Change of Condition – Definition of Terms

Change of Condition and Monitoring 411-054-0040 C270

(1) CHANGE OF CONDITION. These rules define a resident's change of condition as either short term or significant with the following meanings:

(a) Short term change of condition means a change in the resident's health or functioning that is expected to resolve or be reversed with minimal intervention or is an established, predictable, cyclical pattern associated with a previously diagnosed condition.

(b) Significant change of condition means a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that is not expected to be short term and imposes significant risk to the resident. Examples of significant change of condition include, but are not limited to: broken bones, stroke, heart attack or other acute illness/condition onset, unmanaged high blood sugar levels, uncontrolled pain, fast decline in ADL function, significant weight loss, pattern of refusing to eat, level of consciousness change, pressure ulcers (stage 2 or greater).

Definitions

Significant Change: A noticeable decline in a resident's mental or physical health that is evaluated or assessed as not of short duration but is expected to last for some time. In other words, the change is not expected to resolve itself without more than minimal staff or medical intervention. If the decline is a major deviation from the resident's prior level of functioning, a **significant change** has taken place.

There may be a change in the level of functioning in performing **activities of daily living**. If a resident was able to transfer independently from a chair to a standing position and then walk, but now requires the assistance of staff and a walker to do the same activities that would mean the resident experienced a significant change in ambulation and transfer status. The resident could also have a significant change in hearing or vision that would impact ADL function.

There may be changes in the intensity and frequency of a resident's **behavior** such that behaviors that at one time were easily altered by minimal intervention now require more frequent and intensive or complex interventions or a resident develops new behaviors. Behaviors may include pacing, crying out, trying to leave the facility, being verbally or physically abusive, etc.

Change of Condition – Definition of Terms

A resident's bowel or bladder **continence pattern** may change from being continent to being incontinent most or all of the time.

A resident may have an **unplanned weight gain or loss** of 5% in 30 days or 10% in six months. A resident's **pattern of eating** may change related to loss of appetite, difficulty swallowing or chewing, pattern of refusing to eat, regardless of cause, or an increase or decrease in the amounts or frequency of food intake.

Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

The following formula determines percentage of loss:
% of body weight loss = (usual weight - actual weight)/(usual weight) x 100

Usual weight is the most recent stable weight in the facility prior to the weight change. It is not necessarily the ideal body weight.

A resident may have a change in **mood**. A resident's usual mood may have changed so that they appear sad or anxious and they don't respond to staff interventions that have been effective in the past.

A resident may have a change in **level of consciousness**. The resident may be difficult to arouse, or appears less alert or to have difficulty communicating.

A resident may have a change of **health status**, such as, unmanaged high or low blood sugar levels (blood sugar levels that exceed the parameters defined by the physician), a fracture, stroke, heart attack or major surgery.

A resident may have **uncontrolled pain**. He or she may experience a continuous or intermittent pain state which is not being controlled by their current treatment plan and/or interventions. Pain may have been gradually increasing over time or an acute change following an injury, surgery, or developing an infection or pressure ulcer.

A resident may have a significant change in **skin condition,** such as developing a stage 2 (or greater) pressure ulcer.

Change of Condition – Definition of Terms

A **Pressure Ulcer** (also known as decubitus ulcer, pressure sore and bedsore) is defined as an injury to the skin as a result of constant pressure due to staying in one position without moving. Blood flow is reduced to the pressure area and eventually causes cell death, skin breakdown and the development of an open wound. Pressure ulcers usually occur over bony prominences (such as tail bone and heels) and are graded or staged to classify the degree of tissue damage observed.

A Stage 2 pressure ulcer is any injury to the skin and/or underlying tissue in which some degree of skin has been lost. The skin loss primarily involves the top layer of skin. The ulcer is superficial and looks like an abrasion, blister or shallow crater. The injury is in an area of pressure, usually over a bony prominence. This does not include a skin tear, tape burn, rash or excoriation.