Health
Hunter New England
Local Health District

Hunter PRIMARY CARE

NSW Ambulance

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HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

Aged Care Emergency Manual

March 2020

CONTACT AN ACE NURSE

Contact an ACE Nurse

In a medical emergency, always dial 000 to call an ambulance.

Aged Care Emergency Model Overview

The Aged Care Emergency (ACE) model is a partnership between the Local Health District and Primary Care. ACE model is dependent on collaborative relationships with:

- Residential Aged Care Facilities (RACFs)
- Primary Health Network
- Ambulance
- General Practitioners (GPs)
- Residents, families, and carers

The ACE model provides consultancy, clinical support, and advice for RACF staff and GPs. This is so that care for residents can be delivered in the facility where appropriate, and unnecessary transfer to hospital can be avoided.

If the resident does need to be transferred to hospital, the ACE clinicians can facilitate the process and provide information about the resident to hospital staff before admission. The ACE model can provide information and, where appropriate, assist with the coordination of outreach or outpatient services for clinical issues. These can include:

- Wound management
- Continence problems
- Behavioural issues
- Iv antibiotic therapy
- The management of some acute and chronic conditions

The ACE model of care

The ACE service is a model of care that has a multi-faceted approach comprising 7 key elements. At the centre of the model is the resident and ensuring they receive the right care at the right time in the right place.

The following steps are in place to support RACF staff with decision-making:

1. The use of evidence-based algorithms to manage common health issues within the RACF.
2. A 24-hour telephone consultation service, supported by Registered Nurses, for RACF staff to access clinical guidance.
3. Clinical communication using ISBAR (Identify, Situation, Background, Assessment, and Recommendation), including identification of clear goals of care before transferring to an emergency department.
4. Proactive case management within the emergency department.
5. Education and empowerment of RACF staff to navigate the health system and to access clinical experts. Education includes recognition and escalation of the deteriorating resident, the use of evidence-based algorithms, and the use of standardised clinical communication techniques.
6. A Community of Practice to build collaborative relationships within aged care, including:
    - Residents, families, and carers
    - Residential aged care facilities
    - Local health district
    - Primary Care Organisation
    - GPs
    - Primary Health Network
    - Ambulance
    - Emergency departments
    - Educational organisations
7. A management team to implement and support all the above elements.

ACE model goals

- Enhance residential aged-care staff decision-making for residents with non-life threatening acute care by the use of standardised guidelines.
- Reduce unnecessary presentation of aged-care residents to emergency departments.
- Improve communication and collaboration between stakeholders in managing aged residents.
- Ensure aged residents receive the right care at the right time, in the right place for unexpected health conditions.

The senior registered nurse will discuss the clinical issues of the resident and, when indicated, will use the ACE manual as a guide to troubleshoot and advise on the most appropriate management.

In an emergency, always phone 000 to call an ambulance.

Contents

Introduction

Guide to this Manual

This manual is a clinical support tool for the care of acutely unwell residents living in Residential Aged Care Facilities (RACF). General practitioners are the primary medical practitioner responsible for residents in a RACF. This manual aims to support general practitioners and RACF staff in managing acutely unwell residents.

The **Aged Care Emergency Manual** contains clinical information and flow charts to guide RACF and ACE clinicians to determine the clinical needs of the acutely unwell resident.

The ACE manual is divided into sections relating to body systems and each section has a number of clinical issues identified. At the end of each section there is information about how to access advice or referral information and there are links to online resources for further information for this clinical issue. The flowcharts are designed to assist staff in delivering care; however it should always be used in conjunction with sound clinical judgement.

The Aged Care Emergency (ACE) clinicians are available for advice and will discuss the clinical concerns for the resident and refer to the manual as appropriate.

Advice for localisation

This generic manual is based on the Hunter New England Local Health District Aged Care Emergency Manual, who retains copyright in this work.

Before implementing any element of the ACE model in your area, the contents of this manual, algorithms, and other ACE resources must be endorsed by your local clinical guidance newtorks and approved by the clinical governance authority of the local health service so that it aligns with local policies, systems, and processes.

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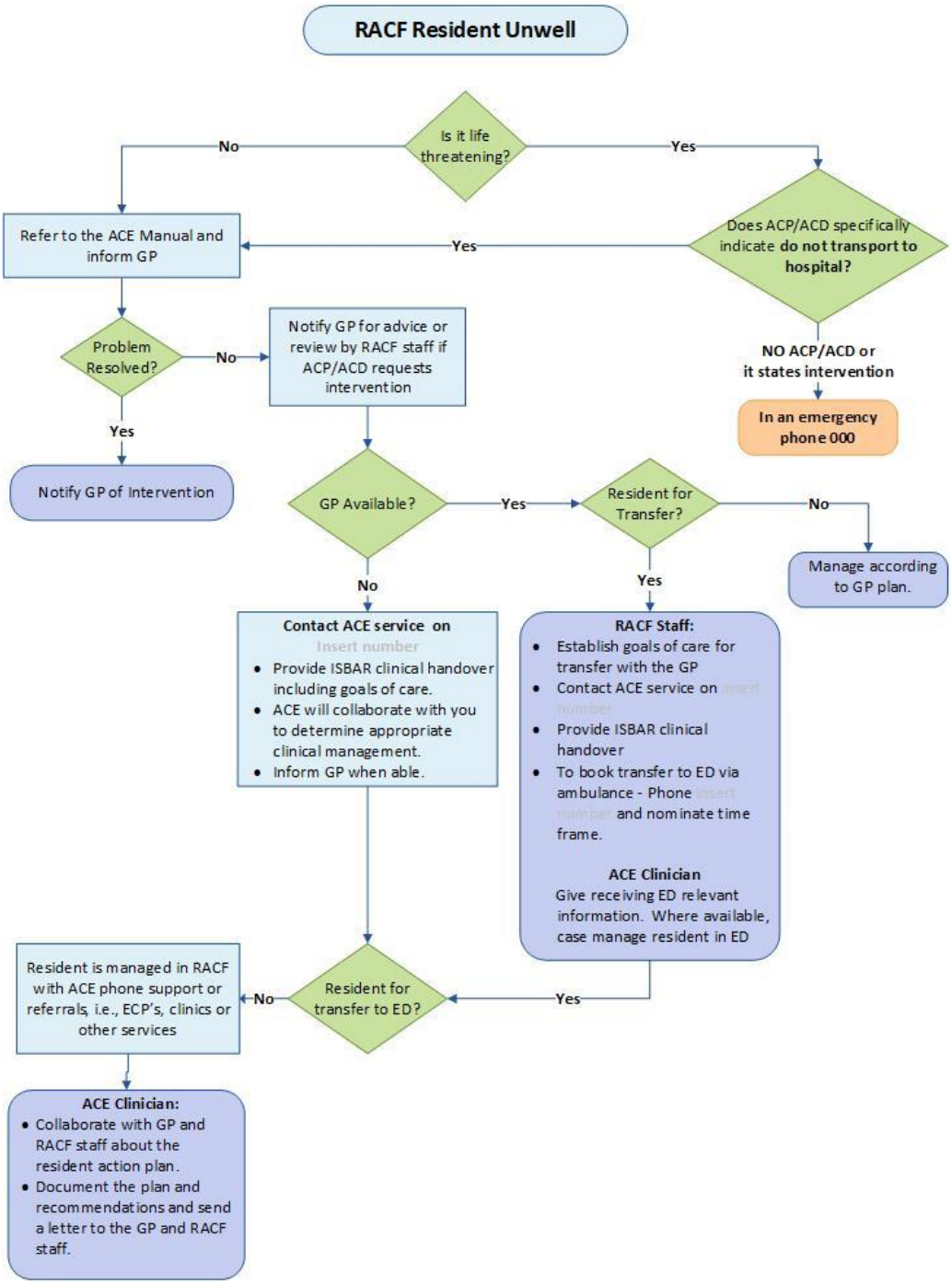
Aged Care Emergency Flowchart

Before deciding to send **any** resident to an emergency department (ED):

1. Determine if the resident has an Advanced Care Plan or Advanced Care Directive (ACP/ACD) – Some ACPs/ACDs specifically request that the resident is **not** transferred to hospital, even if they are experiencing a life-threatening emergency. Other ACPs/ACDs may detail when to send and what treatments are consented to.
2. If an ACP/ACD states "**do not send me to hospital if**..." then it is not appropriate to do this without further discussions with the resident, their GP, and person responsible. If after discussion with the GP and/or person responsible, transfer to hospital is deemed necessary, provide the ED with a very clear goal of care. See Advance Care Planning Guidelines (page 16).



Before Making a Call Regarding an Unwell Resident

1. Consider if the GP has been called for advice or review. If the GP has reviewed the resident and assessed that they need transferring to hospital, the ACE clinician **must** receive all the requested information as part of the clinical handover. This ensures the ED meets the resident's clinical needs in line with their goals of care.
2. Read the following steps and collect all documentation required.

Note: If the resident is being transferred to ED, make copies of all documents and forms listed below.

Action		Done?	Relevant Documentation included?
1.	Collect the resident file and have a copy of the ACE manual, either online or on paper.	❒	❒
2.	Complete the **ISBAR 4 Aged Care Form** (page 12-13) Ensure you have the resident's normal baseline observations and relevant clinical information on hand. You will also need to attend a full set of current observations.	❒	❒
3.	Make sure the following information is available: ▪ resident's regular medications ▪ signing sheets ▪ any additional stat medications or prn medications administered for the resident's current condition	❒	❒
4.	Check the resident's immunisation status, including pneumovax and fluvax.	❒	❒
5.	Inform the resident's GP and person responsible of the resident's current condition, and let them know you are calling the ACE clinician. If the resident is being transferred to ED, encourage the person responsible to attend the ED to support the resident.	❒	❒
6.	Make copies of the following and enclose in an Envelope: ▪ ISBAR4AC Clinical Handover Form ▪ current Advance Care Directive or Plan ▪ any MOLST (Medical Orders for Life-Sustaining Treatment) forms (page 128-131) ▪ other information that will assist with determining appropriate care for the resident, such as the name and contact details of the person responsible ▪ latest GP summary or notes (ensure the correct GP name is on the transfer form) ▪ RACF contact name and direct contact number, RAC ID	❒	❒

Transfer to hospital

If the ACE clinician recommends transfer to hospital, they will advise you of the destination hospital. This is normally the ED closest and/or most clinically suitable.

1. Book the ambulance transfer (page 20) through the normal processes and phone insert number. An appropriate time frame for transfer is required. Mention you have called ACE.
2. Place all documentation in an envelope ready for when the paramedics arrive.

ISBAR 4AC (Identify, Situation, Background, Assessment & Recommendation)

Complete the below ISBAR form to prepare for a structured clinical handover of information during the phone call. ISBAR4AC forms are available for purchase in pads of 50 sheets on the **Hunter Primary Care** (https://hunterprimarycare.com.au/health-professionals/professional-health-services/ace-education-resources/) website.

ACE AGED CARE EMERGENCY SERVICE

ISBAR4AC/Nurse Clinical Handover Information
For Residential Aged Care Facilities

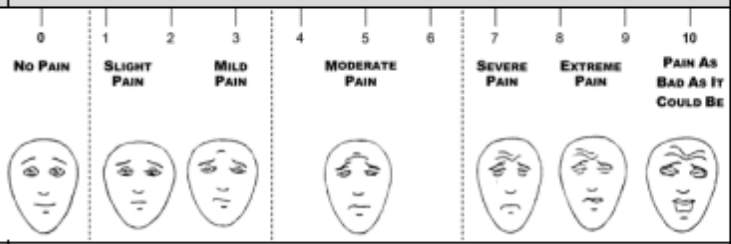
Resident Name:
DOB: / /
Age:

NOTE: Complete ISBAR prior to contacting the GP/ACE Service/NSW Ambulance
If TRANSFER to ED send: **ISBAR4AC, Observations Chart, Medication Chart, Advance Care Plan /** MOLST, Confusion Assessment Method **(CAMi)** **Please use yellow envelope if available**

I Identify	**Your name and role:** **RACF:** **RAC ID:** **Direct phone number for call back:** **RACF Direct Fax number:** **Name and position of person you are speaking to:**	
S Situation	**Resident's main problem /symptom at present?** **How long has this been an issue?**	
B Background	**Is there any relevant medical history?** *(have chart available)* **Medications** *(have chart available)* **Known Allergies:** **Initial treatment and the effect on the resident?** **Has Resident's family been notified of current problem/symptom?** **Yes / No** **Name of the resident's usual GP:** **Is there an Advance Care Plan / Directive or MOLST in place?** **Yes / No** **If yes, what is it?**	
A Assessment	**Baseline Observations:** *(have chart available)* **Date:** **Time:** **Temp:** **Blood pressure:** **Pulse rate** **(regular/irregular)** **Respirations:** **Oxygen saturation:** **BGL:** **Weight:** **Urinalysis:**	**Current Observations:** **Date:** **Time:** **Temp:** **Blood pressure:** **Pulse rate:** **(regular/irregular)** **Respirations:** **Oxygen saturation:** **BGL:** **Weight:** **Urinalysis:**
	1. **Are there any injuries or abnormal findings?** See Symptom Reference Guide over page 2. **Is resident more confused than usual?** If yes, complete Confusion Assessment Method - see ACE Manual — Yes / No; CAM score = 1 2 3 4 (circle) 3. **Is the resident in pain?** If yes, use FACES chart over page to determine amount of pain; Circle the type of pain: — Yes / No; Pain score = / 10; Chronic / Acute / Acute on Chronic	
R Recommendation	**I am requesting assistance with / advice for:** *Symptom management Medication review GP assessment of patient Sending patient to ED Other* **What are the goals of Care** *(consider Advance Care Plans)*: **Doctor's Orders / ACE Advice:** **Name:** **Signature:** **Date:**	**Outcome of ACE call** - resident to be managed: (Please circle) • In facility • With assistance of third party • By GP / Ambulance / Other • Transferred to ED

ISBAR4AC FORM v13 130219

Symptom Reference Guide

Problem	Additional Information	Specific Observations Required
Pain		Faces Pain Scale Instructions: Ask the person to tell you about the pain they are experiencing now and then explain the pictures and ask which picture best represents how much they hurt right now. Revised (FPS-R) used with permission from https://www.iasp-pain.org
Abdominal Pain	Where is the pain worst? What is the pain like? (*Sharp / Dull / Burning / Constant / Comes and goes)* Is there any associated features? (*Nausea / Vomiting / Diarrhoea)* Is there any blood in the stools? *(Bright/ Dark Red /Black)* When the bowels were last opened and what interventions?	Palpation for (*Distention / Guarding / Tender)* ***(If within scope of practice)*** Could this be urinary retention or constipation?
Diarrhoea/ Nausea or Vomiting/Dizziness	What symptoms are present? *(Nausea / Vomiting/ Diarrhoea)* Frequency of episodes? What colour is the bowel motion or vomitus? Is there any visible blood? Does the resident have abdominal pain? Is there a change in appetite or fluid intake?	Is the resident tolerating fluids? Last time bowels open? Lying and Standing Blood Pressure
Urinary Problems	Is there an increase in urinary frequency? Is there pain or burning on urination?	Skin? *(Sweating/ Dry)* Increased confusion? If yes, complete CAMi
Shortness of Breath	How did it develop? (*Suddenly/ Gradually)* Shortness of breath *(At rest/ With exertion/ When Sitting Up/ Lying Down)* Does the resident have associated chest pain/discomfort?	Sputum *(Clear/ Coloured/ Blood)* Audible sounds *(Wheeze/ Gurgling)* Resident appearance *(Pale/ Blue/ Sweaty)* Ankle or lower limb swelling
Chest Pain	Location of pain Does it radiate? *(Arm/ Neck/ Back)* Nature of pain (*Sharp/ Dull/ Burning/ Heavy/ Tight)* Does anything make it worse? *(Exertion/ Movement/ Cough/ Inspiration)* Does anything make it better? *(Rest/ Antacid/ GTN-(Anginine)/O2*	Is the resident short of breath? Resident appearance *(Pink/ Pale/ Sweaty/ Blue)*
Seizures	How long did the episode last? Details of any injuries Is the resident in pain? Is there any new weakness? *(Arm/ Leg/ Face)* What was the resident doing at the time? Did the resident report any: *(Light Headedness/ Dizziness/ Loss of Consciousness)* Is there any: *(Change to Vision / Loss of Speech / Hallucinations/ Incontinence)*	Resident appearance *(Normal/ Pale/ Sweaty/ Anxious)* Limb movement *(Normal/ Decreased)*
Lacerations & Falls	Location of injury(s)? Is the bleeding controlled? Is the resident on anti-coagulants?	Depth and length of wounds? Equipment on-hand? *(Steri-strips / Glue / Suture Kit)*
Confusion & Decreased Level of Consciousness	How did it develop? *(Suddenly /Gradually)* Is the resident on anti-coagulants? Have there been any recent falls? Are there are any other symptoms? *(Chest Pain / Headache / Diarrhoea / Vomiting / Breathing difficulties)* Is there any new arm or leg weakness?	Last bowel motion? Last urine passed? Conscious state: *Normal / Hyper-Alert / Drowsy/Easily roused /Difficult to rouse/ Unrousable)*
Fever	How long has the fever lasted? Is there any *(Cough / Abdominal pain / Rash / Skin infection)* Is resident more confused than usual? If yes, complete CAMi Is there any *(Urinary frequency / Discomfort on urination / Smelly urine)* Does the resident have a urinary catheter?	Resident appearance? *(Shivering/ Sweating/ Both)* Skin? *(Pale /Pink /Cold /Hot /Dry /Moist)*

Recognising a Deteriorating Resident

Treat any rapid deterioration in condition with suspicion.

Check **medical orders for life-sustaining treatment** (page 128-131) (MOLST) and/or ACP, and compare signs and symptoms with **what is normal baseline** for resident before starting or calling for urgent assistance.

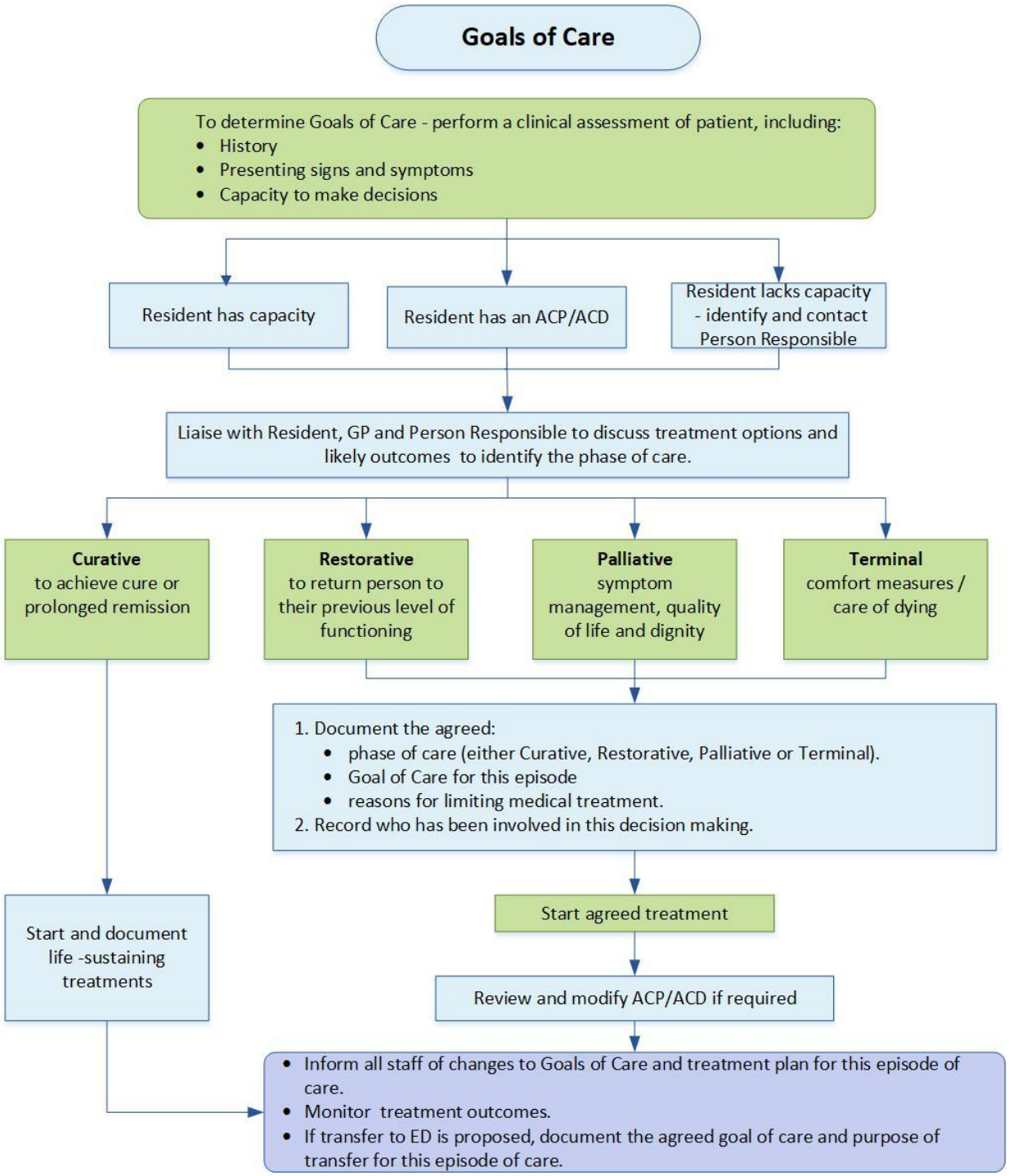
Recognition of a Deteriorating Resident			
Observation	**Green (usual)**	**Yellow (caution)**	**Red (danger)**
Respiratory rate	**10** to **24** per minute	Less than **10** per minute More than **25** per minute	Less than **5** per minute More than **30** per minute
Respiratory effort	Typical for **this** resident **and** SpO_2 normal	Unusually laboured or noisy breathing for **this** resident	Obvious distress **and/or** cyanosis (despite oxygen)
Pulse oximetry (SpO_2) *Beware of the COPD resident who may normally have low saturations*	95 to 100% (with or without oxygen) typical for **this** resident	Less than 95% (despite oxygen) for **this** resident	Less than 90% (despite oxygen)
Blood pressure	**100** to **180** mmHg (systolic = top measurement) typical for **this** resident **Caution!** If a resident's BP is normally 160 mmHg and is now 100 mmHg, this is **not normal** for this resident.	Less than **100** mmHg More than **180** mmHg (systolic = top measurement) For **this** resident	Less than **90** mmHg More than **200** mmHg (systolic = top measurement)
Heart rate	**50** to **120** bpm	Less than **50** bpm More than **120** bpm	Less than **40** bpm More than **140** bpm
Response and cognition	**Alert (A)** **Or** cognition normal for this resident	**Verbal (V)** **Or** cognition normal for this resident	**Pain (P)** or **(U) Unresponsive to Pain or** sudden change to mental state
Temperature	**35.6** to **38.4ºC** With or without anti-pyretic medication If over 37.5 monitor resident and check with RN	Less than **35.5ºC** More than **38.5ºC** Without anti-pyretic medication	More than **38.5ºC** Despite anti-pyretic medication
Pain	**Nil or tolerable** With or without pain medication	**Obvious discomfort** Despite recent pain medication	**Obviously distressed** Despite recent pain medication
Blood glucose	**5** to **7** mmol/L or in range for **this** resident	Less than **4** mmol/L More than **14** mmol/L	Less than **4** mmol/L **and** unresponsive to treatment (oral glucose) More than **28** mmol/L

(Above table adapted from Clinical Excellence Commission and NSW Ambulance Between the Flags)

See also the Chronic Disease Symptom Management Plan (page 17).

Goals of Care

The goals of care for treatment in hospital should be clarified before transfer. Follow the flowchart below to clarify relevant stage of illness, goal of care, and treatment pathway.



Goals of care are reflective of the advanced care directive, MOLST, and/or resuscitation plans.

Flowchart adapted from Tasmanian Government, Department of Health and Human Services – implementing goals of care plan (https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0017/100475/Web_Flow_Chart-Implementing_Goals_of_Care_Plan-Mar2011.pdf).

Advance Care Planning Guidelines

When assessing a medically unwell resident, consider any ACP/ACD if decisions are to be made about treatment. Follow the guidelines below to help in decision-making and care.

1. **Can the resident make their own decisions about their care?** If the resident is capable of making their own decisions about their care, involve them, their general practitioner, and their person responsible (if requested by the resident) in discussions.
2. **Does the resident have an ACP or ACD?** If a resident cannot make their own decisions about their care, check if the resident has an ACP or ACD.

   If the resident has **no** ACP or ACD:

   - discuss with the resident's person responsible what they believe the resident would have wished, and
   - involve the resident's general practitioner in all discussions.

   If the resident **does have** an ACP or ACD:

   - consider if the content of the plan is relevant to the current clinical situation
   - consider if the documents are current and reflect recent discussions
   - involve the resident's general practitioner and person responsible in discussions, and
   - if a resident returns from a hospital admission or ED visit with or without an adult resuscitation plan, use this as a trigger for further conversations with the resident, person responsible, and GP.

Transfer to hospital required

- If a resident needs to be transferred to hospital, contact ACE clinician (page 10). Make sure copies of the ACP or ACD are sent to the hospital with the resident in an envelope.
- If any decisions have been made about withholding treatment, ensure this is very clearly communicated in transfer documents.
- Where possible, the transferring general practitioner should phone the hospital and clearly communicate decisions about the ACP or ACD to the admitting medical officer.
- Ensure a clear goal of care is communicated for each episode of care.

Transfer not required

- If hospital transfer is not required, develop a management plan to reflect the needs of the resident and in the event that the resident's condition deteriorates further. This plan may include attending to relevant referrals needed, such as palliative care or other (ACE may be able to assist).
- Keep the resident's general practitioner and staff informed about the management plan.

In all cases

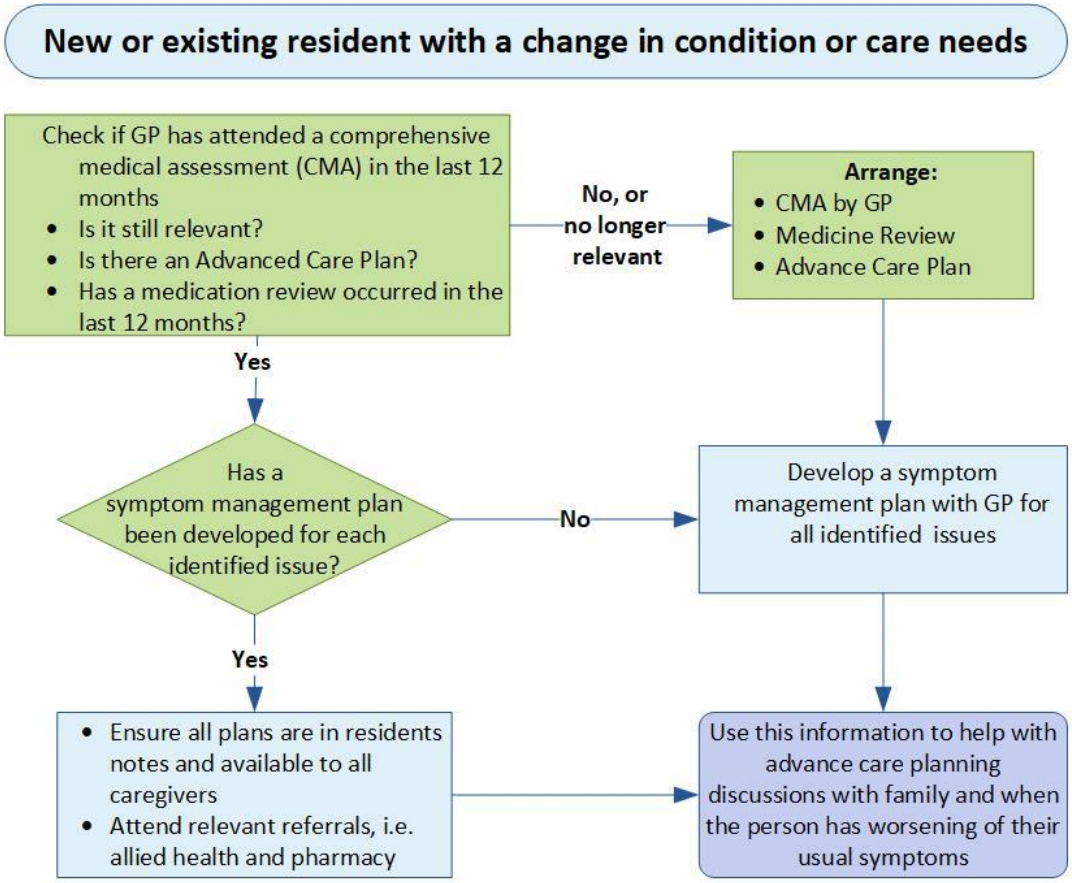
- Make decisions that best reflect the resident's wishes and quality of life.
- Provide clear feedback and support to the resident (if applicable) and person responsible about care decisions.
- Ensure a clear goal of care is communicated for each episode of care.
- If a resident returns from hospital admission or ED visit with an adult resuscitation plan, use this as a trigger for further conversations to develop or update an ACP with the resident, their person responsible, and GP.

References and resources

- Clinical Excellence Commission – End of Life Toolkit (http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/end-of-life-care)
- NSW Ambulance Authorised Care Plans (https://www.ambulance.nsw.gov.au/our-services/authorised-care-plans)
- NSW Health Advance care planning (https://www.health.nsw.gov.au/patients/acp/Pages/default.aspx)
- Talking about dementia and dying: a discussion tool for residential aged care facility staff (https://eprints.utas.edu.au/17257/)

Chronic Disease Management Plan / GP MBS numbers

These plans can be initiated by the RACF staff and completed together with the resident's GP.



Tips for streamlining processes for the GP to maximise resident care planning:

- Plan appointments ahead of time with GP practice managers.
- Allow time for new residents to settle in and staff to get to know the resident and their family.
- Ask the practice manager for the Comprehensive Medical Assessment (CMA) template pre-populate any relevant sections.
- If a CMA already exists and is less than or equal to 12 months old but the care needs of the resident have changed, consider booking a case conference (especially if discussion with person responsible is required with regard to advance care planning).
- If a resident's medications require review, consider booking a medication management review with the GP practice manager.
- Developing chronic disease management plans and end-of-life symptom management plans might also attract an MBS item number for the GP. Inform the practice manager you will need the GP to help with this process.
- Consider grouping together residents who need review by the same GP or GP practice, to minimise time away from practice.
- Ensure all relevant nursing care plans, medication charts, and documents are available.
- Consider standing orders for nursing management strategies, pathology, and medications within the developed symptom management plans.
- Consider a deprescribing regimen for high-risk medications such as anticoagulants. This is especially relevant if resident is at risk of falling **or** does not wish transfer to an ED and wants to remain in RACF. See polypharmacy (page 84) of the manual.

Resources

- Chronic Disease Management Plans and GP MBS item numbers (https://www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement)

ACE and Ambulance

- Each RACF has been allocated a home emergency department (ED) for the ACE model.
- When a resident experiences a life-threatening emergency requiring a **000** response, the Ambulance Matrix will determine the resident's hospital or ED destination in this instance.
- Always choose your allocated **Home ED** option when contacting ACE
- If, after contacting the ACE clinician, the resident is required to go to a specialist hospital (see below), the ACE staff are responsible for contacting the receiving specialist ED.
- RACF staff (**not** ACE staff) must phone Ambulance to arrange transport for transfer to ED – see Calling an Ambulance Flowchart (page 20).
- If transport to hospital has been requested for a resident and they have **not** been physically examined by a GP (i.e. advised to go to ED per phone only), the Ambulance paramedic may perform a full assessment of the resident, decide that the best treatment option is to treat the resident in situ, and recommend an alternate referral pathway. In this instance, the paramedic will provide documentation to the RACF staff.
- As an RACF clinician, you can expect the paramedic to assess under these three pathways:
  1. high-acuity treatment protocols, e.g. STEMI, FAST Stroke, Choking
  2. low-acuity pathways, i.e. Remain in situ with Medical Officer Referral and/or ECP treatment pathways
  3. non-transport pathways, i.e. Ambulance assessment (with or without treatment), and non-referral including palliative care pathways
- RACF staff must give paramedics a comprehensive ISBAR verbal handover when they arrive at the facility and use the ISBAR 4AC form (page 12-13) as a guide to assist with the paramedic handover.
- For all other urgent situations, and after discussion with the ACE service that the resident needs a review in an ED, the resident's destination will be the allocated "Home" Emergency Department **except** for the following circumstances where the destination will be to the nominated referral hospital or other specialised hospital, as determined by the LHD and Ambulance:
  - **Complicated orthopaedics** – Serious fracture injuries requiring orthopaedic intervention, i.e. fractured femur: insert hospital
  - **Other fractures** – Can be managed in the home ED (e.g. wrist fractures). insert hospital
  - **Mental health** – Behavioural Psychiatric: insert hospital Transporting to ED
- After the phone call with ACE clinicians and a collaborative decision has been made to transport a resident, RACF staff must:
  - call Ambulance on **insert number** and request transport to ED
  - advise Ambulance of the suitable time frame for transport as identified by the various parties (RACF, GP if involved, and ACE), which reflects the recognising a deteriorating resident guide (page 14)
  - if the resident deteriorates while waiting for transport, escalate the urgency either via the **000** number (if life threatening) or via insert number to escalate the urgency and state the changes in clinical observations (page 14) and
  - provide a clinical handover to Ambulance upon their arrival using ISBAR. All relevant paperwork/ envelope is transported with resident to hospital with NSW Ambulance
- ACE clinicians must provide a clinical handover of the resident to the receiving nominated ED staff.
- RACF staff may call back if they need to at any time if resident condition changes.

ECP (Extended Care Paramedics)

ECPs are available in some regions and may be able to initiate treatment in the facility instead of the resident being transferred to hospital. To request an ECP, call Ambulance on insert number.

What specific skills can ECPs perform?

ECPs in NSW are authorised to perform a range of extended skills. These include:

- Wound care including glue and sutures
- Urinary catheterisation including supra-pubic
- Replacing gastric tubes
- Back slab plasters for immobilisation of upper limb injuries
- Reduction of certain dislocations
- Digital nerve blocks
- Otoscopy

What problems do ECPs target?

The broad priority areas for ECPs include:

- Aged care
- Aged-care screening
- Falls risk assessment
- Wound assessment and management
- Minor injury and illness presentations
- Musculoskeletal and sporting injuries

Problem descriptions that ECPs are commonly dispatched to include:

- Allergies, hives, medical reactions, stings
- Animal bites or attacks
- Assaults
- Back pain (non-traumatic)
- Breathing problems
- Burns
- Diabetic problems
- Eye problems or injuries
- Falls or traumatic back injuries
- Fitting or convulsions
- Haemorrhage or lacerations
- Illness (specific diagnosis)
- Specific traumatic injuries.

What medications can ECPs give?

In addition to standard NSW Ambulance pharmacology, ECPs can administer:

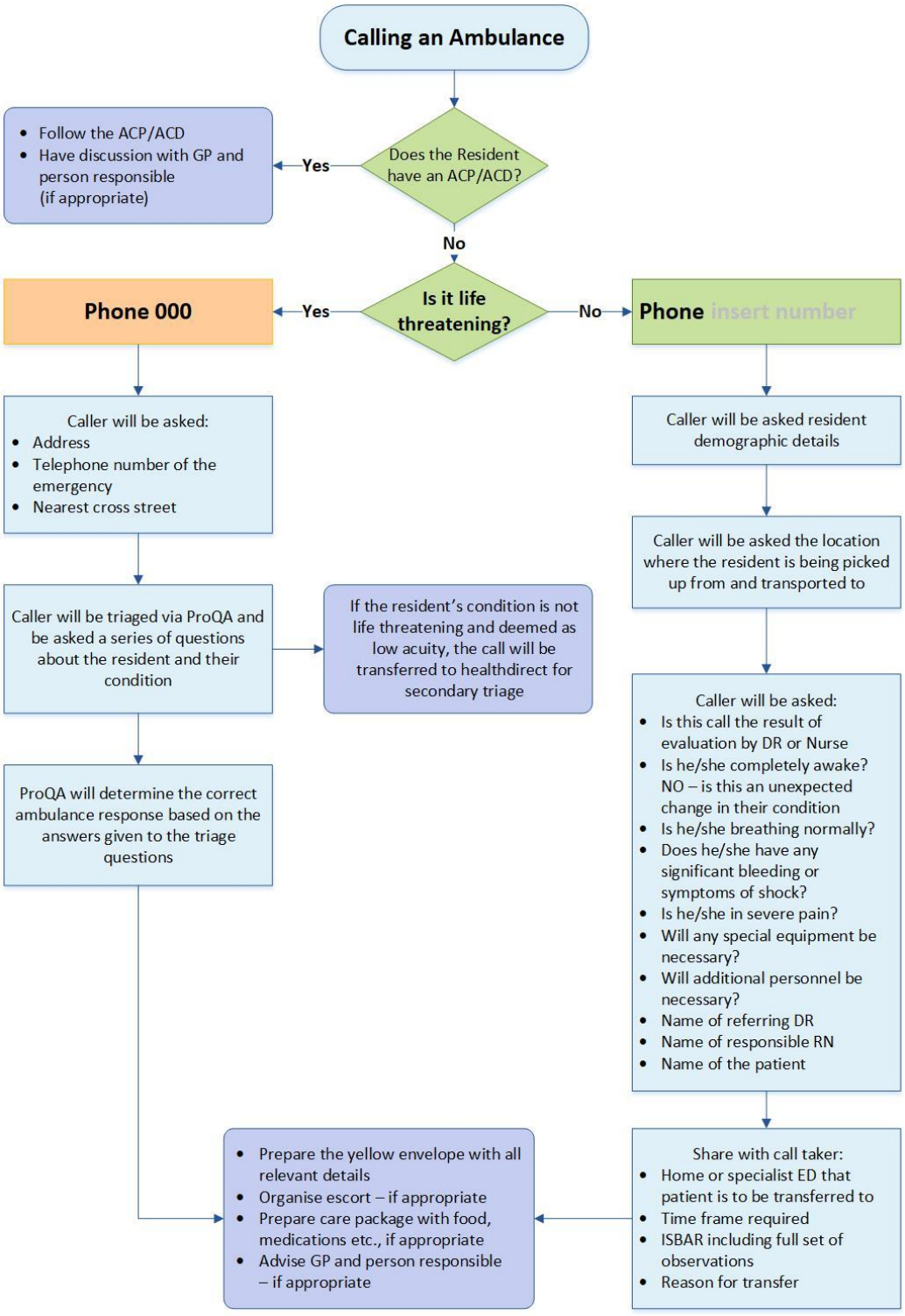
- Amethocaine for pain relief of non-penetrating eye injuries
- Adt vaccine for tetanus-prone wounds
- Antibiotics for mammal bites, upper respiratory and urinary tract infections
- Paracetamol, ibuprofen, combined paracetamol with codeine, and oxycodone for pain
- Prednisone and hydrocortisone. For moderate to severe asthma
- Telfast for minor allergic reactions
- Gastrolyte, an oral rehydration solution

Calling an Ambulance Flowchart

Assumptions

1. Callers who phone the Ambulance booking number must be either a Registered Nurse or GP, **OR** if you are not a Registered Nurse and need to phone insert number, contact either ACE or GP and use their name as referral name.
2. Phoning **000** is for life-threatening emergencies which include, but is not limited to:
   - cardiac arrest
   - severe unrelieved chest pain
   - severe haemorrhag
   - unexpected unconsciousness
   - severe shortness of breath

See also: Transferring a Resident to Hospital (page 21)

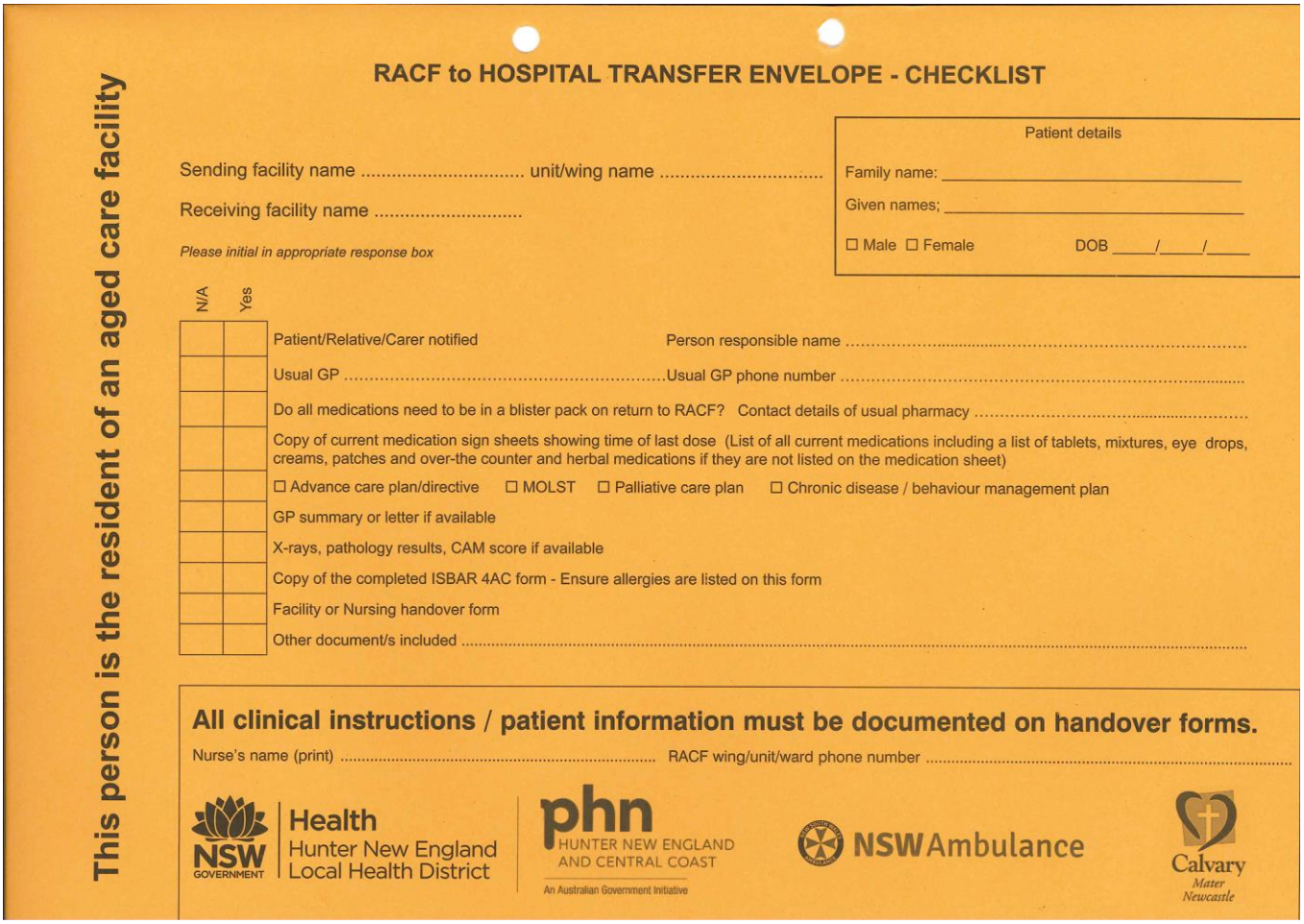


What to Send When Transferring a Resident to Hospital

When transferring a resident to hospital, send the following in an Envelope:

- Name and contact details of:
  - person responsible
  - usual GP
  - usual pharmacy. State clearly if medication must be in a blister pack on return to RACF.
- Copy of the medication chart and any sign sheet. Include a list of tablets, mixtures, eye drops, creams, patches, and over-the counter and herbal medications that are not on the medication chart.
- Advance Care Directive, Palliative Care Plan, MOLST, other disease and/or behavioural management plans.
- GP summary or letter (if available).
- X-rays, pathology results, CAM score if available.
- Full set of current clinical observations (page 14) and baseline observations.
- Copy of the completed ISBAR 4AC form (page 12-13).
- Facility transfer form, or if preferred, use this checklist.

Advise if the person responsible has been notified.



This person is the resident of an aged care facility

RACF to HOSPITAL TRANSFER ENVELOPE - CHECKLIST

Sending facility name ..... unit/wing name .....

Receiving facility name .....

Please initial in appropriate response box

Patient details

Family name: _____

Given names; _____

☐ Male ☐ Female DOB ____/____/____

N/A	Yes	
		Patient/Relative/Carer notified Person responsible name .....
		Usual GP .....Usual GP phone number .....
		Do all medications need to be in a blister pack on return to RACF? Contact details of usual pharmacy .....
		Copy of current medication sign sheets showing time of last dose (List of all current medications including a list of tablets, mixtures, eye drops, creams, patches and over-the counter and herbal medications if they are not listed on the medication sheet)
		☐ Advance care plan/directive ☐ MOLST ☐ Palliative care plan ☐ Chronic disease / behaviour management plan
		GP summary or letter if available
		X-rays, pathology results, CAM score if available
		Copy of the completed ISBAR 4AC form - Ensure allergies are listed on this form
		Facility or Nursing handover form
		Other document/s included .....

All clinical instructions / patient information must be documented on handover forms.

Nurse's name (print) ..... RACF wing/unit/ward phone number .....

NSW GOVERNMENT Health Hunter New England Local Health District

phn HUNTER NEW ENGLAND AND CENTRAL COAST An Australian Government Initiative

NSW Ambulance

Calvary Mater Newcastle

Making a Compliment or Complaint

Compliments and complaints help improve the quality of care and the services we provide.

When a complaint relates to the ACE staff or service provided by either the Local Health District or Primary Care organisation, the relevant local complaint policy is used to guide complaint resolution internally.

To make a compliment or complaint, email insert email.

The feedback is forwarded to the appropriate manager.

When a complaint relates to an external service provider, the complainant is:

- Informed it is not the role of ACE Services to resolve their complaint against the external provider, and
- Encouraged to raise their concern with the external provider directly and follow the escalation process below.

If you wish to make a complaint, follow the steps below for a complaint against:					
	Ambulance	**General Practitioner**	**Residential Aged Care Facility**	**Primary Care Organisation**	**Local Health District**
1.	Speak directly to the person involved.	Speak directly to the person involved.	Speak directly to the person involved.	Speak directly to the person involved.	Speak directly to the person involved.
	If not appropriate or not resolved:				
2.	Speak with the Station Manager.	Speak with the Practice Manager.	Speak with the Facility Manager.	Speak with the line Manager.	Speak with the ward Manager (e.g. ED).
	If not appropriate or not resolved:				
3.	Escalate to state ambulance: ph insert number **or** State Health Care Complaints Commission : ph insert number	State Health Care Complaints Commission: ph insert number	State Health Care Complaints Commission: ph insert number **or** Escalate to the Aged Care Complaints Scheme: ph **1800 550 552**	State Health Care Complaints Commission: ph insert number	Escalate to Local Health District, Health Complaints Line: ph insert number **or** State Health Care Complaints Commission: ph insert number

Telehealth

Telehealth is a platform for delivering healthcare from a distance using information communications technology (ICT). It is used to connect clinicians and other healthcare providers with patients and carers, and to provide care to patients. It can also be used for:

- Assessment
- Intervention
- Consultation
- Education
- Supervision

Telehealth video calls can provide great benefits to residents and staff in RACFs, and residents' families. For example:

- outpatient specialist consultation via Telehealth enables:
  - a resident to remain at their facility for the appointment, which minimises transport issues for the facility and family, and the risk of the resident missing medications or meals
  - RACF staff and the resident's family to participate in the consultation (when appropriate), which helps improve coordination of ongoing care and communication of treatment plans
- some ACE clinicians can offer Telehealth review and assessment from Emergency Department (ED) staff when required, which may:
  - help avoid unnecessarily transferring the resident to ED
  - speed up care once the resident arrives in ED

Telehealth should be encouraged by all clinicians as an option to patients whenever clinically appropriate.

Many specialists have access to Telehealth at their clinics and have dedicated staff to help schedule and coordinate Telehealth appointments.

Advice and referrals

To enquire about making a Telehealth appointment for a resident, contact the local Health district Telehealth support team:

- Email: insert email
- Phone: insert number

Resources and references

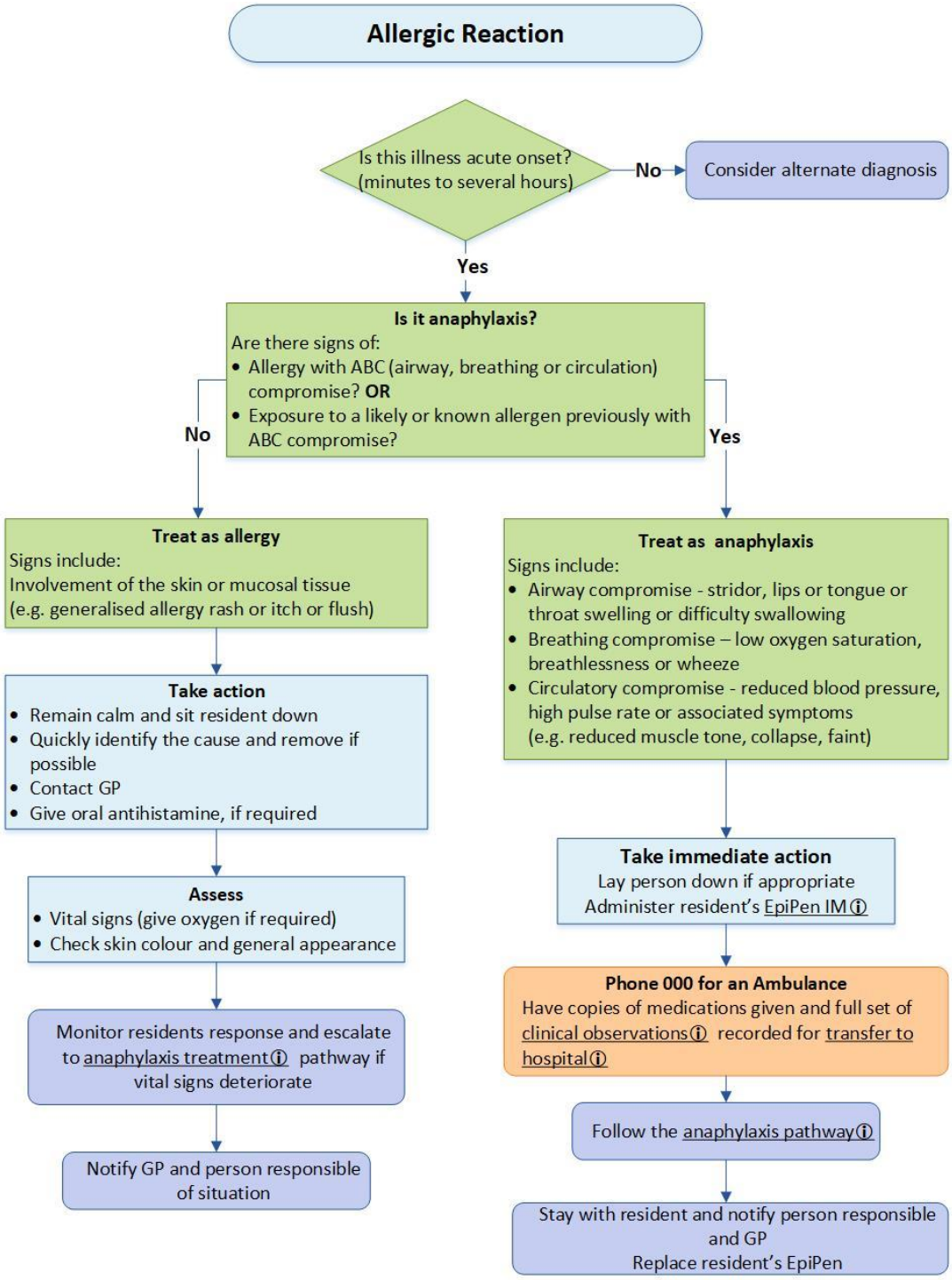
- ACI Telehealth Network – Telehealth in Practice Guide (2019) (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/509480/ACI_0261_Telehealth_guidelines.pdf)

Guidelines

Allergic Reactions/Anaphylaxis

Allergic Reactions Flowchart

An individual clinical management plan should be developed for all residents who have known hypersensitivities. This plan should identify known allergens and management of allergic reactions, and include standing orders for antihistamines and adrenaline (EpiPen).



Anaphylaxis Action Plan

See next page for the Australasian Society of Clinical Immunology and Allergy (ASCIA) Action Plan for Anaphylaxis (personal) for use with EpiPen 2020.

Advice

Poisons Information Centre

Call this number if you think someone has taken an overdose, made an error with medicine or been poisoned. You can call 24 hours a day, 7 days a week from anywhere in Australia.

Phone **13 11 26**

NSW Poisons Information Centre also provides the latest poisons information for overdoses and medication errors, and advice on the management of poisoned and envenomed patients.

Australian Govt Department of Health: https://www.health.gov.au/contacts/poisons-information-centre

NSW Poisons Information Centre: https://www.poisonsinfo.nsw.gov.au/

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

Name: _____ **For use with EpiPen® adrenaline (epinephrine) autoinjectors**

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

The treating doctor or np hereby authorises:

- **Medications specified on this plan to be administered according to the plan.**
- **Prescription of 2 adrenaline autoinjectors.**
- **Review of this plan is due by the date below.**

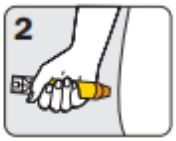
Date: _____

Signed: _____

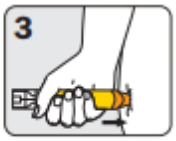
Date: _____

How to give EpiPen® adrenaline (epinephrine) autoinjectors

Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds

REMOVE EpiPen®

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 7.5-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Locate adrenaline autoinjector
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk
- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**

2 Give adrenaline autoinjector

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline doses may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS give adrenaline autoinjector FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

- ***If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre.***
- ***Continue to follow this action plan for the person with the allergic reaction.***

Assaults

Following an assault, the resident may require access to counselling, medical assessment, and treatment. Contact GP or ACE clinican for treatment of injuries and, if life threatening, phone **000**.

If a crime is suspected, contact the police immediately and preserve any potential forensic evidence at the location of the incident. This includes:

- Not disturbing the "scene", or closing off areas where possible
- Not removing the clothing from the victim
- Discouraging the victim from washing or cleaning the area

Mandatory reporting requirements

When you first have a suspicion of or become aware of an allegation of an assault, report it immediately to the most senior member of staff on duty. The Aged Care Act 1997 (https://www.legislation.gov.au/Details/C2019C00294) has compulsory reporting requirements to help protect residents. This means that RACFs are responsible for reporting suspicions or allegations of assault to the local police and the Aged Care Quality and Safety Commission within 24 hours.

A reportable assault is:

- **Unreasonable use of force** on a resident, ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force
- **Unlawful sexual contact**, meaning any sexual contact with a resident without consent

Aged Care Quality and Safety Commission compulsory reporting line – phone 1800 081 549

The law also requires RACFs to report when a **resident is absent without explanation** (missing).

To report a suspicion or allegation of a reportable assault or a missing resident, RACFs need to complete a reportable assault form (https://www.agedcarequality.gov.au/media/87212) or an unexplained absence form (https://www.agedcarequality.gov.au/media/87213) and email it to compulsoryreports@health.gov.au.

Aged Care Quality and Safety Commission:

- Compulsory reporting (https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/responsibilities-of-approved-aged-care-providers#compulsory-reporting)
- Reportable Assault Flowchart for Residential Aged Care (https://www.agedcarequality.gov.au/sites/default/files/media/%5BD19-1430255%5D%20Reportable%20assault%20flowchart%202020.PDF)

Sexual assault

Contact the Local Health District Sexual Assault Service for advice. The Sexual Assault Service provides:

insert web address

- 24-hour on-call crisis support and advice (within 7 days of the assault), crisis counselling
- Collection of forensic evidence in the local emergency department, as required

References and resources

- HealthPathways insert web address
- NSW Ageing and Disability Abuse Helpline: ph **1800 628 221** (Monday Friday, 9 am to 5 pm)
- State Ageing and Disability Abuse Helpline: insert number

Cardiology

Heart Failure Issues

Residents who have a known heart failure and are receiving active treatment should have a clinical management plan in place to manage their exacerbations.

A management plan should include both non-medication- and medication-management strategies, and include:

- Daily weighs – weigh resident at the same time each day. A rapid increase or loss of weight (i.e. 2 kg over 2 days) should trigger a medication response from the GP.
- Fluid management – Monitor fluid intake. This may include a fluid restriction as recommended by the GP or cardiologist.
- Sodium restriction – Reduce salt intake, including no added salt to meals.
- Daily monitoring changes in the following:
  - weight
  - shortness of breath or increased rate of breathing
  - chest pain
  - dizziness
  - fast or irregular pulse
  - ankle swelling, oedema, or bloating
  - acute infections that may exacerbate symptoms
- PRN medication orders, which are helpful for residents who have frequent exacerbations, and should include:
  - oxygen therapy (if SpO_2 <92%)
  - diuretics
  - morphine liquid to assist with breathlessness

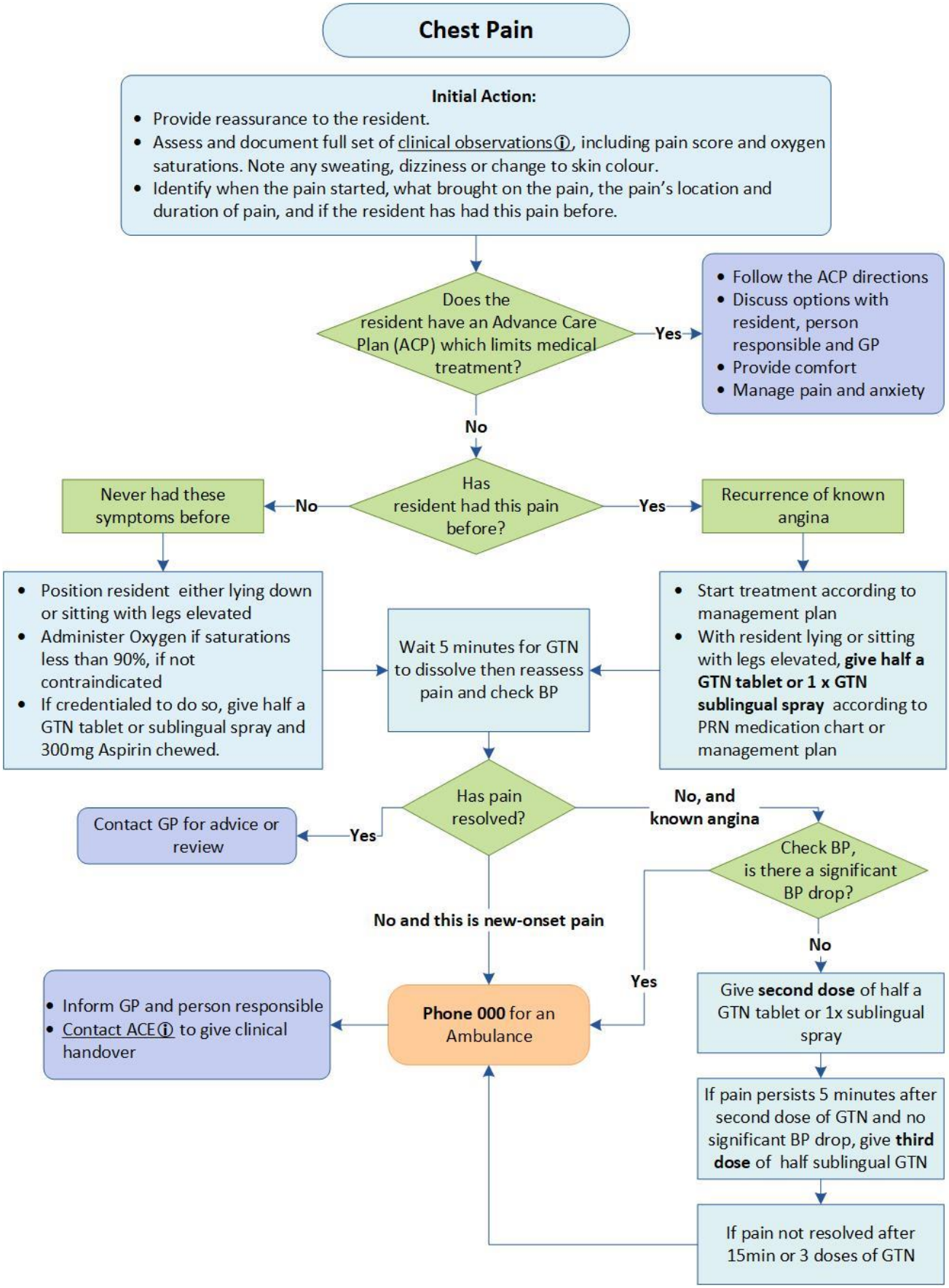
Symptom	Cause	Management
Shortness of breath	▪ excess fluid in the lungs ▪ left ventricular failure or pump failure	▪ rest when needed ▪ oxygen if necessary ▪ extra pillows to sleep if needed ▪ morphine liquid where appropriate if prescribed
Ankle swelling	▪ caused by fluid leaking out of the blood vessels into the tissues (oedema)	▪ inform GP ▪ review fluid intake, diet (especially sodium intake), medications (e.g. diuretics)
Weight gain	▪ fluid build up may cause rapid weight gain ▪ 1 litre fluid = 1 kg increase	▪ weigh every morning before breakfast ▪ monitor fluid and follow fluid restrictions as prescribed ▪ restrict sodium
Tiredness	▪ can be caused be decreased blood flow to the major organs and muscles	▪ adequate rest ▪ use energy conservation techniques ▪ exercise is beneficial with heart failure – ensure exercise tolerance is maintained where possible
Loss of appetite	▪ build up of fluid in the digestive organs ▪ decreased circulation	▪ eat smaller meals, more often
Dizziness	▪ decreased blood flow to the brain ▪ changes in heart rate and rhythm	▪ mobilise slowly ▪ sit or lie down when needed ▪ inform the GP ▪ check pulse – if over 120 or below 40 bpm, contact the GP
Chest pain	▪ chest pain can be caused by reduced blood flow to the heart muscle	▪ See the Managing Chest Pain Flowchart (page 30)
Confusion	▪ confusion can be caused by decreased blood flow to the brain	▪ rest as needed ▪ oxygen if required ▪ communicate clearly and concisely

Managing Chest Pain Flowchart

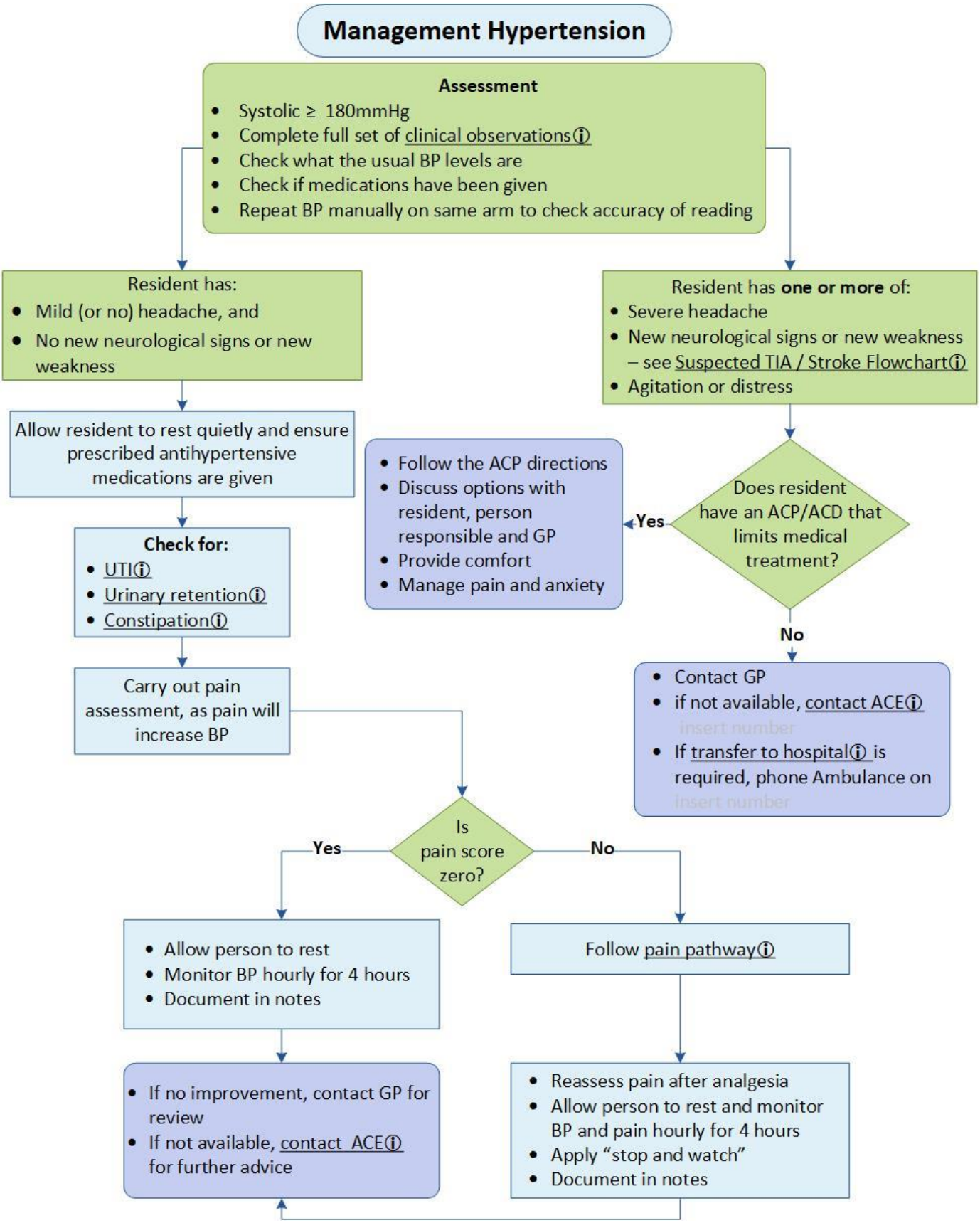
Important: Always wait 5 minutes after administering glyceryl trinitrate (GTN) before taking a BP because GTN lowers BP. A "significant drop" in BP is >20 mmHg.

- GTN tablet/spray is a suggested medication for treatment of acute chest pain. Residents with previous history of chest pain should have a PRN order for GTN on their medication chart.
- GTN is administered sublingually.
  - always check expiry date on GTN spray and ensure spray is primed before using. To prime, remove the lid, face the bottle away from you and depress pump until a mist appears.
  - GTN tablets expire 90 days after opening bottle.

For further advice and support, contact ACE (page 10).



Managing Hypertension Flowchart



Further Information

Advice and referral

HealthPathways – insert web address

References and resources

Chest pain

- Australian Journal of General Practice – The Assessment and Management of Chest Pain in Primary Care: A Focus on Acute Coronary Syndrome (https://www1.racgp.org.au/ajgp/2018/may/chest-pain-in-primary-care)
- Heart Foundation – Acute Coronary Syndromes Resources for Health Professionals (https://www.heartfoundation.org.au/for-professionals/clinical-information/acute-coronary-syndromes)

Heart failure

- Australian Prescriber – Chronic Heart Failure (https://www.nps.org.au/australian-prescriber/articles/chronic-heart-failure) 2017
- Heart Foundation – Heart Failure: Resources for Health Professionals (https://www.heartfoundation.org.au/for-professionals/clinical-information/heart-failure-professionals)
- Heart Online:
  - Heart Education Assessment Rehabilitation Toolkit (http://www.heartonline.org.au/)
  - Heart Failure Medication Titration Plan (https://www.health.qld.gov.au/__data/assets/pdf_file/0018/428121/Medn_Titration.pdf)
- MJA – National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand: Australian Clinical Guidelines for the Management of Heart Failure 2018 (https://www.mja.com.au/journal/2018/209/10/national-heart-foundation-australia-and-cardiac-society-australia-and-new-0)
- NSW Agency for Clinical Innovation – NSW: Clinical Framework for Chronic Heart Failure (2016) (http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2017_006.pdf)

Hypertension

- Australian Heart Foundation – Hypertension (https://www.heartfoundation.org.au/for-professionals/clinical-information/hypertension)
- NSW Emergency Care Institute - Hypertension and Headache (https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/neurology/headache/hypertension-and-headache)

See also

- ACE Manual – Palliative Care (page 78)
- NSW Guidelines for Deactivation of Implantable Cardioverter Defibrillators at the End of Life (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/179990/ACI-Deactivate-ICDs.pdf)
- Heart Online – Treatment and Management (https://www.heartonline.org.au/articles/treatment-management/assessment)

Cellulitis

A guide to disposition of GP patients with cellulitis

These indicators are a guide only. Use clinical judgement. Patients for IV therapy can be referred to Hospital in the Home type (HITH) Services – ph insert number

Refer to "Cellulitis (in adults) considered suitable for IV therapy with Cefazolin at home: GP direct referrals to Hospital in the Home" worksheet.

See also Cellulitis HealthPathways.**This is an example of a local guide to dispostion of patients with cellulitis.**

Clinical feature	Home on oral antibiotics	Home on IV antibiotics	Admit to hospital
Extent of area of cellulitis	small	moderate	significant/extensive/rapidly progressive
Location of cellulitis	extremity	▪ extremity ▪ torso	face, hands, perineum, diabetic foot – surgical or orthopaedic review required
Cellulitic reaction	erythema only	moderate	Any of: ▪ severe ▪ bullae ▪ necrosis ▪ haemorrhage ▪ gas in tissues
Pain	mild	moderate	▪ severe ▪ continuous
Lymphangitis	minimal	moderate	significant
Local co-morbidities			
▪ Lymphoedema (premorbid)	▪ nil	▪ none or minimal	▪ significant
▪ Arterial vascular disease	▪ nil	▪ none or minimal	▪ significant
▪ Venous disease	▪ minimal	▪ may have venous ulcers	▪ extensive
Causes			
▪ Bite (animal, human)	▪ nil	▪ nil	▪ yes
▪ Penetrating injury	▪ nil	▪ nil	▪ yes
Local complications			
▪ Possible collection/abscess	▪ nil	▪ nil	▪ yes
▪ Possible involvement of bone and/or joint	▪ nil	▪ nil	▪ yes

Clinical feature	Home on oral antibiotics	Home on IV antibiotics	Admit to hospital
Systemic effects			
▪ Fever	▪ <38°	▪ <39° in last 24 hours	▪ >39° in last 24 hours
▪ Tachycardia	▪ nil	▪ up to 100 bpm	▪ >100 bpm
▪ Hypotension	▪ nil	▪ systolic >100 mmHg	▪ systolic <100 mmHg
▪ Postural hypotension	▪ nil	▪ 0 to 15 mmHg drop	▪ >15 mmHg drop
▪ Syncope	▪ nil	▪ none in last 24 hours	▪ within last 24 hours
▪ Rigors	▪ nil	▪ none in last 24 hours	▪ within last 24 hours
▪ Nausea	▪ nil	▪ slight/manageable	▪ severe
▪ Vomiting	▪ nil	▪ not more than once in last 12 hours	▪ more than once in last 12 hours
▪ Dehydration	▪ nil	▪ nil	▪ present
System co-morbidities (active)		May be:	
▪ CCF	▪ nil or controlled	▪ some worsening	▪ poorly controlled
▪ Diabetes	▪ nil or normal control	▪ BGLs up to 15 mmol/L	▪ poorly controlled
▪ Immunocompromised	▪ nil	▪ nil	▪ present
Investigation results			
▪ WCC	▪ >4 and <15	▪ >4 and <20	▪ <4 or >20
▪ GFR/eGFR	▪ normal	▪ >10	▪ <10
▪ ALT	▪ normal	▪ <200 IU/mL	▪ >200 IU/mL
▪ Blood cultures	▪ negative	▪ negative	▪ positive
▪ CK if ? fasciitis or muscle involvement	▪ normal	▪ normal	▪ raised
Weight	>45 kg and <100 kg	>45 kg and <120 kg	<45 kg or >120 kg
Vascular access	N/A	adequate	inadequate
Social circumstances and capacity to self-care	adequate	adequate	inadequate
Communications and capacity to access emergency services	N/A	adequate	inadequate
Capacity to rest and obtain adequate nutrition	adequate	adequate	inadequate

This information has been sourced from A Guide to Disposition of GP Patients with Cellulitis (https://hne.communityhealthpathways.org/files/Resources/CellulitisdispositionguideforGeneralPracticepatientsreferredtoHITH.pdf) on HNELHD Community HealthPathways.

Behaviour and Confusion Management

Behaviour Management Identification Tool

Use the following tool to help differentiate between the symptoms of dementia, delirium, and depression.

	Dementia	Delirium	Depression
Onset	Insidious	Acute	Gradual
Duration	Months or years	Hours, days, or weeks	Weeks or months
Course	Stable and progressive, can be step-like (e.g. Vascular)	Fluctuates – worse at night, lucid periods	Usually worse in the morning improves as the day goes on
Progression	Slow but even	Abrupt	Variable, rapid-slow, but uneven
Alertness	Usually normal	Fluctuates; lethargic or hypervigilant	Normal
Awareness	Clear	Reduced	Clear
Orientation	Usually impaired for time and place, may be normal	Fluctuates in severity, generally impaired	Usually normal but may have selective disorientation
Memory	Recent and sometimes remote memory impaired	Recent and immediate memory impaired	Recent memory may be impaired, but remote intact
Thoughts	Slowed, reduced interests, perseveration and delusions common	Often paranoid and grandiose, bizarre ideas and topics.	Usually slowed, preoccupied by sad and hopeless thoughts
Perception	Normal	Distorted, visual and auditory hallucinations are common	Intact, except for severe cases where hallucinations and delusions may be present. In severe cases, negative or somatic themes.
Emotions	Shallow, apathetic, labile, irritable	Irritable, aggressive, fearful	Flat, unresponsive, or sad May be irritable
Sleep	Often disturbed, nocturnal wandering and confusion	Nocturnal confusion	Early morning wakening
Other features		Other physical disease may not be obvious. May linger after physical symptoms resolve.	Past history of mood disorder

Behaviour Management Issues

Delirium

Delirium is a clinical emergency and needs urgent medical review. Many of the causes of delirium are reversible and these causes need to be identified and treated.

Delirium is a sudden change in cognitive function or behaviour and the resident may be either very agitated or quiet and drowsy. Below is a range of symptoms the resident may display:

- confusion
- restlessness
- alteration in mood or emotions
- worsening concentration
- altered level of consciousness
- altered sleep patterns
- agitation
- less communicative or responsive
- difficulties cooperating with reasonable requests

Assessment

1. The Confusion Assessment Method (CAM) (page 127) can assist in making a diagnosis of delirium:
   a. acute onset and fluctuating course
   b. inattention
   c. disorganised thinking
   d. altered level of consciousness

   Residents needs to have both **(a) and (b)** and **either (c) or (d)** to have a delirium diagnosis.
2. Complete a full set of clinical observations (page 14) to identify potential causes of delirium.
3. Assess underlying common causes of delirium:
   - Is the resident unwell?
   - Do they have an infection, e.g. UTI (page 100) or chest infection?
   - Do they have pain? Use pain assessment tools (page 73-76).
   - Do they have constipation (page 54) or urinary issues?
   - Are they dehydrated, e.g. due to low intake or diuretics or recent hot weather?
   - Is the delirium due to polypharmacy, a new medication, or alcohol intake?
   - Are there environmental factors affecting the resident or sensory factors, e.g. sight or hearing deficits?
4. Assess and document any cognitive or functional changes.

Management

- Inform GP of assessment and arrange for treatment of the underlying cause, e.g. antibiotics for infection if appropriate.
- Develop a behaviour management plan and review and update the plan regularly.
- Consider physical, medical, social, and psychological needs of the resident.
- Use Top 5 (https://www.hneccphn.com.au/media/14342/toolkit-cec-top-five-june-2014.pdf) principles to personalise care. Talk to the carer to better understand the cues given by the resident, so staff can better communicate with the residents and allay their fears.
- Pharmacological interventions are considered as a last resort for management of delirium.

A behaviour management plan for delirium should also consider the following needs according to the **PINCHES ME Kindly** approach (Gee et al 2016):

- **P**ain – no pain lots of gain
- **I**nfection – suspect it, spot it, stop it
- **N**utrition
- **C**onstipation – fluids, fibre, footwork
- **H**ydration – don't wait, hydrate
- **E**xercise – make the move to prevent delirium
- **S**leep – don't get delirious, sleep is serious
- **M**edications – don't prescribe delirium
- **E**nvironment – house proud
- **Kindly** – calm, patient and mindful of emotional needs

Reference

Gee, S., Bergman, J., Hawkes, T. & Croucher, M. (2016), Think delirium: Preventing delirium amongst older people in our care. Tips and strategies from the Older Persons' Mental Health Think Delirium Prevention project (http://edu.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Documents/Think-Delirium-236949.pdf#search=pinches%2520me%2520kindly). Christchurch, New Zealand: Canterbury District Health Board.

Medication

The use of medications should not be automatic or invariable. Start with low doses and go slow.

Assessment

Specific to the desired result of either reducing distress, psychotic experience, or assisting rest.

Management

- Some causes of delirium require specific medication for treatment.
- If the resident has recently started or stopped any medications, or it is believed they are currently experiencing or at risk of experiencing a medication-related adverse effect, they may benefit from GP referral for a residential medication management review (RMMR).

Communication with People with Behavioural Symptoms

- Residents may use verbal and non-verbal cues, so read their body language to better understand and assess their needs.
- The resident may not be able to understand what is happening around them or may misinterpret activities or use inappropriate words as they can't remember the correct words. Don't take comments personally and don't argue.
- Speak slowly and clearly and use a gentle tone.
- Use simple concise phrases when speaking with resident. Use closed questions which require a "yes" or "no" answer.
- Use their documented "Top 5" strategies.
- Always plan your safe exit path when entering a room with an aggressive person and don't allow the person to be between you and your exit.

Behaviour Management Plan

An ongoing behaviour management plan can assist with continuity of care and identification of any new issues. When writing a plan, highlight the behaviour of concern and identify the triggers or signs that the resident is escalating and what helps to alleviate the behaviour.

1. **Accept** the resident by listening, engaging, and understanding what they are trying to tell you.
2. **Assess** for physical illness, unmet needs, and carer needs.
3. **Act** by providing person-centred care with activities that are meaningful to the resident:
   - addressing unmet needs, e.g. physical, environmental, psychosocial, and carer needs
   - treating physical illness, pain, and/or psychiatric disorder
4. **Reassess** if problems persist.
   - use non pharmacological management strategies initially
   - pharmacological management
5. **Review** and reassess cognition if no previous diagnosis of dementia and provide carer education.

The above was adapted from the Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) A Handbook for NSW Health Clinicians (https://www.health.nsw.gov.au/mentalhealth/resources/Publications/assessment-mgmt-people-bpsd.pdf) developed by The Royal Australian & New Zealand College of Psychiatrists and NSW Health (2013).

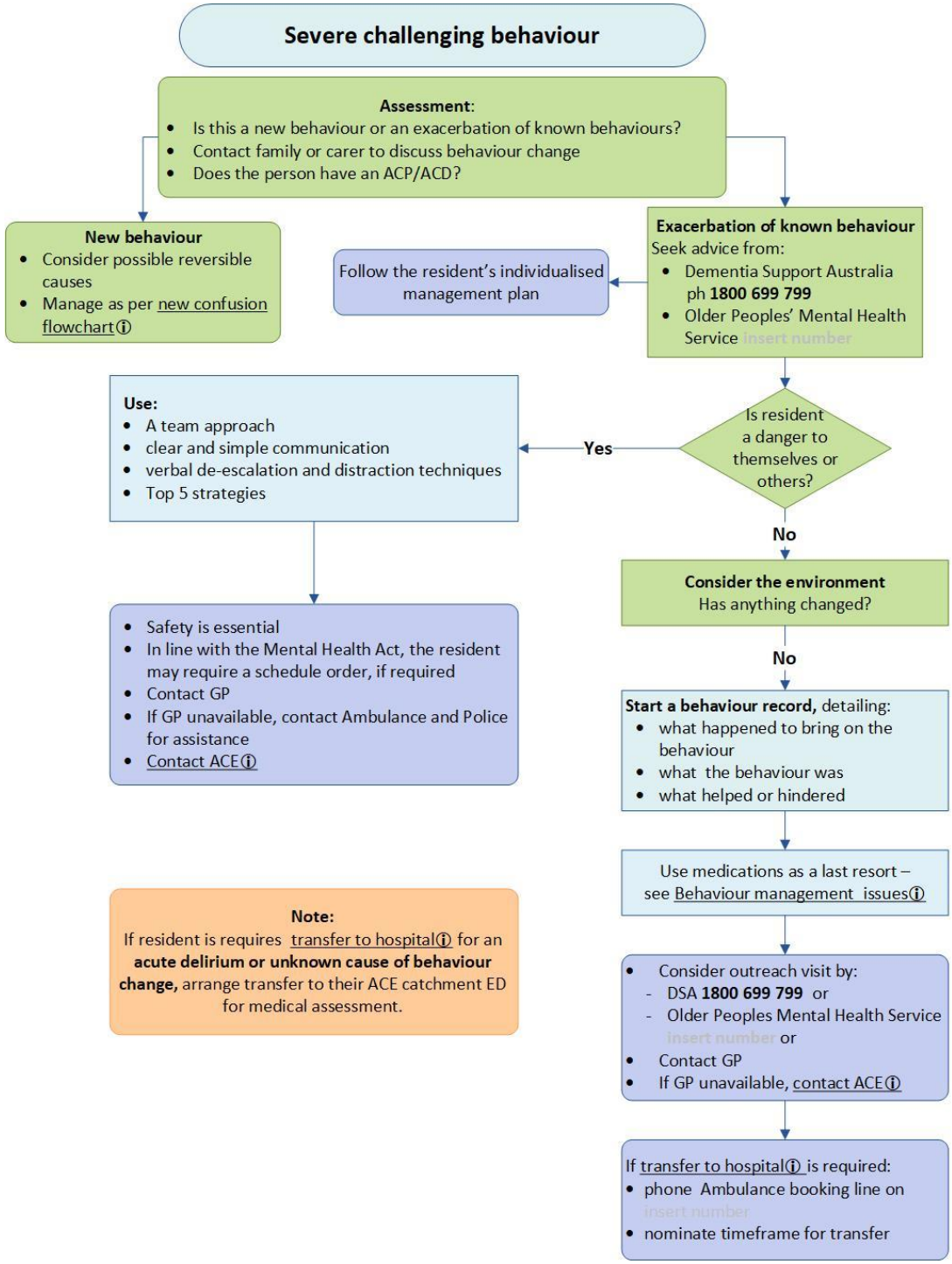
Resident is a Risk to Themselves or Others

If the resident a risk to themselves or others due to mental illness, a referral can be made through the Mental Health Contact Centre. This can be done by anyone contacting **insert number**.

If this resident is at high or imminent risk, they can be transported to hospital for a mental health assessment. This can be arranged by the GP or Ambulance or Police when they enact a schedule under the Mental Health Act so the resident may be taken to hospital involuntarily.

Managing Challenging Behaviour Flowchart

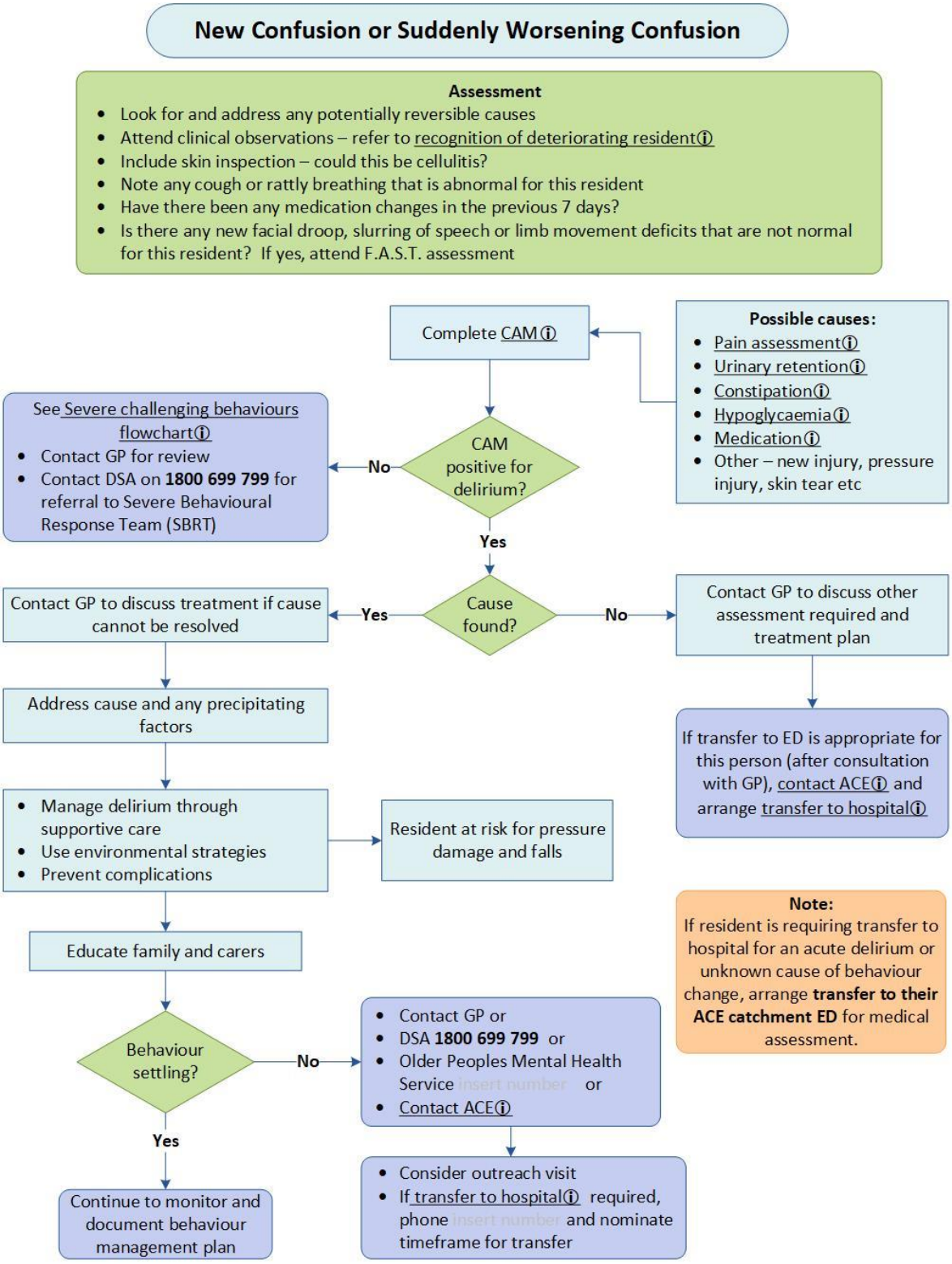
Always attend a full set of clinical observations (page 14), including skin inspection and BGL. Consider if pain is an issue.



Note: For Mental Health referrals contact the Older peoples Mental Health service – insert number

Managing New Confusion or Suddenly Worsening Confusion Flowchart

Residents who are regularly taking 5 or more drugs have an increased risk of confusion. Arrange a comprehensive pharmacy review for these residents. See Polypharmacy in RACFs (page 84)



Accessing Mental Health and Dementia Services

1. Older People Mental Health Service (OPMHS)

Referral to the Mental Health Team is via the Mental Health Telephone Access Line on insert number.

Anyone can refer by phone, but a GP letter outlining specific concerns with issue(s) to be addressed is preferred.

Criteria for referral to OPMHS

Older patients (aged ≥65 years) with:

- Moderate to severe behavioural or psychological symptoms associated with dementia (BPSD), or other long-standing organic brain disorder and would be optimally managed with input from Older People Mental Health.
- Lifelong or recurring mental illness and concerns regarding emerging cognitive impairment.

A thorough mental health assessment will be performed. Medical information, including health history, current medications, and investigations and results (to rule out delirium) will be required to assist this process.

Following the mental health assessment, referral may be made to a psychiatrist, neuropsychologist, or psychogeriatrician. An OPMHS clinician may make other recommendations and/or provide short-term care coordination to support the resident in their recovery. Education specific to mental health may also be offered to the RACF on a needs basis to ensure staff have a good understanding of the condition and treatments specific to the resident.

2. Dementia Support Australia (DSA)

If the main presenting problem is behavioural disturbance in dementia, Dementia Support Australia can be contacted and referrals can be made 24 hours a day through any of the following methods:

- online referral form (https://dementia.com.au/contact/referral)
- phone 24-hour helpline **1800 699 799**
- fax on **1800 921 223**

Dementia Support Australia provides the following services:

Dementia Behaviour Management Advisory Service (DBMAS)

The Dementia Behaviour Management Advisory Service (DBMAS) supports staff and carers with information, advice, assessment, and short-term case management interventions.

Severe Behaviour Response Teams (SBRT)

The Severe Behaviour Response Team (SBRT) provides a range of crisis management services for patients with dementia and severe and extreme behaviour. The SBRT is for people living with dementia, who have severe, very severe, or extreme behavioural and psychological symptoms of dementia.

Specialist Dementia Care Program (SDCP)

The Specialist Dementia Care Program (SDCP) is for people with very severe behavioural and psychological symptoms of dementia (BPSD) who:

- are unable to be appropriately cared for by mainstream aged care services, but
- do not require care more appropriately delivered in other health settings

A SDCP unit is located at Cardiff in Newcastle and provides a regional service.

To make a referral to either DBMAS, SBRTs, or SDCP, use the above Dementia Support Australia referral details.

Note: Delirium is categorised as a medical emergency and is better managed by the GP or acute medical services rather than DSA or OPMHS. Possible causes of delirium need to be ruled out and/or managed before referring to these services with residents with an acute delirium or unknown cause of behaviour change.

3. Residential Aged Care Psychology Program

A Residential Aged Care Psychology Program is provided by insert name.

Psychology services vary between regions.

Psychology services provide psychological treatment and support to permanent residents of aged care facilities who present with **mild** to **moderate** mental health disorders and/or are exhibiting heightened psychological distress. The service also provides information to RACF staff and GPs to better support residents who present with mild to moderate mental health symptoms and/or psychosocial difficulties.

Referrals:

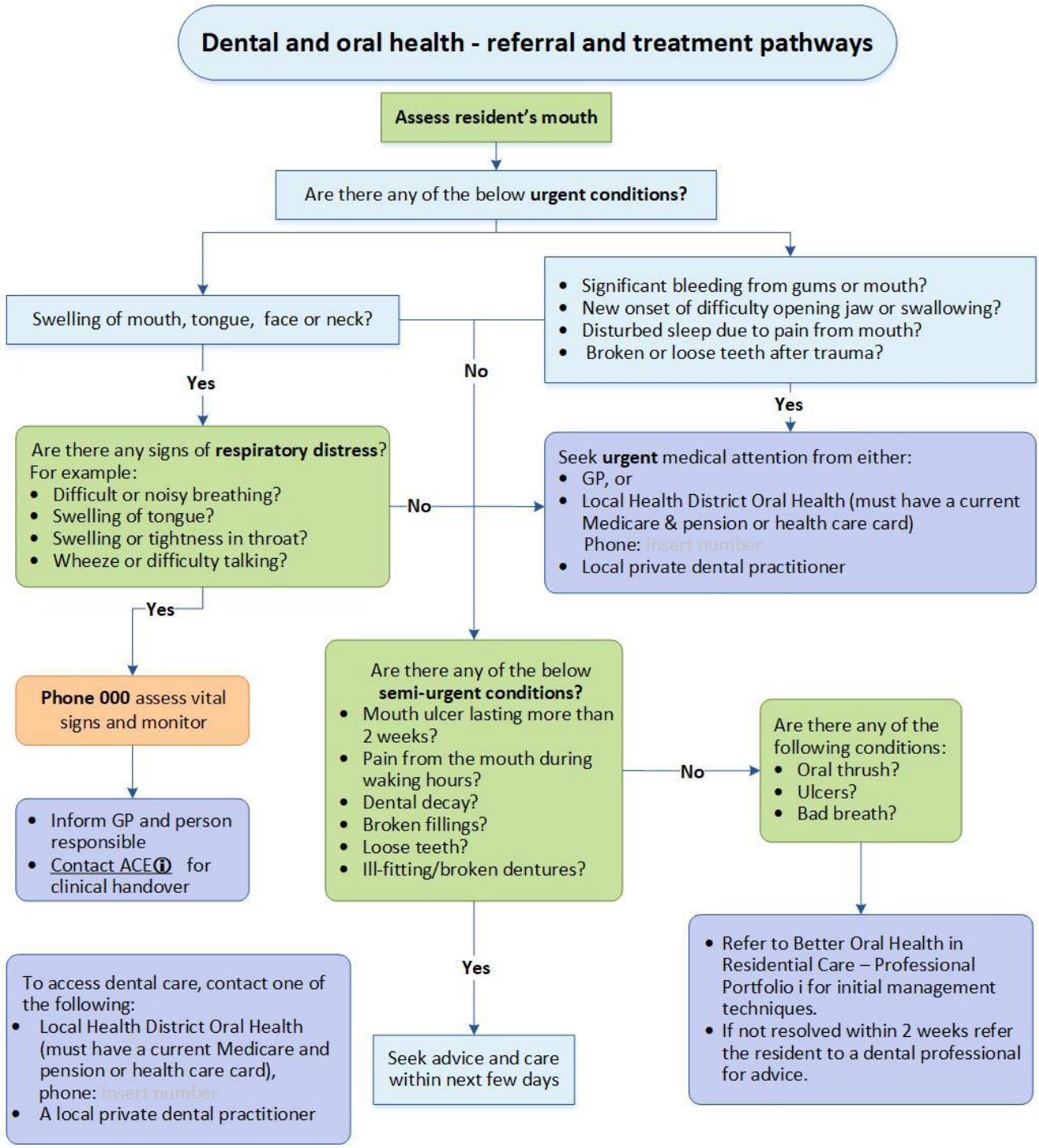
- Phone:
- Email:

References and Resources

- HealthPathways
- Dementia Support Australia (https://dementia.com.au/)
- Dementia Training Australia (https://www.dta.com.au/)
- Dementia Australia (https://www.dementia.org.au)
- Gee, S., Bergman, J., Hawkes, T. & Croucher, M. (2016), Think delirium: Preventing delirium amongst older people in our care. Tips and strategies from the Older Persons' Mental Health Think Delirium Prevention project (http://edu.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Documents/Think-Delirium-236949.pdf#search=pinches%2520me%2520kindly). Christchurch, New Zealand: Canterbury District Health Board.
- The Royal Australian & New Zealand College of Psychiatrists and NSW Health (2013) Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia (BPSD) A Handbook for NSW Health Clinicians (https://www.health.nsw.gov.au/mentalhealth/resources/Publications/assessment-mgmt-people-bpsd.pdf).

Dental and Oral Health

With increases in tooth retention for older adults and increases in medical comorbidities, the below flowchart is designed to improve access to oral health referral and treatment pathways.



References and resources

Oral Health Care for Older People – Toolkit for oral health and health
https://www.health.nsw.gov.au/oralhealth/Publications/oral-health-older-people-toolkit.pdf

Diabetes

Diabetes Issues

Type 1 diabetes

Type 1 diabetes is an autoimmune disease and has an absolute need for insulin.

Guidelines for management

- Ensure the resident has a regular carbohydrate intake.
- Test urine or blood for ketones if blood glucose level (BGL) is >15 mmol/L.
- Managing sick days for type 1 diabetes (https://www.ndss.com.au/wp-content/uploads/fact-sheets/fact-sheet-managing-sick-days-for-type1.pdf)
- **Do not** withhold basal insulin. Rapid acting insulin given before meals should be adjusted based on resident's food intake.

Type 2 diabetes

Type 2 diabetes usually has a slower onset than type 1 diabetes. It is associated with insulin resistance or insulin deficiency.

Guidelines for management

- Ensure the resident has regular carbohydrate intake.
- As type 2 diabetes is a progressive condition, glucose lowering agents are often prescribed to manage their blood glucose levels.

Blood glucose monitoring

Regular blood glucose monitoring tests whether the treatment being followed is helping to manage blood glucose levels or whether you need to adjust your treatment.

- General aim is for BGL of 6 to 8 mmol/L before meals and 8 to 10 mmol/L two hours after a meal. However, these aims may vary in the elderly. If so, diabetic residents should have individualised aims on their Diabetic Management Plan.
- In frail elderly, aim for BGL between 6 to 15 mmol/L to avoid symptomatic hyperglycaemia / hypoglycaemia.

Blood glucose monitoring is required according to the following guidelines:

- Frequency of blood glucose monitoring should follow the recommended guidelines by Diabetes Australia or an individually tailored diabetes clinical management plan as recommended by the resident's Endocrinologist or GP.
- Test more frequently if the resident is unwell or if suspected of having hypo/hyper glycaemia.

Guidelines for management

- Do not use alcohol wipes on the finger before testing BGL.
- Do not test BGL on dirty hands. If you get an unusually high reading, wash the resident's hands and re-test.

Hypoglycaemia

- hypoglycaemia is a BGL <4 mmol/L
- frail older people are at higher risk of hypoglycaemic event: avoid BGL <6 mmol/L

See the Hypoglycaemia Management (page 48) flowchart.

Have a hypoglycaemia kit available to staff in each area with quick acting carbohydrates, e.g. GlucaGen HypoKit, Lucozade, glucose tablets, etc, or as listed on the Hypoglycaemia Management flowchart.

For residents who may have impaired swallowing and require thickened fluids, the following should also be included in the kit:

- 185 mL Flavour Creations Level 3 Full Thick Citrus Cordial Drink
- snack pack apple purée, spoon, and straw

Guidelines for management

- Treat residents who have impaired swallowing and require thickened fluids with caution.
- Do not try to give an oral replacement to an unconscious or drowsy resident.

Hyperglycaemia and Diabetic-Ketoacidosis (DKA)

Given the range of people with diabetes that live in RACFs, there can be no one glycaemic target that suits all residents. High blood glucose levels and ketones can result in diabetic ketoacidosis (DKA), which may require hospitalisation. Targets need be individualised and balanced against the older person's respect and dignity, their expected long term outcomes, stage of illness, symptoms and the risk of severe hypoglycaemia. The GP can define these levels. See also Diabetes and End of Life Care (http://www.racgp.org.au/your-practice/guidelines/diabetes/15-diabetes-and-end-of-life-care/)

Guidelines for management

- Monitor and report symptoms of polyuria (excessive urine production) and polydipsia (excessive thirst).
- Follow the resident's individual diabetes clinical management plan.

Blood Glucose Levels

In frail elderly, aim for BGL between 6 to 15 mmol/L to avoid symptomatic hyperglycaemia.

Ketone levels

1. Urinary ketones:
   - perform urinalysis using a Ketostix
   - if the urine dipstick shows +2 ketones, the resident is at risk of developing DKA
   - +1 or +2 dipstick = blood ketones 1.5 to 3 mmol/L. See table below for actions required
   - +3 or +4 dipstick = blood ketones above 3 mmol/L. See table below for actions required
2. Blood ketones:
   - the Freestyle Optium Neo meter has test strips to check for blood glucose but also has the blood Beta-Ketone test strips, to check for blood ketone levels

Diabetic-Ketoacidosis (DKA) action plan for blood ketone levels	
Normal range for Blood ketones is <0.6 mmol/L	
At risk of DKA if blood ketones are between 0.6 to 1.5 mmol/L.	May indicate development of DKA - keep resident well hydrated and monitor BGLs.
High risk of DKA if blood ketones are between 1.5 to 3 mmol/L.	Additional fast-acting insulin is required – contact GP. If not available, contact ACE (page 10).
Very high risk of DKA if blood ketones are above 3 mmol/L.	Urgent medical treatment is required – contact GP. If not available, contact ACE (page 10).

Table adapted from the Patient information factsheet - Diabetic ketoacidosis (DKA) in adults (https://diabetes-resources-production.s3-eu-west-1.amazonaws.com/diabetes-storage/migration/pdf/Diabetic-ketoacidosis-patient-information.pdf). 2016 University Hospital Southampton NHS Foundation Trust.

Insulin

Insulin is a synthetic hormone used to stabilise a resident's glucose level.

Guidelines for management:

- Store insulin unopened in the fridge
- Once opened, insulin can remain at room temperature for one month
- Each resident must have their own, clearly labelled vial or pen
- Do not use insulin if it is past the expiry date or if the vial or pen has been in use longer than 1 month
- Do not use clear insulins (Humalog, NovoRapid, Fiasp, Apidra, Lantus, Levemir, Ryzodeg, Actrapid, Humulin R, Toujeo) if it has turned cloudy

ALERT: Most insulin formulations are a standard concentration of 100 units/mL and are administered using a 100 units/mL insulin syringe, or a dedicated injector pen. However, there are three high concentration insulin products available: Toujeo (insulin glargine) 300 units/mL, Humulin R U-500 (human neutral insulin) 500 units/mL, and Humalog U200 (insulin lispro) 200 units/mL. Always check the concentration of insulin and administer these high concentration insulins with the supplied device to reduce errors and serious harm. See Safety Notice 007/19 - NSW Health (https://www.health.nsw.gov.au/sabs/Documents/2019-sn-007.pdf).

Foot care

Foot care is important for residents who have diabetes.

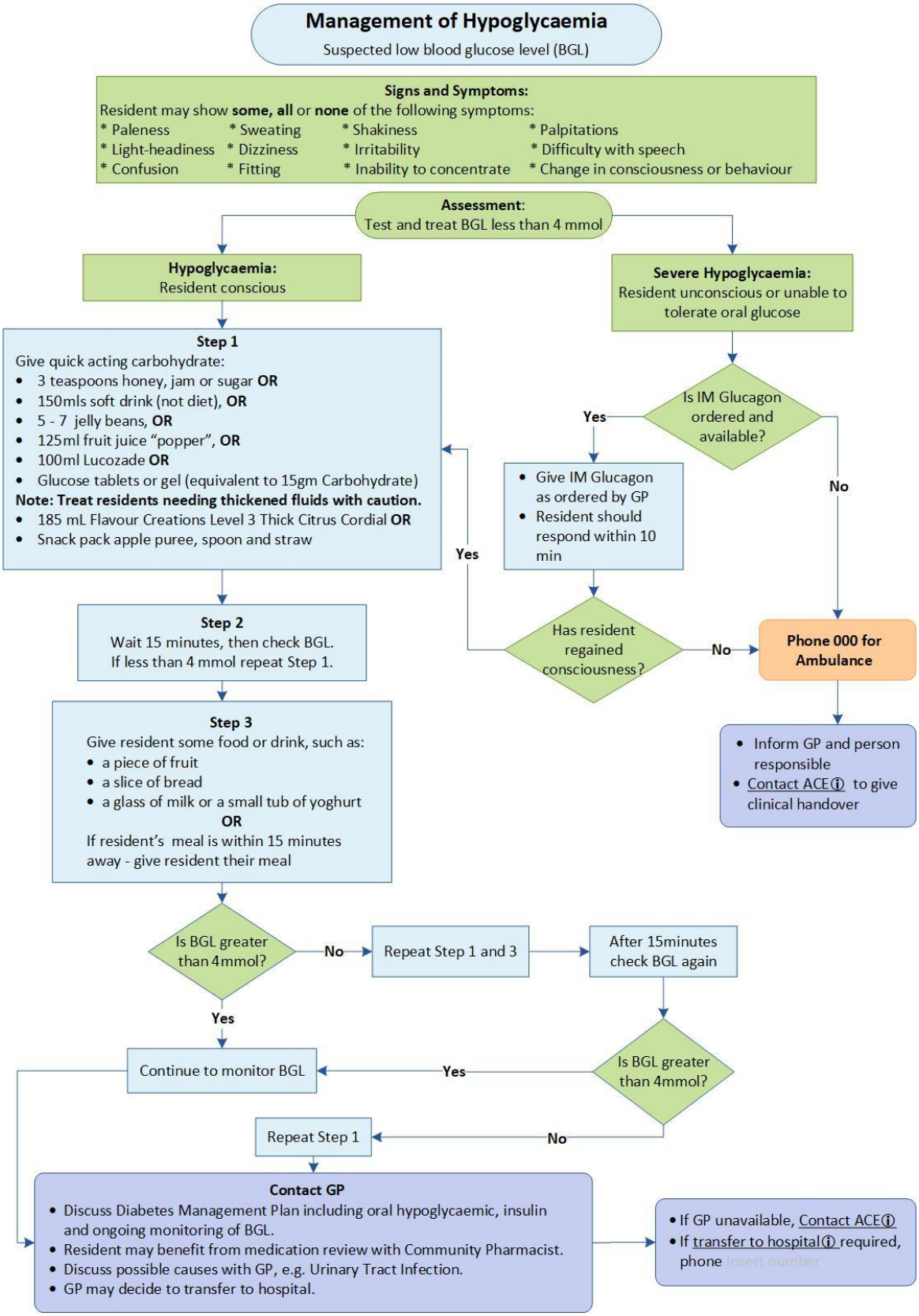
Guidelines for management:

- Residents who have a history of foot ulcer, circulation problems, peripheral neuropathy or have a foot deformity should be referred to a podiatrist or high risk foot clinic
- Practice good foot hygiene – inspect and wash feet daily
- Encourage protective shoes rather than poor fitting constrictive shoes (always check inside the shoe before putting it on a resident)
- Do **not** cut diabetic resident's toenails unless you have been trained to do so

Managing Hypoglycaemia Flowchart

Residents who have known diabetes should have a diabetes Clinical Management Plan.

For those with Type 1 diabetes, it is advisable to have a standing order of IM glucagon in case of severe hypoglycaemia.



Further information

Advice and referrals

- Diabetes NSW and ACT (https://diabetesnsw.com.au/) – ph **1300 342 238** or **02 9552 9942**
- National Diabetes Services Scheme (NDSS) Helpline - ph **1800 637 700**

For generic advice you can also speak with:

- Diabetes educator: insert number
- Dietitian: insert number
- Exercise physiologist: insert number

References and resources

- Diabetes Australia - Best Practice Guidelines for Health Professionals (https://www.diabetesaustralia.com.au/best-practice-guidelines)
- National Diabetes Services Scheme (NDSS)
  - Diabetes management in aged care: a practical handbook (https://www.ndss.com.au/about-diabetes/resources/diabetes-management-in-aged-care/)
  - Diabetes management in aged care: fast facts for care workers (https://www.ndss.com.au/about-diabetes/resources/diabetes-management-in-aged-care/#facts)
  - Managing Hypoglycaemia fact sheet (https://www.ndss.com.au/wp-content/uploads/fact-sheets/fact-sheet-managing-hypoglycaemia.pdf)
  - Audit checklist: management of residents who have diabetes (https://www.ndss.com.au/about-diabetes/resources/audit-checklist-for-aged-care-residents/)
- The McKellar Guidelines for Managing Older People with Diabetes in Residential and Other Care Settings (https://www.choiceagedcare.com.au/wp-content/uploads/2017/04/The-McKellar-Guidelines-for-Managing-Older-People-with-Diabetes.pdf)
- Royal Australian College of General Practitioners (RACGP):
  - Managing sick days for type 1 diabetes – Diabetes Australia (https://www.ndss.com.au/wp-content/uploads/fact-sheets/fact-sheet-managing-sick-days-for-type1.pdf)
  - Diabetes Australia: General practice management of type 2 diabetes 2016–18 (https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/management-of-type-2-diabetes)

Falls

A multifactorial approach to falls prevention can be achieved by addressing risk factors relating to:

- Polypharmacy
- Vision
- Vitamin d and calcium levels
- Mobility
- Muscle strength
- Balance
- Cognition

Managing these falls risk factors will result in increased quality of life for the resident and not just falls preventions.

Risk factors

1. **Polypharmacy**: Residents who regularly take 5 or more drugs have an increased falls risk. Please arrange a Residential Medication Management Review (RMMR) for these residents. See Polypharmacy in RACFs (page 84).
2. **High risk medications**: These can cause falls, particularly within the first month of starting. High risk medications can include: APINCH

   A: anti-infective

   P: potassium and other electrolytes

   I: insulin

   N: narcotics (opioids) and other sedatives

   C: chemotherapeutic agents

   H: heparin and anticoagulants
3. **High risk of significant bleeding**: When a resident has a fall and the following applies they have a high risk of significant bleeding:
   - taking an anticoagulant such as warfarin, dabigatran, rivaroxaban, apixaban, enoxaparin, and heparin
   - taking an antiplatelet such as aspirin and clopidogrel
   - history of a bleeding disorder

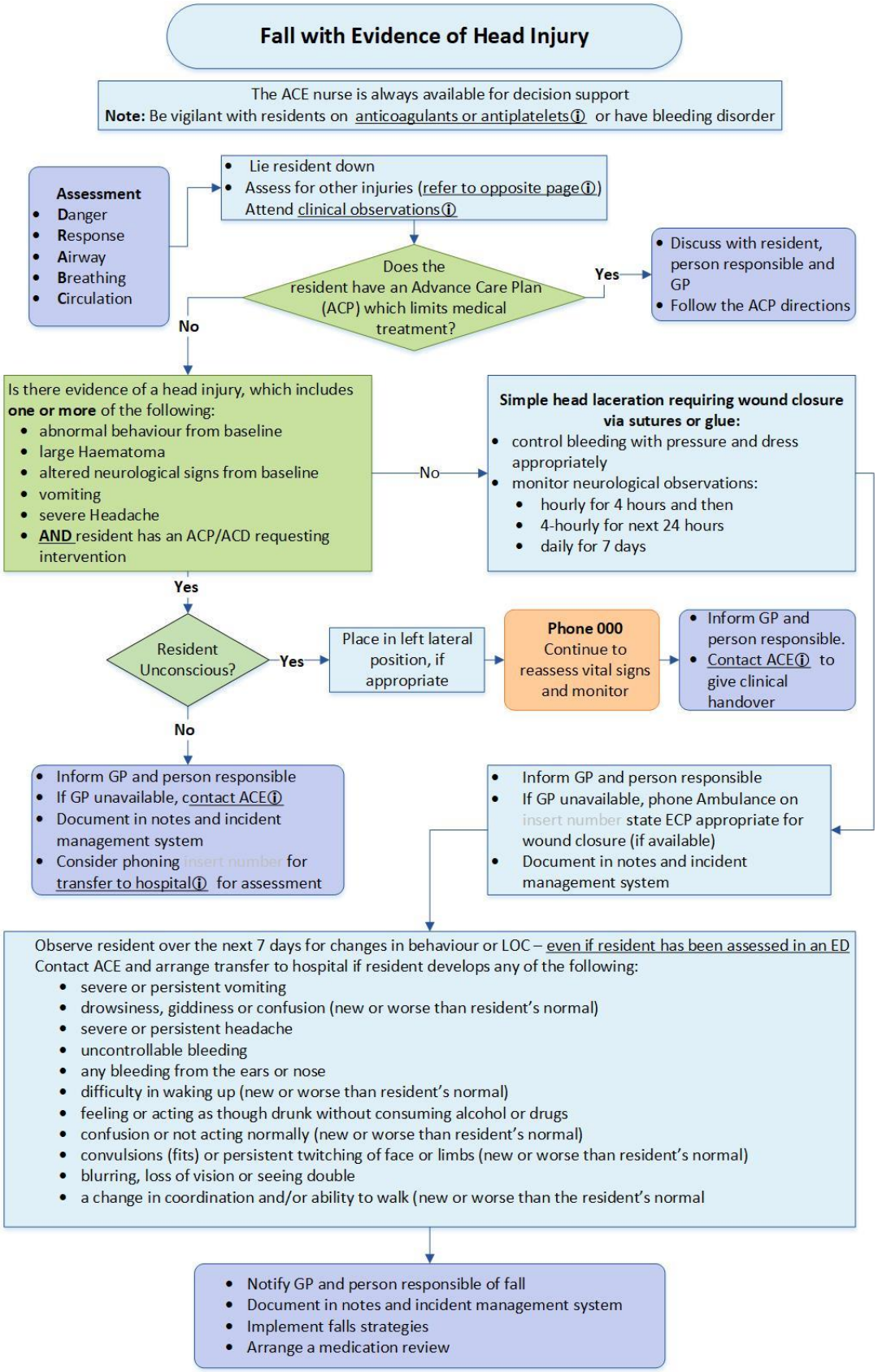
   A resident on an anticoagulant and/or antiplatelet who sustains a fracture, soft tissue injury, or large laceration should be observed (page 14) closely. If a large haematoma develops anywhere on the body, consult the General Practitioner (GP) or Medical Officer. GPs should carefully consider the risk versus benefit of medications in residents with high risk of falling.

   If you are unsure if the resident is on an anticoagulant or antiplatelet, view the Queensland Health list of blood thinning medications (https://www.health.qld.gov.au/__data/assets/pdf_file/0030/686901/bloodthinner.pdf).

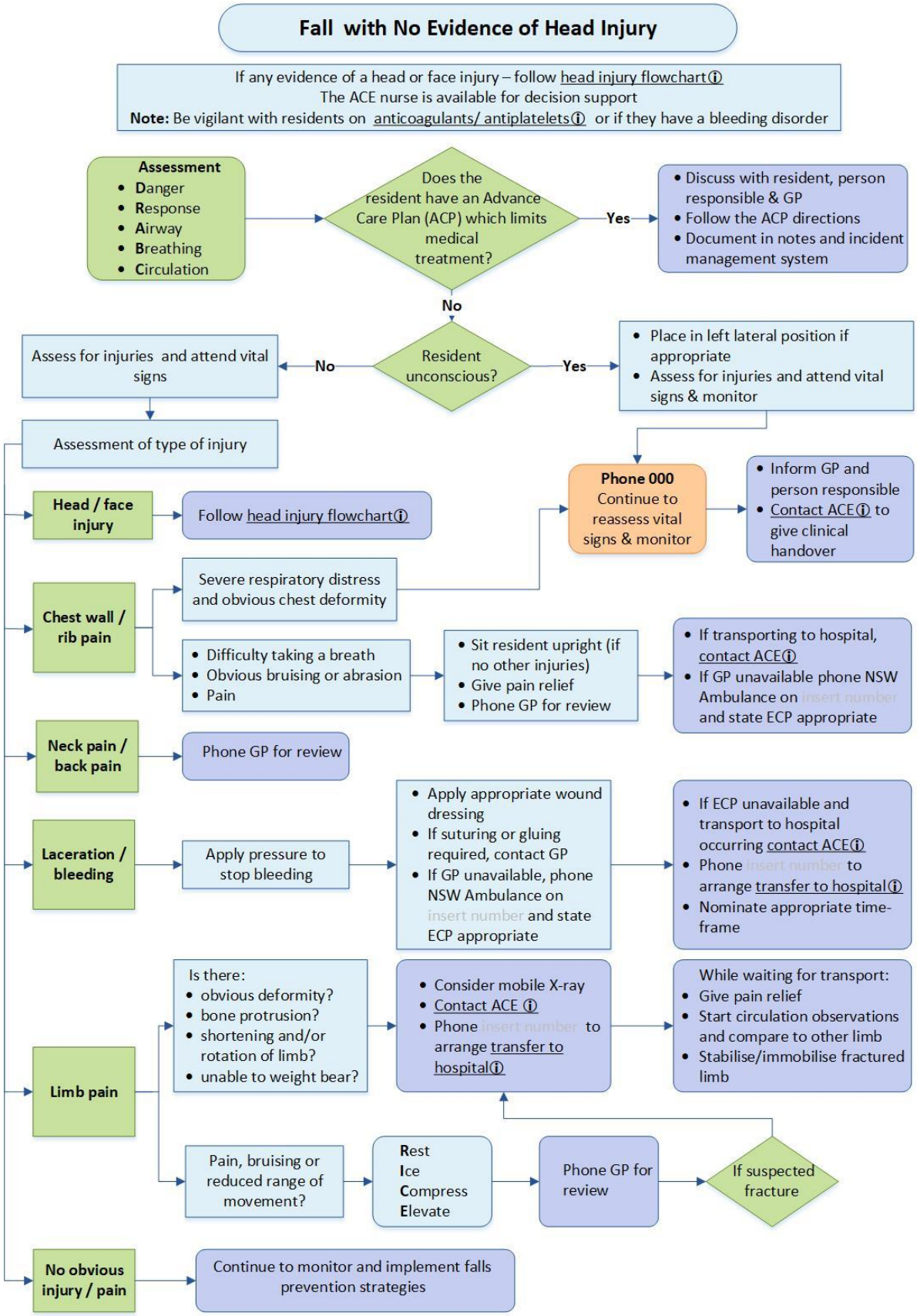
Advanced Care Plan

Always check if there is an advance care plan (ACP). An ACP may also be termed an advance care directive (ACD) or Medical Orders for Life Sustaining treatment (MOLST). When there is one, review the instructions relating to the resident's treatment preferences. Discuss the documented treatment preferences, the current situation and confirm goals of care with the resident, their family and the GP before transferring to hospital.

Management of a Fall (with Head Injury) Flowchart



Management of a Fall (No Evidence of Head Injury) Flowchart



Referral and advice

- orthopaedic Clinic CNC – insert number
- mobile X-ray –insert number

References and Resources

- Institute of Trauma and Injury Management (https://www.aci.health.nsw.gov.au/networks/itim?)
- Head Injury: Assessment and Early Management (https://www.nice.org.uk/guidance/cg176) London, England: National Institute for Health and Clinical Excellence; 2014.
- Implementation Guide for Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals and Residential Aged Care Facilities 2009 (https://www.safetyandquality.gov.au/sites/default/files/migrated/30567-Guidelines-ImplementationGuide.pdf)
- Guidebook for Preventing Falls and Harm From Falls in Older People: Australian Residential Aged Care Facilities (https://www.safetyandquality.gov.au/sites/default/files/migrated/30454-RACF-Guidebook1.pdf)
- Nishijima DK, Offerman SR, Ballard DW, et al. Immediate and delayed traumatic intracranial haemorrhage in residents with head trauma and pre-injury warfarin or clopidogrel use. Ann Emerg Med. 2012; 59:460-468.
- State Insurance Regulatory Authority, NSW Institute of Trauma and Injury Management and the Emergency Care Institute (2016) Mild brain injury discharge advice (for adults) (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/426707/Factsheet-Mild-Head-Injury-Discharge-Advice.pdf)

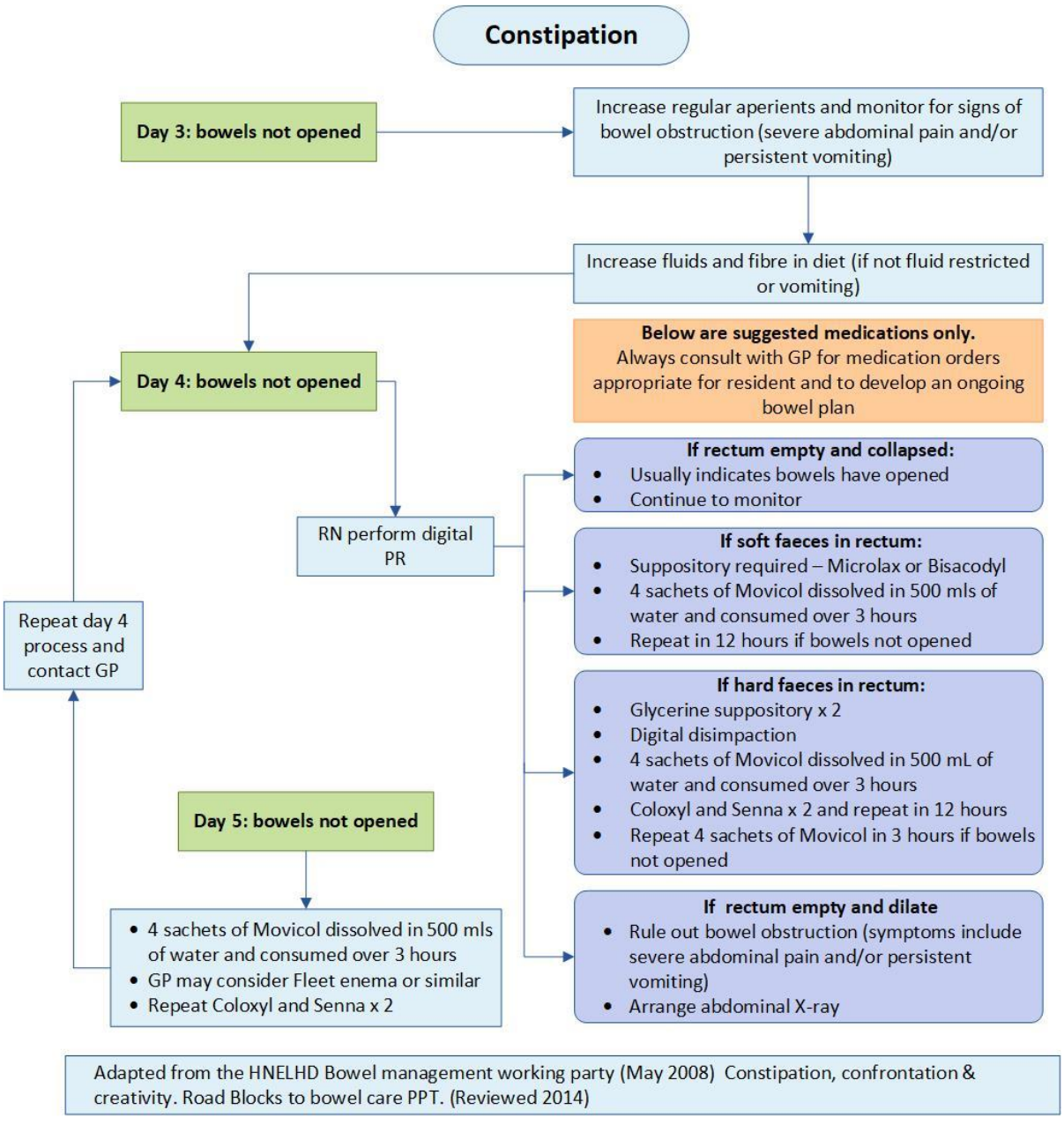
Gastroenterology

Constipation Flowchart

Constipation is avoidable and prevention is far better management for this cohort. Whilst this flowchart addresses constipation once it has occurred, an individualised bowel management plan for ALL residents is a better option.

When bowels open, document in resident's notes/bowel chart.

Residents who are regularly taking 5 or more drugs have an increased risk of constipation. Please arrange a comprehensive pharmacy review for these residents. See Polypharmacy in RACFs (page 84).

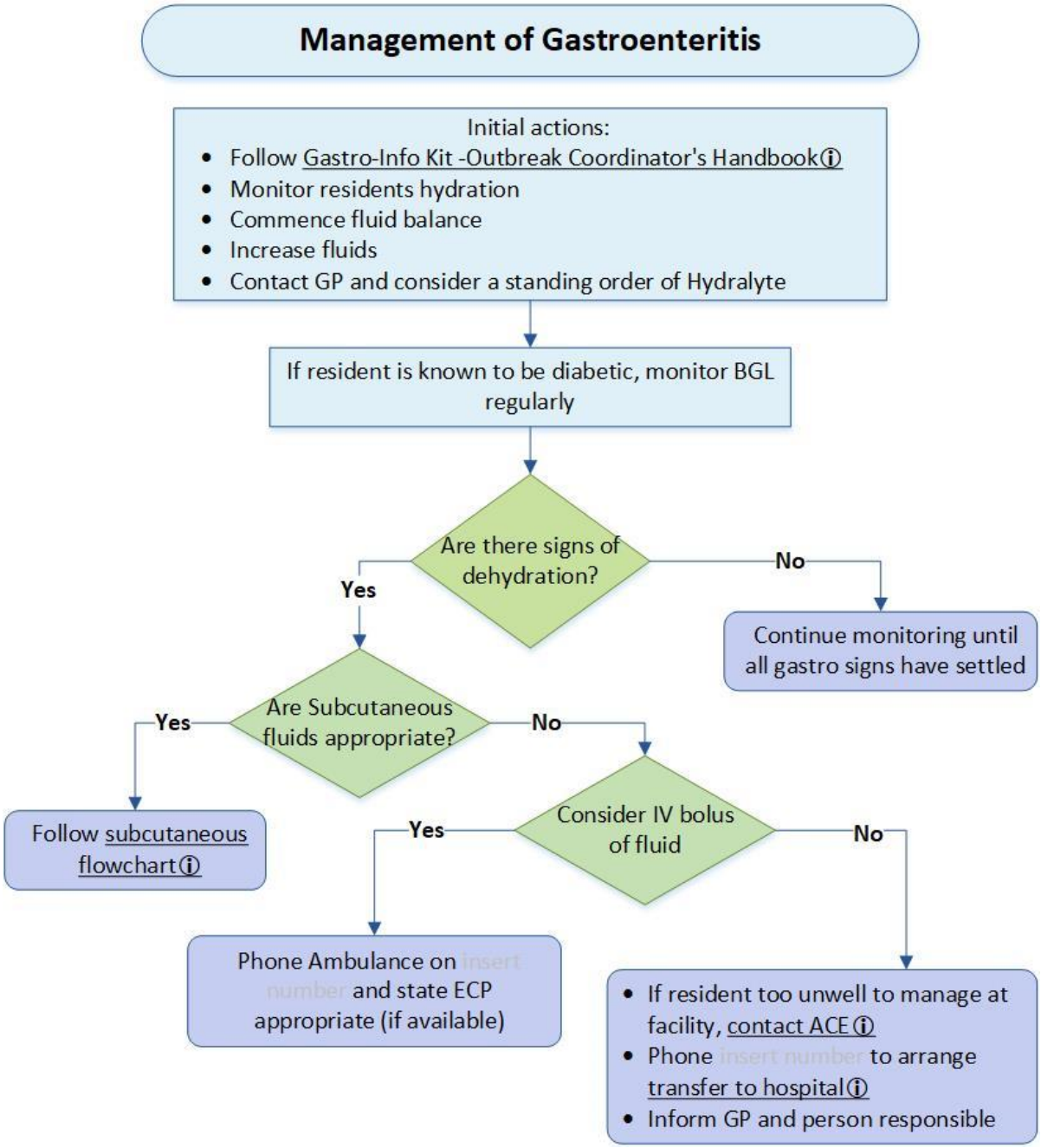


Managing Gastroenteritis Flowchart

Important: A gastroenteritis outbreak is when there are two or more people ill with vomiting or diarrhoea within 24 hours of each other in the facility. You must contact the Public Health team.

Public Health Unit Advice

Phone: insert number



Signs of dehydration include:

- Reduced urine output
- Blood pressure – top reading below 90 mmhg
- Heart rate above 110/minute

References and Resources

- The Gastro-Info Kit – Outbreak Coordinator's Handbook (https://agedcare.health.gov.au/ageing-and-aged-care-publications-and-articles-training-and-learning-resources-gastro-info-gastroenteritis-kit-for-aged-care/gastro-info-outbreak-coordinators-handbook).

Percutaneous Endoscopic Gastrostomy (PEG) Care

Cleaning the feeding tube site (stoma)

- Wash your hands before and after touching the tube, device, or stoma site
- Use soapy or salty water to wash tube and stoma site
- Ensure the:
  - site is dry under the external flange post cleaning using gauze or a clean towel
  - resident receives regular oral hygiene, even if nil by mouth

Positioning the tube

- When you position the tube, make centimetre markings on the skin so you can check it has not migrated internally.
- Ensure the tube is supported and secured appropriately perpendicular (90 degrees) to the skin, and not taped or pulled to the side.
- If not secured by sutures, rotate the tube 360 degrees at least once per day.
- Five days after initial placement, ensure the external flange is positioned 2 to 5 mm off the skin to:
  - prevent pressure injury
  - allow for slight in-out movement of the tube
  - provide adequate air flow under the flange to prevent infection
- Assess and readjust this measurement as needed throughout the life of the tube.

Caring for the stoma site

- Ensure the skin under the external flange is kept clean and dry.
- Dressings can be used under the flange, but should be changed once they become wet to prevent skin breakdown.
- Barrier creams and other products can be used to protect or soothe surrounding skin.

Showering and bathing

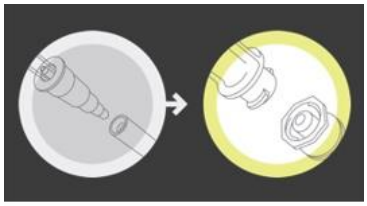
- Showering is permitted the day after initial tube placement.
- Avoid bathing for 3 weeks until the site has healed.

Flushing the tube

- Blockage of feeding tubes by feed or medication is one of the most common complications, so adequate flushing is essential.
- Tap water is fine to use for tube flushing. Warm water (not hot) is best to help clear tube of any oily residue from either feed or medication.
- Tubes not being used for feeding or medication need to be flushed at least twice per day.
- Ensure the tube is well flushed before and after administering any feed or medication.
- Even with regular flushing and excellent care, tubes discolour and stain over time. This is normal and causes no harm.

Connecting devices

- Most new feeding tubes now have an "Enfit" end port, which means any attached syringes or feeding lines need to be screwed in, rather than just pushed in. Do not screw syringes or lines in too tightly as this can damage the Enfit port and make it difficult to unscrew them.
- Enfit syringes designed to connect to Enfit ports are available if needed to administer medications.



Administering medications

- Each medication needs to be given separately.
- Where possible, use liquid or a dissolving form of medication.
- Do not crush medication with enteric coatings or slow / modified release formulations. If unsure, check the Australian Don't Rush to Crush Handbook (available through MIMS Online) or ask a pharmacist.
- Flush the tube with water before the first medication, between each medication, and after the last one.
- Do not use warm or hot water to disperse medications as this may affect their stability. Use room temperature water.
- Prepare medications immediately prior to giving them as dispersed tablets form a sediment if left to stand.

Gastrostomy Tube Issues

Accidental removal of tube

Causes

Tube dislodged

Interventions

- The stoma will begin to close over in 2 to 3 hours, making tube replacement impossible.
- If the tube falls out, replace it immediately with a catheter or tube of the equivalent size or smaller.
- Advance about 8 cm into the stoma tract.
- If an appropriate catheter is not immediately available, it may be possible to wash the dislodged tube and reinsert it to maintain the stoma tract.
- Secure the tube to the abdomen.
- Contact GP or ACE for referral to gastro liaison nurse to arrange tube replacement.

Note: Gastrostomy tubes can be replaced within a RACF, but gastrojejunostomy tubes cannot, as this requires imaging.

Aspiration

Causes

Aspiration of feed and saliva as a complication of gastrostomy

Interventions

- Feeding position to be at least 45 degrees from horizontal.
- Monitor for signs of aspiration pneumonia by assessing chest sounds or cough. If present, stop feeds. Refer to GP or contact ACE (page 10) for referral to gastro liaison nurse.

Bleeding around stoma

Causes

- Hypergranulation tissue (light red or dark pink flesh that forms beyond the surface of the stoma opening)
- Trauma

Interventions

- If hypergranulation tissue is present, a small amount of bleeding is normal.
- Anchor the tube securely.
- If there is excessive bleeding or discomfort, refer to GP or contact ACE (page 10) for referral to gastro liaison nurse.

Blocked tube

Causes

- Inadequate flushing of the tube
- Medication
- Fungal colonisation

Interventions

- Flush using warm water with 50 mL syringe using push-pull method with the plunger. This can take a while. Palpate any obvious blockages in the tube.
- Flush tubes with warm water after giving formula and before and after medication.
- For continuous feeds, ensure the tube is flushed every 4 to 6 hours.
- Do **not** mix formula with medication or multiple medications together.
- Do **not** insert any device into a feeding tube as this could cause a perforation.
- Check that the tube is not kinked or clamped.
- If the blockage is caused by fungal colonisation or there is loss of tube integrity (i.e. bubbling or collapsed section of tube), a replacement tube is required.
- If unable to unblock the tube, refer to GP or contact ACE (page 10) for referral to gastro liaison nurse.

Constipation

Causes

Inadequate fibre / bulk or fluid

Interventions

- Try formula with added fibre
- Increase water if safe to do so, e.g. if not fluid restricted
- Treat constipation as per the Constipation Flowchart (page 54)
- Increase mobility, if possible

Diarrhoea

Causes

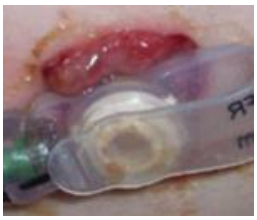
- Rapid feed administration
- Medications
- Tube migrated from stomach to small intestine
- Air in stomach or intestine
- Bacterial contamination
- Cold feeds

Interventions

- Defined as >7 bowel actions per day.
- Wash hands and don non sterile gloves when working with the resident to avoid contamination.
- If feeds are administered via a continuous infusion, return the infusion rate to a previously tolerated rate, then gradually return to the prescribed rate.
- For bolus feeding, extend the time for each feed, allowing for a short break during feeding. Administer smaller but more frequent feeds.

- Cease aperients and consider causes (including faecal impaction).
- Do not add medication to formula. Medications that may cause diarrhoea include:
  - antibiotics
  - cytotoxics
  - GI stimulants
  - metformin
  - beta blockers
  - laxatives
  - stool softeners
  - magnesium sulphate
  - histamine
  - liquid medications with sorbitol
- Dilute current formula with water then gradually decrease water content each feed until back to full strength.
- Do **not** routinely withhold feeds as treatment for diarrhoea.
- Elevate the resident's head during feeding.
- Check that feed:
  - has been mixed properly
  - is at room temperature
  - is fibre enriched
- Vent air. Avoid air in tubing or syringe entering patient.
- Reposition the tube.
- Refrigerate opened feeds for no longer than 24 hours.
- Always hang feeds according to manufacturer guidelines.
- Change feeding set every 24 hours.
- If no improvement in 24 hours:
  - consider changing feed
  - refer to GP or contact ACE (page 10) to correct electrolytes / hydration
- Stool culture may be required to check for *Clostridium difficile* or other possible bowel infections. If positive, treat accordingly and if negative consider giving Imodium (loperamide) or alternative.

Hypergranulation (proud flesh)



Causes

- Excessive moisture
- Infection
- Excessive device movement
- Ill-fitting device

Interventions

- Keep the area clean and dry
- Anchor the tube securely
- If excessive bleeding and discomfort, refer to GP or contact ACE (page 10) for referral to gastro liaison nurse.
- Consider using:
  - foam dressing as first line treatment
  - hydrocortisone 1 to 2% cream
  - silver nitrate, as prescribed
  - medihoney
  - silver-impregnated dressings
  - debridement, if problematic

Infection of stoma

Causes

- Gastric leakage around site
- Stoma site not kept clean

Interventions

- Fix the cause of the leak. A small amount of leakage is normal.
- Inspect and clean the stoma regularly.
- Signs and symptoms of infection include:
  - pain
  - odorous and purulent discharge
  - redness at site or resident febrile
- The following products may assist: topical or oral antibiotics via tube for confirmed infection or antimicrobial dressings.

Leakage of gastric contents

Causes

- Stoma enlarged
- Infection
- Loss of balloon volume
- Constipation
- Delivery of feed too fast

Interventions

- Fix the cause of the leak. A small amount of leakage is normal.
- The tube should exit the stoma perpendicular (at 90 degrees).
- Protect the skin with a skin barrier wipe.
- Refer to constipation above.
- To help with exudate and skin protection, consider using:
  - stoma adhesive powder
  - hydrocolloid and foam dressings

Nausea and vomiting

Causes

- Improper placement of tube
- Feeding too fast
- Patient positioning
- Contamination of formula
- Air in stomach
- Faecal impaction
- Intolerance to feeds

Interventions

- If vomiting, stop feed. The resident may need subcutaneous fluids (page 93).
- Consider requesting review of current medications.
- Ensure strict hygiene is adhered to and keep equipment clean.
- Deliver feeds at room temperature, using appropriate equipment.
- Check tube position before feeding.
- Clear tube of air before feeding. Keep the feed container full so air does not enter through the feeding set.
- Where possible, have the resident sit upright for bolus feeds or elevate the bedhead to a 30 to 45 degree angle and, if able, remain upright 2 hours post-feed. Then encourage ambulation.
- Refrigerate unused formula, making sure to record the date and time of opening. Discard any outdated formula. Only fill the container with enough feed for a 24-hour period.
- Treat constipation and exclude bowel obstruction.
- Ensure adequate hydration.
- Refer to GP or contact ACE (page10) to correct electrolyte or hydration disturbances and check BGL.

Pain and discomfort

Causes

- Newly placed tube
- External flange too tight
- Infection

Interventions

- Some discomfort or pain is to be expected after insertion.
- If pain persists, is associated with the gastrostomy, and lasts longer than a week after initial insertion, perform a medical review to exclude potential complications.

PEG tube Y-port connector leaking

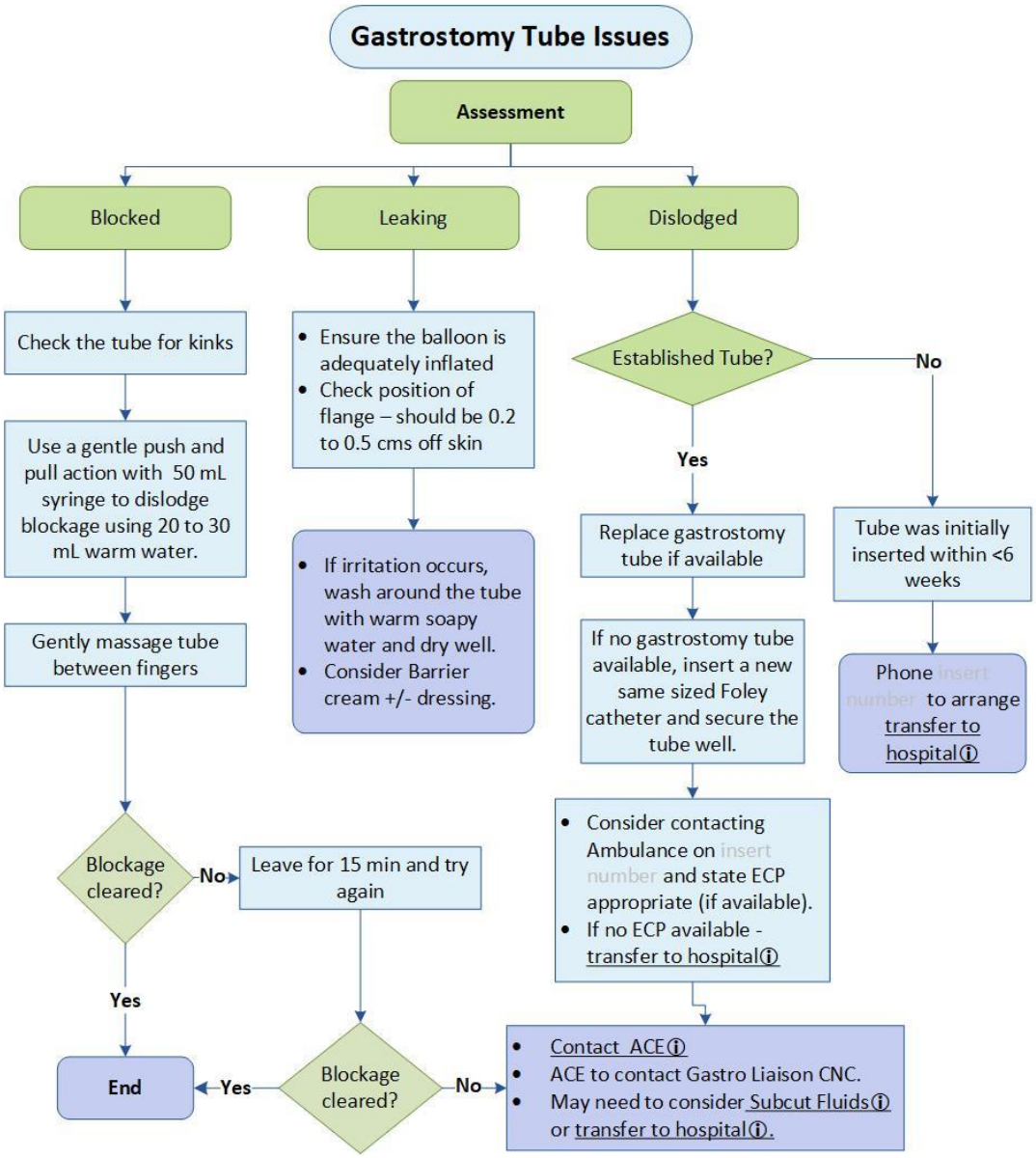
Causes

- Over-tightening Enfit connections can damage the end port.
- Inserting Toomey syringe too far into the Y-port connecter can enlarge the port so the cap doesn't fit.

Interventions

- Gently insert or screw in syringes, depending on the connection type, just enough to get a sealed connection.
- For a non-balloon gastrostomy, the end port can be changed by cutting the tube with clean scissors 1 cm below the Y-port and inserting the new end port into the tube.

Managing Gastrostomy Tubes Flowchart



Stoma Management Issues

Appliance not adhering/leakage

Consider

- Peri-stomal skin damage due to leakage. Changes to the abdominal plane (e.g. weight gain or loss).

Assessment

- Is skin around stoma reddened, broken, weeping, painful, or unusual in appearance?
- Assess the abdomen – Has it changed shape? Is there wound breakdown near stoma?
- Assess the stoma – Has it changed shape or retracted?
- Assess the output from stoma – Has the consistency or frequency changed?
- Lie, sit, and stand the resident to review any changes to the abdomen.

Intervention

1. If available, lightly apply Stomahesive powder to weeping/reddened areas. Using a barrier wipe, lightly pat over the powdered area to seal the powder in place. Apply pouch as normal.
2. Fill any crevices, valleys or dips in the peri-stomal area with stoma paste or seals before reapplying the pouch, if available.
3. Inform GP and contact Stomal Therapy Clinic (see below).

Colostomy / ileostomy inactive

Consider

- Number of days

Assessment

- Is there pain, nausea, vomiting and/or abdominal distension?
- Assess for constipation – How many days since stoma opened, what is normal?
- Abdominal X-ray if indicated
- Digital examination of a stoma to determine if stricture present

Note: To be performed only by clinicians who are experienced in performing digital examinations.

Intervention

1. Cease solid foods, increase fluid intake (if suitable).
2. Treat constipation in residents with a colostomy with aperients. Do not use aperients for residents with ileostomies.
3. Inform GP and contact Stomal Therapy Clinic (see below).

Para-stomal hernia

Consider

- Size
- Intestinal involvement
- Functionality of stoma

Assessment

- Hernia history
- Pain
- Stoma function/output
- Hernia management

Intervention

- Inform GP and contact Stomal Therapy Clinic (see below)
- If stoma is non-functioning and associated with pain, nausea, and vomiting, contact GP

Stomal prolapse

Assessment

- Pain
- Is the prolapse reducible?
- Damage or ulceration to the stoma
- Colour of stoma – Contact GP and if not available, contact ACE (page 10) if stoma or prolapsed bowel is dusky, purple, or black, as this will require urgent treatment.

Intervention

1. Keep the stoma pouch in place to contain the prolapsed bowel.
2. If pouch dislodged, replace the pouching system.
3. Inform GP and contact Stomal Therapy Clinic (see below).
4. Support the stoma with a hernia belt if available before sitting or standing the resident.
5. Educate the resident to support the stoma during episodes of coughing, sneezing, and/or straining.

Stoma management advice and referral

- Stomal Therapy Nurse Consultant insert hours available and contact number

Wound care of stoma site

Consider

- Wound type and location

Assessment

- Colorectal or surgical wounds
- Exuding wounds
- Entero-cutaneous fistula management

Intervention

- Contact stomal therapy clinic for appointment.

Further Information

Referral and advice

Gastroenterology liaison nurse, Insert hours of service and number

References and resources

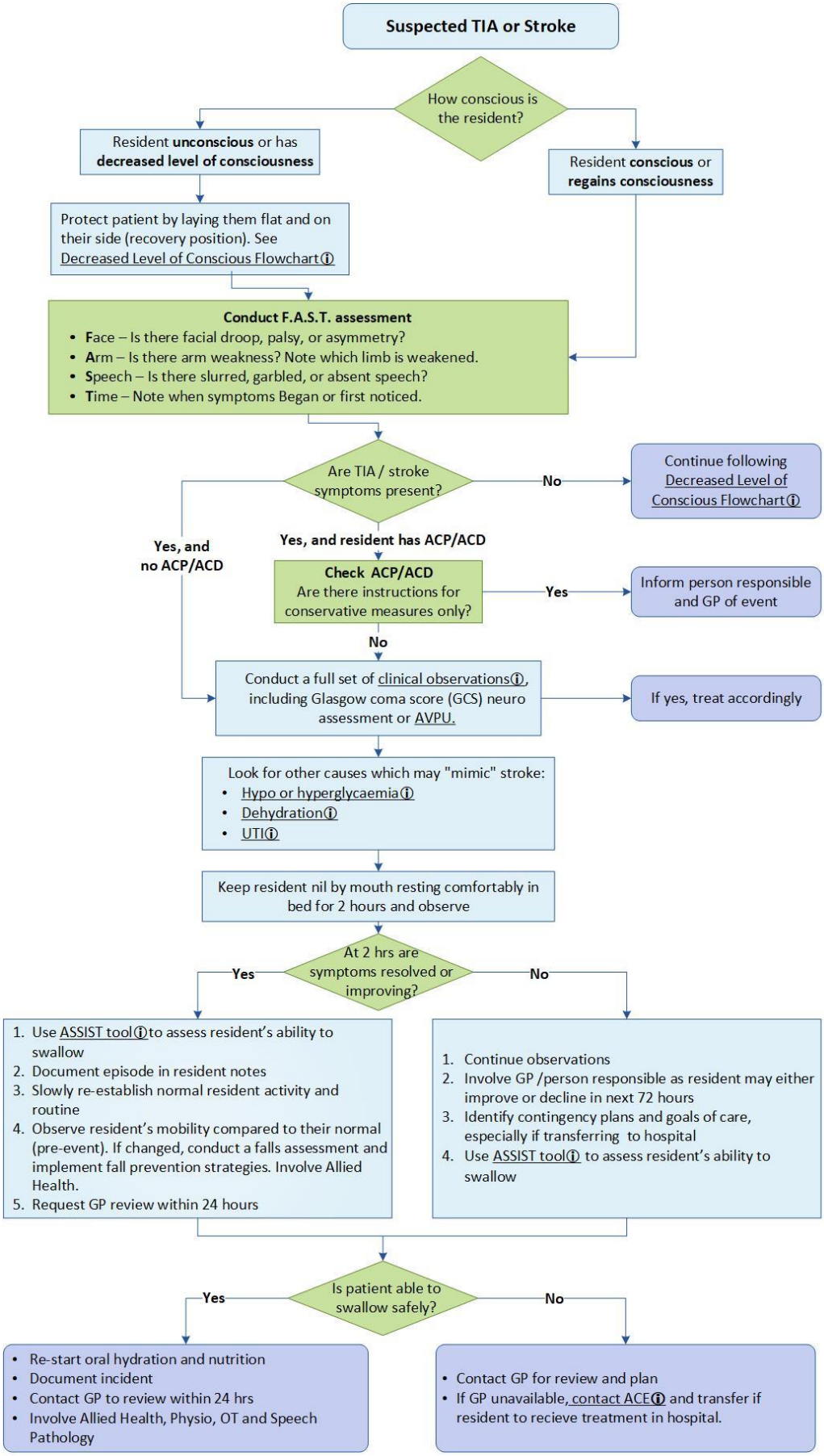
- ACI and GENCA – A clinician's guide: Caring for people with gastrostomy tubes and devices (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0017/251063/gastrostomy_guide-web.pdf)
- ACI – Frequently asked questions factsheet: Caring for people with gastrostomy tubes and devices (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0005/282461/Gastrostomy_FAQs.pdf)
- Australian Don't Rush to Crush Handbook (http://www.mims.com.au/newsletter/201304/Crush.pdf) (available via MIMS Online)

Neurology

Suspected Transient Ischaemic Attack (TIA) or Stroke Flowchart

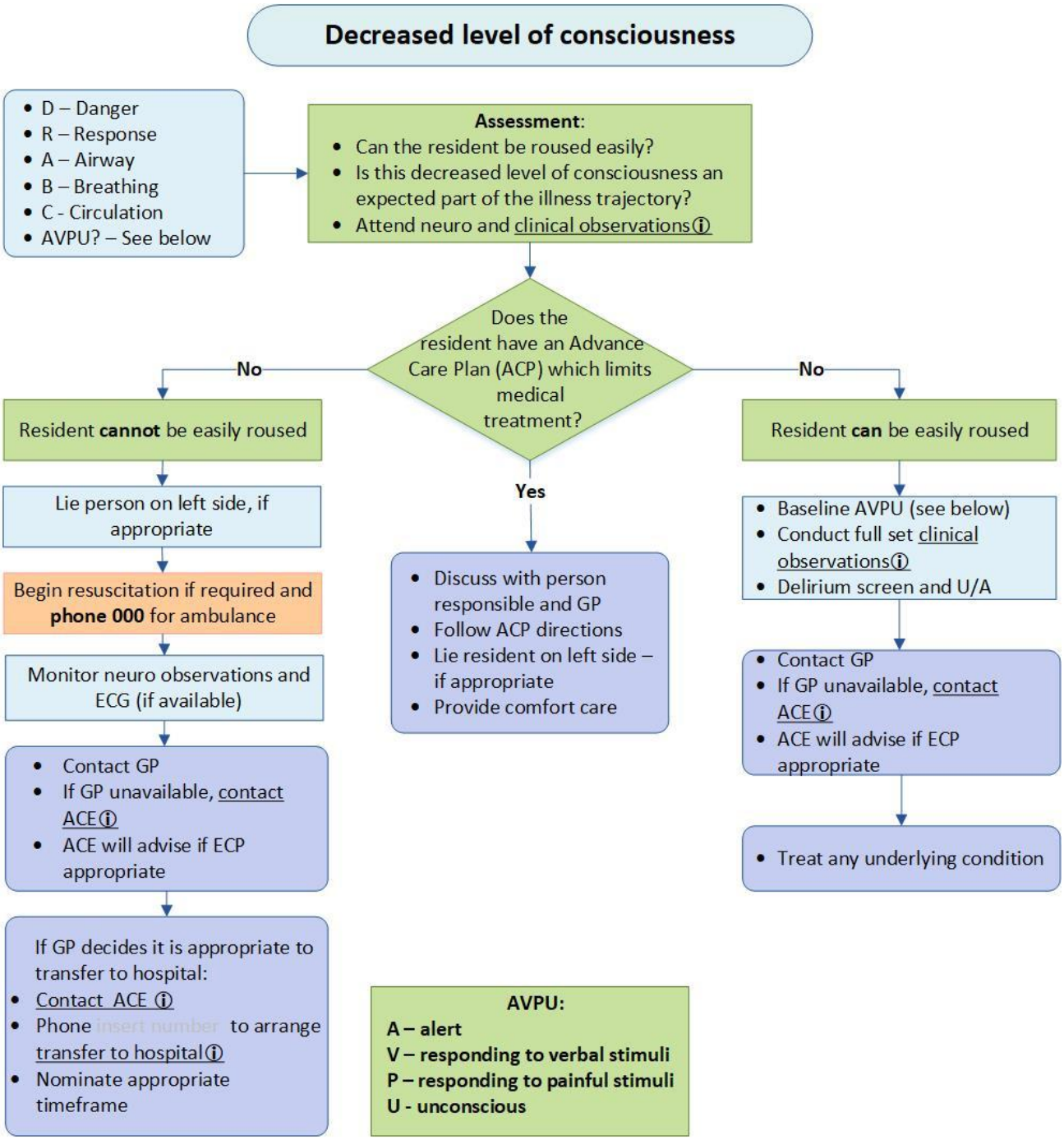
Most RACF residents will not benefit from urgent medical management of stroke, e.g. thrombolysis (clot-busting medication). See Eligibility for endovascular clot retrieval – NSW Referral Guide (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0007/506617/Stroke-Network-NSW-Referral-Guide-Eligibility-for-ECR.pdf).

The aim of TIA or stroke management in these instances is to protect the resident from further insult in the first few hours and to promote ongoing recovery.



Also refer to ASSIST – Acute Screening of Swallow in Stroke/TIA (page 126)

Decreased Level of Consciousness Flowchart



Seizure

Seizure Issues

First seizure

Consideration

Could be due to infection, electrolyte imbalance, new medication, stroke, subdural haematoma (SDH), or a brain tumour.

Assessment

- Urinalysis, routine bloods
- AVPU (**A**lert, **V**erbal - resident responds to voice stimulation, **P**ain - resident responds to pain, **U**nresponsive). Every 30 minutes for 2 hours, then every hour until reviewed
- Clinical observations (page 14) (temperature, pulse, respiratory rate, blood pressure, O_2 saturation, BGL)
- Imaging (CT head or MRI)

Intervention

- Administer first aid and follow Seizure Flowchart (page 70)
- Contact GP to assess and treat underlying cause (e.g. may need antibiotics to treat infection)
- Will need specialist referral and review to rule out stroke, SDH, or brain tumour

Seizure documentation

Consideration

- Consider whether it is a focal seizure (previously known as partial) or a generalised seizure
- Document a detailed description of the seizure in resident's notes

Assessment

If a focal seizure, assess resident's ability to:

- Speak during a seizure
- Obey commands during a seizure
- Recall memory after the seizure

If a generalised seizure:

- Assess resident for any lateralising signs, e.g. do they have jerking movements on one side of their body? If so, which side and which limbs are affected?
- Has resident become cyanotic (bluish in colour) or flushed?
- Does the resident have any head and/or eye deviation (i.e. turned their head and/or eyes to one side only)? Document which side.
- Has resident bitten their tongue or the inside of their mouth (blood noticed in the mouth)?
- Has resident been incontinent of urine or faeces?

Intervention

If the resident does not fully recover because the resident has had:

- Prolonged seizure(s) of longer than 5 minutes, or
- Two or more complex partial seizures less than 2 hours apart, or

- Two seizures without any recovery from the post-ictal state

They may be in status epilepticus, which is a medical emergency and thus the resident will need to be reviewed by a specialist or transferred to the nearest Emergency Department for further treatment and management.

Post-ictal monitoring

Post-ictal = The period of time after a seizure that a resident takes to recover to their pre-seizure state.

Consideration

- Is the resident recovering? (Keep in mind some residents can have post-ictal confusion or inappropriate behaviour for 30 to 60 minutes after a seizure.)
- Provide oxygen therapy

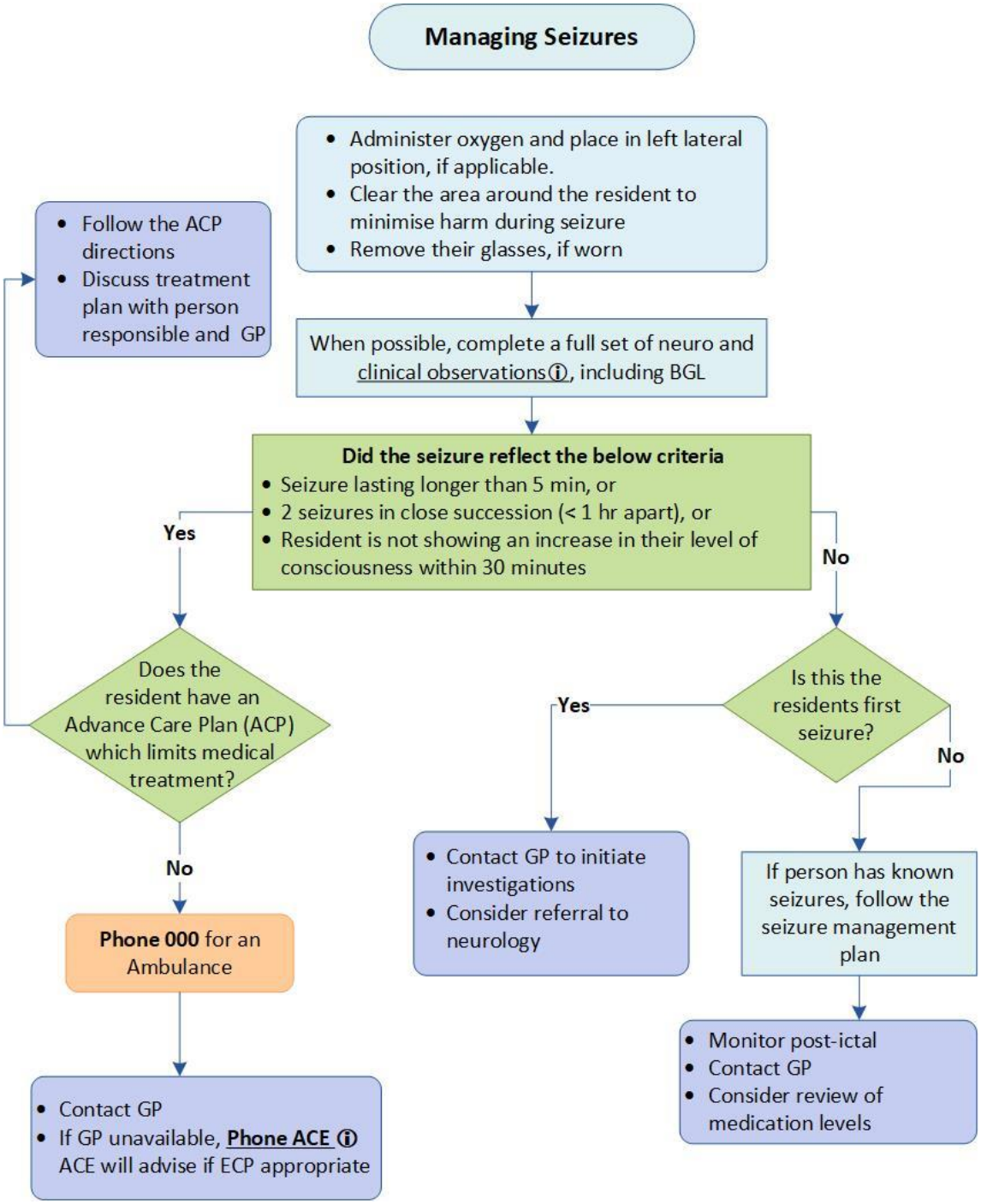
Assessment

- Assess resident's AVPU (**A**lert, **V**erbal – resident responds to voice stimulation, **P**ain – resident responds to pain, **U**nresponsive) every 30 minutes until fully recovered (to resident's pre-seizure state).
- Perform clinical observations (page 14) – blood pressure, heart rate, respiratory rate, and oxygen saturation.

Intervention

- Resident will require GP or specialist referral and possible start of anti-epileptic medications (AEDs).
- If resident is known to have epilepsy and on AEDs, will need to check the therapeutic drug level of that AED.

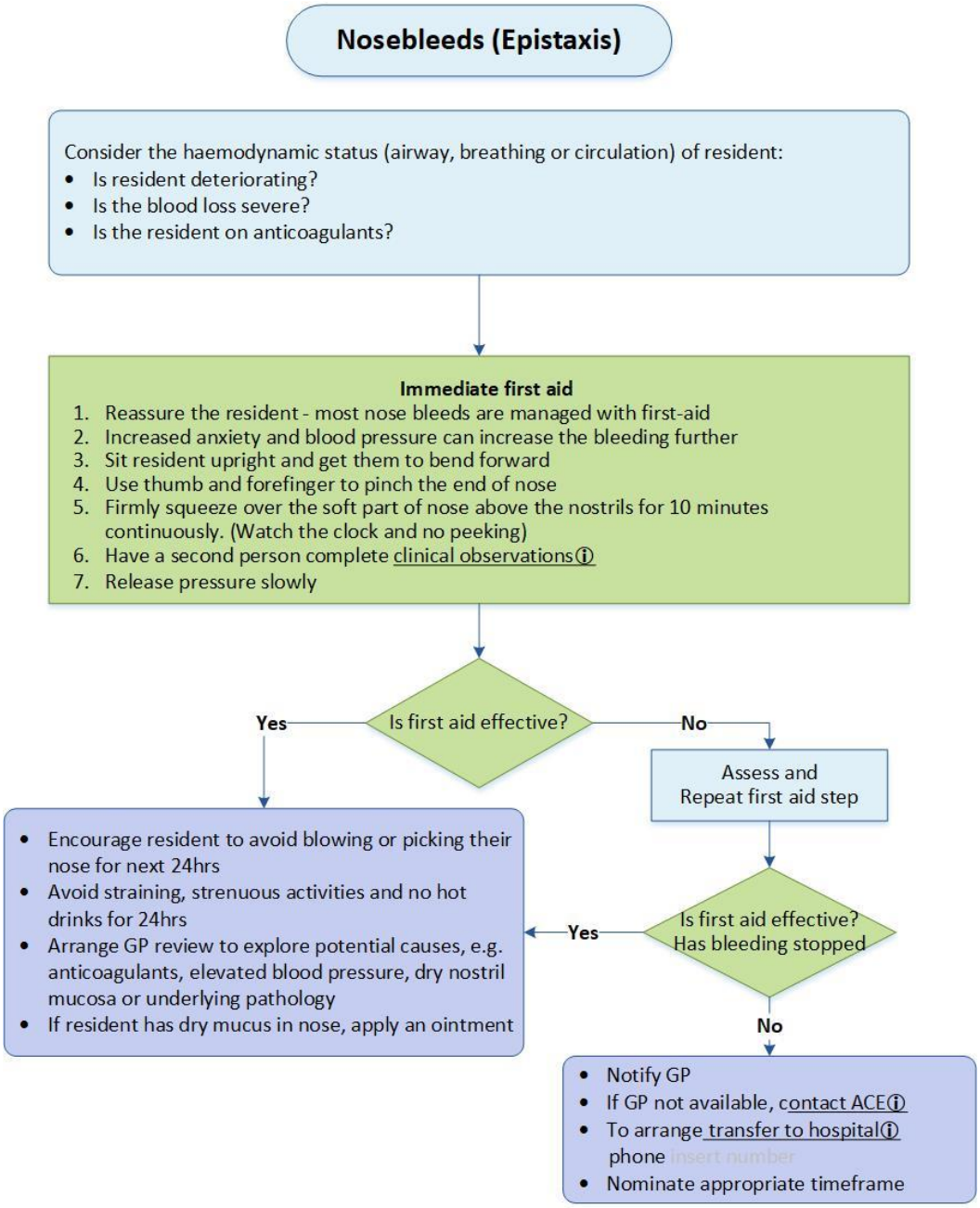
Seizure Flowchart



References and resources

- ACI Stroke Network (https://www.aci.health.nsw.gov.au/networks/stroke)
  - Clinical Guidelines for Stroke Management 2017 (https://informme.org.au/en/Guidelines/Clinical-Guidelines-for-Stroke-Management-2017)
  - Neurological Observation Chart Education Package (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/201753/AdultChartEdPackage.pdf)
  - Eligibility for endovascular clot retrieval – NSW Referral Guide (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0007/506617/Stroke-Network-NSW-Referral-Guide-Eligibility-for-ECR.pdf)
- Epilepsy Action Australia (https://www.epilepsy.org.au/about-epilepsy/)
- Swallowing:
  - ASSIST – Acute Screening of Swallow in Stroke/TIA (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0007/251089/ASSIST_screening_tool.pdf)
  - Do you have trouble swallowing? (Swallowing Brochure.pdf)
  - How Thickened Liquids Work to Improve Swallowing. Watch Now (https://cme.surgery.wisc.edu/watch/458)
  - How Aging Affects Our Swallowing Ability (https://swallowingdisorderfoundation.com/how-aging-affects-our-swallowing-ability/)

Nosebleeds (Epistaxis)



References and resources

- Nurse-led Epistaxis Management Within the Emergency Department. Navid Hakim, Sangha Mitra Mummadi, Karan Jolly, Julian Dawson, and Adnan Darr British Journal of Nursing 2018 27:1, 41-46. Victoria State Government Department of Health – Nosebleeds (Epistaxis) https://www.bettersafercare.vic.gov.au/sites/default/files/2019-07/Epistaxis.pdf

Pain

Key points

- Pain is a common problem in older people and research findings suggest that up to 86% of residents in aged care facilities experience regular pain.
- Pain limits a person's ability to socialise and mobilise. It also affects appetite, sleep, emotional well-being and quality of life (Veal et al 2018).
- Individualised pain management plans may include pharmacological and/or complementary therapies.

Dementia, hearing impairment and dysphagia (difficulty swallowing) are factors associated with the ageing process and may inhibit the elderly person's ability to communicate their pain (Veal et. al. 2018).

Assessment

Comprehensive Pain Assessment includes review of the type of pain, the resident's pain history and medical history, a physical examination, a psychosocial assessment and diagnostic testing where applicable.

To better understand the pain, explore the following:

- Site of pain – where is the pain?
- Character of pain – what's the intensity? Is it sharp, dull, or throbbing?
- History – how long have they had this pain?
- Onset – what brings on the pain?
- Aggravates – what makes it worse?
- Relief – what helps to ease the pain?
- Duration – how long does it last?

Verbal assessment tools

- Individuals report the presence and intensity of their pain.
- Assessment tools may include:
  - Modified Residents Verbal Brief Pain Inventory (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/1_APS_Pain-in-RACF-2_Appendix-1_M-RVBPI.pdf) (M-RVBPI)
  - Numerical Rating Scale (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/2_APS_Pain-in-RACF-2_Appendix-2_NRS.pdf) (NRS)
  - Verbal Descriptor Scale (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/3_APS_Pain-in-RACF-2_Appendix-3_VDS.pdf) (VDS)
  - Faces Pain Scale Revised (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0005/212918/Faces_Pain_Scale_Revised_FPS-R.pdf) (FPS-R)

Non-verbal assessment tools

- Facial expressions (grimacing), vocalisation (moaning, calling out), body movements (guarding or holding body stiffly), behavioural changes, reduced social interactions and mental status changes.
- Assessment tools may include:
  - Pain Assessment in Advanced Dementia Scale (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/6_APS_Pain-in-RACF-2_Appendix-6_PAINAD.pdf) (PAINAD).
  - ABBEY pain scale (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/5_APS_Pain-in-RACF-2_Appendix-5_Abbey_Pain_Scale.pdf).
  - 6-step procedure for all residents who cannot communicate successfully (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Resources/3_APS_Pain-in-RACF-2_Ch2_6-step_ID_non-communicative.pdf).
  - Pain behaviours used in validated observational pain scales (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Resources/4_APS_Pain-in-RACF-2_Ch2_Observational-pain-scales.pdf).
  - Pain smart phone applications (apps) – using facial recognition to detect facial expressions that indicate pain.

Types of pain

1. Nociceptive (pain related to tissue damage)

Superficial:

- Burning, stinging or sharp
- Well-localised and can radiate
- Lesions, ulcers, pressure areas

Deep:

- Aching, gnawing pain, well-localised
- Osteoarthritis, fractures

Visceral:

- Deep, cramping squeezing pain, pressure, diffuse, not localised
- Bowel obstruction, abdominal colic

2. Neuropathic (pain related to nerve damage)

- Burning, shooting, electric shock, pins and needles
- Shingles, diabetic neuralgia, post-stroke, phantom limb, sciatica, tumour infiltration into nerve

3. Nociplastic (pain related to nerve system sensitisation)

- A new mechanistic descriptor defined as “pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain.” E.g. fibromyalgia, chronic low back pain.

Complementary therapies (non-pharmacological)

Complementary therapies can be included in the pain management plan in conjunction with traditional treatments to assist in managing chronic pain and may include the following:

Mind-body interventions – to enhance the mind's capacity to affect the body

- Counselling and psychological therapies
- Mindfulness, relaxation and meditation may help to release muscle tension and reduce stress, anxiety and pain
- Spirituality – some people may find comfort in prayer and quiet contemplation
- Creative therapies such as music or art therapy to express feelings and aide relaxation

Body-based practices – focusing on the structure and systems of the body

- Massage therapy aims to promote deep relaxation in tissue by manually applying pressure, tension and/or vibration
- Aromatherapy used during massage in vaporisers or oil burners (where permitted) to aide relaxation and stress reduction
- Yoga, tai chi, physical activity, reflexology, acupuncture, chiropractic and osteopathy

The above information was obtained from ACI Pain Management Network Complementary Alternative Medical (CAM) Therapies (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/212823/Pain-and-CAM-Therapy.pdf).

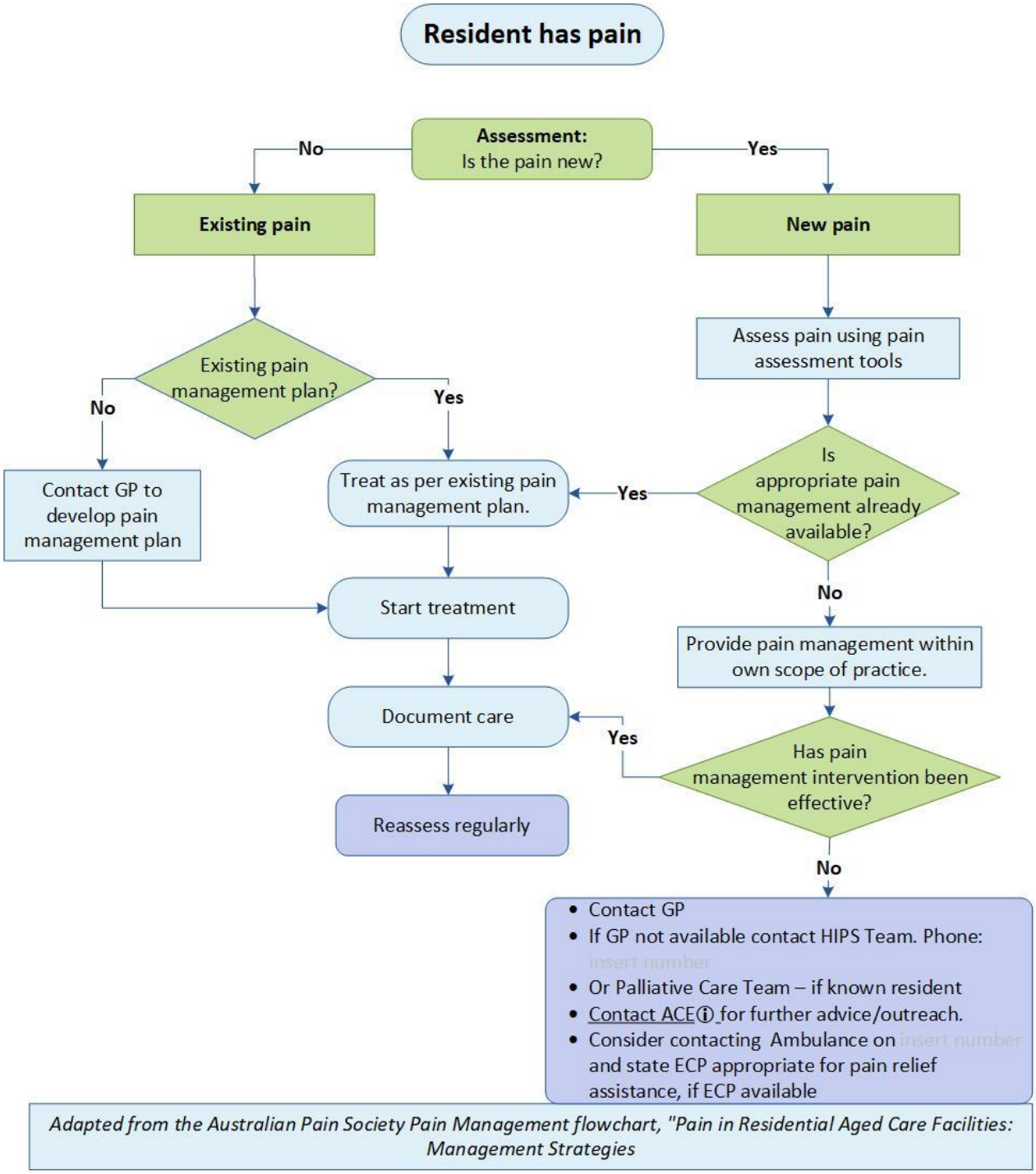
See also Resources for Complementary and Integrative medicine (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/8_APS_Pain-in-RACF-2_Appendix-8_CIM_resources.pdf), The Australian Pain Society aged care resources.

Managing constipation

Constipation is inevitable with opioid use. Starting a laxative with opioids can reduce problems with faecal impaction. A combination of a stimulant plus a stool softener laxative is recommended. See also:

- Constipation (page 54) or Symptom Management in Palliative Care (page 78) in ACE Manual
- Veterans' Medicines Advice and Therapeutics Education Services, (2011) Managing Constipation with Pain Medicines (https://www.apsoc.org.au/PDF/Publications/Veterans_MATES_27_Managing_Constipation_with_Pain_Medicines_VetBrochure_JUN11.pdf)

Managing Pain Flowchart



Adapted from the Australian Pain Society Pain Management flowchart, "Pain in Residential Aged Care Facilities: Management Strategies (https://www.apsoc.org.au/PDF/Publications/Pain_in_Residential_Aged_Care_Facilities_Management_Strategies.pdf)".

Resources and references

- Australian Pain Society:
  - Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition. The Department of Health (https://www.apsoc.org.au/PDF/Publications/Pain_in_Residential_Aged_Care_Facilities_Management_Strategies.pdf)
  - An implementation kit to accompany The Australian Pain Society's Pain in Residential Aged Care Facilities: Management Strategies (https://www.apsoc.org.au/PDF/Publications/PMGKit_2007.pdf)
  - Complementary and Integrative Medicine (https://www.apsoc.org.au/PDF/Publications/Pain_in_RACF2-Appendices/8_APS_Pain-in-RACF-2_Appendix-8_CIM_resources.pdf)
- Painaustralia:
  - The Nature and Science of Pain (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/212850/Understanding_Pain_PA.pdf)
  - Clinical Assessment of Pain (https://www.painaustralia.org.au/static/uploads/files/painaust-factsheet3-jan-16-wfksvufhgrzc-wfyaoehyvpzw.pdf)
- Palliative pain advice – See the palliative care (page 78) section of the ACE Manual
- NSW Agency for Clinical Innovation (ACI)
  - Pain Management Network (https://www.aci.health.nsw.gov.au/chronic-pain/chronic-pain)
  - Complementary Alternative Medical (CAM) Therapies (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/212823/Pain-and-CAM-Therapy.pdf)
- Veal, et al (2018), Barriers to optimal pain management in aged care facilities: an Australian qualitative study, Pain Management Nursing, 19, (2) pp. 1-9. ISSN 1524-9042.
- Veterans' Medicines Advice and Therapeutics Education Services, (2011) Managing Constipation with Pain Medicines (https://www.apsoc.org.au/PDF/Publications/Veterans_MATES_27_Managing_Constipation_with_Pain_Medicines_VetBrochure_JUN11.pdf)

Palliative Care and Last Days of Life Care

What is palliative care?

Palliative care is an approach to care for residents and their families facing life limiting illnesses, including chronic diseases, cancer and dementia. The palliative approach involves holistic assessment and management of physical, psychological, cultural and social needs of residents and their carers, tailored to the individual person. Palliative care is applicable early in the course of a resident's life-limiting illness and may coexist with active treatments. The purpose of palliative care is to enable a resident to continue to engage in meaningful activities, despite serious illness.

Key points for palliative care

- Aged care residents prefer to be involved in decision making and goal setting regarding their own care as able, with their families supported as partners in the process.
- Early opportunities for goal setting and decision making enables the right care at the right time for residents.
- Advance care planning, including preferences for treatment, should be undertaken early in the illness experience. Preferences may evolve during the course of illness, thus care planning requires regular reassessment and documentation.

Defining last days of life care

There are a number of terms used interchangeably during the end of life when a person's life expectancy may be measured in a short number of days; this is the irreversible transition period where physiological functioning wanes and the person dies.

It is difficult to predict when dying will begin. There are factors which, in combination, indicate that a person has entered the last days of life. The Clinical Excellence Commission in NSW has developed a last days of life toolkit to aid with identifying dying and to provide support and management to residents and their families.

Communication of the diagnosis of dying is critical in the last days of life. Families would benefit from an opportunity to explore what to expect in the last days of life. The communication processes are generally outlined in the relevant aged care facility protocols. See the PREPARED Model – A guide for clinicians for conversations about the last days of life (http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0006/359277/LDOL-Toolkit-PREPARED-Model-for-clinicians-Final-April-2016.PDF).

How to recognise that someone is dying

The person:

- Is receiving optimal clinical care with ongoing deterioration
- Finds it increasingly difficult to swallow or tolerate oral medications
- Is increasingly uninterested in food or fluid
- Is profoundly weak and is essentially bed bound
- Is drowsy for extended periods of time

Note: Some individuals with a high level of physical and/or cognitive disability may exhibit the above for weeks to months. In these circumstances the recognition of further decline in the person's baseline level of function may indicate they are actively dying.

(Adapted from the CEC Last Days of Life Toolkit (http://www.cec.health.nsw.gov.au/keep-patients-safe/end-of-life-care/last-days-of-life))

Key points for care in the last days of life

- Ensure that the resident's condition has been reported to relevant staff and their GP.
- Ensure that the resident and family understand the situation and are able to express their preferences for care and comfort, including psychological and spiritual care.
- Review the resident's current treatments and medications and discontinue non-beneficial or harmful treatments.

- Ensure that the resident's current care plan is in alignment with their clinical condition and advance care plans.
- “Whole of person care” is also looking after the needs of the family.

Caring for a resident in the last days of life

Comfort care in the last days of life

Comfort is defined as an immediate experience, and is determined by the meeting of physical, psychological, spiritual, environmental, and social needs. Comfort, therefore, is an individual experience and is defined by the goals of the resident and their family. Important considerations for achieving comfort include:

- Position and posture, e.g. residents may prefer to remain in bed.
- Equipment including pressure relieving mattress may need to be added or removed for the residents comfort.
- Review of resident handling and the resident’s current care plan.
- Ensuring the resident’s environment meets their needs and preferences.

Skin and pressure care

- Pressure relieving mattresses may reduce the frequency of care but do not replace the need for regular pressure area care.
- Provide oral pre-emptive pain relief if required 30 minutes before movement.
- Plan repositioning in conjunction with the family.
- Consider continence management.
- Be aware that an unavoidable Kennedy ulcer may occur towards the end of life.

Nutrition and hydration

- Natural dehydration and anorexia occur frequently during the last days of life.
- Research evidence does not demonstrate survival or quality of life benefit from parenteral fluids or parenteral nutrition (TPN) or nasogastric feeding.
- Mouth care remains a priority when residents are not maintaining oral intake.
- Families may require support and reassurance around the natural processes of declining fluid and food intake at end of life.

Psychosocial care for resident and family

Distress is normal when a loved one is dying and may present as mixed emotional responses. People react individually and differently to grief and loss. This may be influenced by previous experience and family dynamics. It is important to provide residents and families with opportunities to express their distress or concerns.

Avoid

- Attempts to interpret, diagnose, deny or label the experience of distress.
- Forcing people to share feelings.
- Simple reassurances, for example “everything will be ok”.
- Making promises that can’t be kept.
- Telling people how they should be feeling, thinking, or acting.

Facilitate

- Conversations about end of life care.
- Describe what to expect and discuss goals of care.
- Bereavement counselling if required (see your organisation’s process).

Important symptoms in the last days of life

Fatigue

- Fatigue is an expected symptom in the last week of life.
- Residents may prefer to receive their care in bed and discontinue activities on their usual care plan. Care plans should be updated to reflect this.
- Families and carers should be advised that fatigue is a normal part of the dying process.

Pain

In the last days of life, planning for anticipatory drug availability for prompt symptom management is essential.

- Attend a thorough pain assessment and identify the location (and cause) of pain.
- Consider non-pharmacological approaches including positioning and equipment.
- Give oral (or subcutaneous) opioid if non-pharmacological measures are ineffective (see anticipatory prescribing chart (http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0005/359339/LDOL-Anticipatory-Prescribing-Guide-April-2017.PDF)).
- Breakthrough dose is dependent on current opioid use (anticipatory drug chart (http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0005/359339/LDOL-Anticipatory-Prescribing-Guide-April-2017.PDF)).
- Be mindful that psychosocial distress and other contexts may impact on the pain experience.

Breathlessness

- Breathing difficulties and shortness of breath may be due to a number of causes, attend a thorough resident assessment to identify the potential cause.
- Instigate non-pharmacological measures in the first instance including reassurance, repositioning, fans, open windows, and a calm environment.
- Give oral or subcutaneous morphine if non-pharmacological measures are ineffective. Dose is dependent on current opioid use.
- If anxiety present also recommend an anxiolytic (Benzodiazepine) be prescribed.
- Oxygen therapy is only of use in residents with hypoxia (oxygen saturation less than 90% in room). Use of fans has been demonstrated to be effective in relieving breathlessness at the end of life.

Nausea and vomiting

- Nausea and vomiting in the last days of life usually subside unless there is an intestinal obstruction or the symptom has not been previously controlled.
- Medications are a common cause of nausea, assess resident's currently prescribed medications and discontinue non-essential medications.
- Rule out bowel obstruction by conducting an abdominal assessment.
- Metoclopramide is contraindicated in bowel obstruction, Parkinson or Lewy body dementia.
- See anticipatory drug chart.

Restlessness or agitation in the days of life

- Restlessness is common in the last days of life and may be a normal symptom of dying.
- Assess for reversible factors such as urinary retention or faecal impaction.
- Consider indwelling catheter insertion for retention or discomfort.
- Review routine medications and discontinue non-essential medications.
- Assess resident thoroughly and exclude pain as an unrecognised cause of restlessness.
- Assess for spiritual or existential distress (fear or anxiety).

Respiratory tract secretions: noisy, rattling breathing

- Noisy breathing at end of life is a common symptom. It is generally not distressing for the resident, however, it can contribute to family and carer distress.
- The condition is often referred to as the "death rattle" and results from pooling of saliva and respiratory fluids in the upper chest and airways.
- There is no benefit from suctioning in terminal secretions.
- Pulmonary oedema may also be a cause of noisy breathing in residents with relevant medical conditions. Seek medical review if suspected.
- Instigate non-pharmacological measures:
  - reassure family with explanation and cause
  - position semi-prone and on alternate sides to encourage drainage
  - anti-secretory medications may be ineffective or only partially effective

Assessment checklist for residents in the last days of life

1. To make a diagnosis of dying ask yourself three questions:
   - is any aspect of this deterioration likely to be reversible?
   - would you be surprised if this resident was to die within hours to days?
   - has the dying resident previously stated any care preferences that need to be incorporated into the care plan for the next phase of illness?
2. Provide open disclosure to family and carers of the diagnosis of dying to ensure clear understanding of changing care needs.
3. Regularly assess resident for side effects of palliative medications and refer to GP if side effects occur:
   - myoclonus (sudden, involuntary jerking of a muscle/s, usually due to opiates)
   - dry mouth
   - urinary retention
   - constipation
   - nausea
4. Provide regular comfort care for the resident, including:
   - mouth care
   - repositioning for comfort and symptom management
   - pressure area care
   - bladder assessment to ensure resident is not in urinary retention
   - bowel care

Medications in the last days of life - key considerations

The goal for medication at the end of life is to maintain comfort during the final stages of a life limiting illness. When used appropriately they do not hasten death.

- Review the purpose of the resident's currently prescribed medications and whether they align with the person's goals of care. Plan in advance for any medications which may cause withdrawal symptoms by weaning or changing to alternative agent.
- Deprescribing, the process of discontinuing medications, is an active process which may improve the comfort and well-being of the resident.
- Ensure that the route of delivery of medications is optimised and aligns with the person's current needs e.g. if the resident is having difficulty swallowing oral medications.

- Alternative routes of administration include:
  - topical medications
  - patches
  - sublingual tablets or wafers that dissolve under the tongue
  - subcutaneous medications
  - administration via PEG tube
- Consider side effects of prescribed palliative medications and observe (page 14) residents for adverse effects.
- Always review the effect of medications after administration.
- Anticipatory prescribing for end of life will ensure timely supply and access to medications for residents when it is required. For anticipatory prescribing recommendations, see opposite page Last Days of Life Anticipatory Prescribing Recommendations for In-Patient Setting – ADULT (http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0005/359339/LDOL-Anticipatory-Prescribing-Guide-April-2017.PDF).

Bereavement

Bereavement is a process following loss where individuals and families face a number of challenges associated with the death of a loved one. These challenges may occur on a number of grounds including practical, psychosocial, psychiatric and financial, necessitating support and guidance from services.

Important documentation

1. NSW Health Making an Advanced Care Directive (https://www.health.nsw.gov.au/patients/acp/Pages/acd-form-info-book.aspx)
2. MOLST form (page 128)
3. NSW Ambulance Authorised Care Plans (https://www.ambulance.nsw.gov.au/our-services/authorised-care-plans)
4. Each state or territory will have guidence documents reflecting their legislation

References and resources

- Clinical Excellence Commission (CEC) End of Life Program (http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/end-of-life-care)
- Last Days of Life Anticipatory Prescribing Recommendations for In-Patient Setting – ADULT (http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0005/359339/LDOL-Anticipatory-Prescribing-Guide-April-2017.PDF). Clinical Excellence Commission (2017) VERSION 2: APRIL 2017. Accessed 18/11/2019.
- End of Life Directions for Aged Care (ELDAC) (https://www.eldac.com.au/tabid/4887/Default.aspx) provides information, guidance, and resources to support palliative care and advance care planning.
- NSW Health Advance Care Planning (https://www.health.nsw.gov.au/patients/acp/Pages/default.aspx)

Last Days of Life ANTICIPATORY PRESCRIBING RECOMMENDATIONS for in-patient setting – ADULT

MEDICATION	INDICATION(S)	STARTING PRN DOSE for PRN medication	STARTING DOSE for REGULAR medication		GUIDANCE NOTES
MORPHINE	PAIN & 1st line for BREATHLESSNESS	If not taking regular opioid (not on regular opioid for previous 7 days) 2.5 mg subcut 1 (one) hourly PRN max PRN dose in 24 hours = 15mg (equivalent to 6 PRN doses)	See pain and/or dyspnoea management flowchart for guidance on commencing regular subcutaneous morphine		• Morphine is recommended as first line subcut opioid for majority of patients in the last days of life • See guidance notes overleaf for prescribing recommendations for patients with pre-existing end stage kidney disease (eGFR <30) • Seek advice from local Specialist Palliative Care Team if conversion to alternative subcut opioid is required (see overleaf for contact details)
		If on regular opioid (regular opioid use during the previous seven days) See PAIN and/or BREATHLESSNESS management flowchart AND opioid chart on reverse of pain flowchart for guidance on conversion of oral/transdermal opioid to equivalent subcutaneous morphine			
METOCLOPRAMIDE	1st line for NAUSEA and/or VOMITING	10 mg subcut 8 hourly PRN max PRN dose in 24 hours = 30mg (equivalent to 3 PRN doses)	30 mg subcut in 24 hr syringe driver (plus PRN haloperidol)	OR 10 mg subcut 8 hourly regularly (plus PRN haloperidol)	• Seek advice from local specialist palliative care team if recommended antiemetic(s) is contra-indicated: Metoclopramide • Maximum subcut stat volume = 10mg (2mLs) • Caution with abdominal colic • Do not use if bowel obstruction suspected Haloperidol • Preferred antiemetic in renal impairment Metoclopramide & Haloperidol • Do not use in Parkinson's Disease or Lewy Body Dementia • Watch for extrapyramidal side effects (repetitive and involuntary movements, abnormal restlessness and parkinsonism including tremor, rigidity and bradykinesia)
HALOPERIDOL	2nd line for NAUSEA and/or VOMITING & 1st line for RESTLESSNESS and/or AGITATION	1 mg subcut 4 hourly PRN max PRN dose in 24 hours = 3mg (equivalent to 3 PRN doses)	2 mg subcut in 24 hr syringe driver (plus PRN haloperidol)	OR 1 mg subcut 12 hourly regularly (plus PRN haloperidol)	
BENZODIAZEPINE	2nd line for RESTLESSNESS and/or AGITATION & 2nd line for BREATHLESSNESS with ANXIETY	MIDAZOLAM* 2.5 mg subcut 2 hourly PRN max PRN dose in 24 hours = 15mg (equivalent to 6 PRN doses)	MIDAZOLAM* 10 mg subcut in 24 hr syringe driver (plus PRN midazolam)	OR CLONAZEPAM ** 0.5 mg subcut 12 hourly regularly (plus PRN midazolam)	*Midazolam • Is the benzodiazepine of choice for PRN dosing and regular dosing in a syringe driver **Clonazepam • Due to its long half-life, should be used when regular subcut benzodiazepine is required, but not in a syringe driver • Can be given by the SUBLING route as an alternative to SUBCUT route if parenteral access not available
GLYCOPYRRONIUM / GLYCOPYRRROLATE	RESPIRATORY TRACT SECRETIONS	0.2 mg subcut 4 hourly PRN max PRN dose in 24 hours = 1.2mg (equivalent to 6 PRN doses)	1.2 mg subcut in 24 hr syringe driver (plus PRN glycopyrrolate)	OR 0.2 mg subcut 4 hourly regularly (plus PRN glycopyrrolate)	• If respiratory tract secretions occur, prompt management is required • Anticholingeric medications may be ineffective or only partially effective • There is no conclusive evidence of superior efficacy between the different anticholinergics • Hyoscine hydrobromide HAS NOT BEEN RECOMMENDED as a first line agent as it is contraindicated in renal impairment and may potentiate delirium and sedation
OR					
HYOSCINE BUTYLBROMIDE (BUSCOPAN)		20 mg subcut 4 hourly PRN max PRN dose in 24 hours = 120mg (equivalent to 6 PRN doses)	120 mg subcut in 24 hr syringe driver (plus PRN hyoscine butylbromide)	OR 20 mg subcut 4 hourly regularly (plus PRN hyoscine butylbromide)	

Polypharmacy and high-risk medications in RACFs

Polypharmacy

Residents in RACFs are particularly vulnerable to the adverse effect of polypharmacy (5 or more medications) because of metabolic changes and their reduced drug clearance ability, which both relate to the ageing process. The risk of drug interactions, adverse drug events, geriatric syndromes, and hospital admissions increases with the number of medications used (Jokanovic et al., 2016). Polypharmacy includes vitamins, herbs, and food supplements.

High-risk medicines

These are medications that have a high risk of causing injury or harm if they are misused or used in error. High-risk medications are represented by the acronym "**A PINCH**" and include:

- **A**nti-infective agents and anti-psychotics
- **P**otassium
- **I**nsulin
- **N**arcotics and sedative agents
- **C**hemotherapy and other cytotoxic medications
- **H**eparin and other anticoagulants

Risk factors for polypharmacy

- Age >65 years
- Multiple diagnoses, co-morbidities, and/or chronic disease
- Functional dependency
- Recent hospitalisation
- Pain
- Cognitive or sensory impairment
- CALD background
- Mental health issues, e.g. anxiety, depression
- Multiple prescribers

Why is polypharmacy a problem?

An increased number of drugs increases the chance of potential side effects. Polypharmacy can change the metabolism and elimination of drugs, there can be interaction between drugs, and polypharmacy can have an additive effect and side effects, such as drowsiness. Polypharmacy increases the risk of:

- Falls and associated harm (fractures)
- Dehydration
- Frailty and functional decline
- Cognitive impairment and dementia
- Hospitalisation
- Death

(Hilmer and Gnjidic, 2018)

Adverse drug reactions

Medication-related reasons have been implicated in 20% to 30% of all admissions for people 65 years and older (Wang, Bell, Chen. et al., 2018).

The most common medication-related presentations are for:

- Falls
- Postural hypotension
- Heart failure
- Delirium
- Urinary incontinence

Always consider: "Could a medication be the cause of this resident's symptoms?"

Medication-management reviews

Residential Medication Management Review (RMMR) for residents of aged care facilities (MBS item number 903) involves collaboration between a GP and a pharmacist to review the medication-management needs of a resident. See the Department of Health site for:

- Information for GPs (http://www1.health.gov.au/internet/main/publishing.nsf/Content/rmmrinfoforgp.htm)
- Information for Aged Care Homes (https://www1.health.gov.au/internet/main/publishing.nsf/Content/rmmr_info_aged_care_homes)
- Sample RMMR Plan (https://www1.health.gov.au/internet/main/publishing.nsf/Content/A3BFC217BCE04B0ECA257BF0001CAA6F/$File/Sample%20RMMR%20Plan%20PDF.pdf)
- RMMR Service Description Flowchart (https://www1.health.gov.au/internet/main/publishing.nsf/Content/A3BFC217BCE04B0ECA257BF0001CAA6F/$File/RMMR%20Service%20Description%20Flowchart%20PDF.pdf)

Deprescribing

Consider deprescribing when the resident enters care and:

- There is polypharmacy
- Their treatment or care goals have changed
- There has been a fall or an adverse event

Deprescribe one medication at a time and assess for side effects. To minimise withdrawal effects, be cautious when stopping the following drugs:

- Anticholinergics
- Benzodiazepines
- Antidepressants
- Steroids
- Diuretics

There is increasing evidence for safely withdrawing medications. See:

- Evidence-based Clinical Practice Guideline for Deprescribing Cholinesterase Inhibitors and Memantine: Recommendations (http://sydney.edu.au/medicine/cdpc/documents/resources/deprescribing-recommendations.pdf) (Reeve et al, 2018).

- How to de-prescribe and wean opioids in general practice (https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care/how_to_de-prescribe_and_wean_opioids_in_general_practice)
- NSW Therapeutic Advisory Group (http://www.nswtag.org.au/deprescribing-tools/)
- Consultant Pharmacy Services' Deprescribing Resources (http://www.cpsedu.com.au/courses/take/47)

Resources and references

- ACI Pain Management Network - How to de-prescribe and wean opioids in general practice (https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care/how_to_de-prescribe_and_wean_opioids_in_general_practice).
- Australian National Prescribing Service – NPS Medicinewise – Prescribing for frail older people (https://www.nps.org.au/assets/70ea0400a3efa1b8-e5e57db8a6c9-prescribing-for-frail-older-people-40-174.pdf).
- Consultant Pharmacy Services. Deprescribing Documents (http://www.cpsedu.com.au/posts/view/46/Deprescribing-Documents-now-Available-for-Download). December 2015.
- Hilmer, S. N., & Gnjidic, D. (2018). Deprescribing: the emerging evidence for and the practice of the 'geriatrician's salute'. Age and Ageing, 47(5), 638-640. doi:10.1093/ageing/afy014.
- Jokanovic, N., Tan, E. C. K., Dooley, M. J., Kirkpatrick, C. M., Elliott, R. A., & Bell, J. S. (2016). Why is polypharmacy increasing in aged care facilities? The views of Australian health care professionals. Journal of Evaluation in Clinical Practice, 22(5), 677-682. doi:10.1111/jep.12514.
- Reeve E, Farrell B, Thompson W, Herrmann N, Sketris I, Magin P, Chenoweth L, Gorman M, Quirke L, Bethune G, Forbes F, Hilmer S. Evidence-based Clinical Practice Guideline for Deprescribing Cholinesterase Inhibitors and Memantine: Recommendations (http://sydney.edu.au/medicine/cdpc/documents/resources/deprescribing-recommendations.pdf). Sydney: The University of Sydney; 2018.
- Roughhead L, Semple S, Rosenfeld E, Literature Review: Medication Safety in Australia (2013) (https://www.safetyandquality.gov.au/sites/default/files/migrated/Literature-Review-Medication-Safety-in-Australia-2013.pdf). Australian Commission on Safety and Quality in Health Care, Sydney.
- Wang, K.N., Bell, J.S., Chen, E.Y.H. et al. (2018). Medications and Prescribing Patterns as Factors Associated with Hospitalizations from Long-Term Care Facilities: A Systematic Review. Drugs Aging 35, 423–457.

Respiratory

Shortness of Breath (SOB) - New Onset

Important! If the resident has one or more of the following, and their ACP (page 16) states intervention, phone 000.

- Lips are blue
- Nail beds are blue
- Respiratory rate <12/min or >40/min
- Using accessory muscles to breathe
- Sudden pain on breathing
- Unable to speak or only in words
- Temperature <34°C or >38°C
- A new, debilitating cough

Immediate actions

1. Sit the resident upright or in a comfortable position. Give reassurance and assess the severity of the shortness of breath (SOB).
2. Check/assess:
   - respiratory and heart rates
   - temperature
   - pallor, colour (cyanosis)
   - presence of wheeze
   - ability to talk (long or short sentences or words only)
   - chest expansion
   - cough
   - sputum

   See assessment below
3. Apply oxygen:
   - if resident has COPD, Obesity Hypoventilation Syndrome, Bronchiectasis, Neuromuscular Disease or Chest Wall Deformity; give oxygen to maintain SpO_2 88 to 92%
   - if resident has no chronic lung disease; give oxygen to maintain SpO_2 92 to 96%

   Important: Excessive oxygen may be dangerous.

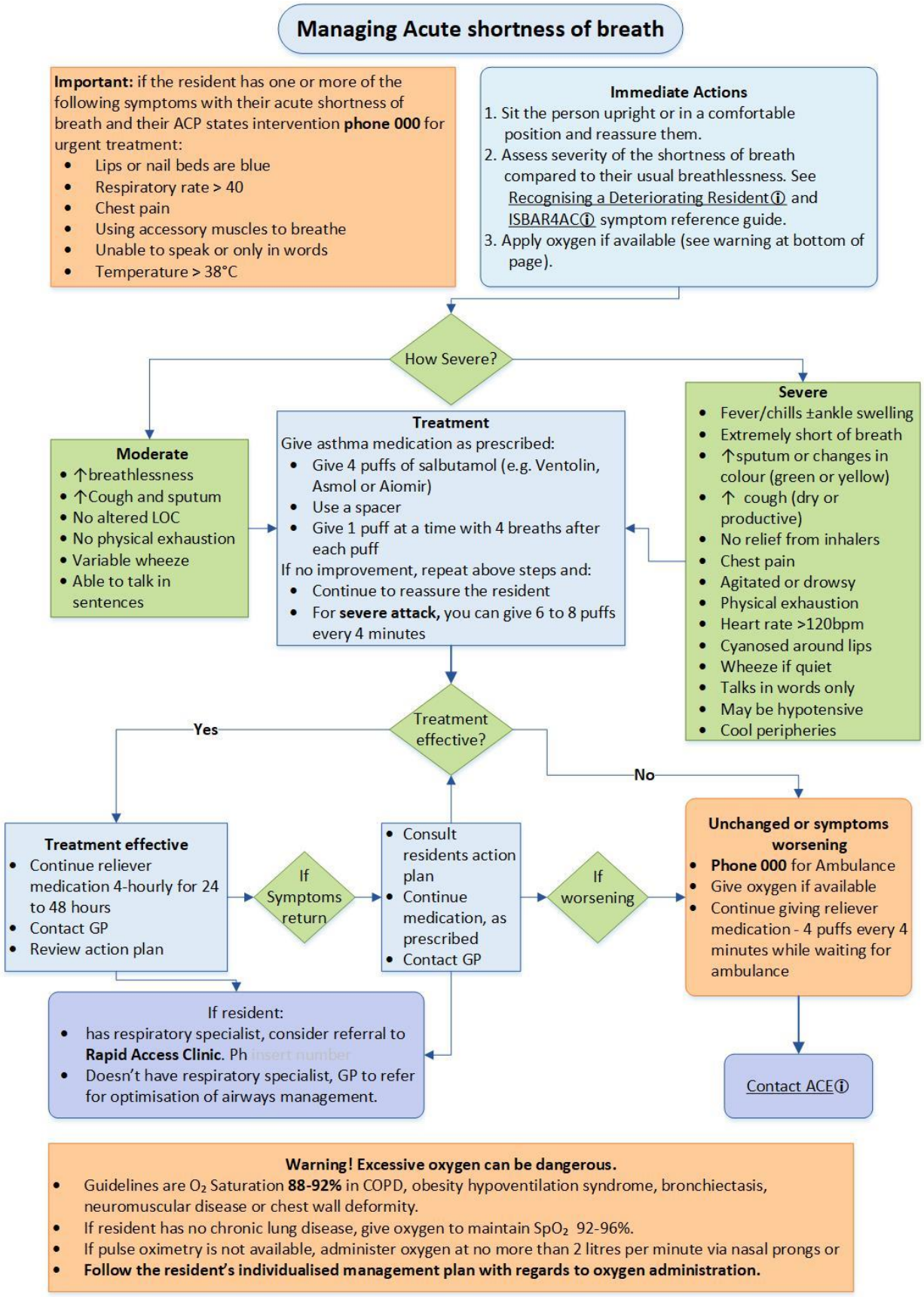
   (TSANZ Guidelines, 2015 (https://www.thoracic.org.au/clinicalpublications/new-releases))

Assessment and next steps

Consider the multiple causes of Shortness of Breath (SOB):

Cause	Other symptoms	Management
Acute coronary syndrome or myocardial infarction	▪ Dull, heavy, or tight anterior chest pain ▪ Pain in throat, jaw, back, or arms ▪ Pallor ▪ Sweating ▪ Nausea	If acute coronary syndrome/myocardial infarction suspected, contact the gp, who may contact ACE (page10) and/or arrange transfer to hospital (page 21).
Asthma	▪ Acute onset ▪ Chest tightness ▪ Cough ▪ Wheeze ▪ Inability to speak in whole sentences indicates a severe attack	▪ If asthma suspected, see shortness of breath (sob) – new onset (page 87). ▪ Contact the gp. ▪ If gp not available, contact ACE (page10) and arrange transfer to hospital (page 21), if necessary.
Congestive heart failure	▪ Waking at night with SOB ▪ Difficulty breathing when lying down ▪ Cough at night or when lying down ▪ Swelling of ankles or lower limbs ▪ Weight gain	See Heart Failure Issues (page 28)
COPD	▪ Gradual onset ▪ Cough ▪ Decreased exercise tolerance	▪ Resident may already have a diagnosis of copd. ▪ See COPD (https://lungfoundation.com.au/health-professionals/conditions/copd/overview/) on the lung foundation australia manual.
Influenza	▪ Fever ▪ Cough ▪ Sore throat ▪ Headache ▪ Muscle aches ▪ Fatigue	See managing influenza outbreaks (page 90)
Palliative	▪ Breathlessness can occur in terminal phase of illness ▪ May be anxiety-related	Contact the palliative care team if the resident is known to palliative care, or contact GP. Consider standing order for anxiolytic.
Pneumonia	▪ Pain localised to one side of the chest ▪ Fever ▪ Cough ▪ Audible crackles in chest	▪ If pneumonia is suspected, contact the GP. ▪ If GP not available, contact ACE (page10) and arrange transfer to hospital (page 21).
Pulmonary embolism	▪ Rapid heart and respiratory rate ▪ New sudden pain on breathing Risk factors include: ▪ History of immobility ▪ Recent surgery ▪ Cancer ▪ Current or previous deep vein thrombosis	▪ If pulmonary embolism suspected, contact the GP. ▪ If GP not available, contact ACE (page10) and arrange transfer to hospital (page 21).

Acute Shortness of Breath Flowchart



Managing Influenza Outbreaks

An Influenza outbreak is when there are 3 or more cases of influenza-like illness (ILI) in residents or staff within 3 days and (72 hours) and the Public Health team are to be notified.

See the NSW Health poster How to identify respiratory outbreaks and what to do next (https://www.health.nsw.gov.au/Infectious/Influenza/Publications/resp-outbreaks-poster.pdf).

Public Health Unit Advice

- Phone: Insert number

Resources and references

- NSW Health online resources for influenza breakouts in Residential care facilities (https://www.health.nsw.gov.au/Infectious/Influenza/Pages/residential-care.aspx)
- Flu-info kit (https://www.health.nsw.gov.au/Infectious/Influenza/Publications/flu-info-kit.pdf)
- Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Facilities in Australia https://www1.health.gov.au/internet/main/publishing.nsf/Content/27BE697A7FBF5AB5CA257BF0001D3AC8/$File/RCF_Guidelines.pdf)

Tracheostomy Issues

Please refer to Tracheostomy Flowchart (page 92)

Excessive secretions

Possible causes

- Infection
- Fluid overload

Interventions

- Encourage resident to cough own secretions
- If unable to clear own secretions – institute suctioning with non-fenestrated inner cannula
- Provide humidification
- As tolerated, position in a semi-upright position
- Keep stoma clean and dry.
- Monitor respirations, pulse, and temperature, and assess changes
- Regularly check and clean inner cannula

Dry secretions

Possible causes

Inadequate humidification

Interventions

- Regular normal saline nebuliser
- Provide warm air humidifier
- Ensure inner cannula is clean and free of crusty sputum

Blood stained sputum

Possible causes

- Irritation
- Insufficient humidification
- Suction issues – too vigorous, deep, frequent, or high pressure
- Infection
- Excessive coughing

Interventions

- Monitor
- Review suctioning technique, educate staff

Follow up required

- Phone **000** if excessive
- Contact ACE (page 10) if unsure

Excoriation to skin surrounding stoma

Possible causes

- Excessive moisture
- Exposure to contaminated secretions
- Infected sputum

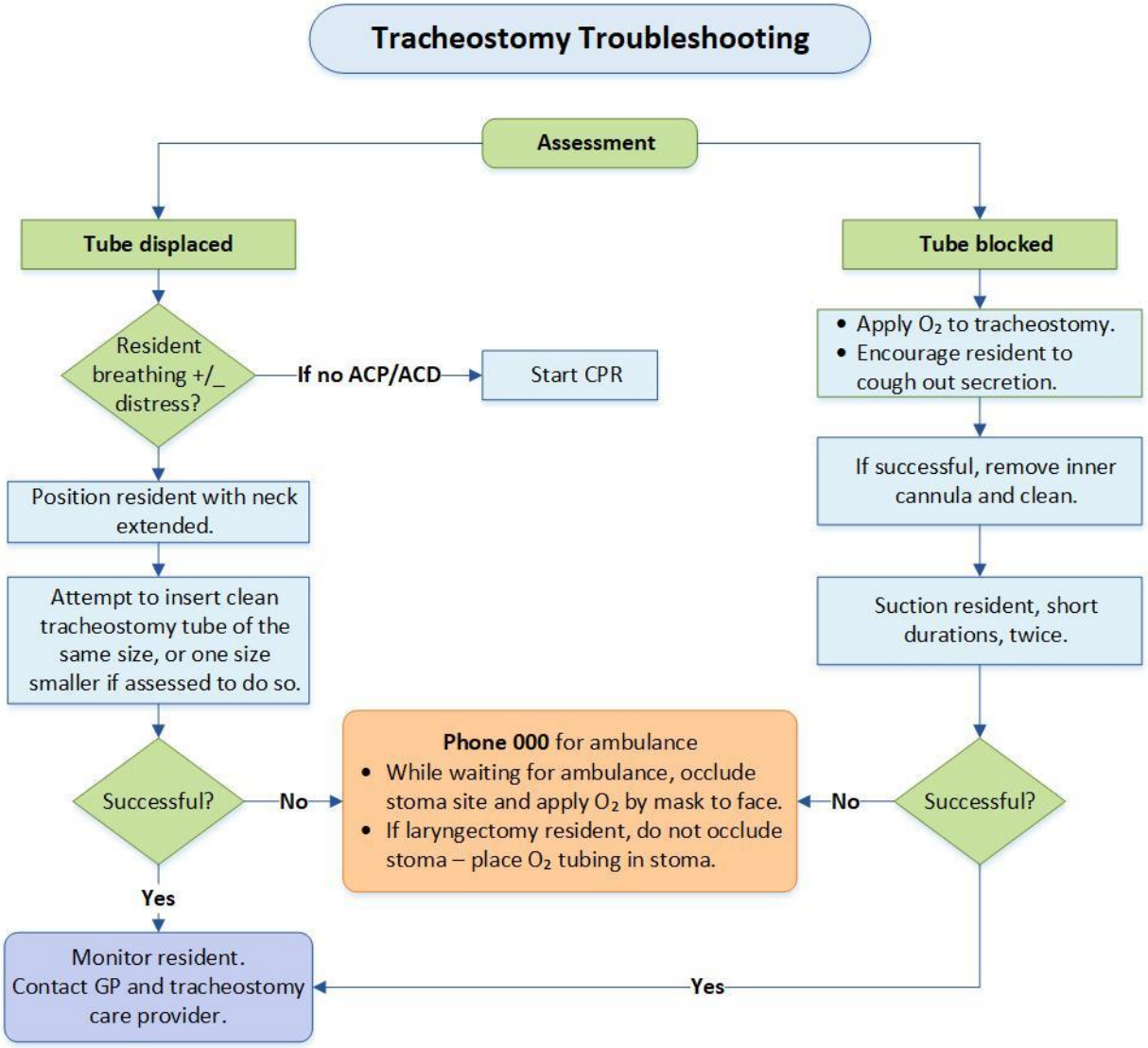
Interventions

- Do not allow secretions to pool around the stoma
- Keep skin under tracheostomy ties clean and dry
- Aggressive wound care
- Frequent dressing changes
- Apply absorbent dressing daily and PRN

Follow up required

- GP review
- Tracheostomy care provider

Tracheostomy Flowchart



Respiratory Advice and Referral:

- Rapid Access Clinic (RAC) - for urgent patients who do not require admission and are known to the Respiratory Department Local Health District COPD and Asthma CNC ph insert number

References and Resources

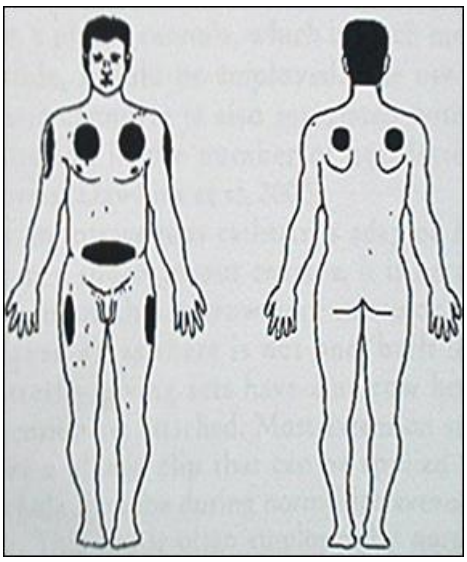
- Lung Foundation Australia:
  - COPD-X Concise Guide for Primary Care: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease (https://copdx.org.au) – including:
  - Stepwise Management of COPD (https://lungfoundation.com.au/resources/?search=stepwise),
  - COPD Action Plan (https://lungfoundation.com.au/resources/?search=COPD%20Action%20Plan&condition=9)
  - Managing Breathlessness – Plan, Prepare, Pace and Pause (https://cope.lungfoundation.com.au/files/file/Module_Three/PlanPreparePaceandPause.pdf)
  - Inhaler device technique: Spacers (https://lungfoundation.com.au/?s=spacers) and Inhaler device use https://www.nationalasthma.org.au/health-professionals/how-to-videos
  - Hand-held fans – video on benefits and how to use https://lungfoundation.com.au/?s=hand%20held%20fan&user_category=

Subcutaneous Fluid Administration

Subcutaneous fluid administration is appropriate for mild to moderate dehydration as a short-term solution. Dehydration may result from poor oral fluid intake, difficulty swallowing, confusion/delirium (page 42), nausea and vomiting, and gastroenteritis.

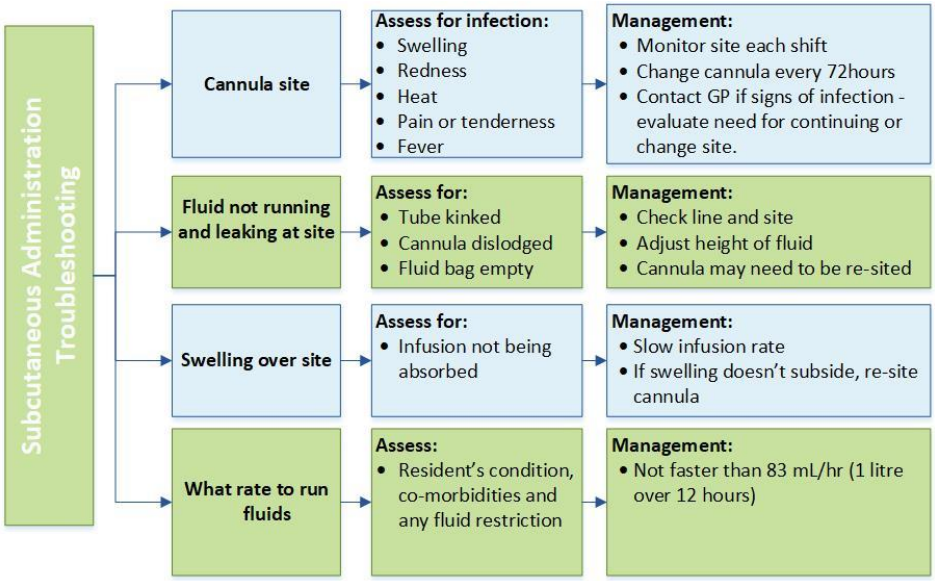
Procedure for subcutaneous fluid administration

1. **General Practitioner (GP)** – Order isotonic fluids for administration (e.g. sodium chloride 0.9%).
   - Insert the subcutaneous device to a non-oedematous position (shown below). Secure with a firm dressing.



Important: If you have any concerns with the procedure, contact the GP or ACE.

   - Run the infusion at a rate no greater than 2 litres per 24 hours (83 mL/hour).
   - Monitor the site each shift and change cannula every 72 hours. If you have any concerns, contact the GP.
2. Monitor the resident's hydration:
   - If the resident is stable, discontinue fluid administration. Re-start if needed.
   - If there is no improvement, the resident is unstable or the resident deteriorates, consult advanced care plan/directive, the GP, and person responsible.
   - If GP unavailable, call ACE (page 10).
   - If transfer to hospital required, phone insert number to arrange transfer to hospital (page 21).



Urology

Indwelling Catheter Issues

Difficulty inserting urethral catheter (males)

Inserting lubricant

- Insert anaesthetic lubricant slowly into the urethra before catheter insertion. Allow up to 2 to 5 minutes for the local anaesthetic to take effect. 10 to 20 mL can be instilled if not contraindicated.

Enlarged prostate

- Check medical history

Intervention:

- Ensure adequate lignocaine lubricant, i.e. 10 to 20 mL. Use a size 16 gauge coude tip catheter (has a curved tip)
  (If a coude catheter is not available, use a size 16 gauge normal tipped catheter)
- Change the angle of the penis, and rotate the catheter gently while inserting the catheter
- GP may consider referral to a urologist for assessment

Urethral stricture

- Decrease the size of the catheter
- Use a firm catheter
- Ensure adequate lignocaine lubricant, i.e. 10 to 20 mL
- If the resident is anxious, ask the resident to take slow, deep breaths then relax. Insert the catheter as resident exhales
- If the resident tenses up, stop inserting the catheter until they relax

Retracted penis

Intervention:

- Have a second nurse gently push either side of the penis to force the penis out
- If possible, ask the resident to take slow, deep breaths then relax. Insert the catheter as resident exhales

Difficulty inserting urethral catheter (females)

Urethral orifice is difficult to visualise

- Ensure adequate lighting is available
- Unable to open legs adequately e.g. arthritis
- Seek assistance from another staff member to position resident appropriately, e.g. on her left side or place a pillow under the buttocks
- Use a size 12 gauge coude catheter (if available)
- If the urethra is red and inflamed or bleeding, lignocaine gel may be required
- **Intervention:** a**i**m the catheter in an upward direction during insertion to avoid entry into the vagina
- Atrophic vaginitis (vulva pale-looking and bleeds easily when labia separated)
- **Intervention**: GP may consider topical oestrogen
- **Intervention**: GP may consider referral to a urologist for insertion of a suprapubic catheter (SPC)

Obesity

- Undertake risk assessment and manual handling assessment to ensure safety of staff or resident, determine the number of staff available to safely position resident before catheter insertion. Escalate to the manager if necessary.
- Contact the CNC Urology insert numnber for advice if the risk assessment indicates that resident is not suitable to be catheterised in the aged care facility.
- Slings could also be considered to hold the resident's legs apart.
- **Intervention**: GP may consider referral to an urologist for insertion of a suprapubic catheter (SPC).

Constipation

- Check recent bowel movement as constipation can cause urinary retention
- Give an enema and/or prescribed aperients as prescribed
- Perform PR check to check for faecal impaction
- **Intervention**: As above and refer to constipation flowchart (page 54)

Difficulty removing suprapubic catheter (SPC)

Consider

- Ridge forming (hysteresis) on catheter when the balloon is deflated. Ridging causes an increase in the catheter diameter.
- Always allow the balloon to self-deflate and do not aspirate as this can increase the risk of ridging. Allowing the balloon to self-deflate will minimise the ridging. To do this, attach a syringe to inflation valve and allow the water to fill the syringe. Do not manually withdraw the water from the balloon.

Assessment

- Check catheter on removal for debris and consider changing catheter type e.g. open ended catheter or brand.

Intervention

- If the catheter cannot be removed, re-inflate the balloon with 0.1 to 0.2 mL of water and remove syringe, this will minimise the ridging. Then rotate the catheter gently while removing.
  - If the catheter still cannot be removed and is **not** blocked, re-inflate the balloon ensuring it is in the bladder and either:
    - inform GP
    - contact the Urology CNC insert number for advice
    - attempt to change the catheter the following day if clinically appropriate
    - call Extended Care Paramedic (ECP) **if available**
  - Refer to blocked catheter below and/or refer the resident to ACE Service, as may require a bladder washout solution
  - **Note**: For spinal cord injury (SCI) residents are prone to autonomic dysreflexia, you may need to leave SPC in situ, insert a urethral catheter and refer the resident to Extended Care Paramedic (ECP) or emergency department.

Difficulty reinserting SPC

Note: Simpla silicone catheters are not recommended for suprapubic use.

Ensure the bladder is full before catheter change if possible

- **Intervention**: Clamp the drainage system (not the catheter) at least 30 to 60 minutes prior
- If unable to insert the same size catheter, try inserting a smaller sized catheter to maintain the tract, and arrange for a urology outpatient clinic review
- If it is not possible to insert a smaller sized catheter, insert a urethral catheter and contact the Urology CNC insert number for advice

- Spinal cord injury: if you have a resident with spinal cord injury above T6 they may be at risk of autonomic dysreflexia, so **do not** clamp the drainage system before catheter removal
  - **Autonomic dysreflexia** is a medical emergency that can occur in people with spinal cord injury where bladder distension can cause a sudden severe rise in blood pressure. If this occurs, follow the NSW Safety Alert on Autonomic Dysreflexia 14-10 (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/155143/algorithm.pdf) algorithm and seek urgent medical care.

Catheter has fallen out

Balloon inflated

- Check for bleeding and trauma from the urethra. Monitor and check for residual urine volumes to establish if catheter is still required
- Re-catheterise if required
- **Intervention**: Inform GP

Balloon deflated

- Check that the balloon is intact
- Monitor and check for residual urine volumes to establish if catheter is still required
- Re-catheterise if required
- If catheter continues to fall out, contact GP to discuss the need for a kidney, ureter and bladder (KUB) ultrasound to check for stones
- **Intervention**: Inform GP if balloon not intact, as a stone may have pieced the balloon

Securing catheter

- Always secure the catheter with an appropriate securing device or place into underwear

Resident confused

- If confusion is new, consider UTI. Complete a set of clinical observations (page 14) and follow UTI flowchart (page 100)
- Observe for localised trauma, bleeding, and infection
- Check the need and suitability of a urinary/suprapubic catheter and assess for alternate option
- **Intervention**: inform GP, ensure the catheter is well secured

Medical device pressure injury

- Urethral erosion cannot be treated and should be avoided by checking the glans penis for signs of pressure including inflammation, ulceration, or tears
- Check the meatus daily. Relieve pressure by repositioning the catheter drainage bag daily to the alternate leg and ensuring the catheter is well secured. Regularly empty the drainage bag at 400 mL to minimise potential tension from the weight of the drainage bag.

Blocked catheters

Forty percent of residents with catheters are "blockers". This is more common in immobile residents due to calcium leeching from bones into the urine. 100% silicone catheters are recommended as they have a larger lumen to provide better drainage and encrust less frequently compared to latex/coated catheters.

Intervention: Change the catheter or use a bladder washout solution.

Hydration

- Monitor fluid intake
- Maintain at least 2 litres of fluid intake per day (unless contraindicated, e.g. fluid restricted)
- **Intervention: c**onsider subcutaneous fluids where appropriate

Constipation

- Assess bowels
- **Intervention:** refer to constipation flowchart (page 54) as a full bowel can compress the urethra and block the catheter

Catheter size, type and material

- Review catheter size, material, and type
- **Intervention:** increasing the catheter size can improve drainage. However, the size for urethral catheters should not exceed 14 gauge for females or 18 gauge for males. 100% silicone catheters, especially an open-ended catheter, provide the best drainage and can be used for both SPC and urethral catheterisation.

Drainage bag

- Assess size of bag tubing
- **Intervention:** large bore tubing provides better drainage
- Ensure there are no kinks or loops in the drainage bag tubing

Drainage system

- Review the type of valve for suitability and function
- **Intervention:** drain the bladder every 4 hours or at volumes no greater than 450 mL. This may increase the time taken to become blocked compared to continuous drainage.

Urinary Tract Infection

- Change the catheter then treat symptomatic infections, as per UTI flowchart (page 100)

Leakage around the catheter (bypassing)

Note: Some bypassing is normal. If the catheter is still draining clear urine, it is not blocked – look for other causes.

Catheter blocked

- Check for:
  - kinks or loops in the catheter or drainage bag
  - debris blocking catheter
  - drainage bag should be lower than the bladder and off the floor
  - constipation
  - urinary tract infection
- **Intervention**: ensure unobstructed flow. May benefit from a bladder washout solution

Urinary Tract Infection (UTI)

- UTI can cause urine bypassing the catheter. Treat symptomatic infections as per urinary tract infection flowchart (page 100).

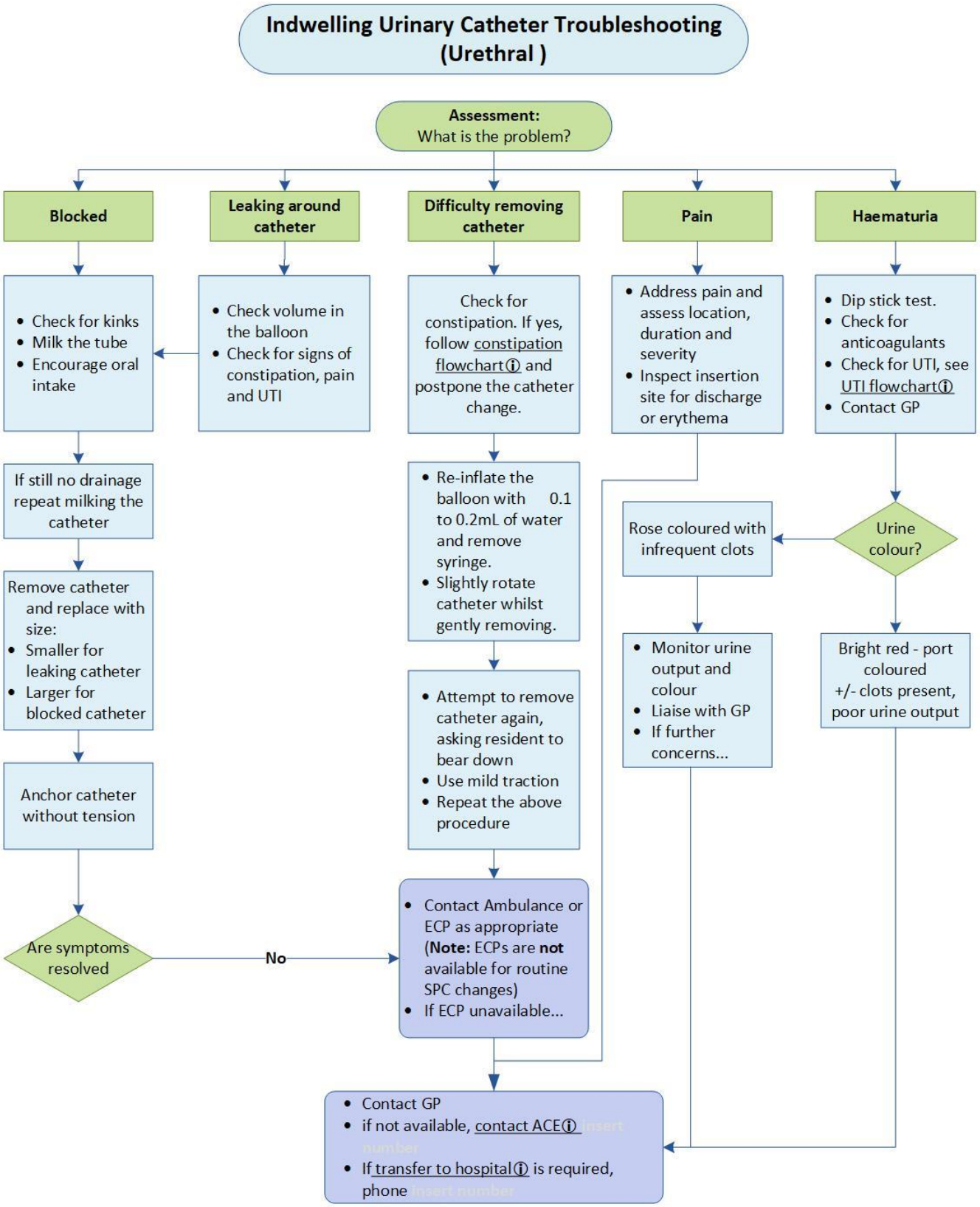
Bladder spasms

- Ensure catheter is secured to minimise movement.
- Treat symptomatic infections, as per urinary tract infection flowchart (page 100)
- Check catheter and balloon size, and decrease urethral catheter if appropriate
- Treat constipation, as per constipation flowchart (page 54)
- **Intervention**: refer to GP to consider anticholinergic medication

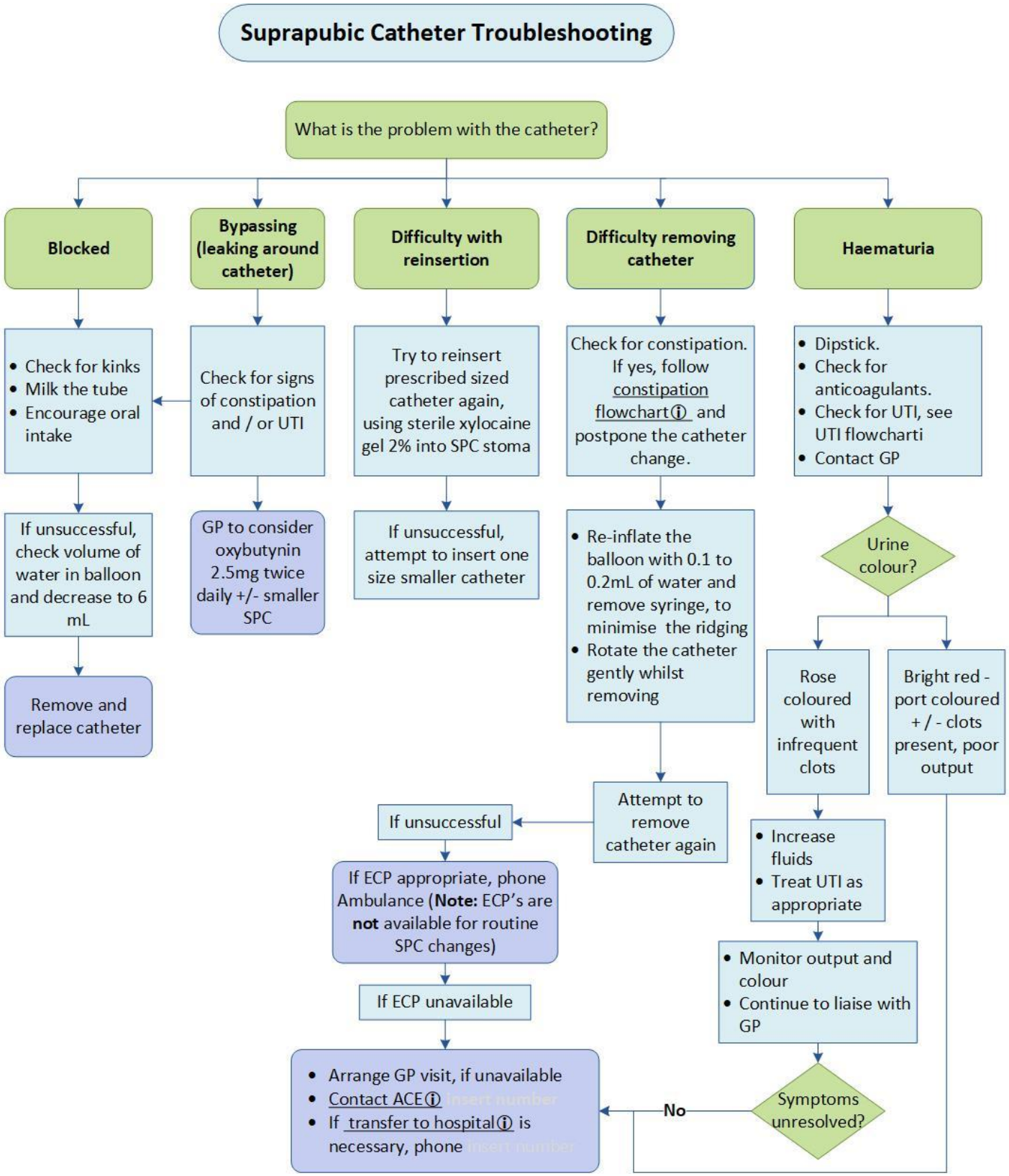
Catheter/balloon size catheter movement

- Check catheter and balloon size
- **Intervention**: change to a smaller size if possible

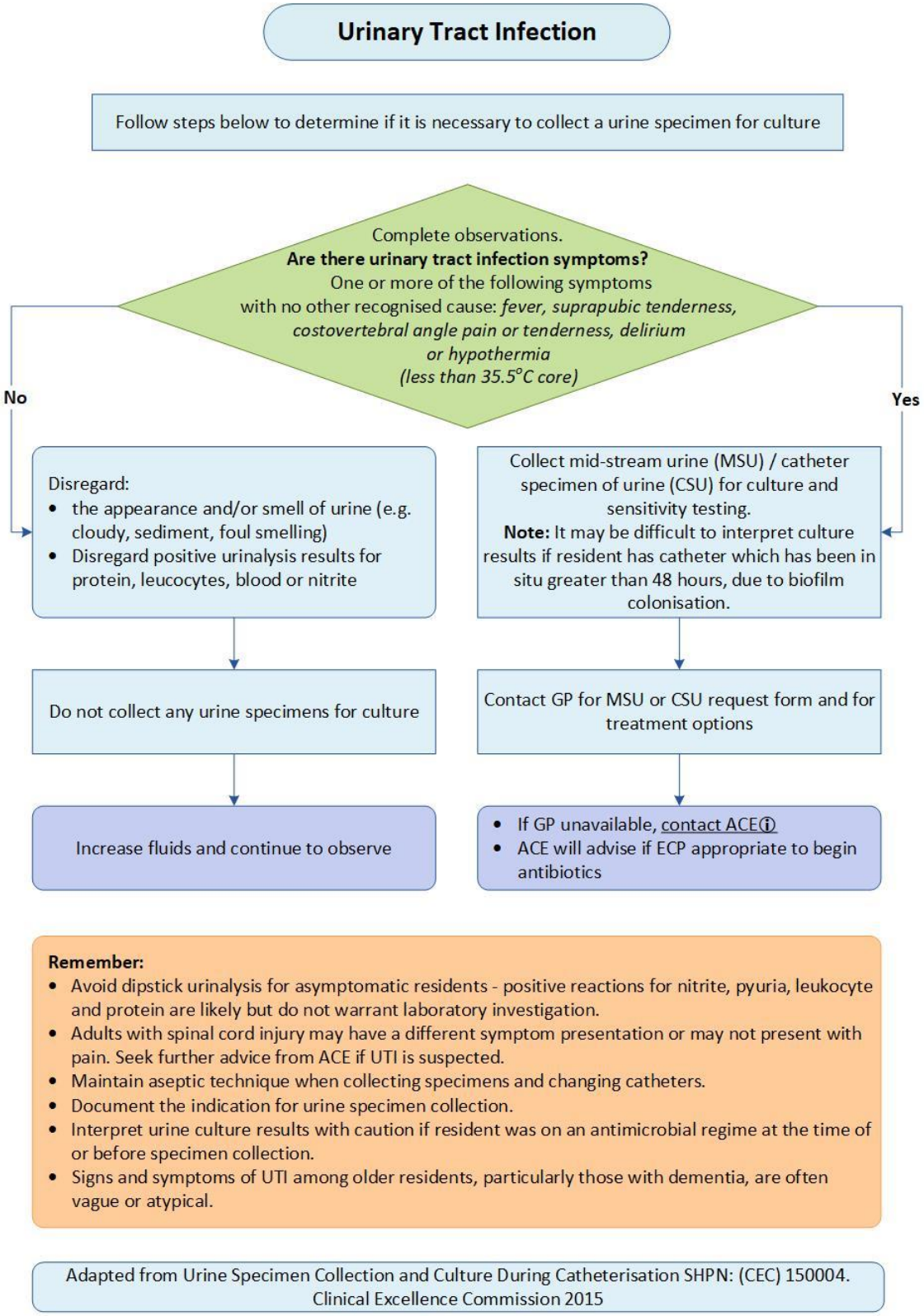
Indwelling Catheter Flowchart



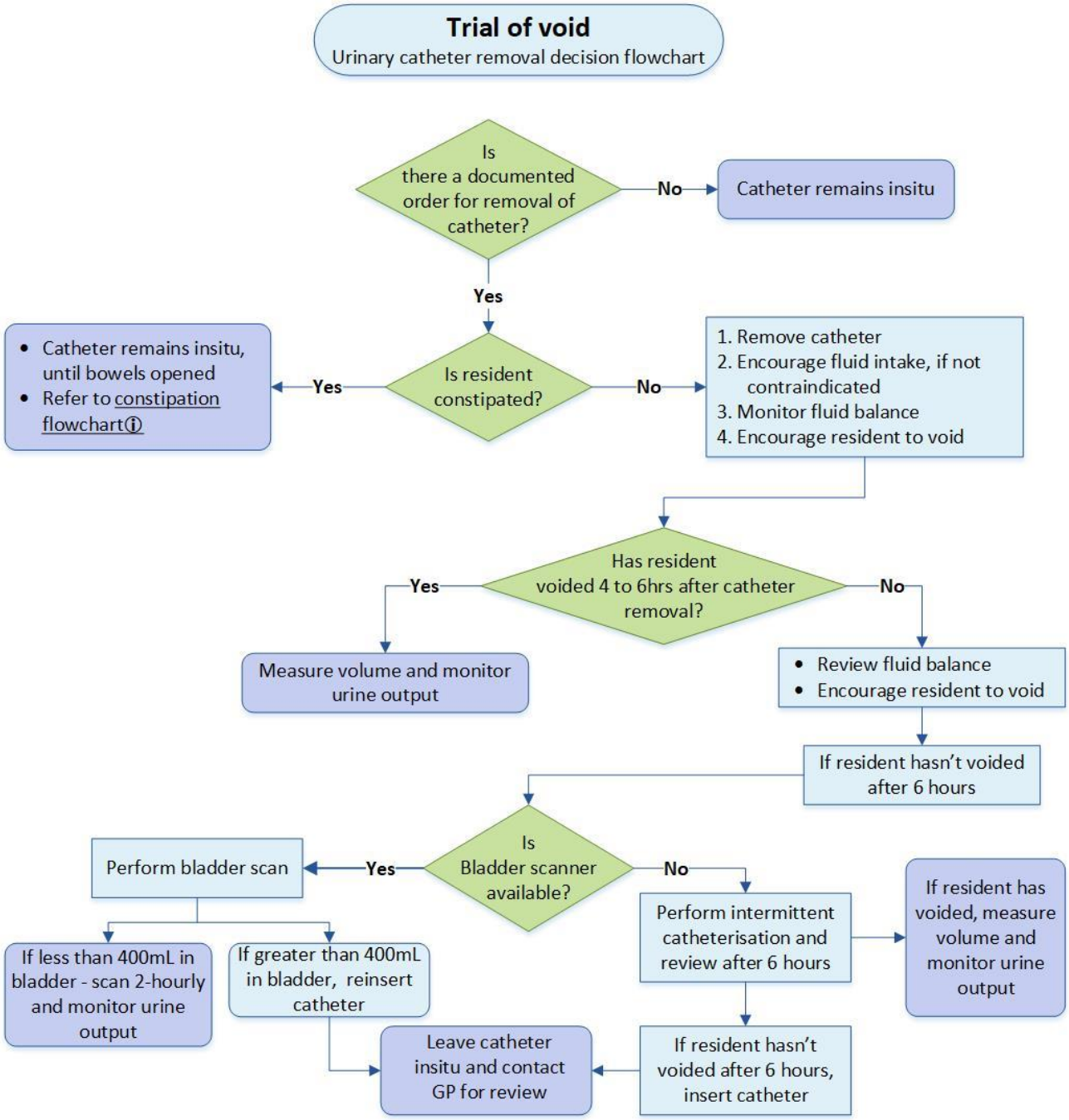
Suprapubic Catheter Flowchart



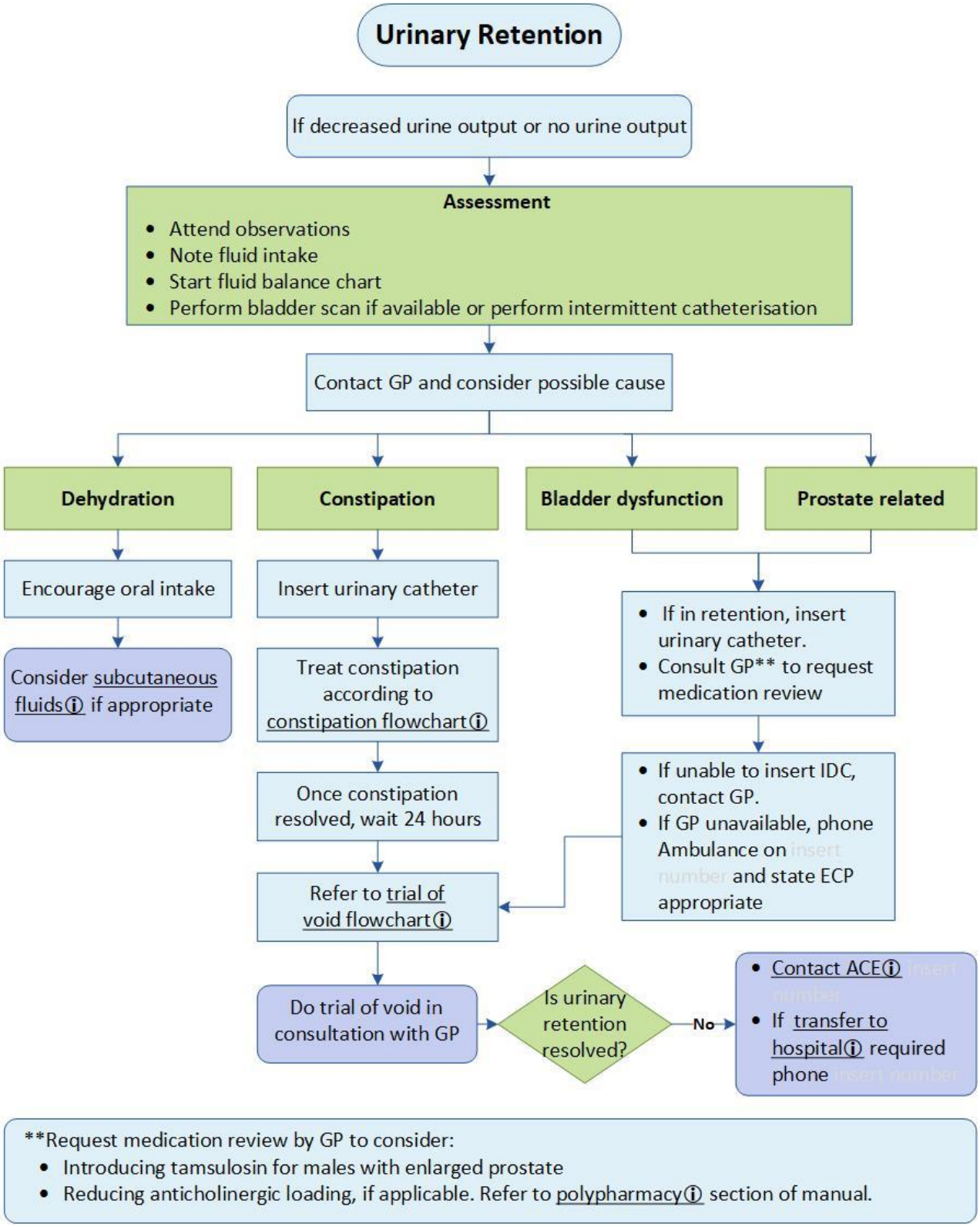
Urinary Tract Infection Flowchart



Trial of Void Flowchart



Urinary Retention Flowchart



Further information

Advice and referral

- Local Health District Urology CNC – Phone insert number

Resources and references

- Clinical Excellence Commission Catheter Associated Urinary Tract Infection (CAUTI) (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/cauti-prevention)
- NSW Safety Alert on Autonomic Dysreflexia 14-10 (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0019/155143/algorithm.pdf)

Wound Care

Management for Various Types of Wounds

- Measure all wounds as a reference
- Use **T.I.M.E** for all general wound assessments:
  - **T**issue management: healthy or non-viable; may require debridement (episodic or continuous)
  - **I**nfection or inflammation control: removed infected foci, topical/systemic antimicrobials
  - **M**oisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression or negative-pressure wound therapy (NPWT)
  - **E**pithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.

Burn Injuries

Immediate first aid

- Cool running water for 20 minutes (no ice or cold packs)
- If it is a chemical burn, continue active cooling for 1 to 2 hours
- Remove any jewellery or constrictive clothing
- Dial **000** to arrange urgent transfer to hospital for any burn covering over 10% of body
- Give adequate pain relief

Assessment

1. Determine the type of injury:
   - Scald:
     - splash – cup with hot contents, soup, shower
     - Immersion – bath, foot bath
   - Chemical burn:
     - body fluids – nasogastric or PEG tube leaking
     - spills – betadine, methylated spirits, or acetic acid
2. Assess mechanism of injury:
     - temperature of source – hot tea, tea cooled with milk, clear or thick soup
3. Assess wound:
   - anatomical location
   - surface area %
   - grade (superficial, partial thickness, full thickness)
4. Assess time of exposure:
   - What was the time of the injury?
   - How long was the skin exposes to the heat source?
   - What was the duration of the first aid provided, e.g. the cool running water?

Management

1. If burn is larger than 2 cm wide, contact GP for referral to Burns Unit.
2. Seek advice from a Burns Unit for burns to face, head, neck, ears, hands, perineum, genitals, or any circumferential burn.
3. Provide adequate pain management, including pre-dressing pain relief, and allow time for pain relief to take effect.

4. Regularly review for signs of infection, depth of burn, and wound healing.
5. Investigate and address circumstances leading to the burn injury.

Burn assessment	Possible depth	Management
No blister or skin loss	Probable epidermal	▪ Apply moisturiser ▪ Monitor for blisters
Capillary return <3 seconds	Probable superficial or mid-dermal	▪ Give pain relief ▪ Dressing to provide a low adherent, moisture-controlled environment – silicone hydrocolloid or antimicrobial if concerns of infection
Capillary return <3 seconds or non-blanching	Possible deep or full-thickness	▪ Give pain relief ▪ Contact gp for initial referral to burns unit ▪ Dress with antimicrobial according to burns unit advice

Table adapted from ACI Clinical Guidelines for Burn Patient Management (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/250020/Burn-patient-management-guidelines.pdf) and HNELDH Community HealthPathways Burn Injuries (https://hne.communityhealthpathways.org/30027.htm).

Advice and referral

- Within NSW: Local Specialist Burns unit: insert number
- Outside NSW: Local Specialist Burns unit: insert number

Resources and references

- ACI Clinical Guidelines for Burn Patient Management (https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0009/250020/Burn-patient-management-guidelines.pdf)

Chronic Wound Management

Wound exudate

Consider

- Amount
- Consistency, colour, odour
- Peri-wound skin condition

Assessment

- Dry wound (no strikethrough)
- Minimal exudate (some strikethrough)
- Moderate exudate (strikethrough with leakage)
- Heavy exudate (strikethrough with leakage requiring > daily changes)

Intervention

- Dry: hydrogels, semi-permeable films, hydrocolloids
- Minimal: silicone, island dressings
- Moderate: calcium alginates, hydrofibres, foams
- Heavy: hydrofibres, foam sheet/cavity, extra absorbent dry dressings, wound/ostomy bags

Odour

Consider

- With or without infection
- Location (groin, skin folds)

Assessment

- Cause of odour
- Consider infective process

Intervention

- Charcoal
- Consider use of antimicrobial or antifungal product

Topical antimicrobials

Consider

- Signs and symptoms of inflammation and infection
- If the wound is not responding to evidence based treatment
- Increasing surface area despite best practice
- Positive swab results
- Length of topical treatment

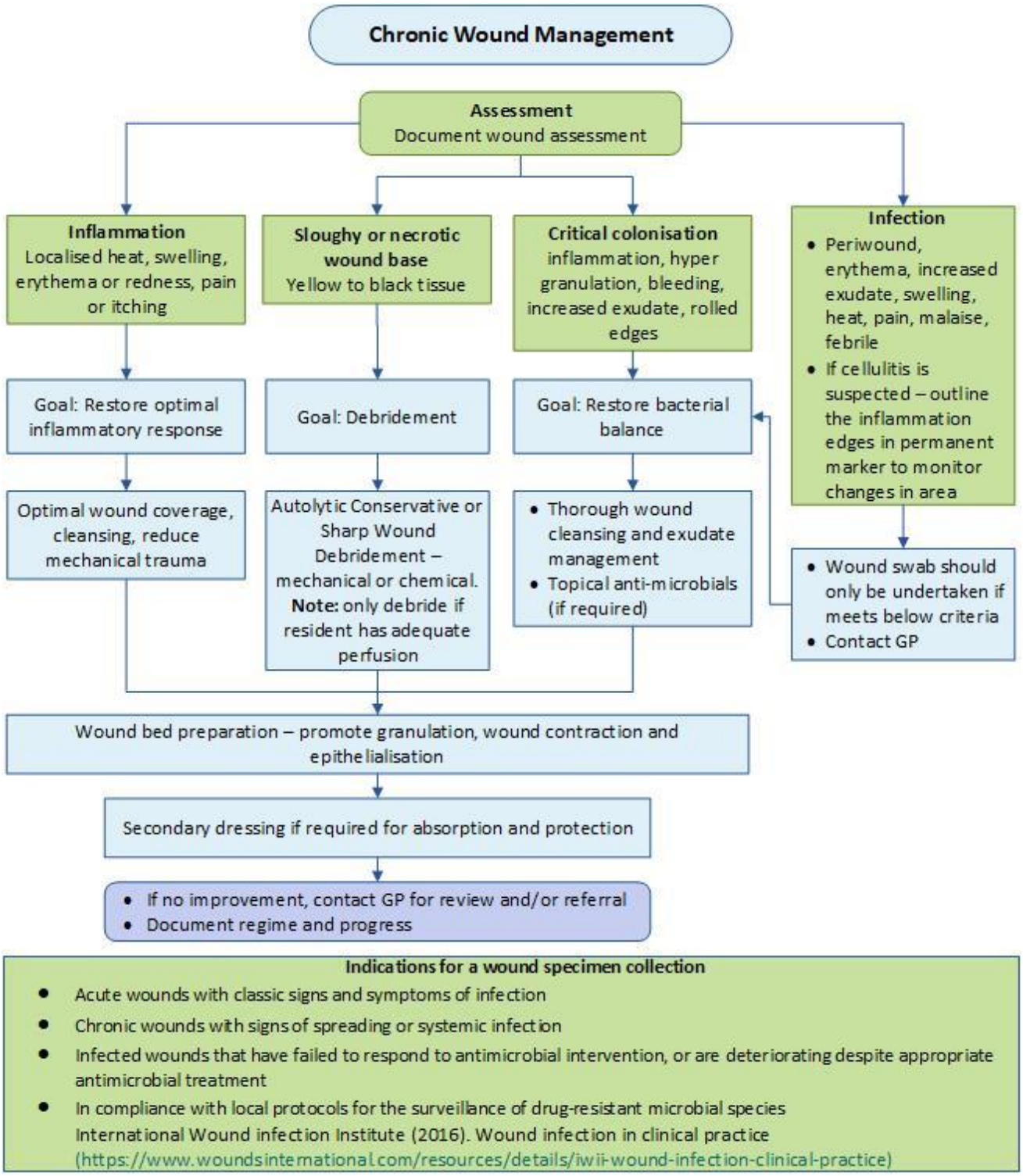
Assessment

- Clinical infection
- Inflammation or erythema
- Increase pain, exudate, odour, and oedema

Intervention

- Bacterial and fungi binding dressings
- Hypertonic saline dressings
- Cadexomer iodine powder/paste/sheet
- Antimicrobial gels
- Medical honey
- Antiseptic, and tulle gras with soft paraffin and 0.5% chlorhexidine acetate
- Silver impregnated dressings
- Referral to wound specialist

Chronic Wound Management Flowchart



Complex Draining Wound / Fistula

Assessment

- To determine the cause of the draining wound or fistula, conduct an assessment of the resident's:
  - medical and surgical history
  - amount, colour, and consistency of drainage

Goal of treatment

- Know origin of fistula
- Contain exudate

Intervention

- Where possible, treat cause of fistula which may include referral to specialist
- Use of ostomy appliances and accessories
- Absorbent dressings

Venous leg ulcer (VLU)

Characteristics and assessment of a VLU

- Resident history – previous venous leg ulcer, varicose veins, deep vein thrombosis (DVT), and dilated and distorted veins
- Dilated veins, ankle flare, location lower third of leg, presence of pulses, dorsalis pedis, and posterior tibial and popliteal
- Oedema
- Measure calf circumference (baseline)
- With or without cellulitis
- Reddish or brown pigmentation
- Hard, woody skin (lipodermatosclerosis)
- Firm and brawny skin
- Venous eczema
- Dry or wet itchy, scaly skin
- Leg appears as inverted champagne bottle shape
- Leaking oedema with pruritus, maceration and scale
- Leg may be warm and itchy
- Location (generally lower third of leg)
- Tissue on the wound bed is shallow
- Wound edges are mostly irregular and can be ragged
- Wound exudate can be moderate to heavy
- Moderate pain
- Exclude arterial disease before compression is started. Complete ankle brachial index (ABI) before compression
- Compression for ABI 0.8 to 1.2
- If ABI is 1.3 or greater, refer for toe pressures.

Goal of treatment

- Promote venous return
- Reduce oedema
- Prevent infection
- Heal the wound

Intervention

- Provide adequate pain management
- Educate resident and family regarding leg elevation, nutrition, exercise, and compression therapy and care of same
- Psychosocial support
- Correct elevation of the lower limb to reduce oedema
- Encourage calf muscle function through exercises
- Optimise nutrition and hydration
- Maintain skin hygiene of the limb
- Moisturise the limb
- Address venous eczema
- Cleanse the leg ulcer with appropriate cleansing agent
- Consider debridement of non-viable tissue (autolytic or conservative sharp wound debridement and serially if required by qualified person)
- Treat clinical infection
- Apply appropriate primary dressing, followed by appropriate secondary dressing and compression

Compression Therapy

After exclusion of arterial disease, or in collaboration with or direction of the vascular specialist consultant, compression therapy should be started as gold standard care. Options for compression include:

- Tubular form (to build tolerance)
- Multi-layer compression bandage systems (light, standard, 2, 3 and 4 layer)
- Compression hosiery
- Wrap garments, and
- Intermittent pneumatic pumps

Compression therapy should be applied by a trained professional and according to manufacturer's guidelines.

- Resident receiving compression therapy should be monitored closely for complications and to ensure tolerance and healing
- Review and consider referral to wound care specialist if not healing
- Maintain compression once healed to avoid recurrence
- Renew compression hosiery and wraps according to manufacturer's recommendations
- Consider donning and doffing abilities

Arterial leg ulcer (ALU)

Characteristics and assessment of ALU

- Severe pain may be experienced with arterial ulcers. Pain at rest, which may be worse at night (resident will often get relief positioning leg over bedside) or when leg is elevated. Pain may occur with exercise.
- Thin, shiny skin with minimal hair growth on leg
- Leg is straight with minimal shape
- Limb may be cool to touch
- Elevated lower limb is pale and dark red on return to dependant position
- Weak or absent foot and leg pulses
- Ulcers are usually punched out in appearance
- Ulcer have a pale wound bed (poorly perfused)
- Wound bed may contain necrotic tissue
- Minimal exudate unless infected

- Prone to infection
- Located on the lower limb and feet
- With or without gangrene

Goal of treatment

- Prevent infection
- Promote comfort
- Vascular referral where indicated
- Heal wound

Intervention

- Vascular consult if required
- Consider specialist wound care consult
- Smoking cessation support
- With or without antimicrobial if infection present
- Simple dry dressing, gently secure secondary dressing
- Protect from pressure
- Avoid extreme temperature
- Skin care

Atypical leg ulcers

An atypical leg ulcer can be suspected if the wound has an abnormal presentation or location and pain out of proportion to the size of the wound and does not heal within 4 to 12 weeks with an evidence-based treatment plan.

Characteristics and assessment of atypical leg ulcers

- Very painful (out of proportion to the size of the wound)
- Prolonged duration (no reduction in surface area in 4 weeks with evidence-based treatment plan)
- Presence of hyper-granulation
- Review pathology and medical history e.g. history of trauma, sun exposure, or rheumatoid arthritis
- Purple hue to the border
- Undermined borders
- Necrosis
- Atypical location, different from venous ulcer which is usually located in gaiter area between the ankle and the calf, or arterial ulcer which is often located on foot, ankle, or lower leg

Goal of treatment

- Prompt diagnosis

Interventions

- Prompt referral for precise diagnosis
- Pain management
- Interdisciplinary team collaboration
- Wound product selection should be based on optimising the wound environment with consideration to products which provide protection from additional trauma and pain

Diabetic foot ulcer (DFU)

Characteristics and assessment of DFU

- Location - plantar ulcers are located on the foot including toes and both dorsum and plantar surfaces
- Punch out appearance
- Round, dry wound
- Bgl levels and circulation compromise
- With or without cellulitis
- With or without gangrene
- Often not painful
- Often on high pressure area
- Often heavy callus on the peri-wound skin

Goal of treatment

- Off-load plantar pressure
- Prevent infection
- Avoid amputation

Intervention

- Foam dressings to offload pressure
- Education on foot or nail care
- Podiatry or high risk foot clinic
- Correct foot wear

Malignant Wounds

Characteristics and assessment of malignant wounds

- History of malignancy
- Odour
- Excessive granulation tissue of the wound bed and/or the wound edges
- Can be atypical leg ulcer location
- Change in appearance of a chronic ulcer (size, hypertrophic wound edges)
- Irregular wound borders
- With or without increasing wound pain
- Bleeding, fragile tissue
- Referral for biopsy

Goal of treatment

- Confirmed diagnosis
- Promote comfort and quality of life
- Decrease odour
- Control exudate
- Prevent and control bleeding
- Resident goals determined

Intervention

- Maintaining good wound cleansing
- Infection and odour:
  - metronidazole gel
  - Medihoney
  - tea bags between primary and secondary dressings
  - stoma accessories used for odour management applied to the outside of the secondary dressing only
  - broad spectrum room deodorisers e.g. Hos-Togel
- Odour: charcoal dressings
- Exudate management: highly absorbent pads, foams
- To control active bleeding, consider calcium alginate dressing, e.g. Kaltostat
- Occlusive dressings are contraindicated for wounds with anaerobic infections
- Consider referral for palliative radiation for fungating wounds
- O'Brien C. Malignant wounds: managing odour (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3303648/). Can Fam Physician. 2012;58(3):272–e143.

Pressure Injuries

Assessment

- Location
- Stage
- Duration of injury
- Pain score
- Risk assessment score
- Support surface required
- Nutrition
- Contamination risk
- Continence assessment

Goal of treatment

- Reduce pressure and shear, through offloading, bed positioning, and correct manual handling techniques and equipment
- Prevent infection
- Promote healing

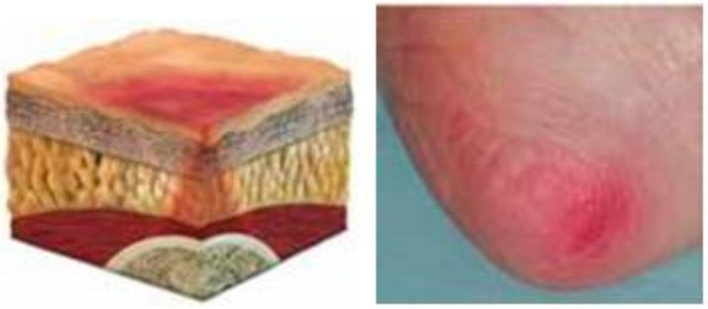
Intervention

- Refer to Pressure injury Flowchart
- Pressure offloading and redistributing devices, such as cushions, mattresses and heel protectors
- Repositioning resident
- With or without debridement
- Moist wound dressings
- With or without antimicrobial if indicated
- Nutritional support

Pressure Injury Stages

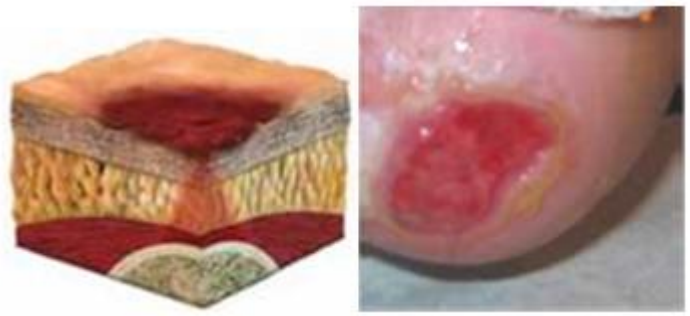
Stage 1 pressure injury: non-blanchable erythema

- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area, may be difficult to detect with dark skin tones.
- The area may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. This is a heralding sign which may indicate the resident is “at risk”.



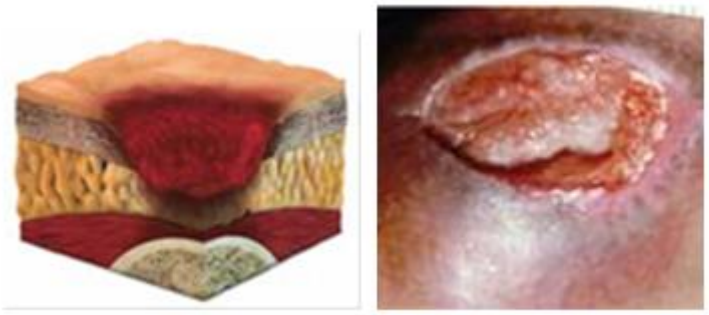
Stage 2 pressure injury: partial thickness skin loss

- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (**note**: bruising indicates suspected deep tissue injury).
- Stage 2 PIs should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.



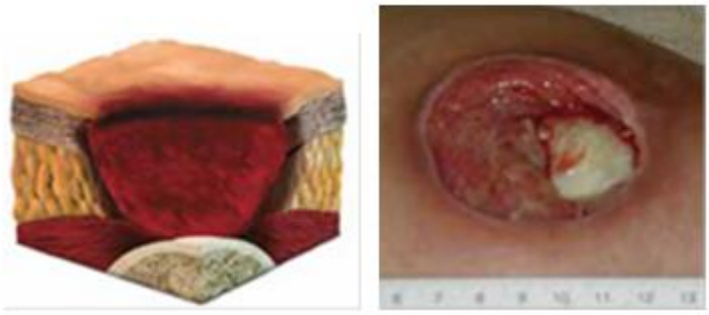
Stage 3 pressure injury: full thickness skin loss

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed.
- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a stage 3 PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage 3 PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage 3 PIs. Bone or tendon is not visible or directly palpable.



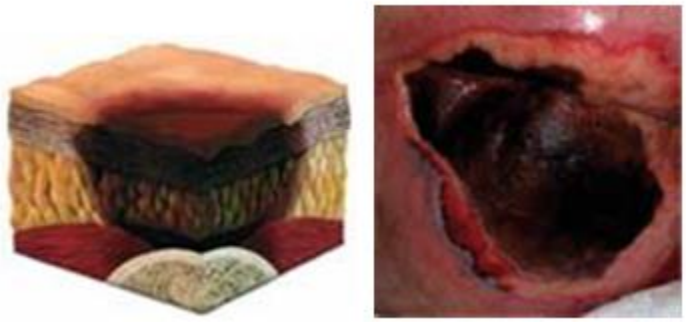
Stage 3 pressure injury: full thickness tissue loss

- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage 4 pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage 4 PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone, tendon visible or directly palpable.



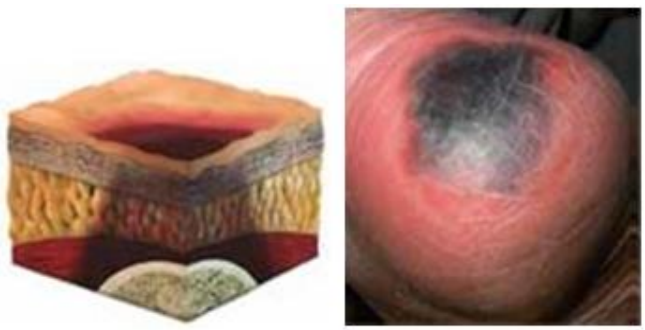
Unstageable pressure injury: depth unknown (treated as stage 4)

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.

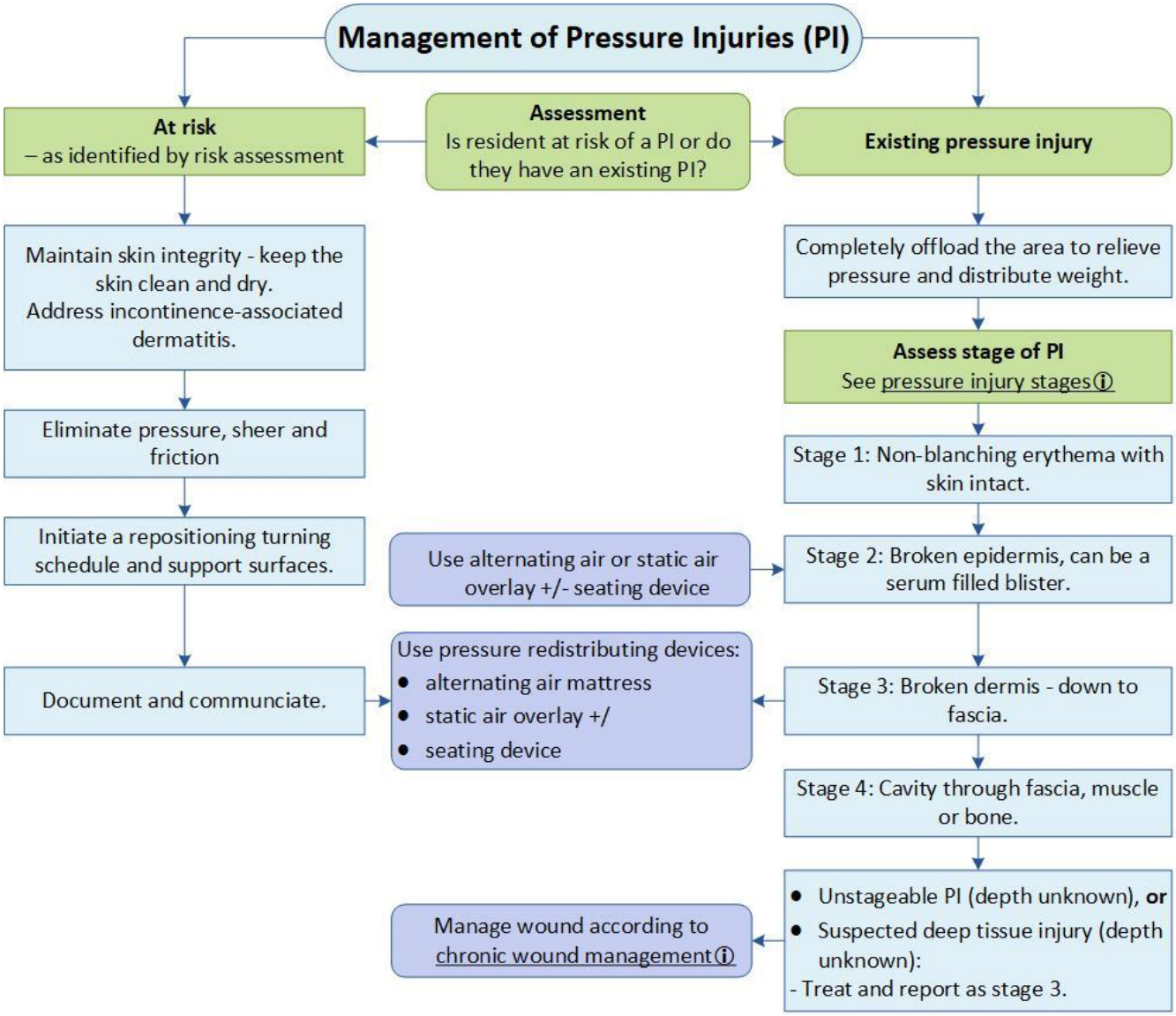


Suspected deep tissue injury: depth unknown (treated as stage 4)

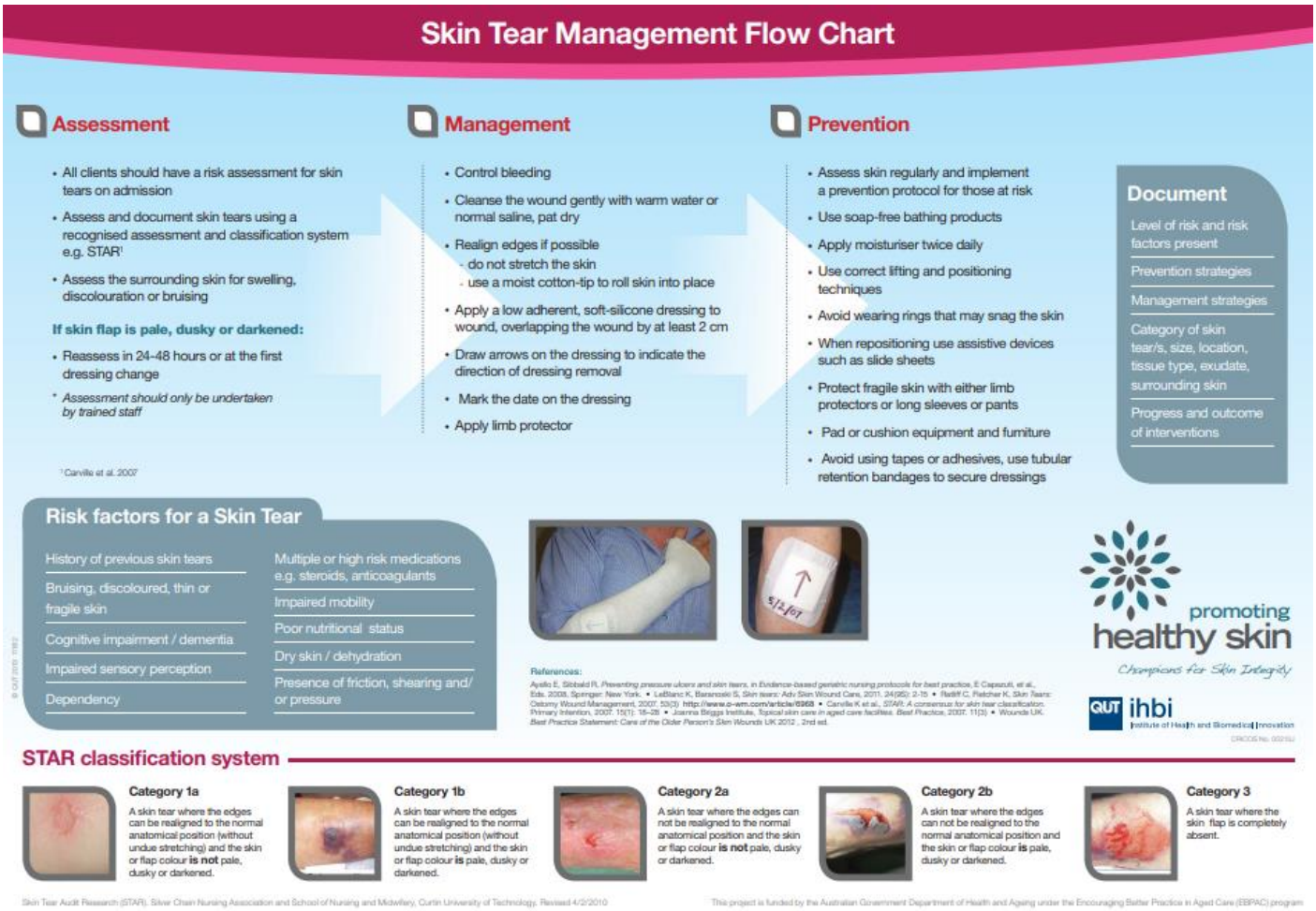
- Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.
- Deep tissue injury may be difficult to detect in individuals with dark skin.
- Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.



Pressure Ulcers Flowchart



Skin Tears



Above Skin Tear Management Flow Chart (https://cms.qut.edu.au/__data/assets/pdf_file/0009/451764/flow-chart-skin-tear-management.pdf) developed by Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010.

Further Information

References and resources

- Clinical Excellence Commission (CEC) Pressure Injury Prevention (http://www.cec.health.nsw.gov.au/patient-safety-programs/adult-patient-safety/pressure-injury-prevention-project).
- O'Brien C. Malignant wounds: managing odour (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3303648/). Can Fam Physician. 2012;58(3):272–e143.
- Skin Tear Management Flow Chart (https://cms.qut.edu.au/__data/assets/pdf_file/0009/451764/flow-chart-skin-tear-management.pdf) developed by Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010.
- Wounds Australia https://www.woundsaustralia.com.au/Web/Resources/Web/Resources/Resources_Home.aspx?hkey=0e7a80cc-f5ff-4c86-80c3-4c18c173e42d
- Wounds International https://www.woundsinternational.com/

Acronyms

ABS	Antibiotics
ACFI	Aged Care Funding Instrument
ACE	ACE Aged Care Emergency
AEDs	Anti-epileptic drugs
ACP/ACD	Advanced Care Plan/Advanced Care Directive
ASET nurse	Aged Care Services in Emergency Teams
ASSIST	Acute Screening of Swallow in Stroke/TIA
AVPU	Acronym to assess level of consciousness: Alert, Verbal – responds to voice stimulation, Pain – responds to pain, Unresponsive.
BD	Twice a day
BGL	Blood glucose level
BP	Blood pressure
BPSD	Behavioural and psychological symptoms of dementia
CAM	Confusion Assessment Method
CCF	Congestive Cardiac Failure
CNC	Clinical Nurse Consultant
CAPAC	Community Acute/Post-Acute Care
CMA	Comprehensive Medical Assessment
COPD	Chronic obstructive pulmonary disease
CPR	Cardiopulmonary resuscitation
DKA	Diabetic ketoacidosis
DSA	Dementia Support Australia
JHH	John Hunter Hospital
CT	Computed tomography
CSU	Catheter specimen of urine
DBMAS	Dementia Behaviour Management Advisory Service
DVT	Deep vein thrombosis
ED	Emergency Department
ECP	Extended Care Paramedics
EpiPen	Epinephrine auto-injectors
F.A.S.T.	The acronym for assessing stroke: Facial drooping, Arm weakness, Speech difficulties, and Time to act
GCS	Glasgow Coma Scale

GP	General practitioner
GTN	Glyceryl trinitrate
HITH	Hospital in the home
HR	Heart rate
Hx	History
ICT	Information communication technology
IDC	Indwelling catheter
IM	Intramuscular
ISBAR	Identify, Situation, Background, Assessment and Recommendation – A mnemonic when providing clinical handover of information during the transfer of care.
ISBAR4AC	Identify, Situation, Background, Assessment and Recommendation for aged care
IV	Intravenous
kg	Kilogram
LOC	Level of consciousness
Mane	Morning
mmol/L	Millimoles per litre
Nocte	At night
NP	Nasal prong
NPWT	Negative pressure wound therapy
MC & S	Microscopic culture and sensitivity
MHCC	Mental Health Contact Centre
MOLST	Medical Order for Life-Sustaining Treatment
MRI	Magnetic resonance imaging
MSU	Mid-stream urine
OPMHS	Older Persons Mental Health Service
PAINAD	Pain assessment in advanced dementia
PEG	Percutaneous endoscopic gastrostomy
PHU	Public Health Unit
PI	Pressure injury
PRN	As necessary
RACF	Residential aged-care facility
RMMR	Residential Medication Management Review
SDH	Subdural haematoma
SBRT	Severe Behaviour Response Team
SDCT	Specialist Dementia Care Program
SCI	Spinal cord injury

SOB	Shortness of breath
SPC	Suprapubic catheter
SpO2	Peripheral oxygen saturation in the blood
S/L	Sublingual
Subcut	Subcutaneous fluids
TIA	Transient ischaemic attack
Trachy	Tracheostomy
U/A	Urinalysis
URTI	Upper respiratory tract infection
UTI	Urinary tract infection
VLU	Venous leg ulcer

Evaluation of the Service / Publications

- Conway J, Dilworth S, Hullick C, Hewitt J, Turner C, Higgins I. A multi-organisation aged care emergency service for acute care management of older residents in aged care facilities. *Australian Health Review* 2015, 39, 514-516.
- Conway J, Dilworth S, Hullick C, Hewitt J, Turner C, Higgins I. Nurse-led ED support for Residential Aged Care staff: An evaluation study. *International Emergency Nursing* 2015, 23 (2) 190-196.
- Conway J, Higgins I. The Implementation of a Nurse Led Model of Care for older people in the Emergency Department at John Hunter Hospital (Final report ED study.pdf).
- Stokoe A, Hullick C, Higgins I, Hewitt J, Armitage D, O'Dea. Caring for acutely unwell older residents in residential aged care facilities: Perspectives of staff and general practitioners, *Australian Journal of Ageing*. Published ahead online 9 Jun 2015 DOI: 10 1111/ajag.12221.
- Briggs S, Pearce R, Dilworth S, Higgins I, Hullick C, Attia J. Clinical pharmacist review: A randomised controlled trial, *Emergency Medicine Australasia*. 2015 27 (5) 419-426.
- Kable A, Chenoweth L, Pond D, Hullick C. Health professional perspectives on systems failures in transitional care for residents with dementia and their carers: a qualitative descriptive study. *BMC Health Services Research*. 2015. 15:567.

Forms

1. NSW Ambulance Authorised Adult Palliative Care Plan
2. Acute Screening of Swallow in Stroke/TIA (ASSIST)
3. The Confusion Assessment Method Instrument (CAMI)
4. Health Summary and Medical Orders for Life-Sustaining Treatment (MOLST)

Insert name of local forms and location of documents

NSW Ambulance Authorised Adult Palliative Care Plan

NSW Ambulance excellence in care

INSTRUCTION SHEET

NSW Ambulance Authorised Adult Palliative Care Plan

NSW Ambulance Authorised Palliative Care Plans (APCP) were developed to enable paramedics to provide individualised care to a patient, who has a life-limiting illness. The APCP will provide paramedics with the plan which has been developed by the medical practitioner in consultation with the patient and/or their person responsible. In order for the paramedic to follow the APCP it must be endorsed by NSW Ambulance. If the APCP is not endorsed, delay in the provision of the required treatment may result. Authorised Care Plans are only processed Mon – Fri (No Public Holidays)

Process for Endorsement

1. The form may be completed by either nurse of medical practitioners. Both medical and nurse practitioners may complete the medications and treatment options section of page 1. Medical practitioners only can complete the resuscitation status section of page 1.
2. In cases where the APCP is completed solely by a medical practitioner, one signature from the medical practitioner only is required on page 3. In cases where the APCP is jointly completed by a nurse practitioner and a medical practitioner both practitioners must sign their respective sections on page 3.
3. All fields must be completed and legible. Failure to complete the form legibly will result in the plans being returned to the author.
4. The completed form must be emailed to AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or faxed to (02) 9320 7380 for NSW Ambulance endorsement.
5. Completed form is reviewed by NSW Ambulance and endorsed. If information is unclear or incomplete, the form may be returned to the author and will result in processing delays.
6. Completed form with a covering letter will be mailed back to the address indicated on the form (this can take up to 10 business days). If the patient/family agrees, the endorsed APCP can be emailed directly to the nominated email address in lieu of post. This will facilitate more timely access to the endorsed APCP. A copy of the endorsed APCP will also be emailed or faxed to the medical practitioner.

N.B. please notify NSW Ambulance if the APCP is no longer required or if the patient dies.
APCPs remain valid for 12 months, after this time paramedics may not be able to follow the plan.

Paramedics carry a limited supply of routine medications (see list below). If the patient requires other medications to be administered to help manage symptoms, these medications must be available in the patient's residence.

Paramedics are not able to access medications that are in a locked medication safe in a residential aged care facility (RACF) if the registered nurse is not available.

Qualified Ambulance Paramedics			
Adrenaline	Aspirin	Benzyl Penicillin	Clopidogrel
Compound sodium lactate	Droperidol	Enoxaparin Sodium	Fentanyl
Fexofenadine	Glucagon	Glucose Gel	Glucose 10%
Glyceryl Trinitrate	Ibuprofen	Ipratropium Bromide	Methoxyflurane
Metoclopramide	Midazolam	Morphine	Naloxone
Ondansetron	Oxygen	Paracetamol	Salbutamol
Tenecteplase			
Advanced Life Support and Intensive Care Paramedics Only			
Amiodarone	Atropine	Calcium Gluconate	Frusemide
Ketamine	Lignocaine	Sodium Bicarbonate	

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

Version 1.3 – 8 May 2019

NSW Ambulance excellence in care

Authorised Adult Palliative Care Plan

NSW Ambulance Trim Number:	NSW Ambulance Document Number:

Patient's Details:	New APCP Patient ☐	Existing APCP Patient ☐
Surname:	Given Name:	Date of Birth: (DD/MM/YYYY) Sex: Male ☐ Female ☐ Other ☐
Street No. & Name		Home Ph: Mobile:
Suburb:		Postcode:
Safety Issues at home: Yes ☐ No ☐ (If yes, please provide details)		
Language:	Interpreter required: Yes ☐ No ☐	Dialect:
Is the patient Aboriginal or Torres Strait Islander? Yes ☐ No ☐ Prefer not to say ☐		
If patient is a hospital inpatient	Hospital Name:	MRN:

This section may be completed by a Medical or Nurse Practitioner

As required medications to be administered to manage symptoms (if required please add extra list)					
Medication	Dose	Route	Frequency	Indication/s	Max 24 hour dose

Treatment Options

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

Respiratory Support: (Check box if appropriate)	Are other non-urgent interventions appropriate? Yes ☐ No ☐
Pharyngeal Suction ☐ Supplemental oxygen ☐ Bag & Mask Ventilation ☐ Intubation ☐	If yes (please check the appropriate interventions): Vascular access ☐ IV Fluids ☐ IV Antibiotics ☐

THIS SECTION MUST BE COMPLETED BY A MEDICAL PRACTITIONER

RESUSCITATION STATUS

In the event of cardiopulmonary arrest: CPR ☐ NO CPR ☐

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

FOR NSWA USE ONLY:	Date of Receipt:	Renewal Date:
	TRIM NUMBER: PT /	DOCUMENT NUMBER:
Endorsed by Name:		
Signature:		Date:
Position		

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

NSW Ambulance Trim Number:	NSW Ambulance Document Number:
Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

LOCATION OF CARE

In the event that care at home becomes too difficult, the choice for future care is at:

_____

How to arrange admission to this location: _____

Whilst every effort to accommodate the patient's preference, NSW Ambulance will review the desired location of care at the time of attending the patient, distances and travelling times will be factored into the destination decision.

PATIENT'S CLINICAL HISTORY (Please print clearly – Attach additional pages if required)

Diagnosis:

History:

Goals of Care:

Is the patient known to a Palliative Care Service: Yes ☐ No ☐ (if yes, please specify)

Allergies:

PATIENT'S CURRENT MEDICATIONS

Drug Name	Dose	Route	Frequency	Indication

MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE THE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body & complete the MCCD?

Yes ☐ No ☐ Comment:_____

Can you be contacted after hours? Yes ☐ No ☐

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours, if the death is not a reportable death under the Coroners Act 2009? Yes ☐ No ☐

Medical Practitioner Completing MCCD details:

A/H or Mobile (if available): _____ Surgery Ph: _____

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

NSW Ambulance Trim Number:	NSW Ambulance Document Number:
Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

CONTACT LIST

Team	Name	Business Hours Contact	After hours contact
General Practitioner			
Palliative Care			
Primary Care Team			
Community Nurse			
Other Health Service			
Spiritual/Religious Supports			

To facilitate more timely return of Authorised Care Plan please provide an email address. (If no email address is provided the endorsed plan will be mailed to the person indicated below):

Email Address:

Name of Recipient:

Relationship of recipient to patient:

PERSON RESPONSIBLE (PLEASE PRINT CLEARLY)

Surname:	Given Name:

Relationship: Enduring Guardian ☐ Family Member ☐ Other ☐

Address:

Contact Number:

Language: Interpreter: Yes ☐ No ☐

Patient's & or Person Responsible's Acknowledgement of this Plan Declaration

As the treating clinician I can confirm that I have discussed this plan with the patient and/or their person responsible. The treatment directives contained within are consistent with the patient's treatment goals	Yes: No:

NURSE PRACTITIONER DETAILS

Name:	Contact Number:
Provider Number:	After-hours contact:

Organisation/Practice Name & Address:

Email:

As the nurse practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements

Signature:	Date:

MEDICAL PRACTITIONER DETAILS

Name:	Contact Number:
Provider Number:	After-hours contact:

Organisation/Practice Name & Address:

Email:

As the medical practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements

Signature:	Date:

Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

ASSIST – Acute Screening of Swallow in Stroke/TIA

MRN No.

Name: .....

Address: .....

Date of Birth: Sex:

Please fill in if patient label is unavailable

Print name & profession: _____

_____

Signature: _____

DATE ☐☐/☐☐/20☐☐ Time of Assessment: ☐☐:☐☐ (Please use 24 hour clock time)

Pre-Screening: Check patient has had CT and no haemorrhage.
Check if NESB

1. Is the patient able to:-
   - Maintain alertness for at least 20 minutes? Yes ☐ No ☐
   - Maintain posture/positioning in upright sitting? Yes ☐ No ☐
   - Hold head erect? Yes ☐ No ☐

STOP HERE if you answered NO to ANY part of Q1. Place patient Nil by Mouth and review when conditions improves. NG recommended for medications.

2. Does the patient have any of these?
   - Suspected brainstem stroke (Check file) Yes ☐ No ☐
   - Facial weakness/droop (Check smile, pout, nasolabial fold) Yes ☐ No ☐
   - Slurred/absent speech (Engage in conversation) Yes ☐ No ☐
   - Coughing on saliva Yes ☐ No ☐
   - Drooling (Check corner of mouth, chin) Yes ☐ No ☐
   - Hoarse/absent voice (Engage in conversation) Yes ☐ No ☐
   - Weak/absent cough (Ask to cough) Yes ☐ No ☐
   - Shortness of breath Yes ☐ No ☐
   - Pre-existing swallowing difficulty (Check file, ask family) Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q2. Place patient Nil by Mouth and refer to Speech Pathology on Page xxxxx.

3. Test the patient with a sip of water and observe:
   - Any coughing/throat clearing Yes ☐ No ☐
   - Change in vocal quality Yes ☐ No ☐
   - Drooling Yes ☐ No ☐
   - Change in respiration/shortness of breath Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q3. Place patient Nil by Mouth and refer to Speech Pathology on Page xxxxx.

4. Observe the patient drink a cup of water:
   - Any coughing/throat clearing Yes ☐ No ☐
   - Change in vocal quality Yes ☐ No ☐
   - Drooling Yes ☐ No ☐
   - Change in respiration/shortness of breath Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q4. Place patient Nil by Mouth and refer to Speech Pathology on Page xxxxx.

5. Commence premorbid oral diet
   - Nursing staff to observe patient with first meal
   - Staff Member reviewing first meal: _____

Time: _____ Date: _____

A spike in temperature and/or deterioration in chest condition may indicate silent aspiration. Place patient NBM and refer to Speech Pathology on Page xxxxx.

Managers of Greater Metropolitan Speech Pathology Services in NSW Health – Stroke Dysphagia Framework *April 2004*
Endorsed by GMCT Stroke Committee June 2004

HUNTER NEW ENGLAND AREA HEALTH SERVICE

Facility _____

THE CONFUSION ASSESSMENT METHOD INSTRUMENT (CAMI)

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
DOB	M.O.

HOSPITAL / WARD

HNEMR52

HNE020500

Feature 1. Acute onset and fluctuating course

This feature is usually obtained from a family member or carer and is shown by positive responses to the following questions:

Is there evidence of an acute change in mental status from the patient's baseline?

Did the (abnormal) behaviour fluctuate during the day, that is, tend to come and go, or increase and decrease in severity? **Yes** ☐ **No** ☐

Feature 2. Inattention

This feature is shown by a positive response to the following question:

Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what is being said? **Yes** ☐ **No** ☐

Feature 3. Disorganised thinking

This feature is shown by a positive response to the following question:

Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? **Yes** ☐ **No** ☐

Feature 4. Altered level of consciousness

This feature is shown by an answer other than "alert" to the following question:

Overall, how would you rate this patient's level of consciousness?

- ☐ Alert [normal]
- ☐ Vigilant [hyperalert]
- ☐ Lethargic [drowsy, easily aroused]
- ☐ Stupor [difficult to arouse]
- ☐ Coma [unarousable]

The diagnosis of delirium requires the presence of:
Features 1 and 2 and Either Feature 3 or Feature 4

☐ **1** ☐ **2** ☐ **3** ☐ **4**

If delirium indicated notify Medical Officer as soon as possible and document finding and referral details in the clinical notes.

Sign: _____ Print Name: _____

Desgination: _____ Date: _____

Reference: Inouye, S. K. 1990. Clarifying Confusion: The Confusion Assessment Method. Annals of Internal Medicine 113(12) 941-948.

07/08 (July 2008)

BINDING MARGIN - DO NOT WRITE

THE CONFUSION ASSESSMENT METHOD INSTRUMENT (CAMI)

Investigation

Health Summary and Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST evidence base

The MOLST was adapted from the American POLST form as part of a Commonwealth funded Dementia End of Life Care Project. The MOLST was originally identified as an appropriate advance care planning document for people living in RACF with advanced dementia.

MOLST purpose

Two key advance care planning process gaps were identified during the Dementia EOL care project:

1. RACF undertaking advance care planning (ACP) were unsure when to follow ACP documents. Staff were unsure of the duty of care response for residents who were declining. The advance care plan may have documented a palliative approach preference, but there was no medical documentation to support the resident remaining at home.
2. RACF residents who presented to ED with ACP documentation in place were not explicit enough for ED staff to be able to make an informed treatment decision for life sustaining treatment initiation when declining residents were transferred from RACF.

www.acem.org.au/media/ACEM_Submission_-_NSW_Health_End_of_Life

The MOLST was identified as an evidence based option to align resident preferences with a supporting medical order re life sustaining treatment initiation. MOLST forms are different in that they are signed medical orders that try to encompass advance wishes of the resident and come up with a medically authorised plan of treatment. As such they are more like no CPR orders than advance directives.

MOLST Population

The MOLST is appropriate for people with advanced chronic disease /dementia who have a **projected life expectancy of 12 months or less**. Identifying this population is based on the recommendations from the Prognostic Indicator Guidance tool from the NHS

1. Asking 'Would I be surprised if this person died in next 12 months?'.
2. Presence of prognostic indicators and advanced disease classification.

The MOLST is **not recommended** for people with a projected life expectancy of greater than 12 months.

Legal status of MOLST

Unlike other States and Territories in Australia, NSW does not have a mandated advance care planning document.

While the legal status of ACD's is uncertain, the legal status of a medically authorised plan of treatment that states clearly the facts and wishes it is based on should be quite clear. Common law demands that residents are treated to a certain standard of care, and this may conflict with an ACD - hence the legal uncertainty. MOLST appears to get round this by certifying that the general practitioner agrees that the course of treatment meets the standard of care as well as being consistent with the resident's wishes.

The MOLST form is designed for use in the RACF /community setting and to provide medically supported treatment guidance in the Emergency Department environment. The MOLST has been designed to work within NSW Health end of life guidelines (see end of this paper). The MOLST contents need to be reviewed and re documented on transfer /admission to an acute care facility.

GP / Medical Officers who sign a MOLST form have a legal responsibility to ensure that the MOLST contents have been consented to by the resident or their person responsible. This means the GP / Medical Officer has discussed and clarified the MOLST document with the resident /person responsible before signing the MOLST. The name of the person providing MOLST consent must be documented on the MOLST form.

There are limited end of life care treatment rulings in NSW. The MJA article titled 'A defence of the requirement to seek consent to withhold and withdraw futile treatments' provides a summary overview of end of life treatment legal decisions in Australia to date.

NSW Health guidelines that address end of life issues:

CPR decisions relating to No cardiopulmonary resuscitation orders

A 'No CPR order' is a medical order to withhold cardiopulmonary resuscitation techniques. As a contemporaneous medical order, it has similar authority to other medical treatment orders where compliance by other health professionals is, by and large, required and brings certain legal protections to health professionals following such orders.

Doctors prescribing medical orders, including 'No CPR orders', hold responsibility for reaching those decisions, in consultation with residents. Where the resident does not have decision-making capacity, doctors are generally required to consult with the 'person responsible' and obtain consent for the provision of medical treatments.

Advance Care Directives (Using)

Where a health professional conducts discussions about end of life care, it is best if they are someone who is identified as significantly involved in active care of the person and can discuss prognostic information in clear terms.

Authority – An advance care directive that complies with the requirements set out in this document is legally binding in NSW, and functions as an extension of the common law right to determine one's own medical treatment. A failure to comply with such an advance care directive refusing a particular treatment may result in the health professional incurring criminal or civil liability for providing that treatment.

End of life care and decision making

Appropriate end-of-life care should intend to provide the best possible treatment for an individual at that time. It recognises that if the goals of care shift to primarily accommodate comfort and dignity, then withholding or withdrawal of life-sustaining medical interventions may be permissible in the best interests of the dying resident.

In order to preserve the trust of those receiving health care, and to ensure that decisions are fairly made, the decision-making process and its outcomes should be clear to the participants and accurately recorded.

Health professionals are under no obligation to provide treatments that, in the circumstances, are unreasonable, in particular, those that offer negligible prospect of benefit to the resident.

HNELHN / NGO Collaborative Community Health Initiative

Health Summary

- for transfer and unplanned medical reviews

Resident / patient identification details or identification label

Refer to this form before making hospital transfer arrangements. Check back of form for specific medical care orders. Inform reviewing Doctors/ After Hours GP of the contents of this form. Send a copy of this form with patient/resident if transferred to hospital or another aged care service.

H1 **Primary Diagnosis & reason for transfer / unplanned medical review:**

Existing System / Organ Co-morbidities - Mark *shaded* check box for existing co-morbidities.

H2

Identify advanced disease states with an **A** in the second check box (*refer to Prognostic Indicator Guide for advanced disease indicators* http://www.goldstandardsframework.nhs.uk/Resources/Gold%20Standards%20Framework/PrognosticIndicatorGuidancePaper.pdf)

Cardiac			**GIT / Liver**			**Cancer**			**Neurodegenerative ***		
Stroke / TIA			**Diabetes**			**Frailty**			**Dementia**		
Respiratory			**Renal**			**Other ***					

*Other co-morbidities /descriptors

Existing artificial support therapies: (Identify type)

Dialysis: Cardiac device:

NIV(CPAP/BIPAP): Infusion therapy:

Prognostic symptoms over past 6 months *(tick all that apply)*

H3

>10% weight loss in past 6 months		Recurrent infections / fevers	
Heavily dependant in most ADL's		Short of breath minimal exertion	
Urinary / faecal incontinence		Repeated hospital admissions	
Swallowing problems / difficulties		Repeated ED presentations	

H4 Have there been advance care planning discussion/s with the patient / person responsible and significant others? **YES / NO**

Where are ACP discussions documented and filed?

In discussion with the person / substitute decision maker, the goal of medical treatment for this person with their existing condition/s is: (*tick most appropriate option)*

H5

- ☐ Aim to extend life for as long as possible with available and offered medical treatment.
- ☐ Accept natural dying –maximise comfort and symptom relief with available medical treatment.

What level of medical response has been consented to? *(tick most appropriate option)*

H6

- ☐ Accept any offered interventional treatment that aims to delay dying – **transfer to hospital** - NO MOLST
- ☐ Agree to defined medical care as documented in the MOLST section on reverse of page
- ☐ Accept natural dying and palliative care as documented on MOLST on reverse of page

Name and contact number/s of a 'person responsible' for medical consent

H7

Name	Name
Contact Number/s	Contact Number/s

Name and contact number of Healthcare Professional completing this form

H8

Print Name: _____

Signature: _____

Date: _____ Contact number: _____

Healthcare Professional Designation:

HNELHN / NGO Collaborative Community Health Initiative

Medical Orders
for Life-Sustaining Treatment (MOLST)

Resident / patient identification details or identification label

First follow these orders, **then** contact Doctor/RN. This is a Medical Order document is completed only for people with a limited life expectancy of less than 2 years due to advanced disease and/or frailty.
Any section not completed implies full treatment for that section in acute care services.

M1

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse or response or is not breathing. *(CPR is not recommended in frail, older people with advanced chronic illness)*

☐ **Attempt CPR - aim** to prolong life ☐ **Do not attempt CPR-** accept natural dying

When not in cardiopulmonary arrest, follow orders in **M2**, **M3** and **M4**.

M2

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **Limited Life Sustaining Interventions** Use medical treatment, IV fluids and medications and cardiac monitor as medically indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation for person's irreversible condition/s. **Transfer** to hospital if indicated. **Avoid** admission to critical care units where possible. Includes care as described below.

☐ **Palliative care during natural dying** Use medication by any route (subcutaneous or oral preferred), positioning, wound care and other measures to relieve pain and distress. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. **Transfer** to appropriate clinical facility if comfort/palliation needs cannot be met in current location.

M3

ANTIBIOTICS

☐ Accept hospital transfer for IV antibiotic therapy - aimed at prolonging life

☐ Use antibiotics to promote comfort and relieve distress only - avoid hospital transfer.

M4

ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION:

☐ Accept transfer to hospital for artificial nutrition (NG or PEG) or hydration (IV) therapy.

☐ Use oral routes only for hydration purposes where swallowing permits - avoid hospital transfer.

M5

Consent to MOLST defined treatment obtained from:

Name: _____ Name: _____

Signature: _____ Signature _____

Relationship to patient: ***Self:*** ☐ ***Person responsible:*** ☐ ***(1. Guardian: 2.Spouse: 3. Carer: 4. Family/friend)***

Contact Number/s: _____ mobile: _____

M6

Medical Officers Signature:

Name: _____

Signature: _____ Date: _____

Contact Number:

M7	**Review Date/s**			

M8

REVOKING THIS MEDICAL ORDER
If medical orders re life sustaining treatment changes, please cross through these orders and write VOID in clearly legible format on both sides of form. Medical Officer must sign and date the voided MOLST section. MOLST section should be clinically reviewed post-acute and/or hospital episode.

SEND THIS FORM WITH ALL PERSON'S TRANSFERRED BETWEEN AGED and ACUTE CARE SECTORS TO ENSURE THAT CONSENT FOR LIFE SUSTAINING TREATMENT IS COMMUNICATED

MOLST: Version 9 – Nov.2013 -Adapted by Lisa Shaw - Project Offcier and Jacqui Culver - Nurse Practitioner -Palliative Aged Care, Hunter New England Health from the POLST paradigm; Centre for Ethics in Health Care, Oregon Health & Science University (2008).
Contact LisaK.Shaw@hnehealth.nsw.gov.au or jacquiculver@hnehealth.nsw.gov.au for MOLST resources or further information.

Manual Consultation and Clinical Editors

This manual has been revised and adapted from the original document developed by The Aged Care Triage (ACT) Service, Aged Care and Rehabilitation Services Concord Hospital SSWAHS, 2008. The original document was prepared by Anthea Temple Aged Care CNC as part of the Older Persons and Aged Care Clinical Re-design Project.

Below is a guide to the services, Streams, and Networks consulted in the development of this document. When adapting this manual for use within your own Local Health District (LHD), please ensure that you consult the experts and gain approvals via your LHD local processes.

We would also like to acknowledge the contributions from Residential Aged Care staff across HNELHD who were personnlly consulted or participated in workshops to contribute their expert knowledge

	Approved	Reviewed	Reviewed
Aged Care Emergency Operational Committee			
Aged Care and Rehabilitation Services	Nov-13	Jul-16	Jan-20
Aged Care Services in Emergency Teams (ASET)	Nov-13	Jul-16	Jan-20
John Hunter Hospital, Tamworth Rural Referral Hospital, Armidale Hospital, Belmont Hospital, Calvary Mater Hospital Newcastle, The Maitland Hospital, Manning Rural Referral Hospital, Tomaree Community Hospital, Singleton Hospital			
Anaesthesia and Pain	Nov-13	Jul-16	Jan-20
Cardiac Stream	Nov-13	Jul-16	Jan-20
Community Aged Care Oral Health Programs			Jan-20
Communicating for Safety - Clinical Governance			Jan-20
Chronic Disease Network	Nov-13	Jul-16	Jan-20
Dementia/Delirium CNC	Nov-13	Jul-16	Jan-20
Diabetes Network	Nov-13	Jul-16	Jan-20
Emergency Stream	Nov-13	Jul-16	Jan-20
Gastrointestinal	Nov-13	Jul-16	Jan-20
Quality Use Of Medicines Committee	Nov-13	Jul-16	Jan-20
Neurology Stream	Nov-13	Jul-16	Jan-20
New South Wales Ambulance	Nov-13	Jul-16	Jan-20
Older People Mental Health Service	Nov-13	Jul-16	Jan-20
Palliative Care and End of Life Network	Nov-13	Jul-16	Jan-20
Public Health Unit	Nov-13	Jul-16	Jan-20
Respiratory Network	Nov-13	Jul-16	Jan-20
Telehealth - ICT Services			Jan-20
Urology	Nov-13	Jul-16	Jan-20
Wound Care	Nov-13	Jul-16	Jan-20

Contact an ACE Nurse

In a medical emergency, always dial 000 to call an ambulance.