Emergency Decision Guidelines

A guide for the acutely unwell, deteriorating resident

The headings assist to direct clinical assessment and action required.

Know the:

- **Goals of care** for the resident:
  - treatment and hospital transfer if required, or
  - treatment but not for transfer to hospital if further deterioration, or
  - palliative treatment
- Resident's and family's **wishes**
- Resident's **care plan** and **advance care directive**

Know what is normal for the resident

Follow **first aid** response requirements:

- **Danger:** remove yourself / the resident from danger
- **Response:** check the resident's Response and then
- **Airway, Breathing and Circulation:** continue with your acute assessment

Assess and Document. Note the time of onset of symptoms

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 certain medical conditions. Any resident requiring medical advice or treatment must be referred to their treating General Practitioner or Nurse Practitioner. While the author/s of this guideline takes every precaution to ensure the currency and accuracy of all medical information contained in the guideline, 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 of information obtained from the use of this guideline or the reliance of any information provided.

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Contents

Service Contact Details

Service Name	Contact numbers – Business Hours Mon-Fri	After Hours Service
Nurse Practitioner Older Persons (RIR)	Phone: 5722 5620 Fax: 5722 5419	Nil
Clinical Nurse Consultant Hospital In The Home	Phone: 5722 5191 Fax: 5722 5419	7 days a week 8.00am to 8.00pm Mobile: 0408 711 461 Mobile: 0409 649 787
Emergency Department Northeast Health Wangaratta	Phone: 5722 5261 All Hours	Weekdays 4.30pm – 8.00am Saturday & Sunday
Palliative Care Service Northeast Health Wangaratta	Phone: 5722 5184 Fax: 5722 5419	1800 817 109 (Your area colour is BLUE) Only if individual assessed and approved for AH services by Community Palliative Care
Continence Nurse Service Northeast Health Wangaratta	Phone: 5722 5333 Fax: 5721 5419	Nil
Dementia Behaviour Management Advisory Service	Phone: 57238970 Fax: 5721 5605	24hr DBMAS Assistance Line 1800 699 799
Older Persons Mental Health Service	Phone: 5723 8970 Fax: 5721 5605	24hr Mental Health Crisis Line 1300 783 347
Stomal Therapy Nurse Consultant, Northeast Health Wangaratta	Phone: 5722 5555 Fax: 5722 5419 Pager: 358	Nil

The **Emergency Trolley** is located at: _____

The **Oxygen Cylinder is** located at: _____

The acutely unwell resident in the Aged Care Facility

Guide to ringing the GP or Nurse Practitioner

This guide is for aged care residential staff to help you provide enough clinical information over the telephone for the GP or Locum or Nurse Practitioner to decide the course of action for the acutely unwell resident. It does not replace clinical care protocols within your facility. The guide may also be useful if you need to ring an ambulance or hospital.

BEFORE phoning have in front of you:

- ☐ Drug chart and allergies + resident's notes
  - Tell the doctor / nurse practitioner
    - ☐ Who you are and title (e.g. RN, EN, etc.) and the resident's name
    - ☐ Main reason for phoning e.g. change in cognitive status / alertness, chest pain, abdominal pain, resident had a fall, suspected UTI, palliative care etc.
    - ☐ Main symptoms e.g. distress, pain, difficulty breathing
    - ☐ Main physical signs e.g. alert, pale, sweating, dry mouth and tongue
    - ☐ How long the problem has been present and whether it is recurrent
    - ☐ Resident's wishes / advance care directive / family or person responsible's wishes
    - ☐ Who assessed the resident (name and title) and at what time
    - ☐ Who requested the doctor be contacted (ACF staff/resident/family)
    - ☐ What action has been taken already eg. pain relief, anginine etc.

1

If you have to leave a message, leave:

- ☐ Name of Aged Care Facility, telephone number and time of call
- ☐ Name of resident
- ☐ Your name and title
- ☐ Main reason for ringing
- ☐ Urgency / how soon you need the doctor or nurse practitioner to ring back

2

AFTER the phone call, document...

- ☐ Name and phone number of GP / locum / nurse practitioner and time phoned
- ☐ Whether the GP / locum / nurse practitioner will attend and date and time expected
- ☐ Immediate instructions / action

... and implement

- ☐ Immediate action / instructions e.g. medication order, monitor resident, call locum, call ambulance etc.
- ☐ Contact family as required

3

Adapted by General Practice South from the resource 'The acutely unwell resident in the Aged Care Home: Guide to basic clinical assessment & ringing the GP', (May 2007 version), which was produced by the North East Valley Division of Gene Practice (Vic)

Vital Information for GP / NP

Resident Name:_____ Date: ___ / ___ / _____ Time:_____hrs	
Identify	State your name, role, facility and the ward that you are calling from. Identify yourself:..... I am calling about (resident details):.....
Situation	Briefly specify the resident's current problem and situation Problem: .... State severity: ☐ Needs review ☐ Concerned ☐ Very concerned ☐ Severe
Background	State the reason(s) for being a residential care and relevant past history Is there a documented Advance Care Plan ☐ Yes ☐ No What is the resident goals of care? ..... Past history: ☐ AMI ☐ CCF ☐ COPD ☐ CRF ☐ Diabetes ☐ IHD ☐ Smoker ☐ Dementia Other: ....
Assessment	Give a description of the resident's condition and most recent observations Vital signs BP:…….mmHg HR:……..bpm RR:……bpm Time:…..…hrs SaO_2…….% Temp:……°C O_2:……L/min FWT: Nitrites:…….+/++ Leuco:…… ..µ/L Protein:……g/L Blood:…… µ/L Ketones:……..mmol/L Pain Score:……. Neurological state: ..... Recent test results: .....
Request	What would you like to see done?..... .... Resident review: ..... When:..... Test or X-ray needed: .....

Abdominal Problems

Act Now

If one or more of the following is present:

- Severe abdominal pain
- Distended or bloated abdomen has not been able to pass wind 12-24 hours
- Persistent vomiting
- 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

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

- Bowels not open within 48 hours of expected motion
- Bowel motion is hard or pellet like
- Streaking of blood on the resident's motions
- If bowels not opened for 48 hours and has nausea or decreased oral intake

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- Consider starting nil by mouth until GP/NP/RIR contacted or transferred to hospital
- If vomiting, call GP/ NP/ RIR as subcutaneous/ intravenous fluids may be required
- Refer to facility documentation for bowel action and changes observed
- Medication as prescribed (with sips of fluid)
- Look for a change in pain or bowel medication and document

TIPS:

- **Position as comfortable**

Check the goals of Care: active or palliative treatment?

Airway and Breathing

Obstructed? Noisy? Problem with Tracheostomy tube or laryngectomy stoma? Choking? (see page 9)

Act Now

If the resident is increasingly breathless AND if more than one or more of the following is present:

- Respiratory rate less than **8** breaths per minute or more than **25** breaths per minute
- Can't say more than a single word or phrases due to breathlessness
- Blood pressure has fallen to below **90** mmHg systolic
- Heart rate is more than **110** beats per minute or less than **50** beats per minute
- Bluish coloured lips, fingernails
- If choking, **5** back blows if the resident can't cough up the obstruction (see choking section page 9)
- If the tracheostomy tube / laryngectomy stoma is blocked, remove the tube and replace with a clean tube

Chest pain – see chest pain section page 8

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

If the resident has any of these symptoms:

- Increasing breathlessness
- Increasing confusion
- Dry or moist cough
- Can't do their regular actvities due to breathlessness

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- Give oxygen at **2** litres / minute via nasal prongs (including residents with COPD)
- If using a mask, give oxygen at **6** litres/minute (excluding residents with COPD)
- Give residents their regular medication and /or prn medications: puffers / inhaler / nebuliser
- Monitor the effectiveness of the oxygen / medications
- Sputum / phlegm: note the colour. Collect a sputum specimen if discoloured

TIPS:

- **Sit upright (if able)**
- **Fan can be useful for comfort**

Check the goals of care: Active or Palliative treatment?

Chest Pain

Act Now

If the resident has any of these symptoms:

- Chest pain or tightness pain not relieved by their prescribed medications such as anginine or their nitrolingual spray (check expiry date)
- Pain / discomfort in the left arm, shoulder or jaw
- Sweaty, clammy, nauseated
- Heart rate is more than **110** beats per minute or less than **50** beats per minute
- Blood pressure has fallen to below **90** mmHg systolic

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

If the resident has any of these symptoms:

- Increasing frequency of chest pain brought on by activity which goes away with rest or medication
- New chest pain at rest which goes away with medication

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- Give oxygen at **2** litres / minute via nasal prongs (including residents with COPD)
- If using a mask, give oxygen at **6** litres/minute (excluding residents with COPD)
- Sit the resident upright
- Loosen tight clothing
- Medication as prescribed (with sips of fluid)
- Document: Pain - type eg. Sharp / dull / burning / pressure / deep / aching. What causes the pain? What time the pain started, eased or stopped? Radiation or spread of the pain? What makes the pain worse?

TIPS:

- **Reassuring presence**
- **Encourage the resident to rest until reviewed by the GP / NP**

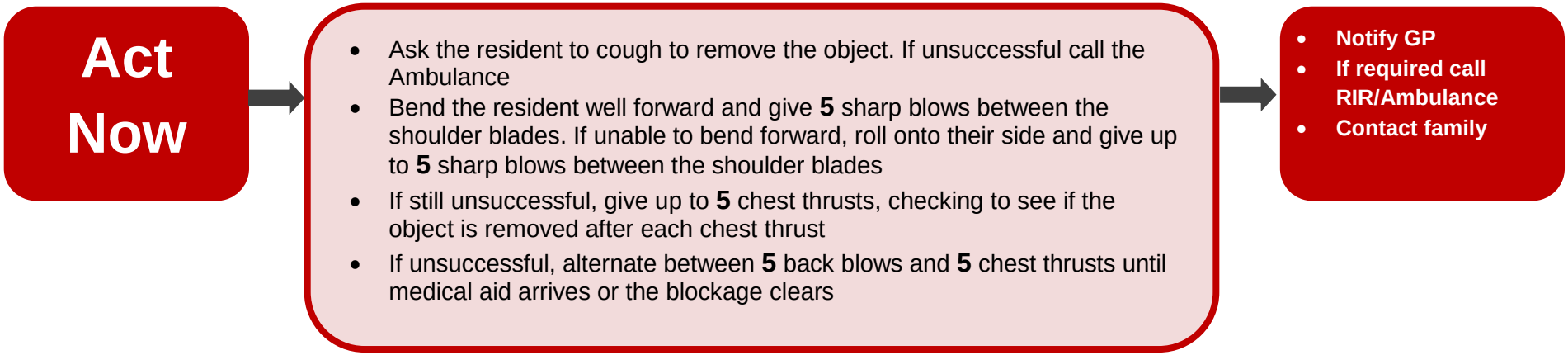
Check the goals of Care: active or palliative treatment?

Choking

The choking person will usually

- Clutch their throat
- Wheeze
- Have trouble speaking or swallowing
- Cough
- Gag
- Make violent attempts to breathe

Their face, neck, lips, ears and fingernails will become increasingly blue and the resident can become unconscious
(Reference: St. John's First Aid for Choking *Adult/Child over one year*)



This information is not a substitute for first aid training.

Circulation and Neurovascular

Act Now

If the resident has any of these symptoms:

- Unrelieved bleeding
- Any limb or area that has moderate / severe pain or increasing pain
  With one or more of the following symptoms
  - Change in temperature – becomes cold to touch or hot to touch
  - Slow to blanch – greater than **3** seconds or whitish or bluish in colour and no pulse palpable
  - Sudden reduction in sensation
  - Sudden swelling of limb or other part of the body
- Heart rate more than **110** beats per minute or less than **50** beats per minute
- Blood pressure has fallen to below **90** mmHg systolic

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

If the resident has any of these symptoms:

- New changes in sensation eg. Pins and needles, stabbing, shooting sensation
- Unrelieved pain
- Gradual swelling of limb

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

Document for the pain:

- Pain type eg. Sharp / dull / burning / pressure / deep / aching.
- What causes the pain?
- What time the pain started, eased or stopped?
- Radiation or spread of the pain?

TIPS:

- **Reassure**
- **Encourage the resident to rest until reviewed by GP / NP**

Check the goals of Care: active or palliative treatment?

Confusion: Delirium / Infection

TIPS TO CHECK:

- **Check bowel chart for constipation**
- **Ensure pain is controlled**
- **Complete a dipstick urinalysis**
- **If the source of infection is identified, contact the GP / NP for pathology and send a sample**
- **There may be more than one cause**
- **Have there been any changes to the medication in the last month?**
- **Check skin integrity / wounds for signs of cellulitis / infection**

Act Now

If the level of confusion is increasing OR change in the level of consciousness AND one or more of the following:

- They pose an immedicate risk to themselves, to other residents or to staff because of their behaviour
- 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^{0}C** or below **35^{0}C**
- Blood pressure has fallen to below **90** mmHg systolic
- Blood glucose level less than **4** mmol / litre or "Hi" on the glucometer
- Moderate / severe pain (following the use of breakthrough / nurse initiated pain relief)

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

If the resident has any of these symptoms:

- Increase or fluctuations in confusion; increased night time confusion
- Behavioural changes eg. Anxiety, wandering, calling out, aggression
- Hallucinations eg. Auditory, visual, such as seeing something that isn't there

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- Avoid over sedating; Offer emotional support, falls / Harm Prevention Program

Check the goals of Care: active or palliative treatment?

Dehydration

Act Now

Unable to drink AND one or more of the following:

- Persistent vomiting and / or diarrhoea for more than **8** hours
- Passed no or little urine for **12** hours
- Blood pressure has fallen to below **90** mmHg systolic
- Heart rate more than **110** beats per minute or less than **50** beats per minute

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

- Decreased intake of food or fluid
- Decreasing urine output and concentrated urine
- Dry mouth and tongue
- Listlessness and decreased appetite

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

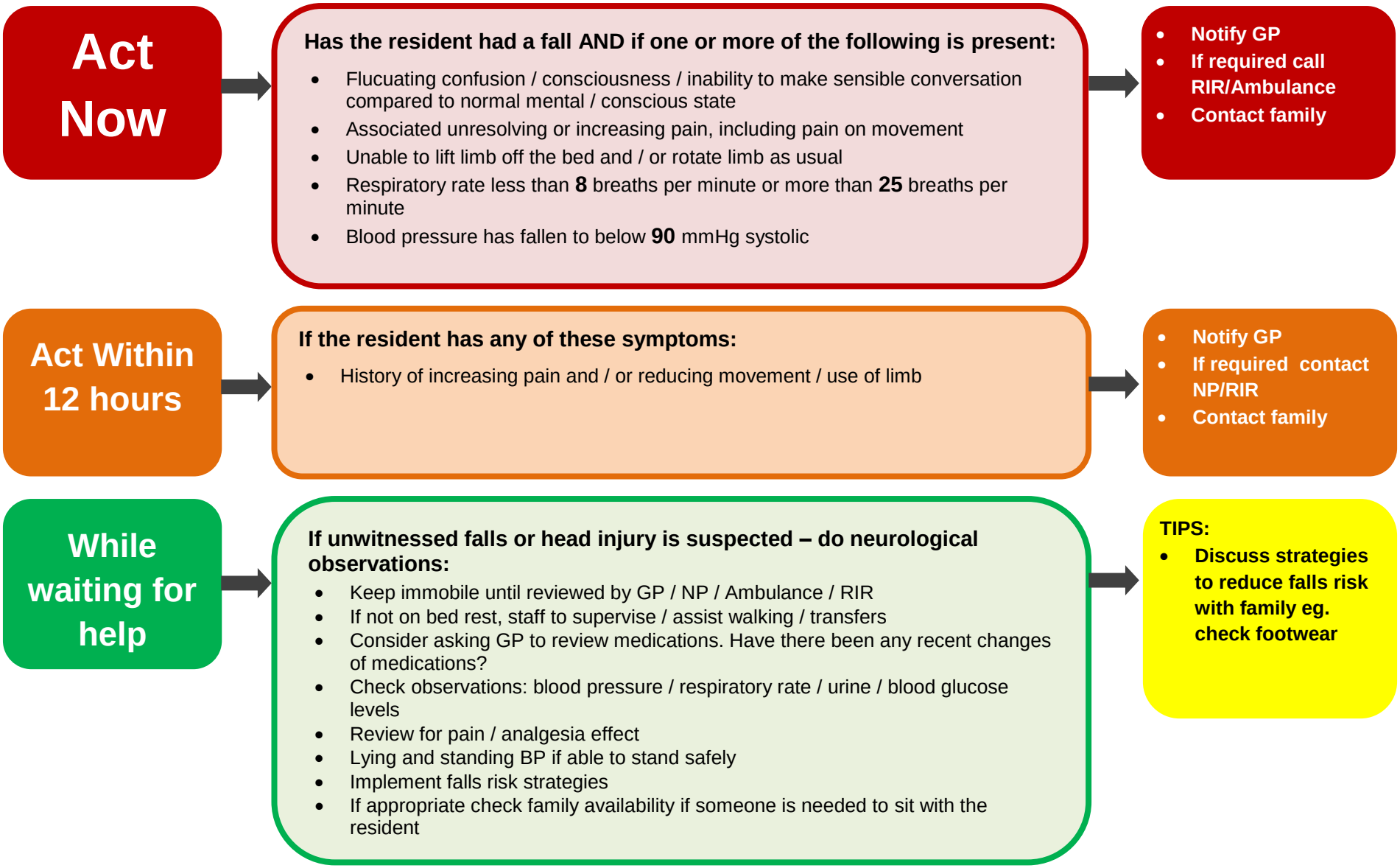
While waiting for help

- If the resident is choking / coughing when sipping water DO NOT give fluids
- If not choking, try half a glass of water every 30 minutes or ice blocks to suck
- Take pulse, blood pressure, respiratory rate and temperature

TIPS:

- **Mouth care**
- **Keep the resident warm but not too hot**

Check the goals of Care: active or palliative treatment?



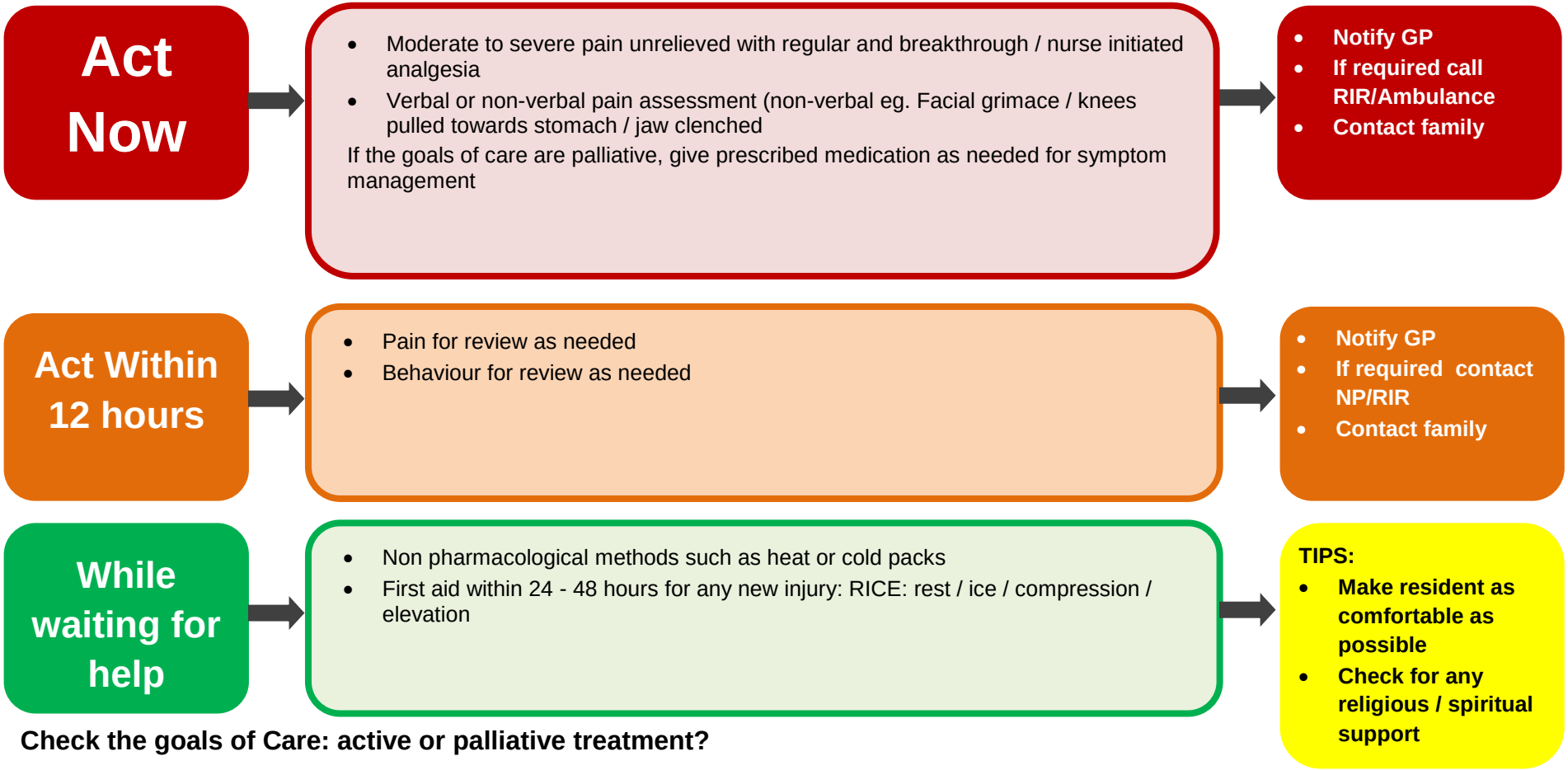
Check the goals of Care: active or palliative treatment?

Pain

Note for the pain:

- Pain Type eg. Dull / sharp / burning / shooting / pins and needles / deep / superficial / aching / heaviness
- What caused it? What contributed to it? eg. Pain on walking, pain when at rest.
- What time the pain started? How long it lasted?
- Radiation of pain / spread of pain
- What eased or stopped the pain? What makes it worse?

Consider the Palliative Care service or Nurse Practitioner



Check the goals of Care: active or palliative treatment?

Seizures

Act Now

If any of the following is present:

- Repeated or prolonged seizures
- Respiratory rate less than **8** breaths per minute or more than **25** breaths per minute
- Blood pressure has fallen to below **90** mmHg systolic
- Heart rate more than **110** beats per minute or less than **50** beats per minute

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

- New: single or short duration seizures – review of resident
- See Confusion: delirium / infection section page 11

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- Do not restrain the resident
- Do not force anything into the residents mouth
- If semi-conscious or unconscious – place in side-lying / coma position
- Pillow under head for comfort and any other surrounding cushioning if seizure action is likely to cause harm

TIPS:

- **Reassure resident**

Check the goals of Care: active or palliative treatment?

Stroke

Act Now

If any of the following is present:

- Think FAST – Face / Arms / Speech and Swallow / Time it occured and lasted
- New facial weakness or has the resident's face / mouth drooped
- New changes in speech eg. slurred. Does the resident understand you?
- New swallowing difficulties, coughing on saliva, fluids / food; gurgling or changes voice after swallowing
- Change in pupil reactions: use Glascow Come Scale
- Any reduction in the Glascow Coma Scale by **1** or **2** points
- Respiratory rate less than **8** breaths per minute or more than **25** breaths per minute
- Blood pressure has fallen to below **90** mmHg systolic
- Heart rate more than **110** beats per minute or less than **50** beats per minute

- **Notify GP**
- **If required call RIR/Ambulance**
- **Contact family**

Act Within 12 hours

- See confusion: delirium / infection section on page 11

- **Notify GP**
- **If required contact NP/RIR**
- **Contact family**

While waiting for help

- If new swallowing difficulties, coughing on fluids / food; gurgling or changed voice after swallowing then complete the Acute Screening of Swallow in Stroke / TIA (UR10-13) OR place resident on Nil Orally while awaiting assessment of swallow (no food, liquid, or medications administered orally)
- Ensure any weak limb is placed in the normal body alignment and supported to prevent subluxation, chronic shoulder pain / joint problems

TIPS:

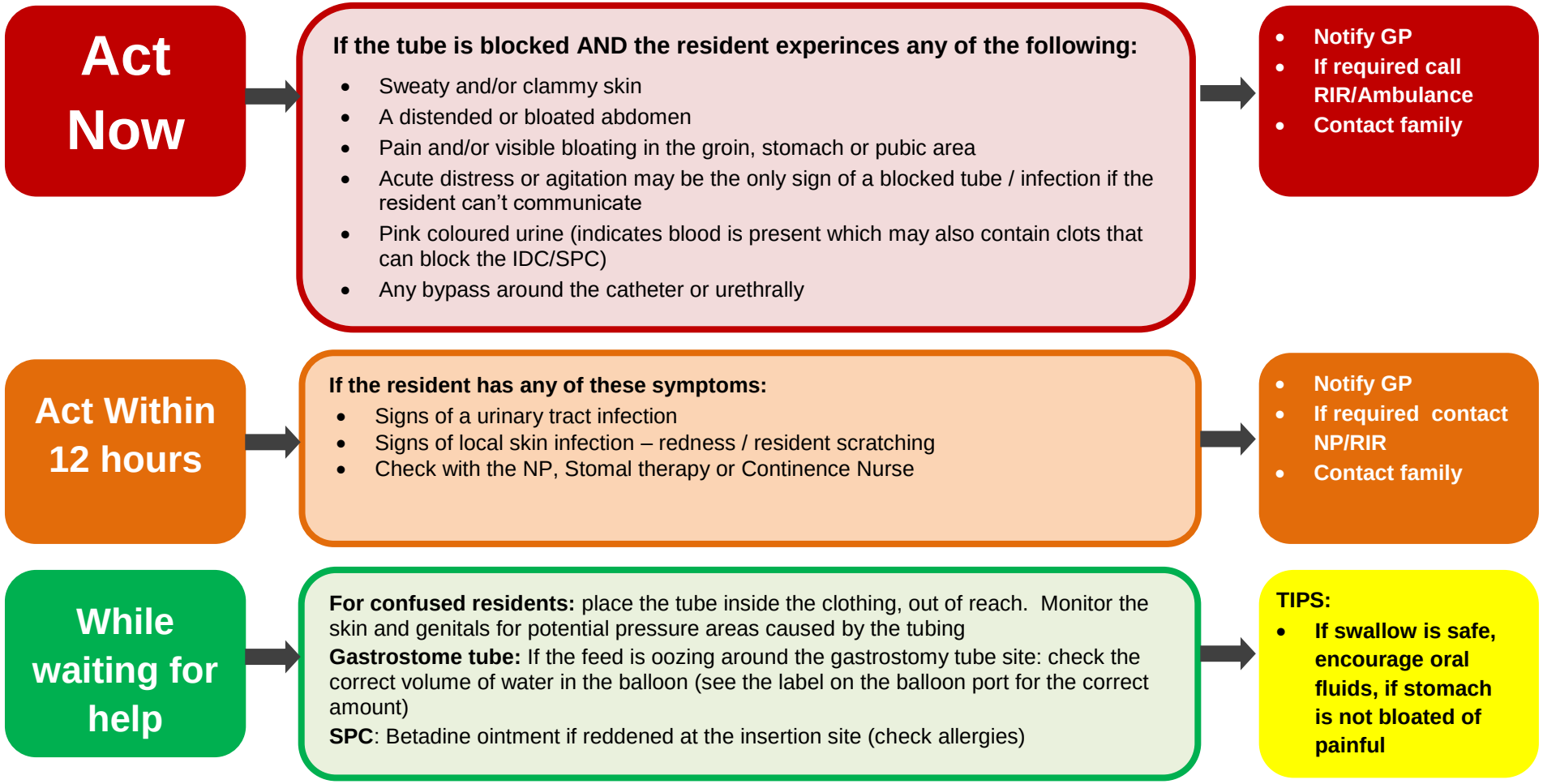
- **Reassure the resident**
- **Mouth care**
- **Contact family**

Check the goals of Care: active or palliative treatment?

Tubes

Indwelling urinary catheter (IDC) / Suprapubic Catheter (SPC) / Gastrostomy tube

- Immediately replace the SPC or Gastrostomy tube if the tube is pulled out or broken. Use a Foley catheter of the same size as the SPC or Gastrotomy tube to keep the hole open until the correct replacement tube can be put in. The gastrostomy tube MUST be secured
- If the tube appears obstructed (nothing going in or out). Flush the IDC / SPC / Gastrostomy Tube



Check the goals of Care: active or palliative treatment?

References

Australian Resuscitation Council http://www.resus.org.au/

Royal Hobart Hospital Medical Emergency Team protocol 2006

St John's First Aid for choking http://www.stjohnnsw.com.au/mc/fs/fs_choking1.html

National Stroke Foundation Australia http://www.strokefoundation.com.au/clinical-guidelines

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