



Hunter  
**PR1MARYCARE**



**phn**  
HUNTER NEW ENGLAND  
AND CENTRAL COAST  
An Australian Government Initiative

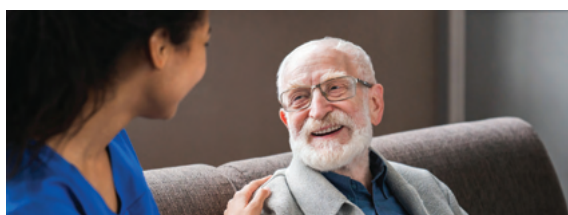
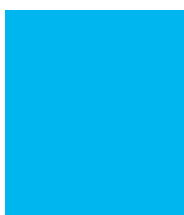
**PRIMARY  
HEALTH  
NETWORK**

# Aged Care Emergency Manual

## 2026 Edition



**ACE** AGED  
CARE  
EMERGENCY SERVICE



Contact an ACE/RAC-I Nurse

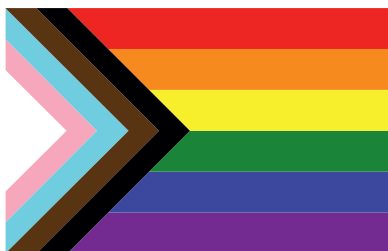
**1300 223 555**

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



## ACKNOWLEDGEMENT

The ACE service acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia and we pay our respects to their elders past, present and future who we share this great region with.



## DIVERSITY COMMITMENT

The ACE service is committed to embracing diversity and eliminating all forms of discrimination in the provision of health services.

We welcome all people of diverse ethnicity, lifestyle choice, faith, sexual orientation and gender identity.

We acknowledge the clinicians within Hunter New England Local Health District streams and networks who have contributed their expert knowledge to the development and review of the 2026 ACE manual. Thank you to the ACE collaborative partners that have contributed to current and previous versions of the ACE manual:

- Hunter New England Local Health District
- Hunter Primary Care
- NSW Ambulance
- Hunter New England Central Coast Primary Health Network
- Residential Aged Care providers
- General Practitioners

All information is correct as of March 2026

CREDIT: Saretta Fielding, OUR CORROBOREE Series 2

This contemporary highly textured artwork brings to life our modern day corroboree. Vivid colour and traditional imagery flow together in gathering circle and songlines to connect people and communities in celebration and unity. Interwoven, intricate imagery captures the diversity of Aboriginal people today and our multicultural nation. It highlights the gathering and strong bonds that link family and friends across time, culture and generations, inclusive of all from past, present and into the future.



## Aged Care Emergency (ACE) Service Overview

The ACE service is a partnership between Hunter New England Local Health District (HNELHD), Hunter New England Central Coast Primary Health Network (HNECCPHN) and Hunter Primary Care (HPC). ACE is dependent on collaborative relationships with:

- Residential Aged Care Homes (RACs)
- NSW Ambulance (NSWA)
- General Practitioners/Nurse Practitioners (GP/NP)
- Residents, families, and carers.

The ACE service provides consultancy, clinical support and expert advice for RAC staff, and GP/NPs. The goal is to enable timely, appropriate care within the facility, reducing unnecessary transfers to hospital.

### Aims of the ACE Service:

- RAC residents receive the **right care**, at the **right time**, in the **right place**.
- Strengthen collaboration and communication among aged care stakeholders.
- Empower RAC staff to manage non-life-threatening conditions within the facility.
- Reduce avoidable emergency department presentations.

Registered nurses can use this manual as a guide to help assess and troubleshoot clinical concerns. They can also speak directly with the ACE team to explore the most appropriate management options.

The ACE resources are available to all RACs across the Hunter New England region. The ACE telephone support **1300 223 555** is available only to facilities within the following hospital catchment areas:

- Armidale Hospital
- Belmont Hospital
- Calvary Mater Newcastle
- John Hunter Hospital
- Manning Base Hospital
- Singleton Hospital
- Tamworth Hospital
- The Maitland Hospital
- Tomaree Hospital.
- RACs in the Cessnock Hospital catchment **Ph: 0427 016 918** for telephone support and the call is answered by staff from the Cessnock Hospital after hours and the Residential Aged Care In-Reach service 8 am to 4 pm.

### Hospital Transfers:

If a resident requires transfer to hospital, ACE clinicians can assist in coordinating the process. They will share relevant clinical information with the receiving hospital staff, helping to ensure a smooth transition of care. ACE may also support access to outreach or outpatient services, where appropriate, for concerns such as:

- Wound management
- Continence problems
- Responsive behaviours
- Management of some acute and chronic conditions

## The ACE Service Model of Care:

The ACE service is a person-centred model of care that places the resident at the centre of all decision-making. It aims to ensure the right care is provided at the right time, in the right place. The model includes seven key elements designed to support informed decision-making by staff in RACs:

1. The use of **evidence-based flowcharts** to manage common health issues within the RAC.
2. Telephone support for RAC staff, provided by experienced Registered Nurses.
3. **Structured communication using ISBAR** (Identify, Situation, Background, Assessment, and Recommendation), including the identification of goals of care before any hospital transfer.
4. **Proactive case management** of RAC residents in the emergency departments.
5. **Staff education and empowerment** to recognise clinical deterioration, apply clinical algorithms and navigate the healthcare system confidently.
6. **A Community of Practice** to build collaborative relationships within aged care, including:
  - ▶ Residents, families, and carers.
  - ▶ RACs.
  - ▶ Hunter New England Local Health District.
  - ▶ Hunter Primary Care.
  - ▶ GP/NPs.
  - ▶ Hunter New England Central Coast Primary Health Network.
  - ▶ NSW.
  - ▶ Emergency departments.
  - ▶ Educational organisations.
7. **Dedicated management team** to implement and support all elements of the model of care.

## ACE Website:

The ACE website provides **electronic access** to the manual, clinical tools, educational resources, and references. To access the ACE website, go to <https://ace.hnehealth.nsw.gov.au>

- Username – aged
- Password – care

For life-threatening emergencies – **Ph: NSWA 000**.

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## Guide to this Manual

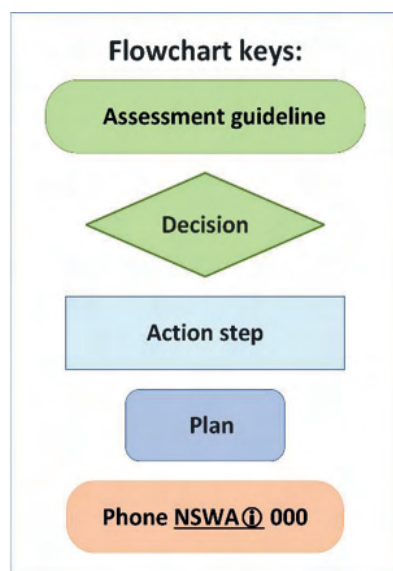
This manual is a clinical support tool for the care of acutely unwell residents living in Residential Aged Care (RAC). General practitioners (GPs) are the primary medical practitioner responsible for residents in a RAC. This manual aims to support general practitioners and RAC staff in managing acutely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

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

The ACE manual is divided into three sections.

1. Section one is the ACE process and how to contact **ACE@ 1300 223 555**, the tools to **Recognise a Deteriorating Resident@**, **ISBAR for aged care@** for clinical handover, how to identify **Goals of Care@** and contacting **NSW Ambulance@** to arrange transfer to hospital for the resident.
2. Section two contains the evidence-based flowcharts to manage common health issues within the RAC. These guidelines are arranged into body systems, e.g., cardiac, respiratory. At the end of each section there is additional information about how to access advice or referral information and there are also links to online resources.  
The flowcharts are designed to assist staff in delivering care, however, it should always be used in conjunction with sound clinical judgement.
3. Section three contains complaint management, forms, acronyms used in the Manual and background information about the ACE Service and the ACE Manual.

## Manual Key

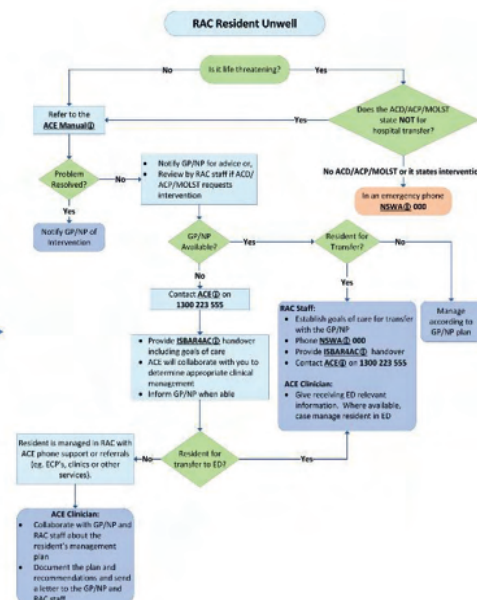


### What does @ mean?

Where an @ appears there is a related flowchart or relevant information section in the manual.

For example,

In an emergency phone **NSWA@ 000**



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## How to Use ACE

Please refer to the steps below **before** Phoning ACE, calling NSW and / or **transferring** a resident to Hospital. If the GP/NP has reviewed the resident and determined they require transfer to hospital, please Phone ACE to provide a clinical handover and refer to **What to Send When Transferring a Resident to Hospital**

In an **Emergency**, always Ph: **NSWA 000**

### What to do **BEFORE** contacting **ACE**:

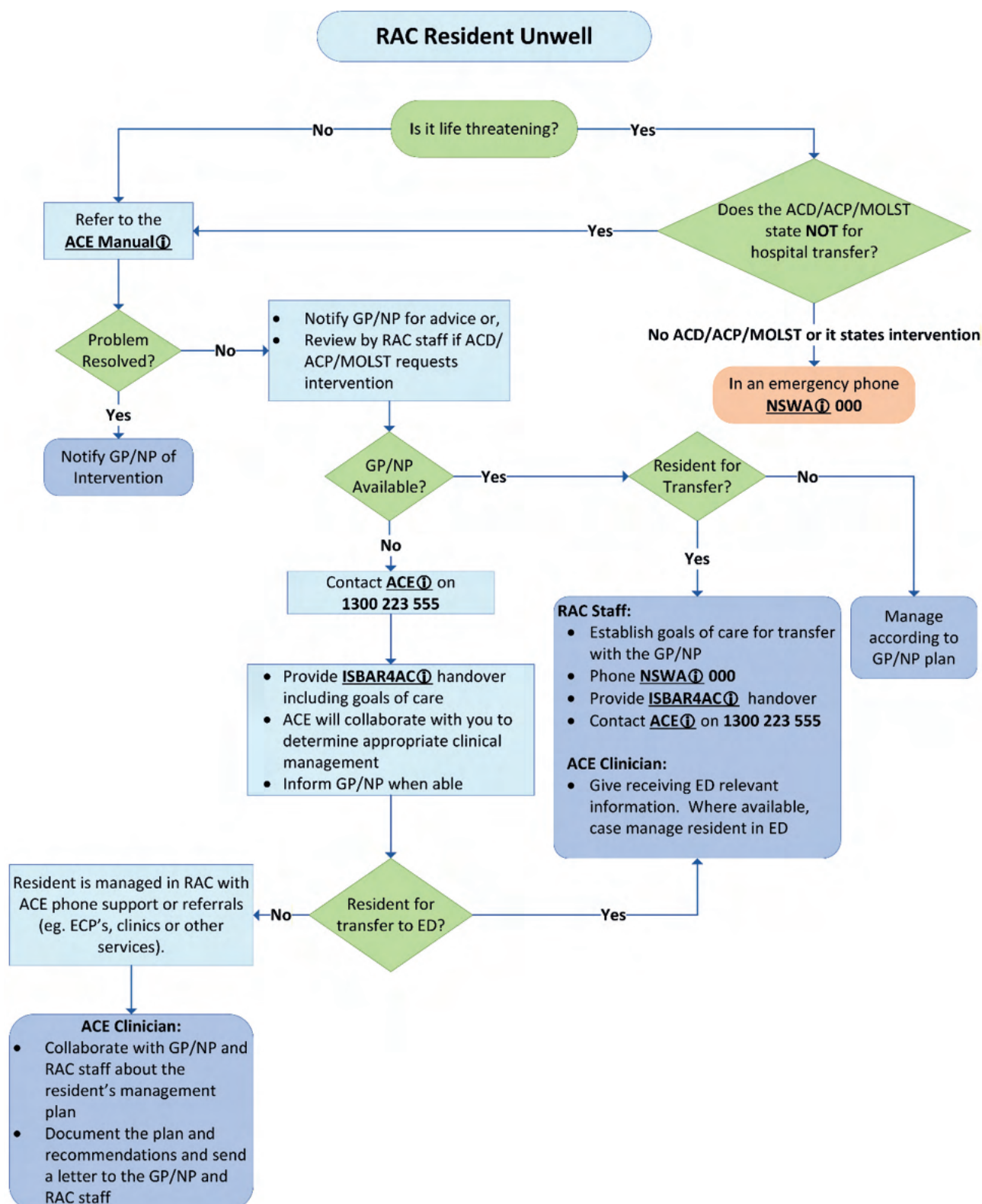
|    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Review the resident file to identify their medical history and baseline observations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 2. | <ul style="list-style-type: none"> <li>Determine if the resident has an Advance Care Directive (ACD), Advance Care Plan (ACP), or Medical Orders for Life-Sustaining Treatment (MOLST).</li> <li>Some ACDs/ACPs/MOLSTs specifically request that the resident is <b>not</b> transferred to hospital, even if they are experiencing a life-threatening emergency.</li> <li>Other ACDs/ACPs/MOLSTs may detail when to send and what treatments are consented to.</li> <li>If an ACP/ACD/MOLST states "<i>do not send me to hospital if...</i>" then it is not appropriate to proceed with hospital transfer without first discussing the situation with the resident (if able), their GP/NP, and the substitute decision maker. If, following these discussions, hospital transfer is considered clinically necessary, ensure the Emergency Department (ED) is provided with a clearly defined goal of care. See <b><u>Advance Care Planning Guidelines</u></b></li> </ul> |
| 3. | Refer to the relevant clinical section or flowchart in the ACE manual based on the resident's presenting condition. Complete the recommended clinical assessments and implement the appropriate actions.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 4. | Refer to the <b><u>Recognising a Deteriorating Resident</u></b> and compare current signs and symptoms with residents' usual baseline observations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. | Locate the resident's regular medications charts, signing sheets, and any additional stat or PRN medications administered for the resident's current condition.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 6. | Complete the <b><u>ISBAR4AC</u></b> to prepare for discussion with GP/NP, ACE and/or NSW.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 7. | Contact the resident's GP/NP and substitute decision maker to discuss the resident's current condition. If the issue remains unresolved, inform them of your intention to contact the ACE service. If the GP/NP is unavailable, or if the GP/NP has assessed the resident and instructed hospital transfer, please contact <b><u>ACE</u> 1300 223 555</b> to coordinate with the ED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 8. | Contact <b><u>ACE</u> 1300 223 555</b> and use your completed <b><u>ISBAR4AC</u></b> during your discussion. Identify the residents' <b><u>Goals of Care</u></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 9. | If it has been agreed that the resident will remain in the RAC, the ACE staff will send a summary of the discussion to the RAC. Please re-contact <b><u>ACE</u> 1300 223 555</b> if the resident's condition changes or deteriorates.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

### What to do **WHEN** transferring to **hospital**:

|    |                                                                                                                                                                                             |
|----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | If it has been agreed that the resident requires transfer to hospital, ACE will advise you of the destination hospital, which is normally the closest ED and / or most clinically suitable. |
| 2. | Phone <b><u>NSWA</u> 000</b> . Provide an appropriate time frame for transfer and mention that you have called ACE.                                                                         |
| 3. | Refer to <b><u>What to Send When Transferring a Resident to Hospital</u></b> and place the documentation in the yellow envelope prior to NSW arrival.                                       |
| 4. | Provide a clinical handover to NSW personnel on their arrival, using the completed <b><u>ISBAR4AC</u></b> Form. Provide a copy of the completed <b><u>ISBAR4AC</u></b> to NSW.              |

## Aged Care Emergency Flowchart

Follow the flowchart when a resident becomes unwell. Refer to the relevant clinical section of the ACE manual that aligns with the resident's presenting condition. Complete the required clinical assessments and actions, and prepare your **ISBAR4AC** to support effective communication with the GP/NP, ACE and / or NSWA.



# ISBAR4AC

Complete the below ISBAR4AC 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 website](#).



## ISBAR4AC - Clinical Communication Record

NOTE: Complete prior to contacting the GP/ACE Service/NSW Ambulance.

Is the resident: ☐ Permanent or ☐ Respite

|                                                   |     |                                                                                              |
|---------------------------------------------------|-----|----------------------------------------------------------------------------------------------|
| FAMILY NAME:                                      |     | MRN:                                                                                         |
| GIVEN NAMES:                                      |     | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER |
| D.O.B:                                            | / / | PHONE:                                                                                       |
| ADDRESS:                                          |     |                                                                                              |
|                                                   |     |                                                                                              |
|                                                   |     |                                                                                              |
| COMPLETE ALL SECTIONS OR AFFIX PATIENT LABEL HERE |     |                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>I</b><br>Identify                 | Your name and role: _____ RAC name/room/wing: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                      | Your direct phone number: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>S</b><br>Situation                | Name/position of person you are speaking to: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                      | Resident's current symptom & time of onset? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>B</b><br>Background               | What initial treatment have you commenced and what is the outcome? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                      | <p>Relevant medical history? <i>(have chart available)</i> Medications: <i>(have chart available)</i></p> <p>Allergies: <input type="checkbox"/> Nil known <input type="checkbox"/> Yes: _____ Vaccinations: <input type="checkbox"/> Up-to-date <input type="checkbox"/> Not up-to-date <input type="checkbox"/> Unknown</p> <p>Advance Care Plan/Directive or MOLST in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Resident declines If yes, describe: <i>(have it available)</i></p> <p>What are the resident's goals of Care? <i>(consider advance care plans)</i></p> <p>Details:</p> <p>Has resident's substitute decision maker been notified? <input type="checkbox"/> Yes: Name: _____ Contact number: _____</p> <p>Has GP/NP been contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____ Contact number: _____</p> <p>Does this resident identify as <input type="checkbox"/> Aboriginal and/or <input type="checkbox"/> Torres Strait Islander or <input type="checkbox"/> Neither <input type="checkbox"/> or Unknown</p> <p>Is an interpreter/Auslan required: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____</p> <p>Is the resident visually or hearing impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No Aide: _____</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>A</b><br>Assessment               | <p><u>Observations: Baseline</u></p> <p>Date: _____ Time: _____</p> <p>Respirations: _____ BGL: _____</p> <p>Oxygen saturations: _____ Weight: _____</p> <p>Blood pressure: (sit) _____ (stand) _____</p> <p>Heart rate: _____ (regular/irregular) _____</p> <p>Urinalysis: _____</p> <p><u>LOC:</u> <input type="checkbox"/> Alert <input type="checkbox"/> Confused (more than usual)</p> <p><input type="checkbox"/> Responding to Voice <input type="checkbox"/> Responding to Pain</p> <p><input type="checkbox"/> Unresponsive</p> <p>GCS: Score: /15 <u>Pupil assessment:</u> _____</p> <p><u>Pain:</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, use FACES chart over page to score pain)</i></p> <p>Pain score = /10</p> <p><u>Injuries/other abnormal findings:</u> <i>(See Symptom Reference Guide over page for focussed assessments)</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p><u>Observations: Current</u></p> <p>Date: _____ Time: _____</p> <p>Respirations: _____ BGL: _____</p> <p>Oxygen saturations: _____ Weight: _____</p> <p>Blood pressure: (sit) _____ (stand) _____</p> <p>Heart rate: _____ (regular/irregular) _____</p> <p>Urinalysis: _____</p> <p><u>4AT assessment:</u></p> <p>Alertness: ___ AMT4: ___ Attention: ___ Acute change or fluctuating course: ___ Score: _____</p> <p><i>(4 or above possible delirium +/- cognitive impairment)</i></p> <p>Type of pain: <input type="checkbox"/> Chronic <input type="checkbox"/> Acute <input type="checkbox"/> Acute on Chronic</p> |
|                                      | <p>I am requesting assistance with / advice for:</p> <p><input type="checkbox"/> Symptom management <input type="checkbox"/> Medication review <input type="checkbox"/> Sending patient to ED <input type="checkbox"/> GP/NP assessment of patient <input type="checkbox"/> Other:</p> <p>Medical Doctor orders: _____</p> <p>ACE/GP/NP/NSWA advice: _____</p> <p><b>Outcome - resident to be managed:</b></p> <p><input type="checkbox"/> In-Facility <input type="checkbox"/> By GP/NP <input type="checkbox"/> NSW Ambulance <input type="checkbox"/> RAC-I <input type="checkbox"/> Transfer to ED <input type="checkbox"/> Other:</p> <p>Name: _____ Signature: _____ Date: _____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>R</b><br>Recommendation / Request | <p>If for transfer to ED: consult transfer to hospital yellow envelope for information required.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |



## Symptom Reference Guide

| Problem                                      | Additional Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Specific Observations Required                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pain                                         | <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>NO PAIN SLIGHT PAIN MILD PAIN MODERATE PAIN SEVERE PAIN EXTREME PAIN PAIN AS BAD AS IT COULD BE</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>Ask the person to describe the pain they are feeling. Then, show them the scale and explain: "These faces show how much something can hurt. The face on the left means 'no pain.' The face on the right means the 'worst pain.' Point to the face that shows how much pain you have now."</p> <p>Document score (0-10). Monitor response to analgesia. Revised (FPS-R) with permission from the International Association for the Study of Pain (IASP) – <a href="https://www.iasp-pain.org">https://www.iasp-pain.org</a></p> |
| Abdominal Pain                               | Where is the pain most severe? Describe the pain (sharp, dull, burning, ache, throbbing, constant, intermittent)? Does the pain spread anywhere (shoulder, back, groin)? Are there factors that improve or worsen the pain (movement, food, medication, position)? Are there any other symptoms (nausea, vomiting, diarrhoea)? Is there any blood in the stool/vomit (bright red, dark red, or black/tarry)? When were the bowels last opened, and was any treatment used (laxatives, suppositories, enemas)?                                                                                                                                        | <p>Inspect abdomen: distension, scars, bruising, changes to skin colour.</p> <p>Palpate for tenderness, guarding, rigidity (if within scope of practice).</p> <p>Urine analysis to exclude UTI or haematuria.</p> <p>Consider constipation or urinary retention?</p> <p>Reduced or no urine?</p> <p><b>Could this be sepsis?</b></p>                                                                                                                                                                                              |
| Diarrhoea/ Nausea or Vomiting                | When did symptoms start? Sudden or gradual in onset? How often (constant, intermittent)? Appearance of stool/vomit (undigested, bile, blood)? Are there other symptoms present (fever, headache, dizziness)? Is oral intake tolerated? Any recent dietary or medication changes?                                                                                                                                                                                                                                                                                                                                                                     | <p>Assess hydration. Tolerance of fluids/foods. Last bowel motion. Stool type (see the Bristol scale). Lying and Standing Blood Pressure (postural BP). Consider infection control precautions. <b>Could this be sepsis?</b></p>                                                                                                                                                                                                                                                                                                  |
| Dizziness                                    | Describe sensation: spinning (vertigo) or faintness (pre-syncope)? Onset: sudden or gradual? Is it linked with positional change? Are there other symptoms? (headache, nausea, visual disturbance, palpitations, weakness). History of recent falls or near falls?                                                                                                                                                                                                                                                                                                                                                                                   | <p>Lying and standing blood pressure (postural BP); check gait stability and balance. Hydration status. Neurological assessment: GCS. Consider OT/PT review. Falls prevention strategies. Consider BGL.</p>                                                                                                                                                                                                                                                                                                                       |
| Urinary Problems                             | Symptoms of urgency, frequency, hesitancy or new/worsening incontinence? Is there pain or discomfort (lower abdominal, flank or back pain)? Is there a change in urine colour, smell or clarity, volume (less/more)? Are there other symptoms (fever, chills, nausea, confusion, change in cognition, falls)?                                                                                                                                                                                                                                                                                                                                        | <p>Vitals signs. Review any cognitive changes, attend 4AT. Urine analysis. Urine input/output.</p> <p>Consider post-void residual volume (if in scope of practice/available). <b>Could this be sepsis?</b></p>                                                                                                                                                                                                                                                                                                                    |
| Shortness of Breath                          | How did it develop (sudden, gradual, constant, intermittent)? Is it present at rest, with exertion, when sitting up and/or lying down? Does the resident have associated chest pain and/or discomfort? Do they have other symptoms (cough, increased sputum, fatigue, dizziness)?                                                                                                                                                                                                                                                                                                                                                                    | <p>Sputum (clear, coloured, blood). Audible sounds (wheeze, gurgling). Resident appearance (pink, pale, sweaty, blue). Ankle or lower limb swelling? Changes in weight? <b>Could this be sepsis?</b></p>                                                                                                                                                                                                                                                                                                                          |
| Chest Pain                                   | When did it start? (sudden, gradual, constant, intermittent). Where is the location of the pain? Does the pain radiate (neck, jaw, shoulder, back or arm)? Describe the pain (tightness, pressure, stabbing, burning, dull ache, heaviness)? How would you score the severity out of 10? (0= nil pain, 10 = worst pain). Does anything make it worse? (exertion, movement, cough, inspiration). Does anything make it better? (rest, antacid, Glyceryl trinitrate, oxygen).                                                                                                                                                                          | <p>Resident appearance (pink, pale, sweaty, blue).</p> <p>Vital signs: including HR rate &amp; rhythm.</p> <p>Is there shortness of breath? Work of breathing? Cough?</p> <p>Is there confusion or agitation?</p>                                                                                                                                                                                                                                                                                                                 |
| Seizures                                     | What did you observe? (LOC, were they responsive, movements, stiffening, twitching, flaccidity, eye deviation, facial movements). Was it witnessed? How long did the episode last? Were there changes in breathing, colour (blue), & was oxygen required? Is there a history of seizures? Is there any new weakness? (arm, leg, face). What was the resident doing at the time? Did they report any preceding light headedness/dizziness? Is there any change to vision, loss of speech, hallucinations? Any other symptoms? (incontinence, injuries (list), head trauma, recent illness, medication changes/missed doses). Is the resident in pain? | <p>Resident appearance (normal, pale, sweaty, anxious). Limb movement (normal, decreased).</p> <p>GCS (Glasgow Coma Scale) and pupil response (equal, reactive).</p> <p>Level of consciousness (LOC) – alert, drowsy, confused, responds to voice, responds to pain, unresponsive?</p>                                                                                                                                                                                                                                            |
| Lacerations & Falls                          | Was it witnessed? What was the mechanism (slip, trip, faint)? Was there a head-strike? Did they lose consciousness? Did they have preceding symptoms? Any new pain? Are there limb deformities? Is the resident on anti-coagulants? If there is bleeding, is it controlled? What is the location of injury(s)? Mobility and function can they weight bare?                                                                                                                                                                                                                                                                                           | <p>Depth and length of wounds? Bleeding control.</p> <p>Equipment on-hand (steri-strips, glue, suture kit)?</p> <p>Neurological assessment: GCS.</p> <p>Limb movement (normal, reduce range of movement).</p>                                                                                                                                                                                                                                                                                                                     |
| 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 any other symptoms (chest pain, headache, diarrhoea, vomiting, breathing difficulties, sign of infection, fever/chills, urinary/bowel changes). Is there any new arm or leg weakness?                                                                                                                                                                                                                                                                                                                                      | <p>Conscious state: normal, alert, hyper-alert, drowsy, easily roused, difficult to rouse, unrousable.</p> <p>Last bowel motion? Last urine passed?</p> <p>4AT assessment.</p> <p><b>Could this be sepsis?</b></p>                                                                                                                                                                                                                                                                                                                |
| Fever                                        | How long has the fever lasted? Is there any; Cough/Abdominal pain/Rash/Skin infection? Is resident more confused than usual? Is there any urinary frequency, discomfort on urination and/or smelly urine? Does the resident have a urinary catheter?                                                                                                                                                                                                                                                                                                                                                                                                 | <p>Resident appearance (shivering, sweating, pink, pale, sweaty, blue, anxious).</p> <p>Skin: (hot/cold, dry/moist).</p> <p>4AT assessment.</p> <p><b>Could this be sepsis?</b></p>                                                                                                                                                                                                                                                                                                                                               |



# Recognising a Deteriorating Resident

**Practice Point: Treat any RAPID deterioration in condition with suspicion!**

Use this table to assist you in recognising if a resident's condition is worsening, so you can act quickly. Look at their clinical notes and usual (baseline) observations and compare these to what they are now. Before asking for help, check their care plans; ACD/ACP/MOLST to guide your next steps.

| Recognition of a Deteriorating Resident - Clinical Observations①                                                                                                                               |                                                                                                                                                                                                                                                               |                                                                                                                             |                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| Observation                                                                                                                                                                                    | Observe                                                                                                                                                                                                                                                       | Yellow (Trigger Caution)                                                                                                    | Red (Trigger Danger)                                                                                                 |
| Respiratory rate                                                                                                                                                                               | 11 to 24 per minute.                                                                                                                                                                                                                                          | Between 6 and 10 per minute.<br>Between 25 and 29 per minute.                                                               | 5 or less per minute.<br>More than 30 per minute.                                                                    |
| Respiratory effort                                                                                                                                                                             | Typical for <b>this</b> resident.                                                                                                                                                                                                                             | Unusually laboured or noisy breathing for <b>this</b> resident.                                                             | Obvious distress <b>and / or</b> cyanosis (despite oxygen).                                                          |
| Pulse oximetry (SpO <sub>2</sub> %)                                                                                                                                                            | 95% to 100% (with or without oxygen) typical for <b>this</b> resident.<br><br><b>Caution!</b> Beware of residents with COPD who may normally have low saturations.                                                                                            | Between 91% and 94% (despite oxygen) for <b>this</b> resident.                                                              | Less than 90% (despite oxygen).                                                                                      |
| Blood pressure<br><i>Systolic is the top and Diastolic is the bottom measurement.</i>                                                                                                          | 100 to 180 mmHg (systolic) or typical for <b>this</b> resident.<br><br><b>Caution!</b> Always consider what is normal for this resident. Significant changes from their usual baseline, even if within a "normal" range, may indicate clinical deterioration. | Between 91 and 99mmHg (systolic).<br><br>Between 181 and 199 mmHg (systolic).                                               | Less than 90mmHg (systolic).<br><br>More than 200mmHg (systolic).                                                    |
| Heart rate                                                                                                                                                                                     | 50 to 120 bpm.                                                                                                                                                                                                                                                | Between 41 and 49 bpm<br>Between 121 and 139 bpm                                                                            | Less than 40 bpm<br>More than 140 bpm                                                                                |
| Cognition & Level of Consciousness (LOC):<br>ACVPU:<br><ul style="list-style-type: none"> <li>Alert</li> <li>Change in behaviour</li> <li>Voice</li> <li>Pain</li> <li>Unresponsive</li> </ul> | <b>Alert (A)</b> = resident is awake and interactive, <b>or</b> cognition is normal for this resident.                                                                                                                                                        | <b>Confusion (C)</b> = change in behaviour; new confusion; delirium.<br><br><b>Verbal (V)</b> = Resident responds to voice. | <b>Pain (P)</b> = Resident only responds to pain, <b>or</b><br><br><b>Unresponsive (U)</b> to pain or other stimuli. |
| Temperature                                                                                                                                                                                    | 35.6 to 38.4°C<br>With or without anti-pyretic medication.<br><br><b>Caution!</b> If over 37.5 °C monitor resident and check with RN.                                                                                                                         | <b>Without</b> anti-pyretic medication.<br><br>Less than 35.5°C.<br><br>More than 38.5°C.                                   | <b>Even with</b> anti-pyretic medication.<br><br>Less than 35.5°C.<br><br>More than 38.5°C.                          |
| Pain<br>Refer to faces pain scale on ISBAR4AC.                                                                                                                                                 | <b>Nil or tolerable.</b><br>With or without pain medication.                                                                                                                                                                                                  | <b>Obvious discomfort.</b><br>Despite recent pain medication.                                                               | <b>Obviously distressed.</b><br>Despite recent pain medication.                                                      |
| Blood Glucose Level                                                                                                                                                                            | BGL between 4 mmol/L and 20 mmol/L or <b>usual range</b> for this resident.                                                                                                                                                                                   | Less than 4 mmol/L <b>or</b> Greater than 20 mmol/L <b>with no</b> decreased Level of Consciousness.                        | Less than 4 mmol/L <b>or</b> Greater than 20 mmol/L <b>with a</b> decreased Level of Consciousness.                  |

Recognising a Deteriorating Resident in a RAC - Version 7 - 24 September 2025. Above table and parameters are adapted from the [Standard Adult General Observation Chart](#)© NSW Clinical Excellence Commission.

## NSWA and ACE

### ED Catchments and the Home ED

- Each RAC has been allocated a home ED.
- When contacting ACE between 08:00 am to 4:00 pm always select your allocated home ED option.
- The Residential Aged Care In-Reach (RAC-I) service is operational in allocated catchments with an automatic diversion into the service via 1300 223 555, during the hours of 8:00 am to 4:00 pm.
- Outside of these hours, calls are automatically directed to the ACE after-hours line.

### Life Threatening Emergencies

- In a life-threatening emergency phone **NSWA 000**, NSW will determine hospital or ED destination in this instance.

### Transfer to Specialist Hospitals

In most cases, residents will be transferred to their allocated home ED, except when specialist care is required. In these situations, transfer is directed to a nominated referral or specialist hospital, determined by the LHD and NSW. Examples include:

- ▶ **Complicated orthopaedics** (e.g., fractured femur): serious fracture injuries requiring orthopaedic intervention will be transferred to Armidale Hospital, John Hunter Hospital, Maitland Hospital, Manning Hospital, and Tamworth Hospital.
- ▶ **Uncomplicated fractures** (e.g., wrist) can be managed at the home ED.
- ▶ **Mental health** (Behavioural Psychiatric): Transfer to Manning Hospital, Maitland Hospital, Calvary Mater Newcastle Hospital, Tamworth Hospital.

#### Practice Point:

In cases requiring transfer to a specialist hospital (not the home ED), ACE staff will notify the receiving ED.

### Arranging Transfer to ED

If it is agreed that the resident requires hospital transfer (following consultation with ACE), RAC staff are responsible for:

- Phone **NSWA 000** to arrange transfer to ED.
- Advise NSW of the suitable time frame for transport as identified by the various parties (RAC, GP/NP if involved, and ACE), which reflects the **Recognising a deteriorating resident guide**.
- If the residents' condition deteriorates then phone **NSWA 000** to provide a clinical update and include updated clinical observations.
- Providing a clinical handover to NSW paramedics upon their arrival using the **ISBAR4AC**.
- Providing all relevant paperwork/yellow envelope to go with the resident to hospital via NSW.
- If the GP/NP has requested the resident to be sent to hospital and the resident has **not** been physically examined, the NSW paramedic will perform a full assessment of the resident and may decide that the best treatment option is to treat the resident in situ or recommend an alternate referral pathway. In this instance, the paramedic will provide documentation to the RAC staff.

### ECP (Extended Care Paramedics)

ECPs are available in the Hunter region and may be able to initiate treatment in the facility instead of the resident being transferred to hospital. To request an ECP, phone **NSWA 000**.

### What specific skills can ECPs perform?

- ECPs are authorised to perform a range of extended skills. These include:
  - ▶ Epistaxis including placement of nasal tampons
  - ▶ Back slab plasters for immobilisation of upper limb injuries
  - ▶ Digital nerve blocks
  - ▶ Otoscopy
  - ▶ Reduction of certain dislocations
  - ▶ Replacing gastric tubes (excluding first tube change and excluding the change of Jejunal or PEJ tubes)
  - ▶ Urinary catheterisation including supra-pubic
  - ▶ Wound care including glue and sutures.

### What medications can ECPs give?

- In addition to standard NSW Pharmacology, ECPs can administer:
  - ▶ Antibiotics for mammal bites, upper respiratory and urinary tract infections
  - ▶ Lignocaine
  - ▶ Paracetamol, ibuprofen, combined paracetamol with codeine, and oxycodone for pain
  - ▶ Phenylephrine for epistaxis
  - ▶ Prednisolone and hydrocortisone for moderate to severe asthma
  - ▶ Fexofenadine for minor allergic reactions
  - ▶ Oral rehydration solutions e.g., Hydralyte
  - ▶ IV fluid boluses

### 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, and
  - ▶ Musculoskeletal and sporting injuries.
- Problem descriptions that ECPs are commonly dispatched to include:

|                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>▶ Allergies, hives, medical reactions, stings</li><li>▶ Animal bites or attacks</li><li>▶ Assaults</li><li>▶ Breathing problems</li><li>▶ Burns</li><li>▶ Cellulitis / wound infections</li><li>▶ Chronic pain and back pain (non-traumatic)</li><li>▶ Diabetic problems</li></ul> | <ul style="list-style-type: none"><li>▶ Epistaxis</li><li>▶ Eye problems or injuries</li><li>▶ Falls or traumatic back injuries</li><li>▶ Fitting or convulsions</li><li>▶ Haemorrhage or lacerations</li><li>▶ Illness (specific diagnosis)</li><li>▶ Nose bleeds</li><li>▶ Specific traumatic injuries.</li></ul> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

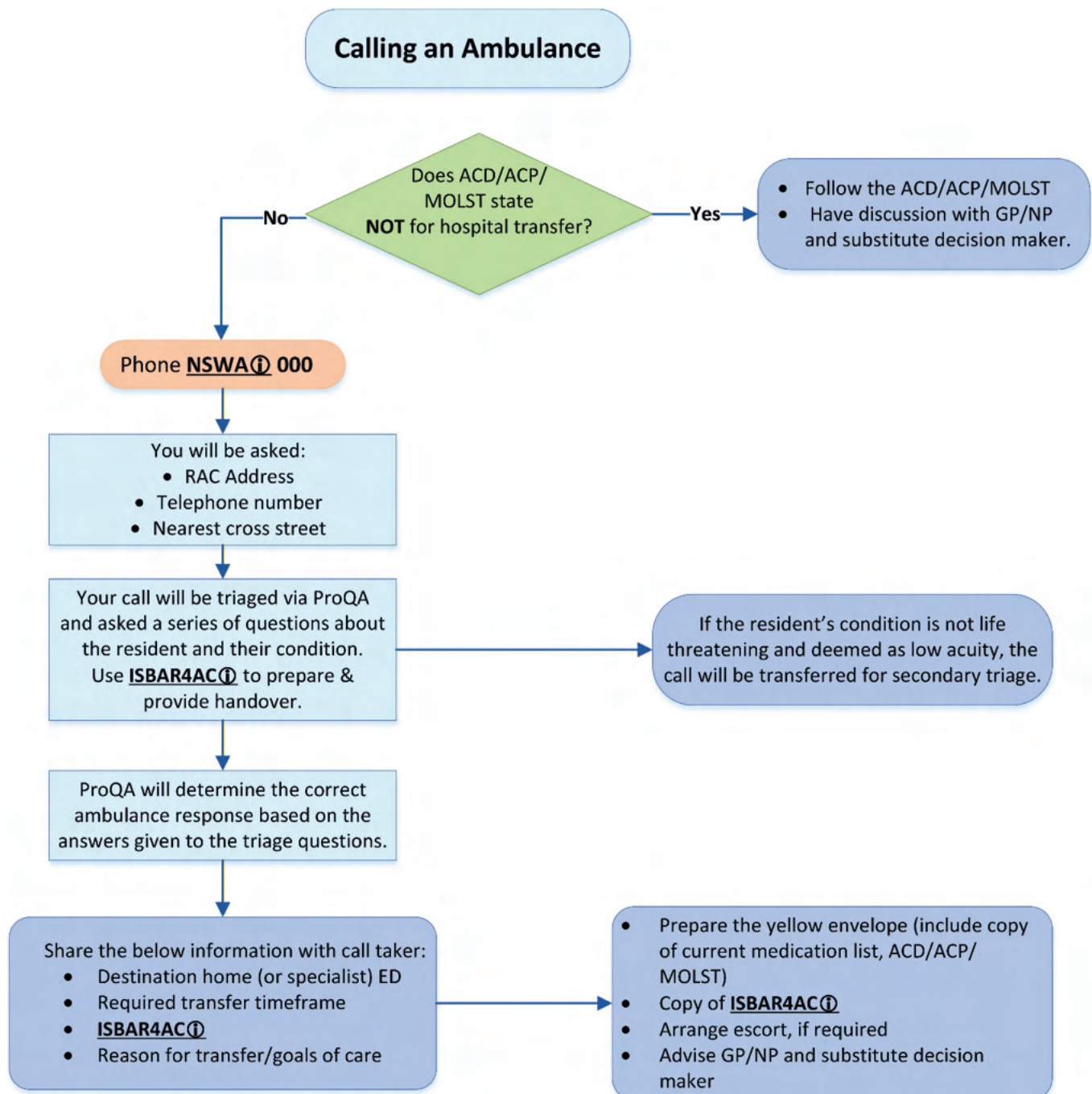
### Paramedics

Paramedics provide care for patients with complex needs and/or are at end of life, see below:

- ▶ [Palliative Care Fact Sheet](#) A guide to paramedics' role in Palliative care
- ▶ [Authorised Palliative Care Plan](#) NSW Ambulance Authorised Adult General Care Plan

## Calling an Ambulance Flowchart

Phone **NSWA 000** for all NSW transfers to the Emergency Department. Use the information from the **ISBAR4AC** form to provide clinical details of the resident's situation and inform the operator you have called ACE, and the ED is expecting the resident.





# What to Send When Transferring a Resident to Hospital

When transferring a resident to hospital, send the following documentation in the **Yellow Envelope**.

- Create a copy of the **ISBAR4AC** (provide to NSW, the home ED and RAC records)
- Name and contact details of:
  - ▶ Substitute decision maker
  - ▶ Usual GP/NP
  - ▶ RAC contact name with direct contact number (include afterhours contacts)
  - ▶ Usual Pharmacy
  - ▶ Identify if medication must be in a blister pack on return to RAC
- Copy of the medication chart and any sign sheet. Include a list of tablets, mixtures, eye drops, creams, patches, and any over-the counter or herbal medications.
- ACD/ACP/MOLST, other disease and/or behavioural management plans.
- GP/NP summary or letter (if available).
- X-rays, pathology results, 4AT if available.
- Full set of current clinical observations and baseline observations.
- RAC transfer / handover form.
- [TOP 5](#): to assist hospital staff to provide reassurance to the resident in an unfamiliar environment in relation to their communication and behavioural needs.
- The [Sunflower tool](#): individualised information about the person and their likes and dislikes.
- Advise whether the resident identifies as being of Aboriginal or Torres Strait Islander, so services can be offered to meet their needs.
- Identify residents with **English as a second language** and those who are **Hearing Impaired**, so an interpreter can be offered / booked.
- Advise if the substitute decision maker has been notified and encourage them to attend ED to support the resident.

**This person is the resident of an aged care facility**

### RACF to HOSPITAL TRANSFER ENVELOPE - CHECKLIST

|                                                                                                                                                                                                                                                                 |     |                                                                                       |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|---------------------------------------------------------------------------------------|--|
| Sending facility name ..... unit/wing name .....                                                                                                                                                                                                                |     | Patient details                                                                       |  |
| Receiving facility name .....                                                                                                                                                                                                                                   |     | Family name: .....                                                                    |  |
| Please initial in appropriate response box                                                                                                                                                                                                                      |     | Given names: .....                                                                    |  |
| N/A                                                                                                                                                                                                                                                             | Yes | <input type="checkbox"/> Male <input type="checkbox"/> Female      DOB ____/____/____ |  |
| N/A                                                                                                                                                                                                                                                             | Yes | Patient/Relative/Carer notified ..... Person responsible name .....                   |  |
| N/A                                                                                                                                                                                                                                                             | Yes | 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) |     |                                                                                       |  |
| <input type="checkbox"/> Advance care plan/directive <input type="checkbox"/> MOLST <input type="checkbox"/> Palliative care plan <input type="checkbox"/> 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 ..... |
|----------------------------|----------------------------------------|



**Health**  
Hunter New England  
Local Health District



**phn**  
HUNTER NEW ENGLAND  
AND CENTRAL COAST  
An Australian Government Initiative



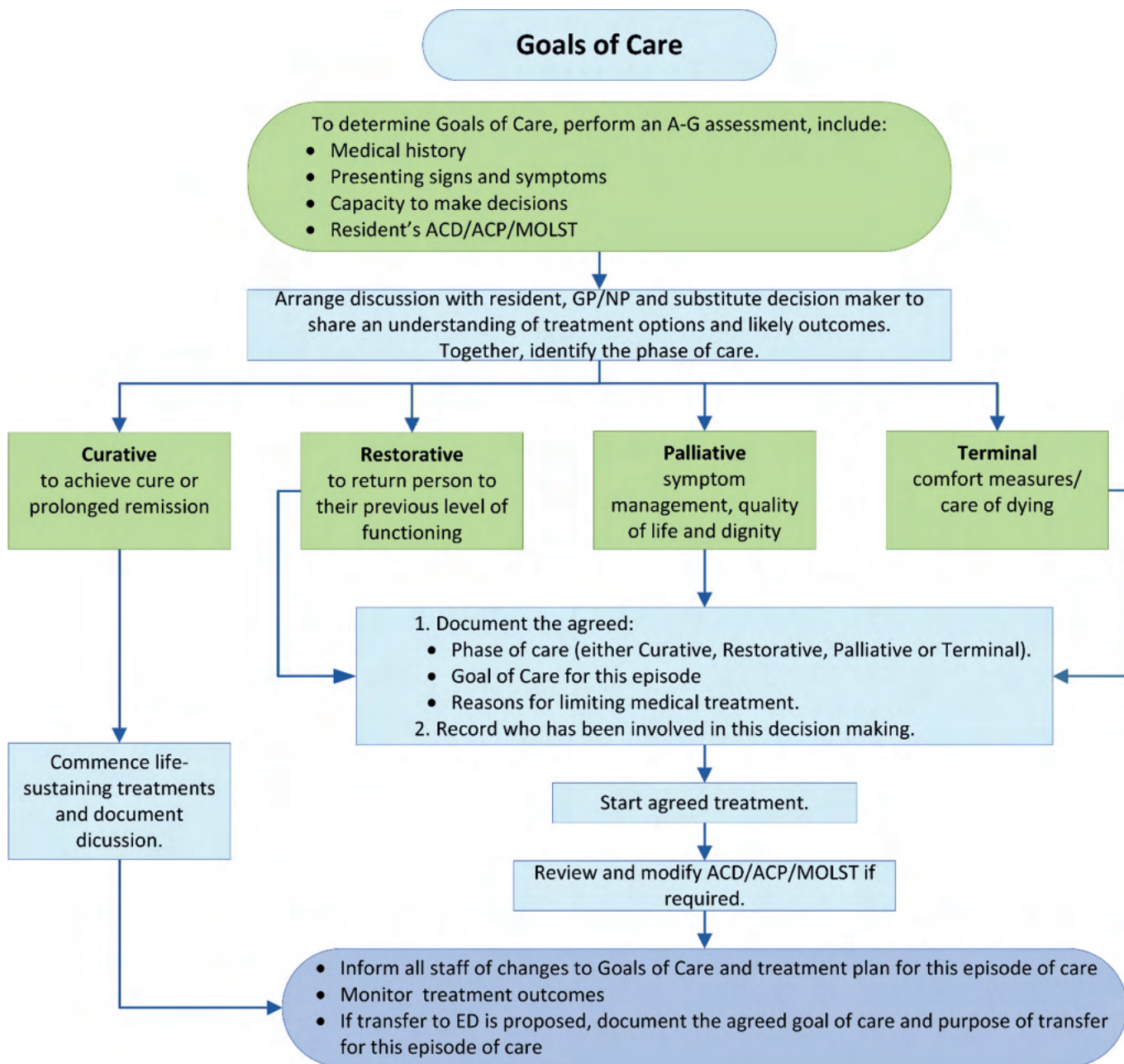
**NSW Ambulance**



**Calvary**  
Mater  
Newcastle

## Comprehensive Care – Identifying Goals of Care

Establishing clear Goals of Care ensures residents receive appropriate treatment aligned with their wishes and preferences. Before arranging a transfer, refer to the flowchart to confirm the resident's Goals of Care. A shared understanding of the resident's clinical needs and personal preferences supports decision-making around treatment plans, including any limitations, in line with their ACD, ACP or MOLST.



Further information:

Australian Commission on Safety and Quality in Health Care

- [Australian Commission on Safety and Quality in Health Care](#)
- [Implementing the Comprehensive Care Standard](#)

## Advance Care Planning Guidelines

When assessing a medically unwell resident, it is essential to consider any documented directions outlined in the ACD/ACP/MOLST when determining appropriate treatment options. The following steps can guide decision-making and care planning:

- Does the resident have **capacity**?

Use the [NSW Government Capacity Toolkit](#) to assist in determining a person's capacity to make legal, medical, financial and personal decisions. If a resident lacks capacity, supported decision-making should be encouraged.

- Does the resident have an **ACD/ACP/MOLST**?

If there is **no** ACD/ACP/MOLST:

- ▶ Discuss the resident's preferences (if appropriate) with them and their substitute decision maker.
- ▶ Involve the resident's GP/NP in all care planning discussions.
- ▶ Refer to the **Goals of Care** flowchart and the resources below to facilitate completion.

If the resident **does have** an ACD/ACP/MOLST:

- ▶ Assess whether the document is relevant to the resident's current clinical condition or stage of illness.
- ▶ Consider if the documents are current and reflect recent discussions.
- ▶ Involve the resident, their GP/NP and substitute decision maker in discussions.
- ▶ When a resident returns from a hospital / ED with or without an adult resuscitation plan, use this as a trigger to review the plan and have further conversations with the resident, substitute decision maker and GP/NP.

### Transfer to Hospital Considerations

If Transfer is Required:

- ▶ Contact **ACE 1300 223 555** to co-ordinate the transfer.
- ▶ Make copies of the ACD/ACP/MOLST and send them with the resident to hospital in the yellow envelope to ensure care and treatment aligns with their documented preferences.
- ▶ If decisions to withhold specific treatments have been made, clearly document and communicate these in transfer documents.
- ▶ Where possible, the transferring GP/NP should phone the hospital to directly communicate any relevant ACD/ACP/MOLST details to the admitting medical officer.
- ▶ Clearly document and communicate the current goals of care for this episode of care.

### If Transfer is Not Required:

- ▶ Develop a Chronic Disease Management Plan (next page) to guide care if the resident's condition deteriorates. This plan may include relevant referrals, such as to palliative care services.
- ▶ Keep the resident, their substitute decision maker, GP/NP and RAC staff informed about the management plan.

### In all Cases:

- ▶ Make decisions that best reflect the resident's known wishes and prioritise their quality of life.
- ▶ Communicate care decisions clearly and compassionately to the resident (if appropriate) and their substitute decision maker.
- ▶ Ensure that a clear goal of care is documented and communicated for each episode of care.
- ▶ When a resident returns from hospital or an emergency department visit with an Adult Resuscitation Plan, use this as a prompt to initiate or review an ACD/ACP/MOLST in collaboration with the resident, their substitute decision maker, and GP/NP.

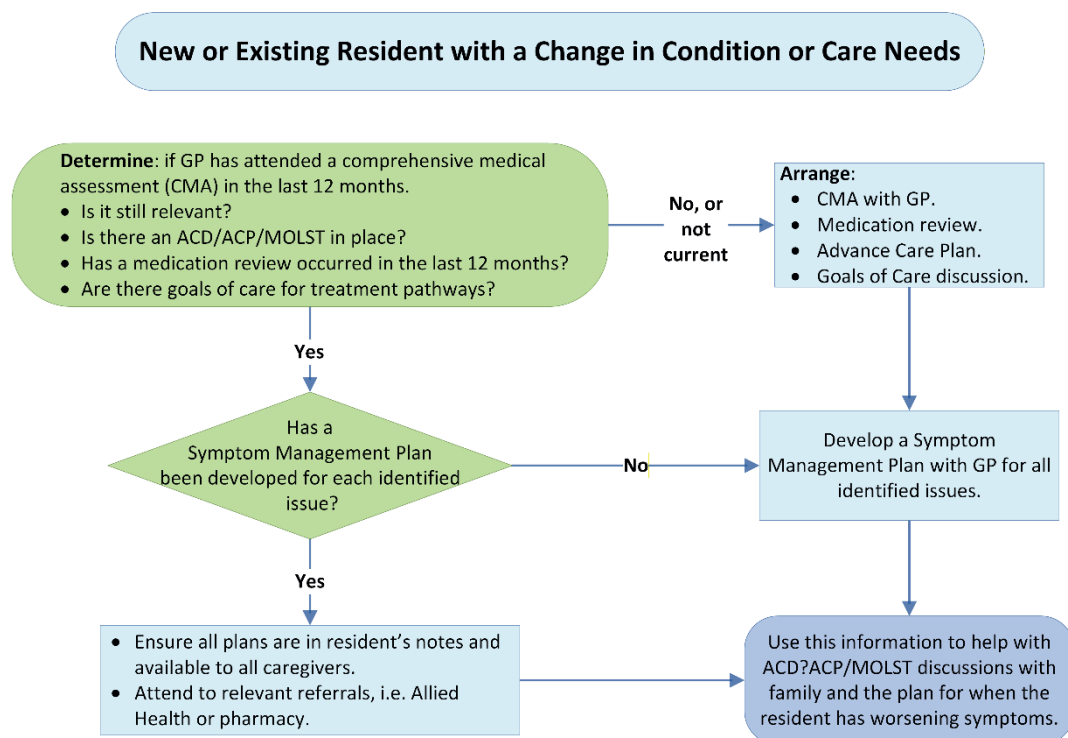
## References and Resources:

- [NSW Health Advance Care Planning](#)
- [Community HealthPathways](#) Care in the last 12 months of life
- [Last Days of Life](#) Clinical Excellence Commission
- [Talking about dementia and dying](#) A discussion tool for RAC staff

## Resident Care Planning

Tips for streamlining GP/NP Involvement in Resident Care Planning:

- **Co-ordinate appointments:** Work with the GP/NP or practice manager to schedule reviews in advance. Where possible, group residents together to minimise the GP/NPs time away from their practice.
- **Allow settling time:** Give new residents time to settle in and allow staff to become familiar with their care needs and family context.
- **Use CMA template:** Request the GP/NPs CMA template and pre-fill relevant sections. If a CMA is less than 12 months old but care needs have changed, consider a case conference, especially for ACD/ACP/MOLST discussions with the substitute decision maker.
- **Review medications:** Schedule a medication review with the pharmacist and/or GP/NP. Consider deprescribing high-risk medications (e.g., anticoagulants), particularly in residents at high falls risk or who wish to remain in the RAC rather than transfer to ED. Refer to the **[Polypharmacy Guideline](#)**
- **Support MBS eligibility:** Chronic disease and EOL symptoms management plans may attract MBS item numbers. Notify the practice manager and involve the GP/NP accordingly.
- **Prepare documentation:** Ensure all relevant care plans, medication charts, and supporting documents are ready ahead of the GP/NP visit.
- **Plan for contingencies:** Include standing orders for pathology and medications in the symptom management plans where appropriate.





# Culturally Safe & Inclusive Care for Older People from Diverse Backgrounds

Australia is a multicultural country with people from many cultural, spiritual, and linguistic backgrounds. It is important that aged care services provide culturally safe, respectful, accessible and person-centred care that meets individual need and preference. Below are some resources to support aged care workers in delivering inclusive and culturally responsive care.

## Working with Diverse Groups in Aged Care

The Australian Government Department of Health Disability and Ageing provides information and guidance for working with people from diverse backgrounds in aged care, including:

- Aboriginal and Torres Strait Islander People
- People from culturally and linguistically diverse (CALD) backgrounds
- LGBTIQ+ elders
- People with diverse life experiences, such as Forgotten Australians and survivors of past Government policies

## Further information:

- [Aged Care Diversity Framework](#) (2017)
- [Multicultural Health Communication Service](#)
- [Working with People from New and Emerging Communities Factsheet HNELHD](#)
- [Cultural Safety for Health Professionals](#) (resources)
- [Centre for Cultural Diversity in Ageing Online Training Modules](#): Inclusive Standards
- [Senior rights service](#) delivering National Aged Care advocacy. **Ph. 02 9281 3600**

## Aboriginal and Torres Strait Islander

Culturally Safe Aged Care supports First Nations Elders to live well, maintain cultural identity, and stay connected to Country, family and community.

## Key Principles of culturally safe care include:

- Space and support for cultural activities, ceremonies, and family visits.
- Connection to nature, bushland gardens, and the outdoors.
- Engaging Aboriginal and Torres Strait Islander staff where possible.
- Respecting cultural traditions and protocols, including men's and women's business.
- Supporting connection to community and cultural identity.

## Further information:

- [Actions to Support Older Aboriginal and Torres Strait Islander People](#): a Guide for Aged Care Providers
- [Caring for Forgotten Australians, Former Child Migrants and Stolen Generations](#): Information package for Aged Care Services (2016)
- [National Aboriginal and Torres Strait Islander Flexible Aged Care Program Manual](#)
- [NSW Health Reflect Reconciliation Action Plan](#)
- [Palliative Care Toolkit for Aboriginal and Torres Strait Islander Health Professionals \(2023\)](#)
- [Trauma Informed Care](#) Hunter New England Community Health Pathways
- [First Nations Hub](#): information and resources

## CALD Services Available:

Translating and Interpreter Service (TIS) Ph: 131 450

- Fully funded services include:
  - ▶ Immediate phone interpreting available 24 hours per day, 7 days per week
  - ▶ Pre-booked phone service or on-site interpreting
  - ▶ [Automated telephone interpreting service](#)
- [Video remote interpreting](#)
- [Actions to Support Older CALD People: A Guide for Consumers](#)
- [Centre for cultural Diversity in Ageing](#) has Multilingual health & aged care information
- [Diverse Workforce A guide to supporting Inclusive Workplaces in Aged Care](#)
- [MCCI Free Training for Residential & Home Care Providers](#)
- [Multicultural Aged Care](#)

## LGBTQIA+ Elders:

Older people of diverse sexual orientation and gender identity should be able to receive care that is sensitive, responsive and respectful of their care needs, whilst considering of their history and any experiences of discrimination and marginalisation.

- [Actions to Support LGBTI Elders: A Guide for Consumers](#)
- [Gender, Bodies and Relationships Passport tool](#)
- [Inclusion Aware and Awareness in Aged Care](#) LGBTI: Department of Health, Disability and Ageing
- [LGBTIQ+ Aged Care Awareness Training](#)
- [LGBTIQIA+ Elders](#) Support for care-leavers

A care leaver is someone who was in an institution or other out-of-home care as a child including:

- ▶ Forgotten Australians
- ▶ Former Child Migrants
- ▶ Stolen Generations
- [Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package](#)
- [Department of Health, Disability and Ageing Virtual Care – Telehealth](#)
- Virtual care, sometimes known as Telehealth, uses video (preferable) or phone technology to offer a convenient way to connect with health professionals.
- Virtual video consultations are conducted securely over the internet, allowing residents to see health professionals without the need and/or inconvenience of travelling to hospital.
- Virtual care via video uses high-speed internet, cameras, speakers, and monitors (or smartphone or tablet), whereby the resident and staff can interact directly with clinicians.
- Virtual care offers convenience and improved care coordination for residents, their families and staff in RACs.

# Hunter New England Local Health District Virtual Care

## Specialist Outpatient Appointments:

- HNE LHD encourages the use of Virtual Care (video or phone) for outpatient appointments whenever clinically appropriate.
- All specialists have access to technology to provide video appointments at their clinics with dedicated staff to schedule and support appointment booking.
- Residents can remain in their facility for their specialist appointment – reducing transport logistics and avoiding disruption to medications and meals.
- RAC staff and the substitute decision maker (where appropriate) can participate in the consultation, supporting shared understanding of care plans and shared decision making around treatment options.
- To book a virtual (video or phone) appointment contact your outpatient clinic appointment team or enquire with the Clinical Telehealth team (below).
- If you have not received connection details, or experiencing technical difficulties, please contact: Clinical Telehealth support, **Ph: 4921 3050** or email: [HNELHD-ICT-ClinicalTelehealth@health.nsw.gov.au](mailto:HNELHD-ICT-ClinicalTelehealth@health.nsw.gov.au)

## Virtual/Telehealth Support:

- For **technical assistance** or to arrange a practice video call, Monday to Friday 8 am – 4.30 pm, **Ph: 4985 5400**.

## ACE - Virtual Capable Services (Residential Aged Care In-Reach {RAC-I})

- **RAC-I** offer video consultations during Monday to Sunday 8 am to 4 pm via an automatic diversion to select hospital catchments via **ACE@ 1300 223 555**. This service can support urgent care needs of a resident whilst remaining in their home / RAC. The RAC-I specialised multidisciplinary team includes geriatricians, career medical officers, nurse practitioners, registered nurses and physiotherapists.
- To connect virtually:
  1. Visit the **RAC-I virtual waiting room** by copying and pasting this link <https://videocall.direct/hneraci> into your web browser, or
  2. Use the weblink provided and follow the prompts, or
  3. Scan the QR Code.



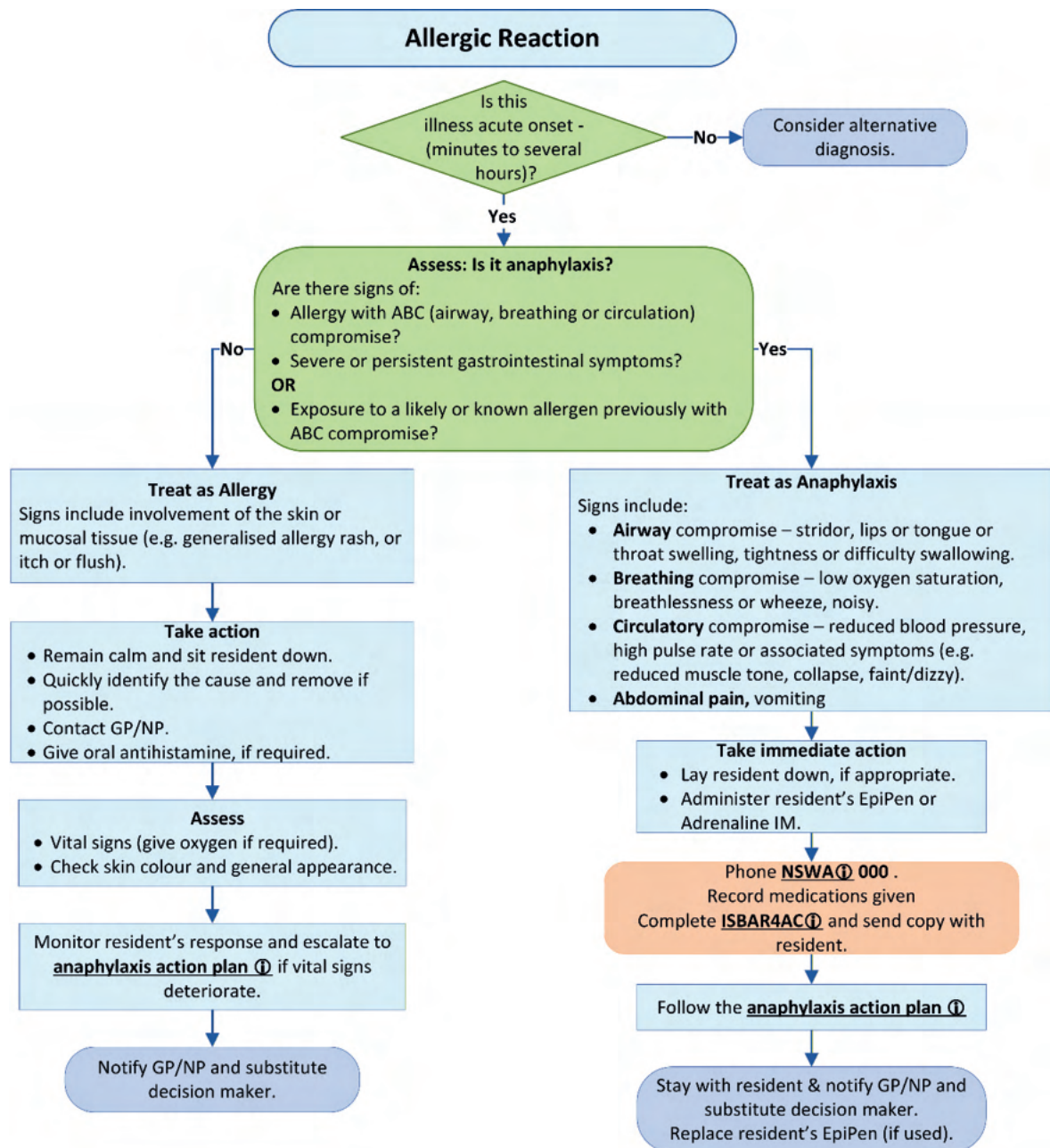
## Resources and References:

- HNELHD Virtual Care site - [https://www.hnehealth.nsw.gov.au/our\\_services2/telehealth](https://www.hnehealth.nsw.gov.au/our_services2/telehealth)

## Allergic Reactions/Anaphylaxis

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

### Allergic Reactions Flowchart



#### Advice:

[NSW Poisons Information Centre](#) – Ph: **13 11 26** - 24/7 advice on poisons information for overdoses, medication, management of poisoned and envenomed patients.

#### References and Resources:

[Community HealthPathways Anaphylaxis](#)



# Anaphylaxis Action Plan

Below [ASCIA Action Plan for Anaphylaxis for use with EpiPen](#). Accessed from Australasian Society of Clinical Immunology and Allergy (ASCIA) on 28/03/2026.



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

## ACTION PLAN FOR Anaphylaxis

Photo

Name: \_\_\_\_\_ Date of birth: DD / MM / YYYY

Confirmed allergen(s): \_\_\_\_\_

Family/emergency contact(s):

1. \_\_\_\_\_ Mobile: \_\_\_\_\_

2. \_\_\_\_\_ Mobile: \_\_\_\_\_

Plan prepared by: \_\_\_\_\_ (prescriber) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

Signed: \_\_\_\_\_ Date: DD / MM / YYYY

Antihistamine: \_\_\_\_\_ Dose: \_\_\_\_\_

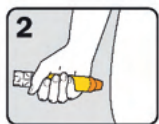
This plan does not expire but review is recommended by: DD / MM / YYYY

**How to give EpiPen® adrenaline (epinephrine) device**



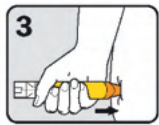
**1**

Form fist around EpiPen® and  
**PULL OFF BLUE SAFETY RELEASE**



**2**

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



**3**

**PUSH DOWN HARD** until a click is heard or felt and hold in place for 3 seconds. **REMOVE EpiPen®**

Scan for adrenaline device instructions, which are also on the device label.



EpiPen® Jr (150 mcg) is prescribed for children 7.5-20kg

EpiPen® (300 mcg) is prescribed for children over 20kg and adults

**MILD TO MODERATE ALLERGIC REACTIONS**

**SIGNS:**

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

Mild to moderate allergic reactions may not always occur before anaphylaxis

**ACTIONS:**

- Stay with person, call for help
- Locate adrenaline device
- Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

**SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)**

**Watch for ANY ONE of the following signs:**

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough

- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)
- Abdominal pain, vomiting - **these are signs of anaphylaxis for insect allergy**

**ACTIONS FOR ANAPHYLAXIS**

**1 LAY PERSON FLAT - do NOT allow them to stand or walk**

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright







**2 GIVE ADRENALINE DEVICE**

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

**4** Phone family/emergency contact

**5** Further adrenaline 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 DEVICE**

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

**ALWAYS GIVE ADRENALINE DEVICE FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice. Anaphylaxis can occur without skin symptoms.**

If device is accidentally injected, use another adrenaline device if available, and contact the local poisons information centre.

© ASCIA 2026 This plan is a medical document that can only be completed by the prescriber and cannot be altered without their permission.

## Assaults

Following an assault, it is essential to ensure the resident receives appropriate medical and emotional support. Contact the GP/NP or ACE service for assessment and treatment of injuries.

If life threatening **Ph: NSWA@ 000**.

If a crime is suspected, contact the police as soon as possible (within 24 hours) and take steps to preserve any potential forensic evidence:

- ▶ Do not disturb the "scene" by closing off the area, where possible.
- ▶ Do not remove the clothing from the resident/victim.
- ▶ Discourage the resident/victim from washing or cleaning any part of their body until advised.
- ▶ Advise against eating or drinking to preserve potential oral evidence if sexual assault is suspected
- ▶ Minimise questioning of the resident, particularly avoid leading or repetitive questions, to prevent compromising any potential criminal investigations.

### Mandatory Reporting Requirements

Under the Serious Incident Response Scheme (SIRS):

- **Priority 1** reportable incidents must be reported to the Commission **within 24 hours** of becoming aware of the incident. For more information on reporting serious incidents go to: <https://www.agedcarequality.gov.au/providers/serious-incident-response-scheme/reportable-incidents/about-reportable-incidents>.
- **Priority 1** incidents include: Physical or psychological injury or discomfort, unlawful sexual contact or inappropriate sexual conduct
- Sexual conduct refers to any behaviour of a sexual nature that may include physical acts, verbal comments, gestures, or visual materials. It encompasses a wide range of actions including, but not limited to:
  - ▶ Unwanted or non-consensual touching of a sexual nature
  - ▶ Exposure of genitals or other intimate body parts
  - ▶ Sexual acts or attempted sexual acts
  - ▶ Inappropriate sexualised comments or advances
  - ▶ Forcing or coercing a person to witness sexual acts or pornography
- **Criminal or unlawful incidents** (e.g., sexual assault) must also be reported to the police within 24 hours.

What is a reportable Assault?

- **Unreasonable use of force** - including violent physical acts or any unwarranted physical contact.
- **Unlawful sexual contact** - any sexual contact with a resident without consent.
- It is important to recognise that assaults can be perpetrated by staff, other residents, or members of the public.

### Sexual Assault Support and Advice:

Contact the [NSW Health Sexual Assault Service](#) for:

- 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.

| Hunter New England Sexual Assault Services | Business Hours | After-Hours Crisis Service |
|--------------------------------------------|----------------|----------------------------|
| Armidale                                   | 6776 9655      | 6776 9500                  |
| Gunnedah                                   | 6741 8000      | 6767 7700                  |
| Inverell                                   | 6721 9600      | 6721 9500                  |
| Kempsey                                    | 6561 2790      | 6561 2600                  |
| Maitland                                   | 4939 2517      | 4939 2517                  |
| Moree                                      | 6757 0200      | 6757 0000                  |
| Muswellbrook                               | 6542 2725      | 4921 3888                  |
| Newcastle                                  | 4924 6333      | 4924 6333                  |
| Tamworth                                   | 6767 8100      | 6767 7700                  |
| Taree                                      | 6592 9315      | 6592 9111                  |

### Advice, Resources and References:

- [Aged Care Quality RAC SIRS](#) – Serious Incident Response Scheme
- [NSW Ageing and Disability Abuse Helpline](#) **Ph: 1800 628 221** between 9:00 am and 5:00 pm Monday to Friday.
- [Community Health Pathways](#)
- [Older Persons Advocacy Network, Education and Training for Aged Care Workers](#)
- [Primary Health Network Local Link Program](#)
- Serious Incident Response Scheme (SIRS) enquiry **Ph: 1800 081 549** between 9:00 am and 5:00 pm Monday to Sunday [sirs@agedcarequality.gov.au](mailto:sirs@agedcarequality.gov.au)

# Behaviour and Confusion Management

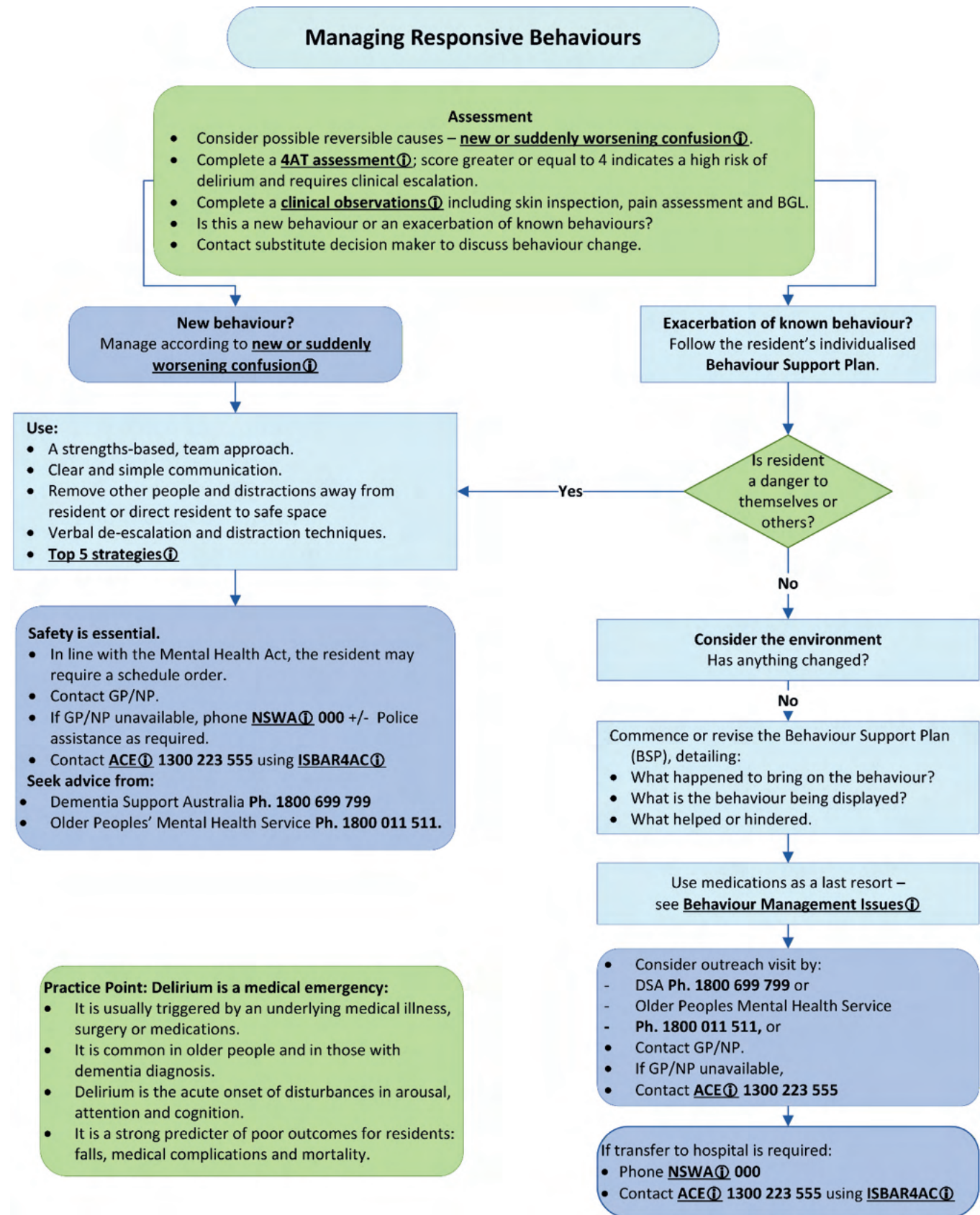
## Behaviour Management Identification table

Use the table to help differentiate between the “3 ds”, symptoms of dementia, delirium, and depression.

|                       | <b>Dementia</b>                                                           | <b>Delirium</b>                                                                        | <b>Depression</b>                                                                                                               |
|-----------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Onset</b>          | Gradual                                                                   | Acute                                                                                  | Gradual                                                                                                                         |
| <b>Duration</b>       | Months or years                                                           | Hours, days, or weeks                                                                  | Weeks or months                                                                                                                 |
| <b>Course</b>         | Progressive with periods of stability - can be step-like (e.g., vascular) | Fluctuates – Worse at night. Lucid periods                                             | Usually worse in the morning. Improves as the day goes on.                                                                      |
| <b>Progression</b>    | Gradual with fluctuations                                                 | Abrupt / sudden onset                                                                  | Variable, rapid-slow, but uneven                                                                                                |
| <b>Alertness</b>      | Usually normal                                                            | Fluctuates drowsiness or hyperactivity common                                          | Normal                                                                                                                          |
| <b>Awareness</b>      | Not consistently clear, variable, declines as condition progresses        | Reduced                                                                                | Clear                                                                                                                           |
| <b>Orientation</b>    | Variable may be impaired for time and place                               | Fluctuates in severity, generally impaired                                             | Usually normal but may have periods of disorientation                                                                           |
| <b>Memory</b>         | Short- and long-term impairment increasing as condition progresses        | Short- and long-term memory impaired. Fluctuates.                                      | Recent memory may be impaired, but remote intact                                                                                |
| <b>Thoughts</b>       | Slowed and can be disjointed                                              | Often paranoid and grandiose, bizarre ideas and topics.                                | Usually slowed, preoccupied by sad and hopeless thoughts                                                                        |
| <b>Perception</b>     | Impaired                                                                  | 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. |
| <b>Emotions</b>       | Apathetic, labile, irritable, teary                                       | Irritable, unregulated,                                                                | Flat, unresponsive, or sad<br>May be irritable                                                                                  |
| <b>Sleep</b>          | Disturbed at times. Naps through the day                                  | Impaired, fluctuates                                                                   | Difficulty waking                                                                                                               |
| <b>Other features</b> | Trajectory varies with each individual                                    | Other Physical disease may not be obvious. May linger after Physical symptoms resolve. | Previous history of mood disorder                                                                                               |



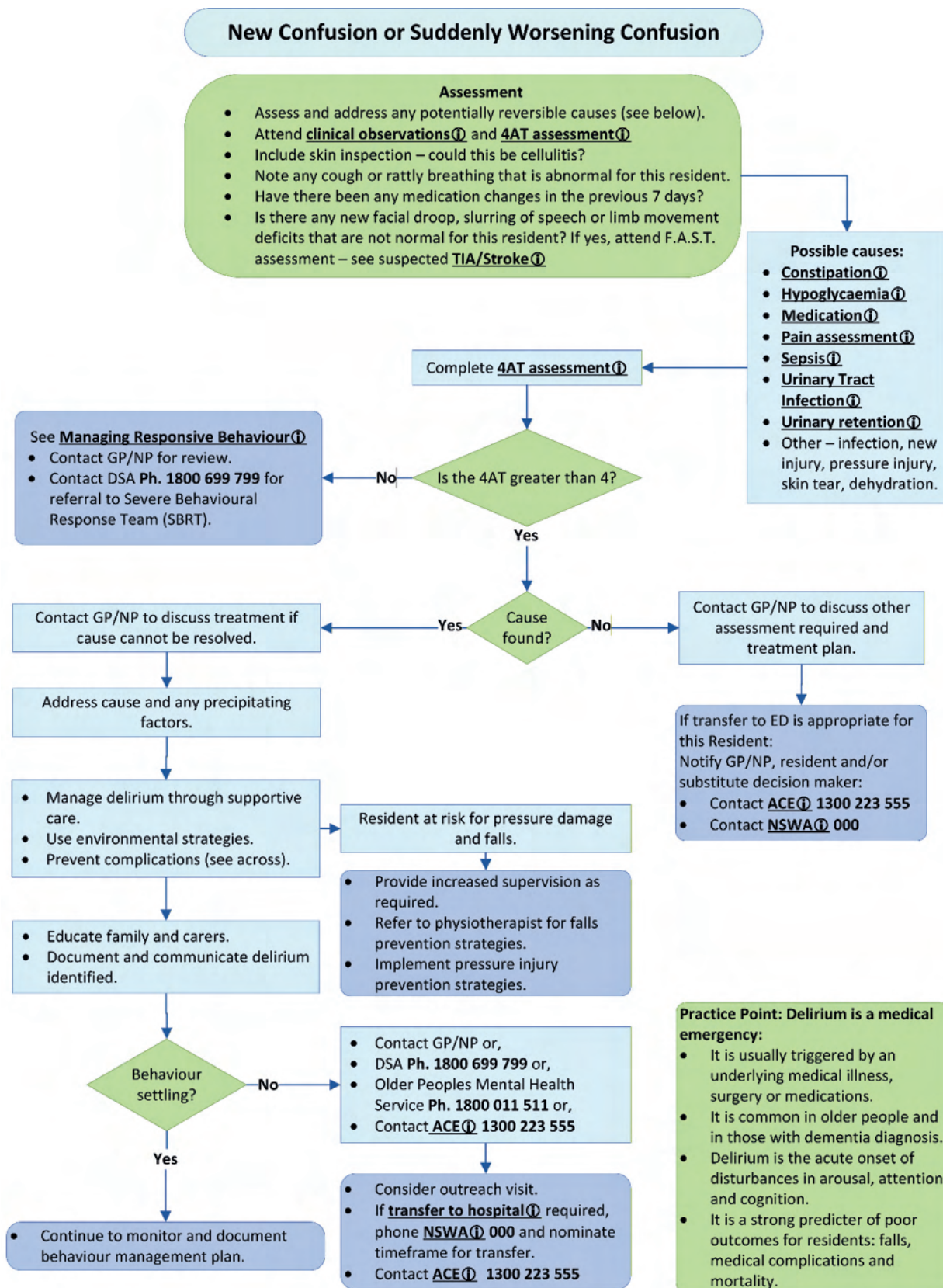
# Managing Responsive Behaviour Flowchart



## Practice Point:

All mental health referrals go through the 24-hour **Mental Health Contact Centre (MCC)** – Ph: 1800 011 511.

## Managing New or Suddenly Worsening Confusion Flowchart



## 1. Delirium

Delirium is a medical emergency and needs urgent medical review. Many causes of delirium are reversible, and these must be identified and treated promptly. It is characterised by a sudden, fluctuating changes in mental status with inattention, disorganised thinking, and altered levels of consciousness. The resident may be either very agitated or on the contrary, quiet and drowsy.

Common Signs and Symptoms of Delirium:

- ▶ Confusion (new or worsening)
- ▶ Restlessness and / or agitation.
- ▶ Alteration in mood or emotions.
- ▶ Worsening concentration.
- ▶ Altered level of consciousness.
- ▶ Altered sleep patterns.
- ▶ Less communicative or responsive.
- ▶ Difficulties cooperating with reasonable requests.

### Delirium Prevention:

|                                                                        |                                  |                                                                       |
|------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------|
| ▪ Use of hearing aids, spectacles.                                     | ▪ Hypoxia.                       | ▪ Clear signage around room                                           |
| ▪ Comfort and Pain Management.                                         | ▪ Use of indwelling catheters.   | ▪ Clock, calendar, cues for orientation                               |
| ▪ Rest and Sleep.                                                      | ▪ Use of nighttime sedations.    | ▪ Minimise disruptive changes to the care environment                 |
| ▪ Blood Glucose Management.                                            | ▪ Polypharmacy.                  | ▪ Reduce clutter and excessive noise.                                 |
| ▪ Eating and drinking (prompt and assist).                             | ▪ Abnormal metabolites.          | ▪ Adjustable lighting – artificial or natural to aid sleep/wake cycle |
| ▪ Safe mobility and daily routine activities.                          | ▪ Effects of alcohol withdrawal. | ▪ Have familiar items close – Photos/music                            |
| ▪ Bladder and bowel management.                                        |                                  |                                                                       |
| ▪ Orientation, mental stimulation, reassurance, meaningful activities. |                                  |                                                                       |

### Risk Factors:

**Predisposing Risk Factors for Delirium Aged 65 years or older.**

- ▶ Cognitive impairment and / or dementia.
- ▶ Current hip fracture.
- ▶ Severe illness (clinical condition that is deteriorating or at risk of deteriorating).
- ▶ Neurological causes (e.g., brain injury, stroke).
- ▶ Previous history of delirium.
- ▶ Visual and hearing impairment.
- ▶ Abnormal sodium, potassium and glucose.
- ▶ Drug / Alcohol / Benzodiazepine use.
- ▶ Residents who are taking 5 or more drugs have an increased risk of confusion. See **Polypharmacy and high-risk medications in RACs**

**Precipitating Factors for Delirium**

- ▶ Use of physical restraint.
- ▶ Use of indwelling catheter.
- ▶ Recent changes in medication.
- ▶ Multiple bed moves / environment changes.
- ▶ Pain.
- ▶ Surgery.
- ▶ Anesthesia and hypoxia.
- ▶ Malnutrition and dehydration.

**Assessment:**

1. 4AT Assessment Tool
  - ▶ The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment.
  - ▶ A score of 3 or more strongly indicates delirium and should trigger an escalation for medical review and trigger investigation of reversible causes.
  - ▶ The GP/NP should formally diagnose and document delirium diagnosis and treatment plan.
2. Complete **clinical observations** to identify potential causes of delirium.
3. Assess underlying common causes of delirium:
  - ▶ Is the resident unwell? **Sepsis** flowchart
  - ▶ Do they have an infection **UTI** flowchart or chest infection?
  - ▶ Are they experiencing pain? **Pain** flowchart
  - ▶ Do they have **Constipation** flowchart or **Urinary Issues**
  - ▶ Are they dehydrated (e.g., due to low intake or diuretics or recent hot weather)?
  - ▶ Could the delirium be related to **Polypharmacy** a new medication, or alcohol intake?
  - ▶ Are there environmental factors or sensory factors contributing (e.g., poor lighting, noise, impaired vision or hearing)?
4. Assess and document any cognitive or functional changes.

**Management**

- Inform GP/NP of your assessment and arrange appropriate treatment of the underlying cause (e.g., antibiotics for infection).
- Develop a Behaviour Support Plan and review and update the plan regularly. [Behaviour Support Plans Fact Sheet for RAC Providers](#)
- Consider physical, medical, social, and psychological needs of the resident.
- Use **'Top 5' principles** to personalise care. Talk to the carer to understand the resident's cues and enhance communication.
- Use the [Sunflower tool](#) to collect important information about the person and summarise their likes and dislikes.
- Pharmacological interventions are considered as a last resort for management of delirium.



A Behaviour Support Plan for delirium should also consider the following needs according to the **PINCHES ME Kindly** approach (Gee et al 2016):

- **Pain** – no pain lots of gain
- **Infection** – suspect it, spot it, stop it
- **Nutrition**, and
- **Constipation** – fluids, fibre, footwork
- **Hydration** – don't wait, hydrate
- **Exercise** – make the move to prevent delirium
- **Sleep** – don't get delirious, sleep is serious
- **Medications** – don't prescribe delirium
- **Environment** – house proud
- **Kindly** – calm, patient and mindful of emotional need

### Delirium References:

- [Utility of the 4AT assessment of delirium in acute care](#): evidence based bedside tool for the rapid screening of delirium across clinical settings
- [Delirium detection in older acute medical inpatients](#) (2019)
- [ACI Screening and Assessment tools for older people](#) (2021)
- [Australian Commission on Safety and Quality in Health Care Delirium Clinical Care Standard](#)
- [Delirium Screening tool](#) – Dementia Support Australia
- [Dementia Training Australia Delirium Action Plan](#)
- [Think delirium](#): Gee, S., Bergman, J., Hawkes, T. & Croucher, M. (2016), Preventing delirium amongst older people in our care. Tips and strategies from the Older Persons' Mental Health Think Delirium Prevention project Christchurch, New Zealand: Canterbury District Health Board.
- [Identifying and responding to pain](#)
- [NICE Delirium: prevention, diagnosis and management in hospital and long-term care](#). Clinical Guideline. Last up-dated 2023.
- [Person Centred Care](#) – NSW Government Clinical Excellence Commission
- [Sunflower tool](#)
- [Top 5](#)

## 2. Medication

The use of medications should be least restrictive and always refer to the Behaviour Support Plan for alternative strategies for addressing Responsive Behaviours. 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 (e.g., antibiotics for infection, analgesia for pain)
- If the resident has recently **started, stopped or changed** 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, NP or Pharmacist referral for a residential medication management review (RMMR).
- RACs need to ensure they are using the medication as prescribed and have appropriate monitoring in place and have obtained consent for administration.

## Behaviour Support Plan

A Behaviour Support Plan is a living document that promotes continuity of care and assists in identifying new and / or escalating behaviours. When developing or updating the plan:

- **Accept** - the resident by active listening, engage and understanding what the resident is trying to tell you.
- **Assess** – consider:
  - ▶ Physical illness
  - ▶ Unmet needs (e.g., hunger, pain boredom)
  - ▶ Carer needs.
- **Act** - deliver person-centred care using meaningful activities:
  - ▶ Address unmet needs, e.g., physical, environmental, psychosocial, and carer needs.
  - ▶ Treating physical illness, pain, and/or psychiatric disorder.
- **Reassess** - if behaviours persist.
  - ▶ Prioritise non-pharmacological strategies
  - ▶ Consider pharmacological interventions only when necessary
- **Review** and reassess cognition if no previous diagnosis of dementia and provide carer education.

## Dementia Support Australia (DSA)

If the primary concern is behavioural disturbance with dementia, support is available through DSA. Referrals can be made 24 hours a day via:

- Online referral form - <https://dementia.com.au/contact/referral>
- **Ph: 1800 699 799** 24-hour helpline
- Fax on 1800 921 223.

DSA offers the following services:

- [Dementia Behaviour Management Advisory Service](#) (DBMAS)
  - ▶ Provides support to staff and carers through information, advice, assessment, and short-term case management for people living with dementia who exhibit behavioural and psychological symptoms of dementia (BPSD). Contact DBMAS 24/7 for immediate guidance on **Ph: 1800 699 799**.
- [Severe Behaviour Response Teams](#) (SBRT)
  - ▶ Offers a range of crisis management services for patients with dementia and severe and extreme BPSD.
- [Specialist Dementia Care Program](#) (SDCP)

A national program for individuals with very severe BPSD who:

- ▶ Cannot be appropriately supported within mainstream aged care services, and
- ▶ Do not require care in an acute hospital setting.
- ▶ The program provides transitional, specialised care within designated Specialist Dementia Care (SDC) units.
- ▶ In NSW, the SDC unit is located at Hammond Care Cardiff.
- ▶ There are 35 units Nationally.
- ▶ The goal is to stabilise or reduce the severity of BPSD to enable transition to a less intensive care setting.

To make a referral to either DBMAS, SBRTs, or SDCP, use the above [Dementia Support Australia referral form](#).

#### Practice Point:

Delirium is a **medical emergency** and is better managed by the GP/NP 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.

### Dementia Australia

Dementia Australia is a supportive service for residents, families, friends and carers, and professionals.

- [Online referral](#)
- [National Dementia Helpline](#) **Ph: 1800 100 500**. Expert information, advice and support 24 hours per day, 7 days per week.
- [Professional Development and training](#)
- [Nightingale Program](#) - Palliative model of advance dementia care, led by specialist nurses. Providing strategies and advice to people living with advanced dementia.

### Hunter Primary Care Nurse Practitioner Behavioural Services

Hunter Primary Care are developing Nurse Practitioner consultancy services.

Further information and referrals are available via:

[Nurse Practitioner Consultancy Behavioural Service - Hunter Primary Care](#) or **Ph: (02) 4935 3241**

### References and resources:

- Aged Care Quality and Safety Commission:
  - ▶ [Behaviour support plans – fact sheet](#)
  - ▶ [Restrictive practices – behaviour support planning webinar](#) (23 August 2021)
- [Assessment and Management of People with Behavioural and Psychological Symptoms of Dementia \(BPSD\): A Handbook for NSW Health Clinicians](#) (The Royal Australian & New Zealand College of Psychiatrists and NSW Health, 2013)
- [Behaviour support plan resources](#) - Dementia Support Australia
- [Dementia Support Australia behaviour support plan resources](#)
- [Dementia Support Australia personal care plans for people with dementia who experience severe behaviours](#)
- [Dementia Training Australia online resource library](#)

# Cardiology

## Heart Failure Issues

Below is a table of common causes of Heart Failure Issues and management strategies.

| Symptom                          | Cause                                                                                                                                 | Management                                                                                                                                                                                                                                                                                                 |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Shortness of breath (SOB)</b> | <ul style="list-style-type: none"> <li>Excess fluid in the lungs.</li> <li>Left ventricular failure or pump failure.</li> </ul>       | <ul style="list-style-type: none"> <li>Rest when needed.</li> <li>Oxygen if necessary. Remember that oxygen should only be given as a treatment for hypoxaemia.</li> <li>Extra pillows to sleep if needed.</li> <li>Morphine liquid if prescribed for symptomatic management of breathlessness.</li> </ul> |
| <b>Ankle swelling</b>            | <ul style="list-style-type: none"> <li>Caused by fluid leaking out of the blood vessels into the tissues (oedema).</li> </ul>         | <ul style="list-style-type: none"> <li>Inform GP/NP.</li> <li>Review fluid intake, diet (especially sodium intake), medications (e.g., diuretics).</li> </ul>                                                                                                                                              |
| <b>Weight gain</b>               | <ul style="list-style-type: none"> <li>Fluid build-up may cause rapid weight gain.</li> <li>1 litre fluid = 1 kg increase.</li> </ul> | <ul style="list-style-type: none"> <li>Weigh every morning before breakfast.</li> <li>If weight increased or decreased by 2 kg from the previous day inform GP/NP.</li> <li>Fluid management-monitor fluid restriction if advised by cardiologist or GP/NP.</li> </ul>                                     |
| <b>Tiredness</b>                 | <ul style="list-style-type: none"> <li>Can be caused by decreased blood flow to the major organs and muscles.</li> </ul>              | <ul style="list-style-type: none"> <li>Adequate rest.</li> <li>Use energy conservation techniques.</li> <li>Exercise is beneficial with heart failure – encourage activity / exercise and maintain where possible.</li> </ul>                                                                              |
| <b>Loss of appetite</b>          | <ul style="list-style-type: none"> <li>Build-up of fluid in the digestive organs.</li> <li>Decreased circulation.</li> </ul>          | <ul style="list-style-type: none"> <li>Eat smaller meals, more often.</li> </ul>                                                                                                                                                                                                                           |
| <b>Dizziness</b>                 | <ul style="list-style-type: none"> <li>Decreased blood flow to the brain.</li> <li>Changes in heart rate and rhythm.</li> </ul>       | <ul style="list-style-type: none"> <li>Mobilise slowly.</li> <li>Sit or lie down when needed.</li> <li>Inform the GP/NP.</li> <li>Check pulse – If over 120 or below 40 bpm, contact GP/NP.</li> </ul>                                                                                                     |
| <b>Chest pain</b>                | <ul style="list-style-type: none"> <li>Chest pain can be caused by reduced blood flow to the heart muscle.</li> </ul>                 | <ul style="list-style-type: none"> <li>See the <b><u>Managing Chest Pain</u></b> flowchart</li> </ul>                                                                                                                                                                                                      |
| <b>Confusion</b>                 | <ul style="list-style-type: none"> <li>Confusion can be caused by decreased blood flow to the brain.</li> </ul>                       | <ul style="list-style-type: none"> <li>Rest as needed.</li> <li>Oxygen if required</li> <li>Communicate clearly and concisely</li> </ul>                                                                                                                                                                   |

## Management principles for people with Heart Failure

- 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/NP.
  - ▶ **Fluid management:** monitor fluid intake. This may include a fluid restriction as recommended by the GP/NP or cardiologist.
- Daily monitoring to detect 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, which may include:
  - ▶ Oxygen therapy (if SpO<sub>2</sub> less than 90%).
  - ▶ Diuretics.
  - ▶ Morphine liquid to assist with breathlessness.

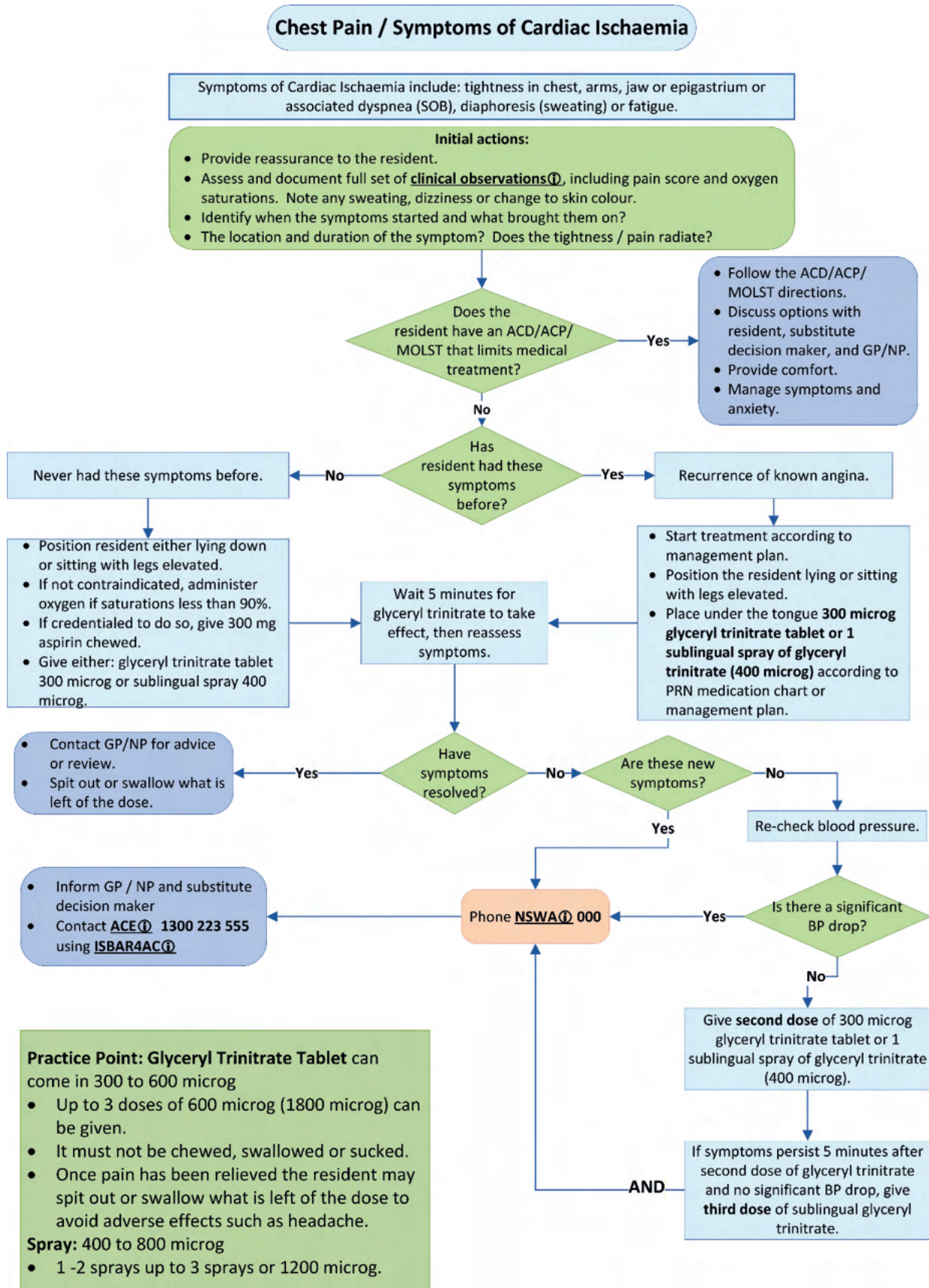
## Managing Chest Pain / Symptoms of Cardiac Ischaemia

### Practice Point:

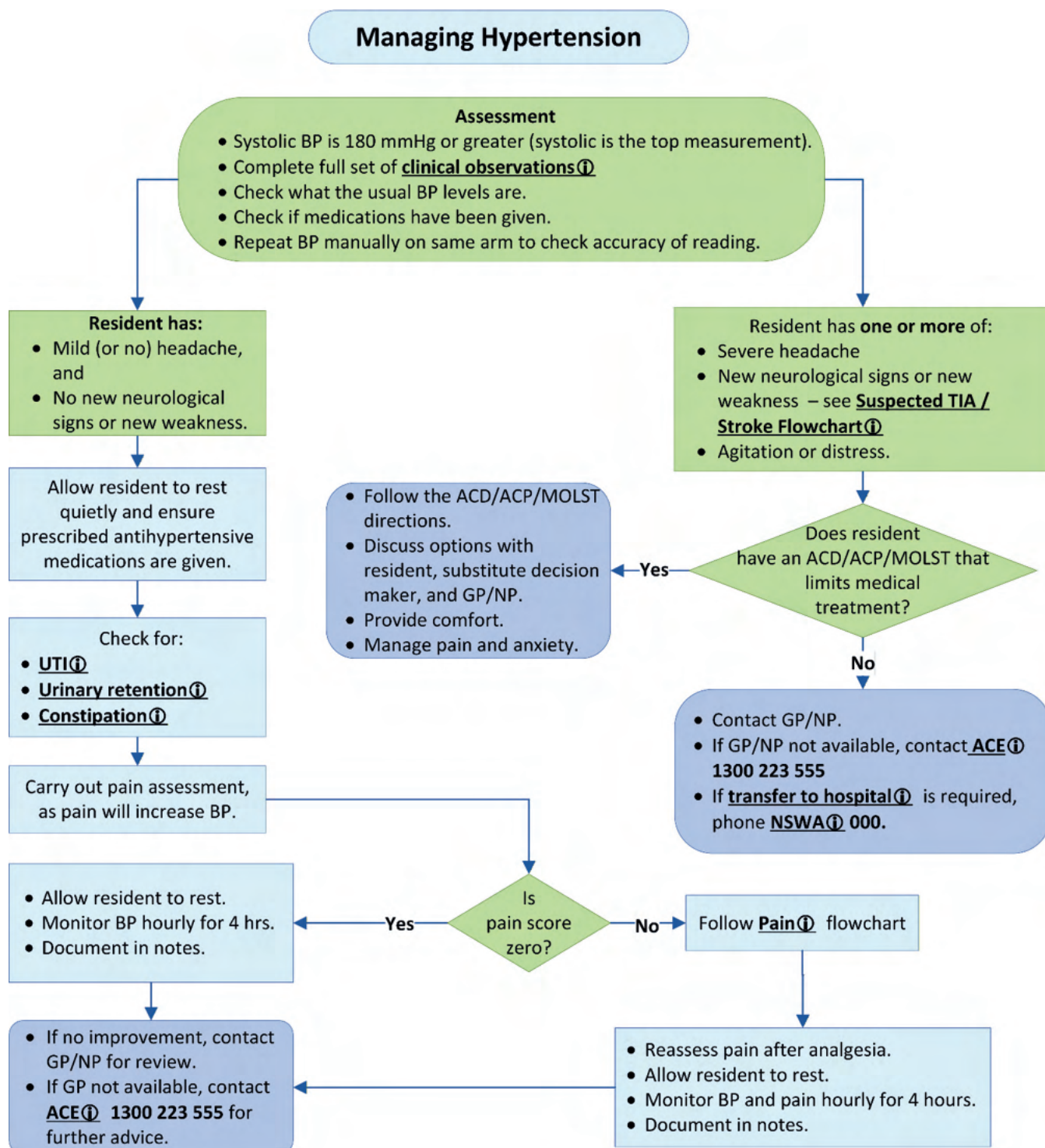
- Glyceryl trinitrate lowers blood pressure.
  - Careful consideration should be given when interpreting blood pressure values after administering glyceryl trinitrate.
  - A “significant” drop is greater than 20mmHg.
- Glyceryl trinitrate tablet/spray is a suggested medication for treatment of acute chest pain. Residents with previous history of chest pain should have a PRN order for glyceryl trinitrate on their medication chart.
  - Glyceryl trinitrate is administered sublingually.
    - ▶ Spray:
      - Always check expiry date on glyceryl trinitrate spray and ensure spray is primed before using. To prime, remove the lid, face the bottle away from you and depress pump **5 times**. An even spray should be observed.
      - After priming, aim the spray under the tongue and press the nozzle once; do not inhale the spray.
    - ▶ Tablets:
      - Ensure the residents’ mucous membranes are moist when using glyceryl trinitrate tablets to make certain tablets will dissolve as intended.
      - The tablet must be placed under the tongue and allowed to dissolve - they are not to be swallowed, sucked or chewed.
      - If pain is relieved, the remainder of the tablet may be spat out or swallowed to avoid adverse effects such as headache.



# Managing Chest Pain / Symptoms of Cardiac Ischaemia Flowchart



# Managing Hypertension Flowchart



## Advice and Referral:

- Community HealthPathways
  - ▶ [Cardiology](#)
  - ▶ [Cardiology Referrals](#)

## References and Resources:

### Chest pain

- [Australian Medicines Handbook July 2025.](#)
- [Heart Foundation](#)
- [Comprehensive Australian Clinical Guideline for Diagnosing and Managing acute coronary syndromes 2025](#)

### Heart Failure

- [Heart Failure](#) Community HealthPathways –
- [Consensus Statement on the current Pharmacological prevention and management of heart failure.](#) MJA - Cardiac Society of Australia and New Zealand. (2022).
- [The Evolving face of heart failure management.](#) Kalsi, M, Dayawansa, N, Winderlich, J, Vaddadi, G. Australian Journal of General Practice. (2022).
- [Heart Online](#) – Heart Education Assessment Rehabilitation Toolkit:
- [Titration of medications in Heart Failure](#)
- [Australian Clinical Guidelines for the Management of Heart Failure 2018](#) MJA – National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand
- [Heart failure tools and resources.](#) Heart Foundation
- [Flexible diuretic regimen: Clinical practice guide 2024](#) Agency for Clinical Innovation
- [Chronic heart failure](#)

### Hypertension

- [Hypertension](#) Community HealthPathways
- [Australian Heart Foundation](#)
- [Hypertension and Headache](#) Emergency Care Institute ACI

### See also:

- [NSW Guidelines for deactivation of implantable cardioverter defibrillators at the end of life \(2022\)](#)
- [Heart Education Assessment Rehabilitation Toolkit](#) Heart Online

# Choking

Choking can occur at any time, even in individuals without a history of swallowing difficulties. It is the second highest preventable death in RACs. Updates to the Aged Care Quality Standards 2025 (Standard 6 Food & Nutrition) reflect a shift toward proactive, well-documented, and standardised choking management protocols.

## Important Considerations:

- People with dysphagia or swallowing impairments are at higher risk for aspiration.
- Symptoms from an aspirated foreign body depends on the location and size of the object as well as the residents health status.
- Residents have the right to make informed decisions regarding food intake and associated risks, and these decisions should be respected and documented.

### Practice Point:

An ACD/ACP/MOLST that includes a "Not for Resuscitation" order **does not stop the provision of first aid**, including in choking situations.

## Risk Management:

### Organisational Readiness

- Ensure 24/7 onsite first aid capability, including the ability to manage airway obstruction.
- All staff must know how to access first aid equipment and call for assistance immediately.
- The service must maintain functioning suction devices, readily accessible to clinical staff.
- Devices should be checked regularly to ensure proper operation.
- Staff must be trained in safe and effective suction technique.
- The organisation should consider a baseline swallowing assessment on admission by a Speech Pathologist.

### Staff Training and Awareness

All staff should:

- Recognise signs of choking:
  - ▶ Excessive coughing, gagging or vomiting in attempt to dislodge object
  - ▶ Red in the face and unable to take a breath
  - ▶ One or both hands clutching at the throat
  - ▶ A look of panic, shock or confusion
  - ▶ Inability to talk; hoarse and weak voice quality
  - ▶ Wheezing, stridor or strained, noisy breathing
  - ▶ Shortness of breath
- Be able to initiate first aid and emergency response measures.
- Clinical staff must be trained in:
  - ▶ Use of suction devices to remove food or liquid from the mouth and throat.
  - ▶ Responding to aspiration and related emergencies.
  - ▶ Provide ongoing education and refresher training in first aid for choking, including referral to accredited training providers such as St John Ambulance or the Australian Red Cross.
- Example of a portable suction device:
  - ▶ [Dechoker ®](#) or [LifeVac ®](#)

## Identify the presence of Risk Factors:

- **Decreased level of consciousness:** trauma, use of sedatives or alcohol, neurological disorders (brain tumours, seizures, Parkinson's disease, intellectual disability, stroke).
- **Age >70 years:** the risk of aspiration is higher in older people, likely due to ageing associated degenerative neurological and cerebrovascular disorders that can cause dysphagia and / or impaired cough reflex.
- **Poor oral health:** can be a source of bacteria that can be aspirated and cause chest infections.



- **Neurological impairment:** stroke, Parkinson's Disease, dementia and brain dysfunction can cause impairment of swallowing and the cough reflex.
- **Underlying medical conditions:** such as COPD, asthma, and other respiratory conditions can result in swallowing difficulties.

### Resident Assessment and Risk Management

Residents at risk of choking require a referral to a speech pathologist for:

- ▶ Swallowing assessments.
- ▶ Recommendations for optimal food texture and fluid consistency, feeding techniques, posture, and timing.
- ▶ Regularly review and update care plans and risk assessments as resident condition changes.
- ▶ Engage in individualised, consumer focused discussions about swallowing risks and food choices.
- ▶ These conversations must be well documented.
- ▶ They should explore quality of life, food enjoyment, safe swallowing, nutrition, and potential outcomes including aspiration or choking.

### Incident Management Following a Choking Event

All choking events must be treated as clinical incidents, triggering:

- ▶ Open disclosure with residents and/or their substitute decision maker.
- ▶ A comprehensive investigation into contributing factors (e.g., food textures, fluid consistencies, feeding techniques, posture, and supervision).
- ▶ Assessment of staff response and timeliness of first aid.
- ▶ Development and implementation of service improvements based on findings.
- ▶ Speech pathology assessment of the resident post-incident.
- ▶ Updated documentation reflecting revised preferences and risk discussions.
- ▶ Staff debriefing and support, recognising emotional and psychological impacts.

### Monitoring of Resident after a Choking event:

#### Immediate Monitoring:

- Observe breathing – ensure it is normal & not laboured or shallow.
- Watch for signs of distress – coughing, wheezing, chest pain or voice changes.
- Encourage coughing: if the person continues to cough, it may help clear residual particles or irritation.

#### Ongoing Monitoring:

- Monitor for signs/symptoms of Aspiration Pneumonia – when food / fluid enters the lungs, increased cough & sputum, fever, respiratory distress, low oxygen saturations.
- Airway swelling or trauma.
- Recurring choking or difficulty swallowing.

### External manoeuvre:



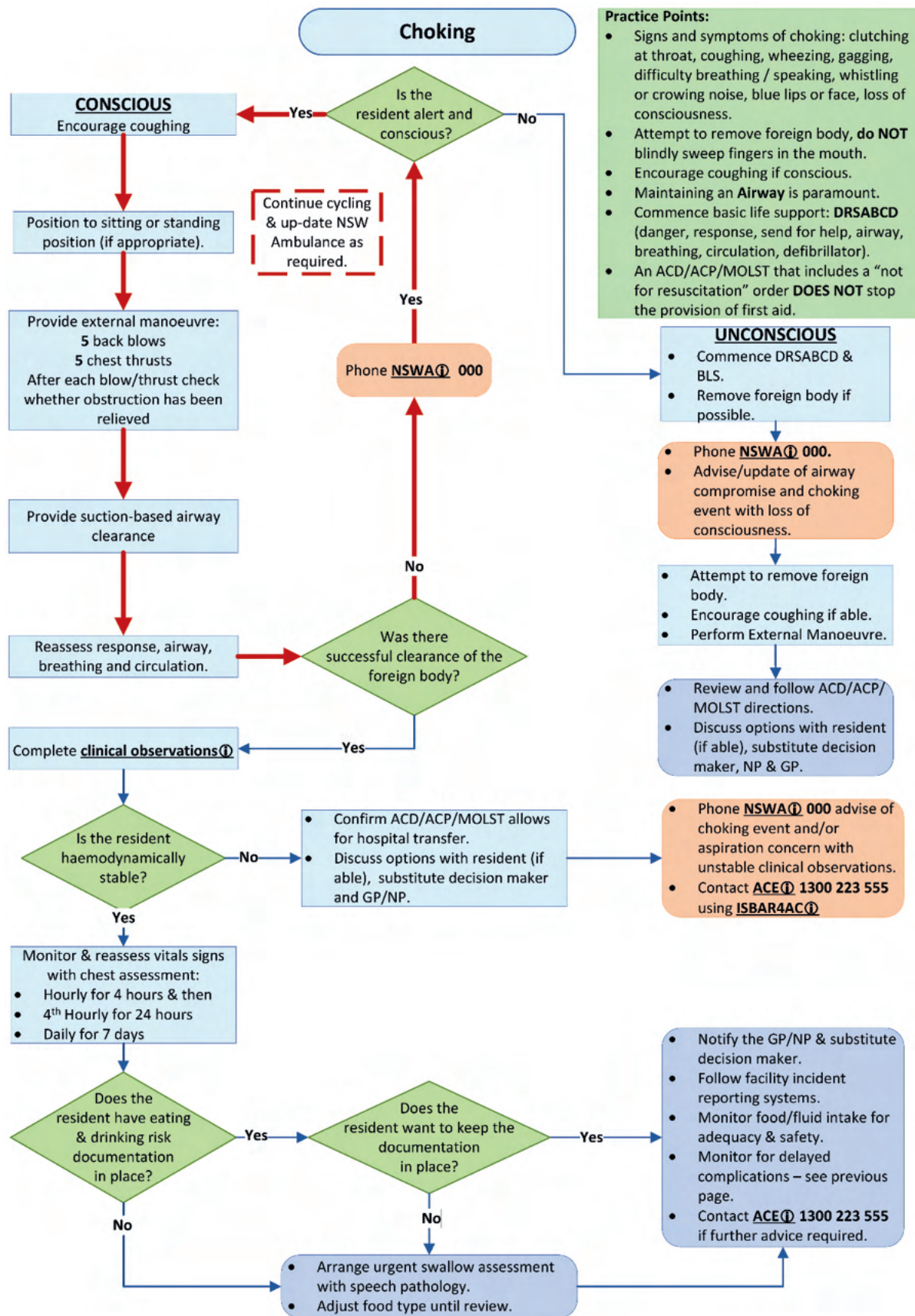
5 back blows

5 chest thrusts

[St Johns First Aid Fact Sheet Choking](#)



## Choking Flowchart



## Dysphagia

The early identification of dysphagia (difficulty swallowing) in residents supports the risk reduction of aspiration, choking, malnutrition, and other complications. Dysphagia is the difficulty or discomfort in swallowing, which may involve problems with any part of the swallowing process. It can lead to serious complications such as aspiration pneumonia, malnutrition, dehydration, and choking.

### Recognising Signs of Dysphagia:

Staff should monitor residents closely for the following visible or audible signs during meals and medication administration:

- ▶ Coughing before, during or after swallowing
- ▶ Frequent throat clearing after swallowing
- ▶ Gurgle or wet-sounding voice after eating or drinking
- ▶ Loss of voice after swallowing
- ▶ Shortness of breath during meals
- ▶ Life-threatening choking or visibly restricted breathing
- ▶ Requiring multiple swallows per mouthful
- ▶ Visible effort or strain to swallow
- ▶ Dribbling of saliva, food, or fluid from the mouth
- ▶ Difficulty chewing food
- ▶ Spitting out food or food particles
- ▶ Food residue in the mouth or cheeks after swallowing
- ▶ Lengthy mealtimes
- ▶ Apparent fear or avoidance of eating/drinking
- ▶ Watery eyes when eating or drinking
- ▶ Nasal regurgitation (food/fluid coming up into the nose)
- ▶ Difficulty swallowing medications
- ▶ Reported pain or discomfort during swallowing

### Symptoms Associated with Dysphagia:

The following clinical signs may indicate underlying dysphagia and should prompt further assessment:

- ▶ Recurrent chest infections or aspiration pneumonia
- ▶ Fever of unknown origin
- ▶ Unintended weight loss
- ▶ Signs of malnutrition or nutritional decline
- ▶ Dehydration

### Recommended Actions:

- ▶ Escalate concerns to the Registered Nurse or clinical lead for assessment.
- ▶ Refer to a Speech Pathologist for comprehensive swallowing assessment.
- ▶ Update care plans to reflect individual swallowing support needs.
- ▶ Open disclosure with substitute decision maker of care changes.
- ▶ Implement: diet and/or fluid modification, feeding strategies, and positioning recommendations as directed by allied health professionals.
- ▶ Document all signs, symptoms, and interventions in the resident's clinical notes.
- ▶ Monitor trends to identify early deterioration, even if individual observations fall within "normal" ranges.

### Supporting Resources:

- [Aged Care Quality and Safety Commission](#) – Ensuring first aid capabilities to manage choking
- [Choking First Aid in RAC](#) Ausmed
- [Outcome 5.5.2](#). Australian Government of Department of Health and Aged Care
- [Best Practice Foreign Body Aspiration](#) BMJ Jan 2025
- [patient handouts on food levels](#) International Dysphagia Diet Standardisation Initiative
- [Fact Sheet Swallowing](#) Speech Pathology Australia
- [Choking](#) St Johns First Aid Fact Sheet

### Services:

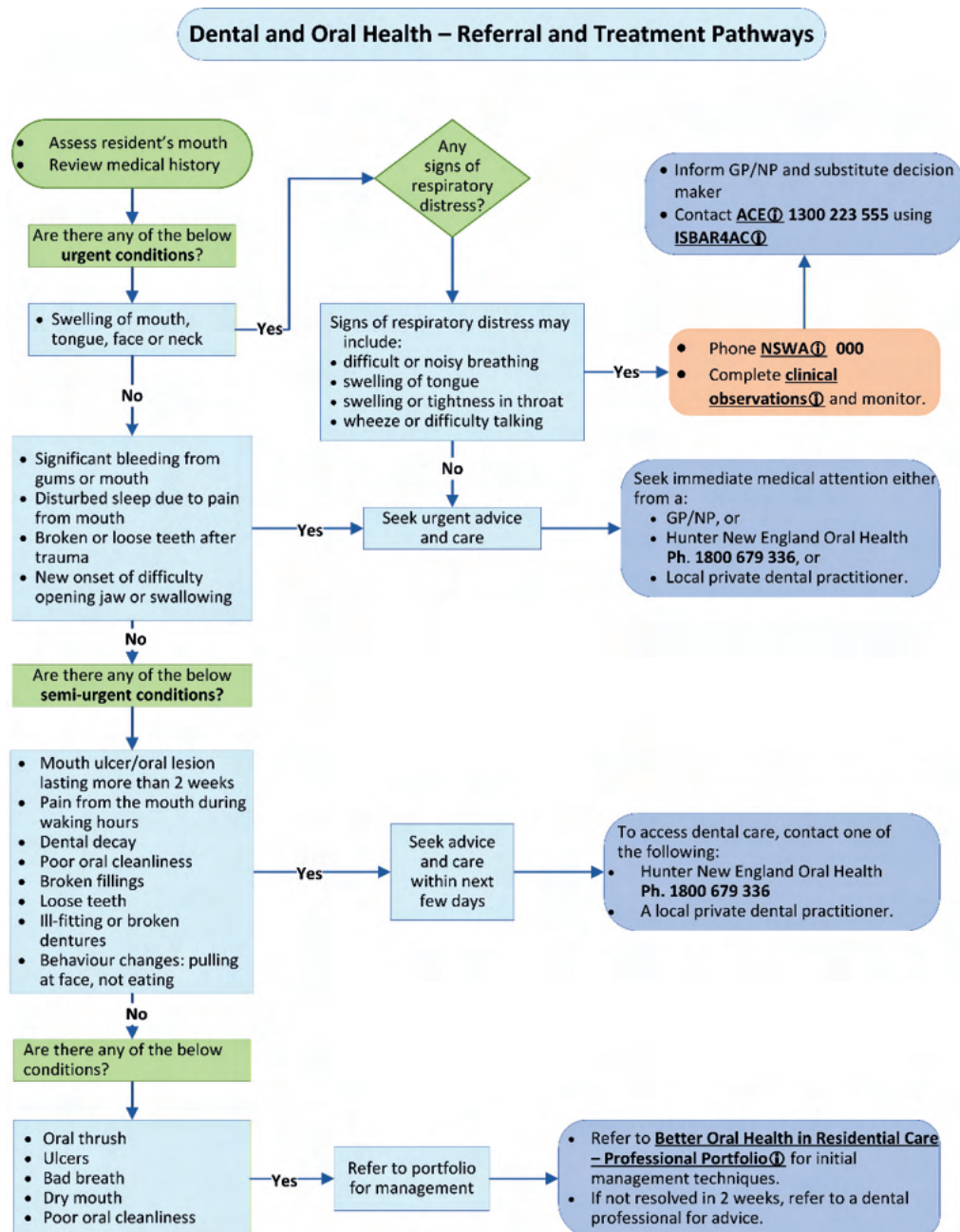
#### Residential Aged Care Services (RACS Team)

Team of speech pathologists and accredited practicing dietitians who provide service to RACs across Greater Newcastle and the Hunter (extending north to Port Stephens and northwest to Scone)

- Dietetics Services include:
  - ▶ Personalised nutrition assessments.
  - ▶ Support for malnutrition and unintentional weight loss, chronic wounds, and increased frailty and falls.
  - ▶ Bowel problems and gastrointestinal diseases.
  - ▶ Management of chronic health conditions like diabetes, kidney disease, and cancer.
  - ▶ Education for residents and their families about nutrition.
  - ▶ Prescribing nutritional supplements to boost strength.
  - ▶ Reviewing menus and mealtimes to meet the 2024 Strengthened Aged Care Quality Standards.
- Speech Pathology services include:
  - ▶ Speech Pathologists see residents who have communication and /or swallowing disorders.
  - ▶ Communication and /or swallowing disorders, including bedside and/or objective assessment measures.
  - ▶ Communication programming.
  - ▶ Food and fluid texture modification.
  - ▶ Use of safe feeding and swallowing strategies to improve quality of life.
  - ▶ RACs speech pathologists are the first in NSW to use flexible endoscopic evaluation of swallowing (FEES) onsite in aged care facilities.
- Please refer via email to:
  - ▶ Speech Pathology: [HNELHD-ResCareSpeech@health.nsw.gov.au](mailto:HNELHD-ResCareSpeech@health.nsw.gov.au)
  - ▶ Dietetics: [HNELHD-ResCareDietitian@health.nsw.gov.au](mailto:HNELHD-ResCareDietitian@health.nsw.gov.au)
  - ▶ For further information **Ph: 02 4921 4859**

## Dental and Oral Health – Referral and Treatment Flowchart

With more older people retaining their natural teeth and experiencing multiple medical comorbidities, regular oral health assessments by dental professionals are essential. Timely access to oral health referrals and treatment pathways is also important. Existing oral health assessments and care plans should be reviewed and updated whenever there are changes in a resident's oral health condition.



### Advice:

Hunter New England Oral Health **Ph: 1800 679 336**

### References and Resources:

- [Better Oral Health in Residential Care](#)
- [Oral Health Care for Older People – Toolkit for oral health and health](#)
- [Oral Health Assessment Form and Oral Health Care Plan](#)

# Diabetes

## 1. 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 greater than 15 mmol/L
  - ▶ the patient is vomiting
  - ▶ the patient is being treated with an SGLT2 inhibitor (dapagliflozin, empagliflozin) and is unwell.
- [NDSS Fact Sheet](#) Managing sick days for type 1 diabetes
- **Do not** withhold basal insulin.
- Rapid acting insulin should be given **before** meals and should be adjusted based on resident's food intake.
- It is advisable to have a standing order of IM Glucagon in case of severe hypoglycaemia.

## 2. Type 2 diabetes

Type 2 diabetes is a progressive condition associated with insulin resistance or insulin deficiency.

### Guidelines for Management:

- Management of type 2 diabetes should always focus on dietary intake and regular exercise.
- Ensure the resident has regular carbohydrate intake.
- Antihyperglycaemic treatment with metformin is recommended for all adults with type 2 diabetes, regardless of their initial HbA1c, unless contraindicated or not tolerated. Additional antihyperglycaemic treatment may be required to achieve glycaemic targets.
- See [Management of type 2 diabetes: A handbook for general practice](#)

## 3. Blood Glucose Monitoring

Regular blood glucose monitoring is required to determine if diabetes treatment is helping to manage blood glucose levels appropriately or whether there is need to adjust 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 or hypoglycaemia.

The frequency of Blood Glucose Monitoring should reflect:

- The resident's individual tailored diabetes clinical management plan as recommended by the resident's Endocrinologist or GP/NP.
- [The Diabetes management in Aged Care: Fast facts for care workers](#), by National Diabetes Services Scheme, Diabetes Australia or
- The need to test more frequently if the resident is unwell or if suspected of having hypoglycaemia or hyperglycaemia.



**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.

**4. Hypoglycaemia**

- Hypoglycaemia is a BGL less than 4 mmol/L.
- Frail older people are at higher risk of hypoglycaemic event: avoid BGL less than 6 mmol/L.
- See the **Hypoglycaemia Management** flowchart
- Have a Hypoglycaemia kit available to staff in each area with quick acting carbohydrates, e.g., GlucaGen HypoKit, Lucozade, glucose tablets, or as listed on the **Hypoglycaemia Management** flowchart.
- For residents who may have impaired swallowing and require thickened fluids, include the following in the kit:
  - ▶ 185 mL Flavour Creations Level 3 Full Thick Citrus Cordial Drink.
  - ▶ Snack pack of apple purée with a 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.

**5. Hyperglycaemia and Diabetic-Ketoacidosis (DKA)**

High blood glucose levels and ketones can result in diabetic ketoacidosis (DKA), which may require hospitalisation. Targets need be individualised and balanced against the person's wishes, their expected long-term outcomes, stage of illness, symptoms and the risk of severe hypoglycaemia. The GP/NP can define these levels.

**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.
  - ▶ Always check BGL in any unwell resident with diabetes.
  - ▶ Additionally check ketones if indicated (next page).

**Ketone levels**

- Check ketone levels in any unwell resident with:
  - ▶ Type 1 diabetes mellitus
  - ▶ Vomiting
  - ▶ Current treatment with SGLT2 inhibitor (dapagliflozin, empagliflozin).
- 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.
- 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 less than 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 and ketones every 2 hours.                                                                                  |
| High risk of DKA if blood ketones are between 1.5 to 3 mmol/L.  | Additional fast-acting insulin is required – contact GP/NP. If not available within 1 hour, contact <b>ACE@ 1300 223 555</b> . DKA can develop within a few hours if not treated promptly. |
| Very high risk of DKA if blood ketones are above 3 mmol/L.      | Urgent medical treatment is required – contact GP/NP. If not available, contact <b>ACE@ 1300 223 555</b> .                                                                                 |

Table adapted from [Monitoring for Ketones](#). 2023. Diabetes Times.

## 6. Insulin

Insulin is a synthetic hormone used to reduce a blood glucose levels.

### 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 insulin vial which is loaded into a pen (e.g., Ryzodeg vials loaded into a NovoPen4) or a pre-filled disposable pen (e.g., Novorapid FlexPen).
- All insulin for subcutaneous injection is to be administered via a pen/prefilled device.
- 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.

#### Practice Point:

- **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 **two high concentration insulin products** available: Toujeo (insulin glargine) 300 units/mL, and Humalog U200 (insulin lispro) 200 units/mL.
- **Warning labels** should be affixed to product packaging, dispensing labels and shelving areas to alert clinicians.
- **Always** check the concentration of insulin and administer these high concentration insulins with the supplied device to reduce errors and serious harm.

[Insulin - Clinical Excellence Commission](#) - [Implementation checklist - High Risk Medicine Standard Insulin](#)

## 7. Foot care

Foot care is important for residents who have diabetes.

### Guidelines for Management:

- Residents who have a history of foot ulcer, circulation problems, and 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.
- See [Community HealthPathways](#)
  - ▶ [Diabetes Foot Screening](#)
  - ▶ [High Risk Foot Assessment](#)

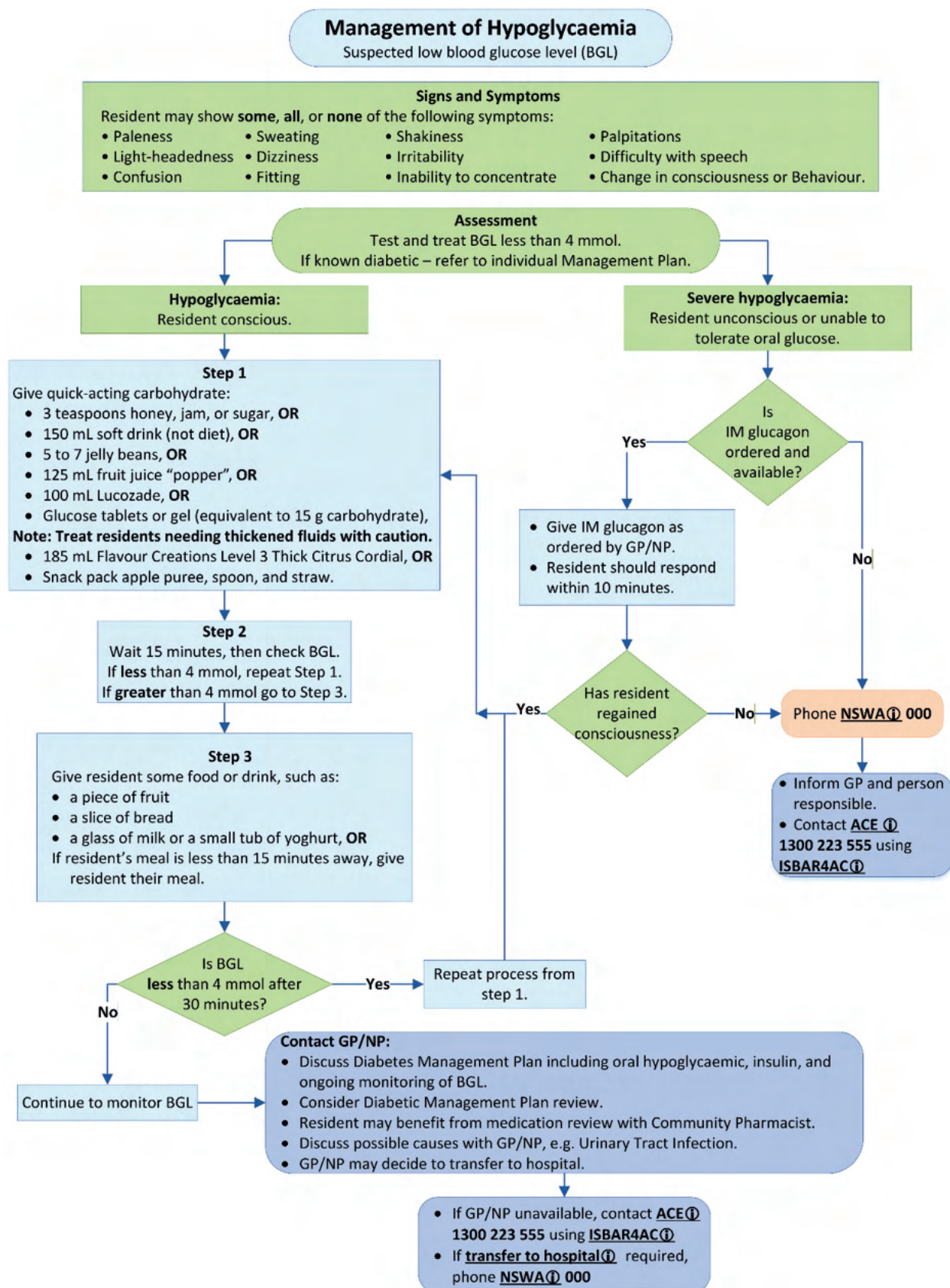
### Advice and Referrals:

- [Diabetes](#) Community HealthPathways
- Diabetes NSW and ACT
  - ▶ <https://diabetesnsw.com.au/>
  - ▶ **Ph: 1800 177 055** or [info@diabetesaustralia.com.au](mailto:info@diabetesaustralia.com.au)
- National Diabetes Services Scheme (NDSS)
  - ▶ Helpline – **Ph: 1800 637 700** or [info@ndss.com.au](mailto:info@ndss.com.au)
- [Diabetes Alliance Program+](#)
  - ▶ Urgent Diabetes and Endocrine Advice Line **Ph: 1300 229 255 (Mon-Fri 8:30 am – 4:30 pm)**. [HNELHD-DiabetesAlliance@health.nsw.gov.au](mailto:HNELHD-DiabetesAlliance@health.nsw.gov.au) – **Ph: 02 4964 7172**
  - ▶ After hours contact JHH switch **Ph: 4921 3000**.
  - ▶ There is always an Endocrine consultant on call for Emergency advice.
- You can also speak with a diabetes educator or dietitian for generic advice, Monday to Friday, 9 am to 4 pm by contacting Greater Newcastle Sector:
  - ▶ Generic email for HNELHD Diabetes Services is [HNELHD-DiabetesServices@health.nsw.gov.au](mailto:HNELHD-DiabetesServices@health.nsw.gov.au)
  - ▶ Diabetes Service – Integrated Care Services – **Ph: 4016 4666**
  - ▶ Diabetes CNC Mobile **Ph: 0407 232 639**

### References and Resources:

- [Diabetes Qualified Short Courses](#) (NB. costs incurred)
- [Guidelines for Managing Older People with Diabetes in Residential and Other Care Settings](#) The McKellar
- National Diabetes Services Scheme (NDSS)
  - ▶ [Resources for staff working in residential aged care facilities](#)
  - ▶ [Managing Hypoglycaemia fact sheet 2022](#)
  - ▶ [Managing sick days for type 1 diabetes](#)
  - ▶ [Sick Day Management Plan \(six minute intensive training poster\)](#)
- [Management of type 2 diabetes: A handbook for general practice](#) Royal Australian College of General Practitioners (RACGP):

# Managing Hypoglycaemia Flowchart



## Falls

Falls are a leading cause of harm, injury and death among older people in RACs. Over one-third of falls result in injury, and one in five leads to hospitalisation, most commonly affecting the limbs, head or face. Fall rates are notably higher in respite care compared to permanent residents (ACSQHC 2025 – [Falls Guideline](#)).

An individual's fall risk factors should be addressed from a multidisciplinary perspective and be tailored to the specific needs of the individual. All older people should be considered at high-risk of falling, and timely individual assessments to identify the most appropriate fall prevention strategies for their needs is essential for predicting, preventing and managing a fall.

### Risk Factors:

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

- Increase with age, frailty, illness, poor functional ability and previous falls.
- Including **intrinsic** (e.g., health conditions, behaviours) and **extrinsic** (e.g., environmental factors).
- Post hospital risk; older people are particularly vulnerable to falls in the first month after hospital discharge.
- Risk factors:
  - ▶ Polypharmacy.
  - ▶ Vision.
  - ▶ Footwear and feet.
  - ▶ Osteoporosis diagnosis or minimal trauma fractures
  - ▶ Vitamin D and calcium levels
  - ▶ Mobility, muscle strength and balance.
  - ▶ Cognition and behaviours.

### Medication Related Risk Factors:

- **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 RACQ](#)**
- **Medications that increase risk of falling:** sedatives, antipsychotics, antidepressants, opioid analgesics, antihypertensives, nitrates, diuretics, anti-parkinsonian medication, alpha-blockers, anticholinergics. See the [Medication related Falls Risk Assessment Tool](#)
- **High risk of significant bleeding:** When a resident has a fall and the following applies, they have a higher risk of significant bleeding:
  - ▶ Taking an anticoagulant such as warfarin, dabigatran, rivaroxaban, apixaban, enoxaparin, or heparin.
  - ▶ Taking an antiplatelet such as aspirin or clopidogrel.
  - ▶ History of a bleeding disorder.
  - ▶ Refer to Queensland Health's list of [blood thinning medications](#)

### Practice Point:

- A resident on an anticoagulant and/or antiplatelet who sustains a fall should be observed closely over the next 7 days (even if seen in an emergency department).
- If a large haematoma develops anywhere on the body, consult the GP/NP or contact **ACEQ 1300 223 555**. GP/NPs should carefully consider the risk versus benefit of medications in residents with high risk of falling.



### Prevention and Response:

- Prevention is everyone's responsibility.
- Staff must be trained to identify and address falls risks.
- Falls prevention should be a part of routine, person-centred care.
- Engaging residents and their families in falls prevention planning enhances outcomes and aligns care with personal values and preferences.
- Open communication with the multidisciplinary team, the older person, and their carers is key.
- Care should support autonomy, reablement and quality of life.
- Every fall should be reviewed. The resident should be reassessed to identify new risk factors that require addressing.

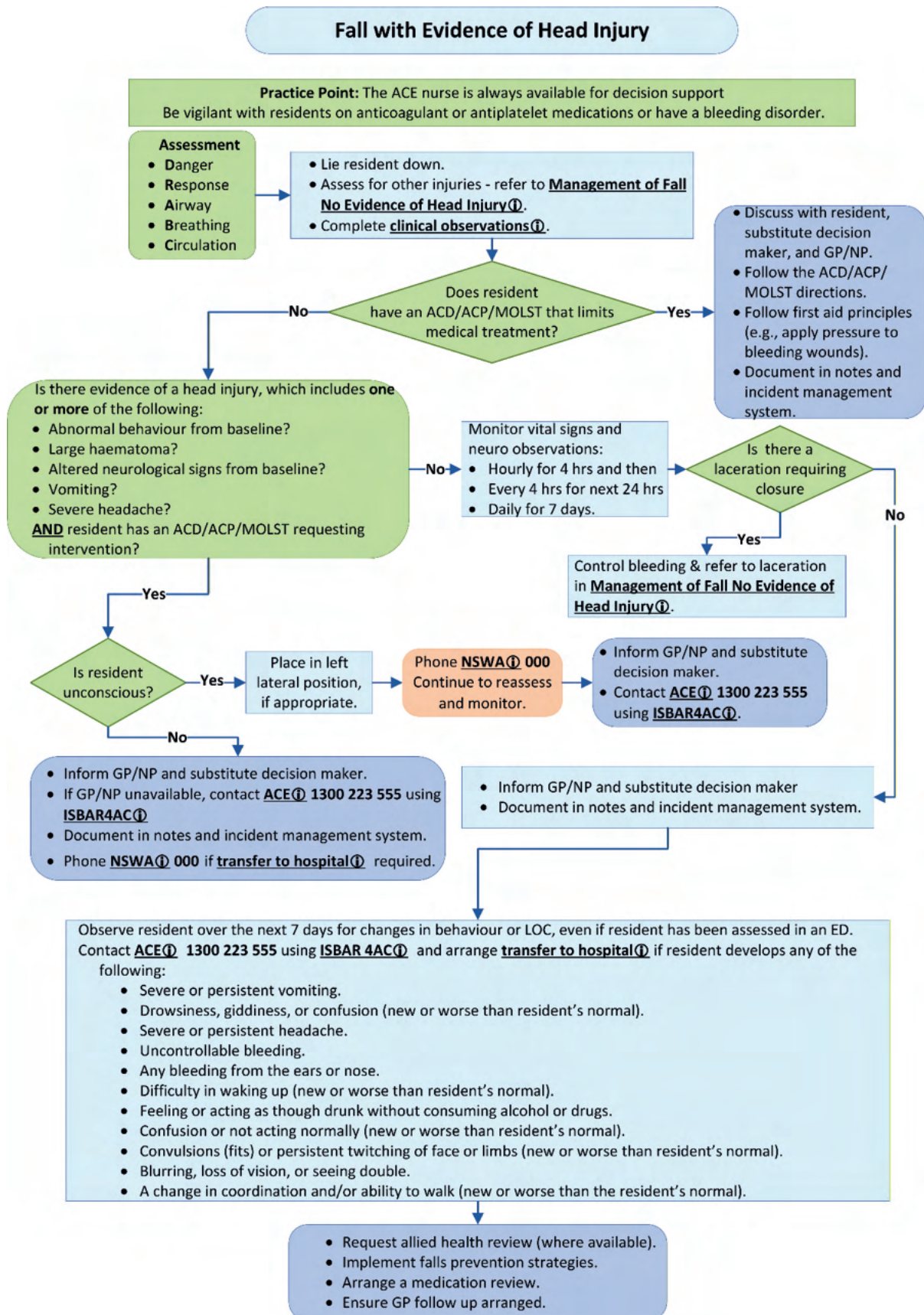
### Prevention Recommendations:

- **Multifactorial Interventions**
  - ▶ Regular assessments for environmental / medication / co-morbidity related interventions.
  - ▶ Tailored falls prevention plans.
  - ▶ Education and workforce engagement for preventing falls and harm from falls in older people.
- **Tailored Exercise:**
  - ▶ Appropriately tailored exercise for all older people who choose to participate.
- **Continued Exercise:**
  - ▶ Even after structured exercise programs have concluded.
- **Hip Protectors:**
  - ▶ Consider the use of hip protectors for older people who are at risk of fall-related hip fractures.
- **Dairy Food provision:**
  - ▶ Dairy servings to meet protein and calcium requirements.
  - ▶ Engage dieticians with menu design.
- **Vitamin D and supplements:**
  - ▶ Administer to all older people unless contraindicated.
- **Osteoporosis Medicines:**
  - ▶ Administer for all older people diagnosed with osteoporosis or history of minimal trauma fractures.

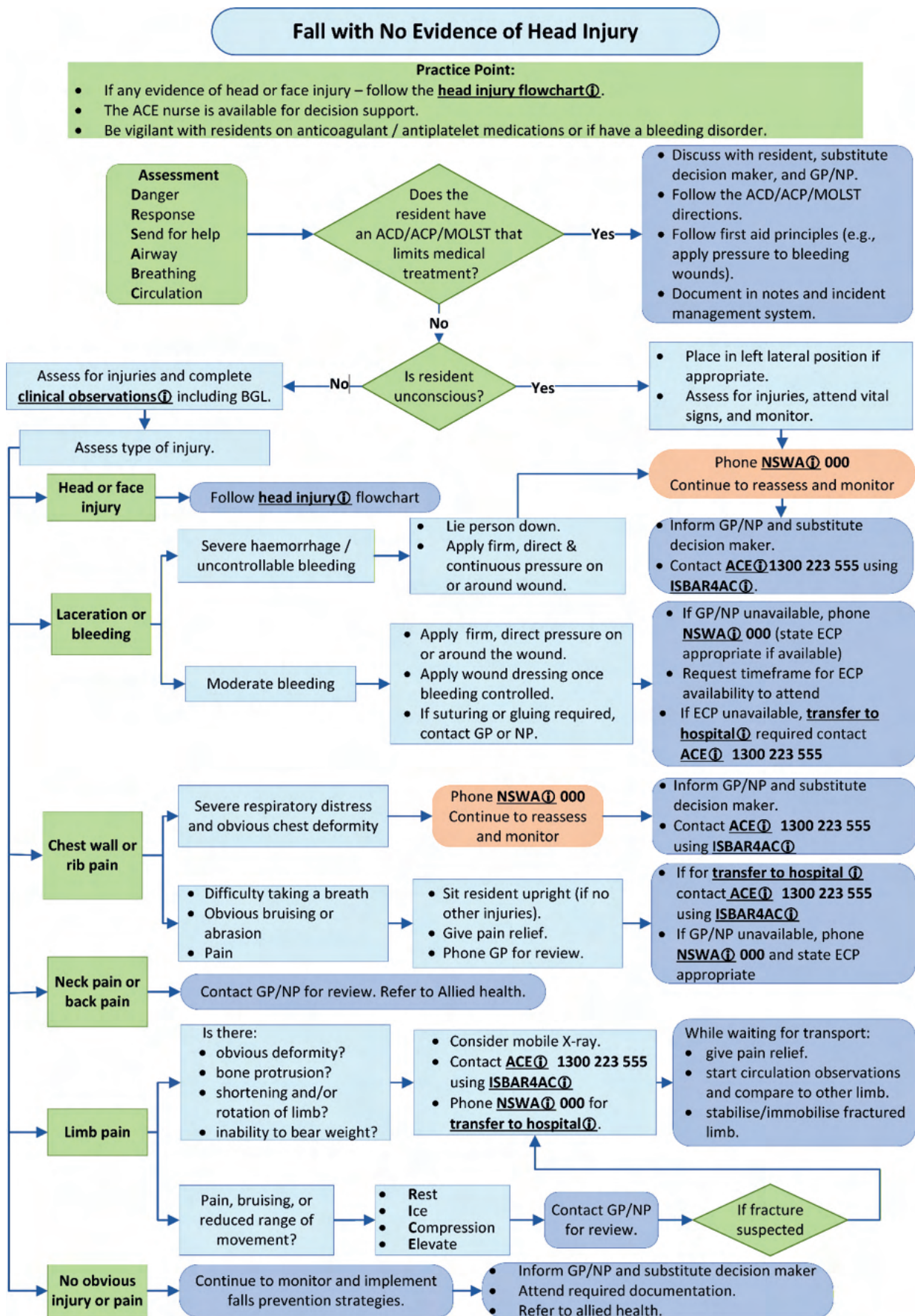
### Advance Care Directive / Advance Care Plan / MOLST:

- An **ACD** is a way for a person to say what health care treatments they would like or like to refuse should they be in a position where they were unable to make these decisions.
  - ▶ An ACD is legally enforceable in NSW. By not complying to an ACD, a clinician may be breaching his or her duty of care.
- Always check if there is an **ACP**.
  - ▶ An ACP can be written by the resident or someone else on their behalf and documents their preferences and values for healthcare and preferred health outcomes.
- **MOLST** is another way for a person to state what medical treatments they are or not willing to have. When there is an order, 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/NP before transferring to hospital.

# Management of a Fall with Head Injury Flowchart



# Management of Fall with No Evidence of Head Injury Flowchart





**Referral and Advice:**

- [Orthopaedics / Musculoskeletal](#) Community HealthPathways
- Hunter region only:
  - ▶ Orthopaedic Clinic CNC – **Ph: 4922 3951** (JHH Campus)
  - ▶ [Compass Mobile Imaging](#) – **Ph: 0437 800 312** Mobile X-ray
  - ▶ Orthopaedic CNS outpatient services – **Ph: 4922 3936**
  - ▶ Enquiries: [HNELHD-AskOrthoClinic@health.nsw.gov.au](mailto:HNELHD-AskOrthoClinic@health.nsw.gov.au)
- Lake Macquarie / Newcastle Region only:
  - ▶ [HNELHD-AgedCareMobileImaging@health.nsw.gov.au](mailto:HNELHD-AgedCareMobileImaging@health.nsw.gov.au) Mobile X-ray – HNELHD
  - ▶ Admin **Ph: 4923 2219**

**Resources and References:**

- [Falls Prevention and Assessment](#) Community HealthPathways
- [Patient Fact Sheet \(2023\)](#). Mild brain injury discharge advice (concussion).
- [Latest Cochrane Evidence 2025](#)

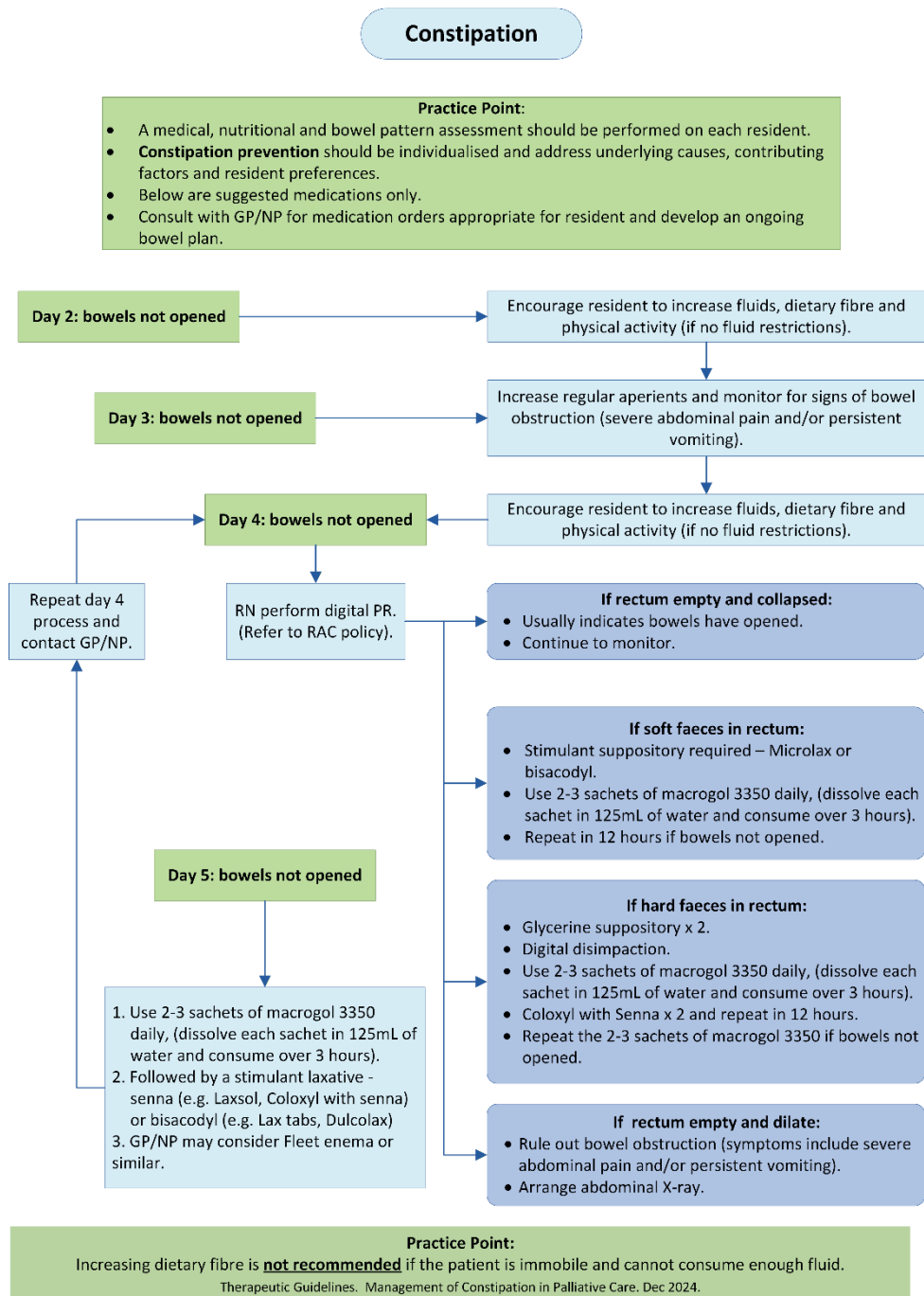
**Falls prevention**

- [Preventing falls and harm from falls in Older People](#): Best Practice Guidelines for Australian Hospitals and Residential Aged Care Facilities 2025.
- [Resources designed specifically for older people living in residential aged care facilities](#). NSW Fall Prevention and Healthy Ageing Network Residential Aged Care.

# Gastroenterology

## Constipation Flowchart

Constipation is avoidable and prevention is far better management. Whilst this flowchart addresses constipation once it has occurred, an individualised bowel management plan for **ALL** residents is a better option. Residents who are regularly taking 5 or more medications have an increased risk of constipation. Please arrange a comprehensive Pharmacy review for these residents. See **Polypharmacy and high-risk medications in RACs**<sup>①</sup>



Adapted from 1. Community HealthPathways - Constipation in Adults (<https://hne.communityhealthpathways.org/13804.htm>). 2. Therapeutic Guidelines - constipation and 3. HNELHD Bowel management working party (May 2008) Constipation, confrontation & creativity. Road Blocks to bowel care PPT. Last Review July 2025.



## 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

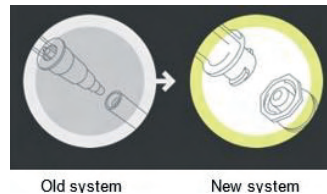
- Showering is permitted the day after initial tube placement.
- Avoid bathing for 3 weeks until the site has healed.

### 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 feeding tubes 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 to administer medications.



## Administering Medications

- First check each individual medicine monograph in the Australian Don't Rush to Crush Handbook (available through MIMS Online, AUS ID, Ezy med, BestMed or similar) to see if the medicine can be dispersed or crushed or ask a pharmacist. [Don't Rush to Crush](#) - MIMSONline
- Only prepare medicines immediately before giving them.
- Prepare and give each medicine one at a time.
- Where possible, use a liquid or dispersible form of medicine.
- Not all medications are suitable to be crushed, and some require special handling if crushed (e.g., perindopril should not be crushed by staff who are pregnant or trying to become pregnant).
- Do not crush medication with enteric coatings or slow / modified release formulations.
- Flush the tube with 30 mL of water before the first medication, with 5 mL of water between each medication, and with 30 mL of water after the last medication.
- More detailed guidance is available in MIMS online - Don't Rush to Crush within the individual medicine monographs.
- 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

### 1. 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/NP or Stomal Therapy Nurse (see below) or contact **ACE@ 1300 223 555** to arrange tube replacement.

#### Practice Point:

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

## 2. 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/NP for referral to Stomal Therapy Clinic or contact **ACE@ 1300 223 555**.

## 3. Bleeding around Stoma

### Causes

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

### Interventions

- If hypergranulation tissue is present, a small amount of bleeding is normal.
- Anchor the tube securely.  
If excessive bleeding or discomfort, contact GP/NP or Stomal Therapy Nurse (see below) or contact **ACE@ 1300 223 555**.

## 4. 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, contact GP/NP or Stomal Therapy Nurse (see below) or contact **ACE@ 1300 223 555**.

## 5. Constipation

### Causes

- Inadequate fibre / bulk or fluid intake.

### 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
- Increase mobility, if possible.

## 6. 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 greater than seven (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
  - ▶ Gastrointestinal stimulants
  - ▶ Metformin
  - ▶ Beta blockers
  - ▶ Laxatives
  - ▶ Stool softeners
  - ▶ Magnesium
  - ▶ 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/NP or contact **ACE@ 1300 223 555** to correct electrolytes / hydration.
- Stool culture may be required to check for *Clostridioides difficile* or other possible bowel infections. If positive, treat accordingly and if negative consider giving loperamide (Imodium) or alternative.

## 7. Hyper-granulation (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, contact GP/NP or Stomal Therapy Nurse (see below) or contact **ACE@ 1300 223 555**. Consider using:
  - ▶ Foam dressing as first line treatment.
  - ▶ Hydrocortisone 1% cream.
  - ▶ Silver nitrate, as prescribed, as a last option when other treatments are not successful.
  - ▶ Medihoney.
  - ▶ Silver-impregnated dressings.
  - ▶ Debridement, if problematic.



## 8. 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.
- These products may assist; topical or oral antibiotics via tube for confirmed infection or antimicrobial dressings.

## 9. 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.
- To help with exudate and skin protection, consider using:
  - ▶ Stoma adhesive powder.
  - ▶ Hydrocolloid or foam dressings.

## 10. 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 Fluid Administration①**
- 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/NP to correct electrolyte or hydration disturbances and check BGL.

## 11. 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.

## 12. PEG Tube Y-port Connector Leaking

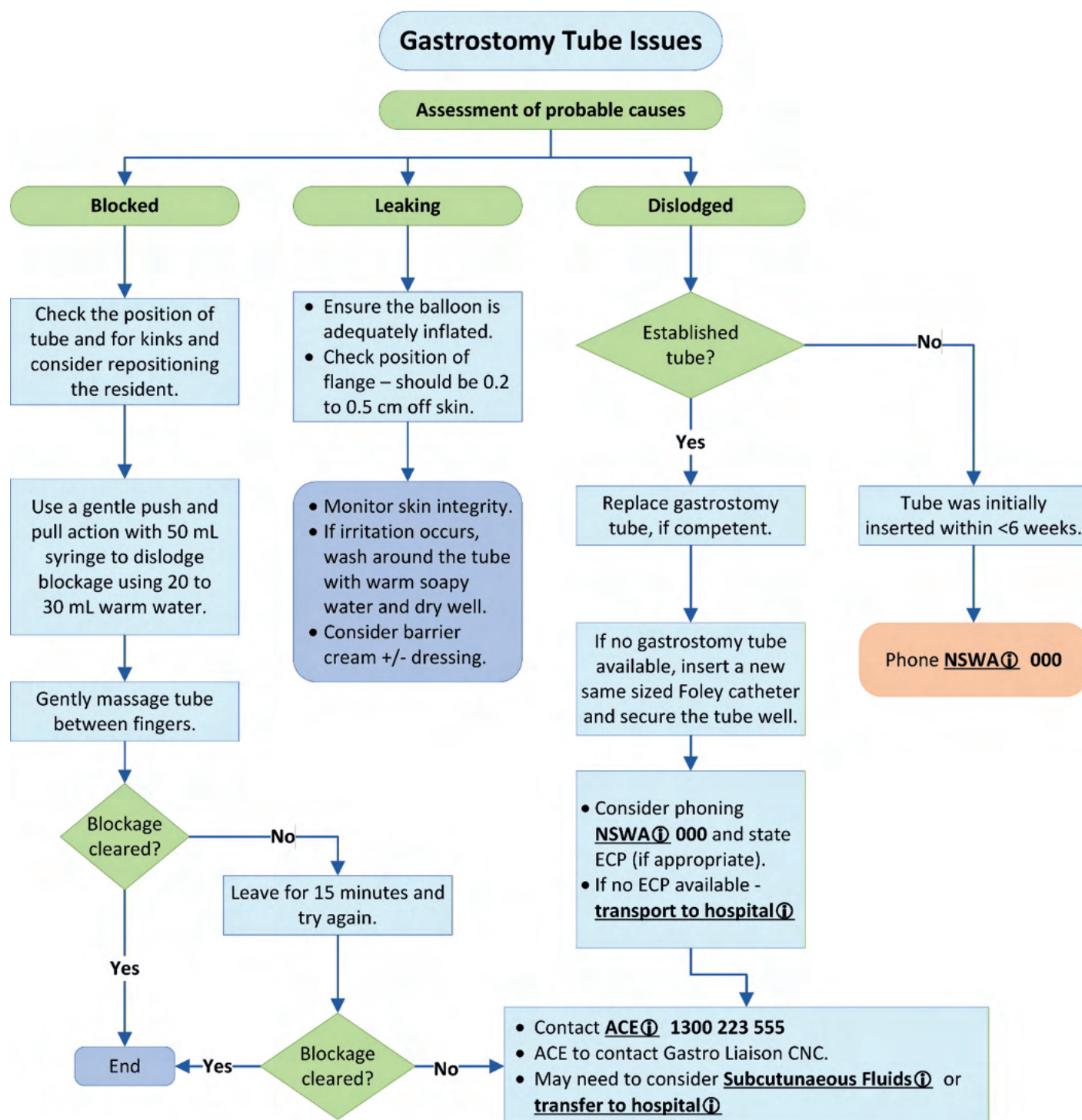
### Causes

- Over-tightening Enfit connections can damage the end port.
- Inserting Toomey syringe too far into the Y-port connector can enlarge port so the cap does not 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



### Practice Point: Preventing blockages

- 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.

## Stoma Management Issues

### 1. 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

- ▶ 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.
- ▶ Fill any crevices, valleys or dips in the peri-stomal area with stoma paste or seals before reapplying the pouch.
- ▶ Inform GP/NP and Stomal Therapy Nurse (phone numbers below).

### 2. Colostomy/ileostomy inactive

#### Consider

- Number of days of inactivity.

#### 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.

#### Practice Point:

To be performed only by clinicians who are experienced in performing digital examinations with resident consent.

#### Intervention

- ▶ Cease solid foods, increase fluid intake (if suitable).
- ▶ Treat constipation in residents with a colostomy with aperients. Do not use aperients for residents with ileostomies.
- ▶ Inform GP/NP and Stomal Therapy Nurse (phone numbers below).

### 3. Para-stomal Hernia

#### Consider

- Size.
- Intestinal involvement.
- Functionality of stoma.

#### Assessment

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

#### Intervention

- ▶ Inform GP/NP or Stomal Therapy Nurse (phone numbers below).
- ▶ If stoma is non-functioning and associated with pain, nausea, and vomiting, contact GP/NP.

### 4. Stomal Prolapse

#### Assessment

- Pain.
- Is the prolapse reducible?
- Is there damage or ulceration to the stoma?
- What is the colour of stoma?
- Contact GP/NP and if not available, contact **ACE@ 1300 223 555** if stoma or prolapsed bowel is dusky, purple, or black, as this will require urgent treatment.

#### Intervention

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

#### Intervention

- Contact Stomal Therapy Nurse for appointment

#### Referral and Advice

- [Community HealthPathways](#) Gastroenterology Referrals
- Stomal Therapy Nurse Consultants
  - ▶ JHH – **Ph: 4921 3000** and ask switch to page **36206** or email [HNELHD-JHHStomal@health.nsw.gov.au](mailto:HNELHD-JHHStomal@health.nsw.gov.au).
  - ▶ Manning region: **Ph: 6592 9469**
  - ▶ New England region **Ph: 6767 7733** Mobile: **0407 776 192**
  - ▶ Maitland region: **Ph: 0429 002 760**

#### Resources and References

- [Gastrostomy tubes and devices](#) Agency for Clinical Innovation
- [Australian Don't Rush to Crush Handbook](#) (MIMS Online)



## Managing Gastroenteritis (Gastro) Flowchart

### Management of Gastroenteritis

#### Outbreak management actions:

- Implement outbreak management plan as per [Gastro-Info Kit -Outbreak Coordinator's Handbook](#)①
- Commence infection control precautions immediately.
- Isolate or cohort affected residents.
- Notify Public Health Unit & DoHDA.
- Collect specimens and request - Rotavirus and Norovirus and stool MCS/PCR to confirm microbial cause.

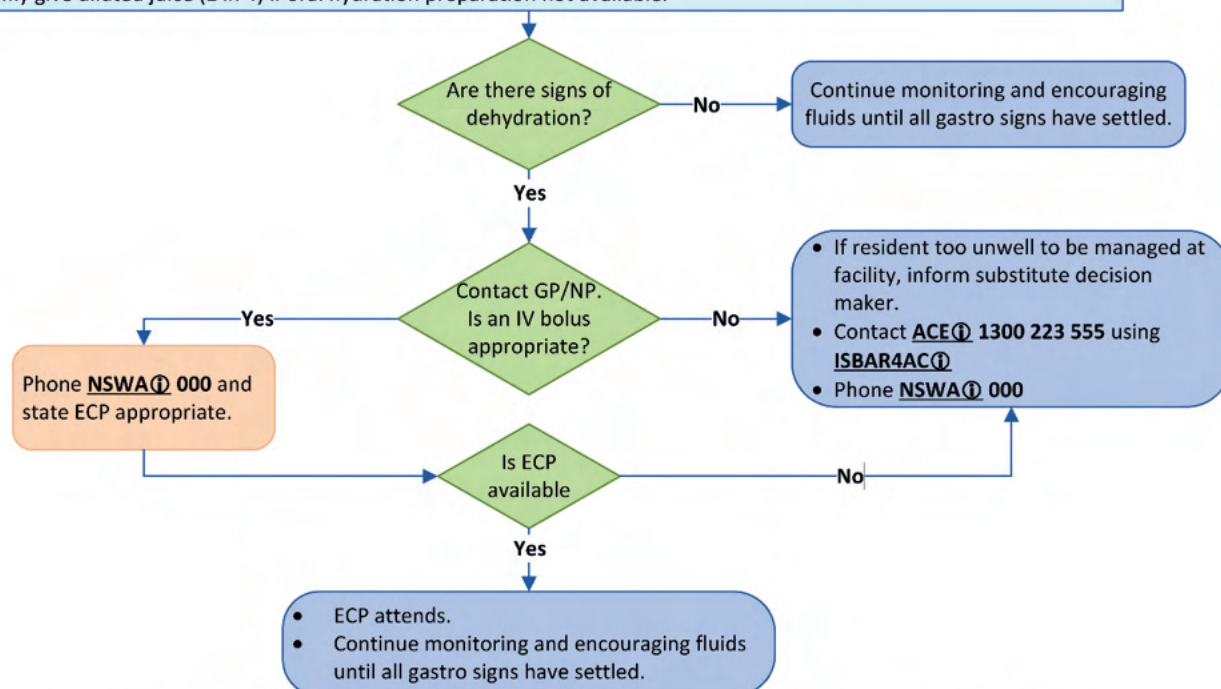
#### Resident assessment:

- Complete [clinical observations](#)① including BGL.
- Start fluid balance chart – compare input and output.
- Monitor resident for signs of dehydration:
  - Reduced urine output and dark urine
  - Thirsty
  - Sluggish capillary refill
  - Decrease in blood pressure
  - Increased heart rate
  - Dry mucous membranes
  - Sunken eyes
  - Headache / dizziness
  - Altered level of alertness / cognition
- Weigh resident daily during acute phase (is there weight loss due to dehydration)

- If resident is known to have diabetes, seek advice on administration of their regular insulin / oral hypoglycaemics, and / or refer to sick-day plan.
- Monitor BGL regularly.

#### Contact GP/NP and consider:

- Standing order of antiemetics, consider using wafer formulation or injection.
- Consider medical conditions when prescribing, e.g., contraindicated in Parkinsons disease.
- Oral rehydration preparations; formulation of liquid, ice blocks or jelly, e.g., Hydralyte.
- Standing order of anti-diarrhoeal medications.
- Obtain advice on fluid intake and whether to administer regular medications, especially if resident on fluid restrictions / cardiac medications or insulin / oral hypoglycaemics.
- Increase fluids, if no fluid restrictions in place offer **125 mLs** each ¼ hour if vomiting or if not vomiting 1 – 2 cups per hour.
- Only give diluted juice (1 in 4) if oral hydration preparation not available.



**Practice Point:** In older people, traditional signs & symptoms of dehydration may be absent, particularly for people on cardiac medications

## Managing Gastroenteritis (Gastro)

**An outbreak** is defined as **two (or more) confirmed cases** or probable cases of gastroenteritis occurring within the same institution. At least one case develops vomiting or diarrhoea within the incubation period after exposure to another infection individual at the same site, (NSW Health 2019). [Gastroenteritis in an Institution Control Guideline](#)

All suspected or confirmed Gastroenteritis outbreaks in RACs must be reported to the local Public Health Unit. Please refer to **Managing Gastroenteritis (Gastro)** flowchart on the previous page for guidance.

### Advice

- To report an outbreak, please go to Infectious disease on the Hunter New England webpage located at [Infectious Disease in Hunter New England](#)

### Hunter New England facility outbreaks

Report on respiratory and gastroenteritis outbreaks in aged care and disability care facilities.

[Report an outbreak \(webform\)](#)

### Outbreak resources

While these resources are designed for residential care and childcare facilities, you can use them to develop your own disease outbreak plan.

Residential care facilities



Childcare facilities



- If further advice is needed, please **Ph: 02 4924 6477** or email [HNELHD-Phcdiseases@health.nsw.gov.au](mailto:HNELHD-Phcdiseases@health.nsw.gov.au)

### References and Resources

- Agency for Clinical Innovation [Gastroenteritis Factsheet](#)
- NSW Health** [Gastroenteritis in aged care facilities](#)
  - [Gastroenteritis Kit for Aged Care](#)
  - [Gastro Info Kit Information Sheet 1 - Recognising and Managing Gastroenteritis.](#)
  - [Gastro Info Kit Information Sheets 2](#)
  - [Gastroenteritis in an institution](#)

## Medication Incident Management

Medication related harm is a significant concern. Medicines are the most common intervention and account for nearly 50% of preventable harm in medical care (ACSQHC 2024). In RACs, where polypharmacy and the use of high-risk medications are common, the potential for medication-related incidents are high.

[The Aged Care Quality Standards - Clinical Standard 5](#) describes the responsibility of providers to deliver safe and quality clinical care services to older people. The outcome required is to encourage and support individuals, aged care workers and health professionals to use medicines in a way that maximises benefits and minimises the risks of harm.

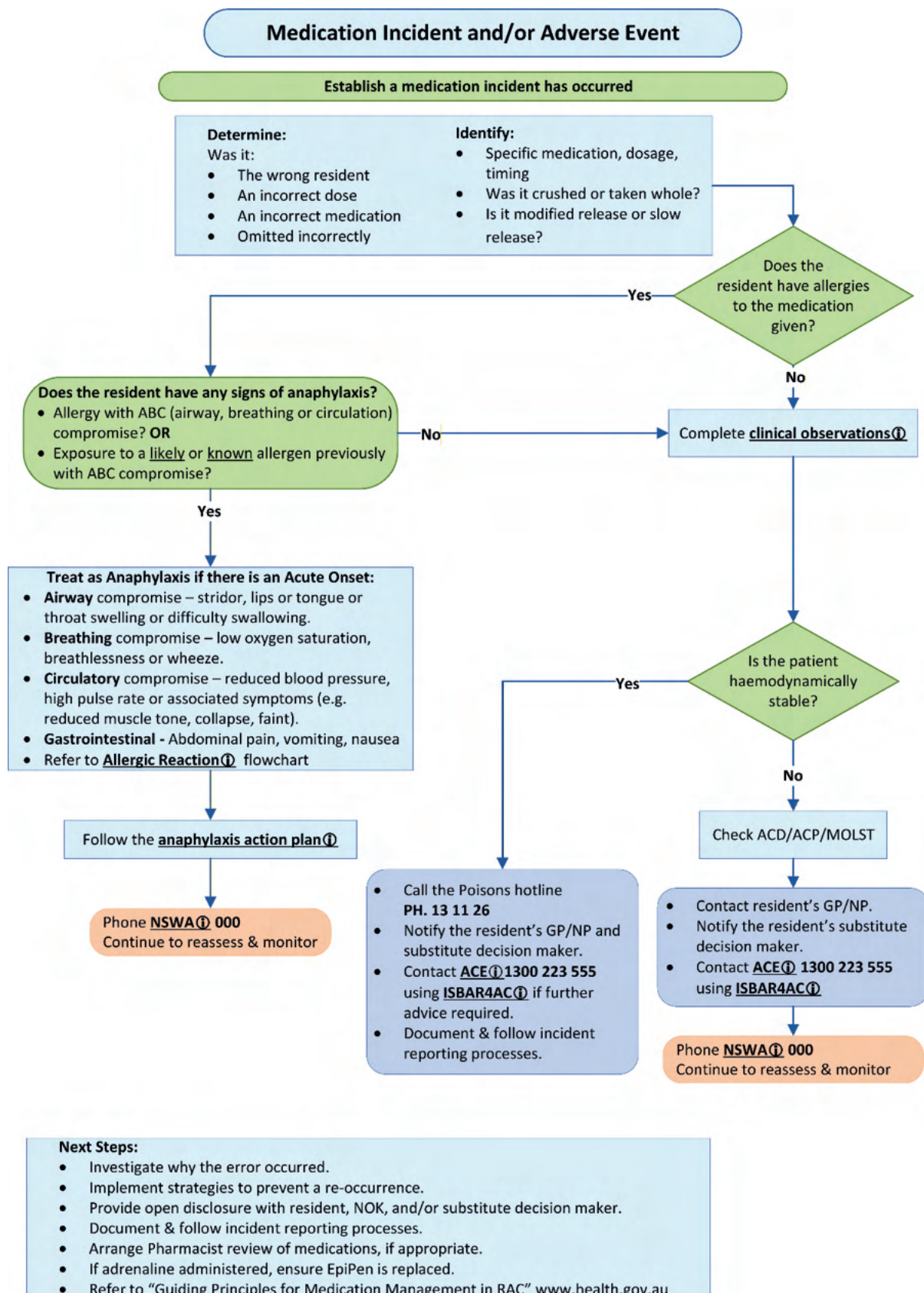
- Best practice requires a strong focus on three priority areas to reduce harm:
  - ▶ Reduce inappropriate polypharmacy.
  - ▶ Minimise harm from high-risk medications e.g., insulin, anticoagulants, opioids, antipsychotics.
  - ▶ Improve safety during transitions of care e.g., hospital admissions and discharges.
- When medication incidents, errors or adverse events occur:
  - ▶ Facility must respond with transparency.
  - ▶ Undertake system reviews.
  - ▶ Implement changes to prevent recurrence.
- Strategies to reduce errors and promote safe and effective medication management, include:
  - ▶ Establish clear communication.
  - ▶ Identify and communicate medicine-related risks as part of the clinical handover.
  - ▶ Regular medication reviews (consider on-site Aged Care Pharmacists, Residential Medication Management reviews, Quality use of Medicines services).
  - ▶ Foster a blame-free environment for reporting incidences.
  - ▶ Compliance and safety in medicines distribution and storage systems.
  - ▶ Provide sound governance for the safe and quality use of medicines.
  - ▶ Use a framework for identifying when there is potential for risk of harm and responding with strategies to reduce the opportunity for error.
  - ▶ Ensure clinicians can safely dispense and administer medicines and monitor their effects.
  - ▶ Inform residents about their medicines and involve them in decision-making.
  - ▶ Acute illness should prompt careful monitoring or dose adjustments of certain medications due to the higher risk of an adverse event.

For example, diabetes sick day management plan (see link below), or the ongoing use of antihypertensives on sick days may compound hypotension.

### Indicators of an adverse event may include:

- |                         |                                                                       |
|-------------------------|-----------------------------------------------------------------------|
| ▶ Change in vital signs | ▶ Falls                                                               |
| ▶ Lethargy              | ▶ Behaviour change                                                    |
| ▶ Drowsiness            | ▶ Blood results                                                       |
| ▶ Rash                  | ▶ Change in resident's condition                                      |
| ▶ Unsteady gait         | ▶ Change in function e.g., no longer able to walk to the dining room. |
| ▶ Bleeding              | ▶ Change in eating and drinking                                       |
| ▶ Aggression            |                                                                       |

# Medication Incident Flowchart





## Resources and References:

- [Strengthened Quality Standards Guidelines](#) Aged Care Quality and Safety Commission.
- [Clinical Care](#) Australian Commission on Safety and Quality in Health Care. Aged Care Quality Standards – Standard 5:
- [Incident Management Guide \(2021\)](#) Australian Commission on Safety and Quality in Health Care.
- [Medication safety standard](#) Australian Commission on Safety and Quality in Health Care.
- [WHO Global Patient Safety Challenge Status report Australia's response. June 2024.](#) Australian Commission on Safety and Quality in Health Care.
- [User Guide – Role of A Medication Advisory Committee \(2022\).](#) Australian Department of Health, Disability and Ageing.
- [Guiding Principles for Medication Management in Residential Aged Care Facilities \(2022\).](#) Department of Health, Disability and Ageing.
- [Sick Day Management](#) - Diabetes Australia.
- [Medication management on sick days. Aust Prescriber.](#) (2017) Oct; 40(5):168-173. DOI: 10.18773/austprescr.2017.057 Lea-Henry TN, et al.



## Mental Health Emergencies

As people age, experiences such as grief, declining independence and major life changes can affect mental wellbeing, increasing vulnerability to depression, anxiety, psychosis or suicide; yet support and recovery remain possible. Staying socially connected, keeping active and engaging in meaningful activities can strengthen resilience, maintain daily functioning and support fulfilling relationships. Older adults—particularly those living in residential aged care, where mental illness affects around three in five residents (Australian Healthcare Associates, 2022) — are at higher risk, and transitions into care can further contribute to mental illness and suicide risk. Help-seeking is often hindered by stigma and the misconception that poor mental health is a normal part of ageing.

### Practice Point:

Rule out delirium – see [Behaviour and Confusion Management](#) and consider BPSD - see [managing responsive behaviours](#).

See the [ACE website](#) for further information on [Managing Mental Health Emergencies](#).

### Contributing factors can include:

- Physical illness and multiple chronic conditions
- Frailty and progressive loss of independence
- Grief and bereavement (loss of partner, friends, peers or home)
- Cognitive decline and dementia
- Social isolation and loneliness
- Changes in living arrangements and loss of familiar environment
- Loss of autonomy and control over daily life
- Financial stress or uncertainty
- Adjustment difficulties when entering residential care
- Sleep disturbance and pain
- Stigma and reluctance to seek help
- Reduced access to meaningful activities and social roles
- Limited family or community support
- Brain injury or neurological conditions

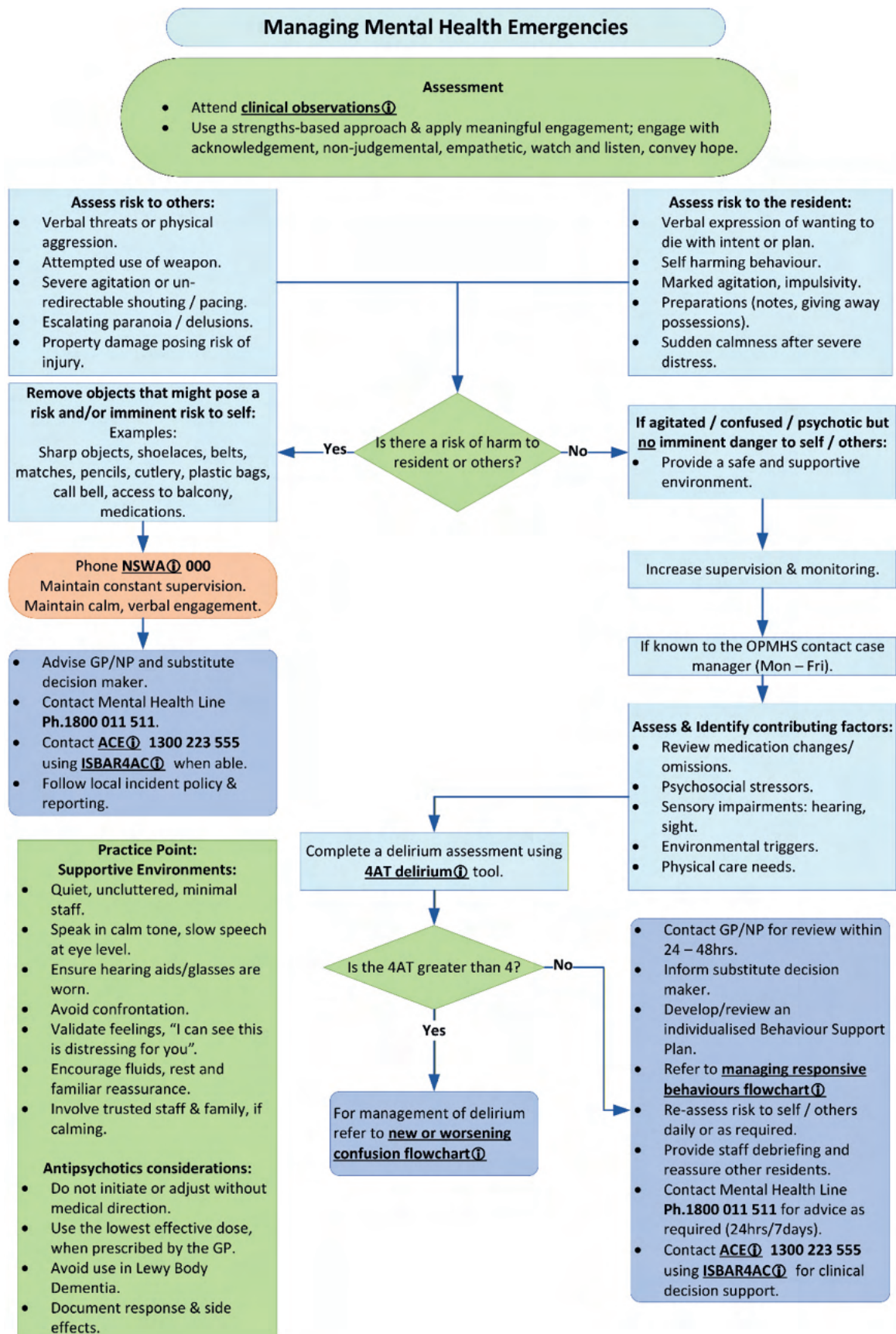
### Screening

- [Mental Health Screening Tool](#) Use a facility approved screening tool or ARIA for listed suggestions

### Resources and references:

- [Screening Tools](#) Aged Care Research & Industry Innovation Australia (ARIA)
- [Comprehensive Care Standard – Mental Health Safety](#). Australian Commission on Safety and Quality in Health Care (2023).
- [Evaluation of the PHNs' Improved Access to Psychological Services in Aged Care Facilities initiative: Final report](#). Australian Healthcare Associates. (2022).
- [Depression and Suicide Prevention in older Adults](#) Beyond Blue (2023).
- [Suicide Prevention Programs: Older People](#) – NSW Health
- [Suicide Prevention for Seniors](#) - Anglicare
- [Clinical Practice Guidelines for Mood Disorders](#). Malhi, G.S. et al. (2021). RANZCP
- [NSW Health \(2021\). Mental Health Care of Older People – Clinical Practice Guidelines](#).

# Managing Mental Health Emergencies Flowchart



## Referrals:

### 1. Older People Mental Health Service (OPMHS)

#### Criteria for referral to OPMHS for RACs

- Older adults aged 65 years or over with:
  - Mental Health disorder such as depression, psychosis, anxiety or a severe adjustment disorder.
  - Present with moderate to severe behavioural or psychological symptoms of dementia (BPSD) for which specialised dementia support services have been engaged but struggling to meet the resident's needs.

**Referral** is via the 24-hour Mental Health Telephone Access Line **Ph: 1800 011 511**. Anyone can refer by phone, but a GP/NP letter outlining specific concerns with issue(s) to be addressed, is preferred.

- To assist with a mental health assessment, medical information, including health history, current medications, and investigations and results (to rule out delirium) will be required.
- An OPMHS clinician may make other recommendations and/or provide short-term care coordination to support the resident in their recovery

### 2. Dementia Support Australia (DSA)

If the primary concern is behavioural disturbance with dementia, support is available through DSA. Referrals can be made 24 hours a day via:

- Online referral form - <https://dementia.com.au/contact/referral>
- 24-hour helpline - **Ph: 1800 699 799**.
- Fax on 1800 921 223.

### 3. Hunter Primary Care Residential Aged Care Psychology Program

A Residential Aged Care Psychology Program is provided by Hunter Primary Care in the following regions:

- |                  |                |
|------------------|----------------|
| ▶ Lake Macquarie | ▶ Cessnock     |
| ▶ Newcastle      | ▶ Singleton    |
| ▶ Maitland       | ▶ Muswellbrook |
| ▶ Port Stephens  | ▶ Dungog       |

The service provides psychological treatment and support to residents who present with **mild to moderate** mental health disorders and/or are exhibiting heightened psychological distress. The service is **not** funded to support residents who require specialist services, such as Older People's Mental Health Service or Dementia Support Australia. The service also provides information to RAC staff and GP/NPs to better support residents.

- Referral Form - <https://hunterprimarycare.com.au/wp-content/uploads/2024/10/ACP-Referral-Form.pdf>
- Send the completed referral form to [mhintake@hunterprimarycare.com.au](mailto:mhintake@hunterprimarycare.com.au)
- GP/NPs can send a letter and email to [mhintake@hunterprimarycare.com.au](mailto:mhintake@hunterprimarycare.com.au)
- For further information, contact the Psychology Aged Care Clinical Manager, **Ph: 02 4925 2259**

### 4. Hunter Primary Care Nurse Practitioner Behavioural Services

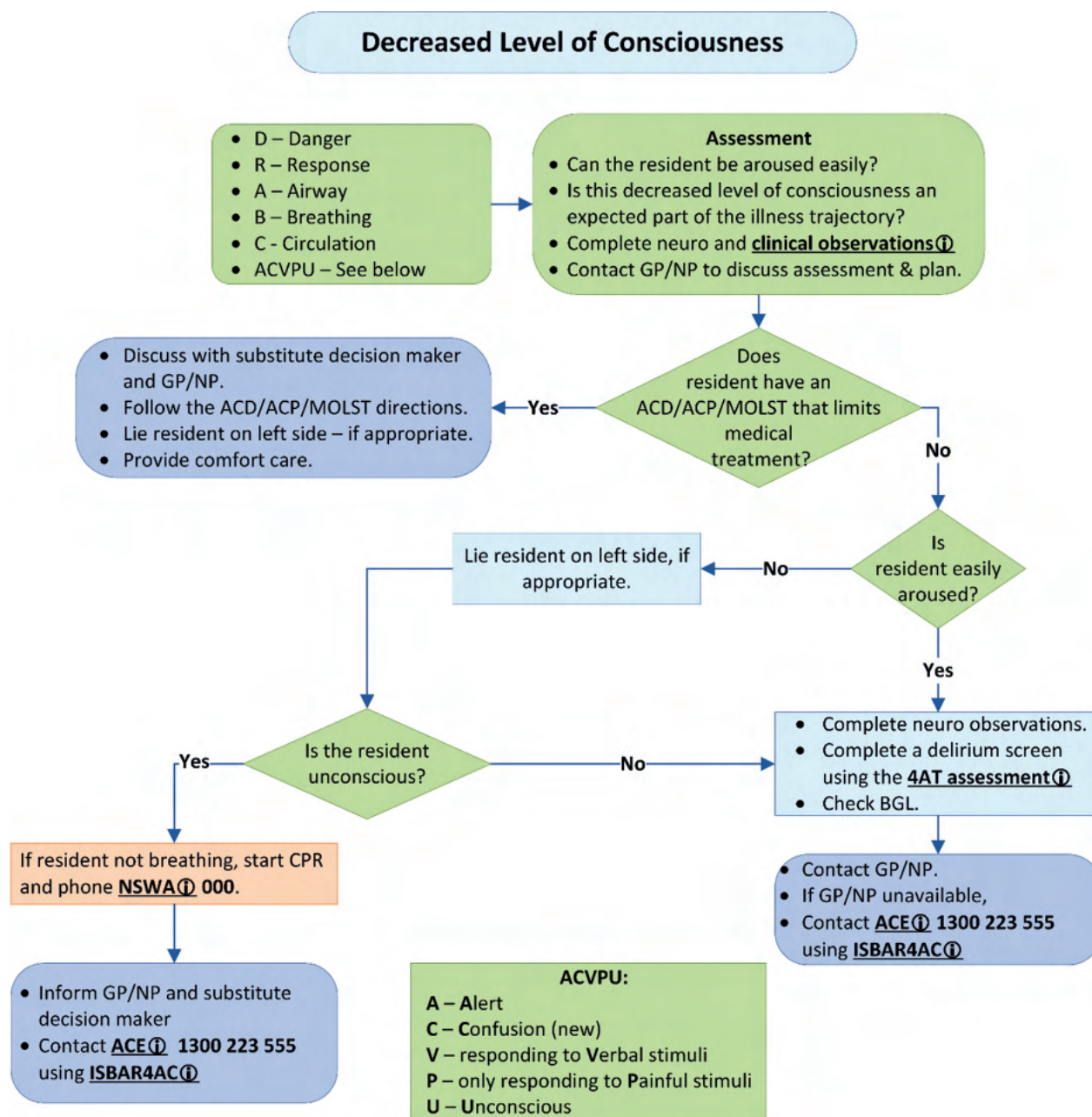
Hunter Primary Care are developing Nurse Practitioner consultancy services.

Further information and referral available via:

[Nurse Practitioner Consultancy Behavioural Service - Hunter Primary Care](#) or **Ph: (02) 4935 3241**

## Neurology

### Decreased Level of Consciousness Flowchart



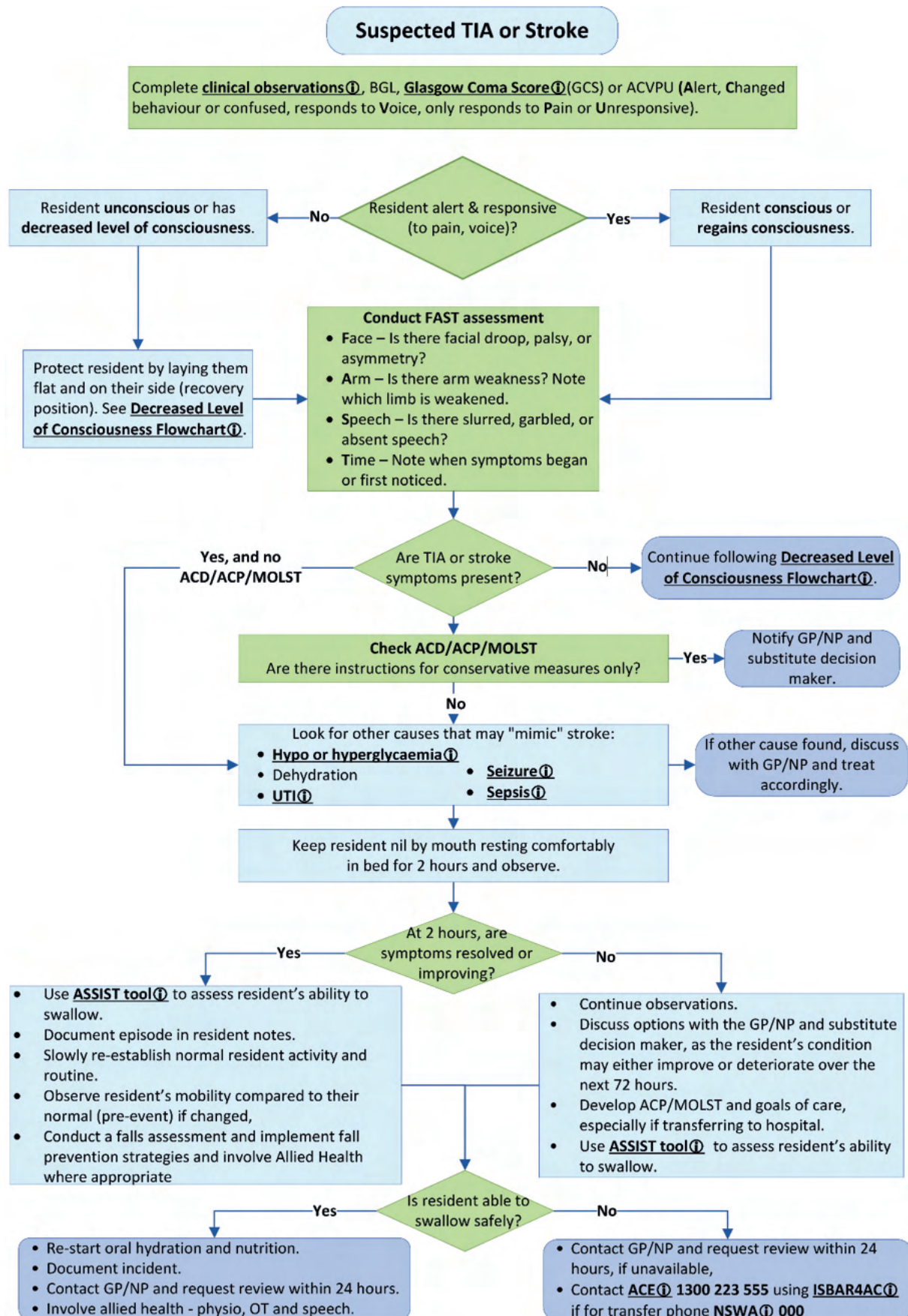
### Suspected Transient Ischaemic Attack (TIA) or Stroke

Most RAC residents will not meet the selection criteria for urgent medical management of stroke, e.g., thrombolysis (clot-busting medication).

- ▶ See eligibility for endovascular clot retrieval – [NSW Referral Guide](#)
- ▶ 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.
- ▶ Refer to **Suspected Transient Ischaemic Attack (TIA) or Stroke Flowchart①**.



# Suspected Transient Ischaemic Attack (TIA) or Stroke Flowchart





## Managing Swallowing Difficulties

Dysphagia or difficulty in swallowing is a common problem affecting older adults. If swallowing difficulties are not recognised this may lead to dehydration, malnutrition, aspiration pneumonia or choking. To assess the resident's swallowing, refer to the [ASSIST screening tool](#).

### Signs & Symptoms of Swallowing Difficulties

- Coughing when eating or drinking.
- Recurrent chest infections or possible aspiration pneumonia.
- Pain or significant discomfort on swallowing.
- Difficulty with or refusing meals and drinks.
- Behavioural / cognitive difficulties with eating or drinking.
- Difficulties swallowing medications.
- Dry mouth or saliva problems.
- Weight loss.

#### Practice Point:

Refer to **Speech Pathology** if the resident has swallowing difficulties and there is no eating and drinking risk documentation in place, or if changes are required.

### Speech Pathology Referrals

- Residential Care Speech Pathology Service (RCPS) go into RACs and can perform Flexible Endoscopic Evaluation of Swallowing (FEES) onsite.
  - ▶ Email [HNELHD-ResCareSpeech@health.nsw.gov.au](mailto:HNELHD-ResCareSpeech@health.nsw.gov.au)
  - ▶ Greater Newcastle based at Rankin Park Centre **Ph: 4921 4859**
  - ▶ Lower Hunter based at Maitland Hospital **Ph: 4931 2003**
- HNELHD Community HealthPathways Lists of all [Speech Pathology Providers](#) across HNELHD.
- Additional resources are located at the end of the Neurology section.

## Seizure

### Seizure Issues

#### 1. First Seizure

#### Consideration

- Some possible causes are infection, electrolyte imbalance, new medication, stroke, subdural haematoma (SDH), or a brain tumour.

#### Assessment

- Complete **Clinical Observations**①.
- ACVPU (**A**lert, **C**onfusion - new confusion / delirium / change in behaviour, **V**erbal – responds to voice stimulation, **P**ain – responds to pain, **U**nresponsive **to pain**). **Every 30 minutes for 2 hours**, then every hour until reviewed.
- Urinalysis, routine bloods.
- Imaging (CT head or MRI) as per resident's goal of care and GP/NP.

#### Intervention

- Administer first aid and follow **Seizure**① flowchart
- Contact GP/NP to assess and treat underlying cause (e.g., may need antibiotics to treat infection).
- May need specialist referral and review to rule out stroke, SDH, or brain tumour depending on goals of care and ACD/ACP/MOLST.

## 2. 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 before and after the seizure, 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?
- Were the resident's eyes open or closed during the seizure?
- Does the resident have any head and/or eye deviation (e.g., 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 has:
  - ▶ A prolonged seizure(s) of longer than 5 minutes, or
  - ▶ Seizures less than 2 hours apart, or
  - ▶ Two seizures without recovery back to normal between seizures,
  - ▶ Then they may be in **status epilepticus**, which is a medical emergency. If appropriate to the resident's goals of care and ACD/ACP/MOLST, the resident will need to be transferred to the nearest Emergency Department for further treatment and management.

## 3. Post-Ictal Monitoring

### Practice Point:

**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 if necessary. Remember that oxygen should only be given as a treatment for hypoxaemia.

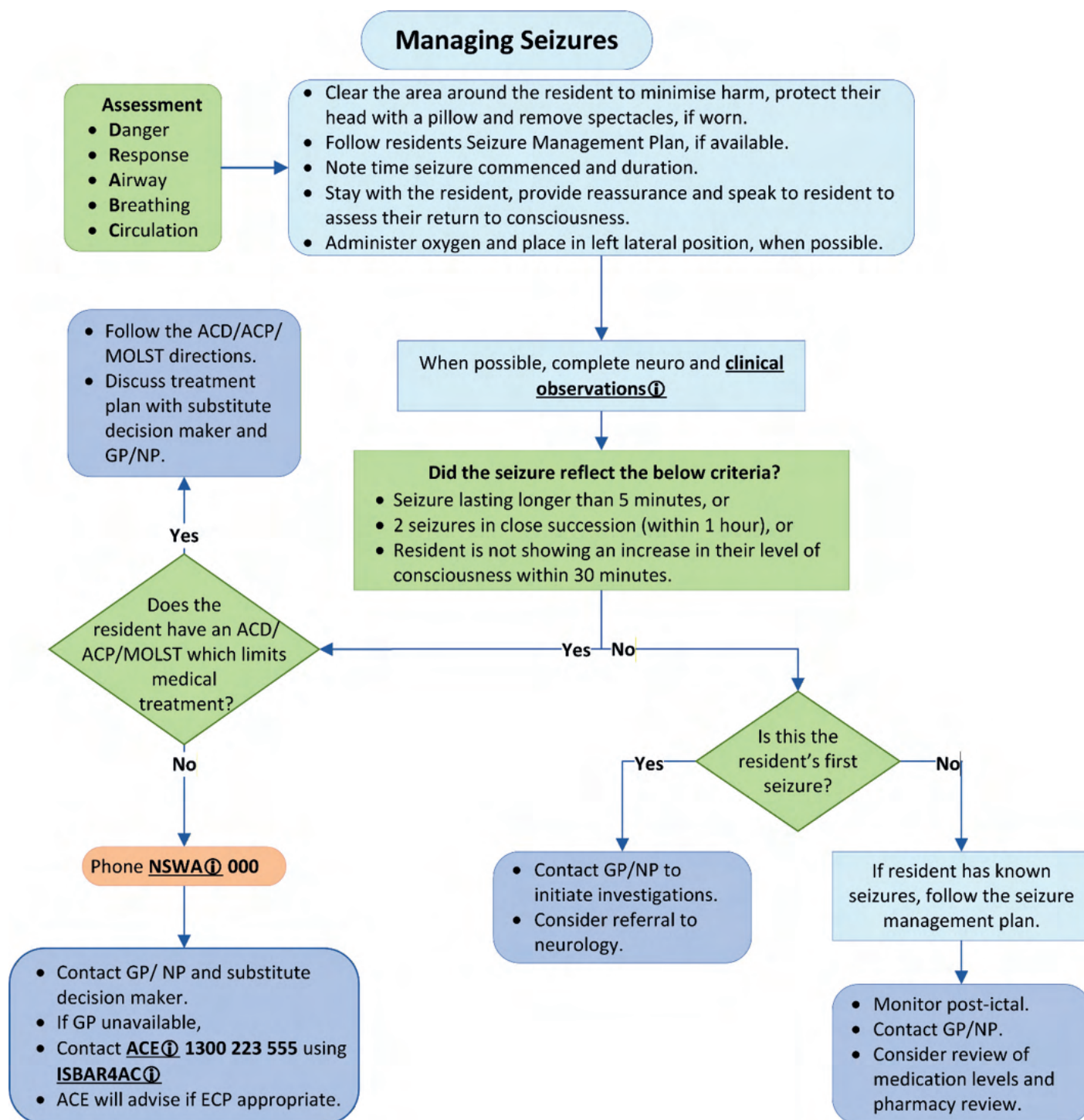
### Assessment

- Assess resident's ACVPU (**A**lert, **C**onfusion - new confusion / delirium / change in behaviour, **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).
- Complete **clinical observations**⓪

### Intervention

- The resident will require GP/NP or specialist referral and possible start of anti-epileptic medications.
- If the resident is known to have epilepsy and on anti-epileptic medications, check the therapeutic drug monitoring levels of their anti-epileptic medications. The blood test needs to be taken a couple of hours before the medication is administered.

## Seizure Flowchart



**Advice and Referral:**

- [Transient Ischaemic Attack \(TIA\)](#) Community HealthPathways
- [Stroke](#) Community HealthPathways
- [Australian Stroke Foundation](#) **Ph: 1800 787 653**

**Stroke or TIA:**

- [ACI Stroke Network](#)
- [Neurological Observation Chart](#) (Includes Glasgow Coma Scale)
- [Eligibility for endovascular clot retrieval](#) – NSW Referral Guide
- [Stroke Foundation website](#)
- [Living Clinical Guidelines for Stroke Management](#)

**Swallowing:**

## Speech Therapist Referrals

- Listing of all [Speech Therapists](#) across HNELHD – Community HealthPathways
  - ▶ [Greater Newcastle and Lower Hunter regions](#)
  - ▶ Greater Newcastle based at Rankin Park Centre **Ph: 4921 4859**
  - ▶ Lower Hunter based at Maitland Hospital **Ph: 4931 2003**

**Resources:**

- [ASSIST – Acute Screening of Swallow in Stroke/TIA](#)
- [Assist Competency Assessment: Response Form](#)
- [How Aging Affects Our Swallowing Ability](#)

**Seizures:**

- [First seizure in Adults](#) - Community HealthPathways
- [Epilepsy Action Australia](#) – Community HealthPathways
  - ▶ [Seizure First Aid poster](#) – Epilepsy Smart Australia
  - ▶ [Seizure First Aid video](#) – Epilepsy Action Australia

# Parkinson's Disease

Parkinson's Disease (PD) is the second most common neurological disease in Australia, following dementia. It is a chronic, progressive and currently incurable neurodegenerative condition that significantly impacts function and quality of life. Management requires a multidisciplinary, person-centred approach tailored to the individual's disease stage and symptom profile.

## What is Parkinson's Disease:

- PD is caused by the gradual loss of dopamine-producing cells in the brain. Dopamine assists with transmitting signals that control movement and coordination.
- The disease progresses through three broad stages: early, mid/advanced and late stage.
- Late-stage PD often involves frequent falls, cognitive impairment, visual hallucinations and increasing care needs.

**Parkinson's Disease Symptoms:** are highly individualised and may include:

### Motor Symptoms (related to movement):

- ▶ Bradykinesia (slowness of movement).
- ▶ Rigidity.
- ▶ Resting tremor.
- ▶ Postural instability.
- ▶ Gait disturbance and falls.

### Non-motor symptoms (often more disabling than motor symptoms):

- ▶ Depression and anxiety.
- ▶ Cognitive impairment and dementia.
- ▶ Sleep disturbances.
- ▶ Pain.
- ▶ Fatigue.
- ▶ Autonomic dysfunction:
- ▶ Orthostatic hypotension (postural drop).
- ▶ Constipation.
- ▶ Urinary urgency.
- ▶ Excessive sweating.
- ▶ Hallucinations or delusions (especially in later stages).

## Management Principles:

- PD medications (especially levodopa) must be given on time, every time as delays can cause acute deterioration.
- Management is highly individualised and often complex. Regular reviews (6-12 monthly) and regular medication reconciliations are essential.
- Complications of missed/delayed dosing include:
  - ▶ Severe tremors or rigidity.
  - ▶ Gait disturbance or falls.
  - ▶ Autonomic dysfunction (e.g. blood pressure instability, tachycardia).
  - ▶ Cognitive decline or altered consciousness.
  - ▶ [Case Report](#) Rare but serious: **Parkinsonism-Hyperpyrexia Syndrome**.



## Recognising Acute Deterioration in Parkinson's Disease

| Issue                                         | Key Considerations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Rapid motor changes (minutes to hours)</b> | <p>Consider advanced therapies:</p> <p>Deep brain stimulation (DBS):</p> <ul style="list-style-type: none"> <li>Battery troubleshooting → Is it on?</li> <li>See manufacturer help lines below</li> </ul> <p>Jejunostomy/PEG Tube infusions:</p> <ul style="list-style-type: none"> <li>Are there connection issues, blockages?</li> <li>Are there equipment issues?</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Delirium</b>                               | <p>Fluctuations in attention, cognition:</p> <ul style="list-style-type: none"> <li>Screen for infection</li> <li>GP/NP review for metabolic imbalance</li> <li>Attend <b>4AT</b>, see <b>New Confusion or Suddenly Worsening confusion</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Pain</b>                                   | May be underreported, assess proactively, see <b>Pain</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Falls</b>                                  | <p>See <b>Management of fall with head injury/no evidence of head injury</b></p> <p>Assess for other causes: specific neurology (See <b>TIA or Stroke</b>)</p> <p>Witnessed:</p> <ul style="list-style-type: none"> <li>Are there any injuries? (e.g., consider head strike, fractures)</li> </ul> <p>Unwitnessed:</p> <ul style="list-style-type: none"> <li><b>Decreased LOC</b>, agitation, discomfort, <b>pain</b>, nausea and vomiting, focal neurology – <b>suspected TIA/stroke</b></li> <li>Are there any injuries?</li> </ul> <p>Often linked to medication effect changes or postural instability</p> <ul style="list-style-type: none"> <li>Assess for precipitants (tight spaces/doorways)</li> <li>Falls prevention; PT input for exercises</li> </ul> |
| <b>Medications</b>                            | <ul style="list-style-type: none"> <li>Avoid dopamine antagonists (e.g., certain antiemetics, antipsychotics)</li> </ul> <p style="text-align: center;"><b>Practice Point: No metoclopramide, prochlorperazine or haloperidol. Domperidone is safe for use.</b></p> <ul style="list-style-type: none"> <li>Avoid large, high protein meals around medication administration</li> <li>Avoid delays in medication administration</li> <li>Monitor closely when medication changes have been made</li> <li>Regular GP/NP and pharmacy reviews</li> </ul>                                                                                                                                                                                                               |
| <b>Environment</b>                            | <p>Consider consistent environment measures</p> <ul style="list-style-type: none"> <li>Stable climate</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

## Management of Non-Motor Symptoms:

| Symptom                        | Key Considerations                                                                                                                                                                 |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Orthostatic hypotension</b> | <ul style="list-style-type: none"> <li>Hydration &gt; 1.5 L per day</li> <li>Increase salt intake</li> <li>Compression stockings</li> <li>Slow posture changes</li> </ul>          |
| <b>Constipation</b>            | <ul style="list-style-type: none"> <li>Assess proactively</li> <li>High fibre diet, hydration, regular exercise, regular aperients, macrogol</li> </ul>                            |
| <b>Hallucinations</b>          | <ul style="list-style-type: none"> <li>Assess hearing and visual requirements (aides)</li> <li>Screen for infection</li> <li>Constipation</li> </ul>                               |
| <b>Swallowing Difficulties</b> | <ul style="list-style-type: none"> <li>Involve speech pathology, consider medication form (tablet, liquid or patch; is it crushable?)</li> <li>Request Pharmacy review.</li> </ul> |
| <b>Sleep &amp; Fatigue</b>     | <ul style="list-style-type: none"> <li>Promote good sleep hygiene (see toolkit)</li> <li>Assess for nighttime symptoms</li> </ul>                                                  |

### Transferring to Hospital:

Upon transfer to hospital, it is essential to:

- **Clearly communicate Parkinson's Disease diagnosis and medication timing requirements.**
- Notify the Neurologist, Geriatrician, or Parkinson's Disease specialist nurse where applicable.
- Handover to ED staff that Parkinson's Disease specialty staff should be notified on arrival, especially if the resident is on advanced treatments or therapies (e.g., DBS, apomorphine infusion, Duodopa intestinal gel).
- **If resident is on advanced therapy**; send all relevant equipment, chargers, pumps, extra cassettes.
- Advise Parkinson's Disease nurse of hospital presentation / admission on **Ph: 4985 5442** – leave message if no answer.
- Send a detailed medication list with exact timing, formulation and instructions

### Transferring to new Residential Aged Care home:

Upon transfer to new facility, it is essential to:

- **Clearly communicate Parkinson's Disease diagnosis and medication timing requirements.**
- Request a detailed medication list with exact timing, formulation and instructions.
- Early involvement of pharmacist and speech pathologist (especially with swallowing problems).
- Request education / support around the management of advanced therapy, if applicable, by contacting the Parkinson's Nurse on **Ph: 4985 5442**.
- Establish follow up plans, if required, with Neurologist or Geriatrician.

### Contact Resources for Advanced Therapies:

- Deep Brain Stimulation (DBS):
  - ▶ Medtronic Patient Services (DBS) **Ph: 1800 652 972**
  - ▶ Boston Scientific (Australia and New Zealand) (DBS) **Ph: 1800 245 559**
- Apomorphine:
  - ▶ ANSSER nursing support (**Apomine** - Interpharma) **Ph: 1800 276 646**
  - ▶ STADA nursing support (**Movapo**) **Ph: 1800 823 230**
- Duodopa and Vyalev (subcutaneous infusion of Levodopa)
  - ▶ Partizan nurses support **Ph: 1800 230 608**

### References:

- [Australasian Journal of Neuroscience](#) (Carrol et al. 2020)
- [Community Health Pathways](#)
- [Ecosystems of Parkinson's in Australia Project](#) (Mellick, G. 2024)
- [Huberman Lab](#) – Toolkit for Sleep
- [National Institute for Health and Care Excellence](#) (2017)
- [NSW Health Safety notice for Medication Management in Parkinson's Disease](#)
- [Parkinsonism-Hyperpyrexia Syndrome](#): A Case Series and Literature Review (Azar et al. 2022).
- [Parkinson's NSW](#) helpline **Ph: 1800 644 189**

# Parkinson's Disease Flowchart

## Parkinson's Disease (PD) – New or Worsening PD Symptoms

### Comprehensive Assessment

- Complete **clinical observations**①

Look for and address any possible reversible causes:

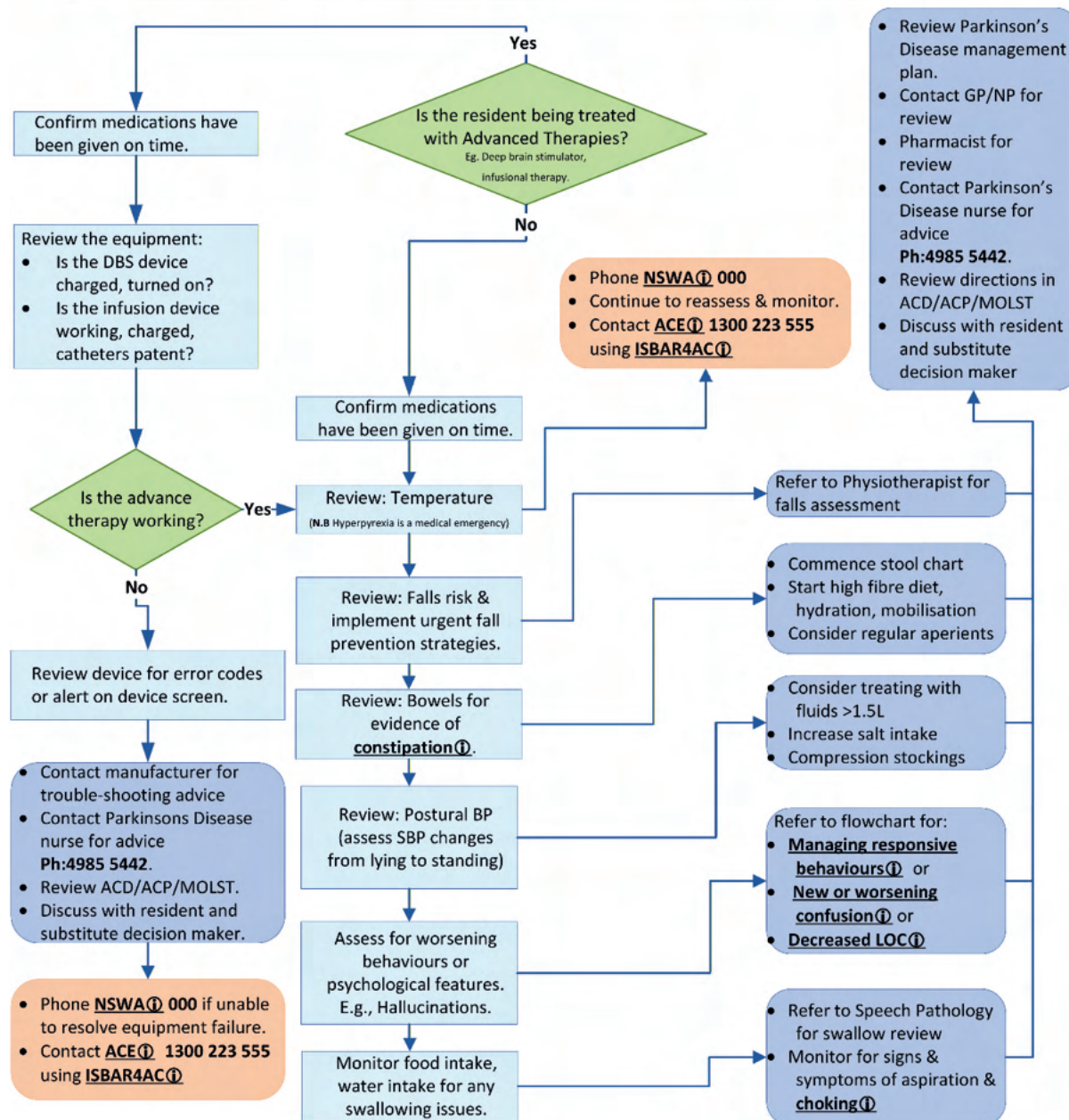
- **Constipation**①, delirium, **pain**①, poor sleep, hypotension.
- Review for **urinary retention**①
- Review pain assessment / analgesia.
- Have there been any medication changes, delays or omissions?
- Is there new facial droop, slurring of speech or limb movement deficits that are not normal, if yes see **suspected TIA or Stroke**①

Assess for signs and symptoms of Infection – see **sepsis**①:

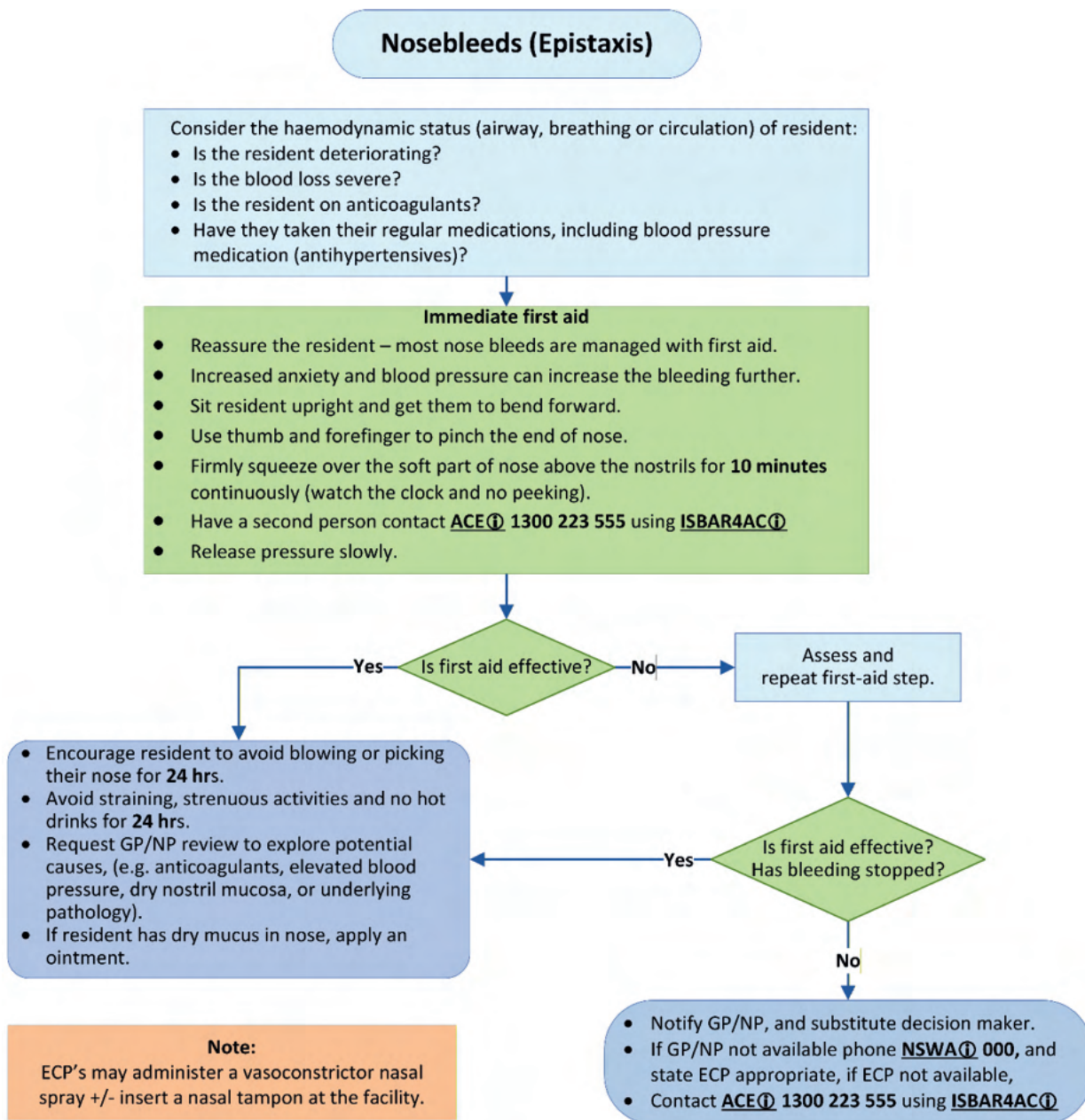
- Include skin inspection – could this be an infection eg. cellulitis?
- Note any cough or rattly breathing that is abnormal for this resident.
- Are there urinary symptoms? Perform urine analysis.

### Important:

Hyperpyrexia could be a **medical emergency**, especially in the context of medication omission.



## Nosebleeds (Epistaxis) Flowchart



### References and Resources:

- [Nosebleed](#) - HealthDirect
- [Nosebleed](#) NSW Health - Emergency Care Institute (ECI) – 2022.
- [Nurse-led Epistaxis Management within the Emergency Department](#). N Hakim, S Mitra Mummadi, K Jolly, J Dawson, and A Darr. 2018 British Journal of Nursing, 27(1), 41-46.



# 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 non-pharmacological therapies.
- Dementia, hearing impairment and dysphagia (difficulty swallowing) are factors that may inhibit the older person's ability to communicate their pain (Veal et. al. 2018).

## Assessment

A Comprehensive Pain Assessment includes the 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

Tools for when the individual can report the presence and intensity of their pain.

- Verbal assessment tools may include:
  - ▶ [Modified Residents Verbal Brief Pain Inventory](#) (M-RVBPI)
  - ▶ [Numerical Rating Scale](#) (NRS)
  - ▶ [Verbal Descriptor Scale](#) (VDS)
  - ▶ [Faces Pain Scale Revised](#) (FPS-R)

## Non-Verbal Assessment Tools

When a person is unable to verbally communicate their pain, alternative methods must be used to assess its presence and intensity.

These may include observing:

- ▶ Facial expressions (grimacing)
- ▶ Vocalisations (moaning or calling out)
- ▶ Body movements (guarding or stiffness)
- ▶ Behavioural changes
- ▶ Reduced social engagement
- ▶ Alterations in mental status



- Non-verbal assessment tools may include:
  - ▶ [Pain Assessment in Advanced Dementia Scale](#) (PAINAD)
  - ▶ [ABBEY pain scale](#)
  - ▶ [6-step procedure](#) for all residents who cannot communicate successfully
  - ▶ Pain behaviours used in [validated observational pain scales](#)
  - ▶ Pain smart Phone applications (apps) - using facial recognition to detect facial expressions that indicate pain.

## 1. Types of Pain Based on Duration

### Acute (Short-Term):

- ▶ Pain that is short-term, often related to recent structural problems.
- ▶ Pain often stops when injury has healed or recovery is complete.
- ▶ Pharmacological therapies as part of a broader approach may be considered.

### Chronic Pain (Persistent):

- ▶ Pain that may persist for 3 months or longer, following an acute event or occurring de novo (by itself).
- ▶ This is often related to altered processing of signals in the central nervous systems and less related to ongoing structural problems.
- ▶ There is evidence for non-pharmacological strategies for this type of pain including exercise and counselling.

## 2. Types of Pain Based on Possible Mechanism

### Nociceptive (pain related to tissue problems)

- Somatic:
  - ▶ Often related to stimuli in skin, muscles, bones etc.
  - ▶ Well-localised.
  - ▶ Can be superficial or deep.
  - ▶ Described as sharp, aching, stinging etc. e.g., pressure areas, ulcers, fractures.
- Visceral:
  - ▶ Related to stimuli in internal organs.
  - ▶ Often poorly localised.
  - ▶ Described as cramping squeezing pressure, diffuse e.g., bowel obstruction, colic.

### Neuropathic (pain related to nervous system damage)

- ▶ Related to stimuli in nervous system.
- ▶ Can be radiating.
- ▶ Described as electric shock, burning, freezing, shooting.
- ▶ Can be associated with sensory or motor changes (tingling, numbness, weakness) e.g., shingles, diabetic neuropathy.
- Nociplastic: (pain related to nervous system dysfunction)
  - ▶ Related to sensitisation rather than damage in the nervous system
  - ▶ Can be widespread
  - ▶ Descriptors can be varied
  - ▶ Can be associated with a history of stress or psychological trauma

### 3. Non-Pharmacological Therapies

#### Movement and exercise

- Physical Exercises (individual or as group)
  - ▶ Aerobic exercise e.g., walking, chair-based exercises.
  - ▶ Balance and strengthening exercise e.g., sit to stand, arm raises.
  - ▶ Mindful movement, yoga type exercise, tai chi.
- Other helpful physical activities:
  - ▶ Unstructured gentle movement e.g., sitting out of bed for increasing periods of time, swaying to music.
  - ▶ Social or playful tasks (e.g., dancing, seated lawn bowls).
  - ▶ Recreational or meaningful activities or hobbies (e.g., gardening, caring for pets).
- Passive approaches:
  - ▶ Application of heat/cold packs or use of TENS machine may be perceived as helpful but this is not based on evidence and there is risk of unintended harm e.g., Burns.

#### Mind-body interventions

- ▶ Counselling and psychological therapies.
- ▶ Mindfulness practices, guided relaxation and meditation spiritual connection practices including quiet contemplation and prayer.
- ▶ Creative therapies such as music or art therapy to channel self- expression and enjoyment.
- ▶ Building helpful connections e.g., Group play, social activities.
- ▶ Encourage good sleep hygiene practices.

#### Social Interventions

- ▶ Creative therapies and psychological therapies.
- ▶ Building helpful connections e.g., group play, social activities.
- ▶ Addressing any unresolved family conflicts.

#### Nutritional optimisation

- ▶ Monitor nutritional status and diet on regular basis.
- ▶ Enable adequate hydration and fibre.
- ▶ Encourage rainbow of vegetables, calcium and protein rich intake.

#### Passive Approaches

- ▶ These approaches may be perceived as beneficial however there is limited supporting evidence, and may carry a risk of unintended harm e.g., burns.
- ▶ Application of heat / cold packs.
- ▶ The use of tens machine.

## 4. Pharmacological Therapies

The use of pharmacological agents to treat pain is a form of passive therapy. It is important to weigh the benefits and harms carefully before initiating or maintaining treatment in the older person.

### Acute Pain

- Pain relieving medications are more effective in treating acute pain than chronic pain.
- Medications such as, paracetamol, non-steroidal anti-inflammatory drugs and opioids all have an established, time-limited place in the management of pain occurring after an acute injury or illness.
- Likewise, anti-neuropathic agents can be helpful in treating acute neuropathic pain.

### Chronic Non-Cancer Pain

- Evidence is not strongly supportive of long-term medication use in the older person.
- Cognitive clouding and increased falls are common adverse effects of psychoactive medications, as is polypharmacy.
- Evidence of medication use for chronic pain management becomes stronger as the person moves towards, and into, the palliative Phase.

## 5. Managing Constipation

Constipation is a common adverse effect of opioid use. Regularly reviewing the ongoing need for opioids is essential, with consideration given to gradual dose reduction where appropriate. To prevent opioid-induced constipation, the use of a combined stimulant and stool softener laxative is recommended.

Refer to: **Constipation** or **Symptom Management in Palliative Care**

## 6. Further Information

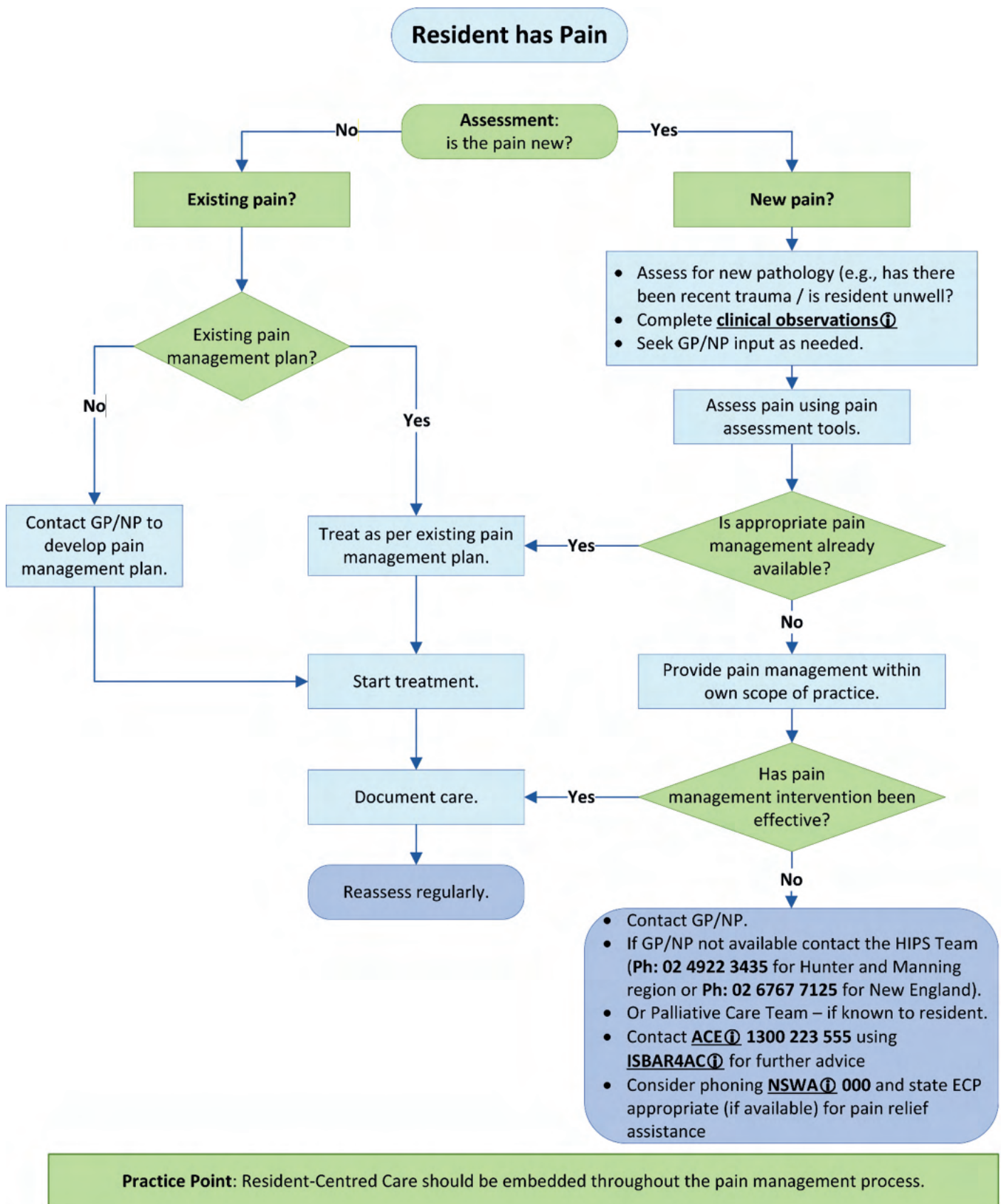
### Advice and Referral

- Hunter Integrated Pain Service (HIPS)
  - ▶ Hunter and Manning region:  
**Ph: 4922 3435**, or Fax referrals to **Ph: 4922 3893**, or email [HNELHD-HIPS@health.nsw.gov.au](mailto:HNELHD-HIPS@health.nsw.gov.au)
  - ▶ Tamworth Integrated Pain Service (TIPS) for the New England Region:  
**Ph: 6767 7125**, or Fax referrals to **Ph: 6767 8273**.

### References and Resources

- [Hunter Integrated Pain Service](#): HealthDirect
- [Pain Management Guide \(PMG\) Toolkit for Aged Care 2<sup>nd</sup> edition 2021](#) The Australian Pain Society
- [Pain](#) HNE Community HealthPathways
- [Pain Management](#) Network, Agency for Clinical Innovation:
- Palliative pain advice: see the **Palliative Care and Last Days of Life Care** section of the ACE Manual
- [Barriers to Optimal Pain Management in Aged Care Facilities](#) Veal F, Williams M, Bereznicki L, Cummings E, Thompson A, Peterson G, Winzenberg T.: An Australian Qualitative Study. Pain Manag Nurs. 2018 Apr; 19 (2):177-185. Epub 2017 Nov 15. PMID: 29153298.

## Managing Pain Flowchart



# Palliative Care and Last Days of Life Care

## What is Palliative Care?

Palliative care is an approach to care that supports residents and their families facing life-limiting illnesses, such as chronic diseases, cancer and dementia. The palliative approach involves holistic assessment and management of physical, psychological, cultural and social needs, tailored to the individual residents. Palliative care can be introduced early during a resident's life-limiting illness and may coexist with active treatments. The primary goal is to optimise quality of life despite serious illness.

## Key Points for Palliative Care:

- Residents in aged care often prefer to be involved in decision-making and goal setting, with families, included as partners in the process.
- Early discussions about goals of care support aligned decision-making that reflects the resident's preferences during periods of deterioration.
- Advance care planning, including treatment preferences, should begin early and regularly reviewed and documented as circumstances change.
- Cultural, religious and spiritual wishes should be clarified and incorporated into care planning processes.

## Defining Last Days of Life Care

The 'last days of life' refers to the period, typically measured in days, when a person is irreversibly approaching death. This stage is marked by declining Physiological function and can be difficult to predict when dying will begin.

The Clinical Excellence Commission (CEC) has developed a toolkit to aid in recognising this Phase and to support appropriate care for residents and their families.

Communication of a dying diagnosis is critical, and families should be given the opportunity to understand and explore what to expect. Communication practices are generally outlined in facility protocols, see [PREPARED model](#) as a guide for conversations about the last days of life.

## How to recognise that someone is dying?

Indicators may include:

- Continued clinical deterioration despite optimal care.
- Difficult swallowing or tolerating oral medications.
- Loss of interest in food and fluids.
- Profound weakness and being bedbound.
- Prolonged drowsiness and increased periods of sleeping.

### Practice Point:

These signs can appear over weeks or months in individuals with advanced disability (Physical and/or cognitive). Further functional decline may indicate active dying. See the [toolkit](#) here.



### Key Points for Care in The Last Days of Life:

- Notify resident's GP/NP and relevant staff.
- Ensure the resident and family understand the situation and are supported in expressing their preferences for care and comfort.
- Include psychological and spiritual.
- Review and discontinue non-beneficial treatments.
- Align the care plan with the resident's current condition and documented wishes.
- Support the needs of both the resident, substitute decision maker, supported decision maker and their family.

## 1. Caring for a Resident in the Last Days of Life

### Comfort Care is Resident Centred

Comfort is a subjective experience defined by physical, psychological, spiritual, environmental, and social needs. Comfort is an individual experience, 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 resident's comfort.
- Review of resident current care plan and ongoing handling techniques/preferences.
- Ensuring the resident's environment supports the resident's comfort.

### Skin and Pressure Care

- Pressure relieving mattresses may reduce the frequency of care, but do not replace the need for regular repositioning.
- Pre-emptive pain relief should be provided prior to movement (if required 30 minutes prior).
- Plan repositioning in conjunction with the family.
- Consider continence management.
- Be aware that an unavoidable Kennedy ulcer may occur towards the end of life. [See Skin Failure](#)

### 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 the Resident, Family and Carers

Reactions to impending loss varies. Distress is normal when a loved one is dying and may be influenced by cultural beliefs, previous experience and/or family dynamics. It is important to provide residents and families with opportunities to express their distress or concerns. See HNE Community HealthPathways for [family/carer support resources](#).

**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 and expectations.
- ▶ Discussion of goals of care and priorities.
- ▶ Bereavement counselling if required (see your organisation’s process).

## **2. Symptom Management in the Last Days of Life**

### **Fatigue**

Fatigue is an expected symptom in the last weeks 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 to ensure the prompt treatment of symptoms 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 [CEC Anticipatory Prescribing Guide](#)
- A breakthrough dose is dependent on current opioid use, see [CEC Anticipatory Prescribing Guide](#)
- Be mindful that psychosocial distress and other contexts may impact on the pain experience.

### **Breathlessness**

Breathing difficulties and shortness of breath may be multifactorial, perform a thorough resident assessment to identify the potential cause(s).

- Begin with non-pharmacological measures first including, reassurance, repositioning, fans, open windows, and a calm environment.
- Administer oral or subcutaneous opioid if non-pharmacological measures are ineffective. The dose will be dependent on current opioid use.
- If anxiety is present, it is recommended an anxiolytic (benzodiazepine) be prescribed.
- Oxygen therapy is only beneficial with hypoxia (oxygen saturation less than 90% on room air). The 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 resolves, 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's Disease or Lewy Body dementia.
- Refer to the [CEC Anticipatory Prescribing Guide](#).

## Restlessness or Agitation in the Days of Life

Restlessness is common in the last days of life and may be a signal for unrecognised pain or other forms of distress.

- Conduct a thorough assessment to identify and address potentially reversible causes, such as urinary retention, faecal impaction or spiritual distress.
- Consider indwelling catheter insertion for retention or discomfort is present.
- Review the resident's routine medications and discontinue non-essential medications.
- Explore and address 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 in suctioning 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, alternating sides to encourage natural drainage.
  - ▶ Provide regular mouthcare to clear pooled secretions.
  - ▶ Anti-secretory medications may be ineffective or only partially effective.

Further information can be found on Community Health Pathways for [symptom control](#).

## 3. Assessment Checklist for Residents in the Last Days of Life

### Practice Point:

#### To make a diagnosis of dying ask yourself three questions:

1. Is any aspect of this deterioration likely to be reversible?
2. Would you be surprised if this resident was to die within hours to days?
3. Has the dying resident previously stated any care preferences that need to be incorporated into the care plan for the next Phase of illness?

Ensure:

- Open disclosure with family and carers of the diagnosis of dying to ensure clear understanding of changing care needs.
- Regularly for side effects of palliative medications and refer to GP/NP if side effects occur:
  - ▶ Myoclonus (sudden, involuntary jerking of a muscle/s, usually due to opiates).
  - ▶ Dry mouth.
  - ▶ Urinary retention.
  - ▶ Constipation.
  - ▶ Nausea.
- Regular comfort care, including:
  - ▶ Mouth care.
  - ▶ Repositioning for comfort and symptom management.
  - ▶ Pressure area care.
  - ▶ Bladder assessment to ensure resident is not in urinary retention.
  - ▶ Bowel care.

#### **4. 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.

See the CEC for further information on Last days of Life [medication prescribing](#).

The goals of medication prescribing should include:

- Review existing medications for alignment with goals of care.
  - ▶ Plan for medications which may cause withdrawal symptoms by weaning or changing to alternate agent.
  - ▶ Deprescribe where appropriate.
  - ▶ Monitor for side effects.
  - ▶ Ensure anticipatory prescribing has been attended to ensure the timely access to medications.
  - ▶ See [CEC Anticipatory Prescribing Guide](#)
- Optimise route of delivery as appropriate. Alternate routes include:
  - ▶ Topical medications or patches.
  - ▶ Sublingual tablets or wafers that dissolve under the tongue.
  - ▶ Subcutaneous medications (see below for Management of Subcutaneous Infusions next page).
  - ▶ Administration via PEG tube.

#### **Subcutaneous Infusion Resources**

- Subcutaneous infusion devices are useful for managing a range of symptoms, especially when other routes of medication administration are no longer available.
- Resources developed by Queensland Health, Centre for Palliative Care Research and Education Guidelines for Subcutaneous Infusion Device Management in Palliative Care and other settings – 3rd Edition 2021
  - ▶ [Management of Subcutaneous Infusions in Palliative Care](#) - an online education program.
  - ▶ [Subcutaneous Infusion Device Guidelines](#) – clinical guidelines

## 5. Voluntary Assisted Dying

### Aged Care Quality and Safety Commission

This [link](#) outlines the role of RAC providers in offering access to voluntary assisted dying (VAD) in their service. The factsheet explains the RAC responsibilities and obligations when a person in their care is thinking about, or wants to access, voluntary assisted dying.

### NSW Health

- [Voluntary assisted dying in NSW](#) - NSW Health
- [Patient information](#) to outline the background, eligibility criteria and process.
- NSW Care Navigator service
  - ▶ **Ph: 1300 802 133** Monday to Friday, 8:30 am to 4:30 pm
  - ▶ Email: [NSLHD-VADCareNavigator@health.nsw.gov.au](mailto:NSLHD-VADCareNavigator@health.nsw.gov.au)

### Hunter New England Voluntary Assisted Dying Support Team

Provides timely and equitable access to person centred care for eligible patients wishing to access voluntary assisted dying within the HNELHD. The service provides outreach services to patients in the community, including but not limited to residential facilities, private entities, and people's homes.

**Ph: 4964 7360** Monday to Friday 8:00 am-4:30 pm

Email: [HNELHD-VAD@health.nsw.gov.au](mailto:HNELHD-VAD@health.nsw.gov.au)

### HNE Community HealthPathways

#### [Hunter New England Community HealthPathways](#)

- ▶ Voluntary Assisted Dying (VAD) in NSW
- ▶ Voluntary Assisted Dying Referrals

## 6. Bereavement

Bereavement is the process individuals and families experience following the death of a loved one. It can involve a range of challenges, including practical, psychosocial, psychiatric and financial challenges, often requiring support and guidance from appropriate services. Resources can be found on Community Health Pathways.

### Advice and Referral

- Community HealthPathways
  - ▶ [Advanced Care Planning](#)
  - ▶ [Bereavement](#)
  - ▶ [Palliative Care](#)
  - ▶ [Palliative Care Referrals](#)

### Documentation

- [MOLST form](#)
- [Making an Advance Care Directive](#) NSW Health
- [Authorised Care Plans](#) NSW Ambulance



## Last days of Life Anticipatory Prescribing Medications

| 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                                                                      |
| <b>MORPHINE</b>                                                                             | PAIN &<br>1st line for BREATHLESSNESS                                                    | 2.5 mg subcut<br>1 (one) hourly PRN<br>max PRN dose in 24 hours = 15mg<br>(equivalent to 6 PRN doses)         | If not taking regular opioid (not on regular opioid for previous 7 days)<br><br>See pain and/or dyspnoea management flowchart for guidance on commencing regular subcutaneous morphine                                                                                      |                                                                                     |
|                                                                                             |                                                                                          |                                                                                                               | If on regular opioid (regular opioid use during the previous seven days)<br><br>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 |                                                                                     |
| <b>METOCLOPRAMIDE</b>                                                                       | 1st line for NAUSEA and/or VOMITING                                                      | 10 mg subcut<br>8 hourly PRN<br>max PRN dose in 24 hours = 30mg<br>(equivalent to 3 PRN doses)                | 30 mg subcut<br>in 24 hr syringe driver<br>(plus PRN haloperidol)                                                                                                                                                                                                           | OR<br>10 mg subcut<br>8 hourly regularly<br>(plus PRN haloperidol)                  |
| <b>HALOPERIDOL</b>                                                                          | 2nd line for NAUSEA and/or VOMITING &<br>1st line for RESTLESSNESS and/or AGITATION      | 1 mg subcut<br>4 hourly PRN<br>max PRN dose in 24 hours = 3mg<br>(equivalent to 3 PRN doses)                  | 2 mg subcut<br>in 24 hr syringe driver<br>(plus PRN haloperidol)                                                                                                                                                                                                            | OR<br>1 mg subcut<br>12 hourly regularly<br>(plus PRN haloperidol)                  |
| <b>BENZODIAZEPINE</b>                                                                       | 2nd line for RESTLESSNESS and/or AGITATION &<br>2nd line for BREATHLESSNESS with ANXIETY | MIDAZOLAM*<br>2.5 mg subcut<br>2 hourly PRN<br>max PRN dose in 24 hours = 15mg<br>(equivalent to 6 PRN doses) | MIDAZOLAM*<br>10 mg subcut<br>in 24 hr syringe driver<br>(plus PRN midazolam)                                                                                                                                                                                               | OR<br>CLONAZEPAM **<br>0.5 mg subcut<br>12 hourly regularly<br>(plus PRN midazolam) |
| <b>GLYCOPYRRONIUM / GLYCOPYRROLATE</b><br><br>OR<br><b>HYOSCINE BUTYLBROMIDE (BUSCOPAN)</b> | RESPIRATORY TRACT SECRETIONS                                                             | 0.2 mg subcut<br>4 hourly PRN<br>max PRN dose in 24 hours = 1.2mg<br>(equivalent to 6 PRN doses)              | 1.2 mg subcut<br>in 24 hr syringe driver<br>(plus PRN glycopyrrolate)                                                                                                                                                                                                       | OR<br>0.2 mg subcut<br>4 hourly regularly<br>(plus PRN glycopyrrolate)              |
|                                                                                             |                                                                                          | 20 mg subcut<br>4 hourly PRN<br>max PRN dose in 24 hours = 120mg<br>(equivalent to 6 PRN doses)               | 120 mg subcut<br>in 24 hr syringe driver<br>(plus PRN hyoscine butylbromide)                                                                                                                                                                                                | OR<br>20 mg subcut<br>4 hourly regularly<br>(plus PRN hyoscine butylbromide)        |

- 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)

- 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)

### \*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

- If respiratory tract secretions occur, prompt management is required
- Anticholinergic 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

| ANTICIPATORY PRESCRIBING IN THE LAST DAYS OF LIFE: Prescribing Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | SYMPTOM MANAGEMENT IN THE LAST DAYS OF LIFE: Supporting Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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| <p>All patients in the last days of life should have subcutaneous PRN medications prescribed pre-emptively to ensure that there is no delay in treating the common symptoms that may be experienced in the last days of life if they occur</p> <p><b>Recommendations for STARTING doses – Last Days of Life</b></p> <ul style="list-style-type: none"> <li>This guide includes the recommended starting dose for first line medications to be pre-emptively prescribed for patients</li> <li>Doses should be adjusted up or down to take into account the needs of the individual patient, including frailty and co-morbidities</li> <li>Lower starting doses and/or PRN frequencies should be considered in the elderly or in patients with severe renal or hepatic impairment</li> <li>Higher starting doses and/or PRN frequencies can be used if appropriate</li> </ul> <p><b>Recommendations for dose TITRATION</b></p> <ul style="list-style-type: none"> <li>Patients should be assessed regularly, at least every 4 hours or more often if symptomatic</li> <li>Response to non-pharmacological interventions and/or PRN medication doses must be assessed following intervention; further management should be instigated if symptom remains despite initial intervention</li> <li>Symptom control should be reviewed at least daily, or more often if symptoms are uncontrolled, and background medication doses titrated upwards accordingly</li> <li>If &gt;3 PRN doses are required in previous 24 hours and/or symptoms persist, regular medications should be commenced or regular doses increased: see symptom management flowcharts for specific guidance on dose titration for each of the common symptoms</li> </ul> <p><b>For patients with pre-existing end stage kidney disease (eGFR &lt;30):</b></p> <ul style="list-style-type: none"> <li>All of the starting medications recommended overleaf can be used in renal impairment</li> <li>For specific prescribing guidelines: seek advice from local Specialist Palliative Care teams.</li> </ul> <p><b>For patients dying in ICU:</b></p> <ul style="list-style-type: none"> <li>The existing intravenous route may be preferred over the subcutaneous route for patients dying in the ICU setting; all last days of life anticipatory medication recommendations in these guidelines can be given intravenously in the ICU setting</li> </ul> <p><b>Syringe Driver Drug Combinations and Compatibilities</b></p> <ul style="list-style-type: none"> <li>Compatibility data supports the combination of life anticipatory medications in a single syringe driver when diluted to maximum volume with 0.9% sodium chloride</li> <li>When using alternative medications for symptom control advice regarding drug compatibility combinations should be sought from a medical officer or specialist nurse with appropriate knowledge and experience prior to administration</li> <li>LHD policy and procedure must be followed when prescribing and administering medications via a subcutaneous syringe driver</li> </ul> <p><b>If required, seek advice from local Specialist Palliative Care team with regard to any of the above</b><br/>See Palliative Care Therapeutic Guidelines (<a href="http://www.tg.org.au">http://www.tg.org.au</a>) for further advice on drug compatibilities</p> <p><b>CONTACT DETAILS FOR LOCAL SPECIALIST PALLIATIVE CARE ADVICE</b></p> <p>Telephone: _____</p> <p>Available hours: _____</p> | <p><b>PRINCIPLES OF SYMPTOM MANAGEMENT IN THE LAST DAYS OF LIFE</b></p> <ul style="list-style-type: none"> <li>Assess patient at least every four hours: to allow existing and emerging symptoms to be detected, assessed and treated effectively</li> <li>If symptom(s) present:             <ol style="list-style-type: none"> <li>Instigate non-pharmacological measures in the first instance</li> <li>If non-pharmacological measures ineffective, give PRN medication and review to assess effectiveness</li> <li>If medication ineffective, reassess and instigate further intervention to manage symptom</li> </ol> </li> <li>Communicate: explain likely cause and management of symptom to patient and family</li> </ul> <p><b>PAIN</b> – see symptom management flowchart for dosage guidance and conversion tables</p> <ul style="list-style-type: none"> <li>Non-pharmacological measures:             <ul style="list-style-type: none"> <li>Ensure comfortable position; consider repositioning and/or alternative mattress</li> <li>Exclude other causes of pain and distress (e.g. urinary retention, anxiety, fear); manage appropriately if present</li> <li>If patients demonstrate opioid side effects or show clinical features of opioid toxicity:                     <ul style="list-style-type: none"> <li><b>Do NOT give an opioid antagonist</b> (such as naloxone), as this will precipitate uncontrolled pain and/or opioid withdrawal symptoms</li> </ul> </li> </ul> </li> </ul> <p><b>NAUSEA AND/OR VOMITING</b> – see symptom management flowchart</p> <ul style="list-style-type: none"> <li>Non-pharmacological measures:             <ul style="list-style-type: none"> <li>Regular and effective mouth care</li> <li>Sips of water and ice chips</li> <li>Provision of tissues and vomit bag within easy reach</li> </ul> </li> <li>Nausea and/or vomiting can have multiple causes (i.e. gastrointestinal, central nervous, intracranial, vestibular and psychological) – see Palliative Care Therapeutic Guidelines (<a href="http://www.tg.org.au">http://www.tg.org.au</a>) for more detailed information and medication recommendations for specific causes</li> </ul> <p><b>RESTLESSNESS AND/OR AGITATION</b> – see symptom management flowchart</p> <ul style="list-style-type: none"> <li>Agitated delirium and terminal restlessness is a COMMON symptom that occurs in the last days of life</li> <li>Non-pharmacological measures should be considered before medications are introduced:             <ul style="list-style-type: none"> <li>Exclude urinary retention; manage with catheterisation if present</li> <li>Exclude constipation; consider management with rectal laxatives if present</li> <li>Consider nicotine replacement therapy if the patient is a smoker</li> <li>Assess for emotional, psychological and existential distress; address appropriately if present</li> </ul> </li> </ul> <p><b>RESPIRATORY TRACT SECRETIONS</b> – see symptom management flowchart</p> <ul style="list-style-type: none"> <li>Respiratory tract secretions are a normal part of dying process: they are not distressing to the patient, but often are for family and carers</li> <li>Non-pharmacological measures:             <ul style="list-style-type: none"> <li>Reassure family with explanation of the symptom, cause, &amp; measures taken used to relieve secretions</li> <li>Position patient semi-prone and on to alternate sides to encourage postural drainage; this may be sufficient</li> <li>Suction is NOT RECOMMENDED and can be distressing to the patient</li> </ul> </li> </ul> <p><b>BREATHLESSNESS</b> – see symptom management flowchart</p> <ul style="list-style-type: none"> <li>Non-pharmacological measures:             <ul style="list-style-type: none"> <li>Reassure the patient and family with explanation of cause and management</li> <li>Position to maximise comfort and airway</li> <li>Use a fan and/or an open window</li> <li>Maintain a calm environment</li> </ul> </li> </ul> <p><b>If required, seek advice from local Specialist Palliative Care team with regard to any of the above</b></p> |

Clinical Excellence Commission (2017) VERSION 2 Last Days of Life Anticipatory Prescribing Recommendations: May 2017.

Accessed 5/6/25.

## References and Resources

### Medications in the last days of life

- [Advanced Care Planning](#) – Advance Care Planning Australia
- [End of Life Care](#) - Clinical Excellence Commission (CEC):
- [Advanced care Directives](#) - ELDAC Factsheet on
  - ▶ [End of Life Directions for Aged Care](#) - (ELDAC)
  - ▶ [An Overview for the Aged Care Sector](#) - End of Life Law in Australia
  - ▶ [Palliative Care in Hunter New England](#) - (HAPCN)
  - ▶ [MOLST](#) - explained
  - ▶ [NSW Health ACP](#)
  - ▶ [Palliative Aged Care Outcomes Program](#)
  - ▶ [Program of Experience in the Palliative Approach](#) - (PEPA)
- [Guidelines for Subcutaneous Infusion Device Management in Palliative Care and other settings](#) - Queensland Health, Centre for Palliative Care Research and Education: – 3rd Edition 2021
- [End of Life Resources online Education Modules](#)

### Providing End-of-Life Care for People from Diverse Backgrounds

- [Providing end-of-life care for Aboriginal and Torres Strait Islander People](#)
- [Palliative Care Australia Discussing Choices](#)
- [Working with diverse groups in aged care](#) - Australian Government Department of Health and Aged Care

# Polypharmacy and High-Risk Medications in RAC

## Polypharmacy

Residents in RAC homes are more sensitive to the side effects of taking many medications at once – this is called polypharmacy (taking 5 or more medicines). As people age, their bodies process medicines more slowly, which can increase the risk of side effects. The more medicines a person takes the higher the risk of:

- Medicines reacting with each other
- Side effects
- Falls, confusion, or other health issues
- Needing to go to hospital (Ibrahim et al., 2021)

Polypharmacy includes vitamins, herbs, and food supplements.

## High-risk medicines

These are medicines that have a high risk of causing significant injury or patient harm when they are misused or used in error. High-risk medicines may:

- Have a small difference between the right dose and a harmful dose (narrow therapeutic index)
- Have a complex or unusual dosing and/or monitoring requirements
- Come in different strengths or forms (e.g. tablets, liquids)
- Have a look-alike or sound-alike name or packaging to other medicines

There are individual Standards requiring mandatory compliance for identified high-risk medicines such as insulin, anticoagulants, opioid analgesics, paracetamol and potassium.

- [High Risk Medicines](#)
- [APINCHS](#) - Australian Commission on Safety and Quality in Health Care:

## Risk Factors for Polypharmacy

- ▶ Age >65 years
- ▶ Multiple diagnoses, co-morbidities, and/or chronic disease
- ▶ Functional dependency
- ▶ Frailty
- ▶ Recent hospitalization
- ▶ Pain
- ▶ Cognitive or sensory impairment
- ▶ Culturally and Linguistically Diverse (CALD) background
- ▶ Mental health issues (e.g., anxiety, depression)
- ▶ Multiple prescribers



## Why Is Inappropriate Polypharmacy a Problem?

- Polypharmacy increases the risk of adverse effects, for example;
  - ▶ Falls and associated harm (fractures)
  - ▶ Dehydration.
  - ▶ Frailty and functional decline.
  - ▶ Cognitive impairment and dementia.
  - ▶ Hospitalisation.
  - ▶ Death. (Hilmer and Gnjidic, 2018).
- One-quarter of people on multiple medicines (polypharmacy) have adverse effects directly attributable to the additive effects of one or more medicines. Certain medicines are common culprits for higher cumulative risk.

These include:

- ▶ Medicines that affect the brain (like antipsychotics or antidepressants)
- ▶ Medicines for pain (like opioids or anti-inflammatory drugs)
- ▶ Medicines that increase urination (diuretics)
- ▶ Medicines that dry the body (called anticholinergics)

If you are concerned, talk to the doctor or pharmacist about whether your resident's medicines are still the best choice for them.

## Adverse Drug Reactions

Medication-related complications 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 and urinary incontinence.

### Practice Point:

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

## Medication-Management Reviews

Residential Medication Management Review (RMMR) for residents of RACs involves collaboration between a GP/NP and a pharmacist to review the medication-management needs of a resident.

- [Residential Medication Management Review and Quality Use of Medicines Programs](#)

## Deprescribing

Deprescribing is a person-centred and systematic process to taper, reduce, or stop the use of potentially inappropriate medicines.

- Deprescribing requires close, consistent monitoring of the person to ensure that the tapering of the medicine, or discontinuation, is both safe and effective.
- Deprescribing should be considered when the resident enters care and their treatment or care goals have changed, and there has been a recent 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:
  - ▶ Medicine with anticholinergic properties such as oxybutynin, antihistamines, and some antipsychotics
  - ▶ Benzodiazepines
  - ▶ Antidepressants
  - ▶ Steroids
  - ▶ Diuretics
- There is increasing evidence on [how to safely withdraw medications and deprescribing guides](#) are available at NSW Therapeutic Advisory Group.
- It is important to communicate and discuss the rationale for deprescribing of medicines with the individual, their carers, GP/NP and other community clinicians to ensure safe ongoing management and care.
- It is important to document the deprescribing discussion in the medical records and discharge summary and include in this documentation whether the person or carer agrees or declines the deprescribing recommendation.

### Resources and references

- [Cumulative Medicines](#) - Medicines Advice Initiative Australia, Autumn 2024
- [How to de-prescribe and wean opioids in general practice](#) - ACI Pain Management Network -
- [Guiding principles for medication management in RACFs](#) - Australian Government Department of Health & Aged Care - (Feb 2023)
- [A systematic review of the evidence for deprescribing interventions among older people living with frailty](#). Ibrahim K, Cox NJ, Stevenson JM, Lim S, Fraser SDS, Roberts HC. *BMC Geriatrics*. 2021 Apr 17; 21(1):258.
- [The anticholinergic burden: from research to practice](#). - Hilmer SN, Gnjdjic D. *Australian Prescriber*. 2022 August 45(4): 118-120.
- [Deprescribing: the emerging evidence for and the practice of the 'geriatrician's salute'](#). Hilmer, S. N., & Gnjdjic, D. (2018). *Age and Ageing*. 47(5), 638-640.
- [Deprescribing Resources](#) - Consultant Pharmacy Services
- [Polypharmacy](#) - Royal Australian College of General Practitioners RACGP
- [Medications without Harm](#) - WHO Global Patient safety Challenge Australia's response 2024

# Respiratory

## 1. Shortness of Breath (SOB) - New Onset

### Practice Point

**Important!** If the resident has **one or more** of the following, and their ACD/ACP/MOLST states intervention:  
Phone **NSWA@ 000**.

- ▶ Lips are blue.
- ▶ Nail beds are blue.
- ▶ Respiratory rate of less than 12 breaths per min or greater than 30 per min.
- ▶ Using accessory muscles to breathe.
- ▶ Sudden pain on breathing.
- ▶ Unable to speak or only in words.
- ▶ Temperature - less than 34°C or greater than 38°C.
- ▶ A new, debilitating cough.

### Immediate Actions:

- Sit the resident upright or in a comfortable position. Give reassurance and assess the severity of the shortness of breath (SOB).
- 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 and work of breathing
  - ▶ Cough
  - ▶ Sputum.
- Apply oxygen:
  - ▶ If resident has COPD, Obesity Hypoventilation Syndrome (OHS), Bronchiectasis, Neuromuscular Disease or Chest Wall Deformity; give oxygen to maintain SpO<sub>2</sub> 88 to 92%. (Start with 2 L/min via nasal prongs).
  - ▶ If resident has no chronic lung disease; give oxygen to maintain SpO<sub>2</sub> 92 to 96%.
- Provide reassurance:
  - ▶ Provide reassurance and encourage the resident to relax their breathing and use breathing techniques e.g., pursed lip breathing, leaning forward.
  - ▶ If the patient has chronic lung disease assist them to follow their normal breathlessness plan.
  - ▶ Stop, position for breathing, use reliever device with spacer (first aid for those with history of asthma), turn on a fan / open a window, stay with the resident, check oxygen flow (if long term therapy).

### Practice Point: Important: Excessive oxygen may be dangerous.

Oxygen is a life-saving therapy but, when given inappropriately, may also be hazardous.

**“Therefore, ... oxygen should only be given as treatment for hypoxaemia.”**

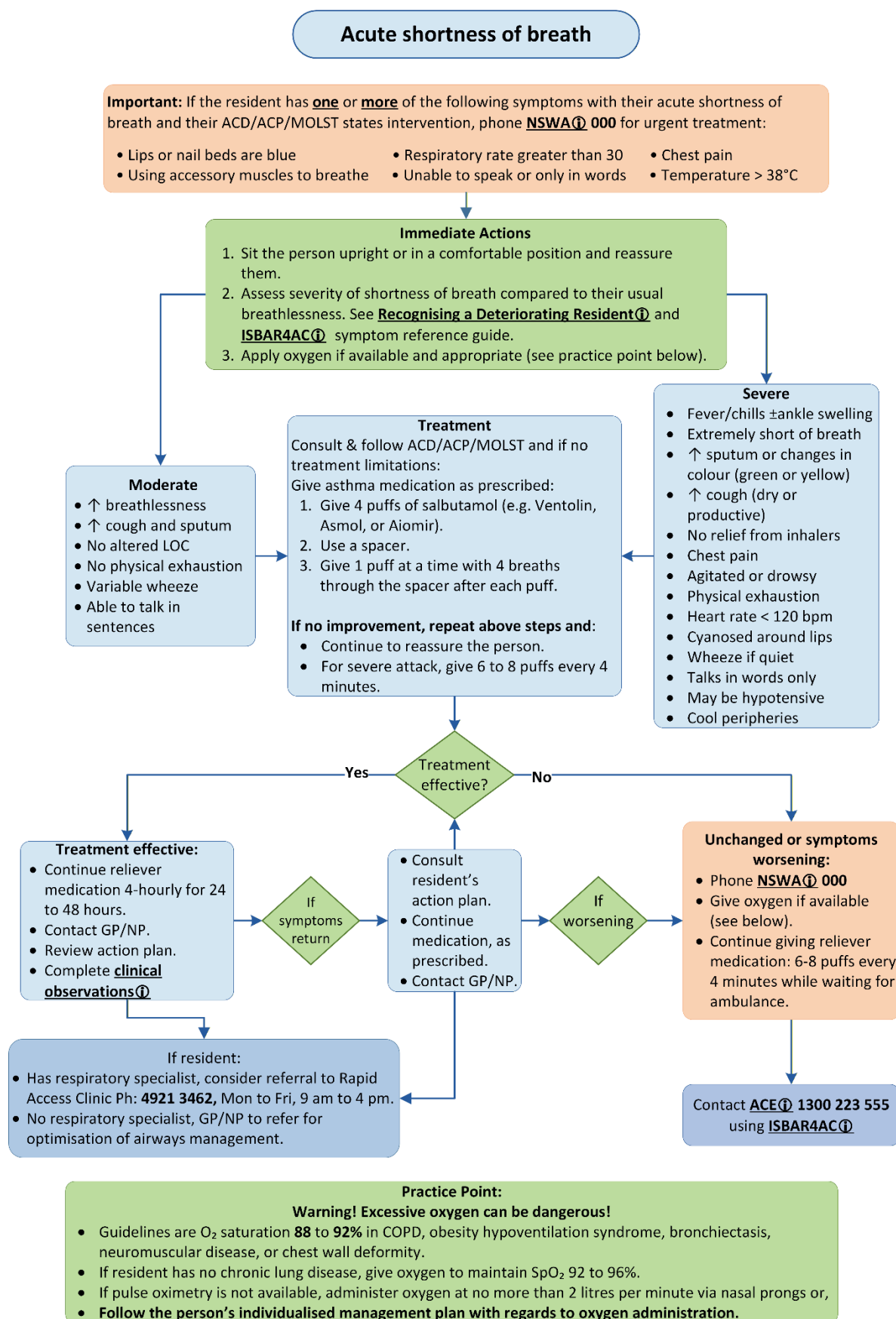
See Thoracic Society of Australia and New Zealand Position Statement on [Acute Oxygen Use in Adults](#):  
“Swimming between the flags”, Feb 2022.

## Assessment and Management Multiple Causes of Shortness of Breath

Consider the below causes of Shortness of Breath (SOB) in conjunction with medical history.

| Cause                                                   | Other symptoms                                                                                                                                                                                                                                                     | Management                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acute coronary syndrome or myocardial infarction</b> | <ul style="list-style-type: none"> <li>Dull, heavy, or tight anterior chest pain</li> <li>Pain in throat, jaw, back, or arms</li> <li>Pallor</li> <li>Sweating</li> <li>Nausea</li> </ul>                                                                          | <ul style="list-style-type: none"> <li>If acute coronary syndrome / myocardial infarction suspected, follow <a href="#">Managing Chest Pain / Symptoms of Cardiac Ischaemia</a> and contact the GP/NP.</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Asthma</b>                                           | <ul style="list-style-type: none"> <li>Acute onset</li> <li>Chest tightness</li> <li>Cough</li> <li>Wheeze</li> <li>Inability to speak in whole sentences indicates a severe attack</li> </ul>                                                                     | <ul style="list-style-type: none"> <li>If asthma suspected, see <a href="#">Shortness of Breath (SOB) – New Onset</a></li> <li>Administer residents own reliever inhaler (e.g., Ventolin).</li> <li>Contact the GP/NP.</li> <li>If GP/NP not available, contact <a href="#">ACE</a> 1300 223 555</li> </ul>                                                                                                                                                       |
| <b>Congestive heart failure</b>                         | <ul style="list-style-type: none"> <li>Waking at night with SOB</li> <li>Difficulty breathing when lying down</li> <li>Cough at night or when lying down</li> <li>Swelling of ankles or lower limbs</li> <li>Weight gain (fluid weight)</li> </ul>                 | <ul style="list-style-type: none"> <li>See <a href="#">Heart Failure Issues</a></li> </ul>                                                                                                                                                                                                                                                                                                                                                                        |
| <b>COPD</b>                                             | <ul style="list-style-type: none"> <li>Chronic symptoms with acute, episodic exacerbations</li> <li>Difficulty talking</li> <li>Breathless</li> <li>Cough</li> <li>Decreased exercise tolerance</li> <li>Increased work of breathing</li> </ul>                    | <ul style="list-style-type: none"> <li>Administer residents own reliever inhaler (e.g. Ventolin/Bricanyl).</li> <li>Breathlessness management techniques e.g., pursed lip breathing, fan, lean forward positioning.</li> <li>Provide reassurance.</li> <li>Access COPD Action plan- and medicate as prescribed.</li> <li>Residents may require escalation of treatment - contact GP/NP.</li> <li>See <a href="#">COPD at Lung Foundation Australia</a></li> </ul> |
| <b>COVID, Influenza and RSV</b>                         | <ul style="list-style-type: none"> <li>Fever</li> <li>Cough</li> <li>Sore throat</li> <li>Headache</li> <li>Muscle aches / fatigue</li> </ul>                                                                                                                      | <ul style="list-style-type: none"> <li>Attend RAT / Respiratory PCR</li> <li>See <a href="#">Respiratory Outbreaks</a> <ul style="list-style-type: none"> <li>COVID-19</li> <li>Influenza or RSV</li> </ul> </li> </ul>                                                                                                                                                                                                                                           |
| <b>Palliative</b>                                       | <ul style="list-style-type: none"> <li>Breathlessness can occur in terminal Phase of illness</li> <li>May be anxiety-related</li> </ul>                                                                                                                            | <ul style="list-style-type: none"> <li>Contact GP/NP or Palliative Care team if the resident is known to Palliative Care.</li> <li>Consider a standing order for anxiolytic/ analgesia.</li> </ul>                                                                                                                                                                                                                                                                |
| <b>Pneumonia</b>                                        | <ul style="list-style-type: none"> <li>Pain localised to one side of the chest</li> <li>Fever</li> <li>Cough</li> <li>Audible crackles in chest</li> </ul>                                                                                                         | <ul style="list-style-type: none"> <li>If pneumonia is suspected, contact the GP/NP.</li> <li>If GP/NP not available, contact <a href="#">ACE</a> 1300 223 555</li> </ul>                                                                                                                                                                                                                                                                                         |
| <b>Pulmonary Embolism</b>                               | <ul style="list-style-type: none"> <li>Rapid heart and respiratory rate</li> <li>new sudden pain on breathing</li> <li>Risk factors include:</li> <li>History of immobility, recent surgery or cancer</li> <li>Current or previous deep vein thrombosis</li> </ul> | <ul style="list-style-type: none"> <li>If pulmonary embolism suspected, contact the GP/NP.</li> <li>If GP/NP not available, contact <a href="#">ACE</a> 1300 223 555</li> </ul>                                                                                                                                                                                                                                                                                   |

# Acute Shortness of Breath Flowchart



## 2. Tracheostomy Issues

### Excessive secretions

#### Possible causes

- Infection.
- Fluid overload.
- Disease Progression.
- Decreased mobility.

#### Interventions

- Encourage resident to cough own secretions.
- If unable to clear own secretions – institute suctioning with non-fenestrated inner cannula.
- Always provide humidification via a Heat and Moisture Exchange (HME) i.e., “Swedish Nose”.
- As tolerated, position in a semi-upright position.
- Keep stoma clean and dry.
- Monitor respirations, pulse, and temperature, and assess changes.
- Regularly check, change and / or clean inner cannula.

### Dry secretions

#### Possible causes

- Inadequate humidification.
- Dehydration.
- Poor mobility.

#### Interventions

- Regular sodium chloride 0.9% via a nebuliser.
- Provide warm air humidifier.
- Ensure inner cannula is clean and free of crusty sputum.
- Oral hydration.

### Blood-stained sputum

#### Possible causes

- Irritation or infection.
- Insufficient humidification.
- Suction issues – too vigorous, deep, frequent, or high pressure.
- Excessive coughing.
- If cuffed tracheostomy with cuff up, consider cuff irritation (over inflated).

#### Interventions

- Monitor.
- Increase humidification, nebuliser + warm air.
- Review suctioning technique, educate staff.
- Monitor cuff pressure.
- Phone **NSWA 000** if bleeding excessive or GP/NP or contact **ACE 1300 223 555** if unsure.



## Excoriation to skin surrounding stoma

### Possible causes

- Excessive moisture.
- Exposure to contaminated secretions or infected sputum.
- Flange too tight.

### Interventions

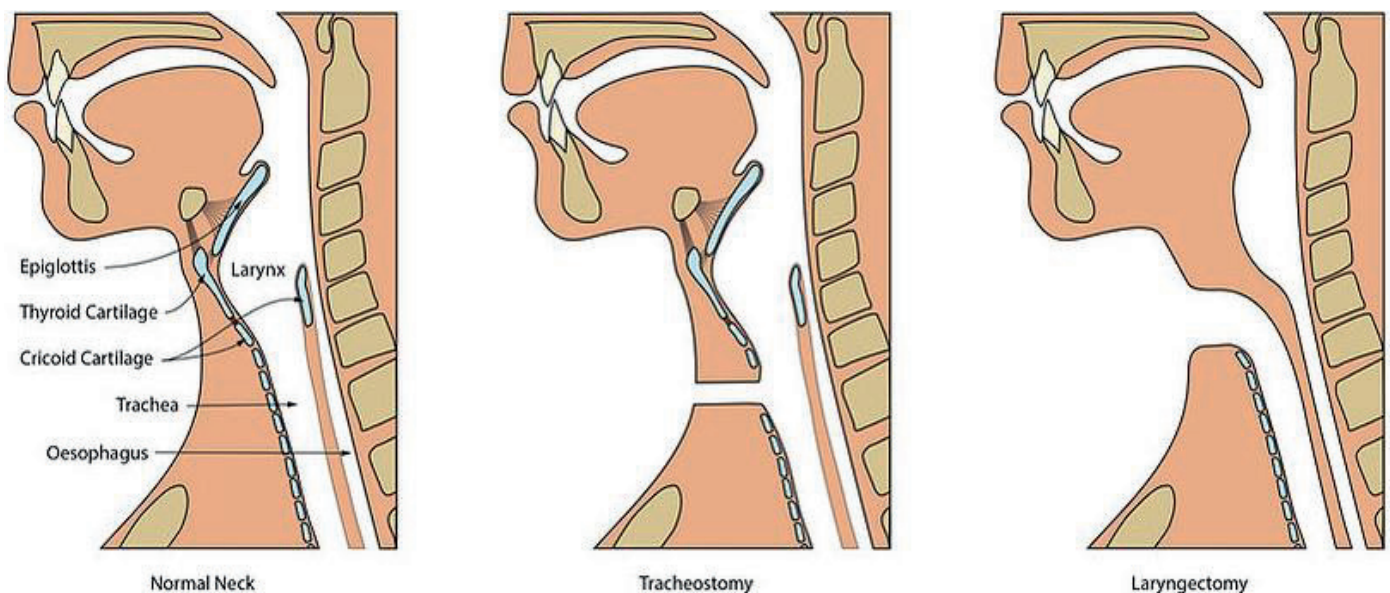
- Do not allow secretions to pool around the stoma. Keep skin under tracheostomy ties clean and dry.
- Check flange and the ties regularly.
- Aggressive wound care.
- Frequent dressing changes and apply absorbent dressing daily and PRN.
- Follow up required by GP/NP and / or tracheostomy care provider.

## 3. Difference between a Tracheostomy and a Laryngectomy

A laryngectomy is the surgical removal of the larynx, and the remaining trachea is sutured to the back of the neck. There is no connection between the lungs and the nose or mouth, so traditional airway management will not work.

### Practice Point:

For emergency airway management of resident with a Laryngectomy, you must use the Laryngectomy Stoma as the airway opening.



- [ENT Education Swansea](#) - The difference between a Laryngectomy and a tracheostomy diagram reproduced from ENT Education Swansea
- [Multidisciplinary guidelines for the management of tracheostomy and laryngectomy airway emergencies](#) - McGrath BA, Bates L, Atkinson D, Moore JA. Anaesthesia. 2012 Jun 26.

## Respiratory Advice, Resources and References

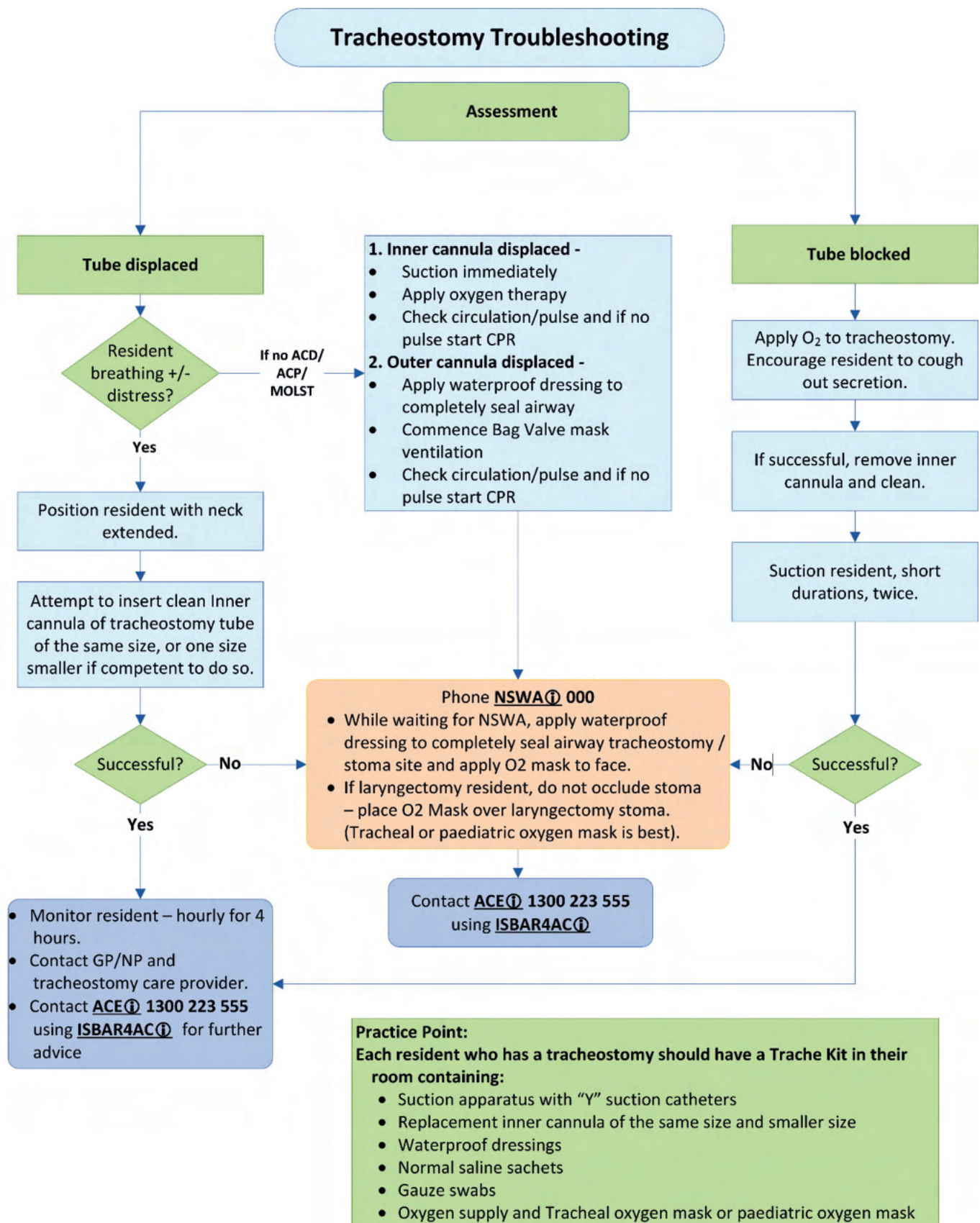
### Advice and Referral:

- [Respiratory](#) HNE Community HealthPathways
- Rapid Access Clinic (RAC) - for urgent patients who do not require admission and are known to the John Hunter Respiratory Department, refer Monday to Friday 9.00 am to 4.00 pm and speak with either:
  - ▶ RAC Nurse **Ph: 4921 3480** or COPD and Asthma CNC HNELHD **Ph: 4922 3240** or Admin **Ph: 4921 3462**

### References and Resources

- [Position Statement on Acute Oxygen Use in Adults](#)  
Barnett A, Beasley R, Buchan C, Chien J, Farah CS, King G, et al. Thoracic Society of Australia and New Zealand: 'Swimming between the flags'. *Respirology*. 2022; 27: 262–276.
- [COPD clinical care standard](#). - Australian Commission on Safety and Quality in Health Care. (2024)
- Lung Foundation Australia:
  - ▶ [Guidelines for the management of Chronic Obstructive Pulmonary Disease](#)- Australian and New Zealand
  - ▶ [COPD Management](#)
  - ▶ [COPD Action Plan](#)
  - ▶ [Inhaler and spacer device techniques](#)
  - ▶ [Video and how to use fans](#) - Hand-held fans
- [Asthma Action Plan](#) Asthma Australia.
- [Australian Asthma Handbook](#). - National Asthma Council Australia. The National guidelines for health professionals.
- [Spacers for pressurised metered-dose inhalers](#). - National Asthma Council Australia.
- [How to use a metered dose inhaler \(puffer\) with a spacer for adults](#). National Asthma Council Australia.

# Tracheostomy Troubleshooting Flowchart



## Respiratory Outbreaks - COVID-19, Influenza or RSV

A COVID-19, Influenza or Respiratory Syncytial Virus (RSV) outbreak is when there are 2 or more cases of influenza-like illness (ILI) in residents within 3 days (72 hours) and the Public Health Unit (PHU) are to be notified.

### Outbreak Advice or to report an outbreak

- To report an outbreak, please go to Infectious disease on the Hunter New England webpage located at <https://www.nsw.gov.au/departments-and-agencies/hnelhd/services/infectious-disease>

### Hunter New England facility outbreaks

Report on respiratory and gastroenteritis outbreaks in aged care and disability care facilities.

[Report an outbreak \(webform\)](#) 

### Outbreak resources

While these resources are designed for residential care and childcare facilities, you can use them to develop your own disease outbreak plan.

Residential care facilities 

Childcare facilities 

- If further advice is needed, please **Ph: 02 4924 6477** or **email** [hnelhd-Phcdiseases@health.nsw.gov.au](mailto:hnelhd-Phcdiseases@health.nsw.gov.au)
- Commonwealth Department of Health and Aged Care
  - ▶ To notify Commonwealth of positive COVID-19 cases, go to My Aged Care provider portal at 'My Aged Care provider portal' - <https://www.health.gov.au/resources/apps-and-tools/my-aged-care-service-provider-portal>.

## Outbreak Resources

### Commonwealth - Department of Health, Disability and Ageing

- [COVID-19 symptoms, spread and prevention](#) – Dept. of Health, Disability and Ageing
- [Influenza](#) – Australian Centre for Disease Control
- [National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection \(including COVID-19 and Influenza\) in Residential Care Facilities](#)

### NSW Health

- [COVID-19 Advice to residential aged care](#) – NSW Health
- [COVID-19 Information for RACs](#) - Community HealthPathways

## Sepsis – Recognising, Responding & Escalating

### What is sepsis?

Sepsis is a life-threatening condition that arises when the body's response to an infection causes damage to its own tissues and organs. **Early recognition** and **prompt treatment** of sepsis can significantly improve outcomes for residents. In Australia, there are over 55,000 cases of sepsis per year. Sepsis contributes up to 50% of all hospital deaths and causes around 8,000 Australian deaths each year ([Sepsis Clinical Care Standard, 2022](#)).

### Who is Affected by Sepsis?

Overwhelmingly a disease of older people, two-thirds of sepsis patients are aged over 65 years. Older adults tend to become more unwell more rapidly and more likely to have serious complications or die from sepsis when compared to younger people. Among survivors, up to 50% suffer physical, psychological or cognitive affects and around one-third of survivors not able to return to their previous level of function (Burkett et al, 2018).

### Recognise, Respond & Escalate – Could it Be Sepsis?

#### Practice Point:

Does the resident have any signs or symptoms of infection, as listed below and in the CEC's Adult Sepsis Pathway?

**Use for patients 16 years or older in any clinical setting to support recognition and management of sepsis**  
 For pregnant women and up to six weeks post-pregnancy use the CEC Maternal Sepsis Pathway  
 Use local febrile neutropenia guideline where relevant

RECOGNISE



### COULD IT BE SEPSIS?

Sepsis is **infection** with **organ dysfunction** and is a **medical emergency**

**Does the patient have any signs or symptoms of INFECTION?**

|                                                                                                         |                                                                          |
|---------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Looks very unwell                                                              | <input type="checkbox"/> Unexplained pain                                |
| <input type="checkbox"/> History of fever, rigors, hypothermia                                          | <input type="checkbox"/> Wound or line redness, pain, swelling, exudate  |
| <input type="checkbox"/> Tachypnoea, short of breath, cough, new O <sub>2</sub> requirement             | <input type="checkbox"/> Non-blanching rash                              |
| <input type="checkbox"/> New confusion, change in behaviour or altered level of consciousness, delirium | <input type="checkbox"/> Abdominal pain, distension, vomiting, diarrhoea |
|                                                                                                         | <input type="checkbox"/> Dysuria, oliguria, frequency, odour             |
|                                                                                                         | <input type="checkbox"/> Raised lactate, WCC or CRP (if known)           |

**AND/OR any of the following risk factors?**

|                                                                       |                                                                                                 |
|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Aged ≥ 65 years                              | <input type="checkbox"/> Patient, carer or family concern                                       |
| <input type="checkbox"/> Frail, chronic condition or recent fall      | <input type="checkbox"/> Recent trauma, surgery, procedure                                      |
| <input type="checkbox"/> Aboriginal and Torres Strait Islander people | <input type="checkbox"/> Known infection not responding to treatment                            |
| <input type="checkbox"/> Immunocompromised                            | <input type="checkbox"/> Re-presentation, deterioration or no improvement with the same illness |
| <input type="checkbox"/> Indwelling medical device or line            |                                                                                                 |

**Commence A-G systematic assessment and document a full set of vital sign observations**

[Adult Sepsis Pathway NSW Health](#)



Older patients with sepsis may exhibit **fewer clinical signs** than younger patients.

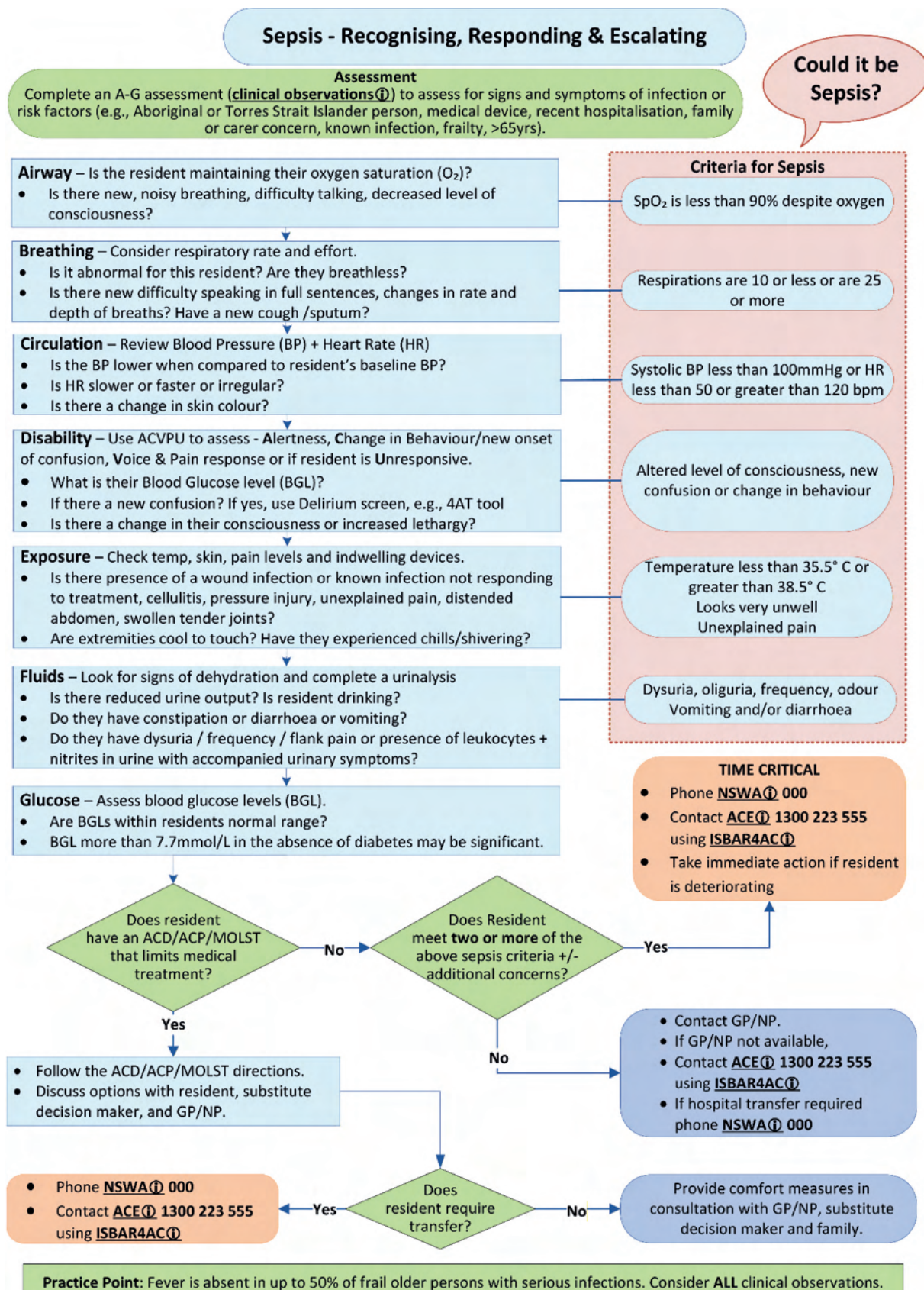
Sepsis **risk factors** may include:

- Adults over 65 years of age.
- Aboriginal and Torres Strait Islander people over 55 years of age.
- Family or carer concern.
- Frailty.
- The presence of an infection that is not responding to treatment.
- Hospital representation within 48 hours.
- Recent hospital admission (e.g., recent serious illness or surgery).
- Invasive procedures.
- Indwelling medical devices (e.g., IDC, SPC, PEG).
- Immunosuppression.

## References and Resources

- [Adult Sepsis Pathway](#) NSW Health
- [National Sepsis Program](#) Australian Commission on Safety and Quality in Health Care -
- [Sepsis Clinical Standard 2022](#) - Australian Commission on Safety and Quality in Health Care -
- [Clinical Standard for Consumers](#) Australian Commission on Safety and Quality in Health care -
- [Coordination of care and post-sepsis support Model of Care Framework](#) ARTD consultants Australian commission on Safety and Quality in Healthcare 2025
- [Sepsis in the older person](#) - Burkett, E., MacDonald, S.P.J., Carpenter, C.R., Arendts, G., Hullick, C., Nagaraj, G., and Osborn, T.M. (2018). The ravages of time and bacteria. *Emergency Medicine Australasia*, 30(2), 249-258.
- [Sepsis website](#) - Clinical Excellence Commission
- [Sepsis](#) - Community HealthPathways
- [Resources](#) - Sepsis Australia
- [About us](#) Sepsis Australia

# Sepsis – Recognising, Responding & Escalating Flowchart



Flowchart adapted from the Sepsis pathway © NSW Clinical Excellence Commission available at  
[https://www.cec.health.nsw.gov.au/\\_data/assets/pdf\\_file/0005/291803/Adult-Sepsis-Pathway.PDF](https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0005/291803/Adult-Sepsis-Pathway.PDF)

# Subcutaneous Fluid Administration

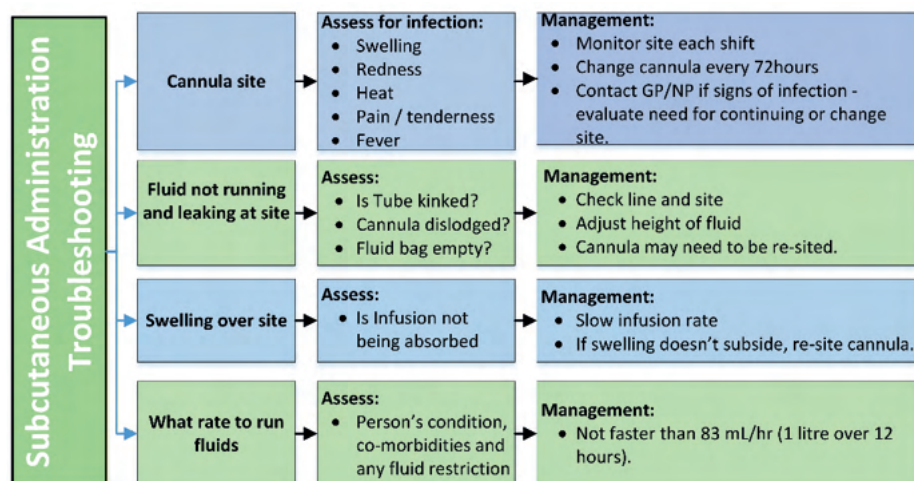
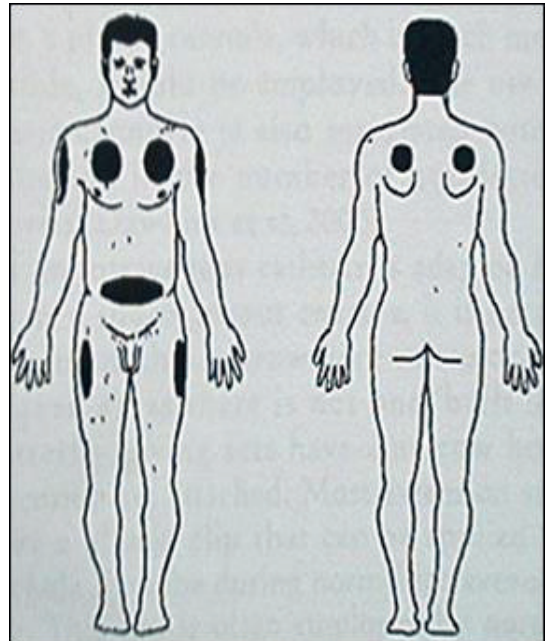
Subcutaneous fluid administration is appropriate for residents with mild to moderate dehydration as a short-term solution. Dehydration may result from poor intake, difficulty swallowing, nausea and vomiting or gastroenteritis.

## Procedure for Subcutaneous Fluid Administration

- GP/NP – order isotonic fluids for administration (e.g., sodium chloride 0.9%).
  - ▶ Insert the subcutaneous device to a non-oedematous position (as shown). Secure with a firm dressing.

**Practice point:** If you have any concerns with the procedure, contact the GP/NP or contact **ACE@ 1300 223 555**

- ▶ Administer the infusion as prescribed; the recommended rate is 20ml/hour to 83ml/hour (maximum); no more than 2 litres per 24 hours.
- ▶ Monitor the site each shift and change the cannula every 1 litre or 72 hours. If you have any concerns, contact the GP/NP.
- Monitor the resident's hydration:
  - ▶ If the resident is stable, discontinue fluid administration. Re-start if needed.
  - ▶ If there is no improvement, or resident is unstable or deteriorates, consult ACD/ACP/MOLST, the GP/NP and the substitute decision maker. If GP/NP unavailable, contact **ACE@ 1300 223 555**



## References and Resources

- [Subcutaneous Infusion of Fluids for Hydration or Nutrition](#) - Caccialanza, R., Constans, T., Cotogni, P., Zaloga, G.P. and Pontes-Arruda, A. (2018): A Review. Journal of Parenteral and Enteral Nutrition, 42: 296-307.
- [Guidelines for Subcutaneous Infusion Device Management in Palliative Care and other settings](#) Queensland Health, Centre for Palliative Care Research and Education – 3rd Edition 2021 Urology



# Urinary Catheter Troubleshooting

## Practice Point:

Urinary catheterisation is a high-risk invasive procedure and should only be performed by qualified clinicians who have completed the relevant education and skills assessment, and who are deemed competent in using sterile equipment and aseptic technique.

## 1. Difficulty Removing the Catheter: Urethral and Suprapubic

### Potential causes

- The balloon still has water in it.
  - ▶ Ensure all water is removed from balloon.
- Hysteresis: (ridging caused by the balloon not returning to its original shape / size).
- Constipation
  - ▶ Check recent bowel movement as constipation can cause urinary retention.
  - ▶ Perform PR check to check for faecal impaction.
  - ▶ Give an enema and/or aperients, as prescribed, refer to **constipation ①** flowchart

### Intervention

- Ensure all water is removed from the balloon.
- Re-inflate the balloon and let it deflate by itself.
- 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 Hysteresis (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:
  - ▶ Contact the Urology CNC JHH **Ph: 4922 3957** for advice.
  - ▶ Attempt to change the catheter the following day if clinically appropriate.
  - ▶ Call Extended Care Paramedic (ECP) – **Ph: NSW ① 000**.
  - ▶ **Note:** If a SP catheter is blocked and cannot be removed insert a urethral catheter.
  - ▶ **Note:** For spinal cord injury (SCI) above T6 could be prone to Autonomic Dysreflexia (hypertensive crisis), you may need to leave SPC in situ, insert a urethral catheter and refer the resident to Extended Care Paramedic (ECP) or ED.

## 2. Difficulty Inserting Urethral Catheter (Males)

### Potential causes

- Enlarged prostate.
- Urethral stricture.
- Insufficient lubricant.
- Catheter size is too large.
- Bladder empty of urine.
- Resident is anxious or tense.

## Interventions

### ▪ Enlarged Prostate

- ▶ 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 toward abdomen, and rotate the catheter gently while inserting the catheter (exception: coude catheters cannot be rotated as inserted).

### ▪ Urethral stricture

- ▶ Decrease the size of the catheter.
- ▶ Use a firm catheter.
- ▶ Ensure adequate lidocaine (lignocaine) lubricant, i.e. usual dose is one syringe (10 mL).

### ▪ Inserting lubricant

- ▶ Insert anaesthetic lubricant (lignocaine 2% gel) slowly into the urethra before catheter insertion. Allow 3 to 10 minutes for the local anaesthetic to take effect. The usual dose required for adequate analgesia is one syringe.
- ▶ Two syringes may be required for difficult insertions if not contraindicated.
- ▶ The GP/NP may consider referral to a urologist for assessment.

### ▪ If the catheter size too large

- ▶ If unable to insert the same size catheter, try inserting a smaller sized catheter.

### ▪ Ensure the bladder retains urine before catheter change

- ▶ Ensure resident is hydrated. If the patient has an empty bladder give them 1-2 glasses of water and wait 10 minutes prior to doing the catheter change.
- ▶ If catheter already in place, clamp the drainage system (not the catheter) at least 30 to 60 minutes prior to removing.

#### Practice Point:

**Spinal cord injury (SCI):** if resident has spinal cord injury above T6 they may be at risk of autonomic dysreflexia, **do not clamp** the drainage system before catheter removal.

### ▪ Resident is anxious or tense

- ▶ 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.

## 3. Difficulty Inserting Urethral Catheter (Females)

### Potential causes:

- The Urethral orifice is difficult to visualise.
- The Urethra is red and inflamed.
- The bladder is empty of urine.
- The catheter size is too large.
- The resident is anxious or tense.

### Interventions:

- Urethral orifice is difficult to visualise
  - ▶ Ensure adequate lighting is available.



- ▶ Undertake risk and manual handling assessment - slings maybe considered to hold resident's legs apart.
- ▶ If unable to open legs adequately (e.g., arthritis), seek assistance from another staff member to position resident appropriately, e.g., on her left side raise with one knee raised or place a pillow under the buttocks.
- ▶ Aim the catheter in an upward direction during insertion to avoid entry into the vagina.
- Urethra is red and inflamed
  - ▶ If the urethra is red and inflamed or bleeding, lignocaine gel may be required.
  - ▶ Atrophic vaginitis (vulva pale-looking and bleeds easily when labia separated). Discuss with GP/NP if topical oestrogen cream applied to external vulval could be a treatment option.
  - ▶ Contact the CNC Urology JHH, **Ph: 4922 3957** for advice if risk assessment indicates resident is not suitable to be catheterised in the aged care facility.
- Ensure the bladder retains urine before catheter change
  - ▶ Ensure resident is hydrated.
  - ▶ If the bladder is empty give them 1-2 glasses of water and wait 10 minutes prior to doing the catheter change.
  - ▶ If catheter already in place, clamp drainage system (not catheter) at least 30 - 60 minutes prior to removing.

**Practice Point:**

**Spinal cord injury (SCI):** if resident has spinal cord injury above T6 they may be at risk of autonomic dysreflexia, **do not clamp** the drainage system before catheter removal.

- Decrease size of catheter
  - ▶ Use a size 12 or 14g gauge catheter.
  - ▶ If unable to insert the same size catheter, try inserting a smaller sized catheter.
- Resident is anxious or tense
  - ▶ If the resident is anxious, ask resident to take slow, deep breaths. Insert the catheter as resident exhales.
  - ▶ If the resident tenses up, stop inserting the catheter until they relax.

#### 4. Difficulty Inserting Suprapubic Catheter

- Ensure the bladder is full before catheter change if possible
- Clamp the drainage system (not the catheter) at least 30 to 60 minutes prior. Note: if resident has spinal cord injury above T6 they may be at risk of autonomic dysreflexia, do not clamp the drainage system before catheter removal. If unable to insert the same size catheter, try inserting a smaller size.

#### Potential causes

- Tract has narrowed or closed
- Bladder empty of urine
- Resident is anxious/ tense

#### Intervention

- Tract has narrowed or closed
  - ▶ Inject lignocaine gel into the suprapubic catheter tract.
  - ▶ If unable to insert the same size catheter, try inserting a smaller size 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 JHH **Ph: 4922 3957** for advice or phone **ACE@ 1300 223 555**.
- Ensure the bladder retains urine before catheter change
  - ▶ Ensure resident is hydrated
  - If catheter already in place, clamp the drainage system (not the catheter) at least 30 to 60 minutes prior to removing.

**Practice Point:**

**Spinal cord injury (SCI):** if resident has spinal cord injury above T6 they may be at risk of autonomic dysreflexia, **do not clamp** the drainage system before catheter removal.

- Resident is anxious or tense
  - ▶ If the resident is anxious, ask resident to take slow, deep breaths. Insert the catheter as resident exhales.
  - ▶ If the resident tenses up, stop inserting the catheter until they relax.

## 5. Catheter is not Draining/ Blocked Catheter

### Potential causes

- Drainage equipment.
- The resident is dehydrated.
- Sediment in the urine.

### Interventions

- Drainage Equipment
  - ▶ Check urine is draining below the level of the bladder, the drainage bag should be lower than the bladder and off the floor.
  - ▶ Check for kinks or loops in the catheter or drainage bag.
  - ▶ Change drainage bag to one which has a larger bore drainage tubing, to increase drainage.
- Resident is dehydrated
  - ▶ Do a Dipstick urinalysis and check the Specific Gravity (SG) and Ph levels: rehydrate resident if required.
  - ▶ Monitor fluid intake.
  - ▶ Maintain at least 2 litres of fluid intake per day (unless contraindicated, e.g., fluid restricted).
  - ▶ Consider subcutaneous fluids where appropriate.
- Sediment in the urine
  - ▶ Check the urine for sediment blocking the catheter.
  - ▶ Change to a 100% silicone open-ended catheter.
  - ▶ Check for sign and symptoms of a UTI.
  - ▶ Change to a catheter valve: drain the bladder every 4 hours or at volumes no greater than 450 mL.

**Practice Point:**

If the catheter is blocked – change catheter

## 6. Leaking around the Catheter (Bypassing)

### Potential causes

- Bladder spasms.
- Drainage equipment.

- Catheter Associated Urinary Tract Infection (CAUTI).
- Constipation.
- Blocked catheter.
- Medications.

### Interventions

- Bladder spasms
  - ▶ Check urethral catheter and decrease size of catheter if appropriate.
  - ▶ Check balloon size, ensure minimum volume of water in balloon per manufacturer's instruction.
  - ▶ Ensure catheter is secured without tension.
- Drainage Equipment
  - ▶ Check urine is draining below the level of the bladder, the drainage bag should be lower than the bladder and off the floor.
  - ▶ Check for kinks or loops in the catheter or drainage bag.
  - ▶ Change drainage bag to one which has larger bore drainage tubing, to increase drainage.
- Catheter Associated Urinary Tract Infection (CAUTI)
  - ▶ Treat symptomatic infections, see **UTI** flowchart
- Constipation
  - ▶ Treat Constipation, see **constipation** flowchart
- Blocked catheter
  - ▶ Check if catheter is blocked, is urine draining?
  - ▶ Change catheter if blocked, flushing catheters contraindicated due to increased risk of CAUTI.
  - ▶ Consider Trial of Void (TOV) to establish if an IDC is still required.
- Medications
  - ▶ Refer to GP/NP to consider anticholinergic medication to treat bladder spasm.

#### Practice Point:

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

## 7. Pain

### Potential causes

- Mucosal pressure injury.
- CAUTI.
- Catheter cystitis.
- Balloon in bladder neck or urethra due to tension or accidental pulling on tubing.

### Interventions

- ▶ Assess the severity, duration and location of the pain.
- ▶ Inspect the insertion site for discharge, erythema or appliance / mucosal pressure injuries.
- ▶ Assess for distended bladder.
- ▶ Consider if a Catheter Specimen of Urine (CSU) is required.
- ▶ Consider deflating balloon to see if pain resolves.
- ▶ Contact GP/NP.

## 8. Haematuria

### Potential causes

- Catheter irritation.
- CAUTI.
- Anticoagulants.

### Intervention

- Check the colour of the haematuria (pale pink to dark brown). If the urine is pale pink to red encourage fluid intake.
  - ▶ If the urine is dark brown increase fluids and if it does not improve in a few hours contact the GP/NP.
  - ▶ Check if they are on anticoagulants as these can contribute to haematuria.
  - ▶ How long have they had haematuria (hours verses days)?
- Do they have symptoms of CAUTI? See **UTI** flowchart
- Are they on free drainage?
- Would they benefit from being on a valve?
- Contact GP/NP if haematuria is severe or if a CAUTI is suspected.

## 9. Catheter has Fallen Out

- **Balloon still inflated:**
  - ▶ Check for trauma and / or bleeding from the urethra.
  - ▶ Monitor and check for residual urine volumes, trial of void (TOV), to establish if catheter is still required.
  - ▶ Re-catheterise if required.
  - ▶ Consider doing a TOV, the resident may be able to be managed with incontinence aids if residual urine is not significant, refer to **TOV** flowchart
  - ▶ Suprapubic catheter; replace ASAP to ensure stoma remains patent.
  - ▶ Inform GP/NP.
- **Balloon deflated:**
  - ▶ Check that the balloon is intact by re-inflating the balloon.
  - ▶ 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/NP to discuss the need for a kidney, ureter and bladder (KUB) ultrasound to check for bladder stones.

### Intervention

- Inform GP/NP if balloon not intact, as a stone may have pierced the balloon.

#### Practice Point:

Always secure the catheter with an appropriate securing device or if using a valve, support the valve with the resident's underwear.

## 10. Resident Confused

If confusion is new, consider **UTI** flowchart and / or refer to **Managing New Confusion or worsening Confusion** flowchart

### Intervention

- ▶ Complete **clinical observations** and follow **UTI** flowchart

- ▶ Do a dipstick urinalysis for Specific Gravity, Ph, Leucocytes, Blood, and Nitrates.
- ▶ Manage symptoms of dehydration. Rehydrate the resident if required.
- ▶ Observe for localised trauma, bleeding and infection.
- ▶ Manage signs of constipation. Refer to **constipation** flowchart
- ▶ Check the need and suitability of a urinary/suprapubic catheter and assess for alternate option.
- ▶ Ensure the catheter is well secured.
- ▶ Inform GP/NP.

## 11. Medical Device Associated Pressure Injury

### Practice Point:

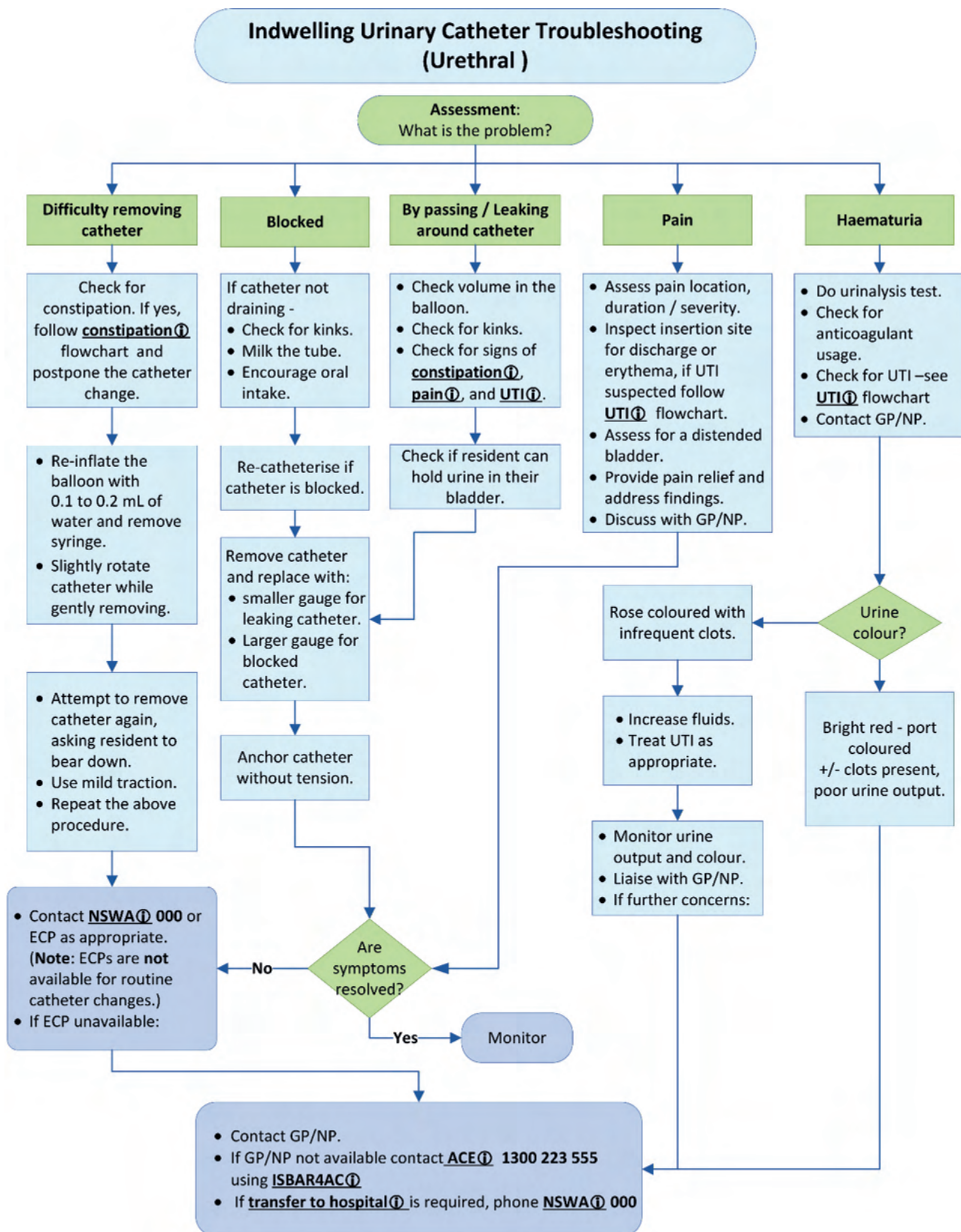
Urethral erosion cannot be treated.

### Intervention

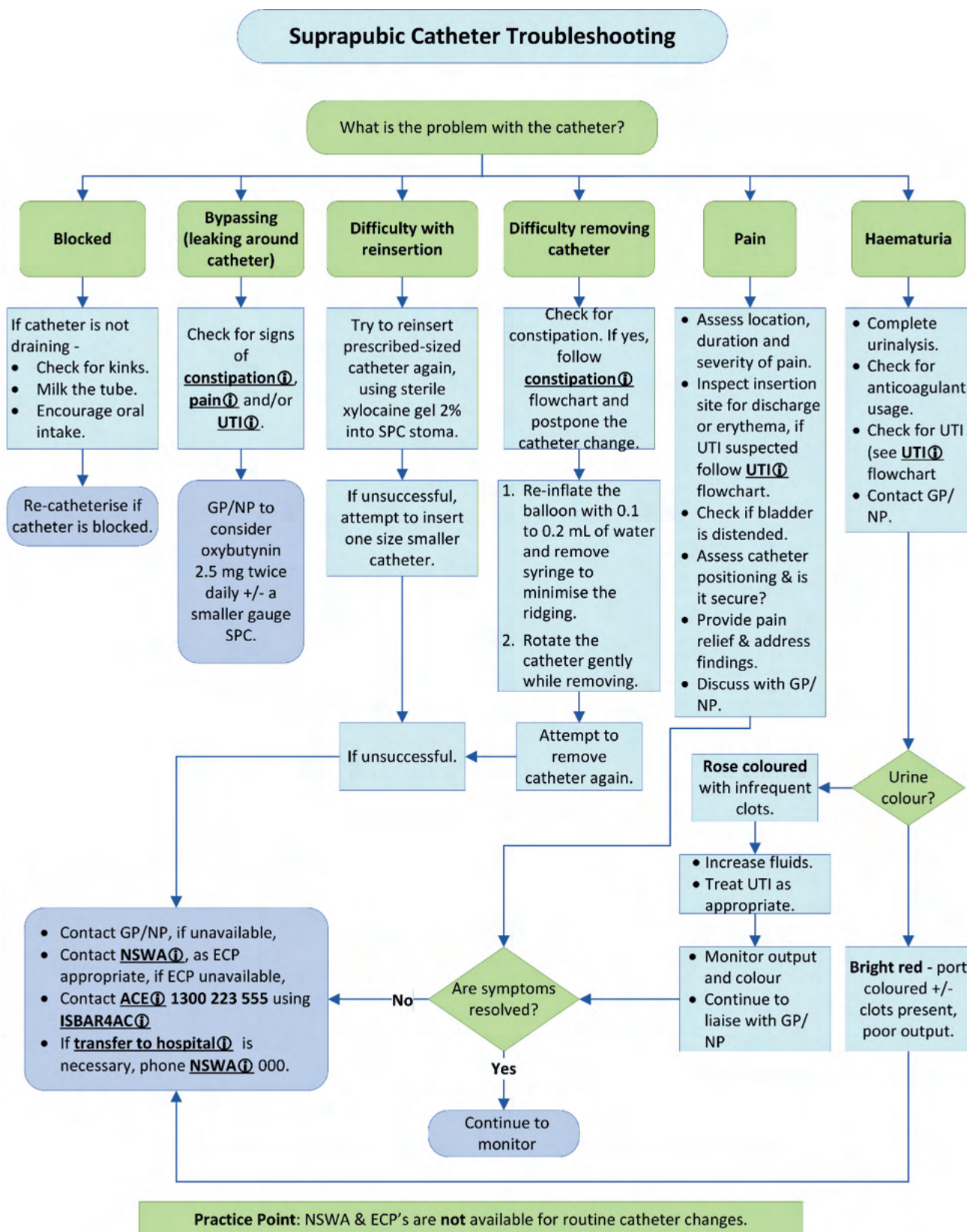
- To avoid urethral erosion, check the meatus / urethra / eye of the penis / glans penis daily for signs of; Pressure injury, inflammation, ulceration, and / or tears.
- Relieve pressure by repositioning the catheter drainage bag daily to the alternate leg and ensuring the catheter is well secured.
- Regularly empty the drainage bag at 400 mL to minimise potential tension from the weight of the drainage bag.



# Urethral Catheter Troubleshooting Flowchart



# Suprapubic Catheter Troubleshooting Flowchart

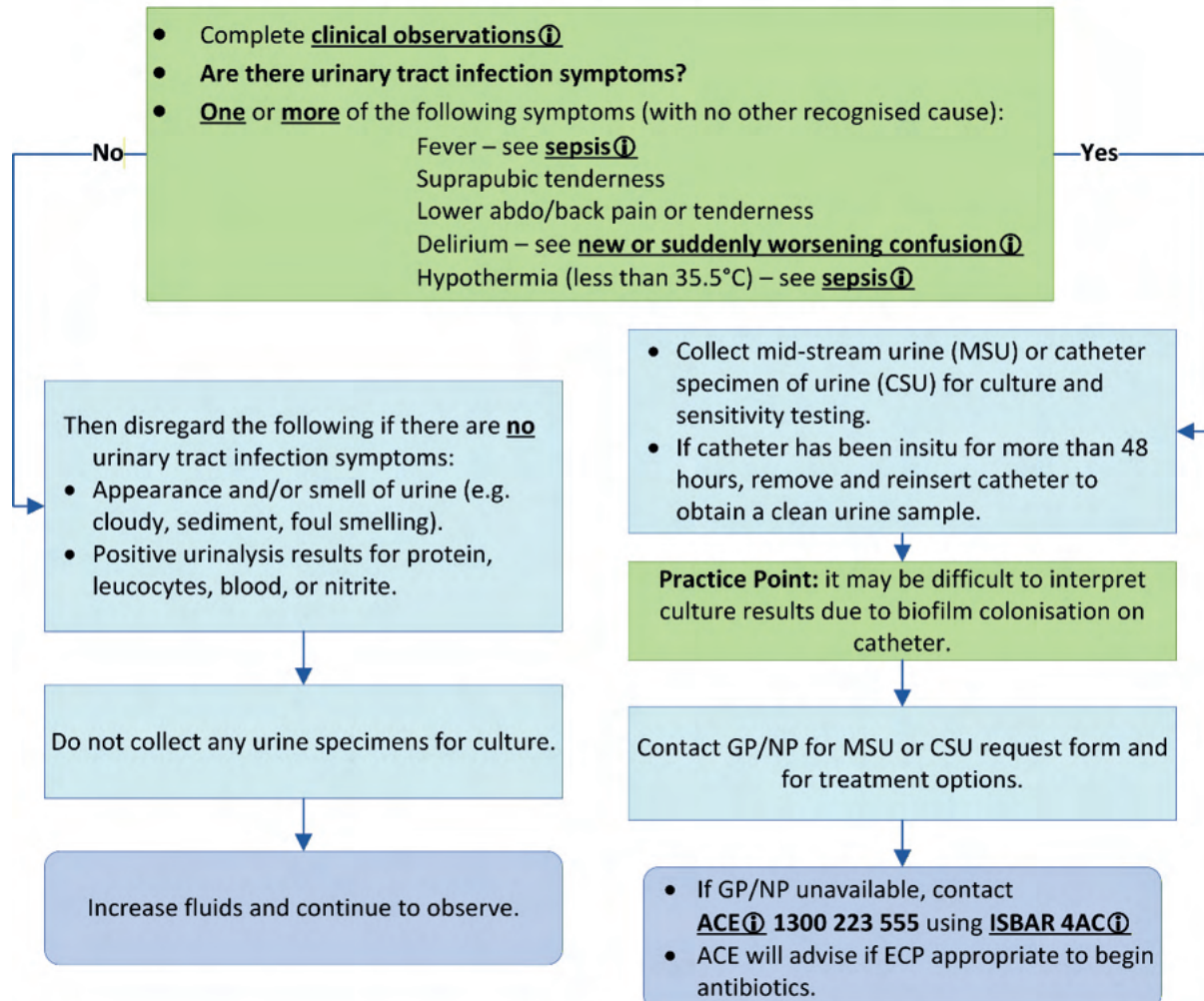




# Urinary Tract Infection Flowchart

## Urinary Tract Infection

Follow steps below to determine if it is necessary to collect a urine specimen for culture.

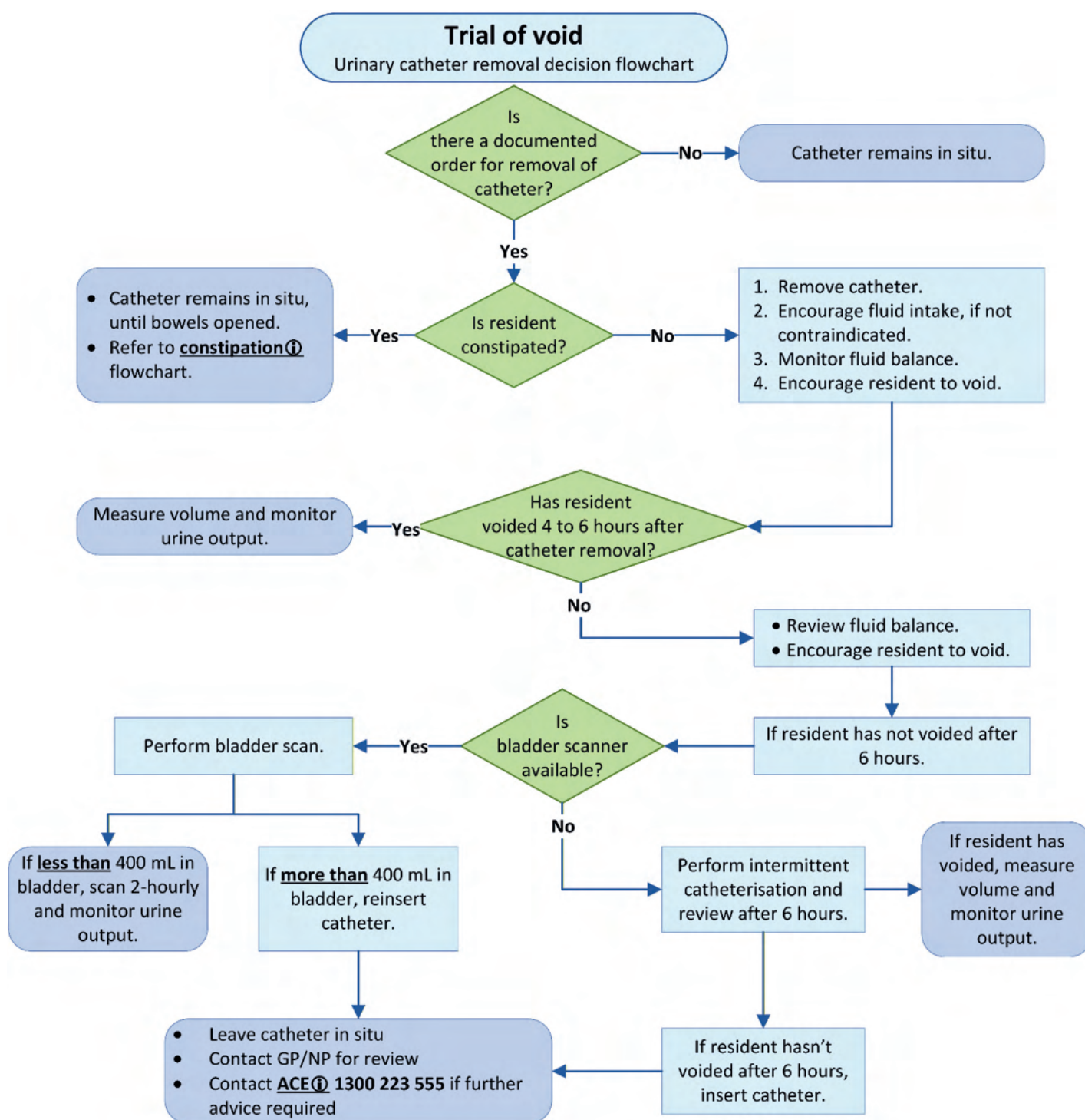


### Practice Point:

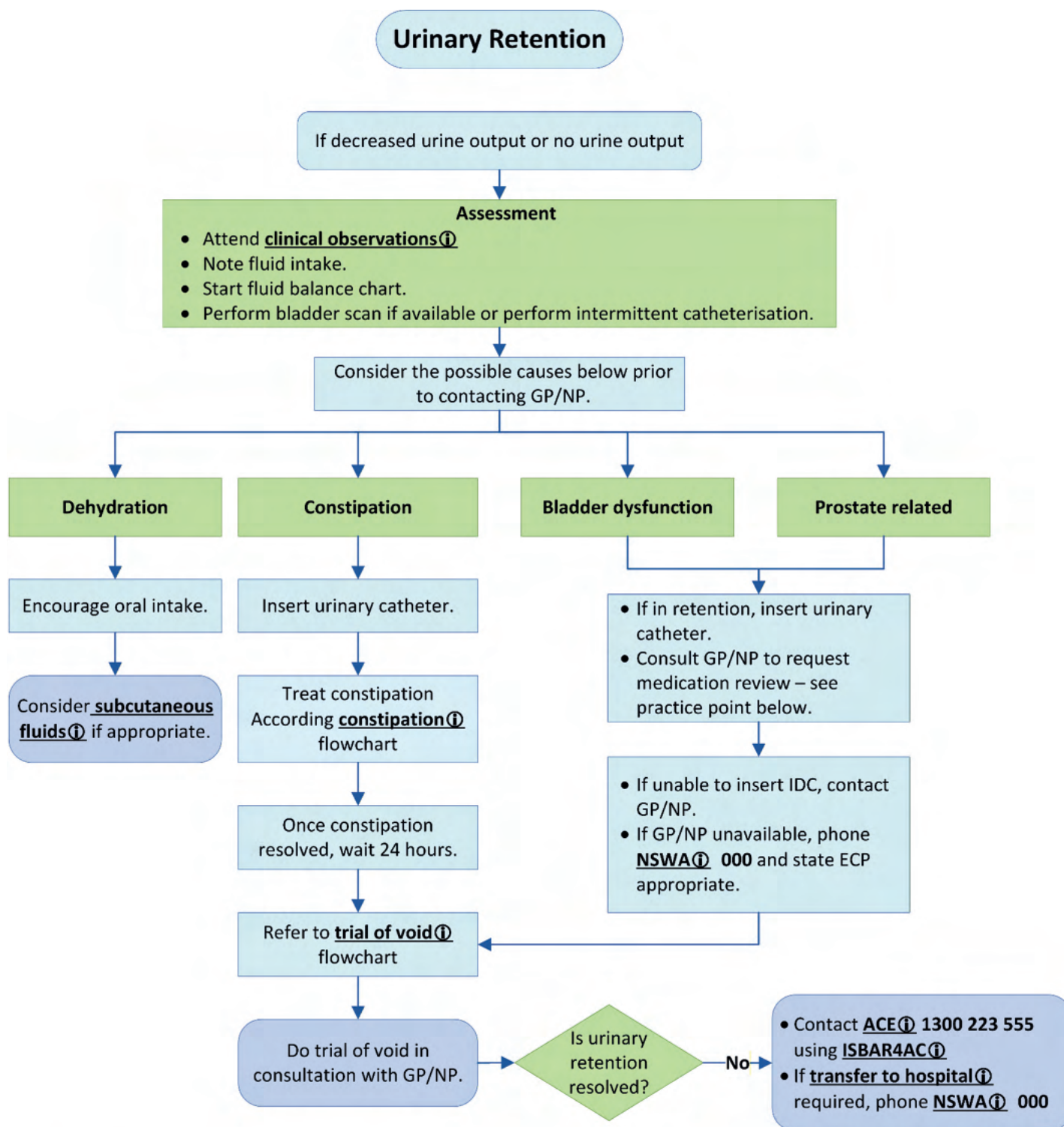
- Avoid dipstick urinalysis for asymptomatic residents – positive reactions for nitrite, pyuria, leukocyte and protein are likely but do not warrant laboratory investigation.
- Adults with spinal cord injury may have a different symptom presentation or may not present with pain. Seek further advice from [ACE ① 1300 223 555](#) if UTI is suspected.
- Maintain aseptic technique when collecting specimens and changing catheters.
- Document the indication for urine specimen collection.
- Interpret urine culture results with caution if resident was on an antimicrobial regime at the time of or before specimen collection.
- Signs and symptoms of UTI among older residents, particularly those with dementia, are often vague or atypical.

Adapted from [Urine Specimen Collection and Culture During Catheterisation ①](#) SHPN: (CEC) 150004. Clinical Excellence Commission 2015

## Trial of Void Flowchart



## Urinary Retention Flowchart



**Practice point: when requesting medication review by GP/NP please consider:**

- Introducing tamsulosin for males with enlarged prostate.
- Reducing anticholinergic loading, if applicable - **Polypharmacy**① section of manual.



## Advice, resources and references

### Advice

- HNEH LHD Urology CNC – **Ph: 4922 3957**, located at John Hunter Hospital
- [Community HealthPathways Urology](#)

### Resources and references

- [User Guide to the Clinical Pathway for older people in aged care homes: Suspected Urinary Tract Infections](#) - Aged Care Quality and Safety Commission – To Dip or Not to Dip
- [Catheter Associated Urinary Tract Infection \(CAUTI\)](#) Clinical Excellence Commission -
- [Treatment Algorithm for Autonomic Dysreflexia \(Hypertensive Crisis\) In Spinal Cord Injury](#)

### Catheterisation Training

- HNELHD offers some catheterisation training for RAC, for details of upcoming training, go to the ACE website and look in the “Education Resources” under catheterisation or email [HNELHD-AdminRACI@health.nsw.gov.au](mailto:HNELHD-AdminRACI@health.nsw.gov.au).
- Urinary Catheterisation and Closed System Drainage training course.
  - ▶ Urinary Catheterisation and Closed System Drainage Train the Trainer Program.
- The resources for RAC staff who have completed the HNELHD Train the Trainer Program are available on the ACE website under Education Resources.
- The resources provide guidance on the delivery of Catheterisation training and competency assessments within aged care environments.
- Catheterisation mannequins are available for RAC to borrow for their staff to practice their Catheterisation skills. **Email:** [HNELHD-AdminRACI@health.nsw.gov.au](mailto:HNELHD-AdminRACI@health.nsw.gov.au) to arrange.

# Wound Care

## Management principles for various types of wounds

### Principles:

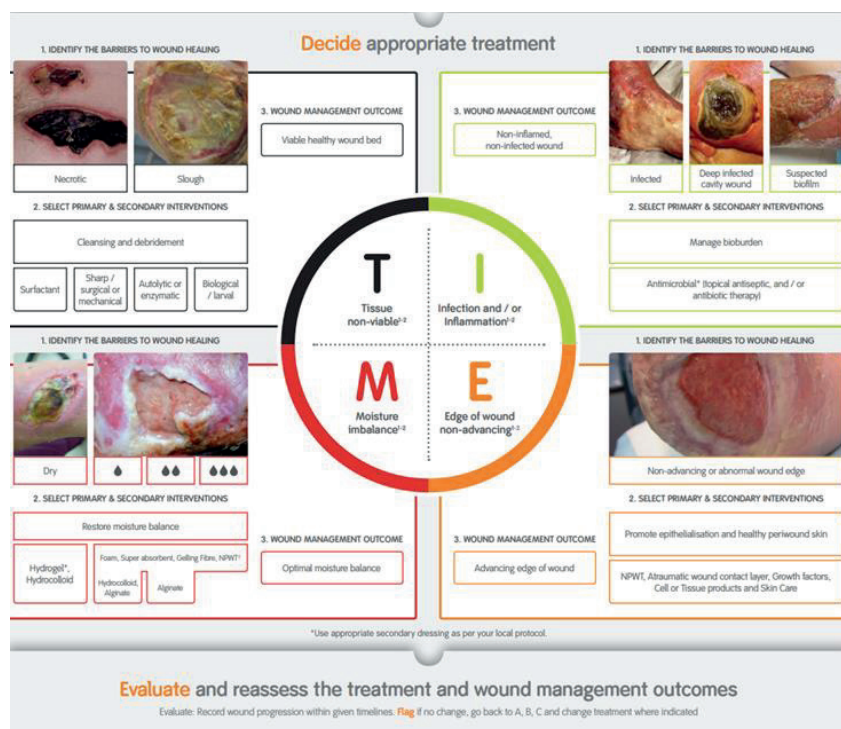
There are five principles of wound management that promote clinical reasoning, team communication and continuity of care. These include:

- ▶ Assessment – gather comprehensive data, around the person and the wound (type, tissue, exudate, odour, peri-wound and pain).
- ▶ Diagnosis – identifying causes and contributing factors.
- ▶ Planning – setting realistic, evidence-based goals.
- ▶ Implementation – apply targeted interventions.
- ▶ Evaluation – review progress and adjust the plan.

These principles focus on a comprehensive, systematic approach to help ensure that wounds heal properly and promptly by addressing both the wound itself and its underlying causes.

### Assessments:

- Cleanse the wound prior to assessment; using suitable solution e.g., normal saline without leaving the wound too long causing risk of wound dehydration.
- Measure and photograph all wounds as a reference - at initial assessment, at regular reviews and if concerned.
- Use **T.I.M.E.S** for all general wound assessments:
  - ▶ **Tissue management**: healthy or non-viable; may require debridement (episodic or continuous).
  - ▶ **Infection or inflammation control**: removed infected foci, topical/systemic antimicrobials.
  - ▶ **Moisture balance**: avoid desiccation and maceration; apply moisture balancing dressing, compression or negative-pressure wound therapy (NPWT).
  - ▶ **Epithelial edge advancement**: non-advancing or undermining, reassess cause or consider corrective therapies.
  - ▶ **Surrounds**: heat, oedema, eczema or hyperkeratosis.



[TIME Clinical Decision Support Tool](#)

# Acute Wounds

## 1. Skin Tears

Skin tears are acute wounds that should typically proceed to closure in a timely fashion and follow an acute wound closure trajectory of 14 – 21 days. Products which are **not** recommended for use in skin tears are iodine-based dressings, film/hydrocolloid dressings, skin closure strips and gauze.



The above [Skin Tear Management Flow Chart](#) was 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.

## 2. Burn Injuries

### Immediate first aid

- ▶ Cool running water for 20 minutes (no ice or cold packs).
- ▶ Chemical burn - if the chemical is a powder, first brush off excess, then irrigate with copious amounts of water for at least 60 minutes. A shower is the best way to wash away any remaining chemical from the body but avoid hypothermia.
- ▶ Remove any jewelry or constrictive clothing.
- ▶ **Phone NSWA 000** to arrange urgent transfer to hospital for any burn covering over 10% of body.
- ▶ Plastic cling wrap is an appropriate dressing for transferring resident to hospital.
- ▶ Give adequate pain relief.

### Assessment

#### Determine the type of burn injury:

- Scald:
  - ▶ Splash – cup with hot contents, soup, and shower.
  - ▶ Immersion – bath, foot bath.
- Chemical burn:
  - ▶ Body fluids – nasogastric or PEG tube leaking.
  - ▶ Spills – betadine, methylated spirits, or acetic acid.

#### Assess mechanism of injury:

- ▶ Temperature of source – hot tea, tea cooled with milk, clear or thick soup.
- ▶ Chemical burns - identify the chemical involved.

#### Assess wound:

- ▶ Anatomical location
- ▶ Surface area % (Rule of Nines - an arm is 9%, front or back of torso is 18% each, a leg is 18% and head is 9%)
- ▶ Depth of burn – epidermal, dermal or full thickness

#### Assess time of exposure:

- ▶ What was the time of the injury?
- ▶ How long was the skin exposed to the heat source?

#### What was the duration of the first aid provided:

- ▶ E.g., the cool running water?

#### Assess for other injuries:

- ▶ If the resident has sustained the burn during a fall or other incident

### Management

- Seek advice from a Burns Unit by contacting GP/NP for referral to Burns Unit
  - ▶ If burn is larger than 2 cm wide.
  - ▶ For burns to face, head, neck, ears, hands, perineum, genitals, or any circumferential burn.
- Provide adequate pain management, including pre-dressing pain relief, and allow time for pain relief to take effect.
- Regularly review for signs of infection, depth of burn, and wound healing.
- Investigate and address circumstances leading to the burn injury.

### Advice and Referral

Royal North Shore Hospital - Burns Unit **Ph: (02) 9463 2111; Email [BurnsRNS@health.nsw.gov.au](mailto:BurnsRNS@health.nsw.gov.au)**

### Resources and References

- [Burn Injuries](#) - Community HealthPathways
- [Agency for Clinical Innovation Statewide Burn Injury Service](#)
- [Burn Patient Management: Clinical Guidelines](#) - Agency for Clinical Innovation:
- [Minor Burn Blister Management](#) - Agency for Clinical Innovation



## Recognising burn depths chart



### Epidermal burn (erythema)

- damage to epidermis only; skin intact, no blisters present
- erythema; red
- brisk capillary refill
- heals spontaneously within 3–7 days with moisturiser or protective dressing.



### Superficial dermal burn

- damage to upper layer of dermis
- pink; blisters present or absent
- brisk capillary refill (under blister)
- should heal within 7–10 days with minimal dressing requirements.



### Mid dermal burn

- damage into mid dermis
- dark pink
- sluggish capillary refill
- should heal within 14 days
- deeper areas may need surgical intervention and referral.



### Deep dermal burn

- burn extends into deeper layers of dermis, but not through entire dermis
- blotchy red/white
- sluggish to absent capillary refill
- generally needs surgical intervention
- refer to specialist unit.



### Full thickness burn

- destruction of entire dermis; sometimes underlying tissue involved
- white, waxy, cherry red, brown, black
- no capillary refill
- surgical intervention and long-term scar management required
- refer to specialist unit.



Statewide Burn Injury Service – NSW Burns transfer guidelines 4th edition

The Recognising Burn Depths Chart below was retrieved from <https://aci.health.nsw.gov.au/networks/burn-injury>, available at [https://aci.health.nsw.gov.au/data/assets/pdf\\_file/0005/959027/ACI-CCBC-Recognising-burn-depths-poster.pdf](https://aci.health.nsw.gov.au/data/assets/pdf_file/0005/959027/ACI-CCBC-Recognising-burn-depths-poster.pdf).



# Chronic Wound Management

## 1. Wound Exudate

### Consider

- Amount.
- Consistency, colour, odour.
- Source – non wound e.g., urine, fistula.
- Status of Peri-wound skin and surrounds.

### Assessment

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

### Intervention

- Cleanse the wound and surrounds
- Dry: hydrogels, semi-permeable films, hydrocolloids.
- Type of exudate:
  - ▶ Minimal: use silicone, island dressings.
  - ▶ Moderate: use calcium alginates, hydrofibres, foams.
  - ▶ Heavy: use hydrofibres, foam sheet/cavity, extra absorbent dry dressings, superabsorbent dressings, wound/ostomy bags.
- Increase frequency of wound, skin hygiene and protection.

## 2. Odour

### Consider

- With or without infection.
- Is it from the product itself e.g., hydrocolloids?
- Location (groin, skin folds).

### Assessment

- Cause of odour.
- Consider infective process and possible contamination.

### Intervention

- Optimal wound cleansing.
- Charcoal and others like Vliwaktiv dressing.
- Consider use of antimicrobial or antifungal product.

## 3. Topical Antimicrobials

### Consider

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

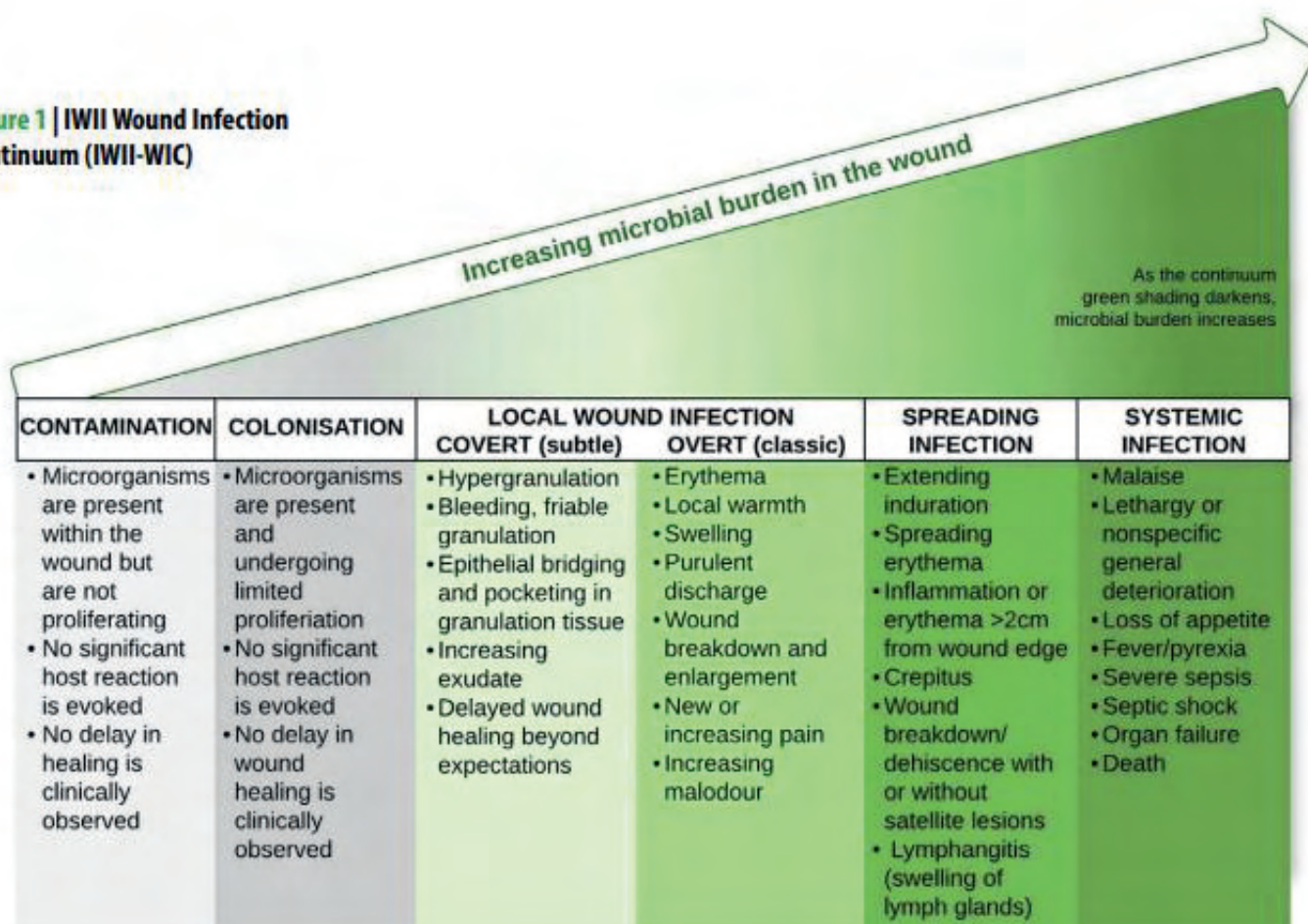
## Assessment

- Clinical infection.
- Inflammation or erythema.
- Increase pain, exudate, odour, and oedema.
- [Wound Infection in Clinical Practice 2022](#) Additional information on pages 7-9 of International Wound Infection Institute (IWII)

## Intervention

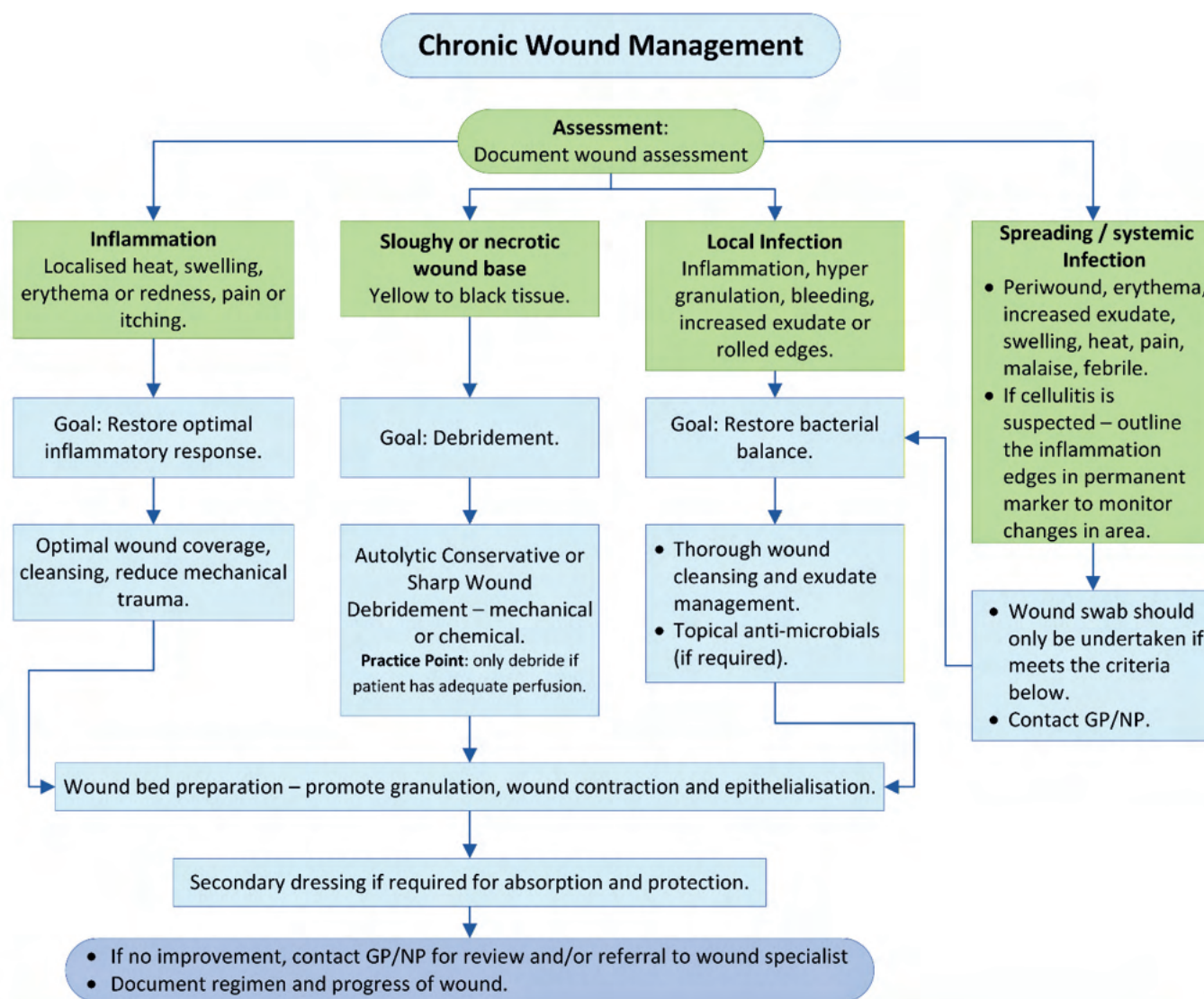
- Bacterial and fungi binding dressings
- Hypertonic saline dressings.
- Cadexomer iodine powder/paste/sheet.
- Antimicrobial gels.
- Medical honey.
- Antiseptic, and tulle gras with soft paraffin and 0.5% chlorhexidine acetate.
- Silver impregnated dressings.
- Referral to wound specialist – see referral options in Wound Infection in Clinical Practice - page 141.

**Figure 1 | IWII Wound Infection Continuum (IWII-WIC)**



International Wound Infection Institute (IWII) [Wound Infection in Clinical Practice 2022](#), page 9

# Chronic Wound Management Flowchart



## Practice Point: indications for a wound specimen collection

- Acute or chronic wounds with signs of spreading or systemic infection.
- Infected wounds that have failed to respond to antimicrobial intervention, or are deteriorating despite.
- Appropriate antimicrobial treatment.
- In compliance with local protocols for the surveillance of drug-resistant microbial species.

## Technique: Use the “Levine technique” to collect swab:

1. Use an antiseptic technique
2. Firmly press the swab down into the wound and rotate the swab over a 1cm<sup>2</sup> area to express fluid from the tissue
3. Repeat the process using a second swab stick to obtain a second sample.

Reference: International Wound Infection Institute (2022). <https://woundinfection-institute.com/wp-content/uploads/IWII-CD-2022-web-1.pdf>

## 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, and
  - ▶ 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
- Dietitian referral.

## Leg Ulcers

### 1. 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 commencing compression. Assess ankle brachial index (ABI). Compression for ABI 0.8 to 1.2 and 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.
- Psychosocial support.
- Correct elevation of the lower limb to reduce oedema.
- Avoid long period seated with legs down or long periods standing stationary.
- 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. Aim for a low-profile secondary dressings, do not use bulky absorbent secondary dressings under 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. This requires regular review by the GP/NP at least annually to confirm exclusion of arterial disease.

Options for compression include:

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

### Practice Point: Compression Hosiery

Not for use during active wound phase as exudate, products damage the hosiery and fit.



## 2. Arterial leg ulcer (ALU)

### Practice Point:

**Red flag!** Seek medical advice if the below are present.

- The 6 'Ps':
  - ▶ **P**ain, **P**allor, **P**ulselessness, **P**erishingly cold, **P**araesthesia and **P**aralysis.
  - ▶ Paraesthesia and paralysis from ischaemia indicate a threatened limb that requires emergency surgical review, regardless of the cause.
  - ▶ Reference: [ACI acute limb ischemia](#)
- Critical limb ischaemia e.g., gangrene, rapidly enlarging wound.
- Suspected osteomyelitis.
- Cellulitis.
- Lymphoedema.

### 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 dependent position.
- Weak or absent foot and leg pulses.
- Ulcers are usually punched out in appearance.
- Ulcers 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

- Consider specialist wound care consult or Vascular consult if required.
- Smoking cessation support.
- Antimicrobial, if infection present.
- Simple dry dressing, gently secure secondary dressing.
- Protect from pressure.
- Avoid extreme temperature, use passive warmth e.g., warm clothing and blankets etc.
- Skin care.

### 3. 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 and other co-morbidities.
- 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.

### 4. 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.
- Punched 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.
- Neuropathy.

#### Goal of treatment

- Off-load plantar pressure.
- Prevent infection.
- Avoid amputation.
- Optimise diabetes management.

### Intervention

- Foam dressings to offload pressure.
- Education on foot or nail care.
- [Community HealthPathways](#) - **Referral** to Podiatry or High-Risk Foot Clinic
- Correct footwear.

## 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.
- Pain management.
- To address infection and odour:
  - ▶ Metronidazole gel.
  - ▶ Microdacyn 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, flesh-coloured dressings and tapes on exposed body sites.
- 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.
- [Ten top tips palliative wound care - Wounds International 2018 | Vol 9 Issue 3](#) - Black J and Hotaling P.

# 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 offloading boots.
- Repositioning resident.
- With or without debridement.
- Moist wound dressings.
- With or without antimicrobial if indicated.
- Nutritional support.

### 1. Pressure Injury Staging

The Pan-Pacific Pressure Injury Alliance (PPPIA) classification tools is displayed on the next page demonstrating the 6 stages of pressure injuries.

Pressure injuries can appear differently for people with different tones and below are links to the PPPIA site for pressure injury classification for all skin tones.

- ▶ [PPPIA Pressure Injury Classification System for Adults with Light Skin Tones](#)
- ▶ [PPPIA Pressure Injury Classification System for Dark Skin Tones - PPIA Pressure Injury Classification System for Asian Skin Tones - Pressure Injury Stages](#)
- ▶ See [Pan Pacific Pressure Injury Alliance \(PPPIA\)](#) for all resources mentioned above.





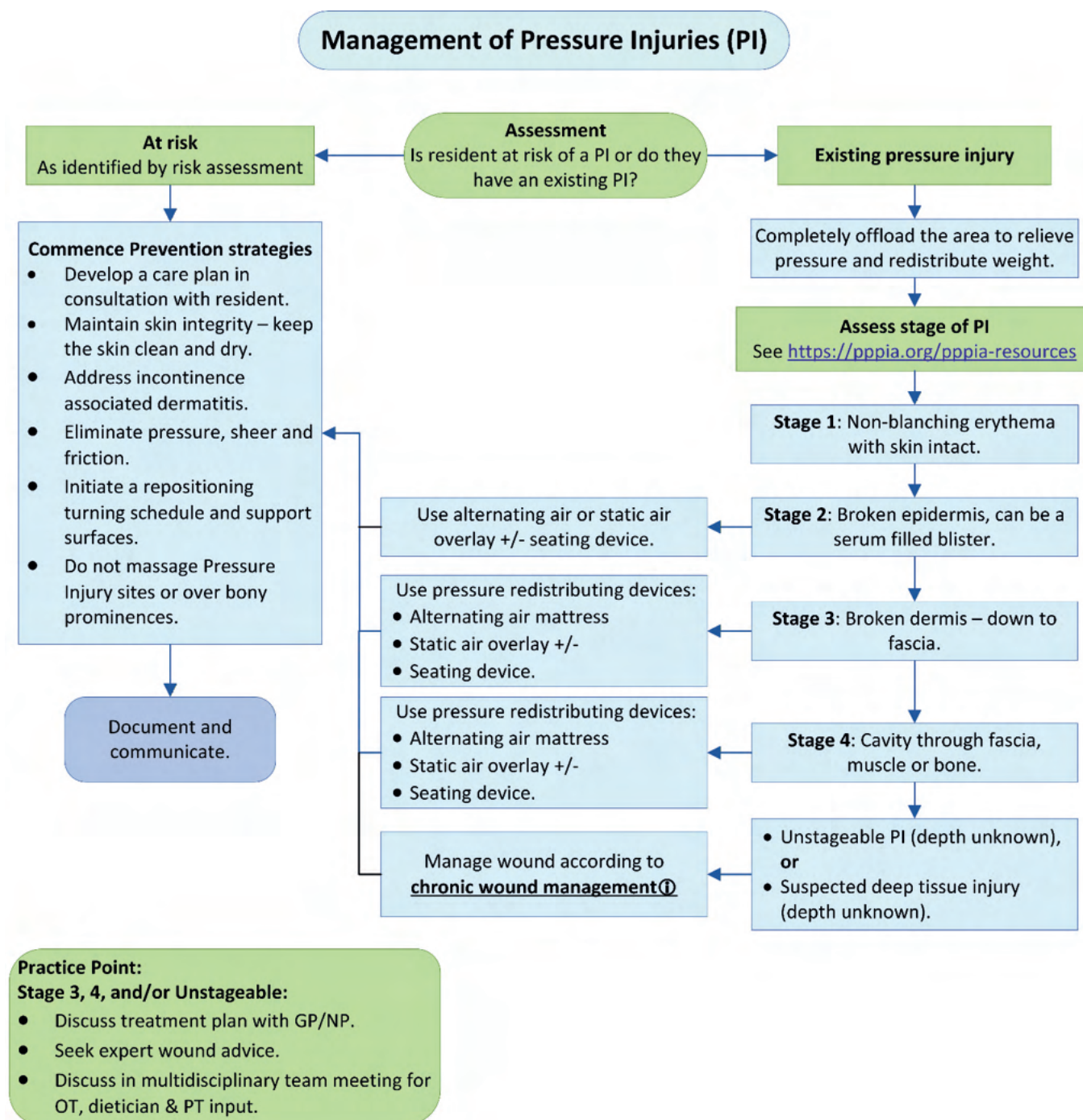
## PAN PACIFIC PRESSURE INJURY CLASSIFICATION SYSTEM FOR OLDER ADULTS

| Normal adult skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Normal older skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>Compared to the skin of younger adults, older skin has a thinner, more wrinkled epidermis and may appear paler or with pigmented (age) spots. Epidermis, dermis and subcutaneous fat layers are thinner. Skin moisture concentration is reduced and skin pH is raised in older adults.</p>                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Stage 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Stage 2                                                                                                                                                                                                                                                                                                                                                                                                                                            | Stage 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Stage 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <p>Intact skin with non-blanchable redness of a localised area usually over bony prominences. Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 pressure injuries may be difficult to detect in older adults with darkly pigmented skin tone. May indicate 'at risk' older adults (a heralding sign of risk).</p>                                                                                                                         | <p>Partial thickness loss of dermis presenting as a shallow open ulcer 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 (bruising indicates suspected deep tissue injury). Stage 2 pressure injuries should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.</p> | <p>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 depth of tissue loss. May include undermining and tunnelling. The depth of a Stage 3 pressure injury varies by anatomical location. The bridge of nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage 4 pressure injuries can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.</p> | <p>Full thickness tissue loss in which the ulcer base is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, (and therefore Stage) cannot be determined. Stable (dry, adherent, intact, no erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed.</p> |
| Unstageable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Suspected Deep Tissue Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p>Purple or maroon localised area of 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 older adults with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and be covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |





## Pressure Injury Flowchart



[The International Guideline 4<sup>th</sup> Edition 2025](#)

## 2. Medical Device Related Pressure Injuries

- A device related Pressure Injury may result from the use of medical devices, (e.g. urinary catheter or oxygen tubing) due to the force exerted from a device that is typically strapped or taped to the body. The resultant pressure injury usually conforms to the pattern or shape of the device.
- Regularly perform skin assessments of the site of the device and periodically reposition of the device.
- **Mucosal Pressure Injuries** – occurs on the soft mucosal tissue at nose, mouth, genitourinary sites and are mostly the result from Medical Devices. Mucosal pressure injuries are different to skin layers and therefore they are not classified using the pressure injury staging classification. Prevention is key and if present assess for use of a product that will adhere to the mucosal tissue e.g., Orabase Protective Base.
- **End of Life Skin Failure** - the skin is as an organ and it can break down during the last days of life. It can present like a pressure injury, but the area will blanch. It occurs due to low perfusion resulting in skin failure and is not from pressure, shear or friction and is referred to as Trombley-Brennan Terminal Tissue Injury.

## 3. Incontinence Associated Dermatitis (IAD)

- It is important to differentiate between a pressure injury and Incontinence Associated Dermatitis (IAD) to be able to prevent and determine the best treatment strategy.
- Incontinence Associated Dermatitis is a type of irritant contact dermatitis found in people with incontinence.
- IAD can cause discomfort, pain, burning, itching or tingling in the affected areas. See below references.

### Advice

- Community HealthPathways
  - ▶ [Specialist Wound Care Referrals](#)
  - ▶ [Cellulitis](#)

### References and Resources

#### Wound Management:

- [Ten top tips palliative wound care](#) - Wounds International 2018 | Vol 9 Issue 3 Black J and Hotaling P.
- [Wound Care Manual - Silverchain](#)- Carville, K. 2023
- [Wound Care](#) - Community HealthPathways
- [Therapeutic wound and skin cleansing: clinical evidence and recommendations 2025](#) International Wound Infection institute.
- [International Wound Infection Institute](#) (IWII) Wound Infection in Clinical Practice. Wounds International. 2022
- [Wounds Australia](#)
- [Wounds International](#)

#### Atypical Wounds

- [European Wound Management Association](#)

#### Venous Leg Ulcers

- [Lower Leg Ulcer Diagnosis & Principles of Treatment. Including Recommendations for Comprehensive Assessment and Referral Pathways](#) Isoherranen K, Montero EC, Atkin L, Collier M, Høgh A, Ivory JD, Kirketerp-Møller K, Meaume S, Ryan H, Stuermer EK, Tiplica GS, Probst S. Journal of Wound Management, (2023);24(2 Sup1):pg1-76. DOI

- [Clinical Practice Guideline for Venous Leg Ulcers: Assessment](#) Venous Leg Ulcer Guideline Committee,. 2<sup>nd</sup> Ed (2025)

### **Chronic Wounds**

- [Therapeutic Wound and Skin Cleansing](#): Clinical Evidence and Recommendations. (2025)

### **Pressure Injury**

- [Pressure Injury Prevention](#) - Clinical Excellence Commission (CEC)
- [The International Guideline](#)
- [Pan-Pacific Pressure Injury Alliance](#)
- [Device-related pressure ulcers: SECURE prevention](#). Gefen A, Alves P, Ciprandi G et al. Journal of Wound Care (2020); 29(Sup2a): S1–S52

### **Skin Tears**

- [Skin Tear Advisory Panel](#) ISTAP International
- [Best practice recommendations for the prevention and management of skin tears in aged skin](#). Wounds International (2018). LeBlanc K et al.
- [Skin Tear Management Flow Chart - Skin Tear Audit Research](#) (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010

### **Incontinence Associated Dermatitis**

- Clinical Excellence Commission (CEC)
  - ▶ [Resources for clinicians](#).
  - ▶ [Best Practice Principles 2021](#) - Incontinence Associated Dermatitis
- [Incontinence Associated dermatitis and pressure injury 2022](#)
- [Incontinence associated dermatitis](#): Wounds International 2025. optimizing skin barrier function, a 3-step approach

## Making a Compliment or Complaint

Feedback, compliments and complaints help improve the quality of care and the services we provide.

It is not the role of ACE, Hunter New England Health, or Hunter Primary Care to become involved in complaint resolution when the complaint relates to the care and treatment provided by an external provider.

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

To make a compliment or complaint, email [HNELHD-AdminRACI@health.nsw.gov.au](mailto:HNELHD-AdminRACI@health.nsw.gov.au). 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.
- ▶ 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: |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |                                                                                    |                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  | NSW Ambulance                                                                                                                                                                                                                                                                          | General Practitioner                                                                                                                                                                                                              | Residential Aged Care                                                              | Hunter New England 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.                                                                                                                                                                                                                                                                                                                                |
| If not appropriate or not resolved:                                              |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |                                                                                    |                                                                                                                                                                                                                                                                                                                                                                       |
| 2.                                                                               | Speak with the Station Manager or the Health Relations Manager.                                                                                                                                                                                                                        | Speak with the Practice Manager.                                                                                                                                                                                                  | Speak with the Facility Manager.                                                   | Speak with the ward Manager (e.g., ED).                                                                                                                                                                                                                                                                                                                               |
| If not appropriate or not resolved:                                              |                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                   |                                                                                    |                                                                                                                                                                                                                                                                                                                                                                       |
| 3.                                                                               | Escalate to NSW Ambulance<br><b>Ph: 1800 269 133</b><br><b>or</b><br>NSW Health Care Complaints Commission<br><b>Ph: 1800 043 159</b><br><a href="https://www.hccc.nsw.gov.au/about-us/compliments-and-complaints">https://www.hccc.nsw.gov.au/about-us/compliments-and-complaints</a> | Escalate to the NSW Health Care Complaints Commission<br><b>Ph: 1800 043 159</b><br><a href="https://www.hccc.nsw.gov.au/about-us/compliments-and-complaints">https://www.hccc.nsw.gov.au/about-us/compliments-and-complaints</a> | Escalate to the Aged Care Quality and Safety Commission<br><b>Ph: 1800 951 822</b> | Escalate to HNE Health Complaints Line<br><b>Ph: 1800 605 172</b> or email <a href="mailto:HNELHD-SRC@hnehealth.nsw.gov.au">HNELHD-SRC@hnehealth.nsw.gov.au</a><br><b>or</b><br>NSW Health Care Complaints Commission<br><b>Ph: 1800 043 159</b><br><a href="https://www.health.nsw.gov.au/Pages/feedback.aspx">https://www.health.nsw.gov.au/Pages/feedback.aspx</a> |

## Acronyms

|                   |                                                                                                                                                                                                                                                                          |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ABS</b>        | Antibiotics                                                                                                                                                                                                                                                              |
| <b>ABC</b>        | Airway, breathing and circulation                                                                                                                                                                                                                                        |
| <b>ACFI</b>       | Aged Care Funding Instrument                                                                                                                                                                                                                                             |
| <b>ACE</b>        | ACE Aged Care Emergency                                                                                                                                                                                                                                                  |
| <b>ACP/ACD</b>    | Advance Care Plan / Advance Care Directive                                                                                                                                                                                                                               |
| <b>ASET nurse</b> | Aged Care Services in Emergency Teams                                                                                                                                                                                                                                    |
| <b>ASSIST</b>     | Acute Screening of Swallow in Stroke/TIA                                                                                                                                                                                                                                 |
| <b>ACVPU</b>      | Acronym to assess level of consciousness: <b>A</b> lert, <b>C</b> onfusion - new confusion / delirium / change in behaviour, <b>V</b> erbal – responds to voice stimulation, <b>P</b> ain – responds to pain or <b>U</b> nresponsive - <b>to pain or other stimuli</b> . |
| <b>BD</b>         | Twice a day                                                                                                                                                                                                                                                              |
| <b>BGL</b>        | Blood glucose level                                                                                                                                                                                                                                                      |
| <b>BP</b>         | Blood pressure                                                                                                                                                                                                                                                           |
| <b>BLS</b>        | Basic life support                                                                                                                                                                                                                                                       |
| <b>CAM</b>        | Confusion Assessment Method                                                                                                                                                                                                                                              |
| <b>CNC</b>        | Clinical Nurse Consultant                                                                                                                                                                                                                                                |
| <b>CMA</b>        | Comprehensive Medical Assessment                                                                                                                                                                                                                                         |
| <b>COPD</b>       | Chronic obstructive pulmonary disease                                                                                                                                                                                                                                    |
| <b>CPR</b>        | Cardiopulmonary resuscitation                                                                                                                                                                                                                                            |
| <b>DKA</b>        | Diabetic ketoacidosis                                                                                                                                                                                                                                                    |
| <b>DRSABCD</b>    | Danger, response, send for help, airway, breathing, circulation, defibrillation                                                                                                                                                                                          |
| <b>DSA</b>        | Dementia Support Australia                                                                                                                                                                                                                                               |
| <b>JHH</b>        | John Hunter Hospital                                                                                                                                                                                                                                                     |
| <b>CT</b>         | Computed tomography                                                                                                                                                                                                                                                      |
| <b>CSU</b>        | Catheter specimen of urine                                                                                                                                                                                                                                               |
| <b>DBMAS</b>      | Dementia Behaviour Management Advisory Service                                                                                                                                                                                                                           |
| <b>DSA</b>        | Dementia Support Australia                                                                                                                                                                                                                                               |
| <b>ED</b>         | Emergency Department                                                                                                                                                                                                                                                     |
| <b>DVT</b>        | Deep vein thrombosis                                                                                                                                                                                                                                                     |
| <b>ECP</b>        | Extended Care Paramedics                                                                                                                                                                                                                                                 |
| <b>EpiPen</b>     | Epinephrine auto-injectors                                                                                                                                                                                                                                               |
| <b>F.A.S.T.</b>   | The acronym for assessing stroke: Facial drooping, Arm weakness, Speech difficulties, and Time to act                                                                                                                                                                    |
| <b>GCS</b>        | Glasgow Coma Scale                                                                                                                                                                                                                                                       |
| <b>GP/NP</b>      | General Practitioner/Nurse Practitioner                                                                                                                                                                                                                                  |
| <b>GTN</b>        | Glyceryl trinitrate                                                                                                                                                                                                                                                      |
| <b>HITH</b>       | Hospital in the home                                                                                                                                                                                                                                                     |
| <b>HR</b>         | Heart rate                                                                                                                                                                                                                                                               |
| <b>HNELHD</b>     | Hunter New England Local Health District                                                                                                                                                                                                                                 |
| <b>Hx</b>         | History                                                                                                                                                                                                                                                                  |
| <b>IDC</b>        | Indwelling catheter                                                                                                                                                                                                                                                      |
| <b>IM</b>         | Intramuscular                                                                                                                                                                                                                                                            |
| <b>ISBAR4AC</b>   | Identify, Situation, Background, Assessment and Recommendation – A mnemonic when providing clinical handover of information during the transfer of care. For aged care.                                                                                                  |
| <b>IV</b>         | Intravenous                                                                                                                                                                                                                                                              |



|                   |                                                   |
|-------------------|---------------------------------------------------|
| <b>kg</b>         | kilogram                                          |
| <b>LOC</b>        | Level of consciousness                            |
| <b>Mane</b>       | Morning                                           |
| <b>MBS</b>        | Medicare Benefits Schedule                        |
| <b>mmHg</b>       | Millimetres of mercury, a measurement of pressure |
| <b>mmol/L</b>     | Millimoles per litre                              |
| <b>Nocte</b>      | At night                                          |
| <b>NP</b>         | Nasal prong                                       |
| <b>NPWT</b>       | Negative pressure wound therapy                   |
| <b>MC &amp; S</b> | Microscopic culture and sensitivity               |
| <b>MHCC</b>       | Mental Health Contact Centre                      |
| <b>MOLST</b>      | Medical Order for Life-Sustaining Treatment       |
| <b>MRI</b>        | Magnetic resonance imaging                        |
| <b>MSU</b>        | Mid-stream urine                                  |
| <b>OPMHS</b>      | Older Persons Mental Health Service               |
| <b>PAINAD</b>     | Pain assessment in advanced dementia              |
| <b>PCR</b>        | Polymerase chain reaction                         |
| <b>PEG</b>        | Percutaneous endoscopic gastrostomy               |
| <b>PI</b>         | Pressure injury                                   |
| <b>PRN</b>        | As necessary                                      |
| <b>RAC</b>        | Residential aged care home                        |
| <b>RAT</b>        | Rapid Access Test                                 |
| <b>RMMR</b>       | Residential Medication Management Review          |
| <b>SDH</b>        | Subdural haematoma                                |
| <b>SBRT</b>       | Severe Behaviour Response Team                    |
| <b>SDCT</b>       | Specialist Dementia Care Program                  |
| <b>SCI</b>        | Spinal cord injury                                |
| <b>SOB</b>        | Shortness of breath                               |
| <b>SPC</b>        | Suprapubic catheter                               |
| <b>SpO2</b>       | Peripheral oxygen saturation in the blood         |
| <b>S/L</b>        | Sublingual                                        |
| <b>SBRT</b>       | Severe Behaviour Response Teams                   |
| <b>Subcut</b>     | Subcutaneous fluids                               |
| <b>TIA</b>        | Transient ischaemic attack                        |
| <b>TRACHE</b>     | Tracheostomy                                      |
| <b>U/A</b>        | Urinalysis                                        |
| <b>URTI</b>       | Upper respiratory tract infection                 |
| <b>UTI</b>        | Urinary tract infection                           |
| <b>VLU</b>        | Venous leg ulcer                                  |

## Evaluation of the ACE 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.
- Carolyn Hullick, Jane Conway, Isabel Higgins, Jacqueline Hewitt, Sophie Dilworth, Elizabeth Holliday and John Attia, Emergency department transfers and hospital admissions from residential aged care facilities: a controlled pre-post design study, *BMC Geriatrics*. 2016. 16:102. DOI 10.1186/s12877-016-0279-1
- 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

### Acute Screening of Swallow in Stroke/TIA (ASSIST)

#### **ASSIST – Acute Screening of Swallow in Stroke/TIA**

Print name & profession: \_\_\_\_\_

Signature: \_\_\_\_\_

MRN No. \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Please fill in if patient label is unavailable

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 premonitory 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.**

# The 4AT Delirium Assessment Tool

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: \_\_\_\_\_

**4AT - ASSESSMENT TEST FOR DELIRIUM & COGNITIVE IMPAIRMENT**

FAMILY NAME \_\_\_\_\_ MRN \_\_\_\_\_

GIVEN NAME \_\_\_\_\_ ☐ MALE ☐ FEMALE

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ M.O. \_\_\_\_\_

ADDRESS \_\_\_\_\_

LOCATION / WARD \_\_\_\_\_

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date: \_\_\_\_\_ Time: \_\_\_\_\_

HNE020703

| Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Score                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| <b>1. Alertness</b><br>This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.<br><br><div style="text-align: right;">             Normal (fully alert, but not agitated, throughout assessment)      0<br/>             Mild sleepiness for &lt; 10 seconds after waking, then normal      0<br/>             Clearly abnormal      4           </div> | circle                 |
| <b>2. AMT4</b><br>Age, date of birth, place (name of the hospital or building), current year.<br><br><div style="text-align: right;">             No mistakes      0<br/>             1 mistake      1<br/>             2 or more mistakes/untestable      2           </div>                                                                                                                                                                                                                                                                                                                            |                        |
| <b>3. Attention</b><br>Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.<br><br><div style="text-align: right;">             Months of the year backwards      Achieves 7 months or more correctly      0<br/>             Starts but scores &lt;7 months / refuses to start      1<br/>             Untestable (cannot start because unwell, drowsy, inattentive)      2           </div>                                                             |                        |
| <b>4. Acute change or fluctuating course</b><br>Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.<br><br><div style="text-align: right;">             No      0<br/>             Yes      4           </div>                                                                                                                                                                                                                                                   |                        |
| <b>4 or above: possible delirium +/- cognitive impairment</b><br><b>1-3: possible cognitive impairment</b><br><b>0: delirium or severe cognitive impairment unlikely</b><br>(but delirium still possible if [4] information incomplete)                                                                                                                                                                                                                                                                                                                                                                  | <b>Total 4AT score</b> |

**GUIDANCE NOTES** Version 1.2. Information and download: [www.the4AT.com](http://www.the4AT.com)

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more suggests delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated solely on observation of the patient at the time of assessment. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

**Alertness:** Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Print Name: \_\_\_\_\_

Designation: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

011219

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Page 1 of 1

HNE020703

4AT - ASSESSMENT TEST FOR DELIRIUM & COGNITIVE IMPAIRMENT

Observation

## The Confusion Assessment Method (CAM)

HUNTER NEW ENGLAND AREA HEALTH SERVICE

Facility \_\_\_\_\_

### THE CONFUSION ASSESSMENT METHOD INSTRUMENT (CAMI)

PLEASE USE GUMMED LABEL IF AVAILABLE

UNIT NUMBER

SURNAME

OTHER NAMES

ADDRESS

DOB

M.O.

HOSPITAL / WARD

HNE020500



THE CONFUSION ASSESSMENT METHOD INSTRUMENT (CAMI)



Investigation



HNE020500

BINDING MARGIN - DO NOT WRITE

#### 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: \_\_\_\_\_

Designation: \_\_\_\_\_ Date: \_\_\_\_\_

07/08 (July 2008)

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



## Neurological Assessment – Glasgow Coma Scale

# GLASGOW COMA SCALE : Do it this way

**GCS** EYES  
VERBAL  
MOTOR

Institute of Neurological Sciences NHS Greater Glasgow and Clyde

**CHECK**

For factors Interfering with communication, ability to respond and other injuries

**OBSERVE**

Eye opening , content of speech and movements of right and left sides

**STIMULATE**

Sound: spoken or shouted request  
Physical: Pressure on finger tip, trapezius or supraorbital notch

**RATE**

Assign according to highest response observed

### Eye opening

| Criterion                                     | Observed | Rating       | Score |
|-----------------------------------------------|----------|--------------|-------|
| Open before stimulus                          | ✓        | Spontaneous  | 4     |
| After spoken or shouted request               | ✓        | To sound     | 3     |
| After finger tip stimulus                     | ✓        | To pressure  | 2     |
| No opening at any time, no interfering factor | ✓        | None         | 1     |
| Closed by local factor                        | ✓        | Non testable | NT    |

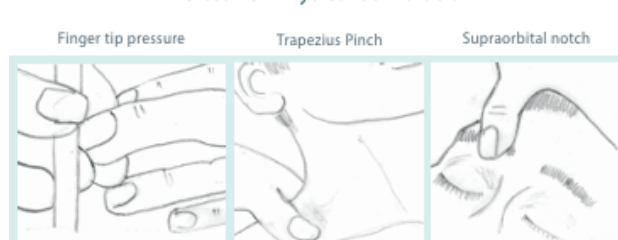
### Verbal response

| Criterion                                   | Observed | Rating       | Score |
|---------------------------------------------|----------|--------------|-------|
| Correctly gives name, place and date        | ✓        | Orientated   | 5     |
| Not orientated but communication coherently | ✓        | Confused     | 4     |
| Intelligible single words                   | ✓        | Words        | 3     |
| Only moans / groans                         | ✓        | Sounds       | 2     |
| No audible response, no interfering factor  | ✓        | None         | 1     |
| Factor interfering with communication       | ✓        | Non testable | NT    |

### Best motor response

| Criterion                                                          | Observed | Rating           | Score |
|--------------------------------------------------------------------|----------|------------------|-------|
| Obey 2-part request                                                | ✓        | Obeys commands   | 6     |
| Brings hand above clavicle to stimulus on head neck                | ✓        | Localising       | 5     |
| Bends arm at elbow rapidly but features not predominantly abnormal | ✓        | Normal flexion   | 4     |
| Bends arm at elbow, features clearly predominantly abnormal        | ✓        | Abnormal flexion | 3     |
| Extends arm at elbow                                               | ✓        | Extension        | 2     |
| No movement in arms / legs, no interfering factor                  | ✓        | None             | 1     |
| Paralysed or other limiting factor                                 | ✓        | Non testable     | NT    |

### Sites For Physical Stimulation



### Features of Flexion Responses

Modified with permission from Van Der Naalt 2004  
Ned Tijdschr Geneesk



[Glasgow Coma Scale](#) acknowledge Glasgow University (GCS) and Sir Graham Teasdale.

## MOLST Form

### MOLST evidence base

The Medical Orders for Life-Sustaining Treatment (MOLST) was adapted from the [American POLST form](https://polst.org/national-form/) as part of a Commonwealth funded Dementia End of Life Care Project (<https://polst.org/national-form/>). The MOLST was identified as an appropriate advance care planning document for people living in RAC homes with advanced dementia.

### Purpose of the MOLST

During the project, two key gaps in advance care planning (ACP) processes were identified:

- Uncertainty in Applying ACPs within RACs

RACs undertaking ACP were often unsure when ACP documents should be followed, particularly as residents' conditions deteriorated. Although some plans indicated a preference for a palliative approach, there was frequently no accompanying medical documentation to support continued care within the RAC rather than hospital transfer.

- Inadequate Clinical Guidance for Emergency Care

When RAC residents presented to Emergency Departments (EDs) with ACP documentation, the information often lacked sufficient detail to guide ED clinicians in decisions about initiating or withholding life-sustaining treatment for deteriorating residents.

The MOLST form was identified as an evidence-based solution to bridge these gaps by aligning resident preferences with a medically authorised order. Unlike standard advance care directives, MOLST forms function as signed medical orders that reflect the resident's expressed wishes and document a medically endorsed treatment plan. In this way, MOLST is more akin to a **Not for Resuscitation (NFR)** order than a traditional Advance Care Directive (ACD).

### MOLST Population Criteria

The MOLST is intended for individuals with advanced chronic disease or dementia and a **projected life expectancy of 12 months or less**. Eligibility is determined using the Prognostic Indicator Guidance tool from the [NHS Gold Standards Framework](#)

This includes:

- ▶ Asking: "Would I be surprised if this person died in next 12 months?"
- ▶ Identifying clinical signs of advanced disease and relevant prognostic indicators.

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

### Legal status of MOLST

The legal status of Advance Care Directives (ACDs) can be uncertain, particularly when they conflict with medical judgement or the clinician's legal duty to provide a standard of care. In contrast, the MOLST form, as a medically authorised plan of treatment, provides greater legal clarity.

MOLST documents the resident's preferences alongside the clinical judgement of the GP/NP, who certifies that the proposed treatment plan meets the required standard of care and aligns with the resident's wishes.

MOLST is designed for use in the residential aged care and community settings, and to guide treatment decisions in the Emergency Department. It is intended to operate within NSW Health End of Life guidelines (see below).

The MOLST form should be reviewed and re-documented upon transfer **to and from acute care facilities** to ensure ongoing clinical relevance.

### Consent and GP/NP Responsibilities

GP/NPs or Medical Officers who sign a MOLST form are legally responsible for ensuring that:

- ▶ The content has been consented to by the resident or their substitute decision maker
- ▶ The MOLST has been clearly explained and discussed before being signed.
- ▶ The name of the consenting individual is documented on the form

### Resources

- [End of Life Directions for Aged Care](#) (ELDAC) provides an overview of end-of-life law and how this relates to aged care practice, go to
- [End of Life Care and Decision-Making guideline](#) NSW Health

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**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.

|                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------|--------------------------|
| <b>H1</b>                                                                                                                                                                          | <b>Primary Diagnosis &amp; reason for transfer / unplanned medical review:</b>                                                                                                                                                                                                                                                                                                                           |                          |                                                               |                          |
| <b>Existing System / Organ Co-morbidities - Mark shaded check box for existing co-morbidities.</b>                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H2</b>                                                                                                                                                                          | Identify advanced disease states with an <b>A</b> in the second check box (refer to Prognostic Indicator Guide for advanced disease indicators <a href="http://www.goldstandardsframework.nhs.uk/Resources/Gold%20Standards%20Framework/PrognosticIndicatorGuidancePaper.pdf">http://www.goldstandardsframework.nhs.uk/Resources/Gold%20Standards%20Framework/PrognosticIndicatorGuidancePaper.pdf</a> ) |                          |                                                               |                          |
|                                                                                                                                                                                    | <b>Cardiac</b>                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> | <b>GIT / Liver</b>                                            | <input type="checkbox"/> |
|                                                                                                                                                                                    | <b>Stroke / TIA</b>                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <b>Diabetes</b>                                               | <input type="checkbox"/> |
|                                                                                                                                                                                    | <b>Respiratory</b>                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <b>Renal</b>                                                  | <input type="checkbox"/> |
|                                                                                                                                                                                    | <b>*Other co-morbidities /descriptors</b>                                                                                                                                                                                                                                                                                                                                                                |                          | <b>Existing artificial support therapies: (Identify type)</b> |                          |
|                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                          |                          | Dialysis:                                                     | Cardiac device:          |
|                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                          |                          | NIV(CPAP/BIPAP):                                              | Infusion therapy:        |
| <b>Prognostic symptoms over past 6 months (tick all that apply)</b>                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H3</b>                                                                                                                                                                          | <input type="checkbox"/> >10% weight loss in past 6 months                                                                                                                                                                                                                                                                                                                                               |                          | <input type="checkbox"/> Recurrent infections / fevers        |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Heavily dependant in most ADL's                                                                                                                                                                                                                                                                                                                                                 |                          | <input type="checkbox"/> Short of breath minimal exertion     |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Urinary / faecal incontinence                                                                                                                                                                                                                                                                                                                                                   |                          | <input type="checkbox"/> Repeated hospital admissions         |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Swallowing problems / difficulties                                                                                                                                                                                                                                                                                                                                              |                          | <input type="checkbox"/> Repeated ED presentations            |                          |
| <b>H4</b>                                                                                                                                                                          | Have there been advance care planning discussion/s with the patient / person responsible and significant others? <b>YES / NO</b><br>Where are ACP discussions documented and filed?                                                                                                                                                                                                                      |                          |                                                               |                          |
| <b>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)</b> |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H5</b>                                                                                                                                                                          | <input type="checkbox"/> Aim to extend life for as long as possible with available and offered medical treatment.                                                                                                                                                                                                                                                                                        |                          |                                                               |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Accept natural dying –maximise comfort and symptom relief with available medical treatment.                                                                                                                                                                                                                                                                                     |                          |                                                               |                          |
| <b>What level of medical response has been consented to? (tick most appropriate option)</b>                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H6</b>                                                                                                                                                                          | <input type="checkbox"/> Accept any offered interventional treatment that aims to delay dying – <b>transfer to hospital</b> - NO MOLST                                                                                                                                                                                                                                                                   |                          |                                                               |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Agree to defined medical care as documented in the MOLST section on reverse of page                                                                                                                                                                                                                                                                                             |                          |                                                               |                          |
|                                                                                                                                                                                    | <input type="checkbox"/> Accept natural dying and palliative care as documented on MOLST on reverse of page                                                                                                                                                                                                                                                                                              |                          |                                                               |                          |
| <b>Name and contact number/s of a 'person responsible' for medical consent</b>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H7</b>                                                                                                                                                                          | Name                                                                                                                                                                                                                                                                                                                                                                                                     |                          | Name                                                          |                          |
|                                                                                                                                                                                    | Contact Number/s                                                                                                                                                                                                                                                                                                                                                                                         |                          | Contact Number/s                                              |                          |
| <b>Name and contact number of Healthcare Professional completing this form</b>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                                                               |                          |
| <b>H8</b>                                                                                                                                                                          | Print Name: _____                                                                                                                                                                                                                                                                                                                                                                                        |                          |                                                               |                          |
|                                                                                                                                                                                    | Signature: _____                                                                                                                                                                                                                                                                                                                                                                                         |                          |                                                               |                          |
|                                                                                                                                                                                    | Date: _____                                                                                                                                                                                                                                                                                                                                                                                              |                          | Contact number: _____                                         |                          |
|                                                                                                                                                                                    | Healthcare Professional Designation: _____                                                                                                                                                                                                                                                                                                                                                               |                          |                                                               |                          |

MOLST: Version 9 – Nov.2013 -Adapted by Lisa Shaw - Project Officer 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](mailto:LisaK.Shaw@hnehealth.nsw.gov.au) or [jacquiculver@hnehealth.nsw.gov.au](mailto:jacquiculver@hnehealth.nsw.gov.au) for MOLST resources or further information.

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.**

|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <b>M1</b> | <b>CARDIOPULMONARY RESUSCITATION (CPR):</b> <u>Person has no pulse or response or is not breathing.</u> (CPR is <u>not recommended</u> in frail, older people with advanced chronic illness)                                                                                                                                                                                                                                                                                             |  |  |
|           | <input type="checkbox"/> <b>Attempt CPR - aim to prolong life</b> <input type="checkbox"/> <b>Do not attempt CPR- accept natural dying</b>                                                                                                                                                                                                                                                                                                                                               |  |  |
|           | When not in cardiopulmonary arrest, follow orders in <b>M2, M3</b> and <b>M4</b> .                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
| <b>M2</b> | <b>MEDICAL INTERVENTIONS:</b> <u>Person has pulse and/or is breathing.</u>                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |
|           | <input type="checkbox"/> <b>Limited Life Sustaining Interventions</b> Use medical treatment, IV fluids and medications and cardiac monitor as medically indicated. <u>Do not</u> use intubation, advanced airway interventions, or mechanical ventilation for person's irreversible condition/s. <b>Transfer</b> to hospital if indicated. <b>Avoid</b> admission to critical care units where possible. Includes care as described below.                                               |  |  |
|           | <input type="checkbox"/> <b>Palliative care during natural dying</b> 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. <u>Do not transfer to hospital for life-sustaining treatment.</u> <b>Transfer</b> to appropriate clinical facility if comfort/palliation needs cannot be met in current location. |  |  |
| <b>M3</b> | <b>ANTIBIOTICS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|           | <input type="checkbox"/> Accept hospital transfer for IV antibiotic therapy - aimed at prolonging life                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
|           | <input type="checkbox"/> Use antibiotics to promote comfort and relieve distress only - avoid hospital transfer.                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| <b>M4</b> | <b>ARTIFICIALLY ADMINISTERED NUTRITION / HYDRATION:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
|           | <input type="checkbox"/> Accept transfer to hospital for artificial nutrition (NG or PEG) or hydration (IV) therapy.                                                                                                                                                                                                                                                                                                                                                                     |  |  |
|           | <input type="checkbox"/> Use oral routes only for hydration purposes where swallowing permits - avoid hospital transfer.                                                                                                                                                                                                                                                                                                                                                                 |  |  |
| <b>M5</b> | <b>Consent to MOLST defined treatment obtained from:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
|           | Name: _____ Name: _____<br>Signature: _____ Signature: _____<br>Relationship to patient: <b>Self:</b> <input type="checkbox"/> <b>Person responsible:</b> <input type="checkbox"/> (1. Guardian: 2. Spouse: 3. Carer: 4. Family/friend)<br>Contact Number/s: _____ mobile: _____                                                                                                                                                                                                         |  |  |
| <b>M6</b> | <b>Medical Officers Signature:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|           | Name: _____<br>Signature: _____ Date: _____<br>Contact Number: _____                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| <b>M7</b> | <b>Review Date/s</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
| <b>M8</b> | <b>REVOKING THIS MEDICAL ORDER</b><br>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 Officer 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](mailto:LisaK.Shaw@hnehealth.nsw.gov.au) or [jacquiculver@hnehealth.nsw.gov.au](mailto:jacquiculver@hnehealth.nsw.gov.au) for MOLST resources or further information.



## ACE Manual Consultation and Clinical Editors

|                                                                                                                                                                                                                                                                                    | Approved | Reviewed  | Reviewed | Reviewed | Reviewed |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------|----------|----------|----------|
| Aged Care Emergency Operational Committee                                                                                                                                                                                                                                          | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Aged Care and Rehabilitation Services                                                                                                                                                                                                                                       | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Aged Care Services in Emergency Teams (ASET)<br>John Hunter Hospital, Tamworth Rural Referral Hospital, Armidale Hospital, Belmont Hospital, Calvary Mater Hospital Newcastle, The Maitland Hospital, Manning Base Hospital, Tomaree Community Hospital, Singleton Hospital | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Cardiac Stream                                                                                                                                                                                                                                                              | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Community Aged Care Oral Health Programs                                                                                                                                                                                                                                    |          |           | Jan 2020 | 2022     | 2025     |
| Clinical Governance - Communicating for Safety, Deteriorating Patient and Sepsis Committees                                                                                                                                                                                        |          |           | Jan 2020 | 2022     | 2025     |
| Clinical Excellence Commission – Patient Safety Improvement                                                                                                                                                                                                                        |          |           |          | 2022     | 2025     |
| HNELHD Chronic Disease Network                                                                                                                                                                                                                                                     | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Dementia/Delirium CNC                                                                                                                                                                                                                                                       | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Diabetes Network                                                                                                                                                                                                                                                            | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Emergency Stream                                                                                                                                                                                                                                                            | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Gastrointestinal                                                                                                                                                                                                                                                            | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| Hunter Primary Care                                                                                                                                                                                                                                                                | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Neurology Stream                                                                                                                                                                                                                                                            | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| New South Wales Ambulance                                                                                                                                                                                                                                                          | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Older People Mental Health Service                                                                                                                                                                                                                                          | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Pain Service                                                                                                                                                                                                                                                                | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Palliative Care and End of Life Network                                                                                                                                                                                                                                     | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Public Health Unit                                                                                                                                                                                                                                                          | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Quality Use of Medicines Committee                                                                                                                                                                                                                                          | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Respiratory Network                                                                                                                                                                                                                                                         | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| Residential Aged Care staff                                                                                                                                                                                                                                                        | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Telehealth - ICT Services                                                                                                                                                                                                                                                   |          |           | Jan 2020 | 2022     | 2025     |
| HNELHD Urology                                                                                                                                                                                                                                                                     | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |
| HNELHD Wound Care                                                                                                                                                                                                                                                                  | Nov 2013 | July 2016 | Jan 2020 | 2022     | 2025     |