CBC Survey "Tips" series

Understanding Changes of Condition

Learning Objectives

At the conclusion of this presentation you will be able to:

- Understand the intent of OAR 411-054-0040 CHANGES OF CONDITION AND MONITORING.
- Understand how to implement systems (policies and procedures) for responding to resident changes of condition.

When we review the statistics related to surveys, the most frequently-cited citation continues to be:

C270 – Changes of Condition and Monitoring.

Why is C270 So Important?

Because when something out of the ordinary happens with a resident, C270 always applies.

Why is C270 So Important?

Because “care” always involves C270.

C270 describes how you should document how you responded to and cared for the resident when something out of the ordinary happened.

C270 ensures the resident's new care needs were identified, the service plan was updated and staff were informed of and trained on the resident's new care needs.

This doesn’t have to be complicated

Let me show you…

An Example:

- Suppose one of your children fell off his or her bike and came running into the house crying.

- What would you do?

Decide What Needs to Be Done.

- Of course you always want to make sure the resident is OK. But then what?
- In your facility, who decides what needs to be done if a resident falls, or gets injured, or starts an antibiotic?
  - The Med Aide?
  - The RN?

Write Down What Needs to Be Done.

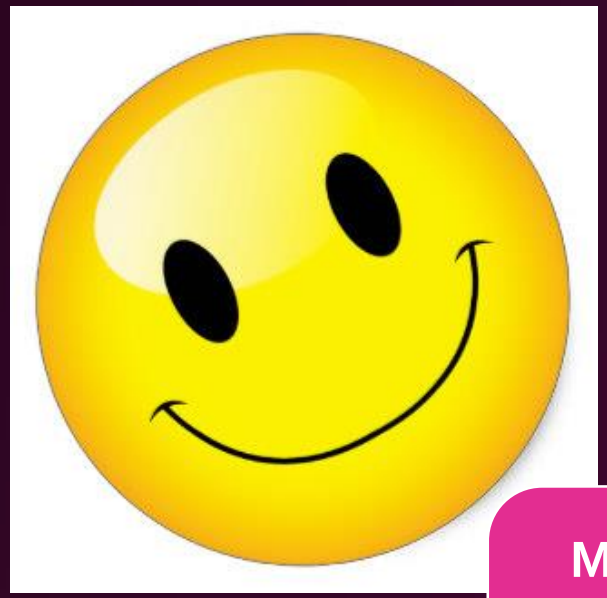
- All your staff need to know what needs to be done and what responsibilities they have.
- In your facility, how do you document this and communicate it to staff?
  - Update the service plan itself?
  - Interim Service Plan (ISP)?
  - Shift Report?
  - Alert Charting Log?

Do It and Document It.

- You told everyone what needs to be done. How do you ensure they are doing it?
- In your facility, how do you document that staff have been doing the action that was decided upon?
  - MAR/TAR?
  - Progress Note?
  - Alert Charting note?

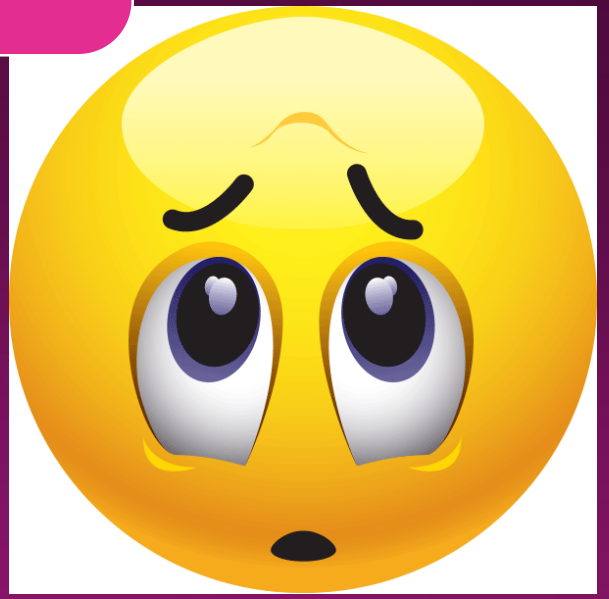
And Make Sure the Care Helps.

- **This is called monitoring.**
- Is the wound healing? Is the rash improving? Has the resident stopped falling?
- In your facility, who documents on the progress of the condition and how do they document?
  - Caregivers? Med Aides? RN?
  - In progress notes? On the MAR?



Healthy and happy resident

Change of Condition



Determine & document needed action

Ensure staff implement the action

Monitor and document progress weekly until resolved

AKA "The Cycle of Care"

- Hopefully, you can see that this is a very logical process.
- In the health care field this process is often called the "Cycle of Care," and generally includes 4 components:
  - Evaluation/Assessment
  - Care Planning
  - Implementation of Care Services
  - Check of Care Services

(*Sounds a lot like C270…*)

What Survey Sees

- Common deficiencies include:
  - Something out of the ordinary happened and the facility did not respond;
  - The needed action(s) weren't written down for staff to review;
  - Staff didn't do what they were directed to do (wound care, documenting);
  - No one "closed the circle" by indicating the condition was resolved.

Documenting the Plan of Care

- "Temporary Service Plans" (TSPs) or "Interim Service Plans" (ISPs) can be great tools if they contain enough information for staff.
- They have to tell staff what needs to be done for the resident.
  - So writing, "Resident had a fall today" does not meet the rule – it does not tell staff what to do.
  - Writing "Resident had a fall today. Resident placed on Alert Charting" is only a little better…
  - Writing "Resident had a fall today. Monitor for bruising or pain around her left knee" is better…

Documenting the Plan of Care

- Writing "Resident had a fall today. Monitor for bruising or pain around her left knee and document each shift" is pretty good…
- Writing "Resident had a fall today. Monitor for bruising or pain around her left knee and document each shift for the next 3 days" is good…
- Writing "Resident had a fall today. Monitor for bruising or pain around her left knee and document each shift for the next 3 days. Notify RN of swelling or pain not relieved by Tylenol" is awesome!

Thoughts about "Alert Charting"

- Alert Charting, done well, can meet the requirements for this rule.
- Unfortunately, survey often sees Alert Charting lacking in a number of areas:
  - Often the AC "Log" lacks an adequate description of what needs to be monitored;
  - Often, though the facility system is to chart on every shift, staff do not chart on every shift;
  - Often, staff don't chart on the condition. For example, a resident fell and had some knee pain, but staff chart "Resident in good mood, ate 100% of his lunch.";

Thoughts about "Alert Charting"

- Often, no one documents the condition was resolved and discontinues the Alert Charting;
- Or, every resident, regardless of the condition, is placed on some kind of standard "72 hour Alert." While it might be reasonable to monitor a resident for the next 72 hours for some changes of condition such as a new medication or for pain following a fall, other conditions such as a skin tear or a more severe wound likely require extended monitoring. Remember the rule requires "weekly progress noted [i.e. "documented"] until the condition resolves."

- *If you write a good ISP, you may not need an Alert Charting log…*

Thoughts about "Shift Reports"

- Survey often sees a facility using the "Shift Report" to document on the progress of a resident's change of condition.
- If this is the only system the facility uses to document on the resident, you may have a problem:
  - Generally, the Shift Report includes information about more than one resident, making confidentiality an issue.
  - You aren't able to make the Shift Report part of the resident's record, which is required in the rule.
  - Many facilities don't even keep Shift Reports more than a month old.
- Survey will cite the facility for failing to ensure that "Staff instructions or interventions…were made part of the resident record…"

The Rest of the Rule

- There are two more requirements in the rule (Change of Condition and Monitoring) that you need to be aware of:
  - What to do if a change of condition is a significant change for the resident.
  - The expectations regarding the monitoring of residents with chronic or recurring conditions.

1) A Significant Change

- If the facility determines the resident has had a significant change in his or her condition, it must evaluate the resident, refer the issue to the facility RN, document the change and update the service plan as needed.

A Significant Change

- The two key requirements that survey looks for are documentation and referral to the RN.
- In your facility, who is responsible to determine if a change is significant?
  - Med Aides? Administrator? RCC? Nurse?
  - Does that person clearly understand what would constitute a significant change for a given resident?
  - Who documents that the change was identified and referred to the facility RN?
  - How do you ensure that the RN received the referral?

2) Monitoring per Condition

- Some residents have chronic or recurring conditions. We expect them to always be present or to occur at some regular frequency.
- These conditions might be noted in the resident's medical history, or may have been identified during the move-in evaluation or subsequent evaluations as you have gotten to know the resident.
- The rule asks us to monitor these conditions.

Monitoring per Condition

- Examples where survey might expect to see some type of monitoring:
  - History of chronic pain, frequent UTIs, constipation;
  - High fall risk with multiple falls;
  - Diabetes with varying blood sugars;
  - History of poor appetite or poor food or fluid intake (hx. of dehydration);

Monitoring per Condition

- Examples where survey might expect to see some type of monitoring:
  - Edema with a history of skin breakdown;
  - Behavioral issues such as hoarding, aggressive/assaultive behavior, exit-seeking, or BiPolar disorder or schizophrenia that results in erratic mood swings, refusal of meds or care, or potential harm to others.

Monitoring per Condition

- When the facility knows the resident has some history of a chronic or recurring condition, there should be a plan for how the facility will monitor that condition.
- The plan should be communicated to staff, and staff should know the system for reporting and documenting.
- Often, facilities will describe a condition of concern in the service plan and provide instructions for what to watch for.

What Survey Sees

- Common deficiencies include:
  - No documentation/information as to what condition to monitor or how to monitor the condition.
  - Changes not communicated to others for follow up.
  - Interventions are not monitored to determine if they were being implemented, were effective or if additional interventions need to be developed. This is very common in the case of a resident who has repeated falls.

Monitoring per Condition

- In your facility:
  - Who identifies these chronic conditions?
  - Who determines what will be monitored and how it will be monitored?
  - How is this information documented and provided to staff?

Monitoring per Condition

- In your facility (continued):
  - If the identified condition changes or a target behavior occurs, is it documented and communicated to others?
  - Who follows up on the change of condition?
  - Who reviews the interventions to ensure they are being implemented and are effective?

Final Thoughts…

- As you review your systems, policies and procedures for effectiveness (i.e. implement a Quality Improvement program), ask yourself the following questions:
  - Do direct care staff understand how to identify, document and report on resident changes of condition?
  - Do all staff know who is responsible for determining and documenting the needed action/intervention for a resident?
  - Is your documenting system/form clear and easy to use? (*Remember: keep it simple*).

Final Thoughts…

- Do staff know what is expected regarding documentation?
- Who reviews your system to ensure actions/interventions are documented, staff are implementing them, staff are documenting properly and the interventions are effective?
- Who decides and documents when a condition is resolved?

Hopefully, answering these questions for your facility will help you meet the rule requirements for responding to changes of condition. Good luck!

Thanks for your attention and participation!

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