Identifying and Managing the Deteriorating Resident and Client

Whiddon

Document Control

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25 June 2020	New Policy and Guide – replacing the position statement for the Deteriorating Resident /Client	GMQCC	1.1
November 2022	Major Changes New Process Guides for Hypo and Hyperthermia	GM QCC	2.0
November 2024	NDIS additional notes. Formatting changes	GMCR&C	2.1

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Identifying and Managing the Deteriorating Resident and Client

Introduction

The aim of this clinical guideline is to provide all Whiddon teams who engage with residents and clients with appropriate understanding when a resident or client appears to be deteriorating.

Deterioration is usually identified when a person 'seems different than usual' or 'something seems wrong'. Deterioration can occur over hours or days and may result from an infection, delirium, constipation, dehydration, medication, fall or other injury.

Whiddon teams are supported to promote a culture that is aligned with Whiddon My Life Our Care Model. One of the elements of the model is Health and Wellness: responding to health needs and proactively promoting wellness. Whiddon team members have the responsibility to acknowledge and act on actual and potential changes that impact on the wellbeing of those who entrust their care to Whiddon team members. Early identification and management of deterioration may result in better outcomes for the resident or client.

Application of Policy

This policy applies to all Whiddon team members working in residential and community care including all Registered Nurses (RN) and Enrolled Nurses (EN) registered with the Australian Health Practitioner Regulation Sections apply to care employees. This policy should be considered for all residents or clients who may be experiencing deterioration and change in their health status related to physiological, mental state, and those receiving end of life care.

Definitions

Acute Deterioration

Physiological, psychological or cognitive changes that may indicate a decline of the resident's or client's health status

Acceptable parameters

A range of measurements for a specific clinical observation for a resident or client that is determined by the GP and regularly reviewed by the GP and/or RN. Measurements outside of the range require escalation and intervention (see definitions). For example, the acceptable parameters documented might be BP 120/60 - 140/80. If the BP is 110/60 then the escalation and intervention is required.

Acceptable parameters are always considered in conjunction with clinical judgement of a registered health practitioner, such as an experienced registered nurse. If clinical measurements are within acceptable parameters but something 'seems wrong' with the resident or client *then clinical judgement overrides the acceptable parameters.* As an example, blood pressure may be within the acceptable range, but the resident or client is dizzy, has a headache, and is vomiting. Clinical judgement would suggest that this resident or client requires further review.

A-G Assessment

Structured approach to physical assessment.

Airway, Breathing, Circulation, Disability, Exposure, Fluids, Glucose

Authorised Representative or Substitute Decision Maker

An authorised representative and substitute decision maker in this guide refers to a person who is legally authorised to make decisions on behalf of the resident or client who lacks capacity to make informed decisions on their behalf.

A person may be legally authorised to make decisions on behalf of a person lacking capacity if:

a) They have been validly appointed to do so by the resident or client when the resident or client had capacity to make an informed decision. For example, an Enduring Guardian or an attorney under an enduring power of attorney. EPA (Enduring Power of Attorney) can make health and accommodation decisions if specified in legal documents.

b) They have been appointed a guardian of the person by a Court or the Guardianship Tribunal in NSW/QLD.

c) They are authorised by legislation for example they are the "person responsible" under the Guardianship Act or an "authorised representative" under the NSW privacy laws or a "health attorney" under the Guardianship and Management of Property Act.

Capacity

Capacity is the ability to make decisions for one's self. A person has capacity, or is deemed competent when they can make their own decisions by understanding the information and choices available to them, weighing up that information to determine what the decision will mean for them (risks and consequence) and are able to communicate their decision. This communication may be verbal or via body language (implied), for example, holding their arm out for an injection.

If a person is unable to process the necessary information to make his or her own decisions, that person is said to lack capacity.

Clinician

A health care provider, trained in a health profession. This term encompasses medical practitioners, nurses, paramedics and allied health professionals, etc.

Deterioration

A worsening of a resident's or client's condition, which may include one or more of the following: their physical health, mental health or cognitive function. Examples of deterioration includes a drop in blood glucose levels not responsive to initial interventions or an episode of confusion that is unusual for the person. Deterioration can occur over minutes, hours, days and even weeks.

Escalation

Escalation means to increase the level of intervention in response to a problem or situation being identified or suspected.

Escalation protocols provide clear, objective criteria that prompt team members to call for help, and endorse calling for help when team members, residents/clients, family members or carers are subjectively concerned about a resident/client acutely deteriorating (Australian Commission on Safety and Quality in Health Care).

Intervention

The intervention is the action taken in response to an event or problem, or the management of the event or problem.

Mental State

Refers to a person's intellectual capacity, emotional state, and general mental health based on clinical

observations and interviews.

Mental state compromises mood, behaviour, orientation, judgement, memory, problem-solving ability and contact with reality.

Policy

This policy applies to consumers in Residential Care and Community Care funded by the Department of Health and Aged Care and the National Disability Insurance Scheme (NDIS) .

To maintain clarity and consistency throughout the policy, the terms "consumers," "residents," "clients," "elders," and "NDIS participants" will collectively be referred to as "consumers," all such references encompass these groups equally.

All Whiddon team members have the responsibility to work within their scope of practice. The role of the Registered Nurses (RN) and Enrolled Nurses (EN) registered with the Australian Health Practitioner Regulation Agency and working at Whiddon, is to recognise when a resident or client is unwell before they become deconditioned, and their wellbeing is compromised. All care teams are to ensure that if they notice changes in the resident or client that they report directly and in a timely manner to the registered nurse or coordinator, who must escalate this to the resident or client's general practitioner and the resident /clients substitute decision maker.

The following actions must be taken when caring for residents and clients.

- Recognition of deterioration in their health and wellbeing
- Measurement and documentation of observations
- Escalation of care to the appropriate person

- Intervention to manage the resident's or client's health needs
- Communication to the team, relevant health professionals and authorised representatives
- Review and ongoing monitoring of the resident's or client's condition
- Documentation of all observations, interventions and communications.

Recognition of Deterioration

Older people can deteriorate rapidly and may at times only display minor noticeable symptoms. Generally, deterioration can be detected early by observing the resident or client and identifying quickly if the resident or client seems different than usual or it appears that something is not right with them.

Clinical judgement and communication with the resident or client, team members, their general practitioner and their authorised representative must be used when deciding if the person's condition appears to be deteriorating. The registered nurse should not solely rely on the resident or clients' observations (vital signs) when making clinical decisions about their wellbeing. Their behaviour, demeanour, communication style, self-reported wellbeing, family /friend's feedback and other relevant factors should be taken into consideration when making a decision regarding escalation for review.

The person may not report feeling unwell for various reasons such as being confused, not wanting to make a fuss, not knowing how to contact team members, not having ready access to their general practitioner, having communication impairment, or believing that the symptoms they have are not serious.

Measurement and Documentation of Observations

Physiological observations

Regular measurement and documentation of physiological observations are essential requirements for recognising and responding to deterioration.

Observations can include:

- Respiratory rate: the number of breaths per minutes
- Respiratory effort: the effort or work of breathing
- Pulse oximetry: measures the level of oxygen in the blood, may also be referred to as oxygen saturation
- Blood Pressure (BP): the pressure or force that is exerted by the blood upon the walls of the blood vessels and especially the arteries as it circulates
- Heart rate: the number of heart beats per minute
- Temperature: the degree of hotness or coldness of the body
- Blood Glucose Level (BGL): the amount of sugar (glucose) in the blood
- Level of consciousness: identifying how awake, alert, and aware of their surroundings a person is. This can be measured using the acronym AVPU which refers to: ○ **Alert:** The person is aware of the examiner and can respond to the environment around them on their own. The person can also follow commands, open their eyes spontaneously and track objects.
- **Verbally Responsive:** The person's eyes do not open spontaneously. The person's eyes open only in response to a verbal stimulus directed toward them. The person is able to directly react to that verbal stimulus in a meaningful way.

- **Painfully Responsive:** The person's eyes do not open spontaneously. The person will only respond to the application of painful stimuli by an examiner. The person may move, moan, or cry out directly in response to the painful stimuli.
- **Unresponsive:** The person does not respond spontaneously. The person does not respond to verbal or painful stimuli.(NCBI)

In addition to regular monitoring of the resident or client's minimum physiological observations

critical occasions where physiological observations may be required are:

- Resident or client experiencing an episode of acute deterioration or are at risk of acute deterioration.
- At time of admission or initial Assessment; and
- Prior or return to service from hospital or leave.

Observations that are outside of the acceptable (or usual) parameters for the resident or client must be referred to the registered nurse or coordinator and then immediately to their general practitioner/medical officer.

Following this, observations must be documented and checked again to confirm accuracy of measurement. In addition, an increase in the frequency of observations (GP or RN is to determine the frequency) may be required.

The Registered Nurse must investigate further to assess:

- Is the deterioration related to a pre-existing condition? If so, what is the treatment order?
- When the last observations were taken? Is there a trends in the observations?

In the absence of a Registered Nurse the GP or ambulance must be called.

The table below indicates observations that would indicate deterioration of the person. Parameters must be individually determined for each resident /client by their GP and in consultation with the resident or client and documented the residents/ client documentation and communicated to care team members.

If the acceptable parameters documented by the GP are broad or inappropriate for the persons condition the RN or coordinator should:

- Attempt to determine safer ranges with the GP.
- Determine and document more appropriate parameters to guide the care team members.

Any rapid deterioration in condition should be treated with suspicion.

Recognition of the Deteriorating Person (adapted from ASNSW BTF)

Observation	Green (usual)	Yellow (caution)	Red (danger)
Respiratory Rate	**10 – 24 breaths /min**	**Less than 9 breaths/min More than 25 breaths/min**	**Less than 5 breaths/min More than 30 breaths/min**
Respiratory Effort	**Typical for this person and oxygen saturation (Sp02) normal**	**Unusually laboured or noisy breathing for this person**	**Obvious distress and/or cyanosis (despite oxygen)**
Pulse Oximetry (SpO2) Beware of the	**95-100% (with or without oxygen) and**	**Less than 95% (despite oxygen) for this person**	**Less than 90% (despite oxygen)**

Observation	Green (usual)	Yellow (caution)	Red (danger)
person with COPD who may normally have low O2 saturations	typical for this person		
Blood Pressure *Systolic = top measurement*	100 – 180 mmHg systolic and typical for this person. *Caution: If a person's systolic BP is normally 160 mmHg and is now 100 mmHg, this is not typical for this person*	Less than 100 mmHg systolic More than 180 mmHg systolic	Less than 90 mmHg systolic More than 200 mmHg systolic
Heart Rate	50 – 120 beats/min	Less than 50 beats/min More than 120 beats/min	Less than 40 beats/min More than 140 beats/min
Level of Consciousness Response and Cognition	Alert (A) Or cognition normal for this person	Verbal (V) Or cognition normal for this person	Pain (P) or (U) Unresponsive to Pain or sudden change to mental state
Temperature	35.6 - 38.4 °C With or without antipyretic medication If over 37.5 monitor person and check with RN	Less than 35.5 °C More than 38.5 °C Without anti-pyretic medication	More than 38.5 °C Despite anti-pyretic medication
Pain	Nil or tolerable With or without pain medication	Obvious discomfort Despite recent pain medication New Pain	Obviously distressed Despite recent pain medication Severe Pain
Blood Glucose Levels – Diabetes Australia	4 - 7.8 mmol/L or in range for this person	Less than 4 mmol/L More than 20 mmol/L with no decrease level of consciousness	Less than 4 mmol/L or More than 20 mmol/L with decrease level of consciousness

A – G Assessment

The A-G Assessment method is a systematic and structured approach to resident or client

assessment both useful in daily clinical practice and emergency situations in recognising deterioration. When writing notes apply the A-G assessment methodology, this will ensure that you have documented and communicated important information to the reader in a person's progress notes.

A - Airway

Is airway clear

- **Listen for noisy breathing**
- **Look for mouth / neck swelling**
- **Feel and look for swelling**

B – BREATHING

- **Count respiratory rate – most important indicator of deterioration**
- **Reduced Oxygen Saturations**
- **Distress / breathlessness**
  - **Is the chest moving?**
  - **Shortness of breath?**
  - **Working hard to breathe?**
    - **Using abdominal muscles to breathe**
- **Noisy breathing e.g. wheezes, grunts**
- **Blue or pale lips / peripheries**
- **Able to talk in full sentences?**
- **Cough?**
- **Sputum?**
- **Leg Swelling?**

C - CIRCULATION

- **Heart Rate / Pulse**
- **Is the Heart Rate / Pulse regular or irregular – check manually**
- **Blood pressure**

- Chest Pain
- Flushed or Pallor
- Sweaty
- Cold or Clammy
- Dizzy

D – DISABILITY (Neurological Assessment)

- Neurological Observations
- Reduced level of consciousness / drowsy
- AVPU
- Headache
- New limb or face weakness?
- Slurred Speech?
- Vision disturbances
- New or worsening confusion
- New injury?
- Falls
- Reduced mobility
- Reduced balance
- New swallowing problems
- Pain

- Temperature

E - EXPOSURE

- Check skin integrity
  - o Wounds
  - o Rashes
  - o Bleeding

- Bruising
- Colour

- Remove wound dressing and assess wound status
- Check skin for new wounds / bruises / bleeding / rashes

F - FLUID

- Fluid intake
- Urine
  - Amount
  - Colour
  - Frequency
  - Odour
- Urinalysis
- Thirst
- Dry mouth / coated lounge
- Swollen legs
- Check bowel management chart
  - Diarrhoea
    - Constipation vs overflow
  - Constipation

G – GLUCOSE / SUGAR

- Blood glucose / sugar level
- Appetite
- Vomiting
- Abdominal pain or bloating
- Eating or drinking?

NSW Health. (2020). Assessing the Deteriorating Resident - DETECT for RACFs

Mental State Assessment

The key factor in recognising deterioration in a person's mental state is noticing changes in a resident or client's behaviour, cognitive function, perception, or emotional state.

In residential care, Autumn Care has the Cognitive Skills – Psychogeriatric Assessment Scale (PAS) to assess mental state. The minimum requirement for frequency of mental state is completed at time of admission if clinically indicated and appropriate, and then as required should any behavioural changes observed. In community care the PAS is located in My Staff Room.

While there are a number of typical signs that can indicate deterioration, these can vary significantly, and individual changes that are reported or observed are critical in recognising deterioration in a resident/client's mental state.

If a resident or client has previously experienced deterioration in mental state, they may have a good understanding of specific factors that can precipitate deterioration for them, as well as factors that contribute to maintaining wellbeing. They may also be likely to have knowledge about what responses are effective should they experience deterioration in their mental state.

Typical Mental State signs that can indicate deterioration	
Reported	**Observed**
• **Verbal commands to do harm to self and others** • **Suicidal ideation** • **Attempt to self-harm** • **Threat of harm to others** • **Situational crisis** • **Psychotic symptoms (hallucinations, delusions, paranoid ideas)** • **Mood disturbance (depression, elevated or irritable)** • **Unstable to wait safely**	• **Agitation** • **Restlessness** • **Bizarre / disorientated behaviour** • **Confusion** • **Ambivalence about treatment** • **Withdrawn** • **Uncommunicative**

Causes of Deterioration

Delirium Screening Assessment and Management Guidelines

Confusion in the elderly person is usually a symptom of delirium or dementia, but it may also occur in major depression and psychoses. Until another cause is identified, the confused person should be assumed to have delirium, which is a serious, potentially preventable, neuropsychiatric disorder occurring in association with underlying disorder.

Noticing confusion when it first appears will assist in early treatment before the older person deteriorates further.

Autumn Care has the Confusion Assessment Tool (CAM), this is to be when there are noted changes with the resident or in residential care.

Some signs of confusion include:

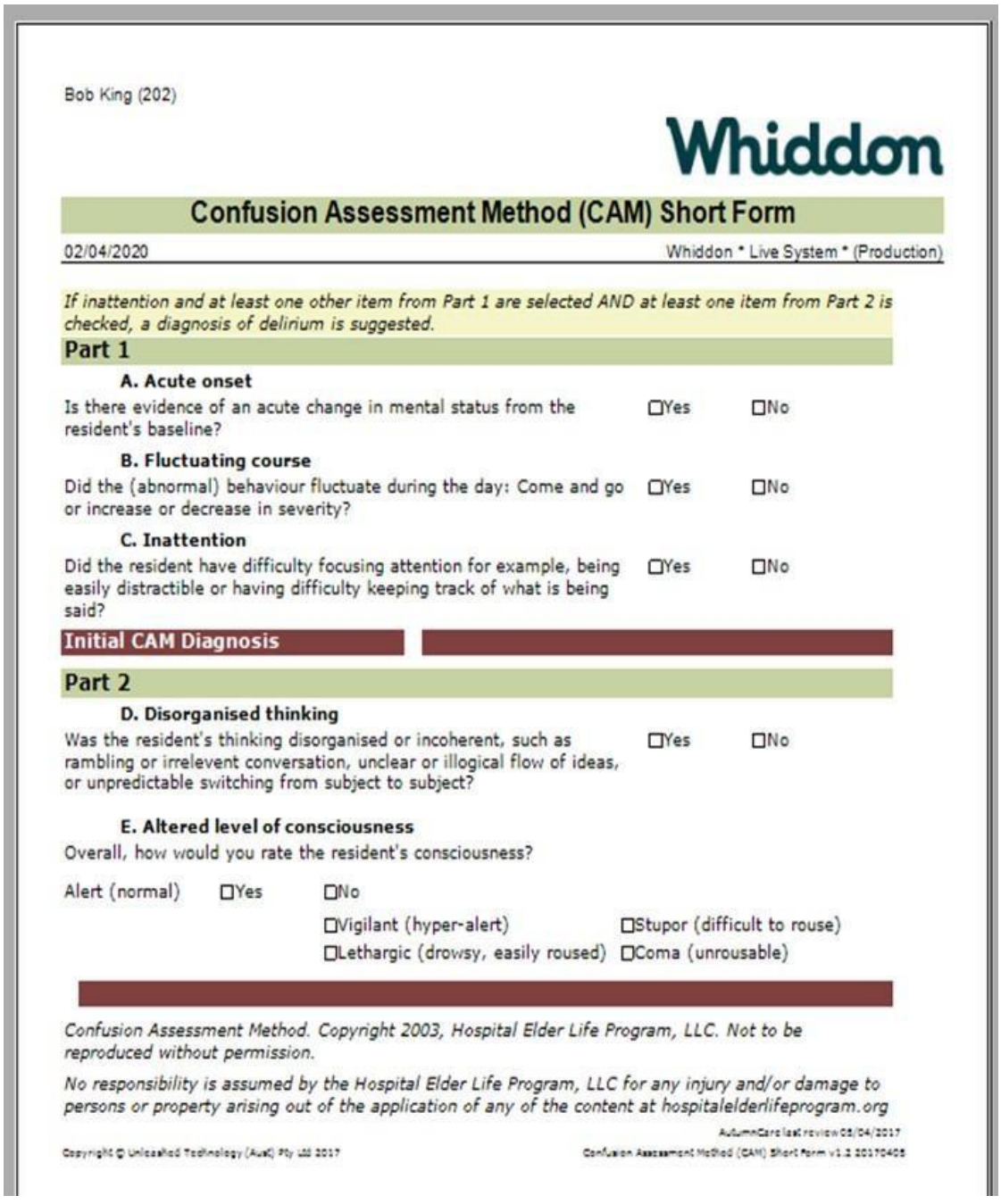
- slurring words or having long pauses during speech
- abnormal or incoherent speech

- lacking awareness of location or time
- forgetting what a task is while it's being performed
- sudden changes in emotion, such as sudden agitation

If confusion follows a head injury or trauma, such as a fall it could be a possible concussion, and you should call 000 right away. It's especially important to call a doctor if you notice confusion alongside the following symptoms:

- dizziness
- rapid heart beat
- clammy skin
- fever
- headache
- shivering
- irregular breathing
- weakness on one side of the body

- slurred speech



Bob King (202)

Whiddon

Confusion Assessment Method (CAM) Short Form

02/04/2020 Whiddon * Live System * (Production)

If inattention and at least one other item from Part 1 are selected AND at least one item from Part 2 is checked, a diagnosis of delirium is suggested.

Part 1

A. Acute onset

Is there evidence of an acute change in mental status from the resident's baseline? ☐Yes ☐No

B. Fluctuating course

Did the (abnormal) behaviour fluctuate during the day: Come and go or increase or decrease in severity? ☐Yes ☐No

C. Inattention

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

Initial CAM Diagnosis

Part 2

D. Disorganised thinking

Was the resident's thinking disorganised or incoherent, such as rambling or irrelevent conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? ☐Yes ☐No

E. Altered level of consciousness

Overall, how would you rate the resident's consciousness?

Alert (normal) ☐Yes ☐No

☐Vigilant (hyper-alert) ☐Stupor (difficult to rouse)

☐Lethargic (drowsy, easily roused) ☐Coma (unrousable)

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AutumnCare last review 05/04/2017

Copyright © Unleashed Technology (Aust) Pty Ltd 2017 Confusion Assessment Method (CAM) Short Form v1.1 20170405

Tool to help differentiate between the symptoms of dementia, delirium, and depression

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

Delirium Risk Factors

A number of factors have been identified that can increase an individual's risk of developing delirium.

Early identification and modification of risk factors can prevent delirium or reduce its intensity.

Predisposing risk factors	Precipitating risk factors
• Age >70 • Pre-existing dementia Severe medical Illness • History of previous delirium • Visual and hearing impairment • Depression • Abnormal sodium, potassium and glucose • Polypharmacy • Alcohol/ Benzodiazepine use • Return from hospitalisation	• Use of physical restraint • Use of indwelling catheter • Adding three or more medications • Multiple bed moves • Pain • Surgery • Anaesthesia and hypoxia • Malnutrition and dehydration

Identify and address the causes of delirium

Obtain History

- Medication ○ recent changes
    - include prescription and over-the-counter medications
- Dehydration – diuretics use, hot weather
- Falls
- Infection
- Bladder and bowel function
- Premorbid cognitive and functional status
- Alcohol history
- Past medical history and comorbidities
- Social history
- History of dietary and fluid intake
- Sensory impairments

This information can be obtained from a number of sources such as documented in medical record from previous admissions and consultation with the person with delirium, their general practitioner and/or carer/family members. People with delirium may provide unreliable histories and information should be sought from family members, GP, residential care staff, etc.

Examination

- Obtain vital signs – temperature, pulse, respirations, blood pressure (lying and standing),
- and oxygen saturation

- Mental state examination
    - Decreased arousal
    - Decreased attention
    - Disorientation
- Neurological observations
    - New signs
- Chest - Auscultation
    - Cough
- Abdomen
    - Palpable faeces/faecal impaction/ listen for bowel sounds
    - Palpable bladder/urinary retention
- Skin Lesions
- - Signs of dehydration

Investigations

The following investigations are used to screen for common causes of delirium:

- Urinalysis and MSU (if urinalysis abnormal)
- Full blood examination
- Urea and electrolytes
- Glucose
- Calcium
- Liver function tests
- Chest x-ray
- Cardiac enzymes
- ECG

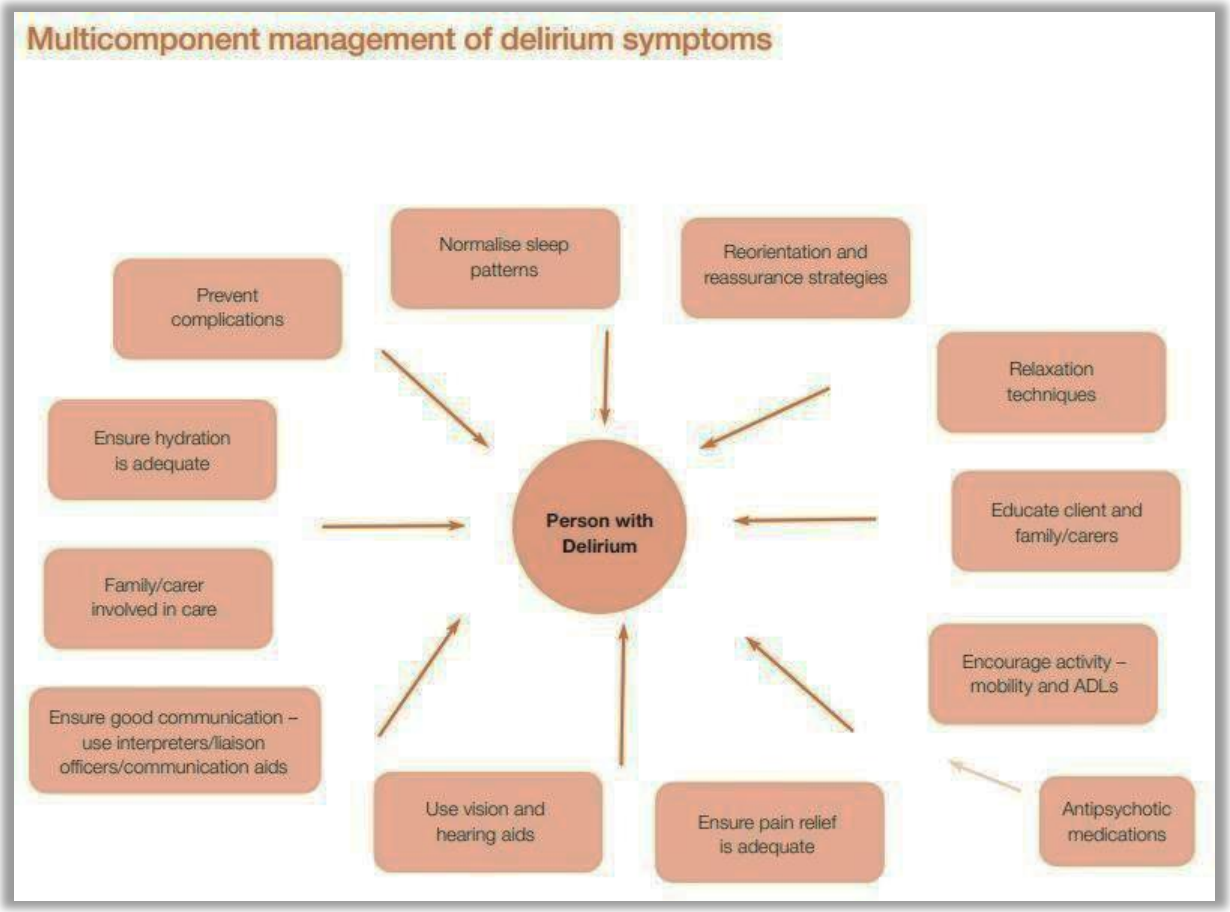
Tips for identifying the cause of delirium

- Start with critical management issues Has hypoxia been ruled out?
- Has hypotension been ruled out?
- Has hypoglycaemia been ruled out?
- Has major electrolyte disturbance been ruled out?
- Has a history regarding all the medications currently taken been obtained?
- Has an infection been ruled out?
- Has urinary retention been ruled out?
- Has constipation and faecal impaction been ruled out?
- If person agitated/distressed; have pain, thirst, and hunger been ruled out?
- Is an alcohol withdrawal syndrome possible?

If delirium is identified

- Inform GP to diagnose delirium
- Implement management strategies of delirium symptoms
- Implement treatment directives by the GP
- Document and review (person may require hospital admission)

Management strategies of delirium symptoms (adapted from Agency for Clinical Innovation, NSW Health, 2019 and Delirium Care Pathways)



Carer /Family involved in care

- Consult the carer / family about their role in the care plan and provide appropriate information (i.e. delirium brochure, dementia fact sheets) support and training.
- Ensure that the carers or family's needs are assessed and supported.
- Be flexible with visiting hours for carers and family members and consider a family roster.

Ensure good communication

- Ensure there is thorough documentation and that a handover of behaviour takes place between each shift.

Ensure wearing of glasses and hearing aids

- Ensure glasses and hearing aids are clean and working.

Ensure adequate pain relief

- Inadequate pain relief can precipitate confusion. Pain should be assessed, monitored and appropriate pain relief administered.
- Opiates can precipitate confusion; they should be used as clinically appropriate and the individual closely monitored.

Antipsychotic medications for severe behavioural disturbance

- Antipsychotics are not effective in the treatment of confusion. Non pharmacological strategies are more effective.
- Antipsychotic medications can be useful for severe behavioural disturbance. They should be used under medical supervision and reviewed.

Encourage activity, mobility and Activities of daily living

- Physical restraints should be avoided, and psychotropic medications should be limited and closely monitored.
- Consider if the older person is at risk of falls.

Provide success based therapeutic activities based on the individual's likes (music, hobbies, reading games) to reduce boredom and frustration, enhance quality of life and cognition. Diversional therapy such as use of rummage boxes are useful for promoting such activities.

Relaxation techniques to help sleeping and reduce anxiety Consider lighting levels and music. *Reorientation and reassurance strategies*

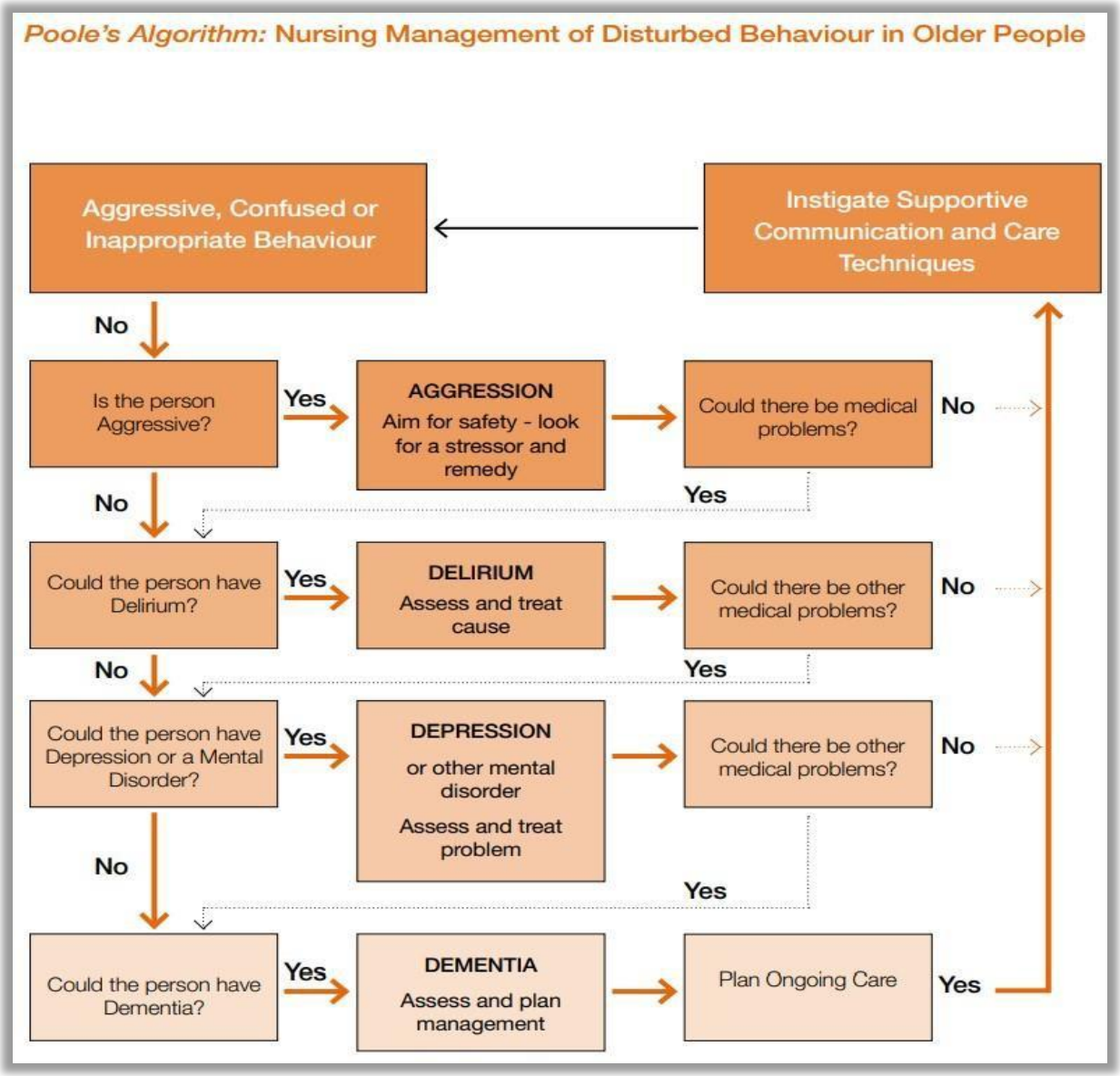
- Involve carers and family in reorientation and reminiscence strategies such as the use of clocks and family photos.
- Create a quiet environment with reduced activity/ stimulation and soft lighting at night (to assist with reorientation).
- Tailor care to the needs of the individual, modify activity and adapt according to need as well as likes and dislike *Normalise sleep patterns*
- Supportive care environments are important. Consider natural lighting during day and a quiet environment with lights turned down at night. *Ensure hydration and nutrition is adequate* Encourage oral fluids.
- Assist with meals as required, including the setting up of meals and opening any packages.

Prevent complications

- Provide timely interventions.
- Closely monitor bowels and use strategies to prevent constipation, manage any signs of constipation early.
- Refer relevant GP, medical staff and allied health in a timely manner
- High observation areas (if possible in residential care) can be used to further assess the individual, minimise harm and provide therapeutic care. *Educate and support older person and family*
- Provide information on confusion, dementia and delirium as appropriate including training for the carer, family, and staff on how to support the older person.

- Provide information on services such as support groups, respite services and other carer support services.
- Provide information in appropriate language, use translators. Be aware of cultural differences.

Nursing Management of Disturbed Behaviour in Older People (adapted from Delirium Care Pathways)



If delirium is problematic to manage

- Refer resident or client for further GP review
- Refer to Escalation of Care Protocols in this Guideline

Identifying Early Stages of Deterioration

Action taken during the early stages of deterioration can prevent further harm to the resident or client. It can also prevent progression of deterioration, admission to hospital and death. Escalation protocols provide timely assistance to residents and clients when deterioration is recognised. They support the team to escalate care until they are satisfied that an effective response has occurred.

Refer to the Guidelines section for information regarding escalation protocols:

- If a resident /client is unresponsive, contact the ambulance (phone 000- triple zero) immediately (not the GP) then call the GP and substitute decision maker.
- If a resident /client seems to be deteriorating and the GP is unable to attend immediately, then the ambulance must be called immediately (000- triple zero)

If the resident/client has any document expressing their future care wishes such as an Advance Care Directive, or a blood transfusion refusal, or an Enduring Guardian, provide the Ambulance with a copy.

Important consideration about capacity

If a resident /client (with capacity) refuses treatment or refuses to go with the Ambulance:

- Explain the risks of refusal of treatment
- Call the GP and the manager to decide on the course of action. Verbal contact must be made with the GP and manager. *Do not rely on email, fax or phone messages*. If the manager cannot be contacted escalate to the next level manager.
- Notify the GP and the manager of the residents/client's condition and observations.
- Check the resident and client care plan to determine if there is a plan of action and wishes documented, e.g. advanced care directive
- Document the discussion with the GP and the resident /client.
- Capacity – it is essential to consult with the GP/family/authorised substitute decision maker at the time deterioration is identified to determine if the resident/client maintains capacity or may be experiencing symptoms and unable to understand that they are unwell and require treatment.

If a resident /client who lacks capacity refuses treatment:

A resident/client that lacks capacity also includes a resident /client whose capacity is uncertain at the time, or the resident /client does not understand that they are unwell or require treatment.

- Team members must follow the steps outlined in this Guideline of escalating the deterioration but must consult with the GP/Manager and the authorised substitute decision maker (this may be the Public Guardian)
- If the resident/client condition requires an ambulance, then the ambulance must be called.
- Capacity can be episodic. A resident /client with capacity may lose capacity when they are unwell or suffering from delirium due to illness and regain capacity when they are no longer unwell.

Advance Care Planning Guidelines

When assessing a medically unwell resident or client, it is important that any Advance Care Plan/Directives (ACP/ACD) are considered if decisions are to be made about treatment. Follow the guidelines below to help in decision-making and care.

1. Can the resident or client make their own decisions about their care? If the resident or client is capable of making their own decisions about their care, it is important that you involve them, their general practitioner, and their family/authorised representative (if requested by the resident) in discussions.
2. Does the resident or client have an Advance Care Plan/Directive? If a resident or client cannot make their own decisions about their care, check if the resident or client has an Advance Care Plan/Directive.

If the resident or client has no Advance Care Plan/Directive:

- Discuss with the resident's or client's authorised representative/family what they believe the resident or client would have wished.
- Involve the resident's or client's general practitioner in all discussions.

If the resident or client does have an Advance Care Plan/Directive:

- Consider if the content of the plan is relevant to the current clinical situation.
- Consider if the documents are current and reflect recent discussions.
- Involve the resident's or client's general practitioner in discussions.
- Involve the resident's client's person responsible/family in discussions.

Intervention

Implement appropriate care for the management of the person's deterioration in line with the general practitioner's orders, and as per the resident's or client's wishes or ACP/ACD and in consultation with their family / representative(s). Refer to the Guidelines in this Manual and/or the relevant Clinical Guidelines, e.g. if the deterioration is due to hypoglycaemia, follow the Clinical Guideline for Diabetes Management.

Offer support and encouragement to the resident/client and their representative(s) by always communicating clearly the actions being taken and the reasons for these actions. Where possible obtain consent.

As soon as practical, document the event, the people involved, and all the actions taken to manage the episode in the residents /clients care notes in Autumn Care (residential) or ComCare (community care). Reassess and continue to monitor the resident or client, ensuring all observations and interventions are documented.

Communication

Communication focuses on two streams: clinical handover and communication with resident/client and/or family/representative(s).

Clinical Handover

Communicate with team members so they are aware of the situation and what actions are required. Ensure that the registered nurse, coordinator and/or manager are kept informed of the resident's or client's condition.

Identify in the clinical handover the resident or client who are at particular risk of deterioration and include communication of information relevant to their management. This information must be documented in Autumn Care Handover, and in the notes. The staff receiving the handover needs to review this documentation and ensure it is understood.

It is recommended to use ISBAR framework (located in Autumn Care) as a communication tool for clinical handover. The ISBAR framework is a standardised approach to communication which can be used when communicating important information regarding the resident's or client's condition to the GP, ambulance and other health professionals. It stands for Introduction, Situation, Background, Assessment and Recommendation. The ISBAR framework ensures completeness of information and reduces the likelihood of missed data, it is an easy and focused way to set expectations for what will be communicated and focuses not on the people who are communicating but on the problem itself.

Communicate verbally with the GP either via phone or in person - **do not email, fax or leave phone messages.** It is essential that contact with the GP is direct. Document all discussions and directions

from the GP in the resident's or client's care notes in AutumnCare or ComCare. Notify the substitute decision maker about the resident/client condition- if this has not been done already. Document this conversation in the resident's or client's care notes. Support the substitute decision maker as required.

Document all actions taken, all consultations with the GP and/or ambulance, all observations, all contact with substitute decision makers, any transfer information and any other relevant information in the resident's or client's care notes.

Complete the required documentation in full for the ambulance transfer (Autumn Care Form –

Hospital Transfer Form, current ACD/P & current medication charts/signing sheets). Provide the

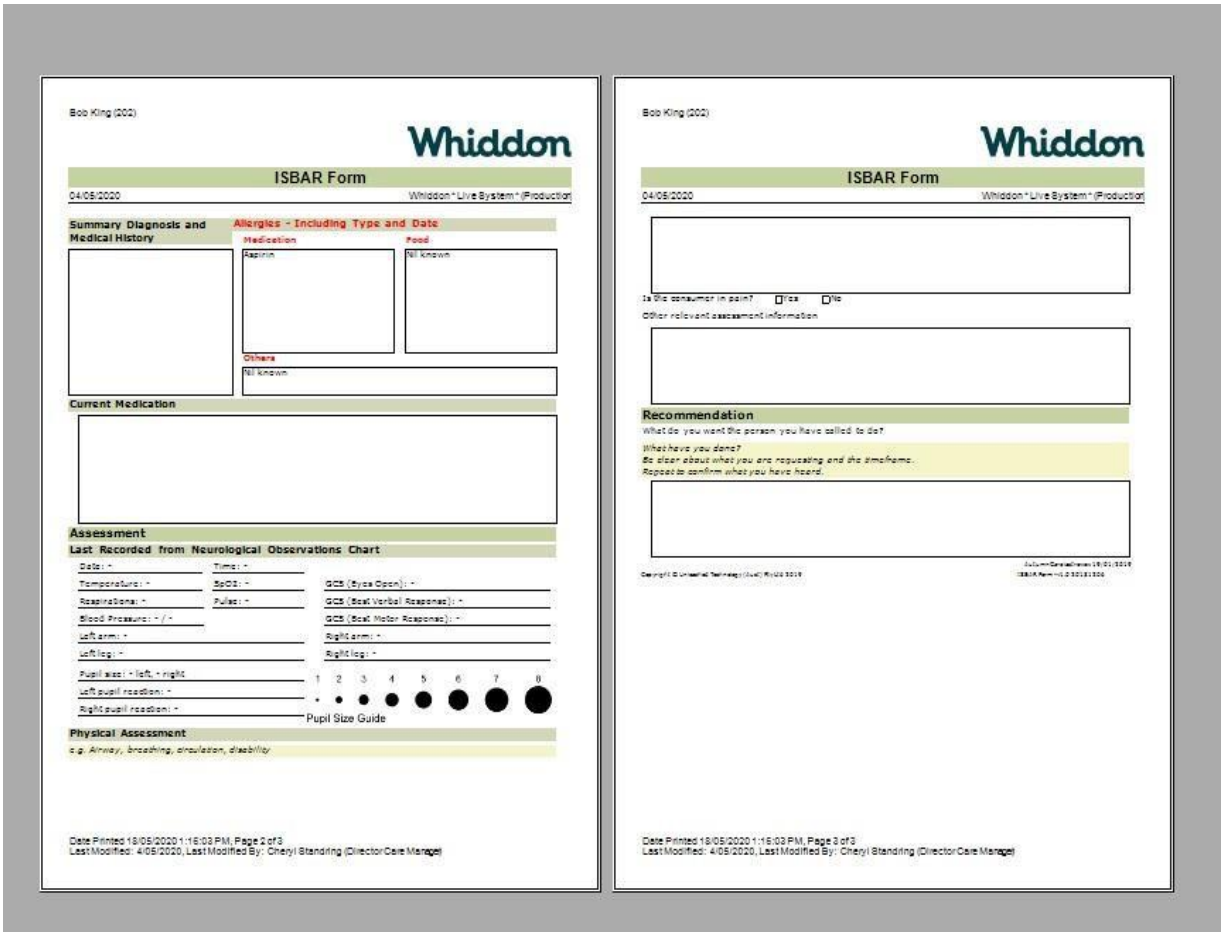
ambulance officer with information related to the resident's or client's wishes such as advanced care

directives and enduring guardians.

Handover information to team members on the following shift or to the coordinator for community

care clients. Provide a verbal report to the person's physical and cognitive conditions including the most recent observations. Reference the electronic clinical record in AutumnCare or ComCare. Include details comparing condition with the resident's or client's previous health condition (such as the before or the week prior) and discuss trends.

Include this in hand over information and changes to the care or treatment plan (care plan), such as frequency of observations, actions to be taken and timeframes for review. Notify team members of who has been notified of the episode and to ensure they are kept up to date (e.g. family/GP).


Bob King (202)

Whiddon

ISBAR Form

04/05/2020 Whiddon * Live System * (Productior

Summary Diagnosis and Medical History

Allergies - Including Type and Date

Medication

Aspirin

Food

Nil known

Others

Nil known

Current Medication

Assessment

Last Recorded from Neurological Observations Chart

Date: * Time: *

Temperature: * SpO2: * GCS (Eyes Open): *

Respirations: * Pulse: * GCS (Best Verbal Response): *

Blood Pressure: * / * GCS (Best Motor Response): *

Left arm: * Right arm: *

Left leg: * Right leg: *

Pupil size: * left, * right

Left pupil reaction: *

Right pupil reaction: *

1 2 3 4 5 6 7 8

Pupil Size Guide

Physical Assessment

e.g. Airway, breathing, circulation, disability

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Last Modified: 4/05/2020, Last Modified By: Cheryl Standring (Director Care Manager

Bob King (202)

Whiddon

ISBAR Form

04/05/2020 Whiddon * Live System * (Productior

Is the consumer in pain? Yes No

Other relevant assessment information

Recommendation

What do you want the person you have called to do?

What have you done?
Be clear about what you are requesting and the timeframe.
Repeat to confirm what you have heard.

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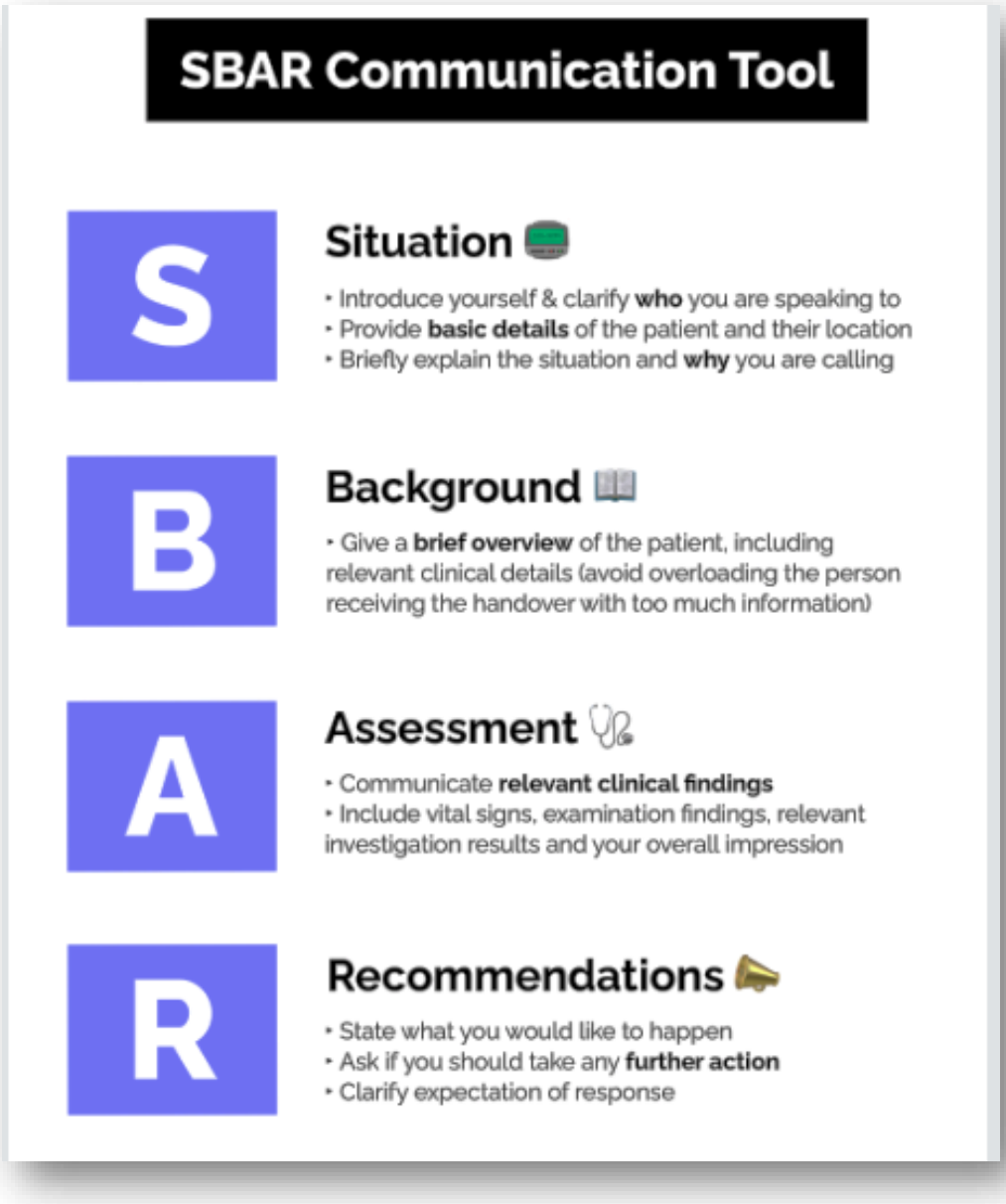
Autumn Care ISBAR Form
ISBAR Communication Tool



Communication with resident/client and/or family/representative(s)

The senior person on duty will ensure the resident/client's family/representative(s) are notified of the resident/client's change in condition as soon as practicable, in line with the resident/client's stated wishes. Ensure communication with the resident or client is calm, clear and respectful. Inform the resident or client of what you are doing and why you are doing it. Ask them how they are feeling and respond appropriately.

The communication with the resident/client and/or family/representative(s) include:

- Recognition that the resident/client's safety and delivery of quality care is person-centred and focused.
- Education of resident/client and/or family/representative(s). The education should

include awareness of the process they can use to escalate care of the resident/client if they are concerned.

- Information about signs of deterioration specific to the resident/client and documentation of this information.
- Information regarding care, and clinical observations; and
- Resident/client's Advance Health / Advance Care Directive and Advance Care Planning

Review and Monitoring

Ongoing Review and Monitoring

The Registered Nurse and/or Enrolled Nurses have a responsibility for the ongoing monitoring of the resident or client with the support of care team members. The Registered Nurse has the overall accountability and responsibility that the appropriate course of action is taken.

Reassess and update the resident's or client's care plan as required. Document the frequency that observations are to be measured.

Visually observe and talk with the resident or client frequently. Instruct a team member to stay with the resident or client if considered appropriate.

If at any point during the interventions, the resident's or client's condition deteriorates, recommence

the sequence of actions from the beginning **(and call an ambulance if required - triple zero -000).**

Adjustments to Frequency of Observations and Assessments

Adjustments to the frequency of observations may occur:

- If the health status of the resident or client changes resulting in a review and assessment by a clinician.
- If on transfer of care (e.g. return from hospital), following review and assessment of the resident or client status by the receiving clinician, an adjustment to the frequency of observations is recommended.
- After an incident, following review and assessment of the resident or client status by a clinician if clinically indicated and appropriate an adjustment to the frequency of observations is recommended.
- When decision to limit or cease some physiological observations are made for resident or client who are in end-of-life phase. This can only be authorised by the resident or client's GP or specialist in reference to the resident or client's advance care plan / advance care directive (if available) and in consultation with the resident or client (where possible) and their representative/s.

It is recommended that this is documented in the resident or client's notes and observation chart.

At the end of treatment

Review and update the resident's or client's assessments and care plan in relation to frequency of monitoring and type of observations to be measured. Continue monitoring the interventions and outcomes to ensure deterioration is not continuing. Increase visual observations of the resident or client for as long as is appropriate.

If the resident's or client's condition is not improving, communicate again with the GP, manager and substitute decision maker and follow all procedures as per clinical guidelines. Document all ongoing observations, assessments, interventions and communications using the electronic care plan or file notes in Autumn Care or ComCare.

Transfer to Hospital

Before Making a Call Regarding an Unwell Resident in Residential Aged Care

First, consider if the GP has been called for advice or review. If the GP has reviewed the resident and made an assessment that they need transferring to hospital, it is still most important that the hospital team receives all the requested information as part of the clinical handover. This is to ensure that the ED meets the resident's clinical needs in line with their goals of care.

Take action in line with the resident's or client's wishes in the event of a deterioration in their condition as per their Advance Care Plan / Advance Care Directive and discussion with their family / representative(s). Refer to Advance Care Planning Guidelines.

Contacting the Ambulance Service

If the GP or the Registered Nurse has determined that a transfer to hospital is required, book the ambulance transfer through the normal processes. An appropriate time frame for transfer is required. *Inform the ambulance service if the transfer is required urgently.*

Be prepared with information to answer the questions you may be asked. These include:

- What is the exact address of the emergency? If there is more than one building on-site, ensure that you provide name of the building the resident is in.
- What is the phone number you are calling from?
- What is the problem, tell me exactly what happened?
- How old is s/he?
- Is s/he conscious?
- Is s/he breathing?

Answering these questions to the best of your ability ensures the ambulance service have the most accurate information about the resident's or client's condition and can assess the situation quickly.

If the resident is being transferred to hospital, make copies of all documents and forms listed below in the Hospital Transfer Information form

Transfer to hospital required (refer to the Hospital Transfer Process Guide in Autumn Care)

If a resident or client needs to be transferred to hospital, call make sure copies of ACP/ACD documents are sent with the resident or client to hospital.

- If any decisions have been made about withholding treatment, ensure this is very clearly communicated in transfer documents.
- Where possible, the transferring general practitioner should phone the hospital and clearly communicate ACP/ACD decisions to the admitting medical officer.

Transfer to hospital not required

If hospital transfer is not required, develop care plans that reflect the needs of the resident or client.

- Make sure there is a clear and comprehensive plan of management in the event that the resident's or client's condition deteriorates further. This plan should include attending to any relevant referrals needed as part of this plan, such as palliative care or other Keep the resident's or client's general practitioner informed.

- Keep all team members informed about the management plan and make sure they are resourced to carry it out.

For all cases

- Make decisions that best reflect the resident's or client's wishes and quality of life.
- Provide clear feedback to the resident or client (if applicable) and authorised representative/family about care decisions.
- Provide information and support to the resident or client (if applicable) and authorised representative/family as required.

PROCESS GUIDE: Recognising Deterioration

Definition:

Acute Deterioration is defined as physiological, psychological or cognitive changes that may indicate a decline of the resident's health status.

Instruction:

- **All care teams are to ensure that if they notice changes in the resident they report directly and in a timely manner to the RN or coordinator, who must escalate this to the GP, and Manager**
- **Clinical judgement and communication with the resident, staff, GP, and authorised representative must**

  be used when deciding if the person's condition appears deteriorating

	Process	Person Responsible	Documentation
Identify	• **Observations that are outside the acceptable (or usual) parameters?** • **Is the change in health status related to preexisting condition?** • **When was the last observation taken?** • **Is there a trend in the observation?** • **Can the resident make their own decision about their care?** • **Does the resident have an Advance Care Directive (ACD)/Advance Care Plan (ACP)?**	**RN / CSM / CCC**	**AC Observation Directive Form** **AC Observation Chart ACD /ACP**
Assess	• **Physiological Observations:** ○ **Respiratory rate**	**RN / CSM / CCC**	**AC Assessments and Charts** **PAS**

	○ Respiratory Effort ○ O^2 Saturation ○ Blood Pressure ○ Heart Rate ○ Level of Consciousness ○ Temperature ○ Pain ○ Blood Glucose Level • Urinalysis / MSU • A-G Assessment: oAirway oBreathing o Circulation ○ Disability ○ Exposure ○ Fluid ○ Glucose • Mental State • Dementia • Delirium • Depression		CAM/Delirium Screening Tool Progress Notes Refer to MyStaffroom: Identifying and Managing the Deteriorating Resident and Client Policy and Relevant Clinical Guidelines
Monitor	• Regular measurement and documentation of physiological observations • Any rapid deterioration in condition should be treated with suspicion • Reassess and update the resident's assessment and care plans as required	RN / CSM / CCC	AC Assessments, Charts, Agreed Care Services Plan Progress Notes

Actions	 	**RN to Implement appropriate care for the management of the resident's deterioration as per GP's order and as per ACD/ACP** **RN to refer to Clinical Guidelines in My Staffroom, e.g. *if the deterioration is due to hypoglycaemia, follow the Clinical Guideline for Diabetes Management*** **In the absence of RN, the GP or ambulance must be called** **If at any point during the interventions, the resident's condition deteriorates, recommence the sequence of assessment and action Call an ambulance if required as per consultation with the GP, resident, authorised representative, and ACD / ACP**	**RN / CSM / CCC**	**AC Agreed Care Services Plan** **ACD / ACP** **Refer to MyStaffroom: Identifying and Managing the Deteriorating Resident and Client Policy and Relevant Clinical Guidelines**
Escalate	 	**Staff to report to the RN any changes in the health status of the resident** **RN to communicate verbally with the GP either via phone or in person – do not email, fax or leave phone messages** **If the acceptable parameters documented by the GP are broad or inappropriate for the resident the RN/coordinator should contact the** **GP to determine safer range and more appropriate parameters**	**RN / CSM / CCC /**	**AC Assessments and Agreed Care Services Plan** **Hospital Transfer Form Progress Notes**

		NB If the consumers GP is unavailable consider review by the ACE Team, Afterhours medical services or Telehealth services. For emergency situations, do not wait ***Call 000*** ***Immediately***		
Liaise	 	**RN to identify in the staff clinical handover (ISBAR Framework) the resident who are at risk of deterioration.** **RN to report the resident's deterioration directly and in a timely manner to the GP and Manager Senior person on duty ensure resident/ family/ authorised representative are notified of the resident's change in condition as soon as practicable.** **Ensure communication with the resident/ family/ authorised representative is calm, clear, and respectful. Ask them how they are feeling and respond accordingly**	**RN / CSM / CCC /**	**AC Handover Progress Notes**

PROCESS GUIDE: Exposure Hypothermia

Definition:

Hypothermia occurs when the body temperature is below 35°C. This can develop with prolonged exposure to temperatures under 10°C, or after prolonged immersion in cold water of less than 20°C

A temperature below 32°C is life threatening.

Instruction:

- **Some people are more at risk of hypothermia due to other medical conditions**
- **People over the age of 75 years are at higher risk of hypothermia**

	Process	Person Responsible	Documentation
Identify	• **Has there been an incident or situation that may lead you to believe that the consumer could be suffering from exposure-*hypothermia* e.g. Outside for a long period of time, long lay on bathroom floor following a fall.** • **Observations that are outside the acceptable (or usual) parameters?** • **The first signs usually include feeling cold and uncontrollable shivering. If the person progresses into severe** • **The person may feel exhausted, and their skin may be cool and pale** • **As Hypothermia advances, other symptoms include fumbling hands, unsteady gait, slurred speech, confusion and drowsiness** • **Symptoms of severe hypothermia include slowing of the heartrate, breathing, dilated pupils and come.**	**RN / CSM / CCC**	**AC Observation Directive Form** **AC Observation Chart** **ACD /ACP**

	• Mild hypothermia is considered when the persons temperature is 32-35°C • Severe hypothermia is when a person's temperature is below 32°C		
Assess	• **Physiological Observations:** ○ Temperature ○ Respiratory Rate ○ Respiratory Effort ○ O^2 Saturation ○ Blood Pressure ○ Heart Rate ○ Level of Consciousness ○ Skin inspection ○ Blood Glucose Level •	RN / CSM / CCC	AC Assessments and Charts Neuro Observations Chart, BGL Chart Refer to MyStaffroom: Identifying and Managing the Deteriorating Resident and Client Policy and Relevant Clinical Guidelines
Monitor	• Regular measurement and documentation of physiological observations • Any rapid deterioration in condition should be treated with suspicion • Reassess and update the resident's assessment • and care plans as required	RN / CSM / CCC	AC Assessments, Charts, Agreed Care Services Plan Progress Notes
Actions	☐ RN to Implement appropriate care for the management of the resident's deterioration as per GP's order and as per ACD/ACP ☐ Move the person out of the cold, and remove any wet clothing ☐ Warm the person at the centre of the body (chest, neck, head and groin) ☐ Do not use direct heat, use heat packs wrapped in towels		RN / CSM / CCC

	☐ Do not massage or rub the person ☐ Keep the person still ☐ If the person is awake-offer warm drinks- do not offer Alcohol ☐ If the person appears dead, start CPR while the person is warming.	
Escalate	☐ For even mild hypothermia an Ambulance should ☐ be called ☐ GP to be notified of all incidents when an ☐ environmental exposure has occurred even if ☐ this does not meet the criteria of mild or severe ☐ hypothermia	RN / CSM / CCC /
Liaise	RN to report the resident's deterioration directly and in a timely manner to the GP and Manager Senior person on duty ensure resident/ family/ authorised representative are notified of the resident's change in condition as soon as practicable. Ensure communication with the resident/ family/ authorised representative is calm, clear, and respectful. Ask them how they are feeling and respond accordingly.	RN / CSM / CCC

PROCESS GUIDE: Exposure 1. Heat Exhaustion and 2. Heat Stroke

Definition:

1. **Heat exhaustions is a mild to moderate illness caused by water or salt depletion, that results from exposure to high heat or strenuous physical exercise.**
2. **Heatstroke is a severe illness where a person's temperature is greater than 40°C, and the person is experiencing delirium (confusion), convulsions, or coma, resulting from exposure to high heat or strenuous physical exercise**

Identify

Assess	• **Physiological Observations:** ○ **Temperature** ○ **Respiratory Rate** ○ **Respiratory Effort** ○ **O^2 Saturation** ○ **Blood Pressure** ○ **Heart Rate** ○ **Level of Consciousness** ○ **Skin inspection** ○ **Blood Glucose Level**	**RN / CSM /CCC**	**AC Assessments and Charts** **Neuro Observations Chart, BGL Chart** **Refer to MyStaffroom: Identifying and Managing the Deteriorating Resident and Client Policy and Relevant Clinical Guidelines**
Monitor	• **Regular measurement and documentation of physiological observations** • **Any rapid deterioration in condition should be treated with suspicion** • **Reassess and update the resident's assessment and care plans as required**	**RN / CSM / CCC**	**AC Assessments, Charts, Agreed Care Services Plan** **Progress Notes**
Actions	**RN to Implement appropriate care for the management of the resident's deterioration as per GP's order and as per ACD/ACP** **Move the person out of the heat, place in cool area, sponge down with cold compress.** **Place cold compress over the centre of the body (chest, neck, head and groin)** **Use a fan to help cool the person**	**RN / CSM / CCC**	**AC Agreed Care Services Plan** **ACD / ACP** **Refer to MyStaffroom: Identifying and Managing the Deteriorating Resident and Client Policy and Relevant Clinical Guidelines**

	If the person is awake-offer small sips of cool water or ice chips. Do not give Panadol **Closely monitor the persons Airway in case the person vomits and aspirates**		
Escalate	☐ **The elderly person may deteriorate quickly as a result of both Heat Exhaustion and Heat Stroke therefore an Ambulance should be called.** ☐ **GP to be notified of all incidents when an environmental exposure leading to either Heat Exhaustion or Heat Stroke.** ☐ **RN to report the resident's deterioration directly and in a timely manner to the GP and Manager Senior person on duty ensure resident/ family/ authorised representative are notified of the resident's change in condition as soon as practicable.** ☐ **Ensure communication with the resident/ family/ authorised representative is calm, clear, and respectful.** ☐ **Ask them how they are feeling and respond accordingly.**	**RN / CSM / CCC**	**AC Handover Progress Notes**

Reference

- Agency for Clinical Innovation, NSW Health. (2019). Management of the older person with confusion, accessed from: https://www.aci.health.nsw.gov.au/chops/chops- keyprinciples/management-of-older-people-with-confusion/management-strategies
- Australian Commission on Safety and Quality in Health Care. (2017). National Consensus Statement: Essential elements for recognising & responding to acute physiological deterioration.
- Care Search, AKPS, accessed from: https://www.caresearch.com.au/caresearch/tabid/3390/Default.aspx#AKPS
- Department of Health and Ageing. (2011). Delirium Care Pathways
- End of life Directions for Aged Care. (2017). Respond to Deterioration
- NSW Health. (2020). Clinical Handover
- NSW Health. (2020). Deteriorating Patients
- NSW Health. (2020). Assessing the Deteriorating Resident - DETECT for RACFs
- NSW Health (2013), Heat related illness including heat stroke
- NSW Health (2022), Hypothermia
- SA Health (2022), Heat Exhaustion and Heat Stroke