**Explain the process that occurs once a nursing assistant recognizes a resident change in condition.**

• What changes warrant communication:

o Immediately?

o at change-of-shift report?

• To whom are changes communicated:

o Staff nurse?

o Charge nurse?

• How are changes communicated:

o Verbally in-person?

o Written on specific form?

o Communication tool used (e.g., INTERACT ™ ‘Stop and Watch’ Early warning tool, CUS strategy (Concerned, Uncomfortable, Safety), etc.)?

• Where are changes documented:

o Paper form?

o Electronic medical record?

o Other (please specify)?

• How is information or feedback regarding resident monitoring/care plan received by the nursing assistant from licensed nursing staff?

**Explain the process that occurs once a licensed nurse is made aware of a resident change in condition.**

• What changes warrant a thorough resident assessment: o Immediately upon nursing assistant communication?

o as needed?

o Other?

• What assessment findings warrant communication:

o Immediately?

o at change-of-shift report?

• To whom are resident changes/assessment findings communicated:

o Charge nurse?

o Resident care provider?

♣ Who contacts the care provider?

o Family?

• How does communication occur:

o Change-of-shift report? Nurse to nurse? Nurse to nursing assistant?

o Progress note?

o Phone call?

o Communication tool (e.g. SBAR (Situation Background Assessment Request), etc.)?

• Where are changes/assessment findings documented:

o Paper form (please specify)?

o 24-hour report?

o Electronic medical record?

• Who has access to documented resident information? (e.g., licensed nurses and providers only, etc.)

• How is information or feedback regarding resident monitoring/care plan received by the resident’s nurse from the charge nurse and/or care provider?

• Do parameters exist for initiating standing orders? (e.g., fever, SOB, duration of symptoms, etc.)

• When and how do licensed nursing, staff have access to laboratory and other testing results:

o Real-time?

o Next day?

o by fax?

o Electronic medical record?

• Who is responsible for communicating lab results, including microbiology culture and sensitivities, to the resident’s care provider?

**Explain the process that occurs once a licensed provider (MD, NP, PA, DO) is notified of a resident change in condition. Include scenarios where the care provider is on-call.**

• What changes warrant a provider assessment:

o In-person? o Nurse delegation via phone instructions?

o Immediately?

o Next scheduled provider visit?

• What assessment findings warrant communication from the licensed provider:

o Immediately?

o Next day?

o Next scheduled provider visit?

o to charge nurse?

o to resident’s nurse?

o To Director of Nursing?

• Where are changes/assessment findings documented:

o Paper form?

o 24-hour report?

o Electronic medical record?

o Other (please specify)?

• How does the licensed provider access documented resident information?

• Do parameters exist for initiating new orders? (e.g., fever, SOB, duration of symptoms, etc.)

• What criteria are used when initiating antimicrobial therapy? (e.g., Loeb)

• When and how does the licensed provider have access to laboratory and other testing results?

o Real-time?

o Next day?

o by fax?

o Electronic medical record?

o Nurse communication?

• Does the licensed provider perform an antibiotic “time-out”?

o Ensure that prescribed antibiotics are still appropriate based on microbiology culture and sensitivity results?

o Discontinue or change inappropriate therapy (drug, dose, duration, route)?

o Consult with staff or consulting pharmacist as needed?

Summarize your findings. Make note of any overall trends or those specific to each staff group: Are all levels of staff knowledgeable about how and to whom they are to communicate information about a resident’s change in condition? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minnesota Antimicrobial Stewardship Program Toolkit for Long-term Care Facilities Nursing Process Evaluation Tool Resident Change in Condition: Page 4 of 8 www.health.state.mn.us Identified areas for improvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are all levels of staff knowledgeable of their responsibilities for documenting a resident’s change in condition? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identified areas for improvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do facility protocols optimize staff time and resources to ensure timely communication of a resident’s change of condition? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identified areas for improvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What barriers impede the recognition, assessment, documentation or communication processes? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identified areas for improvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are redundancies present in processes? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, suggested areas for improvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can workflows be streamlined? Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, suggested areas for improvement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_