

## Nursing Process Evaluation Tool – Resident Change in Condition

An essential component of antimicrobial stewardship is the resident assessment to determine whether signs/symptoms of infection are present. Resident symptoms should be assessed, documented, and communicated to clinicians involved in clinical decision-making in a standardized manner. A complete understanding of how information is communicated is needed to effectively implement and carry out antimicrobial stewardship program (ASP) components, and in turn, to improve resident safety.

### Purpose

This process evaluation tool seeks to answer the question, ‘How does resident information flow between levels of key healthcare personnel?’ Use this evaluation to identify strengths and gaps in how information about a resident’s change of condition is communicated between healthcare personnel involved in the resident’s care (e.g. nursing assistants, licensed nurses, providers).

### How to do it

This evaluation is best conducted as a group discussion; present it at an all-staff meeting or convene a small group session including at least two nursing assistants and at least two licensed nurses. Consider a mix of staff experience. Consider asking one or more providers to attend the session. It may be beneficial to choose a particular resident change in condition scenario (e.g. suspected urinary tract infection) and follow the flow of information between nursing assistants, licensed nursing staff, and providers. A visual aid that may be helpful in guiding the discussion is provided.

### Suggested questions to consider. Make note of any overall trends or those specific to each staff group:

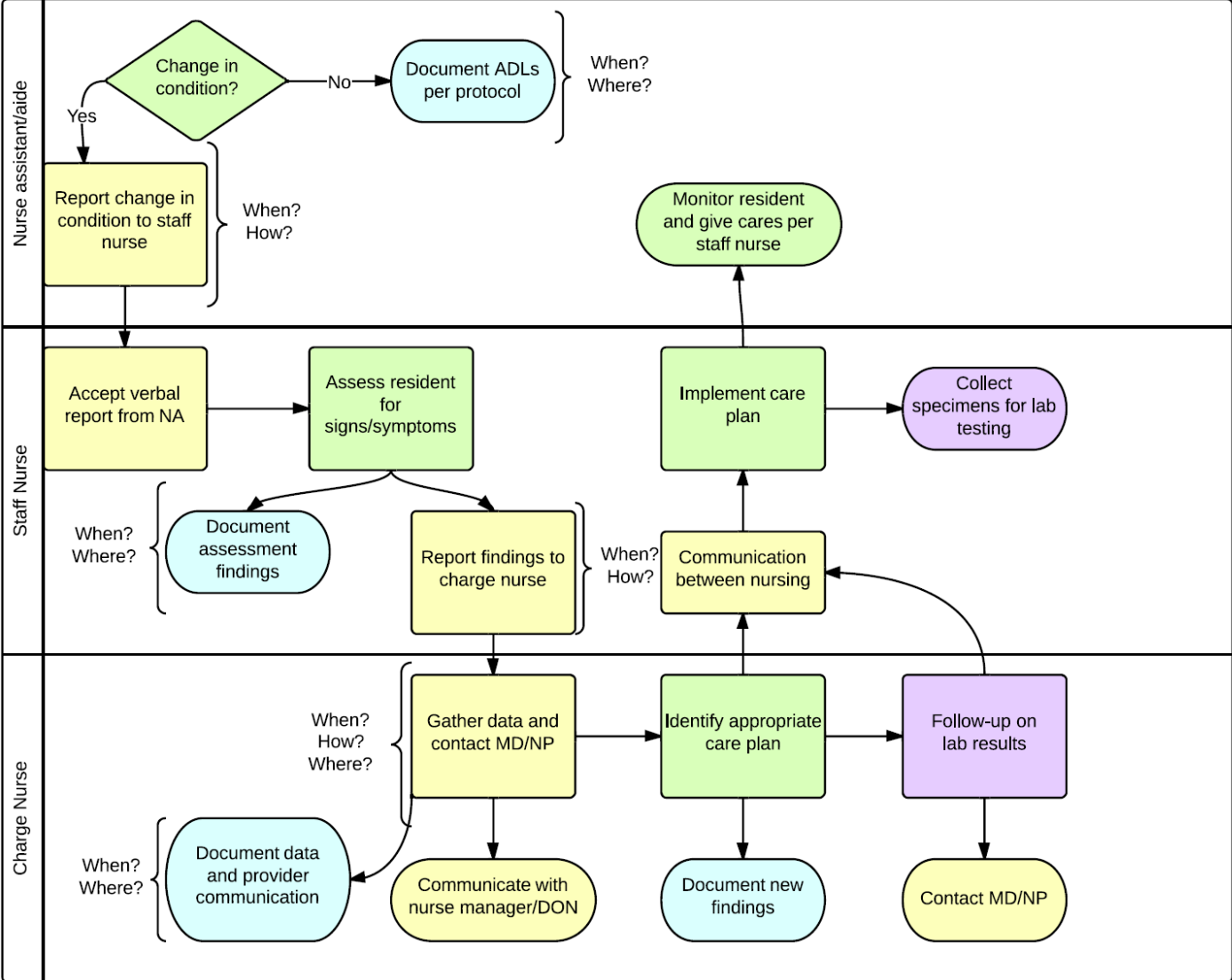
- Are all levels of staff knowledgeable about how and to whom they are to communicate information about a resident’s change in condition?
- Are all levels of staff knowledgeable of their responsibilities for documenting a resident’s change in condition?
- Do facility protocols optimize staff time and resources to ensure timely communication of a resident’s change of condition?
- What barriers impede the recognition, assessment, documentation or communication processes?
- Are redundancies present in processes?
- Can workflows be streamlined?

### What to do with the results

Use the findings from this evaluation to develop or revise processes/protocols for eliciting information, communicating, and documenting a change in condition.

- Use of standardized data collection tools provides consistency with communicating clinical information
- Consider care staff interactions:
  - Nursing assistants and nurses: formalize a process for eliciting information and communicating abnormal conditions –change-of-shift report, intentional check-ins throughout the day, etc.

Nursing Process Algorithm - Resident Change in Condition



**Resident Assessment and care:** Ensure that all levels of facility staff are aware of resident change in condition signs to look-out for. Accurate, timely nursing assessment is key in driving appropriate prescribing of antibiotics by providers. Ensure that your facility protocols and procedures align with evidence-based guidelines regarding signs/symptoms of infection and appropriate nursing interventions.

**Communication:** Communication of resident change in condition between all levels of facility staff must occur in a timely manner. There should be protocols in place at your facility to guide the flow of information and empower all levels of staff to communicate freely. Consider the following questions from the flowchart: When does communication occur? (e.g. immediately) How does communication occur? (e.g. verbal in-person)

**Documentation:** Documentation of resident change in condition and nursing assessment findings is necessary to maintain an accurate record of each resident's medical and overall history. Documentation should occur in a timely manner and should be done in such a way that resident information is available to all parties involved in his or her care. Consider the following questions from the flowchart: When does documentation occur? (e.g. immediately) Where does documentation occur? (e.g. on a paper log, electronic medical record)

**Laboratory specimens:** Policies and procedures should be in place regarding appropriateness of specimen collection for laboratory testing and for the follow-up of testing results. Specimens for microbiology testing should be collected prior to the administration of antibiotic therapy. Testing results are used to guide resident treatment protocols and therefore should be followed-up on in a timely manner by appropriate personnel. Consider the following: Who is responsible for following up on microbiology results? (i.e. susceptibility report)

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

- What changes warrant communication:
  - Immediately?
  - At change-of-shift report?
- To whom are changes communicated:
  - Staff nurse?
  - Charge nurse?
- How are changes communicated:
  - Verbally in-person?
  - Written on specific form?
  - Communication tool used (e.g., INTERACT™ ‘Stop and Watch’ Early warning tool, CUS strategy (Concerned, Uncomfortable, Safety), etc.)?
- Where are changes documented:
  - Paper form?
  - Electronic medical record?
  - 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:
  - Immediately upon nursing assistant communication?
  - As needed?
  - Other?
- What assessment findings warrant communication:
  - Immediately?
  - At change-of-shift report?
- To whom are resident changes/assessment findings communicated:
  - Charge nurse?
  - Resident care provider?
    - Who contacts the care provider?
  - Family?
- How does communication occur:
  - Change-of-shift report? Nurse to nurse? Nurse to nursing assistant?
  - Progress note?
  - Phone call?
  - Communication tool (e.g. SBAR (Situation Background Assessment Request), etc.)?
- Where are changes/assessment findings documented:
  - Paper form (please specify)?
  - 24-hour report?
  - 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:
  - Real-time?

- Next day?
- By fax?
- 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:
  - In-person?
  - Nurse delegation via phone instructions?
  - Immediately?
  - Next scheduled provider visit?
- What assessment findings warrant communication from the licensed provider:
  - Immediately?
  - Next day?
  - Next scheduled provider visit?
  - To charge nurse?
  - To resident’s nurse?
  - To Director of Nursing?
- Where are changes/assessment findings documented:
  - Paper form?
  - 24-hour report?
  - Electronic medical record?
  - 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?
  - Real-time?
  - Next day?
  - By fax?
  - Electronic medical record?
  - Nurse communication?
- Does the licensed provider perform an antibiotic “time-out”?
  - Ensure that prescribed antibiotics are still appropriate based on microbiology culture and sensitivity results?
  - Discontinue or change inappropriate therapy (drug, dose, duration, route)?
  - 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:

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Identified areas for improvement?

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Are all levels of staff knowledgeable of their responsibilities for documenting a resident's change in condition? Describe:

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Identified areas for improvement?

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Do facility protocols optimize staff time and resources to ensure timely communication of a resident's change of condition? Describe:

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Identified areas for improvement?

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What barriers impede the recognition, assessment, documentation or communication processes? Describe:

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Identified areas for improvement?

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Are redundancies present in processes? Describe:

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If yes, suggested areas for improvement?

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Can workflows be streamlined? Describe:

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If yes, suggested areas for improvement:

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