Healthcare

ALERTBULLETIN®

**A Risk Management Update** | 2025 Issue 2

# Change of Condition in Residents: Enhancing Detection and Response

Risk control in aging services organizations involves, among other strategies, identifying process weaknesses and enforcing care-enhancing policies and procedures. One clinical area that calls for such targeted measures is the management of residents who experience a change of condition (COC), which can range from subtle to acute manifestations in their physical and mental conditions.

Over time, residents of aging services facilities may undergo a COC or sustain an adverse event that has clinical repercussions and requires prompt response. Without written response protocols and a record of care that demonstrates awareness of resident changes, organizations and caregivers may not be able to mount a defense against negative outcomes and legal allegations – including such assertions as failure to detect and properly respond to a resident's deteriorating physical or mental condition, neglecting to implement and/or document critical interventions, and delayed reporting of changes to medical personnel and family members, among others.

In order to protect both residents and the organization, leadership should periodically evaluate COC-related policies and procedures from a risk control perspective. The goal is to establish a sound, comprehensive process for identifying, reporting and managing physical and mental changes, thus enhancing quality of care, maintaining regulatory compliance and minimizing liability for poor resident outcomes, including medical deterioration, transfers to an acute care setting and even death.

To help aging services organizations minimize liability exposures associated with a resident's declining health, this *AlertBulletin*® looks at the need to develop an understanding and specific definition of COC that can aid staff in detecting significant changes. In addition, it offers basic risk control measures designed to strengthen clinical detection, reporting and response processes.

## Understanding Change of Condition

Although many COCs manifest as a sudden deviation from a resident's baseline health status, others can be subtle, taking the form, for example, of a slight fluctuation in skin color, appetite or affect. Depending upon the resident and setting, both manifestations may constitute reportable changes. The first step toward understanding how to detect and manage COCs is the ability of staff to differentiate normal changes of aging from important changes in a resident's physical or mental being.

In general, a chronic condition is long-term and frequently incurable, despite medical intervention. Acute conditions, on the other hand, are clinically significant, sudden in onset, often of short duration and typically responsive to clinical treatment. The table below contrasts common chronic disease states with acute conditions:

### Noting the difference...

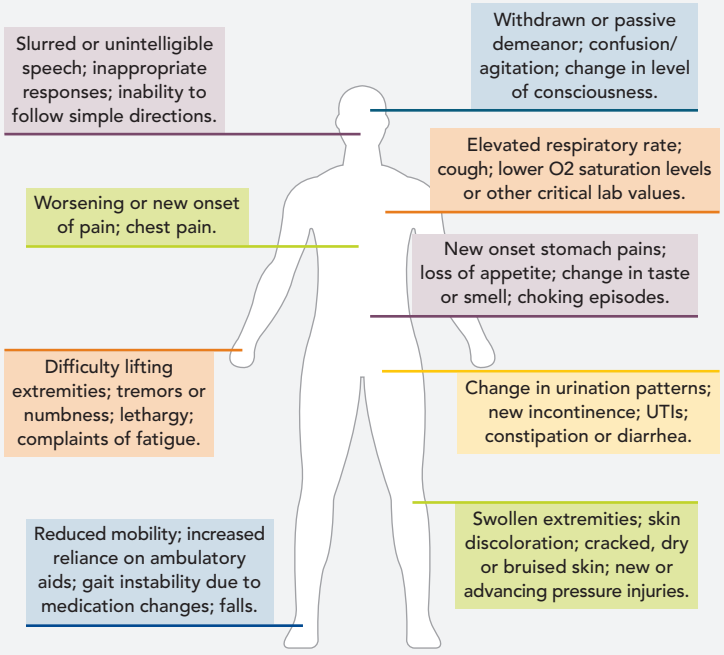
| Chronic Disease | Acute Conditions |
|---|---|
| Chronic obstructive pulmonary disease | Pneumonia |
| Congestive heart failure, hypertension | Heart attack |
| Osteoporosis, arthritis | Fracture |
| Dementia | Delirium |
| Benign enlarged prostate | Urinary tract infection |

Another key step toward early detection is the acknowledgment that changes in resident condition may manifest differently in various settings. Working definitions of COC should therefore be tailored to the acuity level of the facility and the nature of the care provided. For instance, in skilled nursing facilities, a COC may be more clinically pronounced, taking the form of a stroke, heart attack, loss of consciousness or other crisis situation. By contrast, in assisted living facilities (ALFs), a COC may reveal itself less overtly. It is therefore important to clinically pause and investigate subtle changes in ALF residents – e.g., increased reliance on ambulatory aids, alteration in behavior or demeanor, bruises and abrasions, and adverse effects following medication changes – in order to identify whether the resident has experienced a reportable COC. But no matter the setting, reporting triggers should be clearly defined and explained to staff, in order to safeguard residents and lessen exposure to allegations of delayed detection and response.

## Monitoring Resident Condition

Prompt identification of COC requires close, ongoing observation of residents' functional level and mental abilities. Staff should be alert to the following serious changes in condition, among others:

### Common Reportable Changes




## Training Staff and Involving Families

Educational programs designed around the following core objectives, among others, should be offered upon hire and annually thereafter:

- **Becoming familiar with the facility's COC policy,** including documentation and reporting formats.
- **Identifying common symptoms of both acute and chronic illness** in residents, which may signal a COC.
- **Performing and documenting baseline assessments** in response to observed changes.
- **Responding consistently to possible COC situations** by following established protocols.
- **Clarifying when and how to seek help** for residents who may require medical intervention, as well as when to move up the chain of command.

As a COC may occur at any time, identifying new or worsening conditions is a shared responsibility. For this reason, residents and families should be included in care discussions and strongly encouraged to inform staff of observed changes.

## Detecting Significant Changes

Every level of nursing staff should be aware of its own specific duties in regard to monitoring residents and reporting possible changes. The following table summarizes typical COC-related responsibilities for CNAs, LPNs and RNs:

| Role | Responsibilities |
|---|---|
| CNAs | **Be on the lookout for any decline in functioning,** changes in vital signs or new-onset symptoms; elicit feedback from family members; note when changes develop and their degree of variation from normal baseline condition; notify an LPN or RN, if necessary. |
| LPNs | **Initiate data collection, assessment and evaluation;** make shift-to-shift comparisons; note changes in resident vital signs and activities of daily living, as well as fluctuations in fluid intake and output; inform the supervising or charge nurse of documented findings. |
| RNs | **Synthesize collected data,** noting the resident's overall condition, level of awareness and functional status; perform a head-to-toe assessment, examining both cognitive and physical functioning; review medications and obtain vital signs, O2 saturation readings and blood sugar levels, if applicable; consider possible causes, both acute and chronic; clearly document the nature and severity of changes and associated observations; report findings to a provider. |

The following clinical methods and tools, among others, can aid staff in gathering resident data and recognizing changes in health status:

- **Regular health evaluations,** including monthly nursing assessments and more frequent checks by licensed staff, if possible. (Note that *all* staff members are responsible for reporting changes in a resident, including housekeeping, dietary, maintenance, etc.)
- **Widely accepted cognitive function screens** designed to rapidly detect and track mental impairment, e.g., "Brief Interview for Mental Status," "Montreal Cognitive Assessment."
- **Vital sign tracking forms,** which help staff discern fluctuations that may signal an impending change.
- **Electronic healthcare record (EHR) systems that flag significant changes in assessment findings,** vital signs outliers and other telltale deviations, such as the degree of assistance required with activities of daily living (ADLs).
- **Assessment tools tailored to special situations,** e.g., the first three days following admission or readmission after hospitalization, post-fall evaluations, etc.
- **Observation checklists** designed to monitor resident behaviors, medication effects, mobility levels, ability to perform ADLs and other indicators of resident health and well-being.
- **Hourly rounding** to better anticipate and address changing resident needs. (See CNA *AlertBulletin*® 2023-Issue 1, "Hourly Resident Rounding: Key to Enhanced Safety and Satisfaction.")
- **Well-being checks at ALFs,** which should be used to assess residents and detect changes in their condition.

Note that continuity of care helps foster awareness of baseline health status. Therefore, COC is most promptly detected when staff are assigned to the same residents, to the extent possible.

## Communicating Findings

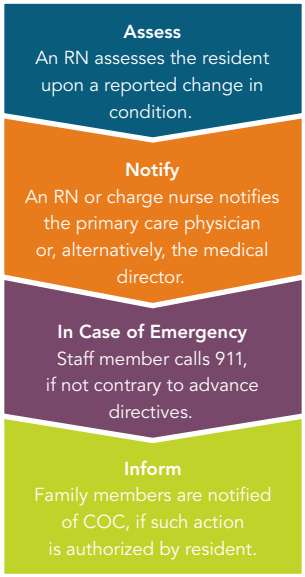
Once a COC is identified, all care team members – including certified nursing aides, licensed nurses and medical providers – must be able to convey the information to others in a clear, succinct and timely manner. The following standardized tools and formats can help enhance both communication and interdisciplinary teamwork:

- INTERACT "Stop and Watch" Early Warning Tool.
- Situation-Background-Assessment-Recommendation (SBAR) methodology.
- TeamSTEPPS 3.0 communication principles.
- I-PASS resident handoff tool.

Of note, common barriers to reporting include an unclear definition of COC, insufficient staff training and lack of standardized reporting formats, among other sources.

## Responding to Changes

Following detection and reporting of a COC, staff members should respond to the situation in a swift and methodical manner, as depicted in the diagram, to the right:




The treatment team should collectively determine whether or not to manage the COC within the facility in light of resident needs, overall prognosis and advance directives, as well as organizational resources. If the situation is handled onsite, resident care or service plans should be updated with respect to specific measurable objectives and overall treatment goals.

## Documenting Changes

Accurate and timely documentation is a critical aspect of COC management for both clinical and legal reasons. The following items, minimally, should be included in the resident healthcare information record:

- **Detailed observations** of the resident's condition.
- **All nursing assessments and evaluations,** including the staff member's name, as well as the date and time of assessment.
- **Pertinent vital signs** and other diagnostic data.
- **Any calls made to a provider,** including name, date and time, as well as orders received and actions taken.
- **Notification of relatives,** including information conveyed, date and time of call, and name of the person(s) spoken to.

For a list of safeguards designed to mitigate exposure to COC-related liabilities, see page 4.

One of the major responsibilities of aging services organizations is to promptly observe resident changes in condition and take necessary steps to prevent or mitigate further deterioration. The risk control suggestions provided in this resource can help ensure that staff members remain vigilant for signs of acute downturns in residents' mental or physical well-being, and respond to such changes in a timely, consistent and well-documented manner.

## Lessening Liability Exposures

| | |
|---|---|
| **Adopt a formal COC protocol** | **Clearly define COC in writing** and emphasize the need to notify fellow team members of significant clinical changes, using the EHR and other approved reporting methods and formats. Avoid placing time limits on changes – e.g., "any change of less than 14 days duration does not constitute a change of condition" – as such arbitrary parameters may lead to under-reporting. |
| **Reinforce notification duties** | **Train staff to promptly notify nursing supervisors, medical providers, leadership and family members** of any notable change in a resident's baseline condition, and include COC-related prompts in standard shift handoff formats and resident rounding activities. |
| **Establish assessment intervals** | **Institute set resident reassessment intervals** to help enhance quality of care and avoid allegations of inconsistent and/or haphazard practices. |
| **Update care plan formats** | **Check electronic-based care plan formats to ensure they accommodate COC-related updates,** in order to preclude the risks and inefficiencies associated with paper-based modifications, such as failure to ensure that hard-copy care plans align with the resident's EHR. |
| **Take measures to reduce falls** | **Implement a systematic fall-reduction program,** alerting staff to higher-risk residents and emphasizing early and frequent assessments, medication management and environmental safety measures. Communicate any risk of falling to residents and their family members, reinforcing safety precautions. |
| **Manage medication profiles** | **Train staff on proper drug administration procedures,** medication review activities and error response protocols, including cross-checking procedures, in order to prevent resident deterioration due to polypharmacy or medication error. Provide this training upon hire and annually thereafter, documenting educational sessions in personnel files. |
| **Monitor nutritional status** | **Regularly assess residents' nutritional status** and adjust diet, if needed, to avoid deficits that can trigger a COC. Care plans should reflect any change in nutritional support needs, including feeding assistance, a dietary intake plan, food/fluid intake measurements, use of supplements and dietitian consultations. |
| **Maintain safe staffing levels** | **Periodically examine staffing numbers,** review personnel practices and take measures to ensure that staffing numbers and skill sets support sound COC detection and reporting practices. |

This table serves as a reference for aging services organizations seeking to evaluate risk exposures associated with change of condition in residents. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your organization and risks may be different from those addressed herein, and you may wish to modify the activities and questions noted herein to suit your individual organizational practice and patient needs. The information contained herein is not intended to establish any standard of care, or address the circumstances of any specific healthcare organization. It is not intended to serve as legal advice appropriate for any particular factual situations, or to provide an acknowledgement that any given factual situation is covered under any CNA insurance policy. The material presented is not intended to constitute a binding contract. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

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