LeadingAge MN
NURSING SOLUTIONS

Nurse Lunch and Learn:
Significant Change in Condition

Presenter(s)

Shelley Hanneken, RN LALD LNHA
Nursing Home Quality Director
St. Francis Health Services of Morris

Dr. Kari Everson, DNP, MSN, MHA, RN, LNHA, LALD, PHN
Vice President of Clinical Services, LeadingAge Minnesota, St. Paul, MN
President, Euvoia Senior Care Consulting, Woodbury, MN

Lunch and Learn Concept

LeadingAge Minnesota is piloting a lunch and learn series. Each month a nurse leadership topic is discussed over a 30minute session from 12:00pm – 12:30pm. During this session there will be 10-15 minutes of presentation followed by a workshop exercise and report back.

We encourage organizations to have their nurses, particularly staff nurses and direct care nurses, attend the workshop. Many have attended via zoom platform with many of their nurses in a room attending together.

If staff can't attend this session in person, the recording is available for organizations to use along with the workshop exercise.

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Workshop Exercise

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SITUATION**:**

In our settings, we are required to report significant changes in condition to physician's, nurses, family members, and other important individuals in the resident's life and involved in the resident's care. Review the following situations.

1. **Scenario #1: Ms. J**
   Ms. J is a mildly confused at baseline, 83-year-old assisted living resident. After helping her with bathing and getting dressed as per her usual routine, the ULP comes to you and describes Ms. J as being "different." She was slightly more confused than usual, said she was too tired to bathe, complained of increased back pain, and slept intermittently in her chair throughout the night. You go to Ms. J's room and find her sitting in her chair in no obvious distress but telling you that she was "not feeling well." She is more confused and states that her back hurts more today than usual and that she is tired. When asked why she didn't go to bed, she says it was "too uncomfortable." Ms. J denies shortness of breath, chest pain, and has no cardiac history; her breathing is even and unlabored. When asked, Ms. J says, "everything is fine; I'm just feeling a little down "Ms. J is

   Sleep: Ms. J did not sleep well last night, which is unusual for her. Tylenol 500mg did not relieve her back pain. Asked why she slept in her chair, Ms. J said that it kept her from coughing—something else that was new. The cough was nonproductive; Ms. J denied feeling ill and said that the coughing seemed to "just come on."

   Problems with Eating : Ms. J normally eats well if the food is cut into small pieces and is fairly soft. Ms. J has not eaten breakfast or lunch because her "stomach is upset." She described a gradual onset of nausea that did not get worse, but said, "Boy, I couldn't eat a thing." Nothing made it better or worse.

   Incontinence: Ms. J denies changes in her bowel or bladder pattern, and the care assistant confirms this. However, she had an episode of urinary incontinence the previous night when she attempted to make it to the bathroom but was hampered in doing so because it was "hard" to get out of the chair.

   Confusion: Ms. J denied confusion: "I'm a little off, but not confused." However, her care assistant emphatically states that something is different: "She is usually sharp as a tack."

Ms. J was alert to person and place but not time. This is a change from her baseline impairment, which includes difficulty with new names, planning for trips, and managing her finances. It was noteworthy that she kept going off track during the assessment and talking about things that did not appear to be relevant to the situation "I'm not eating, but I'm not really a fan of pumpkin pie anyway—did we have pumpkin pie last night?" Redirection would bring her back, but she would quickly go off track again.

Evidence of Falls: There is no evidence of falls on physical examination. Ms. J denied falling, and there is no documentation of her needing assistance to get up from the floor or ground.

Skin Breakdown: Ms. J denies sores and has no history of skin breakdown problems. This portion of the assessment is an opportunity to do a brief physical assessment. She appears slightly pale; skin and mucous membranes are dry; no stomatitis or thrush is found on examination. Although she denied being short of breath the night before, she is notably short of breath even with limited movement.

Pulse: regular sinus rhythm, strong. Peripheral pulses: intact, though weak. Range of motion: full.

2. **Scenario #2: Mr. O**

Mr. O is a high-functioning, cognitively intact 99-year-old assisted living resident. His friend comes to you and describes what appear to have been 2 syncopal episodes that Mr. O has had in the previous 2 days. When you see Mr. O, he is in no apparent distress and is conscious, oriented, with no serious injuries from his falls other than a minor abrasion on his left arm. His first fall occurred while getting tangled in his sheets when rising from bed, and the second occurred while he was using the toilet. Mr. O has no focal neural changes and refuses any treatment, including transfer to the hospital emergency department.

Two days later, dining room staff report that Mr. O dropped his water glass twice and seemed "a little out of it – you know, just not the same." You go to see him, and he tells you some "weird things have been happening." He describes what now appear to be focal neural changes: dropping glasses, a weak grip, and a "clumsy left arm." Mr. O denies other weakness, lower extremity changes, chest discomfort, or palpitations. Vital signs are normal; pulse strength is equal bilaterally; no abnormal movements are noted. Again, Mr. O refuses hospital transfer but agrees to make an appointment to see his physician.

One day later, Mr. O falls again. His friend feels that Mr. O is increasingly confused because he is saying that people have been visiting when they have not. Mr. O denies confusion but says he is feeling anxious. Although conscious and alert, Mr. O is not answering all questions at his usual baseline. Physical assessment is only remarkable for left arm weakness. Vital signs: increasing blood pressure from a baseline of 116/66 to

134/64, and most recently to 154/74. Having made clear his wishes for minimal medical intervention, it is agreed to monitor him more closely without transfer to the hospital.

Fluid-related orthostatic hypotension is not causing his problem: his first fall was the result of environmental events, and the second occurred while sitting on the toilet. It may be an acute coronary event, but this seems unlikely given the presentation. Mr. O denies palpitations, shortness of breath, and chest pain. The fact that he “dropped his water” indicates he is at least trying to drink; skin and mucous membranes appear well hydrated. Although Mr. O's increasing confusion could be related to a worsening pneumonia or other pulmonary etiology and hypoxia, he has no cough; lungs are clear on auscultation, and no cyanosis is noted. There is little to discuss regarding nutrition. Long-term malnutrition can certainly precipitate falls, but that seems unlikely in Mr. O's case. Mr. O also denies changes in swallowing, and assistive personnel confirm this finding. Mr. O's speech is not slurred or otherwise changed. No new or changed medications; thorough review reveals no relationship between medication ingestion and symptom onset. Mr. O is not a diabetic; blood glucose is within normal limits. He has taken his medications as ordered.

Although an infection is possible, symptom presentation and the subsequent course of events makes this highly unlikely. All evaluations were done with his glasses on, hearing aid in, and assistive devices available. Mr. O does not present with the classic signs and symptoms of a cerebrovascular event, but he does have focal weakness, hypertension of unknown etiology, and increasing confusion.

No difficulty with urination or moving his bowels.M: No apparent myocardial problems. Mr. O has an apparent accidental, explainable fall followed by increasing falls over a 1-week period. Additionally, he is unable to participate in normal activities, such as drinking a glass of water with his left hand. He does not report increasing shortness of breath with baseline activities. Mr. O denies pain other than discomfort from his falls and that it is “no big deal.” He does not appear to be in pain. Mr. O's bruises and skin injuries are consistent with his falls, and no suspicion of abuse is present. Additionally, he is social and interactive with family and friends who are concerned about his well-being.

The next day, Mr. O is clearly anxious and obviously confused. He fell again, sustaining a slight shoulder injury. Urine obtained by straight cath is clear. Vital signs reveal a hypertensive emergency, characterized by a blood pressure of 200/100. Fortunately, he is not hypoxic or tachycardic. Mr. O's son is contacted, and the decision is made to transfer him to the local hospital.

DISCUSSION:

1. Does Ms. J's situation constitute a change of condition?
    a. No.
    b. Yes - If yes, when should the change be identified.
2. Does Mr. O's situation constitute a change of condition?
    a. No.
    b. Yes – if Yes, when should the change be identified

3. What are some things you would expect an unlicensed staff member to alert a licensed nurse to that could constitute a change in condition?

If you use this in your community, we'd love some feedback to continue to improve our product. Please email Kari Everson with any thoughts or feedback.

References:
Federal Code: 42 CFR 483
Minnesota Statutes: 144G
Minnesota Rules: 4658
Montgomery, & Mitty, E. (2008). Resident Condition Change: Should I Call 911? *Geriatric Nursing (New York)*, *29*(1), 15–26. https://doi.org/10.1016/j.gerinurse.2007.11.009