**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