Title: INTERACT Care Paths and Change in Condition File Cards
Date Created: 10/1/2015
Date Modified: 10/13/2015; 2/23/2017
Date Approved by Board of Directors: 10/13/2015
Clinical Guideline # CGC-CG-03

Purpose: INTERACT Care Paths and Change in Condition File Cards can be used as decision support tools to help with the recognition, evaluation, management, and reporting of specific symptoms and signs. These tools include explicit criteria for notifying primary care clinicians.

Added to this toolkit, the “Symptoms of Sepsis and Septic Shock” Care Path is an evidence-based tool endorsed by IPRO, an organization providing healthcare assessments and improvement services. IPRO, under contract with Centers for Medicare & Medicaid Services, leads the Atlantic Quality Innovation Network, one of the 14 Medicare-funded Quality Innovation Network-Quality Improvement Organizations operating across the U.S.

Definitions: INTERACT: Interventions to Reduce Acute Care Transfers; IPRO: Improving Healthcare for the Common Good

Procedure: See attachments beginning on next page. It is recommended by the Clinical Governance Committee that prior to notifying the MD/PA/NP in each Care Path, that SNF clinical staff reviews the resident’s wishes. This can include MOLST, eMOLST, DNR order, or any other actionable medical order.

When PPS clinical protocols and pathways are developed through the Clinical Governance Committee(s) of the PPS and approved by the CCN Board of Directors and are applicable to Partner Organization’s delivery of health care services and project participation, such protocols and pathways shall not (1) override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases or (2) interfere with the governing body/established operator of any licensed health care facility or its medical staff in overseeing the provision of clinical services to patients and the quality of care.
**CARE PATH**

**Dehydration (potential for)**

**Change Noted in Resident at Risk for Dehydration**
- Decreased oral intake over 48 hrs
- Multiple episodes of vomiting or diarrhea over 24-48 hrs
- Dependent on others for fluids (dementia, tube feeding)
- Diuretic use
- Swallowing difficulties

**Take Vital Signs**
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

**Vital Sign Criteria (any met?)**
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

**Further Nursing Evaluation**
- Mental Status
- Functional Status
- Cardiovascular
- Respiratory
- Gastrointestinal/abdomen
- Genitourinary
- Skin

**Evaluate Symptoms and Signs for Immediate Notification**
- Acute mental status change
- Not eating or drinking at all
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distension or tenderness
- Inability to stand without severe dizziness or light headedness
- New or worsened incontinence, pain with urination, blood in urine
- Very low urinary output
- New skin condition (e.g. rash, redness suggesting cellulitis, signs of infection around existing wound/pressure ulcer)

**Consider Contacting MD/NP/PA for orders (for further evaluation and management)**
- Portable chest X-ray
- Urinalysis and C&S in indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)

**Evaluate Results**
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

**Tests Ordered**

**Monitor Response**
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

**Notify MD / NP / PA**

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*Refer also to INTERACT GI Symptoms Care Path*

**Refer also to other INTERACT Care Paths as indicated by symptoms and signs**

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**Fever**

**Fever Definition**  
- One temp > 100°F (> 37.8°C)  
- Two temps > 99°F (> 37.2°C) oral or > 99.5°F (> 37.5°C) rectal  
- Increase in temp of 2°F (1.1°C) over baseline

**Take Vital Signs**  
- BP, pulse, apical HR (if pulse irregular)  
- Respirations  
- Oxygen saturation  
- Finger stick glucose (diabetics)

**Vital Sign Criteria (any met?)**  
- Temp > 100.5°F  
- Apical heart rate > 100 or < 50  
- Respiratory rate > 28/min or < 10/min  
- BP < 90 or > 200 systolic

**Evaluate Symptoms and Signs for Immediate Notification**  
- Acute mental status change  
- Not eating or drinking  
- Acute decline in ADL abilities  
- New cough, abnormal lung sounds  
- Nausea, vomiting, diarrhea  
- Abdominal distension or tenderness

**Consider Contacting MD/NP/PA for orders (for further evaluation and management)**  
- Portable chest X-ray  
- Urinalysis and C&S if indicated  
- Blood work (Complete Blood Count, Basic Metabolic Panel)  
- Stool specimen for culture and C. Difficile assay (diabetes)  
- Nasal Pharyngeal swab for influenza

*Refer also to other INTERACT Care Paths as indicated by symptoms and signs*
**CARE PATH**

**Gastrointestinal (GI) Symptoms**

### New or Worsening GI Symptoms or Signs
- Nausea and/or vomiting
- Diarrhea (3 or more loose or liquid bowel movements per day)
- Constipation (no bowel movement in 3 days)
- Abdominal pain
- Distended abdomen

### Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

### Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

### Evaluate Symptoms and Signs for Immediate Notification*
- Abdominal tenderness or distention
- Absent or hyperactive bowel sounds
- Jaundice
- Blood in stool or vomitus
- Recurrent diarrhea after treatment for C. difficile
- Other residents with similar symptoms suggesting outbreak of a GI virus
- Recent initiation or adjustment of enteral tube feeding (diarrhea)
- Recent initiation or adjustment of narcotic medication (constipation)

### Consider Contacting MD/NP/PA for orders (for further evaluation and management)
- Abdominal X-ray or ultrasound (if available)
- Stool specimen for occult blood
- Stool specimen for culture and C. difficile toxin assay
- Blood work
  - CBC, comprehensive metabolic panel (including liver function tests)
  - Amylase, lipase, thyroid function
  - Digoxin blood level (If relevant, for nausea/vomiting)

### Evaluate Results
- Results of abdominal X-ray/ultrasound suggests ileus, obstruction, mass, or perforation
- Critical values in blood work
- Stool analysis suggests infection

### Manage in Facility
- Monitor vital signs and abdominal exam findings every 4-8 hrs
- Monitor intake and urine output (and number of episodes for vomiting and diarrhea)
- Initiate medications for nausea, vomiting, diarrhea, constipation as appropriate
- Consider IV or subcutaneous fluids if needed for hydration
- Update advance care plan and directives if appropriate

### Notify MD / NP / PA
- YES
- NO

### Tests Ordered
- YES
- NO

### Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

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*Refer also to other INTERACT Care Paths as indicated by symptoms and signs*
**CARE PATH** Symptoms of Acute Mental Status Change

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**New Mental Status Change Noted**
- New symptoms or signs of increased confusion *(e.g. disorientation, change in speech)*
- Decreased level of consciousness *(sleepy/lethargic)*
- Inability to perform usual activities *(due to mental status change)*
- New or worsened physical and/or verbal agitation *
- New or worsened delusions or hallucinations *
- Unresponsiveness
- New or worsened memory loss

**Take Vital Signs**
- Temperature
- BP, pulse, apical HR *(if pulse irregular)*
- Respirations
- Oxygen saturation
- Finger stick glucose *(diabetics)*

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**Vital Sign Criteria (any met?)**
- Temp > 100.5˚F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300
- Resident unable to eat or drink

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**Evaluate Symptoms and Signs for Immediate Notification** *
- Not eating or drinking
- Acute decline in ADL abilities
- New cough, abnormal lung sounds
- Nausea, vomiting, diarrhea
- Abdominal distension or tenderness
- Edema
- New or worsened incontinence, pain with urination, blood in urine
- New skin condition *(e.g. rash, redness suggesting cellulitis, signs of infection around existing wound/pressure ulcer)*
- Unrelieved pain
- New irregular pulse

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**Consider Contacting MD/NP/PA for orders (for further evaluation and management)**
- Portable chest X-ray
- Urinalysis and C-S *(if indicated)*
- Blood work *(Complete Blood Count, Basic Metabolic Panel)*
- EKG

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**Manage in Facility**
- Monitor vital signs, fluid intake/urine output every 4-8 hrs
- Oral, IV or subcutaneous fluids if needed for hydration
- Check results of urinalysis and culture *(if ordered)*
- Non-pharmacological interventions for delirium *
- Pain management
- Update advance care plan and directives if appropriate

**Monitor Response**
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

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**Refer also to the INTERACT Behavior Change Care Path**
**Refer also to other INTERACT Care Paths as indicated by symptoms and signs**
Symptoms of Shortness of Breath*
• Difficult or labored breathing that is out of proportion to the resident’s level of physical activity
• New complaint of SOB

Take Vital Signs
• Temperature
• BP, pulse, apical HR (if pulse irregular)
• Respirations
• Oxygen saturation
• Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)
• Temp > 100.5°F
• Apical heart rate > 100 or < 50
• Respiratory rate > 28/min or < 10/min
• BP < 90 or > 200 systolic
• Oxygen saturation < 90%
• Finger stick glucose < 70 or > 300
• Accessory muscle breathing
• Cyanosis
• New or worsening chest pains

Evaluate Symptoms and Signs for Immediate Notification**
• Cough with or without sputum production
• Abnormal lung sounds (wheezing, rales, rhonchi, etc.)
• Edema
• Change in mental status
• Inability to eat or sleep due to SOB
• New irregular pulse
• Mental Status
• Cardiovascular
• Respiratory

Consider Contacting MD/NP/PA for orders (for further evaluation and management)
• Portable chest X-ray
• Blood work (Complete Blood Count, Basic Metabolic Panel)
• EKG (if available)
• Bedside spirometry (if available)

Evaluate Results
• Abnormal CXR suggestive of CHF, COPD, pneumonia, atelectasis, lung CA or pleural effusion
• WBC > 14,000 or neutrophils > 90%
• Critical values in blood count or metabolic panel
• EKG shows new changes suggestive of MI or arrhythmia

Manage in Facility
• Monitor vital signs and urine output every 4-8 hrs
• O2 supplementation as indicated
• Consider initiating or modifying dose of medications (e.g. diuretics, steroids, nebulizers, etc.)
• Respiratory therapy (if available)
• Ensure influenza and pneumococcal immunizations are up to date
• Encourage smoking cessation (if applicable)
• Update advance care plan and directives if appropriate

Monitor Response
• Vital signs criteria met
• Worsening condition and/or immediate notification criteria met

Notify MD / NP / PA

Tests Ordered

* Refer also to the INTERACT CHF and Lower Respiratory Infection Care Path
** Refer also to other INTERACT Care Paths as indicated by symptoms and signs
CARE PATH
Change in Behavior
Evaluation of Medical Causes of New or Worsening Behavioral Symptoms

New or Worsening Behavioral Symptoms
- Physical aggression (e.g., biting, hitting, kicking, spitting, etc.)
- Physical symptoms, non-aggressive (e.g., inappropriate disrobing or voiding, repetitious mannerisms, wandering or attempts to elope)
- Verbal aggression (e.g., cursing, screaming, etc.)
- Verbal symptoms, non-aggressive (e.g., repetitive calling out or requests for attention, constant complaining or whining, etc.)
- Social withdrawal (e.g., isolation, apathy)
- Depression (e.g., crying, hopelessness, not eating, multiple somatic complaints)

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respiration
- Oxygen saturation
- Finger stick glucose (diabetics)

Manage in Facility
- Monitor vital signs, fluid intake/urine output every 4-8 hrs for 24-72 hrs
- If on diuretic, consider holding
- Consider IV or subcutaneous fluids if needed for hydration
- Evaluate for unmet needs, environmental factors, other non-medical causes**
- Consider non-pharmacologic interventions (e.g., sensory, environmental, exercise, others that have been effective for this resident in the past)**
- Update advance care plan and directives if appropriate

Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300

Further Nursing Evaluation
- Mental Status
- Cardiovascular
- Gastrointestinal/abdomen
- Genitourinary
- Respiratory
- Skin
- Pain

Evaluate Symptoms and Signs for Immediate Notification*
- Danger to self or others
- Suicidal ideation
- Symptoms or signs of pain
- Not eating or drinking at all
- Acute decline in ADL abilities
- Nausea, vomiting, diarrhea
- Abdominal distention or tenderness
- New cough, abnormal lung sounds
- New or worsened incontinence, pain with urination or blood in urine
- New skin condition (e.g., rash, redness suggesting cellulitis, signs of infection around existing wound or pressure ulcer)
- Unrelieved pain

Consider Contacting MD/NP/PA for orders (for further evaluation and management)
- Portable chest X-ray
- Urinalysis and C&S if indicated
- Blood work (Complete Blood Count, Basic Metabolic Panel)

Evaluate Results
- WBC > 14,000 or neutrophils > 90%
- Infiltrate or pneumonia on chest X-ray
- Urine results suggest infection and symptoms or signs present

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

Notify MD / NP / PA

Tests Ordered

* Refer also to other INTERACT Care Paths as indicated by symptoms and signs
** See resources available from the Advancing Excellence Campaign at www.nhqualitycampaign.org and from CMS at www.cms-handinhandtoolkit.info/Index.aspx
CARE PATH Symptoms of Congestive Heart Failure (CHF)

Symptoms or Signs of CHF in a resident with known CHF or Risk Factors for CHF
- Unrelieved shortness of breath or new shortness of breath at rest*
- Unrelieved or new chest pain
- Wheezing or chest tightness at rest
- Inability to sleep without sitting up
- Inability to stand without severe dizziness or light headedness
- Weight gain of > 5 lbs in a week
- Worsening edema

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)
- Temp > 100.5˚F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300
- New or worsening chest pain

Evaluate Symptoms and Signs for Immediate Notification**
- Abrupt onset of SOB with resp. distress
- Abrupt onset of progressive bilateral edema with or without shortness of breath
- >5 pound weight gain in 72 hours
- Abrupt onset of abnormal lung sounds (wheezing, rales/rhonchi)

Notify MD / NP / PA

Evaluate Results
- Results of chest X-ray suggestive of CHF or pneumonia
- Critical values in blood count or metabolic panel
- EKG shows new changes suggestive of an acute MI or arrhythmia
- Worsening clinical condition

Consider Contacting MD/NP/PA for orders (for further evaluation and management)
- Portable chest X-ray
- Blood work (Complete Blood Count, Basic Metabolic Panel)
- BNP Level
- EKG

Tests Ordered

Manage in Facility
- Monitor vital signs and urine output every 4-8 hrs
- Oxygen supplementation as indicated
- Consider
  - Initiating or increasing diuretic dose
  - Initiating or modifying other cardiovascular medications
  - Monitoring electrolytes and kidney function
- Update advance care plan and directives if appropriate

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

* Refer also to the INTERACT Shortness of Breath and/or Lower Respiratory Symptoms Care Path
** Refer also to other INTERACT Care Paths as indicated by symptoms and signs
Symptoms or Signs of UTI
- Painful urination (dysuria)
- Lower abdominal (suprapubic) pain or tenderness
- Blood in urine
- New or worsening urinary urgency, frequency, incontinence

Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respirations
- Oxygen saturation
- Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)
- Temp > 100.5°F
- Apical heart rate > 100 or < 50
- Respiratory rate > 28/min or < 10/min
- BP < 90 or > 200 systolic
- Oxygen saturation < 90%
- Finger stick glucose < 70 or > 300
- Resident unable to eat or drink

Evaluate Symptoms and Signs for Immediate Notification
- Abdominal distension
- New or worsened incontinence
- Suprapubic tenderness
- Pain/tenderness in testes suggesting epididymitis
- Gross blood in urine
- Not eating or drinking

Consider Contacting MD/NP/PA for orders (for further evaluation and management)*
- Urinalysis
- Urine culture and sensitivity (if indicated by UA)
- Collect clean voided specimen if possible; in-and-out catheter only if necessary
- For residents with indwelling catheter; change the catheter, send the urine obtained from the new catheter
- Blood work (Complete Blood Count, Basic Metabolic Panel)
- Post Void Residual
- INR if antibiotic therapy ordered + on coumadin

Tests Ordered
- Critical values in blood count or metabolic panel
- WBC > 14,000 or neutrophils > 90%
- PVR > 350 ml
- Urine results suggest infection and symptoms or signs present

Manage in Facility
- Monitor vital signs, fluid intake/urine output every 4-8 hrs
- Oral, IV or subcutaneous fluids if needed for hydration
- Check results of urinalysis and culture
- Consider antibiotic treatment for 7-10 days if culture positive (check allergies)
- DISCONTINUE ANTIBIOTIC IF CULTURE NEGATIVE
- Update advance care plan and directives if appropriate

Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

Notify MD / NP / PA

* Please Note:
1. Overtreatment of asymptomatic bacteriuria labeled as a “UTI” is a major problem contributing to adverse events, C. Difficile infection, and resistant organisms. Antibiotic treatment should be reserved for those who meet specific clinical criteria.
2. Evaluation and management of patients with indwelling catheters includes different criteria.
**CARE PATH** Symptoms of Lower Respiratory Infection

### Symptoms or Lower Respiratory Infection Noted*
- New or worsened cough
- New or increased sputum production
- New or worsening shortness of breath
- Chest pain with inspiration or coughing
- New or increased findings on lung exam (rales, wheezes)

### Take Vital Signs
- Temperature
- BP, pulse, apical HR (if pulse irregular)
- Respiration
- Oxygen saturation
- Finger stick glucose (diabetics)

### Vital Sign Criteria (any met?)
- **YES**
  - Oxygen saturation < 90%
- **NO**
  - Finger stick glucose < 70 or > 300
  - Resident unable to eat or drink

### Evaluate Symptoms and Signs for Immediate Notification**
- **YES**
  - Examine resident for cough with or without sputum production
  - Abnormal lung sounds
  - Edema
  - Change in mental status
- **NO**

### Consider Contacting MD/NP/PA for orders (for further Nursing evaluation and management)
- Portable chest X-ray
- Blood work
  - (Complete Blood Count, Basic Metabolic Panel)

### Tests Ordered

### Evaluate Results
- **YES**
  - Critical values in blood count or metabolic panel
  - WBC > 14,000 or neutrophils > 90%
  - Infiltrate or pneumonia on chest X-ray
- **NO**

### Monitor Response
- Vital signs criteria met
- Worsening condition and/or immediate notification criteria met

### Manage in Facility
- Monitor vital signs every 4-8 hrs
- Oral, IV or subcutaneous fluids if needed for hydration
- Oxygen supplementation as indicated
- Nebulizer treatments and/or cough suppressants as indicated
- Consider antibiotic therapy (check allergies)
- Update advance care plan and directives if appropriate

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* Refer also to the INTERACT Shortness of Breath Care Path
** Refer also to other INTERACT Care Paths as indicated by symptoms and signs

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CARE PATH

Fall

• Unintentional change in position coming to rest on the ground or onto the next lower surface.

Take Vital Signs

• Temperature
• BP, pulse, apical HR (if pulse irregular)
• Respiration
• Oxygen saturation
• Finger stick glucose (diabetics)

Vital Sign Criteria (any met?)

• Temp > 100.5°F
• Apical heart rate > 100 or < 50
• Respiratory rate > 28/min or < 10/ min
• BP < 90 or > 200 systolic
• Oxygen saturation < 90%
• Finger stick glucose < 70 or > 300
• Resident unable to eat or drink

Initial Nursing Evaluation for injury and/or Mental Status Changes

• DO NOT move off floor until a complete exam has been performed
• Suspected fracture or new bone deformity
• Head trauma
• Altered mental status (decreased LOC, unresponsiveness, suspicion of seizure, new or worsened cognitive impairment)
• Laceration requiring sutures/staples

Eval Signs and Symptoms for immediate Notification

• Abnormal lung sounds
• New irregular pulse
• Chest Pain
• Acute decline in ADL’s
• New/worsened incontinence
• Signs or symptoms suggestive of a stroke

Consider Contacting MD/NP/PA for the following Orders

• CBC
• Xray (if needed)
• BMP
• UA/C&S
• EKG

Manage in Facility

• Document Fall per facility policy
• Monitor VS (including orthostatic) x 24-72^1
• Monitor Neuro checks^3 x 24-72^2
• Check for pain level
• Check for new bruising or other evidence of injury
• Review of orders for medications associated with increased fall risk

Evaluate Results

• Urine result suggests infection
• EKG shows new changes suggestive of MI or arrhythmia
• WBC > 14,000 or neutrophils > 90%
• Infiltrate or pneumonia on chest X-ray

Monitor Response

• Vital signs criteria met
• Worsening condition and/or immediate notification criteria met

NOTIFY MD / NP / PA

Tests Ordered

YES

NO

YES

NO
Skilled Nursing Facility Care Pathway - Symptoms of Sepsis and Septic Shock

Sepsis = Infection + life-threatening organ dysfunction
Septic Shock = Sepsis + persistent hypotension despite fluid resuscitation and need for vasopressors to keep MAP >65mmHg.

Notify MD, treat, and monitor for worsening condition

Take Vital Signs and Draw WBC
- Temperature
- BP, pulse
- Respirations

Notify MD/NP/PA

Review resident’s wishes for life-sustaining treatment

Evaluate Results
- WBC >12,000 or <4,000 or >10% bands
- Lactate >2mm/L
- Platelets <100,000
- Serum Creatinine >2.0mg/dL
- aPTT >60secs or INR >1.5
- Bilirubin >2mg/dL
- Hyperglycemia (not diabetic)

Consider Contacting MD/NP/PA for Orders (for further evaluation and management)
- WBC
- Blood cultures X2 (prior to antibiotics)
- Lactate
- Coagulation tests (aPTT/INR)
- Serum Creatinine
- Platelet count
- Bilirubin
- Urinalysis
- Urine culture
- Blood glucose

Manage in Facility
- Monitor vital signs, fluid intake/urine output
- Oral, IV or subcutaneous fluids if needed for hydration
- Update advance care plan and directives if appropriate

Anyone with an infection is at high risk for sepsis.
Potential causes of infection that can lead to sepsis include the following:
- Pneumonia
- Pressure Ulcers
- C.Difique Infection
- Urinary Tract Infection
- Prolonged Use of Catheters
- Chronic Conditions

Early Signs & Symptoms of Infection
- Confusion/altered mental state
- Poor motor skills or weakness
- Decrease in drinking fluids
- Decrease in appetite
- Falling or dizziness
- Agitation
- Other behavioral changes

Symptoms or Signs of Sepsis
- Infection (confirmed or suspected)
- Fever or feeling very cold
- Rapid heart rate
- Rapid breathing
- Shortness of breath
- Confusion or difficulty to arouse
- Complaints of extreme pain

Vital Sign Criteria (any met?)
- Infection (confirmed or suspected)

PLUS

Two or more of the following:
- Altered Mental Status (Glasgow Coma Scale<13)
- Hypotension (systolic<100mmHg)
- Tachypnea (RR>22)
- Decreased urine output or darkened/concentrated urine

YES

NO

YES

NO

Adapted from: Third International Consensus Definitions for Sepsis and Septic Shock- Singer et al. JAMA 2016;315(8) 801-810
This resource is not all inclusive and may not apply to all patients/residents and/or situations. It is intended for educational purposes only and as guidance to support investigation for performance improvement—not as a substitute for treatment or advice from a physician or healthcare provider.
This material was prepared by the Atlantic Quality Innovation Network (AQIN), the Medicare Quality Innovation Network-Quality Improvement Organization for New York State, South Carolina, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 11SOW-AQINNY-TskSIP-SEPSIS-16-23
9/28/16
Immediate Notification

Any symptom, sign or apparent discomfort that is:

- **Acute** or **Sudden** in onset, and:
  - **A Marked Change** *(i.e. more severe)* in relation to usual symptoms and signs, or
  - **Unrelieved** by measures already prescribed

Non-Immediate Notification

- **New or worsening symptoms** that do not meet above criteria

This guidance is adapted from: AMDA Clinical Practice Guideline – Acute Changes in Condition in the Long-Term Care Setting 2003; and Ouslander, J, Osterweil, D, Morley, J. *Medical Care in the Nursing Home*. McGraw-Hill, 1996
## Vital Signs *(report why vital signs were taken)*

<table>
<thead>
<tr>
<th>Vital Sign</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>• Systolic BP &gt; 200 mmHg or &lt; 90 mmHg</td>
<td>• Diastolic BP &gt; 90 mmHg</td>
</tr>
<tr>
<td>Pulse</td>
<td>• Diastolic BP &gt; 115 mmHg</td>
<td>• New irregular pulse</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>• Resting pulse &gt; 100, &lt; 50</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td>• Respirations &gt; 28, &lt; 10/minute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oral temp &gt; 100.5 F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Oxygen saturation &lt; 90%</td>
<td></td>
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<tr>
<td>Weight Loss</td>
<td></td>
<td>• New onset of anorexia with or without weight loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 5% or more within 30 days</td>
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<td></td>
<td></td>
<td>• 10% or more within 6 months</td>
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<tr>
<td>Weight Gain</td>
<td></td>
<td>• &gt; 5 lbs in one week in resident with</td>
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<tr>
<td></td>
<td></td>
<td>- CHF</td>
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<td></td>
<td></td>
<td>- chronic renal failure</td>
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<td></td>
<td></td>
<td>- other volume overload state</td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician*
### Laboratory Tests / Diagnostic Procedures
*(report why the test or procedure was done)*

<table>
<thead>
<tr>
<th>Test/Procedure</th>
<th>Report Immediately*</th>
<th>Non-Immediate</th>
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<tbody>
<tr>
<td>Complete Blood Count</td>
<td></td>
<td>WBC &gt; 10,000 without symptoms or fever</td>
</tr>
<tr>
<td></td>
<td>• WBC &gt; 14,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hemoglobin (Hb) &lt; 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Platelets &lt; 50,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hematocrit &lt; 24</td>
<td></td>
</tr>
<tr>
<td>Chemistry</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood/urea/nitrogen (BUN) &gt; 60 mg/dl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Calcium (Ca) &gt; 12.5 mg/dl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potassium (K) &lt; 3.0, &gt; 6.0 mg/dl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sodium (Na) &lt; 125, &gt; 155 mg/dl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood glucose &gt; 300 mg/dl or &lt; 70 mg/dl <em>(diabetic)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Glucose consistently &gt; 200 mg/dl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hb A1c <em>(any value)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Albumin <em>(any value)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bilirubin <em>(any value)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cholesterol <em>(any value)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Triglycerides <em>(any value)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Other chemistry values</td>
<td></td>
</tr>
<tr>
<td>Consult Reports</td>
<td>Consultant report recommending immediate action or changes in management</td>
<td>Routine consultant report recommending routine action or changes in resident’s management</td>
</tr>
<tr>
<td>Drug Levels</td>
<td>Levels above therapeutic range of any drug <em>(hold next dose)</em></td>
<td>Any therapeutic or low level</td>
</tr>
<tr>
<td>INR <em>(International Normalized Ratio)</em></td>
<td>• INR &gt; 6 IUs <em>(hold warfarin)</em></td>
<td>• INR 3-6 IUs <em>(hold warfarin)</em></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Abnormal result in resident with signs and symptoms possibly related to urinary tract infection or urosepsis <em>(e.g. fever, burning sensation, pain in suprapubic or flank area)</em></td>
<td>Abnormal result in resident with no signs or symptoms</td>
</tr>
<tr>
<td>Urine Culture</td>
<td>&gt;100,000 colony count with a urinary pathogen with symptoms</td>
<td>Any growth with no symptoms</td>
</tr>
<tr>
<td>X-ray</td>
<td>New or unsuspected finding <em>(e.g. fracture, pneumonia, CHF)</em></td>
<td>Old or long-standing finding, no change</td>
</tr>
</tbody>
</table>

*Unless these values are stable and known by the primary care clinician.
## Signs and Symptoms \(A's\)

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain(^1)</td>
<td>Abrupt onset severe pain or distention, OR with fever, vomiting</td>
<td>Mild diffuse or localized pain, unrelieved by antacids or laxatives</td>
</tr>
<tr>
<td>Abdominal Distention(^1)</td>
<td>Rapid onset, OR presence of marked tenderness, fever, vomiting, GI bleeding</td>
<td>Progressive or persistent distension not associated with symptoms</td>
</tr>
<tr>
<td>Abdominal Tenderness(^1)</td>
<td>Associated with fever, continuous GI bleeding, or other acute symptoms</td>
<td>Persistent discomfort not associated with other acute symptoms</td>
</tr>
<tr>
<td>Abrasion</td>
<td>Accompanied by significant pain or bleeding</td>
<td>If bleeding continues or if associated with evidence of local infection</td>
</tr>
<tr>
<td>Agitation(^2)</td>
<td>Abrupt onset of significant change from usual, OR associated with fever or new onset abnormal neurological signs</td>
<td>Continued progression or persistence of symptoms</td>
</tr>
<tr>
<td>Altered Mental Status</td>
<td>Abrupt significant change in cognitive function from usual with or without altered level of consciousness</td>
<td>Persistent change from usual cognitive function with no other criteria met for immediate notification</td>
</tr>
<tr>
<td>Appetite, Diminished</td>
<td>No oral intake 2 consecutive meals</td>
<td>Significant decline in food and fluid intake in resident with marginal hydration and nutritional status</td>
</tr>
<tr>
<td>Asthma</td>
<td>Acute episode with wheezing, dyspnea, or respiratory distress</td>
<td>Self-limited episode that was more extensive or less responsive to treatment than the usual</td>
</tr>
</tbody>
</table>

\(^1\) See INTERACT GI Symptoms Care Path  \(^2\) See INTERACT Change in Behavior Care Path
## Signs and Symptoms  *B’s*

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back, injuries and complaints</td>
<td>Abrupt onset of severe pain secondary to fall or injury, OR pain with new abnormal neurological signs</td>
<td>Persistent back pain not responding to existing or progressive orders</td>
</tr>
<tr>
<td>Behavioral Symptoms</td>
<td>New or worsening physical / verbal aggression <em>(biting, kicking, cursing, screaming, etc)</em> and OR danger to self or others</td>
<td>New or worsening non-aggressive physical / verbal symptoms posing no danger to self or others</td>
</tr>
<tr>
<td>Bleeding, rectal <em>(melena)</em></td>
<td>Persistent, or accompanied by diaphoresis, tachycardia, significant orthostatic BP drop</td>
<td>Recent self-limited bleeding: black stool or melena without change in vital signs; stools positive for occult blood on routine testing</td>
</tr>
<tr>
<td>Blisters</td>
<td>Secondary to any burn more than a minor one</td>
<td>New onset large tense blisters with fever</td>
</tr>
<tr>
<td>Bowel Sounds <em>(absent or hyperactive)</em></td>
<td>Associated with severe abdominal pain / distention with or without fever or vomiting</td>
<td>Continued progression or persistence of symptoms</td>
</tr>
<tr>
<td>Burns</td>
<td>Any burn other than a minor first degree burn with no significant pain</td>
<td>Minor first degree burn in past twenty-four hours</td>
</tr>
</tbody>
</table>
# Signs and Symptoms  

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain, pressure or tightness</td>
<td>New or abrupt onset, unrelieved by current medications, OR accompanied by diaphoresis, change in vital signs or new EKG changes</td>
<td>Relieved by antacids or nitroglycerin, without other symptoms, but recurring more often than usual</td>
</tr>
<tr>
<td>Common cold (symptoms of)</td>
<td>With marked respiratory distress, severe cough, or T &gt; 100.5 F</td>
<td>Change in color of sputum or phlegm; persistent need for symptom relief</td>
</tr>
<tr>
<td>Complaint, medical, by family or patient</td>
<td>Demand to speak to a physician or have a medical assessment without delay</td>
<td>Any persistent or recurrent complaint that might need a physician’s attention</td>
</tr>
<tr>
<td>Confusion¹</td>
<td>See Altered Mental Status</td>
<td>See Altered Mental Status</td>
</tr>
<tr>
<td>Consciousness, altered¹</td>
<td>Sudden change in level of consciousness or responsiveness</td>
<td>Gradual change in level of consciousness not associated with other criteria for immediate notification</td>
</tr>
<tr>
<td>Constipation</td>
<td>Severe abdominal pain, rigid abdomen, absent bowel sounds</td>
<td>&lt; 1 BM in a week</td>
</tr>
<tr>
<td>Contusions</td>
<td>Accompanied by significant pain or bleeding</td>
<td>Associated with a recent fall with no other complications</td>
</tr>
<tr>
<td>Cough²</td>
<td>Associated with blood in sputum, new sputum production, fever or respiratory distress</td>
<td>New or recent onset of persistent or nocturnal cough, causing discomfort or disturbing sleep</td>
</tr>
</tbody>
</table>

1 See INTERACT Acute Mental Status Change Care Path  
2 See INTERACT Symptoms of Lower Respiratory Illness Care Path
<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delirium</td>
<td>See Altered Mental Status</td>
<td>See Altered Mental Status</td>
</tr>
<tr>
<td>Depressed affect (see 'Suicide, potential')</td>
<td>Acute suicidal ideation</td>
<td>Recent onset of significant mood decline, with anorexia, crying, and sleeplessness</td>
</tr>
<tr>
<td>Diabetes, poorly controlled</td>
<td>Any diabetic with altered mental status, or an acute infection, OR hypoglycemic episode in someone on hypoglycemic medication or not responding to additional glucose; Glucose &gt; 300 or &lt; 70 mg/dl</td>
<td>Usually stable diabetic with change in oral intake, thirst, or urination, fluctuating or rising blood sugars</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Acute onset of 3 or more episodes of loose stools</td>
<td>Persistent multiple loose with stable vital signs</td>
</tr>
<tr>
<td>Discoloration of Skin</td>
<td>Any new skin discoloration accompanied by significant pain</td>
<td>Any new skin discoloration without any other symptoms</td>
</tr>
<tr>
<td>Dizziness or unsteadiness</td>
<td>Abrupt onset, with slurred speech, or other focal neurological findings</td>
<td>Minor but persistent change over past 24 hours from usual pattern</td>
</tr>
<tr>
<td>Dyspnea 2 (shortness of breath)</td>
<td>See Shortness of Breath</td>
<td>See Shortness of Breath</td>
</tr>
<tr>
<td>Dysuria</td>
<td>See urination, painful</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

1 See INTERACT GI Symptoms Care Path  
2 See INTERACT Shortness of Breath Care Path
## Signs and Symptoms *E,F,G’s*

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earache</td>
<td>Severe ear pain, bleeding or discharge from canal</td>
<td>Progressive or persistent ear pain</td>
</tr>
<tr>
<td>Edema¹</td>
<td>Abrupt onset unilateral leg edema, with tenderness or redness or progressive bilateral edema with or without SOB</td>
<td>Persistent unilateral or bilateral edema</td>
</tr>
<tr>
<td>Eye injuries (foreign bodies; chemical burns; contusions)</td>
<td>Any eye injury</td>
<td>Any persistent redness of eyes not associated with known injury or infection</td>
</tr>
<tr>
<td>Fainting</td>
<td>Sudden loss of consciousness</td>
<td></td>
</tr>
</tbody>
</table>
| Fall²                               | With any suspected serious injury *(e.g. fracture)*
any hip pain, or more than minor pain elsewhere | Fall with no or minor injury                                                 |
| Fever³                              | New onset T > 100.5 F regardless of any other symptoms *(unless under treatment already and clinician already aware)* | Gradual increase in temperature curve or recurrent daily temperature spikes for more than two days |
| Fractures and dislocation           | Any suspected fracture or dislocation                                      |                                                                                |
| Gait disturbances                   | Abrupt onset with slurred speech, or other new focal neurological findings | Significant recent changes in gait without other symptoms or findings         |

1 See INTERACT Symptoms of CHF Care Path  2 See INTERACT Fall Care Path  3 See INTERACT Fever Care Path
# Signs and Symptoms  
**H, I, J’s**

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td>Abrupt onset of visual or auditory hallucinations</td>
<td>Continued progression or persistence of problem</td>
</tr>
<tr>
<td>Head injuries</td>
<td>Any head injury with change in level of consciousness, other mental status change, or any focal neurological findings</td>
<td>Head injury not meeting Immediate Notification criteria</td>
</tr>
<tr>
<td>Headache</td>
<td>Abrupt onset of progression of severe headache with fever, change in mental status, or focal neurological abnormalities</td>
<td>Persistent nagging headache, unresponsive to standard analgesics</td>
</tr>
<tr>
<td>Hearing loss</td>
<td>Abrupt onset or progression of hearing loss with fever or focal neurological abnormalities</td>
<td>Significant hearing loss without other significant symptoms</td>
</tr>
<tr>
<td>Hematuria(^1) <strong>(blood in urine)</strong></td>
<td>Gross hematuria with pain, fever or other signs of bleeding at other sites</td>
<td>One isolated episode of blood-tinged urine without fever or other signs of bleeding, or other urinary symptoms</td>
</tr>
<tr>
<td>Hypothermia</td>
<td>New onset T &lt; 95F, OR T more than two degrees below usual with change in mental status or other symptoms</td>
<td>New onset T &lt; 95, OR T more than two degrees below usual lower limits of normal, without change in mental status or other symptoms</td>
</tr>
<tr>
<td>Incontinence of urine or stool(^1)</td>
<td>New onset of incontinence with fever, neurological abnormalities or other symptoms</td>
<td>New onset without other abnormalities or other symptoms</td>
</tr>
<tr>
<td>Itching <strong>(pruritus)</strong></td>
<td>Severe unremitting itching, OR occurring after recent change in medications</td>
<td>Persistent mild to moderate itching unrelieved by topical treatment or mild antihistamines</td>
</tr>
<tr>
<td>Jaundice <strong>(yellowing of skin)</strong></td>
<td>Abrupt onset of jaundice with or without nausea / vomiting / fever</td>
<td>Continued progression or persistence of problem</td>
</tr>
</tbody>
</table>

\(^1\) See INTERACT UTI Care Path
## Signs and Symptoms  \( L,M,N\)'s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laceration</td>
<td>Any laceration requiring sutures</td>
<td>Any laceration not requiring sutures and without other symptoms</td>
</tr>
<tr>
<td>Lung Sounds(^1) (abnormal)</td>
<td>Abrupt onset of wheezing, rales or rhonchi  (new)</td>
<td>Self-limited episode of abnormal lung sounds that was more extensive and less responsive to treatment than usual</td>
</tr>
<tr>
<td>Medication error</td>
<td>Causing any new symptoms OR involving a cardiac, psychotropic, or other drug with potential for significant toxic side effects</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medication side effects</td>
<td>Any abrupt symptoms or significant changes in condition that might be associated with one or more medications</td>
<td>Any minor symptoms or changes in status that might be associated with one or more medications</td>
</tr>
<tr>
<td>Memory loss(^2)</td>
<td>Abrupt onset or progression of memory loss with fever, change in level of consciousness, or focal neurological abnormalities</td>
<td>Noticeable decline in memory or mental status without other apparent symptoms</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>Marked localized bruising, swelling, or pain over joint or bone, with or without recent fall</td>
<td>Progressive or more frequent pain</td>
</tr>
<tr>
<td>Nausea(^3)</td>
<td>Associated with fever, vomiting or recent change in condition</td>
<td>Persistent discomfort not associated with other acute symptoms</td>
</tr>
<tr>
<td>Nocturia</td>
<td>N/A</td>
<td>Marked increase in nocturia from usual pattern for &gt;2 days</td>
</tr>
<tr>
<td>Nosebleed</td>
<td>Acute nosebleed which persists despite simple packing or pinching nostrils</td>
<td>Recent minor nosebleed with more than minor blood streaking</td>
</tr>
</tbody>
</table>

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1 See INTERACT SOB Care Path/INTERACT LRI Care Path  
2 See INTERACT Acute Mental Status Change Care Path  
3 See INTERACT GI Symptoms Care Path
## Signs and Symptoms  \( P, R \)'s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>New severe pain, or marked increase in chronic pain</td>
<td>Increase in frequency or severity of pain</td>
</tr>
<tr>
<td>Personality change(^1)</td>
<td>Abrupt significant change from usual, associated with fever, or new onset of abnormal neurological signs</td>
<td>Recent minor but persistent change or fluctuation in behavior, memory, or mood from usual</td>
</tr>
<tr>
<td>Pressure sore</td>
<td>New onset T &gt; 100.5 F in someone with Grade 2 or higher sore</td>
<td>New onset Grade 2 or higher pressure sore, OR progression of pressure sore despite interventions</td>
</tr>
<tr>
<td>Puncture wounds</td>
<td>Deep or open wound, OR with more than minor bleeding</td>
<td>Minor uncomplicated puncture wound</td>
</tr>
<tr>
<td>Rash</td>
<td>Rash in someone taking a new medication, OR one known to cause allergic reaction</td>
<td>Recent onset of localized or diffuse pruritic rash, OR any rash accompanied by other systematic symptoms</td>
</tr>
</tbody>
</table>

\(^1\) See INTERACT Change in Behavior Care Path
### Signs and Symptoms  S’s

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizure activity</td>
<td>Any new onset seizure activity, OR persistent seizure in someone with known intermittent seizure activity</td>
<td>Self-limited seizure in past 24 hours in a resident with known seizure activity who is already on an anticonvulsant</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>Abrupt onset of shortness of breath with pain, fever, or respiratory distress, or with progressive leg edema</td>
<td>Recently progressive or persistent minor shortness of breath without other symptoms</td>
</tr>
<tr>
<td>(dyspnea)1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Tear</td>
<td>Accompanied by significant pain or bleeding</td>
<td>Not associated with immediate notification criteria</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Not applicable</td>
<td>Difficulty sleeping</td>
</tr>
<tr>
<td>Sore throat</td>
<td>Accompanied by respiratory distress or inability to swallow</td>
<td>With mild to moderate symptoms of upper respiratory infection not responding to standard conservative treatments</td>
</tr>
<tr>
<td>Speech, abnormality²</td>
<td>Abrupt change in speech, with or without other focal neurological findings</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Splinters/slivers</td>
<td>If unable to remove readily, with OR accompanied by considerable pain or bleeding</td>
<td>If area appears to be infected, with erythema or purulent drainage, OR if no tetanus shot within past ten years</td>
</tr>
<tr>
<td>Suicide potential</td>
<td>Makes a suicidal gesture, OR discusses a detailed plan for carrying out suicide</td>
<td>New onset of talking about wanting to die, but not making any specific suicidal threats</td>
</tr>
<tr>
<td>Swallowing difficulty</td>
<td>With new onset or progressive choking, aspiration</td>
<td>Decreased intake from dysphagia, with potential risk of dehydration malnutrition</td>
</tr>
</tbody>
</table>
### Signs and Symptoms  \( T, U, V's \)

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toothache</td>
<td>Accompanied by fever, severe pain, redness, or swelling in mouth, cheek, or jaw</td>
<td>Persistent or progressive discomfort not responding to conservative measures</td>
</tr>
<tr>
<td>Urination (painful)</td>
<td>Abrupt onset of painful urination with or without fever, frequency</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Urinary hesitancy or retention</td>
<td>Abrupt decrease in urinary output, with lower abdominal distension, discomfort over bladder, or bladder volume &gt; 400 cc</td>
<td>Decreased in urinary output over 1 - 2 days, or new onset of post-void residual &gt; 300 cc</td>
</tr>
<tr>
<td>Vaginal bleeding</td>
<td>Bleeding with clots that saturate one pad or more every two hours</td>
<td>Episode of bleeding that persist or that resolved spontaneously</td>
</tr>
<tr>
<td>Vaginal discharge or spotting</td>
<td>Not applicable</td>
<td>New or recurrent discharge or spotting</td>
</tr>
<tr>
<td>Vision, partial or complete loss</td>
<td>Abrupt onset with pain, redness, or other symptoms</td>
<td>Recent significant change</td>
</tr>
<tr>
<td>Vomiting ¹</td>
<td>Persistent or recurrent (2 or more within 12 hours) vomiting, with or without abdominal pain, bleeding, distension / fever</td>
<td>Intermittent recurrent vomiting without immediate notification criteria met</td>
</tr>
<tr>
<td>Vomiting blood ¹ (hematemesis)</td>
<td>New onset hematemesis with clots, OR accompanied by rapid pulse or orthostatic BP drop</td>
<td>One isolated episode of blood-streaked vomiting without other significant symptoms</td>
</tr>
</tbody>
</table>

¹ See INTERACT GI Care Path
## Signs and Symptoms  
**W’s**

<table>
<thead>
<tr>
<th>Symptom or Sign</th>
<th>Immediate</th>
<th>Non-Immediate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking difficulty</td>
<td>Acute onset accompanied by other neurological signs</td>
<td>Recent onset not resolving spontaneously</td>
</tr>
<tr>
<td>Weakness, arm or leg</td>
<td>Abrupt onset of noticeable change in strength or use</td>
<td>Gradual recent onset not resolving spontaneously</td>
</tr>
<tr>
<td>Weakness, general</td>
<td>Abrupt onset of general weakness with fever or other acute symptoms</td>
<td>Abrupt onset of general weakness without fever, change in level of consciousness, or other acute symptoms</td>
</tr>
<tr>
<td>Weight, change in</td>
<td>• New onset of anorexia with or without weight loss</td>
<td>• New onset of anorexia with or without weight loss</td>
</tr>
<tr>
<td></td>
<td>• 5% or more within 30 days</td>
<td>• 10% or more within 6 months</td>
</tr>
<tr>
<td></td>
<td>• &gt; 5 lbs in one week in resident with</td>
<td>• &gt; 5 lbs in one week in resident with</td>
</tr>
<tr>
<td></td>
<td>- CHF</td>
<td>- chronic renal failure</td>
</tr>
<tr>
<td></td>
<td>- other volume overload state</td>
<td>- other volume overload state</td>
</tr>
<tr>
<td>Wounds</td>
<td>Any wound that will not stop bleeding, OR that exposes subcutaneous tissue</td>
<td>Apparently minor recent wound now developing redness, swelling, or pain</td>
</tr>
</tbody>
</table>
Clinical Guideline Board Approval History:
Clinical Guideline Revisions:

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision Log</th>
<th>Updated By</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/13/2015</td>
<td>Update with BOD approval date</td>
<td>D. Sculley</td>
</tr>
<tr>
<td>2/23/2017</td>
<td>Added “Symptoms of Sepsis and Septic Shock” Care Path</td>
<td>N. Roselli</td>
</tr>
</tbody>
</table>

This Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network’s senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.