POLICY

It is the policy of Ageia Health Services to promptly implement the Alert Charting system for a resident having a change in condition. A change of condition is defined as an improvement or decline in their physical, mental and/or psychosocial status.

PROCEDURES

1. When a change of condition or change from baseline is observed and reported, the community licensed nurse is responsible to evaluate the resident’s condition. Examples of a condition change are as follows, but not limited to;
   a. Abnormal or change in vital signs
   b. Skin breakdown, open areas, rashes, and indications of bleeding.
   c. Weight loss, gain or change in appetite, change in ability to chew
   d. Diarrhea, new diagnosis constipation, increased or new incontinence
   e. Nausea and vomiting (one episode would constitute a change),
   f. Respiratory distress, nasal or lung congestion
   g. Signs and symptoms of an acute infection
   h. Falls
   i. Elopement, exit seeking, behavior changes, and/or changes in level of consciousness, increased confusion, hallucinations, anxiety or agitation, any change in mental status or memory. Talk of self-harm or harm to others.
   j. Change in gait, motor skills, decline in ADL’s, muscle tremors twitching or jerking
   k. Hospitalization, Hospice admission or discharge, fracture
   l. Lethargy, hyperactivity, insomnia, somnolent, lack of interest in surroundings.
   m. New or increasing pain
   n. New diagnosis

2. Staff will notify the facility Nurse of any change in condition either short term change of condition or significant change in condition

3. If the resident appears acutely ill, contact 911 for Hospital transport unless on Hospice services then contact Hospice.

4. The licensed nurse (LN) will evaluate the change in condition. Depending upon the circumstances the LN will begin the nursing process (assess/establish a nursing diagnosis/plan/implement/evaluate). The LN may advise the staff regarding observable data needed, suggest an immediate action, and/or recommend a plan of care.
5. When a change of condition has been observed, then the Medication Tech (MT) will indicate the “change” on the 24-Hour Communication so that all staff is aware that a resident has been placed on “Alert.”

6. The MT will make a resident MAR entry indicating “Alert” status and include information as to why on alert and what symptoms are staff to observe and report. The MAR entry indicating “Alert” will have med pass times selected once per shift unless the LN directs otherwise. This MAR “Alert” will pop up and remind the MT that the resident is on alert status. The length of time the resident will be on Alert is be selected given the condition or the direction from the LN.

7. MT’s to document in the electronic charting section of the MAR, indicating alert charting and document observations during their shift regarding the alert condition.

8. The community LN at any time may change the reason, observation & reporting criteria, frequency, and/or length of time.

9. Vital signs will be obtained via the discretion of the LN.

10. If applicable, a resident Service Plan update must be completed and filed in the 24-hour report under the “Service Plan Update” tab following the policy.

11. The resident’s family and physician are to be notified. Family notification will be documented in the Progress Note. Physician will be notified via the physician communication form.

12. Any reportable criteria (as designated in the MAR entry) must be communicated to the LN, primary care physician, Hospice (if on hospice services) and resident family promptly. Document all attempts to contact.

13. The LN or designee will review the documentation to determine if the Alert system is being followed and if the care of the resident is being met.

14. The Alert documentation will continue until the RN determines there is resolution of the condition.
15. Discontinuing the Alert process will consist of the following: the temporary Service Plan update resolved as applicable and LN resolution documentation in electric charting notes, the order for “alert” in the MAR dc’d, with a Service Plan update as needed.

16. The Alert Charting printout from the EMAR system will be kept in the 24-Hour Communication Book under the Alert Charting tab following this policy.

FORMS

Alert charting guidelines
Service Plan Update Form
24 report form
Physician communication form