DRAFT Oregon Assisted Living & Residential Care Resident Change of Condition Monitoring Guide

Produced by

Oregon Health Care Association in conjunction with Oregon DHS OLRO

DISCLAIMER

The information, policies, procedures and forms in this guide are to serve as examples. Some of the documents can be used as published and others are intended and should be modified to reflect an individual assisted living or residential care community specific practice or policy. These documents serve as suggested resources and are not mandated by the Department of Human Services Office of Licensing and Regulatory Oversight. This handbook has been reviewed by the Oregon Department of Human Service, Office of Licensing and Regulatory Oversight.

HOW TO USE THIS GUIDE

- ✓ Read the Introduction and background
- ✓ This handbook is meant to guide and assist licensed assisted living & residential care communities to:
  - Understand common age related, high risk conditions and diagnosis
  - Understand the importance of effective evaluation, assessment, service planning and monitoring of resident change of condition.
  - Create systems to efficiently track and monitor all residents and high risk residents.
  - Provide examples of policies, procedures, systems and forms for use in revising or developing community specific practices.
  - Incorporate the NCAL Tier II Clinical Quality Measures into Change of Condition Systems

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THE FRAMEWORK FOR COMPLIANCE – START WITH THE OARs AND BUILD

To print a copy of the Oregon Administrative Rules (OARs) go to the Oregon Department of Human Services Division, Community Based Care Provider Tools web page found at: https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SPPD/APDRules/411-054.pdf or Google: "Community Based Care Provider Tools."

HELPFUL HINT: Make a copy of the OARs for yourself and leadership staff. Also place a copy in the employee break room and/or charting stations, Keep a hard copy handy and/or bookmark or place a shortcut to the assisted living and residential care rules on your computer desktop.

Understanding the regulatory standards for change of condition is critical to achieve compliance and set a solid foundation for quality resident care

We start with the **Compliance and Beyond Framework.** All of the elements of the framework are necessary and must be considered when addressing any aspect of assisted living or residential care operations.

It starts first with:

- **Leadership.** Mission, vision, direction, and execution of goals

Followed by adhering to:

- **Person Centered Care Principles.** Incorporate the key principles of PCC: respect, dignity, independence, choice, and autonomy into all aspect s of community services and operations.

We then rely on a cornerstone of quality improvement, the Team:

- **Interdisciplinary Team.** Identify all key internal and external team members and define roles, responsibilities and accountability.

Meeting regulatory compliance standards is a given:

- **Regulatory Compliance.** Read and understand the OARs governing assisted living and residential care and other applicable regulatory standards.

A consistent and concise resident record is integral to a quality team:

- **Documentation.** Review rule(s) to determine explicit documentation requirements and assure those are addressed. Create documentation quality standards beyond minimal standards.

Well defined systems and process will aid in achieving required and desired outcomes:

- **Policies and Procedures (P&P).** Create and evaluate policies and procedures routinely against the administrative rules. Address documentation in P&P.

Going above and beyond will position a community for quality and sustainability in changing markets:

- **Standards of Practice and Best Practice.** Incorporate evidence based practice standards when creating/revising P&Ps.

Success of an organization is dependent upon its commitment to educating its staff, families and community:

- **Education and Training.** Keep yourself and staff educated on regulatory and professional standards of practice.

There can never be enough:

- **Communication.** Develop consistent and understood processes/tools for communicating information internally and externally.

Hold yourself and your team acco8untable to reaching set goals:

- **Accountability.** Develop or revise quality improvement evaluation tools and systems to reflect standards and to assure sustained compliance and customer satisfaction.

THE IMPORTANCE OF DOCUMENTATION

The saying goes…, "If it was not documented, it didn't happen." Documentation is a critical component of quality care and vital aspect of risk management. Documentation that is clear, consistent, and concise certainly makes a difference if the community is ever faced with a regulatory citation, a complaint investigation or legal action. But more importantly, documentation is simply part of quality standards of care. It is the historical record of the resident's health and well-being during the course of their residency at the community. It is important that assisted living and residential care leadership ensure appropriate documentation is taking place at all levels in the organization e.g. Caregivers, professional staff, outside providers and other care and service partners. It is a good idea to review the OAR's and the simple tips below with your staff on a regular basis. Each community should have quality improvement/assurance reviews of all key documentation systems.

Regulatory Standards and Tips on Change of Condition Documentation:

Providers should keep this statement in mind when evaluating your systems:

Does your documentation tell the full story of a resident's stay in your community? It should illustrate the resident's overall quality of life, health and medical condition (emphasis on changes), professional assessments and evaluations. It should also capture monitoring and reporting of these conditions and the care and services delivered.

Regulatory Standards for Documentation:

The licensing rules for assisted living and residential care (OAR 411-054-0000) in Oregon have no less than two dozen explicit requirements for documentation. Many OAR's do not expressly state "thou shalt document" however, lack of documentation or gaps in a resident record can call into question continuity of care, actual care delivery, identification of resident changes of condition or resolution of issues.

The following OAR's address general documentation guidelines or intent of documentation. This is not a complete list but does highlight the basics related to quality care and documentation as set forth in the regulations. It is important to read each section of the regulation to understand what explicit documentation if required.

411-054-0025 Facility Administration

(1)(a) The licensee is responsible for the operation of the facility and the quality of services rendered in the facility.

(7) POLICIES AND PROCEDURES. The facility must develop and implement written policies and procedures that promote high quality services, health and safety for residents, and incorporate the community-based are principles of individuality, independence, dignity, privacy, choice, and a homelike environment.

(8) RECORDS. The facility must ensure the preparation, completeness, accuracy, and preservation of resident records.

> (a) The facility must develop and implement a written policy that prohibits the falsification of records.
>
> (b) Resident records must be kept for a minimum of three years after the resident is no longer in the facility.
>
> (c) Upon closure of a facility, the licensee must provide the Department with written notification of the location of all records.

(9) QUALITY IMPROVEMENT PROGRAM. The facility must develop and conduct an ongoing quality improvement program that evaluates services, resident outcomes and resident satisfaction.

The basics come down to one primary review standard of compliance which is: **Was something avoidable?**

Avoidable is assessed using the following questions:

1. Did the community have systems in place help recognize and communicate risk factors and/or changes in the resident's condition?
2. Did the community take reasonable measures to problem solve and assist the resident in care planning and/or obtaining needed services?
3. Does the evidence in the record support these activities? Again, is the "story" documented and corroborated with staff, resident, family and/or care partner interview?

If documentation is not present a situation can be perceived as neglect which can potentially meet the definition of abuse which neglect is included and is defined in OAR 411-020-0000 Adult Protective Services.

Abuse means the following including: NEGLECT: (A) Active or passive failure to provide the care, supervision, or services necessary to maintain the physical health and emotional well-being of an adult that creates a risk of serious harm or results in physical harm, significant emotional harm or unreasonable discomfort, or serious loss of personal dignity. The expectation for care, supervision, or services may exist as a result of an assumed responsibility or a legal or contractual agreement, including but not limited to where an individual has a fiduciary responsibility to assure the continuation of necessary care. (B) Failure of an individual who is responsible to provide care or services to make a reasonable effort to protect an adult from abuse.

General Practice Tips on Documentation:

- Remember documentation is reporting facts and not assumptions. It is critical that documentation be objective and avoid statements of opinion.
- Staff should document as soon as possible after an event or shift. Studies have shown that in as little as 15 minutes after an incident occurs, a person's memory begins to dwindle or change. In order for records to be considered credible and reliable, stress the importance of prompt documentation.
- Do not forget the obvious. Documentation should include dates of incidents and the full names and titles of those involved in addition to reporting the incident itself. Document as if you would not be there to explain what occurred in person – be specific and detailed, and objective.
- Be specific. Rather than stating, "Joe doesn't seem to be himself today," record "Joe has been making statements about his brother coming to visit. Joe has previously acknowledged and grieved his brother's death which occurred two years ago. He generally reminisces about good times shared." Spoke with Mary Jones, community RN and she will assess further.
- Remember your documentation may eventually be in court one day. Avoid speculation or writing personal notes on any documents.
- Document informal discussions regarding policies and procedures along the way. Jotting down a quick note at the time of a discussion with a family will help if the community finds it necessary to move forward with any future actions.
- Assure staff regularly and consistently document changes of condition, incidents and accidents.
- Assure your staff feel comfortable with documentation and understand regulatory standards, community policies and best practices for completing it properly. Provide regular trainings and make yourself available to answer questions or concerns that might come up.

CREATING A SYSTEM – POLICIES, PROCEDURES AND FORMS

The first step in developing policies and procedures is to define issues relevant to resident change of condition including but not limited to: resident evaluation and assessment, monitoring processes, service planning processes, communication systems and guidelines, components of direct care provision, care processes, roles and responsibilities of staff, staff education and training, and organizational standards and guidelines and

Policies and procedures direct the activities of the community and the forms provide or supplement documentation.

To develop procedures, evaluate the functions and tasks needed to make the processes effective and determine appropriate roles of staff members. A procedure assigns, prioritizes, and orders responsibilities. "For example, who does what part of the evaluation and assessment, where is it recorded, what should be done with the information collected, or who is authorized to decide what to do next?" How is the information communicated with staff?

Hint: Policy = the "what" (service plan, administrator's responsibilities, caregiver orientation, caregiver training, initial screening, initial evaluation) **Procedure = the "how"** (the specific processes/actions used to carry out the policy) **Form = documenting the "how"** (used to document activities and to help implement a procedure).

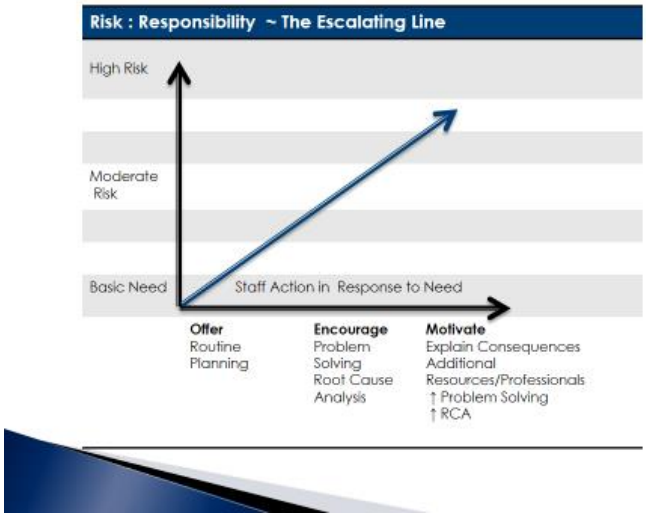
Policies, procedures and forms are needed:

- To comply with the requirements of the ALF/RCF Rules.
- To comply with other state and federal laws pertaining to operating an agency and hiring employees (BOLI, Workers' Comp, OSHA, et al).
- For human resource management: to assure competent staff to meet the needs of the residents.
- To guide and control the financial operations.
- For quality improvement and risk management: to evaluate and monitor the performance, to control disease and risk of injury of both residents and employees, and to set performance standards.
- To guide the marketing and disclosure of the organization.
- To meet the training and educational requirements and needs of employees.
- To record and monitor a resident's individualized care. The record begins when ALF/RCF services are sought and continues until the resident moves out. The forms are used to establish, monitor, record and modify the resident's care as needed, throughout the time the resident receives care or services from the ALF/RCF.

CHANGE OF CONDITION RESOURCES

The following resources are set up as a sample monitoring system for resident change of condition. An organization may likely have similar forms or policies in place. Again, the intent of this guide is to offer resources that can complement or enhance existing community systems. Providers are free to incorporate portions of a document into current system or adopt the system as is. It is important to adopt the forms to an individual community. Full size forms are included the Appendix of this guide.

1. **Risk to Responsibility Escalating line**
   The risk to responsibility model provides a visual graphic to assist community staff in considering the risk involved with a particular resident or set of issues/needs associated with the resident and what is the appropriate or "reasonable" amount of effort the community must put into problem solving and addressing the situation. The higher the risk the more effort and timely response necessary.



2. **Change of Condition Matrix**
   This matrix provides a quick at a glance review of the two change of condition definitions, examples of short term and significant change of condition and the required actions for each change required to be carried out by the community

Change of Condition	Short Term	Significant
Definition OAR 411-054-0005	Change in the resident's health or functioning that is expected to resolve or reverse with, minimal intervention or is an established. predictable, cyclical pattern associated with a previously-diagnosed condition.	Major deviation from the most current evaluation that may affect multiple areas of functioning or health, that is not expected to be short term and imposes significant risk to the resident.
Examples OAR 411-054-0005	• Cold • UTI • Rash • Skin tear	• Broken bones • Stroke or heart attack • Unmanaged high blood sugars • Uncontrolled pain • Fast decline in AOLs • Unplanned weight loss • Pressure ulcers (stage 2+) • Level of consciousness
Response OAR 411-054-0040	• Determine action / intervention • Communicate information to staff • Document instructions • Weekly progress note until resolved	• Evaluate the resident • Seek medical attention • Refer to RN for assessment • Update resident evaluation and service plan w/ monitoring component • Communicate with staff and family

3. **Resident Acuity Roster**

This tool provides a full view of the entire resident population in the community including what types of diagnosis, conditions and risk factors each has. It serves as a common platform that every staff member can reference to better understand not only individual residents but the entire community of residents

SAMPLE RESIDENT ACUITY ROSTER

Complete the Acuity Roster by filling in each resident's name and then checking off each need, condition or diagnosis relevant to each individual. This form is used in conjunction with the Daily ReACCT form and individual resident tracking tools.

Resident Risk & Acuity Roster Conditions and Risk Factors	Resident Name	Resident Name	Resident Name	Resident Name	Resident Name	Resident Name	Resident Name	Resident Name
ADL Decline								
Alzheimer's/ Dementia								
Anticoagulant Therapy								
Antidepressant								
Antipsychotics								
Anxiety								
Behavior								
-Physical								
-Sexual								
-Verbal								
Bowel Issues								
Bladder Issues								
COPD								
Change of Condition Short Term								
Change of Condition Significant								
Depression								
Div. 47 Delegated Task. List task								
Elopement								
EMS Calls								

4. **Resident Acuity and Change of Condition Tracking Tool (Re-ACCTT)**

This is an example of a daily communication tool for staff and other related providers. The intent is to identify residents with changing conditions, high risk issues, care coordination and monitoring needs. This document is intended to be used in conjunction with the Resident Acuity Roster and Individual Resident Logs.

Resident Acuity & Change of Condition Tracking Tool (Re-ACCTT) Date: Staff Present: Staff Absent:			
	Reason/Condition	Start Date/ End Date	Actions follow up (considerations
72 Monitoring			
Short Term Change of Condition			
Significant Change of Condition			
Risk Monitoring	Reason ie, Behavior, Falls, Verbal, Other	Notes	
Pain Management	Type Pain	Notes	

Hospice Services	Company	Contact	Notes	Follow Up
Home Health	Company	Contact	Notes	Follow Up
Labs/Coumadin	Company	Contact	Notes	Follow Up
Out Patient Rehab	Company	Contact	Notes	Follow Up
Oxygen	Company	Contact	Notes	Follow Up

5. **Individual Resident Tracking Logs – Samples provided in Appendix**
   This tool provides a systematic way to organize all incidents for individual residents. Logging all incidents on one form provides makes it easier to spot repeat issues, help identify if interventions work, if follow up occurs and can help target more in depth quality improvement reviews.

SAMPLE: GENERIC INDIVIDUAL RESIDENT INCIDENT LOG 11/13/2013

Directions: Use this form to track and trend each individual resident incident or accident. Use this form in conjunction with the Resident Acuity Roster and the ReACCTT Daily Report.

Incident Tracking		Name of Resident				Move in Date		
Date/ Time	Incident	Location	Type Injury	Medical Attention Provided	Assessment Service Plan Review Interventions Assessed	Med Review	Communication Documentation Follow up Family, Physician, Internal	APS Reportable Y/N Date Reported

6. **Community Wide Incident Tracking Logs**
   This tool will aid the team in identifying community wide trends. It breaks down types of incidents and shifts that they occur on. This can help pinpoint training, staffing or other needs and help focus problem solving.

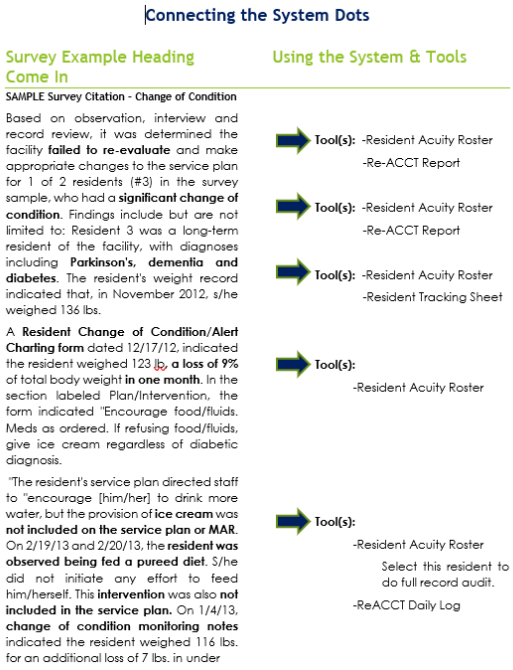
SAMPLE MONTHLY INCIDENT TREND LOG 11/01/2013

Directions: Record the total number of incidents by type and the shift they occurred on. Tally the total for each incident type and for the month.

Incidents/ Shift		January	February	March	April	May	June	TOTALS
Falls Injury	D							
	E							
	N							
Total								
Falls No Injury	D							
	E							
	N							
Total								
Bruises Known	D							
	E							
	N							
Total								

7. **Connecting the Dots**

Illustrates using a case study survey citation how each element of the system works together.



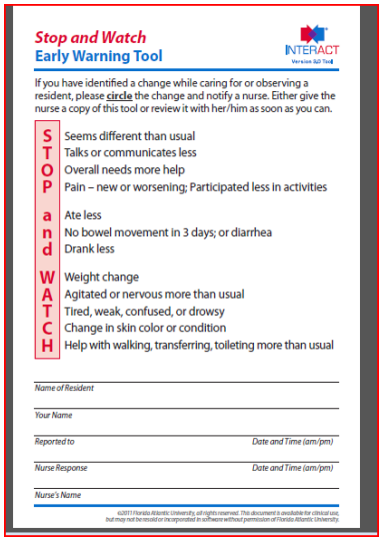
Connecting the System Dots

Survey Example Heading Come In	Using the System & Tools
SAMPLE Survey Citation - Change of Condition Based on observation, interview and record review, it was determined the facility **failed to re-evaluate** and make appropriate changes to the service plan for 1 of 2 residents (#3) in the survey sample, who had a **significant change of condition**. Findings include but are not limited to: Resident 3 was a long-term resident of the facility, with diagnoses including **Parkinson's, dementia and diabetes**. The resident's weight record indicated that, in November 2012, s/he weighed 136 lbs.	**Tool(s):** -Resident Acuity Roster -Re-ACCT Report
A **Resident Change of Condition/Alert Charting form** dated 12/17/12, indicated the resident weighed 123 lb, **a loss of 9%** of total body weight **in one month**. In the section labeled Plan/Intervention, the form indicated "Encourage food/fluids. Meds as ordered. If refusing food/fluids, give ice cream regardless of diabetic diagnosis.	**Tool(s):** -Resident Acuity Roster -Resident Tracking Sheet
"The resident's service plan directed staff to "encourage [him/her] to drink more water, but the provision of **ice cream** was **not included on the service plan or MAR**. On 2/19/13 and 2/20/13, the **resident was observed being fed a pureed diet**. S/he did not initiate any effort to feed him/herself. This **intervention** was also **not included in the service plan.** On 1/4/13, **change of condition monitoring notes** indicated the resident weighed 116 lbs. for an additional loss of 7 lbs. in under	**Tool(s):** -Resident Acuity Roster **Tool(s):** -Resident Acuity Roster Select this resident to do full record audit. -ReACCT Daily Log

8. **INTERACT Tools**

The INTERACT quality improvement program can be found at www.interact2.org. **INTERACT** (**Inter**ventions to **R**educe **A**cute **C**are **T**ransfers) is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in everyday practice in long-term care facilities. The interventions make up a quality improvement program designed to improve the identification, evaluation, and communication about changes in resident status. The website has a full description and implementation outline of the program as well copies of the tools listed below. For the ALF/RCF specific versions of the tools please go to www.ncal.org.

a. **STOP and WATCH Change of Condition Communication Tool**



Stop and Watch
Early Warning Tool

INTERACT

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S T O P
- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities

a n d
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less

W A T C H
- 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

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

b. SBAR for ALF/RCF Caregivers

SBAR for Assisted Living Caregivers

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II

Suggested process as permitted by state regulations, professional licensure laws, and community policy

Before Calling Nurse/Supervisor:
- ☐ **Evaluate the resident** and complete the SBAR for AL caregivers form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR/POLST and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

This started_____
This has gotten (circle one) 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 _____

B BACKGROUND

Primary reason resident is in assisted living _____
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) _____
Vital signs BP_____/_____HR_____ RR_____ Temp_____
Change in function or mobility _____
Medication changes or new orders in the last two weeks if known _____
Mental status changes (e.g. confusion/agitation/lethargy/combative) _____
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/constipation/decreased urinary output/other)
Pain level/location_____
Change in appetite or taking in fluids_____
Change in skin or wound status _____
Advance directives (circle) Full code, DNR, POLST, DNI, DNH, other, not documented.
Allergies _____ Any other data _____

A APPEARANCE

The resident appears (e.g. SOB, in pain, more confused) _____

R Ready to Call

Staff name _____**RN/LPN**
Reported to: Name _____**(MD/NP/PA/Nurse/Supervisor)**
Date_____/_____/_____**Time**_____**a.m./p.m.**
Communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax
☐ **Family or health care proxy notified**
Name_____**Date**_/_____/_____/ **Time** __/_____**AM/PM**
Resident name _____
Return call/new orders from MD/NP/PA/Nurse/Supervisor see attached or chart

*2010 PAU Updated July 2012

c. SBAR for AL/RCG Nurses

SBAR for Assisted Living Nurses

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II

Suggested process as permitted by state regulations, professional licensure laws, and community policy

Before Calling MD/NP/PA:
- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, and/or finger stick glucose if indicated
- ☐ **Review chart if available:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card if in use in your community***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR, POLST, and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

This started_____
This has gotten (circle one) 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 _____

B BACKGROUND

Primary diagnosis and/or reason resident is in assisted living _____
Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) _____
Vital signs BP_____/_____HR_____ RR_____ Temp_____
Pulse Oximetry _____% On RA_____on O2 at _____L/min via_____(NC, mask)
Change in function or mobility _____
Medication changes or new orders in the last two weeks _____
Mental status changes (e.g. confusion/agitation/lethargy) _____
GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)
Pain level/location_____
Change in intake/hydration_____
Change in skin or wound status _____
Labs _____
Advance directives (circle) Full code, DNR, DNI, DNH, POLST, other, not documented
Allergies _____ Any other data _____

A ASSESSMENT (RN) OR APPEARANCE (LPN/LVN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ *-OR*
I am not sure of what the problem is, but there had been an acute change in condition.
(For LPNs/LVNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:
- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ New orders (see attached)_____
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ Transfer to the hospital

Staff name _____**RN/LPN**
Reported to: Name _____**(MD/NP/PA) Date**____/____/____**Time**_____**a.m./p.m.**
If to MD/NP/PA, communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax
Resident name _____
(Complete a progress note on the back of this form)

ALF/RCF Resident Change of Condition Guide Resource Appendix

STEP 1

Resident Acuity Roster

- ☐ Does your community use some type of resident acuity roster?
  - ☐ Yes ☐ No
- ☐ If you do use a roster, are there any high risk issues not listed on it?
  - ☐ Yes ☐ No
- ☐ Do you think this would be a helpful tool for keeping track of resident conditions?
  - ☐ Yes ☐ No

If yes, what are the advantages?

If no, what are the barriers?

SAMPLE RESIDENT ACUITY ROSTER

Complete the Acuity Roster by filling in each resident's name and then checking off each need, condition or diagnosis relevant to each individual. This form is used in conjunction with the Daily ReACCTT form and individual resident tracking tools.

Resident Risk & Acuity Roster **Conditions and Risk Factors**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**
ADL Decline								
Alzheimer's/Dementia								
Anticoagulant Therapy								
Antidepressant								
Antipsychotics								
Anxiety								
Behavior								
-Physical								
-Sexual								
-Verbal								
Bowel Issues								
Bladder Issues								
COPD								
Change of Condition Short Term								
Change of Condition Significant								
Depression								
Div. 47 Delegated Task. List task								
Elopement								
EMS Calls								
End of Life								
ER Visits								
Fall Risk or Hx								
Falls Repeat								
Home Health								

Resident Risk & Acuity Roster **Conditions and Risk Factors**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**	**Resident Name**
Hospice								
Hospitalizations								
Medication								
-More than 6 meds								
-PRN's								
-Refusals								
Mental Illness								
Mobility Device								
New Treatment or Med Order last 30 d								
Nutritional Risk: i.e., Assist, Dysphagia, Modified Texture, Supplements								
-Eating Assistance								
-Modified textures								
-Supplements								
-Dysphagia								
Pain								
Pressure Ulcer Stage 2 +								
Restraint or Supportive Device								
-Side or bedrail								
-Positioning device i.e., lap buddy								
-Tab or bed alarm								
-Seatbelt								
Skin at risk								
UTI Risk or Hx								
Weight +/-								
Weekly Weight								
Meal Monitoring								

STEP 2

Daily ReACCT Report

- ☐ Does your community use some type of a daily resident report (i.e. 24-hour report)?
  ☐ Yes ☐ No

- ☐ If you do use a report, are there any checklists or reminders on it?
  ☐ Yes ☐ No

- ☐ Do you think this would be a helpful tool for keeping on top of resident monitoring and follow up?
  ☐ Yes ☐ No

If yes, what are the advantages?

If no, what are the barriers?

COMPLETED SAMPLE DAILY Re-ACCTT Form

Directions: This is an example of a daily communication tool for staff and other related providers. The intent is to identify residents with changing conditions, high risk issues, care coordination and monitoring needs. This form is used in conjunction with the Resident Acuity Roster and Individual Resident Logs.

Resident Acuity & Change of Condition Tracking Tool (Re-ACCTT) **Date:** **Staff Present:** **Staff Absent:**			
	Reason/Condition	**Start Date/ End Date**	**Actions follow up (considerations**
72 Monitoring			
J Depp	Post Cataract Surgery	9/13 9/16	Monitor per instructions from physician. Check off on MAR
Short Term Change of Condition			
Significant Change of Condition			
S Survey	Weight loss due to late stage dementia	12/17	Significant Wt. Loss (9% in 1 month) Weekly Weights Nutritional Supplements
Risk Monitoring	**Reason ie. Behavior, Falls, Verbal, Other**	**Notes**	
T Rowe	Falls	Bring out to sitting area at 3 pm to listen to music. Refer to Service plan.	
Pain Management	**Type Pain**	**Notes**	
B Goode	Chronic Back	See MAR & Service Plan for Interventions	

Hospice Services	**Company**	**Contact**	**Notes**	**Follow Up**
Home Health	**Company**	**Contact**	**Notes**	**Follow Up**
B James	Acme HH	Jane Jones PT	Continue with mobility exercises	Progress note left in chart
Labs/Coumadin	**Company**	**Contact**	**Notes**	**Follow Up**

Out Patient Rehab	Company	Contact	Notes	Follow Up
Oxygen	**Company**	**Contact**	**Notes**	**Follow Up**
C Wright	Airgas	Pete	Refills Q week	See Service Plan
Dialysis	**Company**	**Contact**	**Notes**	**Follow Up**
Nutrition/ Supplements	**What**	**When**	**Who**	**Notes**
S Survey	High Calorie Foods & Shake	All meals	Food Service, DC Staff,	Check MAR
Weights	**Frequency**	**Notes**		
S Survey	Weekly			
Side Rails/Supportive Devices	**Type of Device**		**Instructions/Other**	
Private Duty Caregiver	**Caregiver**	**Contact Info**	**Scope of Duties**	
Smoking				
Drinking				
EMS	Reason for Call			
Hospitalization	Reason for Transfer			

Staff Signatures/Date:

_____ _____

SAMPLE DAILY Re-ACCTT Form – OPTION 1

Directions: This is an example of a daily communication tool for staff and other related providers. The intent is to identify residents with changing conditions, high risk issues, care coordination and monitoring needs. This form is used in conjunction with the Resident Acuity Roster and Individual Resident Logs.

Resident Acuity & Change of Condition Tracking Tool (Re-ACCTT) **Date:** **Staff Present:** **Staff Absent:**			
	Reason/Condition	**Start Date/ End Date**	**Actions follow up (considerations**
72 Monitoring			
Short Term Change of Condition			
Significant Change of Condition			
Risk Monitoring	**Reason ie. Behavior, Falls, Verbal, Other**	**Notes**	
Pain Management	**Type Pain**	**Notes**	

Hospice Services	**Company**	**Contact**	**Notes**	**Follow Up**
Home Health	**Company**	**Contact**	**Notes**	**Follow Up**
Labs/Coumadin	**Company**	**Contact**	**Notes**	**Follow Up**
Out Patient Rehab	**Company**	**Contact**	**Notes**	**Follow Up**
Oxygen	**Company**	**Contact**	**Notes**	**Follow Up**

Dialysis	**Company**	**Contact**	**Notes**	**Follow Up**
Nutrition/ Supplements	**What**	**When**	**Who**	**Notes**
Weights	**Frequency**	**Notes**		
Side Rails/Supportive Devices	**Type of Device**		**Instructions/Other**	
Private Duty Caregiver	**Caregiver**	**Contact Info**	**Scope of Duties**	
Smoking				
Drinking				
EMS				
Hospitalization				

Staff Signatures/Date:

_____ _____

SAMPLE DAILY Re-ACCTT Form – OPTION 2

Date of Report:

	Reason for Monitoring or Service	Start Date	End Date	Communication with all that apply □ Physician/RN □ Caregivers □ HH/Hospice □ Spouse/Family □ Case Manager/Other	Documentation check. Review all that apply. □ RN Assessment or Evaluation (if applicable) □ Service Plan □ Progress Notes □ Incident & Tracking Logs
72 Hour Monitoring					
Short Term Change of Condition Monitoring					
Significant Change of Condition					
Risk Monitoring					

	Company/ Contact	Start Date	End Date	Direction from Outside Provider	Community Follow Up □ Communicate with staff □ Service Plan Update □ Community RN Follow Up
Home Health					
Hospice					
Therapy (PT,OT,ST)					

	Health Organization i.e. Hospital, Clinic, Physician	Date Went	Paperwork sent	Reason	Directions from Outside Provider
Health Appointment					
Hospital					
EMS					

Staff Signatures/Date:

_____ _____

STEP 3

Individual Resident Logs

- ☐ Does your community use a resident incident log or trending report?
  ☐ Yes ☐ No

- ☐ If you do use a log, how is it used with your other systems?

- ☐ Do you think this would be a helpful tool to see trends more easily and then analyze resident incidents and effectiveness of interventions?
  ☐ Yes ☐ No

If yes, what are the advantages?

If no, what are the barriers?

There is a generic version of an incident tracking log plus several other examples of resident tracking tools for review.

SAMPLE GENERIC INDIVIDUL RESIDENT INCIDENT LOG

Directions: Use this form to track and trend each individual resident incident or accident. Use this form in conjunction with the Resident acuity Roster and the ReCCTT Daily Report.

Incident Tracking		**Name of Resident**				**Move in Date**		
Date/ Time	**Incident**	**Location**	**Injury Type**	**Medical Attention Provided**	**Assessment Service Plan Review Interventions Assessed**	**Med Review**	**Communication Documentation Follow up Family, Physician, Internal (all shifts)**	**APS Reportable Y/N Date Reported to APS ___/___/20__**

SAMPLE MONTHLY INCIDENT TREND LOG

Directions: Record the total number of incidents by type and the shift they occurred on. Tally the total for each incident type and for the month.

Incidents/ Shift		January	February	March	April	May	June	TOTALS
Falls Injury	D							
	E							
	N							
Total								
Falls No Injury	D							
	E							
	N							
Total								
Bruises Known	D							
	E							
	N							
Total								
Bruises Unknown	D							
	E							
	N							
Total								

Incidents/ Shift		January	February	March	April	May	June	TOTALS
Skin Tears	D							
	E							
	N							
Total								
Wound/Pressure Ulcer	D							
	E							
	N							
Total								
Behavior Episodes	D							
	E							
	N							
Total								
Total Incidents								

Identify Trends Using Tracking Tools

Resident Name: Bob - Falls							
Date/Time	**Incident**	**Location**	**Type Injury**	**Medical Attention Provided**	**Interventions Assessed**	**Med Review**	**Reportable Y/N Date Reported**
1/15/10 3:00pm	Slip to Floor	Apartment Living Room	No Injury	No	Yes	Yes	No
1/30/10 8:00pm	Slide off toilet to floor	Apartment Bathroom	No Injury	Referred to Licensed Nurse	Yes	Yes	No
3/5/10 4:00pm	Fall in Shower	Bathroom	Skin tear	First aid referred to LN	Yes	Yes	no
3/25/10 6:00pm	Fall	Apartment Living Room	Bruised hip	Yes Portable x ray ordered	Yes	Yes	no
4/10/10 3:30pm	All	Apartment bathroom	Potential fx hip	Yes Transported via ambulance	Yes	Yes	no

Monitoring the Story: Sample Tool

Resident Name: Joe Jobs - Behaviors							
Date/Time	**Incident Investigation/Report Completed?**	**Location Injury**	**Type Injury Encounter**	**Medical Attention Provided**	**Service Plan Interventions Assessed**	**Med Review**	**Reportable Y/N Date Reported**
1/15/10 3:00pm	Combative with caregiver during personal care yes	Apartment Bathroom	No Injury to caregiver or resident	No	Yes	Yes	No
1/30/10 8:00pm	Grabbed caregivers breast during shower Yes	Apartment Bathroom	No Injury	Referred to Licensed Nurse	Yes	Yes	No
3/5/10 4:00pm	Found in female residents room Yes	Room 100	Female resident yelled for him to leave	n/a	Yes	Yes	no
3/25/10 6:00pm	Found in female residents room attempting to climb into bed	Room 100 bedroom	Female resident yelled and very upset	Physician and family contacted	Yes	Yes	Yes

Monitoring the Story:

Sample tool – ER/Hospital Transfers

Resident Name: Joe Jobs							
Date/Time Transfer	**Transferred to ER Urgent Care**	**Location**	**Reason for transfer**	**Medical Attention Provided**	**Admitted Returned to Community Other**	**Outcome Orders**	**Community Follow up RN Notified Family Notified Progress Notes Alert Charting**
3/13/13	ER	Good Sam South	Fell Comp of hip pain	X ray Negative	Returned	Yes Pain med Contact physician if further complaints	Yes 72 h alert charting See physician in 3 days
What other information is needed? **Transfer information to daily report**							

How to use this document: Each resident who starts on hospice or home health shall have an Outside Provider Visit and Care Coordination Log. This tool serves as an internal checklist and quality improvement tool to assure that all the steps in care coordination are occurring.

SAMPLE Outside Provider Visit and Care Coordination Log

Resident Name: Jack Black

Date/ Time of Visit or Communication	**Reason for Visit**	**Service plan** -Review -Update -Meeting(as needed)	**Communication** -Staff -Family -Nurse -Other	**Coordination with Facility RN**	**Service plan modified/ Chart notes updated**	**Family or significant other communication**	**Other notes**
1/15/10 3:00 pm	Initial Assessment by HH of Wound	Physician orders obtained for wound treatment and interventions	Staff have been alerted to change on SP at stand up and via ACCTT communication tool.	RN has reviewed HH assessment and concurs. Weekly communication or as needed will take place between FN and HH	Yes Weekly progress notes Check in with staff at daily stand up Updated Resident ACCTT form	Yes	Reviewed communication protocols with HH agency staff
1/22/10 11 am	HH RN visit.	No changes required. Continue current orders.	Left documentation re: progress of wound	Checked out with RCA. HH RN noted that didn't see need to talk with RN. If questions contact HH.	NA Continue current SP interventions and monitoring protocols	NA	Check in weekly with resident.

How to use this document: Each resident who starts on hospice or home health shall have an Outside Provider Visit and Care Coordination Log. This tool serves as an internal checklist and quality improvement tool to assure that all the steps in care coordination are occurring.

SAMPLE Outside Provider Visit and Care Coordination Log

Resident Name: Jack Black

Date/ Time of Visit or Communication	**Reason for Visit**	**Service plan** -Review -Update -Meeting(as needed)	**Communication** -Staff -Family -Nurse -Other	**Coordination with Facility RN**	**Service plan modified/ Chart notes updated**	**Family or significant other communication**	**Other notes**
						+	

Individual Resident Tracking Tool

Resident Name: Bobbi Sox							
Date/Time Meting	**Issue addressed**	**How addressed service plan review/service plan meeting**	**Results Action Plan**	**Interventions assessed**	**Service plan modified/chart notes updated**	**Family or significant other communication**	**Staff communication other**
1/15/13 3:00pm	Smoking inside building near back exit	Meeting to review community rules and agreements	Resident acknowledge the no smoking policy	Reviewed areas where smoking is allowed on campus	Yes Remind resident of appropriate smoking areas monitor for use.	Talked with family 1/16	Reviewed at daily meeting added to daily log update acuity roster
1/30/13 11:00am	RCA reported smell of smoke in residents bathroom. Found cigarette butt in sink	Service plan meeting held to develop managed risk agreement	Managed risk agreement in place	Administrator to check in weekly with resident re: agreement review daily log	Yes Continue current SP interventions. Staff to monitor room for evidence of smoking and follow managed risk protocols	Called family 1/30/13	Staff informed of monitoring and other interventions

INTERACT Resources

SBAR Resources

- ☐ Does your community use an SBAR Assessment tool?
  ☐ Yes ☐ No

- ☐ If you do use SBAR, how is it used with your other systems?

- ☐ Do you think this would be a helpful tool for nursing assessments, contracting physicians or for caregivers to use with the community nurse?
  ☐ Yes ☐ No

If yes, what are the advantages?

If no, what are the barriers?

SBAR for Assisted Living Caregivers

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II
Interventions to Reduce Acute Care Transfers

Suggested process as permitted by state regulations, professional licensure laws, and community policy

Before Calling Nurse/Supervisor:

- ☐ **Evaluate the resident** and complete the SBAR for AL caregivers form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR/POLST and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

_____

This started _____

This has gotten (circle one) 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 _____

B BACKGROUND

Primary reason resident is in assisted living _____

Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) _____

_____

Vital signs BP _____/_____ HR _____ RR _____ Temp _____

Change in function or mobility _____

Medication changes or new orders in the last two weeks if known _____

Mental status changes (e.g. confusion/agitation/lethargy/combative) _____

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/constipation/decreased urinary output/other)

Pain level/location _____

Change in appetite or taking in fluids _____

Change in skin or wound status _____

Advance directives (circle) Full code, DNR, POLST, DNI, DNH, other, not documented.

Allergies _____ Any other data _____

A APPEARANCE

The resident appears (e.g. SOB, in pain, more confused) _____

R Ready to Call

Staff name _____ **RN/LPN**

Reported to: Name _____ **(MD/NP/PA/Nurse/Supervisor)**

Date _____/_____/_____ **Time** _____ **a.m./p.m.**

Communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax

☐ **Family or health care proxy notified**

Name _____ **Date** _/_____/_____/ **Time** __/_____ **AM/PM**

Resident name _____

Return call/new orders from MD/NP/PA/Nurse/Supervisor see attached or chart

Updated July 2012

SBAR for Assisted Living Nurses

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

Suggested process as permitted by state regulations, professional licensure laws, and community policy

Before Calling MD/NP/PA:

- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS:** BP, pulse, respiratory rate, temperature, and/or finger stick glucose if indicated
- ☐ **Review chart if available:** recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card if in use in your community***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR, POLST, and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

_____

This started _____

This has gotten (circle one) 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 _____

B BACKGROUND

Primary diagnosis and/or reason resident is in assisted living _____

Pertinent history (e.g. recent falls, fever, decreased intake, pain, SOB, other) _____

_____

Vital signs BP _____/_____ HR _____ RR _____ Temp _____

Pulse Oximetry _____% On RA _____ on O2 at _____ L/min via _____ (NC, mask)

Change in function or mobility _____

Medication changes or new orders in the last two weeks _____

Mental status changes (e.g. confusion/agitation/lethargy) _____

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)

Pain level/location _____

Change in intake/hydration _____

Change in skin or wound status _____

Labs _____

Advance directives (circle) Full code, DNR, DNI, DNH, POLST, other, not documented

Allergies _____ Any other data _____

A ASSESSMENT (RN) OR APPEARANCE (LPN/LVN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____ *-OR*

I am not sure of what the problem is, but there had been an acute change in condition.

(For LPNs/LVNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:

- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ New orders (see attached) _____
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ Transfer to the hospital

Staff name _____ **RN/LPN**

Reported to: Name _____ **(MD/NP/PA) Date** ____/____/____ **Time** _____ **a.m./p.m.**

If to MD/NP/PA, communicated by: ☐ Phone ☐ Left Message ☐ In person ☐ Fax

Resident name _____

(Complete a progress note on the back of this form)

☐ Family or health care proxy notified
Name_____Date_____/_____/_____/ Time __/_____AM/PM

Progress Note

Return call/message new orders from MD/NP/PA Date_____/_____/_____/ Time _____/_____AM/PM

Signature _____RN/LPN/LVN Date_____/_____/_____/ Time _____/_____AM/PM

Resident Name _____

STOP AND WATCH

Communication Tool

- ☐ Does your community use the STOP AND WATCH Tool?
  ☐ Yes ☐ No

- ☐ If you do use STOP AND WATCH, has is it improved communication between caregivers and nurse?

- ☐ Do you think this would be a helpful tool for improving staff and family communication?
  ☐ Yes ☐ No

If yes, what are the advantages?

If no, what are the barriers?

Stop and Watch
Early Warning Tool

INTERACT
Version 4.5 Tool

If you have identified a change while caring for or observing a resident/ patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual; Symptoms of new illness
T Talks or communicates less
O Overall needs more help
P Pain - new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change; swollen legs or feet
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient/Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Connecting the System Dots

Survey Example Heading

Based on observation, interview and record review, it was determined the facility **failed to re-evaluate** and make appropriate changes to the service plan for 1 of 2 residents (#3) in the survey sample, who had a **significant change of condition**. Findings include but are not limited to: Resident 3 was a long-term resident of the facility, with diagnoses including **Parkinson's, dementia and diabetes**. The resident's weight record indicated that, in November 2012, s/he weighed 136 lbs.

A **Resident Change of Condition/Alert Charting form** dated 12/17/12, indicated the resident weighed 123 lb**, a loss of 9%** of total body weight **in one month**. In the section labeled Plan/Intervention, the form indicated "Encourage food/fluids. Meds as ordered. If refusing food/fluids, give ice cream regardless of diabetic diagnosis.

"The resident's service plan directed staff to "encourage [him/her] to drink more water, but the provision of **ice cream** was **not included on the service plan or MAR**. On 2/19/13 and 2/20/13, the **resident was observed being fed a pureed diet**. S/he did not initiate any effort to feed him/herself. This **intervention** was also **not included in the service plan.** On 1/4/13, **change of condition monitoring notes** indicated the resident weighed 116 lbs. for an additional loss of 7 lbs. in under one month, or a total loss since November 2012, of 14% of body weight.

Using the System & Tools

Tool(s): -Resident Acuity Roster

-Re-ACCT Report

Tool(s): -Resident Acuity Roster

-Re-ACCT Report

Tool(s): -Resident Acuity Roster

-Resident Tracking Sheet

Tool(s):

-Resident Acuity Roster

Tool(s):

-Resident Acuity Roster

Select this resident to do full record audit.

-ReACCT Daily Log

There **was no re-evaluation of** the resident's **ongoing weight loss**, **no current RN assessment** and **no nutritional interventions developed** and added to the service plan to prevent further loss. On 2/21/13, Staff 3 (RCC) stated the

resident was **sometimes given a high-calorie shake made with Ensure** (a nutritional supplement), ice cream and other ingredients. It was documented on the facility's **nutrition monitoring records.** The records indicated Resident 3 received a high calorie shake once in December, twice in January and for one week, at breakfast and lunch in February. On 2/21/13, Staff 2 (RN) was asked why the facility had not considered a routine nutritional supplement. She indicated it **was the facility's usual policy**, but it had somehow been **overlooked** in Resident 3's case.

Tool(s):

-Resident Acuity Roster

-ReACCT Daily Log

Tool(s):

-Resident Acuity Roster

-ReACCT Daily Log

Tool(s):

-Use the Framework for Compliance & Beyond & OAR review re: Policies.