Nursing Documentation for the Six Qualifying Conditions

RN/LPN Training Slides

NY-RAH Goals

The goal of the **N**ew **Y**ork–**R**educing **A**voidable **H**ospitalizations (NY–RAH) project is to reduce the number of potentially avoidable transfers and hospitalizations

Efficient and effective communication is the cornerstone of the care delivery process

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Objectives

Early identification and recognition of signs and symptoms of any of the six qualifying conditions in nursing facility residents

Documenting complete, consistent, and accurate information in the residents' charts

Reporting findings appropriately via the Stop and Watch, SBAR, **AND** verbal communication

Improve the quality of communication between the staff while improving clinical outcomes for residents

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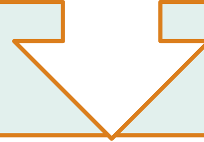
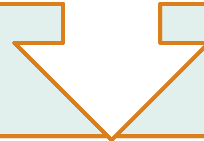
Evidence Best Practices

The development and implementation of evidence-based clinical practice guidelines is an effective tool for improving the quality of care



Consistency of information content and sequence enables the giver and receiver to know what to expect and execute the **BEST** next steps



Information presented will assist to enhance your **practice**

Documentation Leads to Better Communication

Standardizing the communication between nurses and physicians helps to ensure accuracy and effectiveness in the information to meet patients' needs (SBAR)

Consistency of information content and sequence enables the giver and receiver to know what to expect

The practitioner will use your information as the basis for his/her identification of the likely cause of an ACOC, interventions, and whether the ACOC can be managed in the facility or not

24 hour report is **not** part of the resident's medical record, and vital signs need to be documented separately

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Stop and Watch

What is Stop and Watch?

- An early warning documentation tool

What is it for?

- To document and communicate changes in a resident's condition to the nurses

Why is it important?

- Routine monitoring high risk residents

Who can complete it?

- Can be completed by CNAs, all nursing home staff, and family members

Stop and Watch
Early Warning Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S Seems different than usual
T Talks or communicates less
O Overall needs more help
P Pain – new or worsening; Participated less in activities

a Ate less
n No bowel movement in 3 days; or diarrhea
d Drank less

W Weight change
A Agitated or nervous more than usual
T Tired, weak, confused, or drowsy
C Change in skin color or condition
H Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

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SBAR

What is SBAR?

- **S**ituation (a concise statement of the problem)
- **B**ackground (pertinent and brief information related to the situation)
- **A**ssessment (analysis and considerations of options—what you found/think)
- **R**ecommendation (action requested/recommended—what you want)

Why use SBAR?

- Standardizes and improves **communication**
- Provides a **consistent** language and **clear** guidelines
- Concise, factual communications among clinicians is important for **resident safety**

When SBAR should be used?

- Use as a **change in condition** progress note
- **Before** you call to notify MD/NP/PA about resident's change of condition
- Change of shift report
- Hand-off between nursing home and hospital

Helpful Tips: to use SBAR correctly ensure that SBAR is filled out:

- **Completely**
- **For COC** not just transfers
- **Before** communication takes place

Stop and Watch/SBAR Workflow

CNA notices something not quite right with a resident

CNA completes a Stop and Watch form

RN/LPN reviews the tool and assesses the resident

If the resident has a change of condition, the RN/LPN completes an SBAR form PRIOR to calling the practitioner

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When to Document

- For all transfers
- End of shift progress notes
- Change in plan of care
- Change of conditions; abnormal assessment
- Resident outcomes after interventions
- For 3 days after a COC

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Why Documenting is So Important

Nursing documentation is a basic requirement for all nurses

Recording all activities helps the clinical team to understand what is happening with the resident at all times

- Should tell a story, including worsening/improvement of the resident's condition

Helps alert the clinical team when the resident's condition changes and further interventions may be required

Charting the progress of a resident's COC helps the next shift to eliminate repetition/inconsistencies and to confirm physician orders have been carried out

ALWAYS DOCUMENT VITAL SIGNS!

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NY–RAH Qualifying Conditions

CHF

- **Qualifying Diagnosis:**
  - Chest X-ray confirmation of a **NEW** pulmonary congestion, edema, or bilateral pleural effusions
- **OR**
- **TWO or more of the following:**
  - O_2 sats ≤ 92% (room air or on resident's usual O_2 requirements)
  - New/worsening pulmonary rales
  - New/worsening edema
  - New/increased jugular vein distention
  - BNP ≥ 100 or NTproBNP ≥ 900 in the absence of renal failure (GFR ≤ 60)
  - Weight gain of 3lbs or more in one day, or 5lbs or more in one week

COPD/Asthma

- **Qualifying Diagnosis:**
  - Known diagnosis of COPD/Asthma **OR** Chest X-ray showing COPD with hyperinflated lungs and no infiltrates
- **AND**
- **TWO or more of the following:**
  - New or worsening wheezing, cough, shortness of breath, or sputum production
  - O_2 sats ≤ 92% (room air or on resident's usual O_2 requirements)
  - Acute reduction in Peak Flow or FEV1 on spirometry
  - Respiratory rate ≥ 24 breaths/minute

Pneumonia

- **Qualifying Diagnosis:**
  - Chest X-ray confirmation of a **NEW** pulmonary infiltrate
- **OR**
- **TWO or more of the following**:
  - Fever ≥ 100◦ F (oral) or two degrees above baseline
  - O_2 sats ≤ 92% (room air or on resident's usual O_2 requirements)
  - Respiratory rate ≥ 24 breaths/minute
  - Evidence of focal pulmonary consolidation on exam including rales, rhonchi, decreased breath sounds, or dullness to percussion

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NY–RAH Qualifying Conditions

Fluid/ Electrolyte Disorder

- **Qualifying Diagnosis:**
  - Any acute change in condition
- **AND**
- **TWO or more of the following:**
  - Reduced urine output in 24 hours or reduced oral intake by approximately 25% or more of average intake for 3 consecutive days
  - New onset of systolic BP ≤ 100mmHg (lying, sitting, or standing)
  - 20% increase in BUN OR 20% increase in Creatinine
  - Sodium ≤ 135 or ≥ 145
  - Orthostatic (drop in systolic BP of 20mmHg or more going from supine to sitting/standing)

UTI

- **Qualifying Diagnosis:**
  - ≥ 100,000 colonies of bacteria growing in the urine with no more than 2 species of microorganisms
- **AND**
- **ONE or more of the following:**
  - Fever ≥ 100◦ F (oral) or two degrees above baseline
  - Peripheral WBC count ≥ 12,000
  - In the case of catheter-associated UTIs: acute back pain, flank pain, epididymis pain, purulent exudate from catheter insertion site, or prostate pain
  - Symptoms of dysuria, new/increased urinary frequency, new/increased urinary incontinence, gross hematuria, or acute costovertebral angle pain/tenderness

Skin Ulcer/Cellulitis

- **Qualifying Diagnosis:**
  - Infection with **NEW** onset of warm and/or erythematous and/or swollen/indurated skin requiring oral or parenteral antibiotic or antiviral therapy
    - **OR**
  - **IF** associated with an existing skin ulcer or wound, there is an acute worsening with **NEW** signs of infection such as purulence, exudate, and/or induration
- **AND**
- **ONE or more of the following:**
  - Fever ≥ 100◦ F (oral) or two degrees above baseline
  - WBC count ≥ 12,000

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CHF
What to Report and Document

Information to Document

- Blood pressure
- Heart rate – regular or irregular
- New or worsening edema
- Respiratory rate and quality
  - Labored, mouth breathing, pursed lips
  - New or worsening pulmonary rales
- Oxygen sat
- Cough
  - Dry
  - Productive and color of sputum
- Body weight
- Temperature – rectal if able
- Assess for JVD

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COPD/Asthma
What to Report and Document

Respirations

- Number of breaths per minute
- Rate: regular or irregular
- Depth: shallow or slow
- Type: labored, mouth breathing, pursing the lips
- Lung sounds

Pulse

- Rate
- Rhythm regular or irregular

Pulse oximetry

- Room air or on resident's usual O_2 settings

Cough

- Dry
- Productive

Sputum color

- Clear, white, pink, green or yellow

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Pneumonia
What to Report and Document

Temperature; Fever ≥ 100*F or two degrees above baseline

Respiratory rate above 24 breath/minutes

Respiratory Assessment:
- Lung sounds: rales, wheezing, decreased BS
- Presence of cough and type (dry or productive)
- Color of secretions
- Dyspnea
- Chest pain on inspiration or re-producible

Blood Oxygen Saturation level ≤92% on RA or on usual 0_2 settings in residents with chronic oxygen requirements

Chest x-ray results if ordered for confirmation of new infiltrate

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Fluid/Electrolyte Disorder
What to Report and Document

Monitor for a decrease in Intake and Output

Blood work
- Serum electrolytes:
- Na (Sodium concentration used to determine the cause of the fluid shortage)
- Creatinine (monitor kidney function and body's water balance)
- BUN

Decreased urine output

Decrease in blood pressure (Orthostatic Hypotension)

Monitor medications review
- Medications like diuretics can be a potential cause of the electrolyte imbalance
- Anticholinergics like (Xanax and Cimetidine) and narcotic analgesics like (Fentanyl and Methadone) are examples of drugs that can interfere with bladder emptying

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UTI
What to Report and Document

Fever ≥ 100*F or two degrees above baseline

WBC Count ≥ 14,000

In the case of catheter-associated UTIs: acute back pain, flank pain, epididymis pain, purulent exudate from catheter insertion site, or prostate pain

Symptoms of dysuria, new/increased urinary frequency, new/increased urinary incontinence, gross hematuria, or acute costovertebral angle pain/tenderness

Urine Culture with CC ≥ 100,000

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Skin Ulcer/Cellulitis
What to Report and Document

Observe for new onset of:

- Pain
- Warmth
- Swollen and Indurated skin
- Purulent drainage
- Exudate
- Fever

Review current medications and dressing change orders

Current Wound Consultation and Debridement (if applicable)

Monitor and report any signs and symptoms to avoid sepsis

Questions?

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