Murrumbidgee Acute Care Decision Guidelines

VERSION 2.0

phn MURRUMBIDGEE
An Australian Government Initiative

NSW GOVERNMENT Health
Murrumbidgee
Local Health District

VERSION 2.0 AND NEW PATHWAYS

Version 2.0 of the Acute Care Decision Guidelines for RACFs has undergone a clinical review and update, and in response to consultation findings by user groups, has been repackaged to improve ease of use and expanded to include additional conditions.

The following new pathways have been developed.

- At risk behaviours
- Blood loss
- Closed head injury
- General deterioration of unknown origin or attribution
- Psychological distress

CONTENTS

ISBAR Form

ATTENTION: **DATE:** **TIME:**

FAX No.: **No. of pages:**

Identity	RACF: _____ Staff member: _____ Position: _____ Direct Phone Number: _____	**Resident's Details** **Full Name:** _____ D.O.B: _____ Noom No. _____ Allergies?: _____

Situation	What is the main problem / symptoms at present? If **URGENT**, please follow up with a phone call to the General Practice.	Is a **Palliative care plan** in place? Yes / No Is an **Advance Care Plan** in place? Yes / No

Background	History of the main problem / symptoms? Initial treatment and the effect on the resident? What is the relevant medical history? What are the current medications? Name of the resident's usual GP?	

Assessment	*(Complete* **ALL** *domains of the clinical assessment before faxing or phoning.)*				
	Temperature:		**Pulse:**	regular/irregular	
	Respirations:	/minute	**SaO2:**	**Usual SaO2:**	
	Current BP: /	**Usual BP:** /		**Blood glucose level (if diabetic):**	
	Urinalysis:		**Urine output:**	similar / less / more	
	Pain: yes/no	**Location:**	**Pain Score** (0-10)**:**	(Consider Abbey pain scale)	
	Last seen by GP:		**Recent treatment for infection/Hospitalisation?**		
	Confusion/change in alertness?:				
	Other observations:				

Request	State what you need or ask what else should you do?	

Please respond to (staff name):	**Date resident is due for medication chart renew:**
Return Fax No.(RACF to complete):	

GP / PRACTICE RESPONSE

GP will visit on ..... OR within 24 / 48 / 72 hours OR:

Please complete the following orders:

GP Signature:	Date:	Time:

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Abbey Pain Scale

for measurement of pain in people who cannot verbalise

How to use scale:
While observing the patient, score questions 1 to 6

Q1. Vocalisation
(eg. whimpering, groaning, crying)
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression
(eg. Looking tense, frowning, grimacing, looking frightened)
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language
(eg. fidgeting, rocking, guarding part of body, withdrawn)
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behaviour change
(eg. increased confusion, refusing to eat, alteration in usual patterns)
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change
(eg. Temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor)
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes
(eg. Skin tears, pressure areas, arthritis, contractures, previous injuries)
Absent 0 Mild 1 Moderate 2 Severe 3

Add score for 1 – 6 and record here **Total Pain Score**

Now tick the box that matches the Total Pain Score:

0-2 No pain	3-7 Mild	8-13 Moderate	14+ Severe

Finally, tick the box that matches the type of pain:

Chronic	Acute	Acute on Chronic

Reference: Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002

Consciousness Assessment

Assessing level of consciousness using the Glasgow Coma Scale (GCS)

Eye opening (E):	
Spontaneous	4 points
Responds to verbal command	3 points
Responds to pain	2 points
No eye opening	1 point
Best verbal response (V):	
Oriented	5 points
Confused	4 points
Inappropriate words	3 points
Incomprehensible sounds	2 points
No verbal response	1 point
Best monitor response (M):	
Obeys commands	6 points
Localises to pain	5 points
Withdraws from pain	4 points
Flexion to pain	3 points
Extension to pain	2 points
No movement	1 point

SCORING

To score GCS, check the resident's best response to each of the three categories and compare this to the resident's normal response.

Document the score for each of the **Eye Opening, Best Verbal Response** and **Best Motor Response** and add the total together.

The total score should be between 3 (lowest possible score) and 15 (highest possible score).

Example: A resident who is drowsy and is responding only by opening their eyes to pain, groaning in response in response to pain, and flexes (bends their arms) to pain has a GCS of **7, (E2 + V2 + M3).**

If GCS <9, call an ambulance. If GCS is normally 10 and drops to <10, call GP.

Be alert for COVID-19

COVID-19 affects different people in different ways. Most infected people will develop mild to moderate illness. Older people are at considerably higher risk of severe disease and death from Covid-19.

If a resident develops any of the following symptoms, arrange COVID-19 testing and activate processes to immediately isolate the resident until a negative result is received. Symptoms associated with COVID-19 and known variants may include:

- Temperature over 37.5
- Sore throat
- Coughing
- Runny/blocked nose
- Shortness of breath
- Aches and pains
- Headaches
- Loss of taste or smell

For information about testing in the Murrumbidgee region, visit the Murrumbidgee Local Health District Webpage.

TIPS

- **Undertake routine screening of all people entering the service, including staff, visiting health professionals, service providers and visitors**
- **Closely monitor people receiving care for signs of COVID-19 regularly and know the local pathway for testing**
- **Ensure you can quickly identify the close contacts of all staff (including health professionals and others visiting the service) and consumers to identify who may have contracted COVID-19 and put mechanisms in place rapidly to reduce further transmission**
- **Stay up to date with advice by regularly visiting https://www.agedcarequality.gov.au/covid-19-coronavirus-information**

Abdominal Problems

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Severe abdominal pain (use pain score or Abbey Pain Scale)
- Distended abdomen and has not been able to pass wind 12-24 hours
- Persistent vomiting or diarrhoea
- Large volume PR bleeding

- Assess vital signs
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- Call 000 for Ambulance if unable to obtain immediate instructions from GP
- Contact family
- Keep resident nil by mouth until medical review (in case surgical intervention is required)

Act within 12 hours

If the resident has any of these symptoms or signs:

- Mild to moderate abdominal pain
- Bowels do not open within 48 hours of expected motion
- Bowel motions hard or pellet-like
- New onset nausea, vomiting or diarrhoea
- Small volume PR bleeding

- Assess vital signs and complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

While waiting for help

- Position as comfortable
- Consider the possibility of gastroenteritis and the need to implement additional infection control measures
- Administer PRN medications as appropriate e.g., for constipation consider nurse-initiated aperients and enemas
- Monitor and document response to treatment
- Administer usual medications as prescribed (with sips of fluid)

At Risk Behaviours

Act NOW

If the resident has any of these symptoms or signs:

- Threat of or actual acts of violent behavior towards self and/or others (staff, other residents, or visitors)
- Physical or verbal acts including hitting (open or closed fist), punching, banging, slapping, pinching

- Conduct a risk assessment and monitor vital signs as far as possible without putting yourself at risk of harm
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- Establish safety within the immediate environment for yourself, the affected resident, co-residents, visitors, and staff
- Reassure the resident and acknowledge their grievances or concerns in a non-threatening, empathic, positive, and calm manner
- Maintain eye contact
- Try to identify any triggers leading to the aggressive event and eliminate or mitigate the trigger as far as possible
- Ensure that you and others maintain a safe distance from the resident
- Ask open ended questions, avoid value judgements, and maintain sensitivity
- Be clear, concise, and simple with any messages or instructions to the resident
- Consider referring to psychological distress guideline

Act within 12 hours

If the resident has any of these symptoms or signs:

- Monitor the resident's level of anxiety, moodiness, disorientation, or memory problems
- Continue to identify triggers leading to any aggressive event and avoid the triggers
- Identify needs and wants proactively to avoid future triggers to aggressive behaviour
- Consult with significant other/family of the Resident to determine if a life altering event has occurred (death of a loved one, sale of family home, loved one away and not visiting on a regular basis)

- Conduct a risk assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

Special Instructions

- Monitor the resident's mood, level of anxiety, orientation, or memory problems
- Continue to identify triggers leading to any aggressive event and avoid, remove, or modify the triggers
- Identify & meet the resident's needs and wants. Avoid future triggers to aggressive behaviour

While waiting for help

- De-escalate potential aggressive behaviours with review of strategies/interventions to avoid or modify potential triggers
- Check for any physical causes and manage these per appropriate guideline if relevant
- Check for any social causes
- Consider referring to psychological distress guideline

TIPS

Offer to call resident's family for emotional support, if it does not put family members or support persons at risk

Be supportive and reassuring

Breathing Difficulties

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Breathlessness that is severe or rapidly worsening, this may include:
  - » Breathing that is unusually laboured or noisy **for this resident**
  - » Inability to say more than single words or phrases due to breathlessness
  - » Central cyanosis (blue lips / tongue)
- Vital signs indicative of a rapidly deteriorating resident:
  - » Heart rate <50 or >120 bpm
  - » Systolic BP <90 or >200 mmHg
  - » Respiratory rate <10 or >25 breaths/min
  - » SaO2 <95% and not typical **for this resident**

- Call for help from a nearby colleague
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Call 000 for Ambulance; do not wait for GP instructions
- Assess and monitor vital signs
- Complete ISBAR form only when you are no longer needed in the provision of direct emergency care
- Contact GP to inform of Hospital Transfer
- Contact family

Special Instructions

If breathlessness is associated with AIRWAY OBSTRUCTION, clear the airway.

- Encourage the resident to COUGH to expel the foreign material
- If unable to cough or cough is ineffective, bend the resident forward and perform up to 5 sharp back blows. This should be delivered to the middle of the back between the shoulder blades, using the heel of your hand. Check after each back blow to see whether it has relieved the airway obstruction
- If back blows are unsuccessful, keep the resident upright and perform up to 5 sharp chest thrusts. This should be delivered to the lower half of the sternum, using the heel of your hand. Check after each chest thrust to see whether it has relieved the airway obstruction
- If still unsuccessful, and the resident remains responsive, continue alternating 5 back blows with 5 chest thrusts until medical aid arrives.
- If resident becomes unconscious, follow DRSABCD protocol
- If tracheotomy / laryngectomy tube is blocked, remove the tube, and replace with a clean tube

Act within 12 hours

If the resident has any of these symptoms or signs:

- New or increasing breathlessness that is not severe or rapidly worsening e.g., inability to do usual activities due to breathlessness
- New or worsening cough
- Temperature >37.5 degrees
- New or increasing swelling of feet / ankles / calves

- Assess vital signs and complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

While waiting for help

- Sit resident upright, encourage resident to rest until seen by a doctor, provide reassurance
- Administer oxygen to achieve
  - » SaO2 of 94-98% for residents without COPD
  - » SaO2 of 88-92% for resident with COPD
- Administer PRN inhaler via spacer or nebuliser if charted
- Monitor vital signs and response to treatment

TIPS

Sit upright (if able)

Use spacer (if appropriate)

Blood Loss

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Evidence of severe external bleeding or severe internal bleeding
- Severe pain

Symptoms or signs of shock:

- Dizziness, thirst
- Feeling cold, shivering
- Anxiety, confusion, agitation
- Changes in consciousness: drowsiness, fluctuating consciousness, collapse
- Pale, cool, and clammy skin

Vital signs indicative of a rapidly deteriorating resident:

- Heart rate <50 or >120 bpm
- Systolic BP <90 or 200 mmHg
- Respiratory rate <10 or >25 breaths/min
- SaO2 <95% and not typical for this resident

Note: internal bleeding may be difficult to recognise but should always be suspected where there are symptoms or signs of shock

- Call for help from a nearby colleague
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Call 000 for Ambulance; do not wait for GP instructions.
- Assess and monitor vital signs
- Complete ISBAR form only when you are no longer needed in the provision of direct emergency care
- Contact GP to inform of Hospital Transfer
- Contact family

Special Instructions

External bleeding:

- Wearing gloves, apply firm direct pressure over the bleeding point using your hands or a pad and bandage
- If bleeding continues, apply a second pad and a tighter bandage
- Restrict movement by immobilisng a bleeding limb
- Keep resident nil by mouth until medical review (in case surgical intervention is required)

Act within 12 hours

If the resident has any of these symptoms or signs:

- Evidence of external bleeding that has since stopped and *without* symptoms or signs of shock
- Evidence of internal bleeding *without* symptoms or signs of shock. This may include:
  - Bruising
  - "Coffee ground" vomit, rectal bleeding, or black tarry stools
  - Coughing up blood
  - Blood-stained urine
  - Vaginal bleeding or bleeding from the penis

- Assess vital signs and complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

Special Instructions

For a nosebleed:

- Wearing gloves, apply pressure equally to both sides of the nose over the soft part below the bony bridge
- Lean the resident forward to avoid blood flowing down the throat. Encourage the resident to spit out the blood rather than swallow it.
- It may be necessary to maintain pressure for at least 10min, and on a hot day it might be necessary to maintain pressure for at least 20min
- If there is bruising to a limb and no external bleeding, apply pressure and a cold pack if available

While waiting for help

- Lie the resident down, keep resident warm, encourage resident to rest until seen by a doctor, provide reassurance
- Withhold aspirin, clopidogrel and any anticoagulant medications until assessed by a doctor
- Administer oxygen to achieve
  - SaO2 of 94-98% for residents without COPD
  - SaO2 of 88-92% for residents with COPD
- Document: amount of blood loss (if visible)
- Monitor vital signs and response to treatment

Chest Pain

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Pain or discomfort in the chest, neck, jaw, or arms (with or without shortness of breath, nausea or vomiting, sweating, or dizziness), **where symptoms are severe, rapidly worsening, or last longer than 10 minutes**
- Vital signs indicative of a rapidly deteriorating resident:
  - Heart rate <50 or >120 bpm
  - Systolic BP <90 or >200 mmHg
  - Breathing unusually laboured or noisy **for this resident**
  - Respiratory rate <10 or >25 breaths/min
  - SaO2 <95% and not typical **for this resident**

- Call for help from a nearby colleague
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Call 000 for Ambulance; do not wait for GP instructions
- Assess and monitor vital signs
- Complete ISBAR form only when you are no longer needed in the provision of direct emergency care
- Contact GP to inform of Hospital Transfer
- Contact family

Special Instructions

- If resident has been prescribed angina medicine (e.g., nitrolingual spray), administer a dose and wait 5 minutes
- Still has symptoms? Administer a second dose and wait another 5 minutes
- Still has symptoms? Administer a third dose, administer 300mg aspirin (unless resident has known anaphylaxis to aspirin) and call an ambulance
- If resident has NOT previously been prescribed angina medicine, administer 300mg aspirin (unless the resident has known anaphylaxis to aspirin), and call an ambulance immediately

Act within 12 hours

If the resident has any of these symptoms or signs:

- Pain or discomfort in the chest, neck, jaw or arms (with or without shortness of breath, nausea or vomiting, sweating, or dizziness) **that has resolved with rest or with angina medicine**

- Assess vital signs and complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your afterhours access process
- If required contact NP
- Contact family

While waiting for help

- Sit resident upright, encourage them to rest until seen by a doctor, provide reassurance
- Note that ANZCOR suggests AGAINST the routine administration of oxygen for patients with suspected heart attack. However, if SaO2 is low or if resident is breathless or in shock, administer oxygen to achieve
  - SaO2 of 94-98% for residents without COPD
  - SaO2 of 88-92% for residents with COPD
- Document: location and radiation of the pain, nature of the pain (e.g., sharp, dull, burning, heavy pressure); what triggered the pain; what time the pain started, eased, or stopped.
- Monitor vital signs and response to treatment

TIPS

Offer a reassuring presence

Encourage the resident to rest until reviewed by Medical Officer

Choking (Airway Obstruction)

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

The symptoms and signs of airway obstruction can be very variable, depending on the cause and severity of the condition:

In the conscious person who has inhaled a foreign body, there may be:

- extreme anxiety
- gasping sounds or stridor coughing
- loss of voice or hoarseness
- the universal choking sign: clutching the neck between the thumb and fingers

In the non-breathing unconscious person:

- there may be no obvious signs
- airway obstruction may not be apparent until rescue breathing is attempted

- Call for help from a nearby colleague.
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Call 000 for Ambulance; do not wait for GP instructions
- Assess and monitor vital signs
- Complete ISBAR form only when you are no longer needed in the provision of direct emergency care
- Contact GP to inform of hospital transfer
- Contact family

Special Instructions

CLEAR THE AIRWAY

- Encourage the resident to COUGH to expel the foreign material
- If unable to cough or cough is ineffective, bend the resident forward and perform up to 5 SHARP BACK BLOWS. This should be delivered to the middle of the back between the shoulder blades, using the heel of your hand. Check after each back blow to see whether it has relieved the airway obstruction
- If back blows are unsuccessful, keep the resident upright and perform up to 5 SHARP CHEST THRUSTS. This should be delivered to the lower half of the sternum, using the heel of your hand. Check after each chest thrust to see whether it has relieved the airway obstruction
- If still unsuccessful, and the resident remains responsive, continue ALTERNATING 5 BACK BLOWS WITH 5 CHEST THRUSTS until medical aid arrives
- If the resident becomes unconscious, follow DRSABCD protocol
- If tracheostomy / laryngectomy tube is blocked, remove the tube, and replace with a clean tube

This information is not a substitute for first aid training: https://stjohn.org.au/first-aid-facts

Closed Head Injury

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Prolonged loss of consciousness (>5mins), becomes unconscious, appears to "blackout" or have a seizure
- Initial GCS assessed 3-8 (Severe Head injury) or GCS 9-13 (Moderate Head Injury)
- Persistent or worsening headache, escalating need for analgesics for their pain
- Impaired ability to converse at the resident's normal mental/conscious level
- Prolonged amnesia (>30 min)
- New onset blurred vision and/or slurred speech
- Inability to focus the eyes and/or abnormal eye movements
- Blood or clear fluid loss from the ears, nose, or mouth
- Boggy swelling anywhere on the skull to suggest fracture, swelling around eye sockets
- Vomiting more than once, nausea
- Irritability, change in mood and/or memory loss, especially for very recent events
- Impaired balance and/or coordination, new weakness, or paralysis

- Call for help from a nearby colleague, if required
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Assess vital signs, including a Glasgow Coma Scale (GCS) and pupil reaction
- Do general assessment, looking especially for signs of trauma, both skull and the rest of body
- Complete ISBAR form
- Call 000 for Ambulance (do not wait for GP instructions)
- Contact GP to inform of hospital transfer
- Contact family

Special Instructions

- If the resident is currently taking anticoagulant/antiplatelet medication, has a coagulopathy and has had a fall with suspected head strike, arrange transfer to hospital
- Withhold anticoagulant/antiplatelet medication
- Keep resident nil by mouth until medical review (in case surgical intervention is required)
- Commence monitoring at least half-hourly for the first 4 hours, then 4 hourly for up to 48 hours if stable and not being transferred

Act within 12 hours

If the resident has any of these symptoms or signs:

- GCS 9-13 at 2 hours post injury or deteriorated by >/=2 from initial GCS
- The resident does not remember time, place or person, new event, or recognise familiar people or places/environment
- Light-headedness, spinning sensation, increased confusion, and disorientation, feeling of increase pressure to head
- Unsteady gait and problems with maintaining balance
- More sensitive to noise or light
- Difficulty concentrating or paying attention
- Memory difficulties or forgetfulness, amnesia for the immediate events
- Feeling vague or "foggy thinking"
- Deterioration in problem solving and making basic decisions
- Difficulties in sleeping and restless behaviour
- Vital observations deteriorating

- Supportive care of ABCDE's
- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process

Closed Head Injury

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

While waiting for help

- Keep the resident immobile until reviewed by the local GP, afterhours GP service, ambulance service or Hospital to maintain resident safety
- If the resident remains unsettled and mobile, a staff member should remain with the resident to supervise and assist walking/transfers
- Contact the Resident's spouse/family to provide emotional assistance to assist in reducing anxiety/distress
- Review the Residents medication chart, has there been a recent change in medication?
- Continue to monitor vital signs, BP, pulse rate, temperature and respiratory rate including urine and BGL levels in diabetics
- Monitor neurological signs every 30 minutes until GCS is within normal limits, then continue hourly for the next four hours, then two-hourly until 24 hours of observation has been reached or you are advised otherwise
- For a resident who is prescribed anticoagulant/ antiplatelet medication or has a bleeding disorder, observations (neurological and vital signs) should continue four-hourly for 72 hours

Confusion: Delirium / Infection

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Confusion (including hallucinations and delusions) of acute onset OR
- Change in level of consciousness AND one or more of the following:
  - » Heart rate more than 110 beats per minute or less than 50 beats per minute
  - » Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
  - » Persistent temperature above 38°C or below 35.5°C
  - » Blood pressure below 90mmHg systolic
  - » Blood glucose level less than 4 mmol/litre or 'Hi' on the glucometer
  - » Moderate – severe pain (following use of breakthrough / nurse initiated pain relief)

- Conduct assessment and continue to monitor vital signs
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

If there is an immediate risk to self, to other residents or to staff because of significant behavioural changes, ensure everyone's safety by adequate supervision of the resident while awaiting further advice or transfer.

- Consider the possibility of Covid-19 if URTI symptoms (Temperature >37.5, runny nose, cough) and arrange testing
- Consider the possibility of head injury and refer to appropriate guidelines
- Perform dipstick test of urine
- Look for signs of infection or trauma (e.g., wounds, cellulitis, diarrhoea, abdominal tenderness).

Act within 12 hours

If the resident has any of these symptoms:

- Change in usual level of functioning
- Increase or fluctuations in confusion, increased night-time confusion
- Behavioural changes (e.g., anxiousness, wandering, calling out, aggressiveness)
- Hallucinations (e.g., auditory, visual such as seeing something that isn't there)

- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required, contact NP

While waiting for help

- Ensure pain is controlled but avoid over-sedating
- Ensure the safety of the resident, offer emotional support
- Falls / harm prevention program

TIPS

Check fluid and dietary intake, bowel chart

Check for any recent changes of medication

Dehydration

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Unable to drink AND one or more of the following:
  - » Persistent vomiting and/or diarrhoea for more than 8 hours
  - » Passed little or no urine for 12 hours
  - » Blood pressure has fallen below 90 mm Hg systolic
  - » Heart rate more than 110 beats per minute or less than 50 beats per minute

- Conduct assessment and continue to monitor vital signs and urine output
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Act within 12 hours

If the resident has any of these symptoms or signs:

- Decreased intake of food or fluid
- Decreasing urine output and concentrated urine
- Dry mouth and tongue
- Listlessness and decreased appetite
- Gently pinch back of hand using two fingers, release to assess any delay in normal skin turgor

- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required, contact NP
- Contact family

While waiting for help

- If the resident is choking or coughing when sipping water, DO NOT give fluids
- If not choking, try half a glass of rehydration solution (e.g., ½ strength lemonade, electrolyte solution) every 30 minutes or ice block to suck
- Monitor pulse, blood pressure, respiratory rate, and temperature

TIPS

Mouth care

Keep resident warm but not too hot. Gentle cooling may be required if ambient or resident's temperature is high

Falls

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- A fall AND one or more of the following is present:
  - An actual or suspected head strike
  - Fluctuating or deteriorating confusion / consciousness / inability to make sensible conversation compared with normal mental / conscious state
  - Associated resolving or increasing pain, including pain on movement
  - Visible shortening and/or rotation of limb upon inspection, with or without severe pain
  - Unable to lift limb off the bed and / or rotate as usual
  - Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
  - Blood pressure has fallen below 90mmHg systolic

- Conduct assessment and monitor vital signs
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- If head strike witnessed or suspected, include GCS and pupil response. Refer to Head injury guideline
- Transfer to hospital if the resident is on any anticoagulant / antiplatelet medication
- If fracture suspected, support or immobilise the affected limb
- If transfer to hospital being considered, keep the resident nil by mouth

Act within 12 hours

If the resident has any of these symptoms or signs:

- History of increasing pain (use pain score or Abbey Pain Scale) and/or reducing movement or use of limb

- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- Consider referral for mental healthcare and supports
- If required, contact NP
- Contact family

While waiting for help

- Continue monitoring vital signs and affected limbs – HR, BP, respiratory rate, urine, and blood glucose levels as appropriate.. Record GCS and pupil signs if head injury suspected
- Keep immobile until reviewed by GP, ambulance, or hospital
- If not on bed rest, staff to supervise / assist walking and transfers
- Has there been any recent changes of medications?
- Review for pain and response to analgesia
- Measure lying and standing BP if able to stand safely
- Review and Implement falls risk strategies – FRAT Assessment
- If appropriate, check family availability if someone is needed to sit with the resident

TIPS

Discuss strategies to reduce falls risk with family

Involve physiotherapist for review and prevention

Check for any recent changes of medication?

General Deterioration of Unknown Origin or Attribution

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Residents will experience different illness trajectories of deterioration in their health conditions. Consider the following:

- **Short term period of evident decline** – residents may have good function for a long period followed by a few weeks or months of rapid decline prior to death
- **Long term limitations with intermittent serious episodes** – residents will have gradual decline in function. During each acute episode, the resident is at risk of dying, however, will continue to decline
- **Prolonged dwindling** – the resident has a long-term progressive disability/ disease and a reduction in function. Death maybe caused by infections, falls or fractures

Consider the overall condition of the resident, if the resident does not appear to be themselves and something doesn't seem "right" or seems "off" compared with the resident's usual health status (e.g., - there is a change in the resident – more drowsy, less active, not able to get out of bed, weight bear or walk). Consider what action should be taken from the list below.

Act NOW

If the resident NEWLY DEVELOPS any of these symptoms or signs:

- Disorientation to time, place, and person
- Inability to maintain sensible conversation as opposed to their normal mental/ conscious state
- Agitation and restlessness
- Blurred vision and slurred speech
- Feeling faint or drowsy
- Becomes unconscious, appears to "blackout" or have a seizure
- Cannot be woken up easily
- Severe headache that does not respond to non-medication/medication therapy
- Feeling dizzy or unwell with vomiting or nausea

- Conduct assessment, including GCS if appropriate, and monitor vital signs
- Complete ISBAR form.
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

If consciousness impaired, monitor GCS. If GCS <9, call an ambulance. If GCS is normally 10 and drops to <10, call GP.

Consider possible causes, depending on presentation and assessment. Refer to most appropriate guidelines, e.g.,

- Confusion: delirium / infection
- Closed head injury / falls
- Dehydration
- Pain
- Stroke

Act within 12 hours

If the resident has any of these symptoms or signs:

- Increase in confusion and disorientation to time, place, and person
- Increase in agitation, listlessness, and restlessness
- Increase in drowsiness and loss of consciousness
- Difficulty concentrating or paying attention
- Feeling vague or "foggy thinking"
- Deterioration in problem solving and making basic decisions
- Difficulties in sleeping and restless behaviour
- Decrease in appetite, food, and fluid intake
- Dry mouth and tongue with an alteration in skin turgor
- Decrease in urine output and concentrated (darker than usual) urine

- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

General Deterioration of Unknown Origin or Attribution

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

While waiting for help

- Ensure resident safety by keeping them immobile until reviewed by the local GP, afterhours GP service, ambulance service or hospital
- If the resident remains unsettled, staff to remain with the resident to supervise and assist walking/transfers
- If distressed, contact the resident's significant other/family to provide emotional support
- Review the resident's medication chart for recent changes
- Consideration to report if the Resident is taking anticoagulant medication
- Continue to monitor vital signs, BP, Pulse rate, Temperature and Respiratory Rate, GCS if appropriate, urine and BGL levels in diabetics

TIPS

Consider reviewing goals of care

Check for any recent changes of medication

Pain

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Moderate to severe pain unrelieved with regular and breakthrough or nurse-initiated analgesia
- New, undiagnosed or escalating pain

- Conduct assessment and monitor vital signs
- Complete ISBAR form
- Indicate which pain scale has been used (verbal or Abbey)
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- If Goals of Care are palliative, give prescribed medication as needed for symptom management
- Assess pain using verbal or non-verbal scale (non-verbal – refer to Abbey pain scale)
- Establish the nature of the pain:
  - Is it new or an exacerbation of pre-existing pain?
  - Is it sharp? dull? burning? pressure? shooting? pins and needles?
  - Is it constant or coming and going?
  - What makes it better (e.g., lying still) or worse (e.g., walking)?
  - Does the pain radiate or spread anywhere? If transfer to hospital is being considered, keep resident nil by mouth

Act within 12 hours

If the resident has any of these symptoms or signs:

- Pain escalating despite, or not responding to, regular or PRN medication as ordered
- Escalating agitation or other behaviours as determined by Abbey pain chart

- Conduct assessment
- Complete ISBAR
- Indicate which pain scale has been used (verbal or Abbey Pain Scale)
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP

While waiting for help

- Make the resident as comfortable as possible
- Use non-pharmacological methods such as heat or cold packs, massage or re-positioning for relief
- Use first aid for any new injury – 'RICE': rest, 'ice' (cold packs), compression, elevation
- Consider contacting the resident's significant other / family for emotional support and reassurance

TIPS

Consider palliative care services for assistance with pain management

Offer to arrange spiritual or religious support if desired by resident

Neurovascular Compromise

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

Neurovascular compromise in a limb may occur after cast application, surgery, infection, or musculoskeletal trauma. If the resident has any of these symptoms or signs in a limb:

SUDDEN onset (within minutes to hours) of:

- PAIN that is disproportionate to the injury, deep localized extreme pain unrelieved by analgesia, increased pain upon passive stretch of the involved muscle. Note that indication of pain in non-verbal residents includes restlessness, grimacing, guarding, tachycardia, hypotension or sweating
- ALTERED SENSATION: including decreased sensation, loss of sensation, numbness, tingling, pins or needles at and beyond the level of concern
- REDUCED MOVEMENT upon assessment of the following nerves:
  - Thumb abduction (radial nerve)
  - Thumb opposition: ability to bring the tip of the thumb and little finger together (median nerve)
  - Finger abduction (ulnar nerve)
  - Dorsiflexion of ankle and toes (peroneal nerve)
  - Plantar flexion of ankle and toes (tibial nerve)
- REDUCED PERFUSION: pale, cold, reduced pulses, capillary refill >3 seconds
- SWELLING of limb, may feel tight and look shiny
- Unexplained loss of bowel or bladder function or perineal numbness (may indicate spinal trauma)

- Assess vital signs
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- Call 000 for Ambulance if unable to obtain immediate instructions from GP
- Contact family

Special Instructions

- Immobilise and limit movement of affected limb
- Elevate the affected limb to the level of the heart. Do not elevate above the heart level as this will decrease perfusion to the limb overall
- Loosen any restrictive bandages or dressings
- Split / cut tight casts and bandages (if advised to do so by a doctor)
- Place resident nil by mouth until medical review (in case surgical intervention is required)
- Make resident as comfortable as possible

If the resident is currently taking anticoagulant/ antiplatelet medication, has a coagulopathy or has had a fall with suspected headstrike, arrange transfer to hospital.

- Withhold Anticoagulant/antiplatelet medication
- Place resident nil by mouth
- Commence monitoring at least half hourly for the first 4 hours, then 4 hourly if stable and not being transferred

Act within 12 hours

If the resident has any of these symptoms or signs in a limb:

GRADUAL onset (over days to weeks) of:

- Unrelieved pain
- Altered sensation
- Reduced movement
- Reduced perfusion
- Swelling, pressure or tightness of limb

- Assess and monitor progressively vital signs and limb signs and complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

While waiting for help

- Make the resident as comfortable as possible; provide reassurance
- Administer analgesia if charted
- Monitor and document response to treatment

Psychological Distress

Act NOW

- Threat of or actual self-harm (cutting, burning, punching, hitting, poisoning self) and/or indirect self-harm behaviours including refusing to eat/drink and refusal of essential medications
- Potential or actual attempt at suicide or the resident has communicated (written or verbal) that they wish to end their life
- The resident has depressive symptoms and a history of self-harm or previous history of suicide attempts
- The resident without cause, begins to give away valuable belongings and/or finalises their affairs and communicates their goodbyes to significant others/ family

- Conduct a risk assessment and monitor vital signs
- Assess for delirium and refer to the appropriate guideline
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions).
- Contact family

Special Instructions

Provide empathetic support and do not leave the resident alone until it has been established safe to do so.

Contact Accessline for specialist advice: 1800 800 944

Act within 12 hours

- Significant change in mood, increased anxiety, easily startled
- Increase sense of fear particularly when triggered by certain objects, situations, or events
- Continuously thinking about the same negative self-limiting beliefs or physical symptoms or decline, sense of dread, panic, upsetting dreams or flashbacks, unwanted intrusive thoughts, loss of motivation, neglect of self-care, social withdrawal, expressions of negative thoughts, increased moodiness, irritability, profound sadness, hopelessness, and feelings of worthlessness
- Physical pains and/or gastrointestinal symptoms without any discernable cause
- Unexplained insomnia or hypersomnia
- Extreme fatigue or reduction in energy for daily activities
- Psychomotor retardation

- Conduct risk assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- Consider referral for mental healthcare and supports
- If required, contact NP
- Contact family

While waiting for help

- Immediately remove all access to life threatening items (knives, any sharp objects, poisonous or harmful liquid, matches or cigarette lighters or any other equipment that can cause strangulation or possible hanging)
- Allocate a staff member to provide one on one care until emergency care or treatment is available
- Seek permission to involve the support of the significant other or family member
- Encourage the resident to express any emotions or feelings to a trusted staff or family member, a friend or GP
- Provide emotional support to the resident with empathy and effective listening skills
- Consider a review of the resident's cognitive status, as depression and anxiety may co-exist with a diagnosis of dementia
- Consider a GP review/assessment and a referral to a Older Person's Mental Health Services, Psycho-geriatrician or DBMAS – Dementia Behaviour Management Advisory Service

TIPS

Check for any recent medication changes

Offer to arrange spiritual or religious support if desired by resident

Seizures

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- Repeated or prolonged seizures
- Status epilepticus (when a seizure lasts longer than 5 minutes or when seizures occur close together and the person doesn't recover between seizures)
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Blood pressure has fallen below 90 mmHg systolic
- Heart rate more than 110 beats per minute or less than 50 beats per minute
- Failure to return to baseline level of cognition following (even short-term) seizure
- New onset of even a single short-duration seizure

- Call for help from a nearby colleague
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Conduct assessment and monitor vital signs
- Complete ISBAR form if time permits
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- In the event of status epilepticus, medical treatment in a hospital setting is required. Immediately call the ambulance
- If resident is alert and able to swallow administer anti-epileptic medication if ordered and clinically indicated
- Identify and eliminate or mitigate possible triggers to seizures (light)
- Maintain resident's airway
- If consciousness impaired, monitor GCS. If GCS <9, call an ambulance. If GCS is normally 10 and drops to <10, call GP
- If transfer to hospital is being considered, keep resident nil by mouth

Act within 12 hours

If the resident has any of these symptoms or signs:

- Persistent or fluctuating drowsiness after seizure
- Increased temperature

- Further assessment and continue monitoring vital signs, GCS, BGL
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your afterhours access process If required
- Contact NP
- Contact family

While waiting for help

- Do not restrain the resident
- Do not force anything into the resident's mouth
- If semi-conscious or unconscious – place in side-lying / coma position and apply oxygen
- Place a pillow under head for comfort and any other surrounding cushioning if seizure action is likely to cause harm
- Check BGL, if less than 3.5mmol/L and resident can swallow safely, encourage oral intake of orange juice or glucose drink

TIPS

Reassure resident

Consider neurological follow up for management and prevention

Skin Problems

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- A new skin problem AND one or more of the following:
  - A burn to an area of skin, with blistering and pain
  - Difficulty breathing
  - Temperature above 38°C or below 36°C
  - Blood pressure less than 90 mmHg systolic
  - Heart rate more than 130 beats per minute or less than 40 beats per minute
  - Respiratory rate greater than 30 or less than 8 per minute
  - Increasing agitation, confusion, or pain associate with a rash

Swelling of face, lips, eyes, tongue, or throat is a medical emergency. Contact ambulance immediately.

- Conduct assessment and monitor vital signs
- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- Keep resident nil by mouth

Act within 12 hours

If the resident has any of these symptoms or signs:

- A new rash or itch
- A new ulcer or large traumatic wound, e.g., skin tear
- Redness, pain, heat or swelling of an area of skin
- New pain, discharge from, or redness surrounding an existing ulcer

- Conduct assessment, monitor vital signs
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required, contact NP
- Contact family

While waiting for help

- Check the resident's temperature and other observations
- Replace skin flap over any skin tears; apply a non-stick dressing and crepe bandage to any open wounds
- For burns, immediately flush with cold running water for 20 minutes and cover loosely with clingfilm

Stroke

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- New facial weakness/numbness or has the resident's face / mouth drooped
- New changes in speech e.g., slurred. Does the resident understand you?
- New swallowing difficulties, coughing on saliva, fluids / food; gurgling or changed voice after swallowing
- New limb weakness
- Any reduction in Glasgow Coma Scales by 1 to 2 points
- Changed conscious level e.g., drowsy, less responsive
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Blood pressure has fallen below 90 mmHg systolic
- Heart rate more than 110 beats per minute or less than 50 beats per minute

- Follow EMERGENCY MANAGEMENT (DRSABCD) protocol
- Call Ambulance (do not wait for GP to come back with instructions)
- Conduct assessment
- Complete ISBAR form if time permits
- Contact family

Special Instructions

- Act immediately- an actual or suspected stroke is a medical emergency- call the ambulance
- Think FAST: Face – Arms – Speech / Swallow – Time it occurred and lasted)
- Maintain resident's airway

Act within 12 hours

If the resident has any of these symptoms or signs:

- Fluctuating or resolving neurological symptoms as above
- See Confusion: Delirium / Infection guideline if appropriate

- Conduct assessment
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your afterhours access process
- If required contact NP
- Refer to Confusion: Delirium/Infection guideline
- Contact family

While waiting for help

- If new swallowing difficulties, coughing on fluids / food; gurgling or changed voice after swallowing – then place resident on nil orally while awaiting assessment of swallow (No food, liquid, or medications administered orally)
- Ensure any weak limb is placed in normal body alignment and supported to prevent subluxation, chronic shoulder pain or other limb / joint problems
- Monitor vital signs

TIPS

Be supportive and reassuring

Offer to arrange spiritual or religious support if desired by resident

Mouthcare

Tubes

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

Tube appears blocked AND the resident experiences any of the following:

- Sweaty and / or clammy skin
- A distended or bloated abdomen
- Pain and / or visible bloating in groin, stomach, or pubic area
- Acute distress or agitation (may be the only sign of a blocked tube / infection if the resident cannot communicate)
- Pink coloured urine (indicates blood is present which may also contain clots that can block IDC/ SPC)
- Any bypass around catheter or urethrally

- Conduct assessment and monitor vital signs
- Complete ISBAR form
- Contact GP for urgent instruction
- If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Special Instructions

- Immediately replace SPC or PEG if the tube is pulled out or broken. Use Foley catheter of same size as SPC or PEG tube to keep the stoma (hole) open until correct replacement tube can be inserted
- If the tube appears obstructed, e.g., nothing going in / coming out, check patency
- Flush IDC / PEG / SPC
- If transfer to hospital is being considered, keep resident nil by mouth

Act within 12 hours

If the resident has any of these symptoms or signs:

- Signs of urinary tract infection
- Sign of local skin infection – redness / resident scratching

- Conduct assessment, monitor vital signs
- Complete ISBAR form
- Contact GP for care instructions. If afterhours, follow your afterhours access process
- If required contact NP
- Contact family

Special Instructions

Check with Wound Management/Stomal Therapy Clinical Nurse Consultant

MLHD – Tel (02) 6938 6487
Fax (02) 6938 6622 Mobile 0427 460 024
or Continence Advisor, MLHD –
Tel (02) 6938 6377

While waiting for help

- For confused residents: place tube inside clothing out of reach
- Note: monitor skin / genitals for potential pressure sores caused by tubing
- If feed oozing around PEG site – check correct volume of water in balloon (see label on balloon port for correct volume)
- SPC and PEG: clean with normal saline if reddened at insertion site
- Abbreviations: Indwelling Urinary Catheter (IDC); Suprapubic catheter (SPC); Percutaneous Endoscopic Gastrostomy (PEG) tube

TIPS

Comfort and reassure resident

If swallow is safe, encourage oral fluids if stomach not bloated or painful

Urine

Check the Goals of Care: active or palliative treatment? Refer to the resident's advanced care directive.

Act NOW

If the resident has any of these symptoms or signs:

- If you suspect a urinary tract infection AND one of the following is present:
  - The resident's temperature is above 38 °C or below 36 °C
  - Heart rate is more than 130 or less than 40 per minute
  - Blood pressure is less than 90 systolic
  - Respiratory rate is greater than 30 breaths per minute
  - Increasing confusion or agitation or severe pain

- Conduct assessment and monitor vital signs
- Complete ISBAR form
- Contact GP for urgent instruction. If afterhours, follow your afterhours access process
- If required, call Ambulance (do not wait for GP to come back with instructions)
- Contact family

Act within 12 hours

If the resident has any of these symptoms or signs:

- Burning of stinging on passing urine
- Blood-stained urine
- Offensive-smelling, thick or dark urine
- Passing urine more frequently
- Appears in pain and rubbing groin or abdomen
- Chills or rigors

- Conduct assessment (complete communication & assessment form)
- Contact GP for care instructions. If afterhours, follow your after-hours access process
- If required contact NP
- Contact family

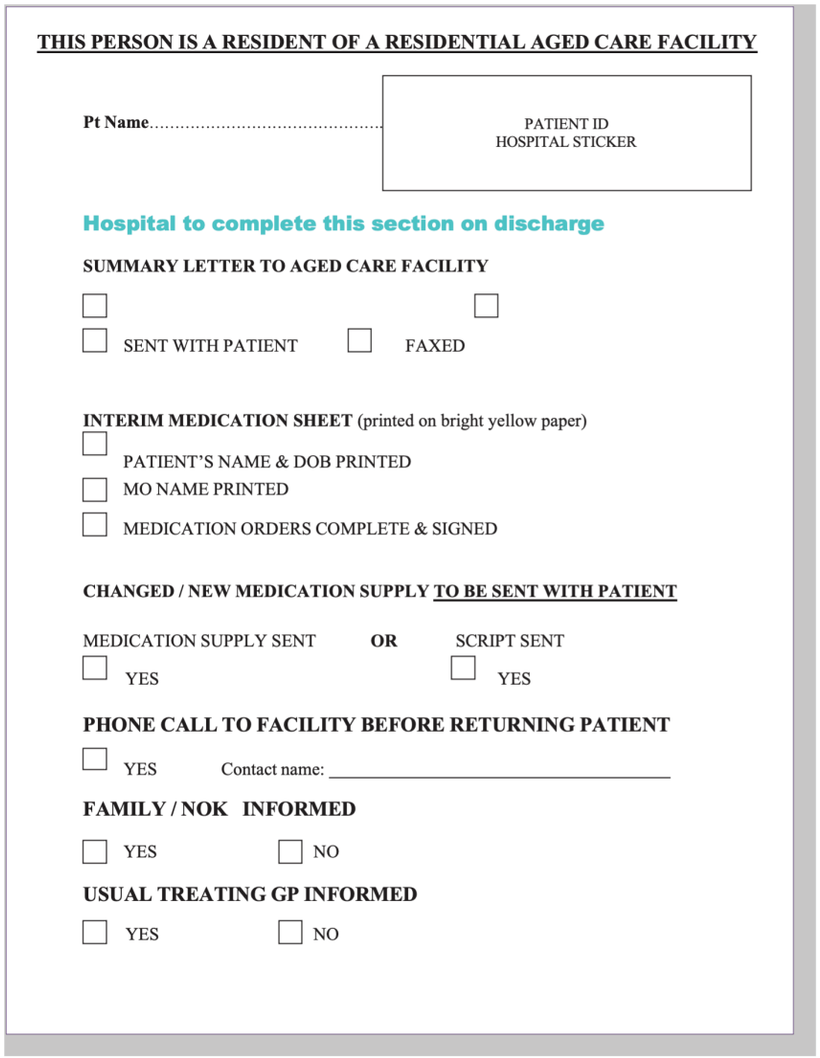
While waiting for help

- If symptomatic, take a clean urine sample and perform a urine dipstick test (only useful in residents who have a low pre-test probability), document results
- Check and record resident's blood glucose
- Encourage oral fluids if able to swallow
- Check observations according to local policy, or every 15 minutes if fits red 'Act Now' description

Transfer of resident to hospital

Yellow envelope

Transfer of residents from residential aged care facilities to hospital is a high risk clinical handover scenario. As well as containing documents, the back of the envelope features a checklist of crucial and other handover information to be included when a resident is being transferred.



THIS PERSON IS A RESIDENT OF A RESIDENTIAL AGED CARE FACILITY

Pt Name.....

PATIENT ID
HOSPITAL STICKER

Hospital to complete this section on discharge

SUMMARY LETTER TO AGED CARE FACILITY

☐ SENT WITH PATIENT ☐ FAXED

INTERIM MEDICATION SHEET (printed on bright yellow paper)

☐ PATIENT'S NAME & DOB PRINTED
☐ MO NAME PRINTED
☐ MEDICATION ORDERS COMPLETE & SIGNED

CHANGED / NEW MEDICATION SUPPLY TO BE SENT WITH PATIENT

MEDICATION SUPPLY SENT ☐ YES **OR** SCRIPT SENT ☐ YES

PHONE CALL TO FACILITY BEFORE RETURNING PATIENT

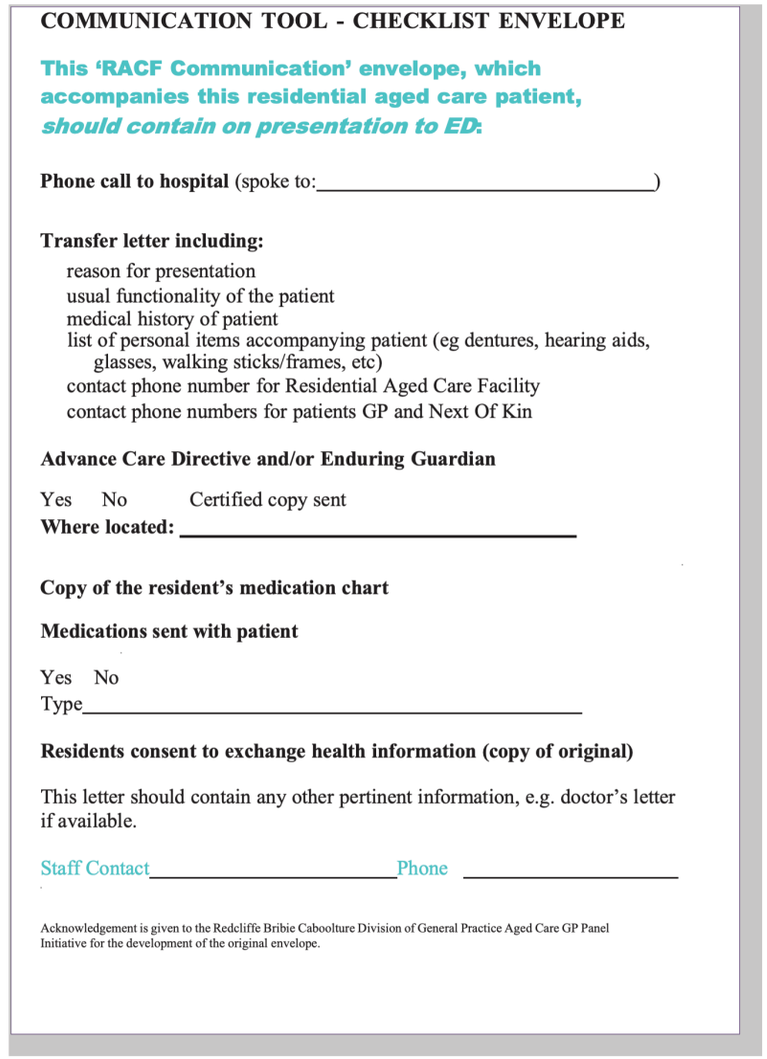
☐ YES Contact name: _____

FAMILY / NOK INFORMED

☐ YES ☐ NO

USUAL TREATING GP INFORMED

☐ YES ☐ NO



COMMUNICATION TOOL - CHECKLIST ENVELOPE

This 'RACF Communication' envelope, which accompanies this residential aged care patient, *should contain on presentation to ED*:

Phone call to hospital (spoke to:_____)

Transfer letter including:

reason for presentation
usual functionality of the patient
medical history of patient
list of personal items accompanying patient (eg dentures, hearing aids, glasses, walking sticks/frames, etc)
contact phone number for Residential Aged Care Facility
contact phone numbers for patients GP and Next Of Kin

Advance Care Directive and/or Enduring Guardian

Yes No Certified copy sent
Where located: _____

Copy of the resident's medication chart

Medications sent with patient

Yes No
Type_____

Residents consent to exchange health information (copy of original)

This letter should contain any other pertinent information, e.g. doctor's letter if available.

Staff Contact_____Phone _____

Acknowledgement is given to the Redcliffe Bribie Caboolture Division of General Practice Aged Care GP Panel Initiative for the development of the original envelope.

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References: Abdominal

- Sydney Local Health District, Clinical Support Guidelines for Residential Aged Care Facilities, viewed 26 July 2021, https://libguides.library.usyd.edu.au/c.php?g=508212&p=3476130

References: Breathing Difficulties

- ANZCOR Guideline 4 – Airway, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- ANZCOR Guideline 11.6.1 – Targeted Oxygen Therapy in Adult Advanced Life Support, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- ANZCOR Guideline 9.2.1 – Introduction to and Principles of In-hospital Resuscitation, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- Choking Adult or Child (over 1 year), St John Ambulance Australia, viewed 15 July 2021, https://stjohn.org.au/assets/uploads/fact%20sheets/english/Fact%20sheets_choking%20adult.pdf
- Recognising a Deteriorating Patient, HNE Aged Care Emergency Guidelines, viewed 15 July 2021, https://ace.healthpathways.org.au/index.htm

References: Blood Loss

- ANZCOR Guideline 9.1.1 – First Aid for Management of Bleeding, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- ANZCOR Guideline 9.2.2 – Shock, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- ANZCOR Guideline 11.6.1 – Targeted Oxygen Therapy in Adult Advanced Life Support, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
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- Recognising a Deteriorating Patient, HNE Aged Care Emergency Guidelines, viewed 15 July 2021, https://ace.healthpathways.org.au/index.htm

References: Chest Pain

- ANZCOR Guideline 9.2.1 – Recognition and First Aid Management of Suspected Heart Attack, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
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- Recognising a Deteriorating Patient, HNE Aged Care Emergency Guidelines, viewed 15 July 2021, https://ace.healthpathways.org.au/index.htm

References: Choking

- ANZCOR Guideline 4 – Airway, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
- ANZCOR Guideline 11.6.1 – Targeted Oxygen Therapy in Adult Advanced Life Support, Australian Resuscitation Council, viewed 15 July 2021, https://resus.org.au/guidelines/
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References: Neurovascular compromise

- ACI Musculoskeletal Network 2018, Neurovascular Assessment Guide, Agency for Clinical Innovation, Chatswood, NSW. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0004/458185/ACI_0147-MSK-compartment-guide_V4.pdf
- Neurovascular observations, Clinical Guidelines (Nursing), The Royal Children's Hospital Melbourne, viewed 25 July 2021, https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Neurovascular_observations/

References: Closed Head Injury

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Version History

Version 2.0, published 2021

Version 2.0 of The Acute Care Decision Guidelines for RACFs, was developed from a review of Version 1.0, published in 2016. Version 2.0 of the Acute Care Decision Guidelines for RACFs has undergone a clinical review and update, and in response to consultation findings by user groups, has been repackaged to improve ease of use and expanded to include additional conditions.

Version 1.0, published 2016

Version 1.0 was developed as part of the Building Partnerships in Aged Care Program as a collaborative project with representatives from general practice, residential aged care facilities and the local health district. Version 1.0 was compiled using the Emergency Decision Guidelines developed by Southern Medicare Local and the R.E.S.P.O.N.D Guidelines for Nurses and Carers developed by Great South Coast Medicare Local. The original emergency decision guidelines were developed by Southern Tasmania Area Health Service and Ku-rin-gai Health Service.

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002.

Acknowledgement of Country

Murrumbidgee Primary Health Network acknowledge the Traditional Custodians of the land in the Murrumbidgee region. We pay respect to past and present Elders of this land: the Wiradjuri, Yorta Yorta, Baraba Baraba, Wemba Wemba and Nari Nari peoples.

Acknowledgement of participation

Special thanks to the steering committee for their dedication and guidance in developing this document, including our local partner organisation, Forrest Centre and MPHN staff. Thank you to Community Options Australia who were engaged to undertake the consultation and redevelopment of the Acute Care Decision Guidelines for RACFs.

Acknowledgement of Funding

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Disclaimer

The medical information provided in this guideline is intended as a guide for the management of the acutely unwell and deteriorating resident. The use of this guideline is not intended to provide a substitute for medical advice on the diagnosis and treatment of medical conditions. Any resident requiring medical advice or treatment must be referred to their treating general practitioner. While the author/s of this guideline have taken every precaution to ensure the currency and accuracy of all medical information contained herein, the author/s does not offer any warranties as to the currency of information in this guideline. The author/s are not responsible for any loss or damage, including consequential loss, suffered in connection with reliance on information obtained from the use of this guideline or the reliance of any information provided.

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NSW GOVERNMENT Health
Murrumbidgee Local Health District