**Title**: Change in Resident Condition/Physician Notification

**Audience**: All Nursing Staff

**Lesson Plan Objectives**:

1. Define change in resident condition.
2. Identify events that constitute a change in resident condition.
3. Determine action(s) to take when there is a change in resident condition.
4. Review circumstances in which an assessment must be completed by an RN.

**Lesson Content**:

1. A change in resident condition is defined as any deviation from the resident’s clinical baseline status/norm.
2. Examples of change in condition include any change in baseline vital signs, new or increased/worsening confusion (altered mental status), new or worsening pain, nausea and vomiting, any injury.
3. When there is a change in resident condition, a licensed nurse must:
	* conduct a thorough assessment/evaluation of the resident
	* inform the primary care physician (or medical director is PCP cannot be reached) of the change (have pertinent information ready)
	* inform the resident and/or healthcare representative of the situation and the doctor’s orders for management/treatment, including transfer to an acute care setting if applicable.
	* input the new orders in the EMR and update the CCP and CNAAR where applicable.
	* place on 24-hr report
	* communicate changes to unit staff, including at the change of shift report.
	* inform the RN Supervisor
4. The following situation require an assessment by a registered nurse:
	* Injuries of unknown origin
	* Ineffective pain management
	* Medication errors, including overdose
	* Need for hospital transfers, including emergency transfers
	* Significant change in vital signs
	* Circulatory changes, including the absence of pulses
	* Changes in respiratory status, including congestion or dyspnea
	* Nausea and vomiting
	* Chest Pain
	* Identification of new or worsening pressure ulcers/wounds
	* Incident /Accidents
	* Altered mental status
	* Critical lab values
	* Abnormal x-ray/diagnostic test results