

Significant Change Form Instructions for Private Duty Nursing

Bureau of Long Term Care

Purpose

These instructions are intended to assist our agencies providing Private Duty Nursing (PDN) to identify significant changes in participant status that result in an increase or decrease in the Child PDN Care Elements and/or Nursing functions.

Instructions

- 1) Verify the participant has had a change in functioning that is significant enough to warrant a change in the participant's amount of help they need in any areas listed below. Review the guideline definitions and determine if there has been a change in any of the functioning areas.
- 2) Provider supervising personnel should visit the participant to assess what functioning areas have been impacted. Only in emergency situations will the regional reviewer consider a modification request without a provider visit to the participant's home.
- 3) If a change has occurred in any of the functioning areas, describe the participant's specific ability in the appropriate box. If there is no change in an area on this form, please mark the No Change box for that section.
- 4) Under "Justification Overview for Change" at the top of the form, please note what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in functioning will continue. Include in this area any changes to Available Supports when applicable.
- 5) Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes.
- 6) The Provider Supervising personnel (if completed the request), Provider RN and the participant or the participant's representative must sign and date the request.
- 7) If the participant refuses to sign, the Agency will mark the box for refusal. The Agency RN or Supervising Personnel will sign and date where appropriate
- 8) If the change is approved by the BLTC Reviewer. The Plan of Care (Service Agreement) must be updated to reflect the change.

PDN CARE ELEMENTS	
MEDICATION/IV DELIVERY NEED	<ul style="list-style-type: none"> ▪ Medication Delivery: <ul style="list-style-type: none"> ▪ Oral ▪ G-Tube ▪ IV ▪ NG ▪ NJ ▪ 1 to 3 doses per day ▪ 4 to 6 doses per day ▪ 7 doses or more per day ▪ <1x per week ▪ 1 x per week ▪ Peripheral IV access ▪ Central line of port, PICC Line, Hickman (Flush Only) ▪ Central line of port, PICC Line, Hickman (Currently utilized for treatment) ▪ IV Tx less often than every 4 hours (does not include hep flush) ▪ IV Tx q 4 hours or more often ▪ TPN with associate protocols for monitoring.
NUTRITION NEEDS	<ul style="list-style-type: none"> ▪ Routine oral feeding ▪ Occasional reflux and/or aspiration precautions ▪ Nutrition Needs <ul style="list-style-type: none"> ▪ G-Tube ▪ NG Tube ▪ J-Tube ▪ Mic-key button care ▪ Difficult or multiple prolonged oral feeding (4 or more times per day) ▪ Tube feeding (routine problems or continuous) ▪ Tube feeding (combination bolus and continuous) ▪ Complicated tube feeding, residual checks, aspiration precautions (slow feed or other problems)

RESPIRATORY NEEDS	
Tracheostomy Care	<ul style="list-style-type: none"> ▪ No tracheostomy, unstable airway (desats common, airway clearance issues) ▪ Tracheostomy care (routine) ▪ Tracheostomy (special care-wounds, breakdown, frequent pull-out, replacement) ▪ Oral suctioning (every 1-2 hours and affecting respiratory status) ▪ Infrequent nasopharyngeal suctioning (less than every 8 hours, but at least daily) ▪ Frequent nasopharyngeal suctioning every 2 to every 8 hours ▪ Tracheal suctioning every 3 to every 8 hours ▪ Tracheal suctioning every 2 hours or more frequently
Oxygen	<ul style="list-style-type: none"> ▪ Oxygen requiring SAT monitoring PRN ▪ Oxygen requiring titration – daily use ▪ Oxygen requiring titration at least weekly
Ventilator	<ul style="list-style-type: none"> ▪ Non-invasively at night ▪ Rehab transition/active wearing ▪ Less than 12 hours per day ▪ 12 hours or more per day, but not continuous ▪ No respiratory effort or 24 hours/day in assist mode
Treatments	<ul style="list-style-type: none"> ▪ BIPAP ▪ CPAP ▪ IPPB (administered and adjusted by RT) ▪ Nebulizer treatments less than daily, but at least weekly ▪ Nebulizer treatment every 4 hours or less frequently ▪ Nebulizer treatment every 3 hours ▪ Nebulizer treatment every 2 hours or more frequently ▪ Chest PT, ABI Vest or Cough Assist, less than daily, at least weekly ▪ Chest PT, ABI Vest or Cough Assist, every 4 hours or less frequently ▪ Chest PT, ABI Vest or Cough Assist, every 3 hours ▪ Chest PT, ABI Vest or Cough Assist, every 2 hours or more ▪ Chest PT, ABI Vest or Cough Assist (combination of two or more)
ASSESSMENT NEEDS	<ul style="list-style-type: none"> ▪ General Head to Toe Assessment ▪ VS/GLU/NEURO/RESP <ul style="list-style-type: none"> ▪ Assess less often than every 4 hours but at least daily ▪ Assess every 4 hours or more often ▪ assess every 2 hours or more often
SEIZURES	<ul style="list-style-type: none"> ▪ Mild Seizures <ul style="list-style-type: none"> ▪ At least daily, no intervention ▪ Requires minimum intervention – at least weekly ▪ Moderate Seizures <ul style="list-style-type: none"> ▪ Requires minimum intervention – at least daily ▪ Requires minimum intervention – 2 to 4 times per day ▪ Requires minimum intervention – 5 times or more per day ▪ Severe Seizures <ul style="list-style-type: none"> ▪ Requires IM/IV/Rectal Med Administration – 2 to 4 times per week ▪ Requires IM/IV/Rectal Med Administration – at least daily ▪ Requires IM/IV/Rectal Med Administration – 2 to 4 times per day ▪ Requires IM/IV/Rectal Med Administration – 5 times or more per day
WOUND CARE	<ul style="list-style-type: none"> ▪ Wound Vac ▪ Stage 1-2 wound care at least daily, dressing change other than trach, PEG or IV site ▪ Stage 3-4, multiple wound sites
PDN NURSING	
OTHER NURSING CARE ELEMENTS	<ul style="list-style-type: none"> ▪ OT-PT-ROM (at least daily) ▪ Colostomy Care ▪ Urostomy Care ▪ Complicated Bowel Program (requiring nursing intervention to determine when to administer suppositories, enemas, etc.) ▪ Any sterile procedure (not noted elsewhere)

	<ul style="list-style-type: none"> ▪ Intermittent Straight Catheter
FUNCTIONAL LIMITATIONS	<ul style="list-style-type: none"> ▪ Amputation, Ambulation, Bowel/Bladder (incontinence), Speech, Contracture, Legally Blind, Hearing, Dyspnea with Minimal Exertion, Paralysis, Endurance, Other
ACTIVITIES PERMITTED	<ul style="list-style-type: none"> ▪ Complete Bed Rest, Transfer Bed/Chair, Bed Rest – Bathroom Privileges (BRP), Partial Weight Bearing, Up as Tolerated, Independent at Home, Crutches, Walker, Cane, No Restrictions, Wheelchair, Other
MENTAL STATUS	<ul style="list-style-type: none"> ▪ Oriented, Disoriented, Alert, Lethargic, Comatose, Behavior, Forgetful, Developmentally Disabled, Mood Indicators, Other

For questions or assistance please call 877-799-4430. Please review to ensure the form is complete and fax to (208) 639-5731 or email (click the region below).

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