Recognition of Acute Change of Condition in the Developmental Disabilities Setting

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Definition

- An acute change of condition (ACOC), is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains.
- "Clinically important" means a deviation that, without intervention, may result in complications or death.

Regulatory Expectations

- "Registered Nursing Supervision of Unlicensed Direct Care Staff in Residential Facilities Certified by the Office of Mental Retardation and Developmental Disabilities" (Now OPWDD)
- Administrative Memorandum (ADM) 2003-01

Regulatory Expectations

- ADM 2003-01
- "There shall be an RN available to unlicensed direct care staff 24 hours a day, 7 days a week. The RN must be on site or immediately available by telephone."

- Note: "Immediately available" has been defined as responding within 30 minutes.

Regulatory Expectations

- Professional Nursing Availability (cont.)

- "The residence RN, or during off hours, the RN on call, will be immediately notified of changes in medical orders for a consumer and/or of changes in a consumer's health status"

Telephone Triage

- In DD facilities, telephone triage is often the primary method for RNs to manage reports of change of condition.

- The purpose of telephone triage is to direct the individual to the right place, at the right time, so that he/she receives the optimum treatment.

Telephone Triage

- Is an encounter with a caller in which an RN utilizing **Clinical Judgment** and the **Nursing Process** is guided by medically approved decision tools, to determine the urgency of the problem and to direct the caller to the appropriate level of care.

Why do Telephone Triage?

- Provides for improved quality of care for the people we serve.
- Provides professional direction and support for unlicensed direct care staff.
- Reduces the number of avoidable ER visits/Hospital admissions.

Why reduce ER Visits/Hospitalizations?

- Transfer to a hospital is disruptive for Individuals with I/DD.

- It exposes Individuals to risks:
- Under-nutrition;
- Hospital Acquired Infections;

Why reduce ER Visits/Hospitalizations?

- Skin Breakdown;
- Adverse Drug Reactions;
- Disruption of Established Routines;
- Loss of Established Abilities;
- Need for 1:1 Staffing;
- ER Utilization/Hospitalization is the **most costly level of care.**

Managed Care Emphasis

- In Medicaid Managed Care programs, one of the goals/standards on which providers of care are judged is the ability to reduce costs through reducing:
- Potentially Preventable Hospitalizations:
- Potentially Preventable Readmissions;
- Potentially Avoidable ER Visits.
- Some plans reward Providers for meeting goals in these and other areas.

Risk of Acute Change of Condition (ACOC)

- Step 1. Identify Individuals at risk for ACOCs.
- ACOCs are very common in individuals with I/DD. Although some ACOCs are unpredictable, many can be anticipated by identifying risk factors such as pre-existing conditions, previous complications, or the course of a recent hospitalization.

Examples of Predictable ACOCs

- Premature discharge from an acute care facility ("Quicker and Sicker").
- Individuals with CHF, or Hypertension.
- Impaired Mobility.
- Recurrent falls.
- Prolonged Bed Rest.
- Urinary Retention,

Pre-Existing Conditions that may Predispose Individuals to ACOCs

Condition	ACOC Risks
Congestive Heart Failure	Acute Dyspnea
COPD	Pulmonary Edema/Respiratory Infection
Diabetes	Fluid/Electrolyte Imbalance Hypoglycemia
GI Bleeding	Acute Recurrence of Bleed
Neurogenic Bladder	UTI
New Medication	Falls Altered Mental Status

Approaches to Assessing Risk for ACOCs

Step	Approaches
Evaluate Current Condition and Status.	Determine Expected Course/Known Complications.
Identify all Current Problems.	Create a Problem List.
Identify Risk for Poor Outcomes (Death, Skin Breakdown, Failure to Regain Weight)	Identify Risk Factors.(eg. Functional/Cognitive Status, Number of DXs.
Identify Interventions to Reduce Risks/Prevent Complications.	Eg. Turning/Positioning, Medication reduction, reduce incidence/severity of complications.

Step 2.
Describe and Document
Symptoms/Condition Changes

- Individuals with I/DD are most likely to report symptoms to a DSP, Manager or Nurse. It is rare for an Individual to report directly to a practitioner.
- It is important that caregiving staff describe symptoms as accurately and completely as possible, so that practitioners may determine their significance.

Describing/Documenting (cont.)

- DSP/Nurse should, at minimum:
- Ask the Individual how they are feeling or how symptoms developed;
- Take Vital Signs;
- Determine overall condition, LOC and function.

Describing Symptoms

- An Individual's symptoms or test results may represent anything from normal variation to serious underlying illness.
- The Practitioner needs a detailed description of condition to determine whether a symptom is problematic or simply a normal or expected variant.
- For example, "agitation" may represent momentary anxiety in an otherwise calm person, or at the other end of the spectrum, acute psychosis or delirium.

Describing Symptoms

- Caregiving staff should describe and document the nature, extent, and severity of symptoms, abnormalities, and condition changes clearly and in sufficient detail to help practitioners distinguish their potential causes and consequences.
- Observation, description and documentation of symptoms must be distinguished form interpretation.
- Caregivers making observations may not be qualified to interpret those observations and should not attempt to do so. Appropriately qualified practitioners should follow up on those observations and document and interpret their findings.

Describing Symptoms

- Use correct terminology and document sufficient details to describe the observations to help practitioners compare symptoms, identify the effectiveness of specific interventions, and distinguish between similar symptoms that have significantly different causes.

Examples

- Hyperventilation is not dyspnea.
- Tremor or shaking is not a seizure.
- Apathy is not depression.
- Motor restlessness is not agitation.
- Fatigue is not weakness.
- Loose stools are not diarrhea.

Examples of Appropriate Descriptions of Symptoms

General statement:

- "Patient more agitated than usual"

More Appropriate/Specific:

"Pt. required interventions 3X this shift."

- "Pt. not responding to redirection."
- "Pt. refused meds 2x in last 2 days."
- "Pt. shouting,hitting,etc."

Appropriate Descriptions

General Statement

- "Pt. is not her usual self"

More Appropriate/Specific

- "Pt. not participating in activities."
- "Pt. not interacting in usual manner."
- "Pt. did not brush her hair and put on make-up as she usually does."

Appropriate Descriptions

General Statement

- "Pt. is not eating/not drinking"

More Appropriate/Specific

- "Pt. ate only 50% of breakfast and 25% of lunch over the past two days."
- "Pt. is not eating solid foods."
- "Pt. seems to be having pain when chewing."
- "Pt. is refusing fluids."
- "Pt. has not voided in two shifts."

Appropriate Descriptions

General Statement

- "Pt. seems weak"

More Appropriate/Specific

- "Pt. requires help with ADLs that she usually performs unassisted."
- "Pt. is dropping things with his left hand."
- "Pt. has had two non-injurious falls in the past week."

Facilitating Clear Communication in the Team

- Agencies should encourage effective, multidirectional communication that recognizes the value of relevant input from various sources, including family members, managers, and clinical staff, as well as DSPs.
- Relevant information from Day Service and Transportation Providers should also be sought.

Facilitating Communication

- Direct-Support Professional staff should be trained in recognition of signs and symptoms of illness and should be encouraged to freely report their observations to Nursing staff.
- Many times, observation by DSPs can provide early warning of Acute Change of Condition.

Facilitating Communication

- DSPs who identify possible ACOCs should immediately report their findings to the RN.
- Nurses should follow written guidelines (protocols, decision trees, Triage Manuals, etc.) to determine what signs and symptoms to report to Physicians.
- HOWEVER: Protocols should NEVER substitute for Nursing Judgment.

Facilitating Communication

- When reporting information to a Practitioner, Nurses should not assume that the Practitioner knows the Pt. well, or remembers relevant details such as current meds, etc.
- It is helpful to give the Practitioner a brief review of any relevant medical history.

Recommended Procedures for Ensuring Recognition of ACOCs

- Communication of all Pt. related information follows a defined process.
- All team members (not just DSPs) are expected to report findings that might represent ACOCs.
- In-depth discussion of ACOCs occurs at specific times. Ex. Shift to shift communication.
- Responsibility for entering information in the medical record is clearly assigned.

Facilitating Communication

- Breakdowns in communication should be promptly addressed by RNs and Supervisory staff.
- Poorly written notes, or notes that fail to provide important information should be addressed.
- Nursing Peer review is a good tool to improve communication and documentation.
- Reviews should be a LEARNING Tool, NOT a criticism.

PQRST Mnemonic

- P: Palliation, Provocation
- What makes the symptom better or worse?

- Q: Quantity, Quality
- How much is the patient bothered by the symptom and what is the degree of discomfort?

PQRST

- R: Region, Radiation
- Where are the symptoms located? Do they move from one part of the body to another?
- S: Signs, Symptoms
- What signs and symptoms coincide with the primary findings? (For example, is pain accompanied by sweating and elevated pulse?)

PQRST

- T: Temporal Relations
- What changed around the time of onset of symptoms or condition change?
- What other active problems are on the Pt.'s problem list?
- Have the same or similar episodes occurred in the past? What was happening at those times?
- What solutions have or have not been effective previously?
- Have the Pt.'s meds or physical routine changed recently?

Step 3. Define the Pt.'s stability and Identify why the Situation is Problematic

- Many symptoms and abnormalities are seen in LTC populations. However, only some of those are problematic, and only some of those are that are problematic require or are likely to respond to treatment. For example:
- Blood Pressure may fluctuate without requiring immediate attention;
- Alertness or functioning of a Pt. with Alzheimer disease may fluctuate throughout the day;
- An Individual with COPD or CHF may periodically breathe irregularly or with some difficulty.

Step 3, cont.

- Considerable judgment based on knowledge and experience is required to distinguish symptoms which may not require intervention, from symptoms that are both problematic and likely to respond to treatment.
- When an Individual is observed to have a condition change, it is common for caregivers to call a practitioner immediately, or rush the person to the ER. In many cases, these actions are premature.

Step 3 cont.

- Unless an Individual’s condition is deteriorating rapidly, or vital signs are markedly abnormal or unstable, the RN generally has ample time to conduct an assessment prior to initiating treatment or transfer.
- Isolated findings or test results rarely indicate a need for hospital transfer. There is generally time for decision making, unless the issue is emergent.
- Standardized protocols for decision making are available, and should be used.

HOWEVER:

- Standardized protocols should NEVER be used as a substitute for Nursing Judgment.
- The expectation is not for “Cookbook Medicine” But rather for use of informed judgment, ASSISTED by decision-support tools.
- “When in Doubt, send them out!

Categories of Symptoms that may help to define ACOCs

- Respiration:
- Observe for the following;
- Respiratory rate >28 BPMs;
- Marked change from usual respiratory pattern/rhythm;
- Irregular breathing, long pauses between breaths, audible noises related to breathing;
- Struggling to breathe (gasping, using accessory muscles of the neck)

Categories of Symptoms

- Temperature:
- A range of 98.2-99.9F is considered normal. It is good to establish a pt.'s normal range;
- A sudden or rapid change may indicate an ACOC;
- After an isolated temp reading outside the pt.'s normal range, repeat reading Q4H for 24 hours and assess for other S&S;
- Hypothermia may also indicate an ACOC;

Categories of Symptoms

- Blood Pressure:
- Good to establish normal range for the Individual;
- Normal is approx. 100-140 mmHg systolic and 60-90 mmHg diastolic;
- A change in BP is more often a symptom than a cause of an ACOC. Isolated BP elevations are generally not significant;
- A decrease in systolic BP >20mmHg when moving from a prone to a seated position, or a seated to a standing position, signals orthostatic hypotension;
- Significant decrease in BP may signal an ACOC, especially if accompanied by other symptoms.

Categories of Symptoms

- Pulse:
- Normal range 60-100 BPM, can vary up to 10%. The following presentations may indicate an ACOC and should be assessed further;
- Sustained change from normal rate;
- Change in rhythm or regularity;
- Pulse >120 BPM or< 50 BPM;
- Pulse >100 BPM with other symptoms (e.g., palpitations, dyspnea or dizziness).

Categories of Symptoms

- Pain:
- The following may indicate an ACOC and should be assessed further;
- Pain worsening in severity, intensity, or duration, and/or occurring in a new location;
- New onset of pain associated with trauma;
- New onset of pain greater than 4 on a 10 point scale.

Categories of Symptoms

- Weight/Eating Patterns:
- An abrupt change in appetite may indicate an ACOC before a significant change in weight occurs;
- Rate of weight gain/loss may be a more important indicator of a possible ACOC than amount of weight gain or loss;
- A change in intake patterns (e.g., consuming <75% of all meals in 24 hours or <25% of any one meal) should trigger additional evaluation for a possible ACOC;

Categories of Symptoms

- Weight/Eating Patterns Cont.:
- In documentation of intake, identify both solid and liquid intake in as much detail as possible;
- Evaluate S&S that may suggest fluid imbalance (e.g., edema or change in edema);
- Acute, rapid weight gain may indicate an ACOC accompanied by fluid accumulation (e.g., acute CHF)
- Acute, rapid weight loss over several days should trigger concern about a hydration emergency.

Categories of Symptoms

- Level of Consciousness:
- LOC should be distinguished from aspects of cognition, such as orientation and memory;
- LOCs are alert, drowsy/lethargic, stuporous, and comatose.
- The following may indicate an ACOC and should be assessed further:
- Frequent fluctuations in LOC;
- A reduction of one level or more in LOC
- Hypersomnolence

Categories of Symptoms

- Weakness:
- New onset of weakness, or significant change from baseline may indicate an ACOC and should be assessed further;
- Classify weakness as generalized or localized and describe in detail.

Categories of Symptoms

- Falls.
- The following may indicate an ACOC and should be assessed further:
- Repeated falls on the same day;
- Recurrent falls over several days to weeks;
- New onset of falls, not attributable to a readily identifiable cause;
- A fall with consequent change in neurological status, or findings suggesting a possible injury

Categories of Symptoms

- Change in Elimination Patterns.
- The following may indicate an ACOC and should be assessed further:
- Appearance of frank blood in stool, urine or vomit;
- Abrupt change in frequency of urination or defecation;
- Frequent loose stools (three or more in 24 hours);
- Worsening incontinence of bowel or bladder.

Categories of Symptoms

- Behavioral Symptoms:
- Significant change in nature or pattern of usual behavior;
- New onset of resistance to care;
- Abrupt onset or progression of significant agitation or combative behavior;
- Significant change in affect or mood;
- Violent/destructive behaviors directed at self or others.

Categories of Symptoms

- Cognitive Symptoms:
- Abrupt onset of or increase in confusion;
- Onset of hallucinations, delusions or paranoia;
- Significant fluctuations in level of confusion during the day, or over several days.

Categories of Symptoms

- Functional Symptoms:

- Sudden or persistent decline in function;
- Loss of ability to perform ADLs.
- New onset or increase in communication difficulties.

Stages of Recognition and Assessment of a Suspected ACOC.

- Recognition and Assessment of a suspected ACOC has three stages.
- Stage 1 (Primary) Initial observation and reporting of S&S by individuals in close contact with the pt.
- e.g., a DSP , day service provider or family member observes a change in eating patterns; a DSP notes a significant change in function.

Stages of Recognition and Assessment of a Suspected ACOC

- Stage 2 (Secondary) Additional clinical observations to help define the nature, severity, and possible causes of the problem.
- e.g., a unit manager or nurse verifies that the pt.'s condition shows a distinct change from his/her usual status. A nurse describes details (onset, duration, frequency, etc.) of pain or problematic behaviors.

Stages of Recognition and Assessment of a Suspected ACOC

- Stage 3 (Tertiary). Advanced clinical analysis of the nature, severity, causes, and other aspects of the problem.
- e.g., a practitioner examines the pt. and identifies specific physical and psychological changes, performs a more detailed examination, or orders and interprets diagnostic tests.

Examples of Condition Changes to Report to a Practitioner

- Report Immediately.
- **Acute change in mental status.**
- **Bleeding**:
- Uncontrolled or repeat episode within 24 hours (e.g. prolonged nosebleed, bloody emesis;
- Bloody stools not from hemorrhoids;
- Profuse vaginal bleeding;
- Grossly bloody urine.

- Report Next Day.
- Gradual onset.
- Controlled, no further episodes.
- Bleeding from hemorrhoids.

Condition Change Reporting

- Report Immediately
- **Chest Pain;**
- New onset or recurrent, not relieved by Nitro x3;
- Accompanied by changes in vital signs, diaphoresis, nausea, vomiting, shortness of breath.

- Report Next Day
- Increase in frequency of episodes in a pt. with a known Hx of chest pain.

Condition Change Reporting

- Report Immediately

Combative/Aggressive Behavior:

Unresolved by environmental interventions;

New onset associated with change in medication or medical status.

- Report Next Day
- Increase in frequency of episodes of mildly aggressive behavior.

Condition Change Reporting

- Report immediately
- **Constipation**:
- Severe abdominal pain, rigid abdomen;
- Absence of bowel sounds.

- Report Next Day
- Unresolved symptoms.
- >2 episodes in 30 days.

Condition Change Reporting

- Report immediately.
- **Decreased Fluid Intake:**
- Drinking <50% of usual fluid intake in previous 24 hours;
- > 1 episode of vomiting within 24 hours.

- Report Next Day.
- Persistent symptoms for more than 24 hours despite interventions.

Condition Change Reporting

- **Report Immediately.**
- **Depressed Mood/Reactive Depression:**
- Realistic expression of suicidal intent (e.g., a specific plan that could be carried out)

- **Report Next Day.**
- Persistent sadness
- Expression of suicidal thoughts without a specific plan or prior history of suicidal attempts.

Condition Change Reporting

- **Report Immediately**
- **Diarrhea:**
- Acute onset of multiple stools with change in vital signs.

(e.g., temp >101F and/or altered mental status, etc.);
Accompanied by positive fecal occult blood test.

- **Report Next Day**
- Persistent loose stools for >48 hours while diarrhea is treated symptomatically;
- Chronic loose stools;
- Recurrence of diarrhea after resumption of normal diet.

Condition Change Reporting

- **Report Immediately**
- **Edema;**
- Sudden onset in pt. with lung, heart or kidney disease;
- Accompanied by sudden onset SOB, and/or chest pain;
- Sudden onset in one leg;
- Loss of sensation in swollen leg;
- Sudden onset with tenderness and redness.

- **Report Next Day**
- Known Hx. Of edema with progressive unilateral/bilateral increase in severity;
- Gradually progressive edema accompanied by weight gain;
- Skin changes associated with edema.

Condition Change Reporting

- **Report Immediately**
- **Emesis:**
- Bloody or coffee ground vomit;
- > 1episode within 24 hours;
- Accompanied by abdominal pain and changes in vital signs.

- **Report Next Day**
- Single Episode.

Condition Change Reporting

- **Report Immediately**
- **Eye Discomfort:**
- Severe, persistent eye pain;
- Sudden vision change;
- C/O seeing halos

- **Report Next Day**
- Persistent symptoms unrelieved by measures in protocol.

Monitoring ACOCs

- A nurse should closely monitor any individual being treated for an ACOC.
- Daily contact should be made with staff.
- Staff should be instructed on any new protocol developed.
- Notes should be written at least once weekly.
- Monitoring must continue until the condition is resolved.

Monitoring ACOCs

- Interventions should be adjusted based on the patient's response to treatment.
- Response/non response to treatment should be communicated to the practitioner.
- The individual should be seen if adequate response to treatment is not evident.

A Note of Caution

- No Standard of Care or Practice Guideline is to replace the experience and judgment of clinicians and caregivers.
- Standards and Guidelines should only be used **with supervision and consultation of a qualified Physician, based on the case history and medical condition of a particular patient.**

Questions???

- My Contact info: Wetzelfm@gmail.com
- Materials used in this presentation are from the:
- AMDA Clinical Practice Guideline-Acute Change of Condition in The Long-Term Care Setting.
- **Best of Luck in Your Practice!**