CHANGE IN CONDITION

Resident Name __________________________________________________ Room/Bed __________________ Date _____ / _____ / ______ Time ______________

S - SITUATION

The change in condition (including symptoms or signs) I am calling about is _________________________________. Since this started on ____ / ____ / ______, it has gotten □ Worse □ Better □ Stayed the same.

The condition gets worse when _________________________________________________________________.

This change in condition has occurred before. □ No □ Yes: _________________________________________________________________.

The resident had a recent change in medications. □ No □ Yes: _________________________________________________________________.

Treatment for last episode (if applicable): _____________________________________________________________.

B - BACKGROUND (check all that apply)

B1. General information

Medical History
☐ Indwelling Catheter   ☐ Diabetes Mellitus
☐ Emphysema/COPD   ☐ On Warfarin/Coumadin
☐ Other: ___________________

Medication Allergies
__________________________________________________________

Additional information
Advanced Care Wishes: ________________________________
Recent events or changes in condition: ________________________________

B2. Vital Signs

Blood Pressure _____/_____  Pulse Oximeter ______  Temperature > 100.5°F or repeated Temp > 99°F
Pulse Rate _______  Temperature _______  O2 saturation < 90%
Respiratory Rate _______  Glucose Level _______  BP < 90 or > 200 systolic

B3. Localizing Signs or Symptoms

Urinary Tract
☐ Obvious blood in urine
☐ Painful or difficult urination
New or increased:
☐ Urgency or Frequency of urination
☐ Suprapubic Tenderness per Pt or nurse exam
☐ CVA Tenderness
☐ Urinary Incontinence
☐ Other:

Respiratory
☐ New or increasing cough
☐ Pleuritic chest pain
☐ Shortness of breath
☐ Blood in purulent sputum
☐ Runny, stuffy nose and/or sneezing
☐ Sore throat/headache
☐ Other infections in the community

Skin or Soft Tissue
Location: ________________________________
☐ New or increasing pus draining from wound
☐ New or expanding redness around wound
☐ Pain/Tenderness
☐ New or increased swelling at the site
☐ Increased odor

Gastrointestinal
☐ Vomiting: _____ times in past 24 hours
☐ Diarrhea: _____ times in past 24 hours
☐ Other vomiting or diarrhea in community

B4. Non-Localizing Signs or Symptoms

New or worsening:
☐ Agitation
☐ Pain
☐ Decrease in eating or drinking
☐ Sleepiness or decreased alertness
☐ Decline in function or gait
☐ Shaking or chills in past 24 hours
☐ Recent fall
☐ Recent weight gain

Other:

A – ASSESSMENT

Abnormal Vital Signs? (Any checked in B2)  Localizing Symptoms? (Any checked in B3)  Non-localizing Symptoms? (Any checked in B4)  Other significant findings?

Higher Risk (Go to R1 & R2)  Review McGeer’s Criteria  Lower Risk (Go to R2)

Suggested Script for Low-Risk Change-In-Condition

“According to my assessment, this resident is experiencing a low-risk change-in-condition. I would like your permission to initiate our active monitoring care plan. I would not recommend testing the urine or starting antibiotics at this time.”
**R - RECOMMENDATIONS**

### If higher risk: R1 and R2

#### R1. Diagnostic and Therapeutic Orders

- [ ] Urinalysis
- [ ] Oxygen supplementation
- [ ] Urine Culture
- [ ] Nebulizer treatment
- [ ] CBC w/Diff
- [ ] Cough suppressants
- [ ] Chest X-Ray
- [ ] Other: ____________________________

Start Antibiotic(s) for this indication:

- Antibiotic: __________  Dose: _____  Frequency: _____  Days: _____
- Antibiotic: __________  Dose: _____  Frequency: _____  Days: _____

Start these other medications:

Other orders: ___________________________________________________________

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### If lower risk: R2

#### R2. Monitoring and Supportive Care Orders

- [ ] Monitor vital signs every _____ hours
- [ ] Oral fluids for hydration: _____ cc _____ hr.
- [ ] IV fluids for hydration _____ cc _____ hr.
- [ ] Monitor fluid intake/urine output every _____ hours
- [ ] Notify provider if symptoms worsen or if unresolved in _____ hours / days
- [ ] Other orders: _______________________________________________________

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**COMMUNICATION**

Name of Family or Health Care Agent Notified:  
Date: ___ / ___ / ___  
Time:  
[ ] AM  
[ ] PM

Name of Primary Care Clinician Notified (specify MD/NP/PA):  
Date: ___ / ___ / ___  
Time:  
[ ] AM  
[ ] PM

Pending Notification Tasks:

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Staff Name (RN/LPN) and Signature:

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**NURSING NOTES**

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