



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

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GOVERNOR

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MEMORANDUM

DATE: June 29, 2004

TO: Long Term Care Facilities

FROM: MDCH/Clinical Advisory Panel
Quality Improvement Nurse Consultants

SUBJECT: *Process Guideline for Acute Change Of Condition*

Best clinical practice is only worthwhile to the extent that we use it to guide care for our residents.

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. (AMDA, Acute Change of Condition. 2003). Collaboratively, our current focus area seeks to enable staff to evaluate and manage residents at the facility and avoid transfer to a hospital or emergency room (ER); by recognizing an ACOC and identifying its nature, severity, and causes. The purpose of the following instructions is to clarify how to apply the Documentation Checklist: *Process Guideline for Acute Change Of Condition*. Attached is a copy of the Process Guideline. It is also available on the Quality Improvement Nurse Consultant website: www.michigan.gov/qinc. This **optional** "best practice" tool for the management of acute change of condition was presented to you at the Fall 2004 Joint Provider/Surveyor Training on September 2, 2004. The effective date for usage of the tool is October 4, 2004.

Both facilities and surveyors will have the opportunity to use the Documentation Checklist when the management of an acute change in a resident's condition is of concern. Facilities will be accorded the opportunity to demonstrate that they have followed the steps in this guideline, as evidence to support an appropriate care process related to acute change of condition management.

A workgroup including doctors, nurses, and aides with experience in geriatrics, nursing home care, and infectious disease discussed in depth the topic of acute change of condition in the long-term care population. They used available references about geriatric acute change of condition to help them prepare the process guidelines. The documentation checklist contains a series of steps related to managing acute change of condition issues in nursing home residents.

Best clinical practice information helps each facility provide the best possible care throughout the year. Along with information in the federal OBRA regulations, our surveyors will use these process guidelines to review how your facility is managing acute change of condition concerns

**Documentation Checklist: Process Guideline
Acute Change Of Condition Cover Sheet**

Resident:_____

Date:_____

If a concern related to an acute change of condition is triggered during the survey process, the facility will be given the opportunity to demonstrate that it has followed the steps in this checklist, as evidence to support an appropriate care process related to acute change of condition. Evidence of appropriate care process will be considered in determining whether an adverse event (a negative outcome), or the potential for an adverse event, related to the management of an acute change of condition can be attributed to a deficient facility practice. If attributable to a preventable (avoidable) deficient facility practice, this checklist may also be used in analyzing the severity of the deficiency, if a citation should result.

F-tags, which could be associated with acute change of condition concerns, are provided for each of the Tables. Other tags may also be appropriate.

**Documentation Checklist: Process Guideline for Acute Change of Condition
June 29, 2004**

ACUTE CHANGE OF CONDITION: Assessment/Problem Recognition			
May relate to F-tag: 272 (Assessment), 309 (Quality of Care)	Yes	No	NA
1. Did the facility identify significant risks for an ACOC?			
2. Did the facility describe and document symptoms and/or conditions changes?			
3. Did the facility clarify the nature of the problem?			
ACUTE CHANGE OF CONDITION: Diagnosis/Cause Identification			
May relate to F-tag: 272 (Assessment, 385 (Physician services), 386 (Physician review of total plan of care)	Yes	No	NA
4. Did the facility staff and practitioner seek causes of the symptoms or condition change, or can they justify sending the individual out of the facility to evaluate possible causes?			
5. If a plausible cause was not found readily in someone with an ACOC, were delirium, fluid and electrolyte imbalance, infection, and medication-related effects considered?			
ACUTE CHANGE OF CONDITION: Treatment/Problem Management			
May relate to F-tag: 279/280 (Comprehensive Care Plans), 309 (Quality of Care), 386 (Physician review of total plan of care)	Yes	No	NA
6. Did the facility address the ACOC or identify why it was not appropriate to do so, and review as part of its QA process why it was necessary to send an individual elsewhere to address an ACOC?			
7. Was appropriate supportive and cause-specific treatment given OR was there an explanation why it was not feasible or not provided?			
ACUTE CHANGE OF CONDITION: Monitoring			
May relate to F-tag: 272 (Assessment), 309 (Quality of Care)	Yes	No	NA
8. Were the individual's ACOC and related causes monitored and treatment adjusted accordingly?			
9. Does the facility monitor its unplanned hospital transfers as part of its QA program and seek to improve on related processes?			

Signature of Person(s) completing the form:

Signature Date

Signature Date

ACUTE CHANGE OF CONDITION

CARE PROCESS STEP	EXPECTATIONS	RATIONALE
<p align="center">ASSESSMENT/PROBLEM RECOGNITION</p>		
<p>1. Did the facility identify significant risks for an ACOC?</p>	<ul style="list-style-type: none"> - The facility should have a method to guide staff and practitioners to identify major risk factors in common situations. - The staff and practitioner should seek and document major factors that predispose an individual to having an ACOC; for example, a recent serious medical illness, a recent hospitalization (especially one with complications), or taking a high-risk medication. [See AMDA ACOC CPG Table 3] - The staff and practitioner should define a baseline condition for each new admission. 	<ul style="list-style-type: none"> - Risk factors for subsequent acute illness or condition change have been clearly identified, and are common in the nursing home population; many – although not all — acute changes in condition can be anticipated. for example, pneumonia, deep vein thrombosis, delirium, angina pectoris, pulmonary edema, urinary tract infection, atrial fibrillation, etc. [Reference: Bernardini B, Meinecke C, Zaccarini C et al. Adverse clinical events in dependent long-term nursing home residents. J Am Geriatr Soc 1993;41:105-111]. - Identifying risk factors is a key step in trying to prevent them from becoming full-fledged illnesses and being able to recognize and respond to complications when they occur. - Hospitalized patients are often discharged without a clear plan or instructions to receiving facilities for appropriate follow-up. - Documenting risk factors helps alert other care providers to the risks and any plans to intervene.
<p>2. Did the facility describe and document symptoms and/or condition changes?</p>	<ul style="list-style-type: none"> - The staff should describe symptoms accurately and in detail. - Facility staff should communicate adequate information to the practitioner in a timely fashion. - The practitioner should help clarify the nature (location, intensity, characteristics, etc.) of any symptoms. - The facility should have a system, including sufficient guidance to nursing staff and expectations of practitioner response, to facilitate adequate communication of, and response to, this information. 	<ul style="list-style-type: none"> - Adequate diagnosis and management requires more than a superficial listing of symptoms such as “pain” or “agitation.” - Erroneous or premature interpretation of symptoms can lead to inappropriate treatment or the lack of pertinent interventions. - Practitioners need details to try to identify causes of symptoms. - Physicians are trained to understand the meaning of symptoms and to know how to clarify them. - Symptomatic treatment based on inadequate assessment may constitute little more than “guesswork.”
<p>3. Did the facility clarify the nature of the problem?</p>	<ul style="list-style-type: none"> - The staff and/or practitioner should formulate a relevant problem statement and identify the urgency of the situation. 	<ul style="list-style-type: none"> - Not all symptoms are problematic or require a medical intervention. - Not all symptoms or condition changes require the same degree of urgency.

DIAGNOSIS/CAUSE IDENTIFICATION		
<p>4. Did the facility staff and practitioner seek causes of the symptoms or condition change, or can they justify sending the individual out of the facility to evaluate possible causes?</p>	<ul style="list-style-type: none"> - The facility should have some written guidance for staff and practitioners for identifying causes of common symptoms and condition changes in the population. - The facility should clearly indicate the kinds and levels of diagnostic testing support (labs, X-Rays, etc.) that it can provide. - There should be evidence that the physician and staff have sought possible causes. 	<ul style="list-style-type: none"> - Many diverse symptoms in the nursing home population have a relatively few common, recurrent causes. - An adequately detailed history and assessment can often provide helpful information about the most likely causes of an ACOC. - In many cases, a sufficient conversation between staff and the practitioner can identify likely causes of an ACOC in a specific case.
<p>5. If a plausible cause was not found readily in someone with an ACOC, were delirium, fluid and electrolyte imbalance, infection, and medication-related effects considered?</p>	<ul style="list-style-type: none"> - Each case where a cause was not readily identified should be reviewed for evidence of a possible underlying medical problem. - Staff and the physician should review the current medication regimen for medications that may cause significant symptoms and condition changes. <p>[See CAM Tables 20 & 21] [AMDA AMS CPG]</p>	<ul style="list-style-type: none"> - Delirium is an acute change in mental status and level of consciousness due to medical causes; it is common and requires prompt assessment and intervention because it may be associated with significant complications, including an increased risk of death. - Many categories and combinations of medications can cause ACOCs or symptoms that are indistinguishable from those related to acute medical illnesses.
TREATMENT/PROBLEM MANAGEMENT		
<p>6. Did the facility address the ACOC or identify why it was not appropriate to do so, and review as part of its QA process why it was necessary to send an individual elsewhere to address an ACOC?</p>	<ul style="list-style-type: none"> - The facility should have general guidelines for its staff and practitioners about deciding on transferring patients elsewhere to treat an ACOC. - The staff and practitioner should take into account a resident / patient's wishes (such as those in an advance directive) and the reflection of those wishes by family or another substitute decision maker. - There should be clear justification for a hospital transfer that is not consistent with a patient's wishes. <p>[AMDA ACOC CPG Table 18]</p>	<ul style="list-style-type: none"> - For example, guidance might include how often can the staff monitor vital signs and document patient condition, whether the staff can start IVs, and whether appropriate supplies are available. - Treatment goals should be relevant to the individual's condition, prognosis, wishes, causes, etc. - A resident/substitute decision maker has the right to consent to, as well as to refuse, treatment. Informed consent requires education about the benefits and risks associated with the treatment, and consequently, the risks and consequences of not providing said treatment. - There is not an obligation to treat all medical conditions or to transfer ill patients to the hospital if circumstances don't warrant it. - The choice to be a "full code" does not necessarily warrant hospital transfer to manage an acute illness. - In the event that the resident or family declines relevant alternatives offered by the facility to manage a resident's ACOC effectively, the facility may be challenged or unable to meet resident or family expectations for improvement, cure, or stabilization.

<p>7. Was appropriate supportive and cause-specific treatment given OR was there an explanation why it was not feasible or not provided?</p>	<p>- The staff and practitioner should provide care related to identified or suspected causes of the ACOC, or they should indicate why they could not or should not have done so for that resident (for example, known cause not treatable, previous adverse reaction to a medication, terminal condition, etc.).</p>	<p>- It is often possible to target treatments to specific causes, based on evidence of what is more or less likely to work. - Even when causes are unclear, a systematic approach may help the Interdisciplinary Team provide more rational care.</p>
<p>MONITORING</p>		
<p>8. Were the individual's ACOC and related causes monitored and treatment adjusted accordingly?</p>	<p>- In conjunction with the physician, staff should monitor the progress of an individual with an ACOC, at least once during every shift while the individual is unstable or significantly symptomatic, and should document relevant findings in the patient's record. - Staff should document a review of the overall progress of each patient with an ACOC at least daily until the patient is stable and mostly asymptomatic. - If an ACOC worsens during the subsequent 48 hours (or other appropriate time frame established by the care team) after initiating treatment, or is not resolving within a week (or other appropriate time frame established by the care team), then staff should review current interventions with the physician and discuss whether/how to modify the interventions. The discussion and resultant decisions should be documented. - AMDA ACOC CPG, Table 17</p>	<p>- A systematic approach and descriptive documentation helps the staff identify more clearly the outcomes of treatment, measure the results more objectively, and determine if modifications are necessary or appropriate. - Underlying causes of ACOCs may resolve, or the individual's condition may change over time. Periodic monitoring is part of a systematic approach to care. - A response to treatment other than what is anticipated requires re-evaluation of approaches. - The physician may need to see a patient with a more complicated ACOC or who is not improving as anticipated. - The problem or condition for which treatment was started may improve or resolve to the point where treatment can be adjusted or stopped.</p>
<p>9. Does the facility monitor its unplanned hospital transfers as part of its QA program, and seek to improve on related processes?</p>	<p>- The facility administrator, staff, Director of Nursing, and medical director should review the systems and processes related to managing ACOCs and unplanned ER transfers and hospital admissions, seek areas for improvement, and give staff and practitioners appropriate feedback. - AMDA ACOC CPG, Table 18</p>	<p>- There are many reasons for unplanned hospital transfers, some of which can be traced to inadequate or problematic systems and processes, which can often be improved. - Hospitalization presents many risks to the frail older or chronically ill patient and should be used judiciously to address ACOCs. - Some acute hospitalizations may be preventable.</p>

Table 1.

Factors Associated with Hospital Admissions from Long-Term Care Facilities

Reasons Related Primarily to Patient's Current Condition or Status

- Availability of in-house diagnostic and support services (e.g., radiology, laboratory, pharmacy)
- Level of care to which patient is assigned on admission to long-term care facility
- Patient's level of dependency in performing activities of daily living
- Patient's underlying medical complexity or comorbidity
- Premature discharge from acute-care facility to long-term care facility
- Presence or absence of advance care planning instructions about management of acute medical illness (e.g., a "Do Not Hospitalize" order)

Reasons Less Directly Related to Patient's Current Condition or Status

- Inability of staff at long-term care facility to obtain medical supervision of ACOC
- Inadequate practitioner nurse communication
- Inadequate reimbursement for provision of acute care in the long-term care facility
- Pressure from family, nursing staff, or physician to hospitalize the patient
- Time of day or week when ACOC occurs

TABLE 3
Pre-Existing Conditions That May Predispose Patients to ACOCs

Cardiopulmonary

- Congestive heart failure - Hypertension

Functional

- Acute impairment of one or more ADLs
- Impaired mobility
- Recurrent falls during past 3 months
- Prolonged bed rest
- Urinary retention

Metabolic

- Diabetes mellitus
- Malnutrition
- Weight loss

Musculoskeletal

- Muscle weakness secondary to old stroke
- Osteoporosis

Neuropsychiatric

- Confusion
- Depression
- Dizziness, impaired balance
- Mild/moderate dementia

Sensory

- Vision/hearing impairment

Systemic/General

- Postoperative status
- Pain
- Pressure ulcers
- Use of multiple medications

Other

- Cancer
- Cerebrovascular disease
- Endocrine disease
- Gastrointestinal disease
- Infectious disease

Table 10.
Categories of Symptoms That May Help to Define ACOCs

Physical Symptoms

Vital Signs

-- **Respiration**

Observe the patient for the following signs and symptoms:

- Respiratory rates > 28 breaths/min (normal in younger adults is 12-15 breaths/min; in the elderly, 16-25 breaths/min, with approximate 2:1 inspiration/expiration ratio)
- Marked change from usual respiration pattern or rhythm
- Irregular breathing, long pauses between breaths, audible noises related to breathing
- Struggling to breathe (e.g., gasping for breath, using accessory muscles of the neck)

-- **Temperature**

- A range of 98.2°F (36.8°C) to 99.9°F (37.7°C) oral temperature is considered normal. A patient's normal temperature will vary by up to 0.9°F (0.5°C) daily. As quickly as possible after admission, try to establish the patient's normal temperature range.
- A sudden or rapid change from normal temperature may suggest an ACOC. One temperature reading above 100°F, two readings above 99°F, or an increase of 2°F above the upper end of the patient's normal range may indicate an ACOC.
- After an isolated temperature reading that is outside the patient's normal range, repeat temperature readings approximately every 4 hours up to 24 hours and seek other signs and symptoms to determine whether an ACOC exists.
- Hypothermia may also indicate a possible ACOC.
- An electric thermometer is the preferred method for taking temperature.
- Assess the patient for factors that may affect temperature, such as medications.

-- **Blood Pressure**

- As soon as possible after admission, establish the patient's usual blood pressure (BP) range. (Normal range is approximately systolic 100-140 mmHg, diastolic 60-90 mmHg.)
- A change in BP is more often a symptom than a cause of an ACOC. Isolated BP elevations generally are not significant. Sustained elevations in systolic pressure should trigger further assessment. A BP change alone should not trigger a call to the practitioner without additional signs or symptoms (e.g., sustained elevation, new neurological symptoms).
- A decrease in systolic BP \geq 120 mmHg when moving from a prone to a seated position or from a standing position signals orthostatic hypotension.
- Any significant decrease in BP may signal an ACOC (e.g., systolic BP < 100 mmHg if baseline is 110 mmHg, decline in BP accompanied by other symptoms such as dizziness, decline \geq 15 mm in systolic BP, combination of pulse > 100 beats per minute [BPM] and/or systolic BP < 100 mmHg).

-- **Pulse**

Normal pulse ranges from approximately 60-100 BPM, but this can vary by about 10%. The following clinical presentations may indicate an ACOC and should be assessed further:

- Sustained change from normal range

Table 10 continued (Page 2 of 3)

- Change in usual pulse rhythm or regularity
- Pulse > 120 BPM or < 50BPM
- Pulse > 100 BPM combined with other symptoms (e.g., palpitations, dyspnea, or dizziness)

-- ***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 (for more information about pain scales, please refer to AMDA's clinical practice guideline Pain Management in the Long-Term Care Setting)

-- ***Weight/Eating Patterns***

- An abrupt change in appetite may indicate an ACOC before a significant change in weight occurs.
- Rate of weight gain or 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.
- In documentation of intake, identify both solid and liquid intake in as much detail as possible.
- Evaluate signs and symptoms that may suggest fluid imbalance (e.g., edema or change in edema).
 - Acute, rapid weight gain may indicate an ACOC that is accompanied by fluid accumulations (e.g., acute CHF).
 - Acute, rapid weight loss over several days should trigger concern about a hydration emergency.
(For more information about fluid imbalance, please refer to AMDA's 2001 clinical practice guideline Dehydration and Fluid Maintenance.)

-- ***Level of Consciousness***

- Level of consciousness (LOC) should be distinguished from aspects of cognition such as orientation and memory.
- Levels of consciousness 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 (e.g., from alert to lethargic, or from lethargic to stuporous)
 - Hypersomnolence (more sleepy than usual or sleepy for most of the day)

-- ***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.

Table 10 continued (Page 3 of 3)

-- **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

-- 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

-- 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

-- 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

-- **Functional Symptoms**

- **Sudden or persistent** decline in function (i.e., ability to perform ADLs)

Table 13.
Examples of Condition Changes to Report to a Practitioner

>greater than, < less than

Condition	Report Immediately	Report on Next Office Day
Acute change in mental status	Sudden onset	Gradual onset
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	-- Controlled, no further episodes -- Bleeding from hemorrhoids
Chest pain	-- New onset or recurrent, not relieved in 20 minutes by previously ordered nitroglycerin x 3 -- Accompanied by change in vital signs, diaphoresis, nausea, vomiting, shortness of breath	-- Increase in frequency of episodes in a resident with a known history of chest pain
Combative/aggressive behavior	-- Unresolved by environmental interventions -- New onset associated with change in medication or medical status	-- Increase in frequency of episodes of mildly aggressive behavior
Constipation	-- Severe abdominal pain, rigid abdomen -- Absence of bowel sounds	-- Unresolved symptoms -- <u>>2</u> episodes within 30 days
Decreased oral intake of fluids (dehydration risk)	-- Drinking <50% of usual fluid intake in previous 24 hours -- >1 episode of vomiting within 24 hours	-- Persistent symptoms for more than 24 hours in spite of interventions
Depressed mood/reactive depression	-- Realistic expression of suicidal intent (e.g., a specific plan that could be carried out)	-- Persistent sadness -- Expression of suicidal thoughts without a specific plan or prior history of suicide attempts
Diarrhea	-- Acute onset of multiple stools with change in vital signs (e.g., temperature >101°F) and/or altered mental status, etc. -- Accompanied by positive fecal occult blood test	-- Persistent loose stools for >48 hours while diarrhea is being treated symptomatically -- Chronic loose stools -- Recurrence of diarrhea after return to usual diet
Edema	-- Sudden onset in resident with lung, heart, or kidney disease -- Accompanied by sudden onset of shortness of breath and/or chest pain -- Sudden onset in one leg -- Loss of sensation in swollen leg -- Sudden onset with tenderness and redness	-- Known history of edema with progressive unilateral or bilateral increase in severity -- Gradually progressive edema accompanied by weight gain -- Skin changes associated with edema
Emesis	-- Bloody or coffee ground vomit -- >1 episode within 24 hours -- Accompanied by abdominal pain and changes in vital signs	-- Single episode
Eye discomfort	-- Severe persistent eye pain -- Sudden vision change -- Resident complains of seeing halos	-- Persistent symptoms unrelieved by measures in protocol

Table 14.
Framework for Reporting Changes in Vital Signs or Laboratory Values to a Practitioner

>greater than, <less than

Acute Sign/Laboratory Test	Report Immediately	Report on Next Office Day
Vital Signs	<ul style="list-style-type: none"> • Systolic BP >210 mmHg, <90 mmHg • Diastolic BP >115 mmHg • Resting pulse >130 bpm, <55* bpm, or >110 bpm and patient has dyspnea or palpitations • Respirations >28, <10*/minute • Oral (electronic thermometer) temperature >101°F 	Diastolic BP routinely > 90 mmHg <ul style="list-style-type: none"> • Resting pulse > 120 bpm on repeat exam
Weight loss		<ul style="list-style-type: none"> • New onset of anorexia with or without weight loss • 5% or more within 30 days • 10% or more within 6 months
Complete blood count	<ul style="list-style-type: none"> • WBC >12,000* • Hemoglobin (Hb) <8* • Hematocrit < 24* • Platelets < 50,000* 	WBC > 10,000 without symptoms or fever
Chemistry	<ul style="list-style-type: none"> • Blood/urea/nitrogen (BUN) >60 mg/dL* • Calcium (Ca) >12.5 mg/dL • Potassium (K) <3.0, >6.0 mg/dL • Sodium (Na) <125, >155 mg/dL • Blood glucose <ul style="list-style-type: none"> ○ >300 mg/dL in diabetic patient not using sliding-scale insulin ○ >430 mg/dL (or machine registers high) in diabetic patient using sliding-scale insulin ○ <70 mg/dL in diabetic patient ○ <50 mg/dL in nondiabetic patient 	<ul style="list-style-type: none"> • Glucose consistently >200 mg/dL • Hb A1c (any value) • Albumin (any value) • Bilirubin (any value) • Cholesterol (any value) • Triglycerides (any value) • Other chemistry values
Drug levels	<ul style="list-style-type: none"> • Levels <i>above</i> therapeutic range of <i>any</i> drug (hold next dose) 	<ul style="list-style-type: none"> • Any therapeutic or low level, unless resident shows evidence of possible adverse drug reaction despite therapeutic or low result
Prothrombin time (PT) International normalized ratio (INR)	<ul style="list-style-type: none"> • INR >6 IUs (hold warfarin) • PT (in seconds) 3x control (hold warfarin) 	<ul style="list-style-type: none"> • INR 3-6 IUs (hold warfarin) • PT (in seconds) 2x control (hold warfarin)
Urinalysis	<ul style="list-style-type: none"> • Abnormal result in patient with signs and symptoms possibly related to urinary tract infection or urosepsis (e.g., fever, burning sensation, pain, altered mental status) 	<ul style="list-style-type: none"> • Abnormal result in patient with no signs or symptoms
Urine culture	<ul style="list-style-type: none"> • >100,000 colony count with symptoms 	<ul style="list-style-type: none"> • Any colony count, no symptoms
X-ray	<ul style="list-style-type: none"> • New or unsuspected finding (e.g., fracture, pneumonia, CHF) 	<ul style="list-style-type: none"> • Old or long-standing finding, no change

*Unless values are consistently at this level and practitioner is aware of this.

Adapted from Texas Nurses Association. Used with permission.

Table 17.

Examples of Staff Roles and Responsibilities in Monitoring Patients With ACOCs

Nursing assistant

- Recognize and report condition changes
- Make frequent observations of the patient's condition and symptoms
- Review patient status with nursing assistants from the next shift before leaving for the day
- Communicate findings to a nurse and request nursing follow-up
- Advise a charge nurse or unit manager if nursing follow-up has not occurred

Staff nurse

- Recognize condition change early
- Assess the patient's symptoms and physical function and document detailed descriptions of observations and symptoms
- Update the charge nurse or supervisor if patient's condition deteriorates or patient fails to improve within expected time frame
- Report patient's status to the practitioner as appropriate

Charge nurse

- Ensure consistent, timely evaluation, documentation, and reporting of relevant information about the patient
- Ensure effective communication of necessary information to other members of the interdisciplinary team, including relevant clinicians, CNAs, patient, health care surrogates, ancillary staff, therapists, and others responsible for the patient's care

Covering/attending practitioner

- If notified by telephone, listen to initial concern and ask sufficient questions to arrive at a tentative diagnosis and begin workup and/or appropriate treatment
- Ensure that all diagnostic and therapeutic interventions are consistent with patient's advance directives
- Visit patient when direct patient assessment or review of pertinent intervention is needed to manage the situation
- Remain in contact by telephone as necessary until patient's condition stabilizes
- Communicate with other relevant practitioners (e.g., covering physicians, nurse practitioners, consultants) involved in patient's care about interventions, care plan adjustments, etc.
- Follow-up with nursing staff about the progress of patients with ACOCs. Do not assume that "no news is good news."
- Communicate information to appropriate family member or other responsible party; for example, to discuss change in advance directives or patient's failure to improve as expected

Table 18.
Analysis of Unplanned Hospital Transfers

Category Aspect of Care	Avoidable	Possibly Avoidable	Unavoidable
Recognition	<ul style="list-style-type: none"> Examination and review by a nurse and/or practitioner was inadequate. Patient had a condition or problem that was known or could have been anticipated. Patient's condition was not significantly unstable (i.e., beyond the identified capacity of the facility to monitor and manage). Attending or covering practitioner was not notified of condition change in a timely fashion. Monitoring equipment was unavailable or malfunctioning. 	<ul style="list-style-type: none"> Nursing or practitioner assessment was suboptimal. Staffing issues hindered ability to adequately monitor a somewhat unstable patient. Patient's condition was mildly unstable. 	<ul style="list-style-type: none"> Patient's condition was too complex or unstable to be adequately managed in the facility.
Assessment	<ul style="list-style-type: none"> Problem was characterized incorrectly or inadequately (e.g., patient described as unresponsive was little different than usual; nature, intensity and other specific features of chest pain were not defined). Diagnostics were available in a timely fashion but were not used. Diagnostics should have been available when needed, but were not. Patient's condition change reflected a known or readily identifiable problem that should have been diagnosed at the time it occurred. 	<ul style="list-style-type: none"> Some diagnostics were available but their use was delayed. Cause could not be immediately identified, but the patient's condition was sufficiently stable that more time could have been taken to perform the evaluation at the facility. It is unclear whether the patient's condition change was related to a problem that was known or could have been anticipated. 	<ul style="list-style-type: none"> It was not feasible for the facility to obtain relevant diagnostics. Symptoms were too obscure to be readily diagnosed or related to a known or potentially identifiable cause.
Treatment	<ul style="list-style-type: none"> A condition change had been identified but was not addressed in a timely fashion. Aggressive medical treatment was not indicated for the patient. An available treatment was not used. Caregiving staff did not recognize that the patient's condition, although not fully resolved, was stable or improving. 	<ul style="list-style-type: none"> Patient was not responding rapidly to treatment, but treatment had only been initiated within the previous 24 hours. Patient was sent to the ER or the hospital but sent back to the facility within 48 hours. 	<ul style="list-style-type: none"> Treatment was too complex to be managed internally. Patient's condition was worsening despite several days of treatment in the facility.
Ethical issues	<ul style="list-style-type: none"> Patient's condition and prognosis were not discussed adequately or in a timely fashion. Practitioner did not discuss with patient or family in a timely fashion whether hospitalization was a potentially beneficial treatment option. 	<ul style="list-style-type: none"> There had been insufficient time, or the family had not been readily available, to discuss ethical issues. 	<ul style="list-style-type: none"> Hospitalization had been selected as a desired option in the event of a condition that was too severe or unstable to be readily managed within the facility.

Table 18 continued

Ethical issues continued	<ul style="list-style-type: none"> • Advance directives or other care instructions that indicated the patient should not be transferred to the hospital were unavailable or overlooked. • Treatment in the hospital was similar to the treatment the patient could have received at the facility. 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
Family issues	<ul style="list-style-type: none"> • Family was not adequately informed of the patient's condition or prognosis or of the facility's capacity to manage certain condition changes without a hospital transfer. 	<ul style="list-style-type: none"> • Family demanded hospital transfer despite efforts to explain why it was not necessary. 	<ul style="list-style-type: none"> • Conflict among relevant substitute decision makers about scope and aggressiveness of medical treatment could not readily be resolved.
Practitioner issues	<ul style="list-style-type: none"> • An attending or covering practitioner failed to respond in a timely fashion to notification of a condition change. • Upon responding, the practitioner insisted on transfer before discussing the case adequately with a nurse. • Wrong practitioner was notified of the condition change. • Attending practitioner could not be reached or had insufficient backup coverage to respond. 	<ul style="list-style-type: none"> • Practitioner was adequately informed about the patient's condition but remained unsure of the seriousness or cause(s) of the situation and therefore was unable to readily initiate empirical treatment. 	<ul style="list-style-type: none"> • Practitioner identified significant medical concerns about the patient that were beyond the scope of the facility's capabilities or required a higher level of monitoring or more complex treatment that the facility could readily provide.
Miscellaneous Facility Issues	<ul style="list-style-type: none"> • Relevant policy or procedure was unavailable or available but not used. • A procedure was not followed correctly. • Appropriate supervisory staff were not consulted as they should have been. • Pertinent documentation (e.g., previous hospital discharge information, diagnoses, family consents) was not on the patient's chart, not available, or not reviewed. • Facility has not adequately identified the degree to which it can monitor and manage medically unstable patients. 	<ul style="list-style-type: none"> • Relevant policy or procedure did not adequately cover the situation. • Appropriate supervisory staff were consulted but were not sure what to do. • Some necessary care might have exceeded the scope of the facility's capabilities, staffing, equipment, and supplies. 	<ul style="list-style-type: none"> • Required care would have exceeded the scope of the facility's capabilities, staffing, equipment and supplies.

TABLE 21 -- CONFUSION ASSESSMENT METHOD (CAM)

The Confusion Assessment Method Instrument:

1. **[Acute Onset]** Is there evidence of an acute change in mental status from the patient's baseline?
- 2A. **[Inattention]** Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keep track of what was being said?
- 2B. **[If present or abnormal]** Did this behavior fluctuate during the interview, that is, tend to come and go or increase and decrease in severity?
3. **[Disorganized thinking]** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. **[Altered level of consciousness]** Overall, how would you rate this patient's level of consciousness? (Alert [normal]; Vigilant [hyperalert, overly sensitive to environmental stimuli, startled very easily]; Lethargic [drowsy, easily aroused]; Stupor [difficult to arouse]; Coma [unarousable]; Uncertain)
5. **[Disorientation]** Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital or difficulty remembering instructions?
6. **[Memory impairment]** Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
7. **[Perceptual disturbances]** Did the patient have any evidence of perceptual disturbances, for example, hallucinations, illusions or misinterpretations (such as thinking something was moving when it was not)?
- 8A. **[Psychomotor agitation]** At any time during the interview did the patient have an unusually increased level of motor activity such as restlessness, picking at bedclothes, tapping fingers or making frequent sudden changes of position?
- 8B. **[Psychomotor retardation]** At any time during the interview did the patient have an unusually decreased level of motor activity such as sluggishness, staring into space, staying in one position for a long time or moving very slowly?
9. **[Altered sleep-wake cycle]** Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?

The Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset and Fluctuating Course

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

Feature 2: Inattention

This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

Feature 3: Disorganized thinking

This feature is shown by positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered level of consciousness

This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4.

CAM Instrument and Algorithm adapted from Inouye, S., van Dyck, D., Alessi, C., Balkin, S., A & Horwitz, R. (1990). Clarifying confusion: the confusion assessment method. *Annals of Internal Medicine*, 113 (12), 941-948. Reprinted with permission.