration of resident’s condition.

### Guidelines when not Significant

- Discrete & easily reversible case documented in the record (anticipated side effect of new med)
- Short term illness
- Predictable cyclical pattern of clinical signs and symptoms with previously diagnosed condition

### Assessment Requirements

- When a resident’s status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.
- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident’s status in the progress notes.
- ARD must be within 14 days after determination of SCSA

### PASRR and Significant Change

- SCSA for an individual known or suspected to have a mental illness may need a new Level II PASRR
- If necessary facility should not wait until the SCSA is complete to begin PASRR
PASSR

- Website: http://health.mo.gov/seniors/nursinghomes/pasrr.php
  - Instructions
  - Blank forms
  - Significant change
  - Flow chart for admissions

Key To Significant Change

- DOCUMENTATION
  - Whether is it or is not a significant change
  - Show the IDT their thought process.

Clinical Significant Change

Identification of Change:

- Components –
  - Baseline
  - Assessment skills & knowledge of resident
  - Change that is observable & measurable

Identification (cont):

- Setting the baseline
  - Know the resident
  - Utilize all sources of information
    - Chart, resident, family/friends, staff
    - Subjective/objective
    - Adequate documentation
    - Complete resident picture

Communication of Change:

- Staff
- Family/legal guardian
- Physician
  - Preparation for contact essential
  - Record keeping
Communication (cont)

- Documentation reflects:
  - Specific changes
  - Communication with family/legal guardian about changes
  - Communication with provider
  - Follow-through of provider orders
- Care plan interventions
  - Evaluated for effectiveness
  - Revised if not effective or other changes needed.

Pitfalls: Common Aging Changes

- Aging alters strength and function of tissues and organs (i.e., immune system, skin, mucosa, resp., GI, CV and GU changes)
- Classic signs/symptoms of infection frequently absent:
  - Often no fever or only low grade temp (what is normal temp for elderly?)
  - Altered pain response

Aging Changes/Predispositions

- Waning T-cells, antibody response decreased impacting vaccine effects
- Slower rate of healing
- Decreased ciliary action
- Decreased cough response
- Change in stomach acid, decreased intestinal motility
- Nutritional issues
- Co-morbidities
- Social factors

Observation and Assessment for Change

- Document any indication of instability or high probability of an unstable condition
- These situations should be evident in nurses' notes & not be assumed.
- Identify dates and treatments initiated to stabilize residents condition

Possible Unstable Conditions

- Pulse rate <50 >120
- Systolic BP <90 >160
- Diastolic BP <60 >90
- Persistent fever
- Acute loss of function of a body part
- Active bleeding
- Severe blood gas or electrolyte abnormality
- Recent exacerbation of resident's condition
- Evidence of respiratory condition and problems
- Cardiac abnormalities, arrhythmias, etc.
- Urine output <30cc/hr

Possible Unstable Conditions (Cont)

- Adverse reaction to meds/chemotherapy
- Instabilities requiring frequent venipunctures
- Changes in treatment regime requiring frequent medication changes
- Wound dehiscence or evisceration
- Acute or progressive sensory, motor, circulatory or respiratory deficiency
- Progressive acute neurological difficulties
- Medical problems that interfere with restorative care
### Predisposing Factors to Infection

- Diabetes
- Dysphagia
- Chronic immobility
- Pressure ulcers
- Urinary incontinent/treatment measures: caths, incontinence products
- Cancer
- Chronic resp. and cardiac conditions
- Dementia

### MEDICATIONS

- Indicate how often PRN medication is required
  - Does resident request and know the need or must the nurse assess and determine the need by skilled care
- Document antibiotic therapy and response
- Document any medication allergies and/or reactions

### Bronchopulmonary Diseases

- Indicate tolerance to activity and strength level with the amount of exertion displayed
- State ability to handle ADLs and if it alters medical status (SOB, cyanosis, etc.)
- Indicate sensorium (consciousness or mental clarity) status
- Describe edema (type, degree, amount of rest required to control)

### Bronchopulmonary (Cont)

- Record quality of respiration’s and irreg. lung sounds
- Define negative findings including:
  - frequency, presence or absence of dyspnea or SOB, cyanosis
  - presence of sternal retraction, unequal chest expansion, distention of neck veins
  - presence of any type of cough, productive, non-productive, quality of sputum, etc.

### Bronchopulmonary (Cont’d)

- Describe respiratory support needs (nebulizer, IPPB, continuous O2) and related situations
- Document need for nasopharyngeal or tracheostomy suctioning including frequency

### Cancer/Terminal Conditions

- Define changes in body systems indicating manifestations of the disease process:
  - pain, weight loss, respiratory status (dyspnea, rales)
  - jaundice, edema, nausea and vomiting, color (ashen, cyanosis)
- Note the skin condition and/or status of any surgical or radiation sites
**Cancer/Terminal Conditions (Cont)**

- List symptomatic needs relating to vital sign variables, strength and functioning problems (activity level) and change in sensorium (consciousness or mental ability)
- Document special therapies (cobalt, chemotherapy, radiation) and what negative physical responses are manifested

**Cancer Conditions (Cont’d)**

- List support equipment, supplies and mechanical interventions required (nasogastric tube, Foley, IVs, O2, IPPB, suctioning, tracheotomy, central lines, hyperalimentation, dressings, G-tubes
- Indicate the ability to effectively communicate needs and if the care requires assessment and determination by the nurse

**Cerebrovascular (CVA)**

- Indicate mental status including the attitude and ability to learn
- Indicate what resident CANNOT do for himself and why. Re-emphasize impairments weekly
- Describe activity tolerance in time, frequency and number of persons required, what equipment needed - walker, lift, cane, etc.

**CVA (Continued)**

- Document mode of feeding, mechanical intervention, and frequency.
  - If tube feeding, include dates, feedings received and amount, frequency and type. Identify any oral intake
- Identify assessments of vital sign variables, skin condition, neurological (strength, paresthesia, paralysis, balance, tremors, visual disturbance, syncope, headache pain, tremors, contractures

**Cardiovascular Conditions: CHF, MI, Ischemia, etc.**

- List negative CV symptoms found; be descriptive
- Are symptoms aggravated by physical active, intermittent or constant, reaction to mobility changes and/or increases

**Cardiovascular (Cont’d)**

- Assess stability of respiratory and circulatory systems
  - Vital signs including irregular heartbeats
  - Presence or absence of cyanosis, dyspnea or cough (particularly with activity)
  - Edema in lower extremities (use tape measurements and weights to monitor)
Cardiovascular (Cont’d)

- Assess stability (cont)
  - Complaints of chest, neck, jaw or arm pain
  - Pacemaker, palpitations and syncope
  - Skin color, temperature, any diaphoresis
  - Evidence of peripheral vascular impairment (pedal pulse)

- Document all lab results, physician notification, and changes in care plan
- Assess response to medication regime/changes:
  - Coumadin - evidence of bleeding
  - Diuretics - edema and output
  - Digoxin - daily apical pulse
  - Other - arrhythmia/flutter
- Describe resident’s participation in therapeutic regime

Decubitus Ulcers

- Document location, size (width, depth and length) and condition of stage III or stage IV decubitus including color and odor of the drainage on a weekly basis
  - Use clock hours to document size.
- If unable to measure depth due to necrosis - describe exactly how the decubitus looks

- Include information on resident’s height, weight and body structure
- Document any changes in treatment regimen and resident response.
- Document nutritional status and any changes in intake patterns.

Diabetic Conditions

- Identify mental status such as confusion and memory loss
- Identify physical limitations such as limited range of motion, amputation, or severe arthritis
- Note lab tests; indicate results and physician notification
- List response to Diabetic teaching

- Document:
  - level of conscious, orientation changes, headache, lethargy, weakness, visual disturbances, drowsiness
  - skins conditions, diaphoresis, presence of decubitus, wounds, infections, gangrenous sites with treatment and responses
  - polyuria, hunger and thirst
  - Indicate procedures and interventions needed to control s/s of hyper/hypoglycemia
### Orthopedic Problems
- Include complaints of muscle spasms, weakness, contractures or tremors
- What resident can/cannot do for self
- Define activity tolerance level in time, frequency and response to activity
- Indicate what medication intervention is required and the resident’s response
- Describe location and intensity of pain
- Document any X-ray results and physician notification
- Mental status & willingness to learn

### Urological Problems
- Describe abnormalities of urine - color, consistency, odor, etc.
- List complaints: discomfort or pain with voiding and treatment (burning, frequency, urgency and abdominal distention)
- Indicate what medication treatment intervention is required (irrigation or antibiotics)
- Consider an increase in agitation as a possible indicator of a UTI.

### Urological Problems (Cont’d)
- Document signs of fluid retention (increased weight, rales, edema, etc.)
- If teaching and bladder training is being done, document the results with resident response.
- Assess frequency of lab tests; document results and physician notification
- Indicate reasons for any catheterization (intermittent or indwelling), frequency, and results.

### Next Webinar
- Monday April 20, 2015
- 5 STAR How are they determined.