AHRQ Safety Program for Long-term Care: HAIs/CAUTI

Communicating Changes in Resident Condition

National Content Webinar Series

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Learning Objectives

Upon completion of this training, participants will be able to:

- Define an acute change of condition (ACOC) and describe strategies to recognize acute changes of conditions.
- Recognize characteristics of effective communication.
- Identify and apply TeamSTEPPS communication strategies that can be used to share residents' ACOCs.
- Utilize training materials to educate facility staff about communicating changes in resident condition.

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Residents Depend on Everyone to Detect and Communicate Changes in their Condition

- Nursing assistants
- Therapists
- Licensed nurses
- Activities
- Social workers
- Clerks
- Dietary
- Physicians
- Maintenance
- Laundry
- Housekeeping
- Family and friends

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What is an ACOC?

Sudden deviation from a resident's baseline in physical, cognitive, behavioral or functional health that, without intervention, may result in resident harms.

- LTC residents are at high risk for ACOCs
- As many as 50% of residents may experience an ACOC every two months
  - 14-28% of ACOCs lead to transfer to the hospital
  - Risk of hospitalization is highest immediately following admission to LTC facility
- Signs and symptoms are often ambiguous, non-specific and may occur abruptly or over several hours or days

(AMDA 2003)

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Recognizing ACOCs

- Early recognition of ACOC signs and symptoms help prevent poor outcomes and negative impact on quality of life and care
- Timely evaluation and intervention helps address ACOCs effectively in LTC
- Primary goals of identifying ACOCs:
  - Enable staff to evaluate and manage a resident in the facility
  - Avoid transfer to a hospital or ED
- Staff and practitioners
  - Recognize an ACOC and identify its nature, severity and cause(s)
  - Observe behavioral and functional health symptoms

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Keys to Recognizing a Resident Change

Know the resident's:

- Baseline condition
- Ability to move around
- Activity of daily living status
- Preferences

Changes from the resident's normal condition can signal an acute change of condition.

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Top 12 Changes in Residents

Physical Changes

- Walking
- Urination and bowel patterns
- Skin
- Level of weakness
- Falls risk
- Vital signs

Non-Physical Changes

- Demeanor
- Appetite
- Sleeping
- Speech
- Confusion or agitation
- Resident complaints of pain

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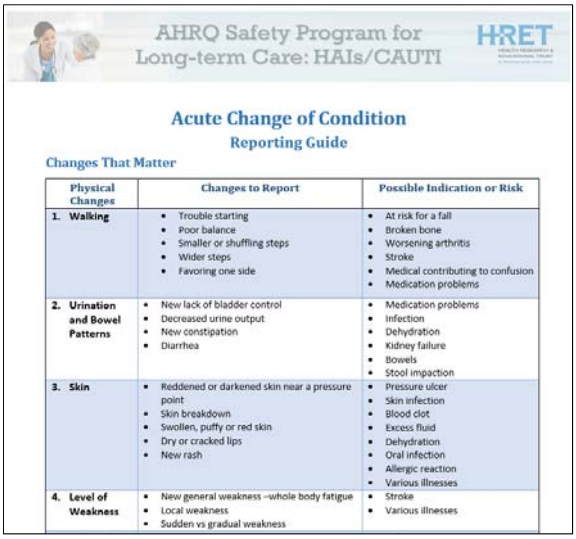
ACOC Reporting Guide



AHRQ Safety Program for Long-term Care: HAIs/CAUTI

HRET

Acute Change of Condition

Reporting Guide

Changes That Matter

Physical Changes	Changes to Report	Possible Indication or Risk
1. Walking	• Trouble starting • Poor balance • Smaller or shuffling steps • Wider steps • Favoring one side	• At risk for a fall • Broken bone • Worsening arthritis • Stroke • Medical contributing to confusion • Medication problems
2. Urination and Bowel Patterns	• New lack of bladder control • Decreased urine output • New constipation • Diarrhea	• Medication problems • Infection • Dehydration • Kidney failure • Bowels • Stool impaction
3. Skin	• Reddened or darkened skin near a pressure point • Skin breakdown • Swollen, puffy or red skin • Dry or cracked lips • New rash	• Pressure ulcer • Skin infection • Blood clot • Excess fluid • Dehydration • Oral infection • Allergic reaction • Various illnesses
4. Level of Weakness	• New general weakness –whole body fatigue • Local weakness • Sudden vs gradual weakness	• Stroke • Various illnesses

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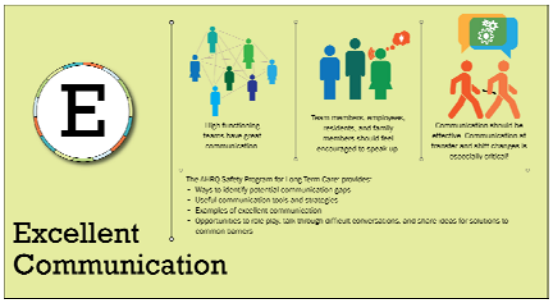
Communication is Critical and TeamSTEPPS Can Help!



Effective and clear communication between interdisciplinary team members, including nurses and providers, leads to:

- Prevention of ACOCs
- Improved identification and management of ACOCs
- A safer resident care environment

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CHAT Effective Communication

What are some characteristics of effective communication?

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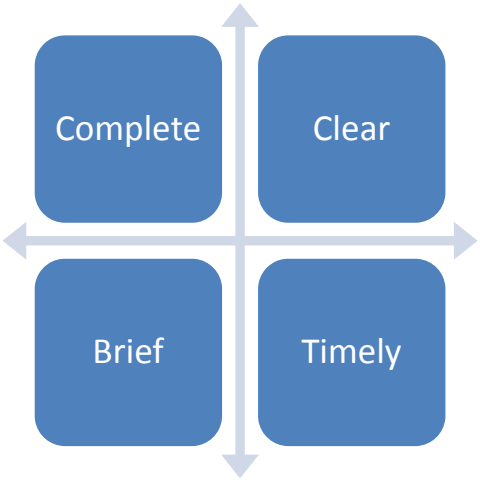
An Example: A Discharge Medication Prescription



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TeamSTEPPS Information Exchange Strategies

- SBAR
- Call-Out
- Check-Back
- Handoff

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SBAR

- **S**ituation—What is happening with the resident?
- **B**ackground—What is the clinical background?
- **A**ssessment—What do I think the problem is?
- **R**ecommendation—What would I recommend?

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SBAR – A Clinical Example

- **Situation:** Mrs. Smith's daughter is concerned because her mother's urine appears cloudy in her catheter drainage bag.
- **Background:** Mrs. Smith has an indwelling catheter due to a diagnosis of neurogenic bladder. Her vital signs are all within her normal parameters. She is displaying her usual level of orientation. She has no pain or discharge around the catheter.
- **Assessment:** Mrs. Smith has no signs or symptoms of CAUTI. Her fluid intake was reduced a little today from her normal amount.
- **Recommendation:** I'd like to continue to encourage fluids for Mrs. Smith and continue to closely assess her status, including her vital signs, and alert you if there is a change in her status.

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A Tool to Help with this Call: CAUTI Criteria - NHSN Definitions Pocket Cards

Catheter-associated Urinary Tract Infection (CAUTI)

Criteria for defining CAUTI in long-term care residents:

One or more of the following, with no alternate source:

- ☐ Fever*
- ☐ Rigors (shaking chills)
- ☐ New onset hypotension
- ☐ New onset confusion/functional decline AND increased leukocytosis*
- ☐ New costovertebral angle pain or tenderness
- ☐ New or increased suprapubic pain or tenderness
- ☐ Acute pain, tenderness , or swelling of the testes, epididymis, or prostate
- ☐ Pus around the catheter insertion site

AND

Any of the following:

If catheter removed within past 2 calendar days:

- ☐ Clean catch (voided) urine culture with 100,000 or more colonies ($\geq 10^5$ CFU/ml) of no more than 2 species of microorganisms
- ☐ In/Out catheter urine culture with 100 or more colonies ($\geq 10^2$ CFU/ml) of any number of microorganisms

If indwelling urinary catheter in place:

- ☐ Positive urine culture with 100,000 colonies or more ($\geq 10^5$ CFU/ml) of any number of microorganisms

REV. 2015-Jul

***Constitutional Criteria for Long-term Care Residents**

Fever

Must have one of the following:

- ☐ Single oral temperature >100°F (37.8°C)
- ☐ Repeated oral temperature >99°F (37.2°C) **OR** rectal temperature >99.5°F (37.5°C)
- ☐ Repeated rectal temperatures >99.5 ºF
- ☐ Single temperature >2°F (1.1°C) over baseline for oral or rectal

Leukocytosis

Must have one of the following:

- ☐ >14,000 white blood cells (leukocytes)/mm³
- ☐ Increase in immature white blood cells (Left Shift) with >6% bands or > 1,500 bands/mm³

Acute Change in Mental Status (within last 7 days)

All components must be present :

- ☐ Confusion (with no alternate diagnosis and leukocytosis)
- ☐ Fluctuating Behavior (comes and goes, or changes in severity)
- ☐ Inattention (difficulty focusing and cannot maintain attention)
- ☐ Disorganized thinking (thinking is incoherent or hard to follow)

OR

Altered level of consciousness (change is different from baseline, may be sleepy, lethargic, difficult to arouse)

Acute Functional Decline

- ☐ New 3 point increase in total activities of daily living (ADL) score from baseline (range: 0-28)

Each ADL scored from 0 (independent) to 4 (totally dependent), including: bed mobility, transfer, locomotion within facility, dressing, toilet use, personal hygiene and eating

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CASE Angela Jimenez (Part I)

- 84-year-old female
- Diagnoses: hypertension, hyperlipidemia, anemia, hammertoe, dementia
- Weighs 2 lbs. less than last month
- Less responsive, not participating in activities
- Ate 25% of last two meals, won't accept fluids
- Indwelling urinary catheter inserted yesterday for possible urinary retention, poor urine output
- Medications: lisinopril, pravastatin, chlorthalidone, fish oil, multivitamin with minerals, baby aspirin
- Allergy: sulfonamides
- Full code

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CASE Angela Jimenez (Part 1)

This morning, the CNA found Angela leaning to the side in her chair and she was very lethargic and unable to be aroused. This was reported to the nurse who assessed Angela and noted the following:

- Skin turgor is poor and skin is warm and dry.
- Vital signs:
  - Blood pressure: 90/60 mmHg
  - Pulse: 104 beats/minute
  - Respirations: 26 breaths/minute
  - Temperature: 99.9°F
  - Pulse Oximetry: 93% on room air

What should the nurse communicate to the physician?

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CASE SBAR with Angela Jimenez (Part II)

- **Situation:**
  Over the last two days, Angela has not been participating in her usual activities and has been less responsive than usual. This morning, the CNA found Angela leaning to the side in her chair and she was very lethargic and unable to be aroused. Her appetite is poor, as is her fluid intake.
- **Background:**
  Her weight is 98 lbs., 2 lbs. less than last month. Yesterday, an indwelling urinary catheter was inserted for possible urinary retention and poor urine output. Her skin turgor is poor and skin is warm and dry. Her vital signs include: B/P: 90/60, P: 104, R: 26, T: 99.9°F, PO: 93% on RA.
- **Assessment:**
  Angela appears to be dehydrated and shows early signs of sepsis.
- **Recommendation:**
  Because of Angela's poor by-mouth intake, I think IV hydration should be considered as well as labs to determine if she has an infection. She does not have an approved indication for her catheter so I would like to remove it. We will be sure to monitor her closely and keep you and her family updated on her status.

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CASE Angela Jimenez (Part III)

The nurse and physician decide on a care plan for Mrs. Jimenez.

- **Interventions ordered**
  - STAT labs
  - Peripheral IV
  - Removal of indwelling urinary catheter
  - Antibiotics
- Within 24 hours, Mrs. Jimenez returned to her baseline
- 48 hrs. later, urine culture shows no growth
  - Antibiotics discontinued
  - IV fluids discontinued as oral intake was deemed sufficient to maintain hydration

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CASE Jack Thompson (Part I)

- 88-year-old male
- Number of recent hospitalizations. Advance directives outline his wishes for comfort care and a do not resuscitate (DNR) order
- Refused to get out of bed this morning, complained of shortness of breath, legs are more swollen than usual
- He declined his breakfast for the past two days
- Diagnoses: congestive heart failure, atrial fibrillation, high blood pressure, chronic obstructive pulmonary disease, depression, insomnia, degenerative joint disease
- Medications: digoxin, furosemide, warfarin, metoprolol, albuterol inhaler, fluoxetine, trazodone as needed
- Nurse assessment:
  - bilateral crackles in his lungs, extensive wheezing, 3+ edema in his legs
  - Vital signs are T: 98°F, B/P: 90/66, P: 66, R: 38
  - 12 lb. gain in one week

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CASE Using SBAR with Jack Thompson (Part II)

- **Situation**:
  Mr. Thompson has increased shortness of breath, weight gain and edema.
- **Background**:
  Mr. Thompson's lung assessment revealed bilateral crackles. He has extensive wheezing and 3+ edema in his legs. Vital signs are T: 98°F, B/P: 90/66, P: 66, R: 38. He has gained 12 lbs. in the last week. His advance directives were recently updated to reflect that he does not want to return to the hospital and he has a DNR order.
- **Assessment:**
  Mr. Thompson's breathing is labored and causing him distress. He has a marked increase in edema.
- **Recommendation:**
  In the past, we have increased Mr. Thompson's diuretics for limited periods of time with excellent results. Additionally, he responds well to nebulizer treatments. Would you consider these measures again? Additionally, Mr. Thompson and his family would like a hospice consult. Would it be okay to proceed with requesting that? We will monitor his intake and output and continue to assess his vital signs and breathing status. We will update you with any changes in his status.

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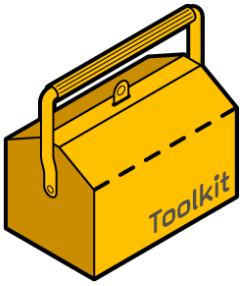
SBAR Toolkit

3-Step Training Process

1. Introductions
2. Practice
3. Summarize



SBAR Toolkit

- Developed by Kaiser Permanente
- Available free on the IHI website

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Practice, Practice, Practice

Examples of communication exchanges

- Nurse to doctor
- Nurse to nurse
- Nursing assistant to housekeeper
- Maintenance staff to administrator
- Administrator to director of nursing
- Nurse to resident and family

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CHAT

Let's Chat!

How will you incorporate SBAR into your facility's communication processes?

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Ideas for Sharing Information about SBAR

- Visual reminders
- "Have you used SBAR today?"
- Games and pop quizzes
- Debrief and reconstruct
- New employee orientation
- Annual competencies
- All staff and physicians

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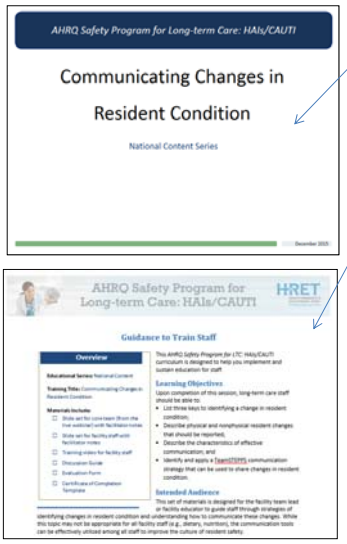
Educate All Staff About Communicating ACOCs



- Use slide set with facilitator's notes
- Share recorded session for all staff who interact with residents
- Use the training guidance for suggestions and tips about staff education
- Provide copies of the tool about what resident changes need to be communicated
- Provide Evaluation Form and Certificate of Completion

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Your Role in Training Staff

- Provide staff with important insights to help them detect changes in resident condition.
- Promote the use of the TeamSTEPPS communication strategy, SBAR.

Review video and accompanying discussion guide before facilitating conversation with front-line staff and providers	Share information with all staff and teammates	Identify how you can infuse TeamSTEPPs communication strategies into facility processes	Recognize staff who participate and engage in activities that improve safety culture

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Summary

- An ACOC is a sudden, clinically-important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains.
- Transfer to acute care is disruptive, costly and exposes residents to many risks, including delirium, undernutrition, serious infections, skin breakdown and adverse drug reactions.
- TeamSTEPPS communication tools help staff communicate ACOCs with providers so appropriate interventions can be implemented.
- Communication practice is essential to ensure all staff know what to expect when communicating with each other.

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Stay Updated with Useful Resources

1. *AHRQ Safety Program for Long-term Care: HAIs/CAUTI* Project Website
   Login information
   Username: ltcsafety
   Password: ltcsafety
2. TeamSTEPPS® for Long-term Care
3. NHSN CAUTI Definition Pocket Cards
4. AHRQ Module 1: Detecting change in a resident's condition - Session 2

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References

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