Sydney Local Health District (SLHD) Clinical Support Guidelines for Residential Aged Care Facilities (RACFs)

A guide for making decisions about unwell residents and their referral to SLHD RACF Outreach Service

For clinical triage and advice contact Access Care Team (ACT)

Phone: 1300 722 276

1 Section
Medical Emergencies

2 Section
Clinical Advice

3 Section
Other Resources and Tools

✓ Right Care
✓ Right Time
✓ Right Place

NSW GOVERNMENT Health
Sydney Local Health District

Before phoning the Access Care Team (ACT) consider:

- Is the GP aware?
- What is the main problem and recent changes that require assessment and intervention?
- What advice or intervention do you think is required?
- Resident's notes including relevant medical history
- Recent or current observations
- Resident's medication chart
- Advance Care Plan/Directive
- Ambulance Authorised Palliative Care Plan
- Using the ISBAR handover tool

These guidelines are provided for information only.

While SLHD have made every effort to make sure the information in this guide is accurate and informative, the information does not take the place of professional or medical advice. Any resident requiring medical advice or treatment should be referred to their treating General Practitioner, (GP).

SLHD and the authors of this guide do not accept any liability for any injury, loss or damage caused by the use of the information in this document.

Acknowledgement:

This resource has been compiled adapting from the Acute Care Decision Guidelines produced by the Murrumbidgee Local Health District and PHN.
The original Emergency Decision Guidelines were developed by the Southern Tasmania Area Health and Ku-ring-gai Health Services.

Foreword

The Residential Aged Care Facility (RACF) Outreach Service is a District-wide initiative which recognises and responds to the clear need for improved access to high quality healthcare for residents of aged care facilities. The RACF Outreach model allows our team to work in partnership with families and staff in residential aged care facilities, alongside GPs and existing services within Sydney Local Health District, to provide the most appropriate coordinated care, in the right setting for the person at the time.

These Clinical Support Guidelines have been developed in collaboration with staff, consumers, and GPs from Residential Aged Care Facilities, GP practices and communities throughout Sydney Local Health District.

The guidelines support our Model of Care for RACF Outreach in Sydney Local Health District. The aim of the model of care is to provide excellent, integrated care between acute and community services with a focus on ensuring our residents, their families and carers are at the heart of everything we do.

We hope that the information in the guidelines will support you in making decisions to provide excellent care for our residents and their loved ones and we look forward to continuing to work in partnership to provide care in the right place, at the right time, every time.

Dr Teresa Anderson AM
Chief Executive
Sydney Local Health District

Section 1:
Medical Emergencies

Is this a Medical Emergency?

- Sudden collapse or loss of consciousness
- Chest pain
- Breathing difficulty
- CVA/Stroke: sudden onset weakness, numbness, paralysis, language changes, expressive aphasia and co-ordination changes
- Injury with suspected fracture or limb deformity
- Uncontrollable bleeding
- Unexplained seizures
- Severe burn
- Fall from height
- Severe abdominal pain

Is this resident for Active or Palliative treatment?

Is there an Advanced Care Plan/Directive?

Is there a NSW Ambulance Authorised Palliative Care Plan?

If this is a medical emergency
and the plan of care is to transfer the resident to hospital

Call an Ambulance "000"

(see DRSABCD guide overleaf)

If the plan of care is to remain in facility ensure resident is comfortable.

Discuss next steps with GP / ACT / family

DRSABCD Guide

Sudden collapse or loss of consciousness?

DRSABCD Action Plan

In an emergency **call triple zero (000)** and ask for an ambulance

D DANGER

Ensure the area is safe for yourself, others and the patient

↓

R RESPONSE

Check for response—ask name—squeeze shoulders

No response

↓

Response
Make comfortable
Monitor response

S SEND for help

Call triple zero (000) for an ambulance
or ask another person to make the call

↓

A AIRWAY

Open mouth—if foreign material present
Place in recovery position
Clear airway with fingers

↓

B BREATHING

Check for breathing—look, listen, feel

Not normal breathing
Start CPR

↓

Normal breathing
Place in recovery position
Monitor breathing

C CPR

Start CPR—30 chest compressions : 2 breaths
Continue CPR until help arrives
or patient recovers

↓

D DEFIBRILLATION

Apply defibrillator if available
and follow voice prompts

St John

Clinical Guidelines for recognising a deteriorating resident

Life threatening conditions include	Red (danger)	Yellow (caution)
Breathing difficulties	Respiratory Rate **≤5/min or ≥30/min**	Respiratory Rate **≤10/min or ≥25/min**
Chest pain or chest tightness	Respiratory Effort **Obvious distress and/or cyanosis**	Respiratory effort **Unusually laboured or noisy breathing**
Sudden onset of weakness, numbness or paralysis of the face, arm or leg	Level of responsiveness **Responding to painful stimuli or Unresponsive**	Level of responsiveness **Responding to verbal stimuli**
Unconsciousness	Heart Rate **≤40/min or ≥140/min**	Heart Rate **≤50/min or ≥120/min**
Uncontrollable bleeding	Systolic Blood Pressure **≤90mmHg systolic or ≥200mmHg systolic**	Systolic Blood Pressure **≤100mmHg systolic or ≥180mmHg systolic**
Sudden collapse or unexplained fall	Blood Glucose Level **≤4mmol & unresponsive or ≥28mmol or HI**	Blood Glucose Level **≤4mmol or ≥14mmol and responsive**
Unexplained fitting		Temperature **≤35.5° or ≥38.5°**
Severe burns		

A to G Assessment

(comprehensive assessment for deteriorating resident)

		Look	Listen	Feel
A	**Airway** Take note of accessory muscles, speech, extra sounds, wheeze. Tracheal tug present?			
B	**Breathing** Conscious, respiratory rate (count 1 minute). Take note of chest movements, bilateral air entry. Respiratory distress present? Check – Oxygen saturation			
C	**Circulation** Take note of skin colour – pale, cyanosis, jugular venous pressure, warm hands and feet, pulse rate and rhythm, blood pressure, fluid balance, urine output and colour			
D	**Disability (neurological assessment)** Neuro obs – pupils, facial symmetry, limb movements, slurred speech, plantar reflexes, change in level of consciousness – See Glasgow Coma Scale			
E	**Exposure** Bleeding, rash, bruising, wounds, check drains, bags and bottles, aspirates. Look underneath the resident.			
F	**Fluids** Check fluid chart, check drains/tubes outputs, skin turgor, central venous pressure			
G	**Glucose** Confusion, sweaty, loss of consciousness Conduct – Blood Glucose Level (give glucose if below 3mmol/L)			

Give oxygen if required

Position your resident

Call for help if you can't manage

Never leave a deteriorating resident without a priority management and review plan

Communicating with your healthcare team: Access Care Team, General Practitioner, NSW Ambulance

Clinical deterioration	
Introduction	• Introduce yourself, your role and location • Identify the resident
Situation	• State the immediate clinical situation
Background	• Provide relevant clinical history and background, including medical history • Presenting problems
Assessment	• Work through A–G physical assessment • What clinical observations are of particular concern? • What do you think the problem is? • Do you have current observations and information ready?
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 time frame • Repeat to confirm what you have heard

ISBAR form

Identify

Firstly identify your name and where you are calling from

Resident information

Full name _____

D.O.B _____

Allergies _____

Situation

State why you are calling _____

What is currently happening _____

Is a palliative care plan in place Yes ☐ No ☐

Is an Advanced Care Plan/Directive in place Yes ☐ No ☐

Background

Date and time of event _____

History of event _____

Brief Medical History _____

Medications _____

Brief summary of action taken/interventions tried _____

Assessment

Temperature: _____ Pulse: _____ regular / irregular

Respiration rate: _____ per min SaO2: _____ Usual SaO2: ____

Current BP: ____ / ____ Usual BP: ____ / ____

Blood glucose level if diabetic: _____

Urinalysis: _____

Urine output: _____ Similar/less/more

Pain: Yes/No Location: _____ Pain score (0–10): ____

Date last seen by GP: _____

- Recent treatment for infection or hospitalisation?
- Confusion/change in alertness?
- Medication/treatments given to relieve symptoms?

Request

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

Have you contacted GP? Yes ☐ No ☐

Have you contacted family? Yes ☐ No ☐

Recommendations for transferring a resident to hospital

When transferring a resident to hospital, send the following

Copy of the completed ISBAR form (page 11)

- Include Clinical Handover Form in CESPHN Yellow Envelope (see page 47–48)
- Copy of the medication charts, GP management plan or other important documentation (including from private specialist)
- Advance Care Plan/Directive
- RACF Transfer Form if your facility has one
- Full set of observations
- Advise if resident is associated with possible or confirmed infectious outbreaks

Please advise if the carer or family has been notified

Section 2:
Clinical Advice

Abdominal Problems

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

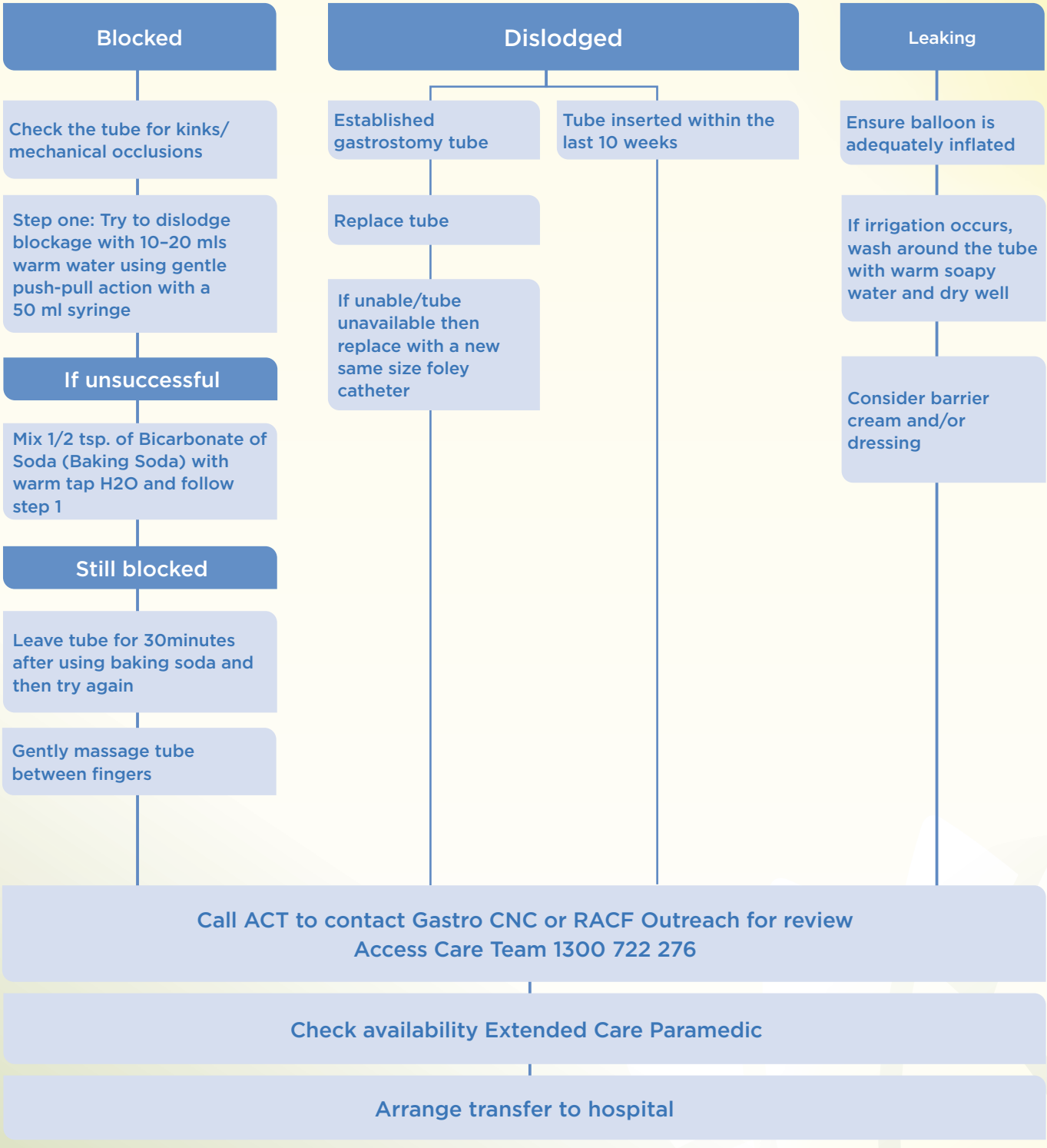
Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	If one or more of the following is present: • Severe abdominal pain – use pain score or Scale (see pages 38–40) • Distended or bloated abdomen and has not been able to pass wind 12–24 hours • Persistent vomiting	• Conduct full A–G Assessment (page 9) • Medical Emergency: Ambulance 000 (do not wait for GP) or, • Contact GP for care instructions (if after-hours phone on-call GP) • Contact family
Act within 12 hours	• Bowels not open within the last 72 hours (constipation) • Bowel motions hard or pellet-like (constipation) • Streaking of blood in resident's motions • Bowels not opened for 72 hours with associated nausea or decreased oral intake	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions • Call ACT on 1300 722 276 • Contact family
While waiting for help	• Consider possible Gastroenteritis Outbreak • Consider starting nil by mouth until GP contacted or transferred to hospital • If vomiting call GP as subcutaneous / intravenous fluid may be required • Refer to facility documentation for bowel action and changes observed (e.g. Aperients and nurse initiated enemas if constipation is suspected) • Medication as prescribed (with sips of fluid) • Look for a change in pain or bowel medication and document • Consider the possibility of urinary retention and palpate/percuss or scan bladder	**Tips:** • Position as comfortable

Gastrostomy Tubes Flowchart (troubleshooting)



If your RACF has residents with Gastrostomy tubes in situ, please ensure there are spare stock available for replacements. Please take care with PEG, Enfit instructions to preserve connections.

Behaviour Management

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

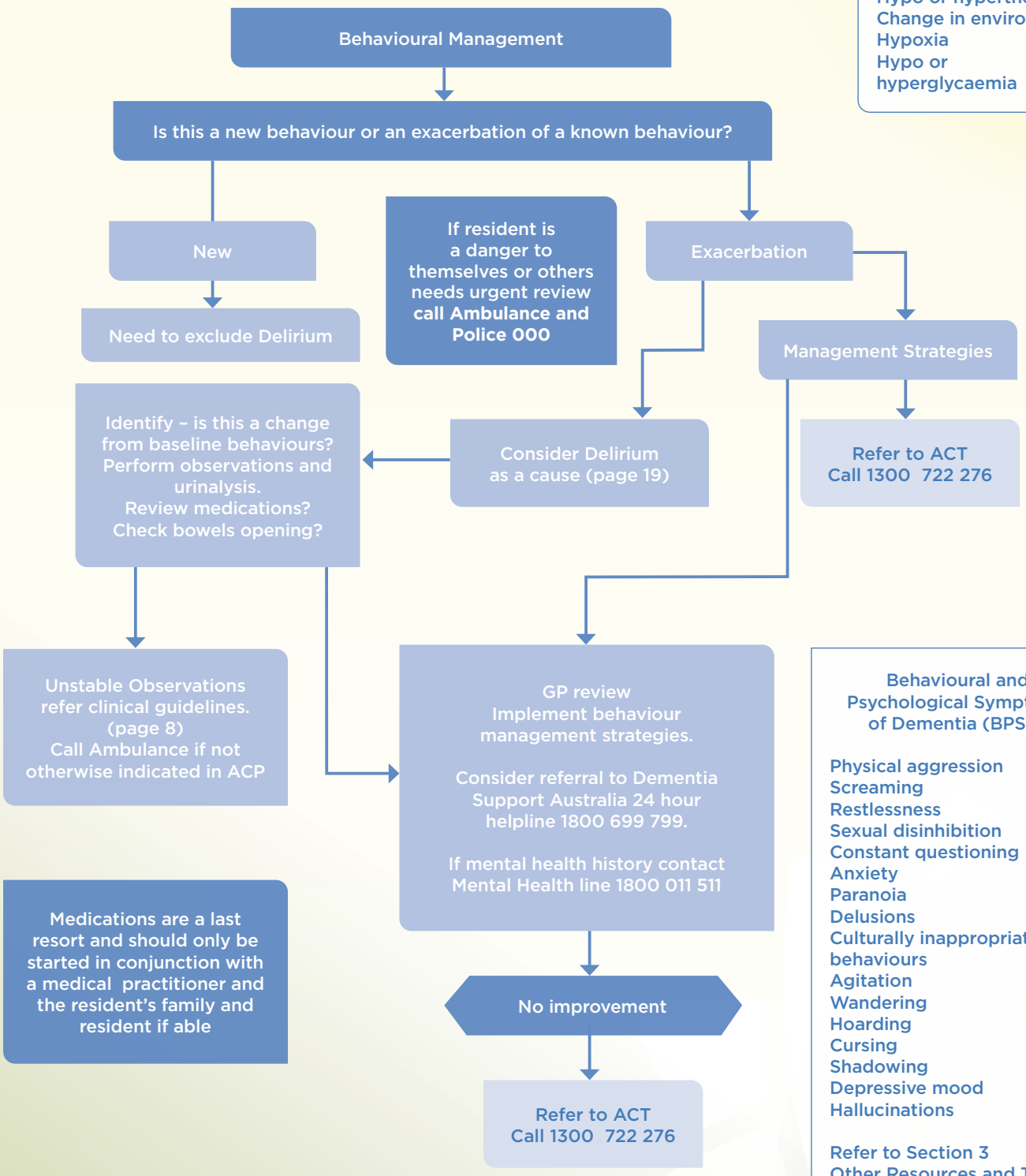
Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	• Acute onset • Risk to themselves, others or staff with attempts to de-escalate the behaviour unsuccessful (e.g. suicidal, violence verbal or physical) • Consider Stroke / CVA: FAST (stroke) positive (Face, Arms, Speech, Time) See FAST assessment resource (page 35)	• Conduct full A–G Assessment if resident is calm (page 9) • Medical Emergency: Call an ambulance Triple Zero (000) (do not wait for GP) or, • Contact GP for care instructions (if after hours phone on-call GP) • Contact family
Act within 12 hours	• Change in usual level of function from "baseline" behaviours • Increased night-time confusion or wandering 'sun downing' • Increase or fluctuations in confusion • Behavioural changes e.g. anxiousness, wandering, calling out, aggressiveness, hallucinations: auditory, visual (refer to behaviour management flow chart (overleaf)	• Conduct full A–G Assessment if resident is calm (page 9) • Contact GP for care instructions • Call ACT on 1300 722 276 • Contact family • Contact Mental Health line on 1800 011 511 if appropriate/history for referral to SMHSOPs (Specialist Mental Health Service for Older People) • Call Dementia Support Australia on 1800 699 799
While waiting for help	• Consider Delirium and investigate (check bloods, Blood Glucose Level, Urinalysis) • Perform full set of observations • Avoid sedation and review medications • Consider neurological changes • Remain with resident and continue to monitor • Change the environment • Provide emotional support • Identify potential triggers (e.g. pain, note pain scales (see page 38–40), Constipation, dehydration, recent injuries, e.g. possible fracture) • Monitor effectiveness of medications • Consider UTI • Inform family	**Tips:** • Identify causes for behaviour • Check: hydration, oral intake • Dentures, hearing aids • Assess for pain • Bowels open? • Any new medication or changes to medication • Perform a urine dipstick and get sample • Initiate falls prevention strategies

Behaviour Flow Chart



Causes of Delirium

- Infection
- Dehydration
- Acute blood loss
- Fluid overload
- Medications
- Urinary or bowel issues
- Hypo or hyperthermia
- Change in environment
- Hypoxia
- Hypo or hyperglycaemia

Behavioural and Psychological Symptoms of Dementia (BPSD)

- Physical aggression
- Screaming
- Restlessness
- Sexual disinhibition
- Constant questioning
- Anxiety
- Paranoia
- Delusions
- Culturally inappropriate behaviours
- Agitation
- Wandering
- Hoarding
- Cursing
- Shadowing
- Depressive mood
- Hallucinations

Refer to Section 3 Other Resources and Tools (pages 32-34)

Behaviour Management Strategies

Environmental strategies	Clinical Practice strategies
• Lighting appropriate to time of day – windows with a view to outside, curtains and blinds open during the day, and minimal lighting at night may reduce disorientation • Provision of single room – reduces the disturbance caused by staff attending other residents in the same room • Quiet environment especially at rest times – noise reduction strategies (e.g.: use of vibrating pagers rather than call bells) • Provision of clock and calendar that residents can see • Encourage family and carer involvement – includes encouraging them to visit • Encourage family/carer to bring in resident's personal and familiar objects • Avoid room changes – frequent changes may increase disorientation	• Encourage/assist with eating and drinking to ensure adequate intake • Ensure that residents who usually wear hearing and visual aids are assisted to use them • Regulation of bowel function – avoid constipation • Encourage and assist with regular mobilisation • Encourage independence in basic ADLs • Medication review • Promote relaxation and sufficient sleep – can be assisted by regular mobilisation, massage, encouraging wakefulness during the day • Manage discomfort or pain • Provide orienting information including name and role of staff members • Minimise use of indwelling catheters • Avoid use of physical restraints • Avoid psychoactive drugs • Use of interpreters and other communication aids for Culturally And Linguistically Diverse (CALD) residents/clients • Use of Aboriginal and Torres Strait Islander (ATSI) liaison officer for ATSI populations • Diversional Activities

Delirium

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care plan/directive which may alter the management of the resident.

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

Tips to check

- Check bowel chart for constipation / diarrhoea; check fluid / diet records
- Ensure pain is controlled
- Complete dipstick urinalysis; check skin integrity / wounds for signs of cellulitis / infection
- Have there been any changes to medication in the last month?
- If source of infection is identified, contact GP for pathology order and send sample to pathology
- There may be more than one cause
- Refer Behaviour Management tips (page 16)

	Symptoms present	Your interventions
Act now	If confusion (including hallucinations and delusions) is an acute onset **OR** change in level of consciousness **AND** one or more of the following: • They pose an immediate risk to themselves, to other residents or to staff because of significant behavioural changes • Moderate – severe pain (following use of breakthrough / nurse initiated pain relief)	• Conduct full A-G assessment (page 9) • Contact GP for care instructions (if afterhours phone on call GP) • If required call Ambulance (do not wait for GP to come back with instructions) • Contact family • Call ACT to discuss options for review in facility 1300 722 276
Act within 12 hours	If the resident has any of these symptoms: • Change in usual level of function • Increase or fluctuations in confusion; increased night-time confusion • Behavioural changes e.g. anxiousness, wandering, calling out, aggressiveness • Hallucinations e.g. auditory, visual such as seeing something that isn't there	• Conduct full A-G assessment (page 9) • Contact GP for care instructions (if afterhours phone on call GP) • Contact family • Call ACT 1300 722 276
While waiting for help	• Avoid sedation; offer emotional support; monitor for falls	

Dehydration

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	Unable to drink AND one or more of the following: • Persistent vomiting and or diarrhoea after 8 hours • Passed no or little urine for 12 hours (less than 1–1.5 litres) • Reduced Level Of Consciousness (LOC)	• Conduct full A–G Assessment (page 9) • Medical Emergency: Ambulance 000 (do not wait for GP) or, • Contact GP for care instructions (if after hours phone on-call GP) • Contact family • Call ACT 1300 722 276
Act within 12 hours	• Decreased intake of food or fluid • Decreasing urine output and concentrated urine • Dry mouth and tongue • Decreased appetite • Increasing drowsiness	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions • Call ACT on 1300 722 276 • Contact family
While waiting for help	• Consider possible Gastroenteritis Outbreak (as per page 37) • If the resident is choking / coughing when sipping water DO NOT give oral fluids • If able to swallow, try half a glass of rehydration solution (e.g. 1/4 strength lemonade, electrolyte solution) every 30 minutes or ice chips/ block to suck or contact GP to consider commencement Subcutaneous fluids (in particular for suspected Gastroenteritis Outbreak). • Monitor vital signs	**Tips:** • Mouth care • Keep resident warm but not too hot

Falls

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	If the resident has had a fall AND if one or more of the following is present: • Unconscious, fluctuating consciousness or increasing confusion • Associated increasing pain, including pain on movement • Visible shortening, deformation and rotation of limb upon inspection • Unable to lift limb off the bed and/or rotate as usual • Check if taking anticoagulant or antiplatelet therapy where head injury cannot be ruled out • Severe bruising, laceration or bleeding	• Conduct full A–G Assessment (page 9) • Medical Emergency: Call an ambulance Triple Zero (000) (Do not wait for GP) or, • Contact GP for care instructions (if after hours phone on call GP) • Contact family
Act within 12 hours	If resident has any of these symptoms: • Increasing pain (see pain scales, (pages 38–40) or reduced or reducing movement of limb. • Change in level of consciousness or increasing confusion or headache or vomiting (concussion) • Note there may be late signs/symptoms (as above) of a head injury after 24 hours i.e. unconsciousness, fluctuating or increasing confusion or consciousness • Moderate bruising, laceration or bleeding • Consider mobile X-ray	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions (if after hours phone on call GP) • Call ACT on 1300 722 276 • Contact family
While waiting for help	If unwitnessed fall or head injury is suspected – do neurological observations as per RACF guidelines • Once assessed, stay with resident and keep as comfortable as possible/position appropriately • RICE (Rest, Ice, Compression, Elevation) for affected area • Laceration: apply pressure to stop bleeding, dress appropriately • If safe to do so, assist with transferring to bed or chair • Consider Extended Care Paramedic (ECP) for skin gluing or suturing • Check observations: blood pressure, respiratory rate, oxygen saturation, blood glucose level & urinalysis • Review for pain and give analgesia	**Tips:** • Discuss strategies to reduce falls risk with family e.g. Check footwear, visual aids, mobility aids • Review current medications for any new or change in medications • Implement falls prevention assessment/interventions as per RACF guidelines

Pain Management

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

Assessment Tips:

- Description of pain: sharp, dull, shooting, pins and needles
- When did it start, how long has it lasted?
- Where is the pain?
- What eased or stopped the pain?

Consider medical history e.g. whether resident is experiencing acute or chronic pain, consider if resident is Palliative, and referral appropriate to Palliative Care Service via ACT for assistance with pain management.

	Symptoms present	Your interventions
Act now	• Moderate to severe pain unrelieved with regular and breakthrough / nurse initiated analgesia (see PAINAID or Visual Analogue Scale) (page 38–40) • If Goals of Care are palliative, give prescribed medication as needed for symptom management and call GP or ACT for appropriate referral pathway. • If the resident is requiring PRN medication every 1–2 hours, this may indicate they need escalation for review (GP or ACT)	• Conduct full A–G Assessment (page 9) • Medical Emergency: Ambulance 000 (do not wait for GP) or, • Contact GP for care instructions (if after hours phone on call GP) • Contact family
Act within 12 hours	• Increasing pain or moderate pain (see PAINAID and Visual Analogue Scale) (page 38–40) • Consider escalation of behaviours could be related to pain • If the resident is requiring PRN medication every 3–4 hours. This may indicate they need a more timely review (GP or ACT)	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions • Call ACT 1300 722 276 • Contact family
While waiting for help	• Non-pharmacological methods such as heat or cold packs (as per RACF guidelines, music, massage, distraction techniques) • First aid for any new injury: 'RICE': rest, 'ice' (cold packs), compression, elevation	**Tips:** • Make resident as comfortable as possible • Does pain medication need review? • When was the last pain relief given and what dosage? Was the strength appropriate? • Check for any religious / spiritual support (especially when Palliative) • When did the resident open their bowels last? • Consider constipation may reduce effectiveness of oral pain medications

Palliative Care and End of Life (EOL)

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Palliative care is an approach that improves the quality of life of residents and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO, July 2018, **www.who.int/cancer/palliative/definition/en/**)

- Not all palliative care is EOL
- Not all EOL requires specialist Palliative Care input
- All RACFs and GPs are encouraged to assist residents and their families with Advance Care Plans or Directives on admission to the RACF and when significant clinical changes to the resident's condition have occurred.
- The SDN Palliative Care and RACF Outreach teams are here to support where needed
- To access palliative care support contact **ACT 1300 722 276**
- Refer to SLHD **"My Wishes"** website for palliative care documents: **www.slhd.nsw.gov.au/myWishes/**

  www.slhd.nsw.gov.au/btf/pdfs/Amb/Adult_Palliative_Care_Plan.pdf

Palliative Care and End of Life (EOL)

	Symptoms present	Your interventions
Act now	• Moderate to severe pain unrelieved with regular and breakthrough / nurse initiated analgesia (see PAINAID and Visual Analogue Scale (see pages 38–40) • Unstable: agitation, distress • Decreased level of consciousness, unable to swallow (can signify EOL) • If the resident is requiring PRN medication for pain relief every 1–2 hours, this may indicate they need a more timely review (GP or ACT) • When Goals of Care are palliative, give prescribed medication as needed for symptom management.	Check resident's recent history (e.g. signs of infection/UTI) and any change in medication (e.g. increase in opioids) for any reversible conditions. If symptoms are reversible (not EOL) conduct full A–G Assessment (page 9) If symptoms indicate EOL, initiate EOL (palliative) plan If unable to stabilise or manage symptoms: • Check for Ambulance Authorised Palliative Care Plan • Medical Emergency: Call an ambulance (000) • Call ACT 1300 722 276 for appropriate referral pathway and to start EOL (palliative) Care • Contact GP (or after hours GP) • Give PRN Medications for symptom management • Contact family
Act within 12 hours	• Increasing restlessness, agitation, pain (e.g. groaning, moaning) • Reduced Alertness, Verbal responses, increasing Pain, Unresponsiveness (AVPU) • Fluctuating consciousness but comfortable • Reduced level of function: reduced oral intake, dehydration • If the resident is requiring PRN medication for pain relief every 3–4 hours. This may indicate they need a more timely review (GP or ACT)	• Contact GP for care instructions (if after hours phone on call GP) • Call ACT on 1300 722 276 • Initiate EOL plan (ensuring all reversible causes have been checked and addressed before initiating) • Contact family
While waiting for help	• For EOL symptoms, initiate EOL plan • Focus on EOL Goals of care • Maintain resident's comfort • Mouth care • Pressure Area Care • Pain management (page 22) • Review bowels and consider constipation • Medication review (de-prescribe) • Check subcutaneous medications orders (agitation and cannot swallow) • Non-pharmacological measures: music, aromatherapy, spiritual and cultural preferences • Bereavement support	**Tips:** • Pre-organise EOL subcutaneous medications prior to EOL stage (as these can take up to 48 hours to organise) • Identify any possible reversible causes for distress • Identify EOL plan • To assist with breathing, position is important, tilt the head of the bed 30 degrees • Check for Ambulance Authorised Palliative Care Plan

Sepsis

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone ***See Clinical Observations (page 8)*** Medical Emergency – Call 000	**Medical Review** ***See Clinical Observations (page 8)*** • Contact GP/After hours GP • Call Access Care Team 1300 722 276 Repeat and increase frequency of observation as indicated

Sepsis is a life-threatening organ dysfunction due to a dysregulated host response to infection. Septic shock is defined as a subset of sepsis in which particularly profound circulatory, cellular, and metabolic abnormalities substantially increase mortality.

Recognition **Are you concerned that your resident could have sepsis?**	Have they experienced Risk Factors for Sepsis? • Recent surgery or wound • Indwelling medical device • Immunocompromised • Age > 65 years • Fall Absence of risk factors does not exclude sepsis as a cause of deterioration. Does your resident have any new onset of the following signs and symptoms of infection? • Observations in the RED zone or two or more YELLOW zone (page 8) • Fever or rigors • Dysuria/frequency • Cough/sputum/breathlessness • Line associated infection/redness/swelling/pain * • Abdominal pain/distension/peritonism • Altered cognition
Interventions	• Medical Emergency: Ambulance 000 (do not wait for GP) • Conduct full A–G Assessment Contact GP for care instructions * Description of medical device/line, date of insertion/last changed/size • Contact GP for care instructions • Call ACT 1300 722 276 • Cantact family

Stroke/Cerebrovascular Accident (CVA)

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	If any of the following signs and symptoms of stroke are present: • (Think FAST: Face – Arms – Speech / Swallow – Time it occurred and lasted) (page 35) • New facial weakness or has the resident's face / mouth drooped • New changes in speech e.g. slurred. Does the resident understand you? • New swallowing difficulties, coughing on saliva, fluids / food; gurgling or changed voice after swallowing • Changed conscious level e.g. drowsy, less responsive	• Medical Emergency: Call an ambulance (000) • Inform GP • Call ACT 1300 722 276 for appropriate referral destination • Conduct full A to G Assessment • Contact family • If suspected Stroke/CVA call ambulance
While waiting for help	• If new swallowing difficulties, coughing on fluids / food; gurgling or changed voice after swallowing – then place resident on nil orally while awaiting assessment of swallow (No food, liquid, or medications administered orally) • Ensure any weak limb is placed in normal body alignment and supported to prevent subluxation, chronic shoulder pain or other limb / joint problems • Monitor vital signs	**Tips:** • Reassure resident • Mouth care

Urine/Catheters

Check the Goals of Care

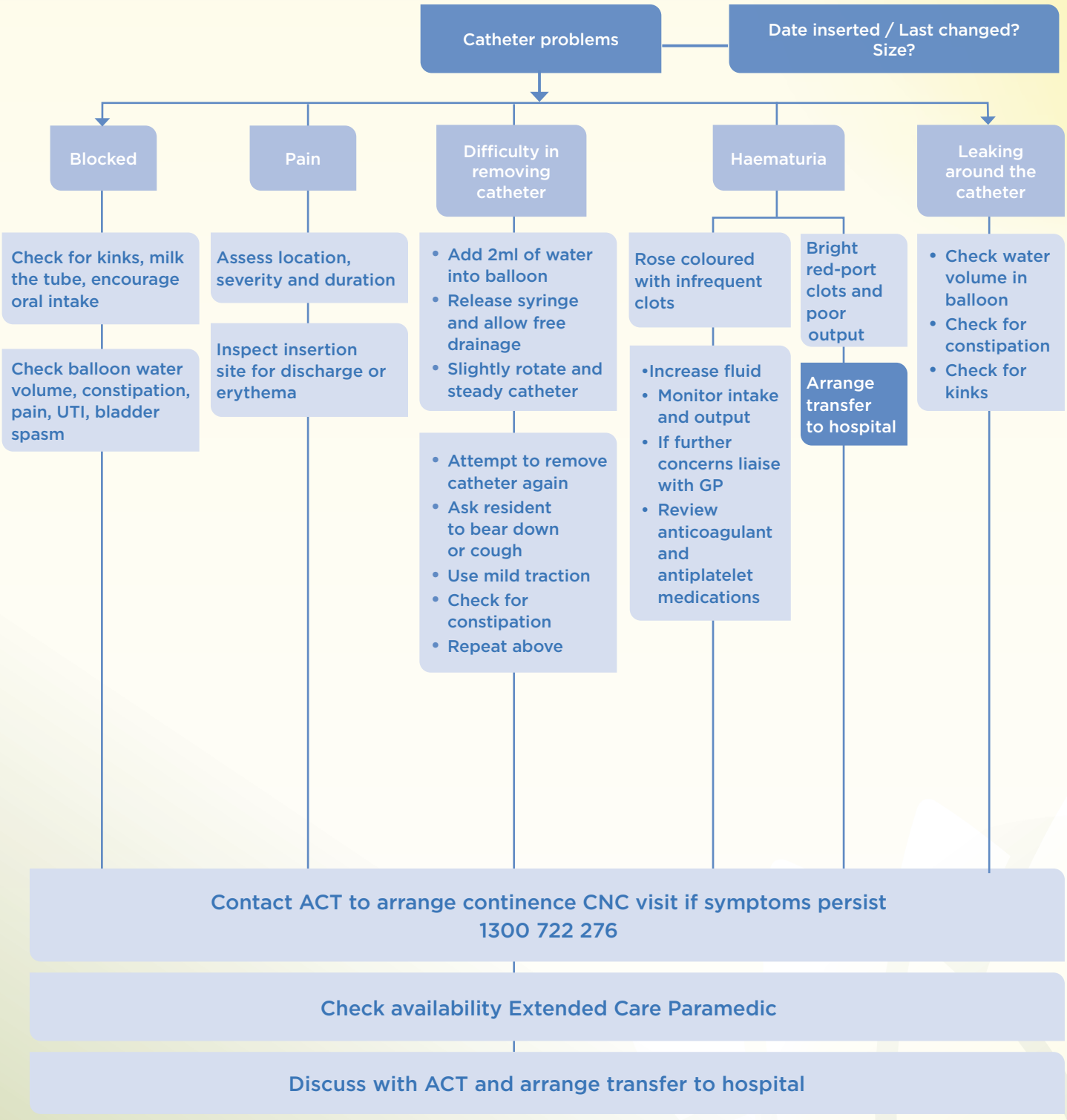
Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone ***See Clinical Observations (page 8)*** Medical Emergency – Call 000	**Medical Review** ***See Clinical Observations (page 8)*** • Contact GP/After hours GP • Call Access Care Team 1300 722 276 Repeat and increase frequency of observation as indicated

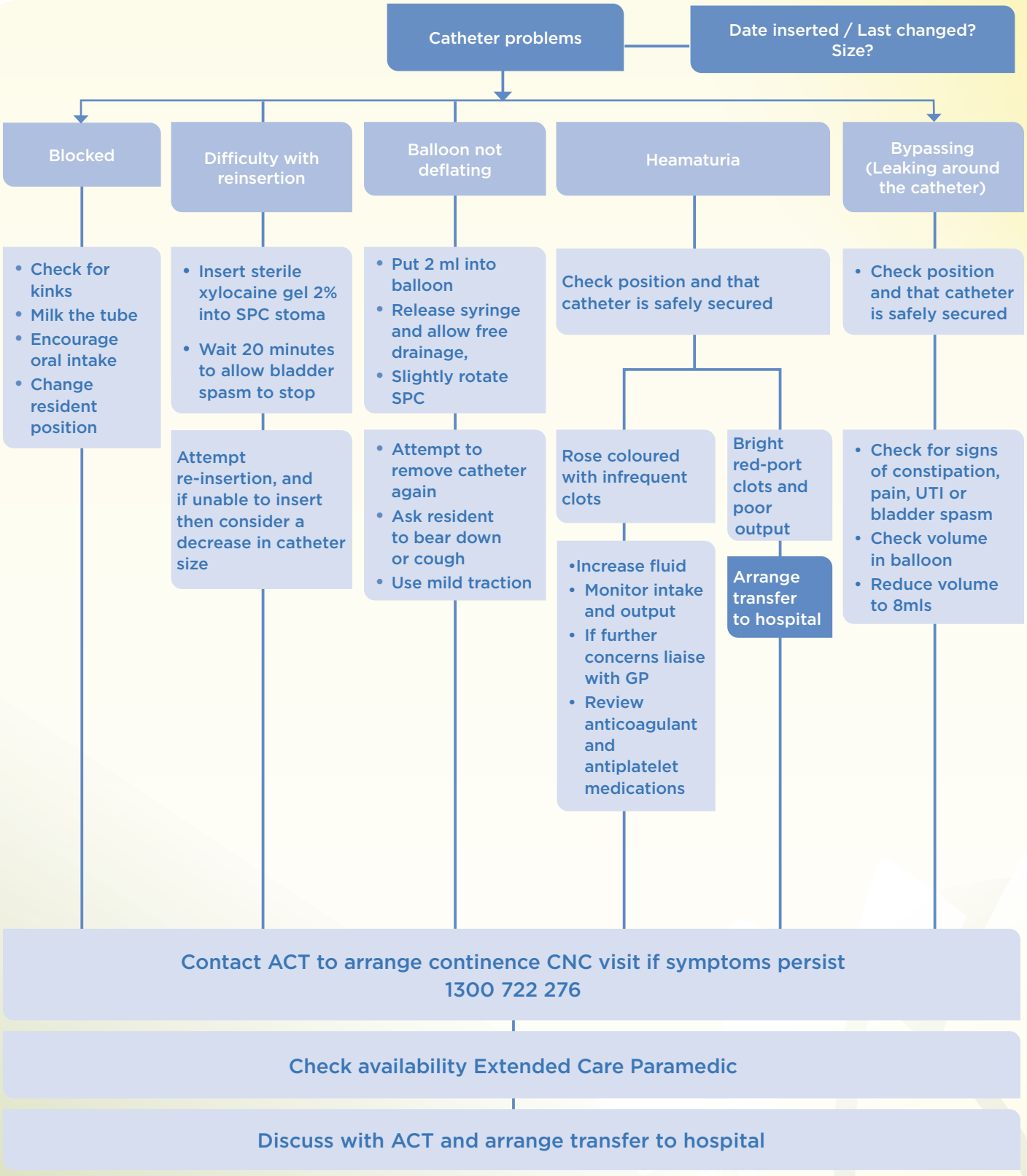
	Symptoms present	Your interventions
Act now	If you suspect a urinary tract infection (UTI) **AND** one of the following is present consider Sepsis, (see page 25): • Increasing confusion or agitation or severe pain • Decreased level of consciousness • Decreased fluid / oral intake • Decreased urine output	• Conduct full A–G Assessment (page 9) • Medical Emergency: Ambulance 000 (do not wait for GP) or, • Contact GP for care instructions (if after hours phone on-call GP) • Contact family • Call ACT 1300 722 276
Act within 12 hours	If the resident has developed any of the following symptoms: • Burning or stinging on passing urine • Blood-stained urine • Offensive-smelling, thick or dark urine • Passing urine more frequently/incontinence • Appears in pain and rubbing groin or abdomen • Catheter in situ (refer to trouble shooting guides for Indwelling Catheter (IDC) and Suprapubic Catheters (pages 28 and 29)	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions • Call ACT 1300 722 276 • Contact family • For IDC and SPC consider referral through ACT to continence nurses
While waiting for help	• Take a clean urine sample and perform a urine dipstick test. Document results • Encourage oral fluids if able to swallow • Monitor vital signs and Blood Glucose Level • Monitor residents urine output and oral intake • Review bowels and consider constipation	**Tips:** • If the resident has an Indwelling Catheter (IDC) or Suprapubic Catheter (SPC) in situ – greater risk of Urinary Tract Infection (UTI)

Indwelling Catheters (IDCs) Flow Chart



If any residents in your facility have an IDC in situ it is important to ensure there is spare stock available for replacement

Suprapubic Catheters (SPCs) Flow Chart



If any residents in your facility have an SPC in situ it is important to ensure there is spare stock available for replacement

Wound Management, Pressure Injuries, Skin Care

Check the Goals of Care

Could the required care be provided in the facility according to the resident and family wishes?
Is there any existing information available about your resident to guide the priorities of care?
Is the resident for active or palliative treatment?
Do they have an Advanced Care Plan/Directive or a NSW Ambulance Authorised Palliative Care Plan?

Follow advance care directive which may alter the management of the resident.

Red Zone
See Clinical Observations (page 8)
Medical Emergency – Call 000

Medical Review
See Clinical Observations (page 8)
- Contact GP/After hours GP
- Call Access Care Team 1300 722 276

Repeat and increase frequency of observation as indicated

	Symptoms present	Your interventions
Act now	If the resident's wound is not healing as would be expected **AND** one or more of the following: • Consider Sepsis (see page 25) • Signs of infection: swelling, redness, with blistering and pain to any area of skin • Contact GP for care instructions (if after hours phone on-call GP) • Increasing agitation, confusion or pain possibly associated with wound • Reduced mobility associated with wound • A burn to any area of skin	• Conduct full A–G Assessment (page 9) • Medical Emergency: Ambulance 000 (do not wait for GP) or, • Contact GP for care instructions (if after hours phone on call GP) • Call ACT 1300 722 276 • Contact family
Act within 12 hours	If the resident has developed any of the following symptoms: • Malaise/tiredness • Presence of necrotic tissue: slough (dead tissue, usually cream or yellow in colour), or eschar (dry, black, hard necrotic tissue) • Increased wound size, delayed healing • Exudate: colour, amount, consistency, malodorous • Erythema: reddening of the skin, new rash or itchiness, history of Cellulitis • A new ulcer or large traumatic wound, e.g. skin tear • New pain and increasing exudate from wound	• Conduct full A–G Assessment (page 9) • Contact GP for care instructions • Call ACT on 1300 722 276 • Contact family
While waiting for help	• Monitor and document the resident's vital signs including blood sugar level • Skin care: protect surrounding skin (e.g. barrier cream) • Ensure sufficient pain relief and promote comfort • Reduce fever: Antipyretic (e.g. paracetamol) if appropriate and other measures e.g. hydration • Pressure area: initiate pressure relief regime • Skin tear: replace skin flap over any skin tear. Place silicon foam dressing over skin tear and mark with arrow in direction of skin tear, to ensure correct dressing removal. • Burns: immediately flush with cold running water for 20 minutes. • Choose suitable dressing as per (page 41)	Other considerations: • Diabetes Mellitus • Obesity • Compliance • Malnutrition • Medications • Reduced blood supply • Wound management regime appropriate? • Wound swabs are no longer recommended for collection. Most recent evidence suggests that results do not assist in clinical decision making for treatment of wounds.

Section 3:

Other Resources and Tools

Clinical Care Standards

CARING FOR COGNITIVE IMPAIRMENT

DELIRIUM

Key steps for treatment and prevention

- Early screening
- Assessing for delirium
- Interventions to prevent delirium
- Identifying and treating underlying causes
- Preventing falls and pressure injuries
- Minimising use of antipsychotic medicines
- Transition from hospital care

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS
A better way to care

REDUCING INAPPROPRIATE USE OF ANTIPSYCHOTICS
in people with behavioural and psychological symptoms of dementia (BPSD)

Antipsychotics are medicines that can reduce symptoms of psychosis but have limited benefit for BPSD

Antipsychotics are overused for BPSD

Use of antipsychotics in Australia is **high** for BPSD in all settings

Around **1 in 5** residents in Australian aged care homes are prescribed at least one antipsychotic medicine

Guidelines recommend that antipsychotics **should not be used** as first-line treatment for BPSD

Inappropriate use of antipsychotics is a problem

For every **five** people with dementia given an antipsychotic, **only one will benefit**

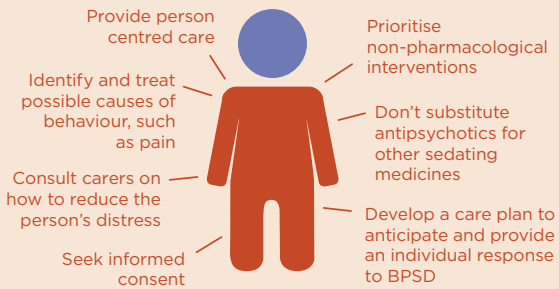
Antipsychotics can cause harm and **increase the risk** of stroke, pneumonia and fractures

They are often used for **too long**, and without proper consent or monitoring

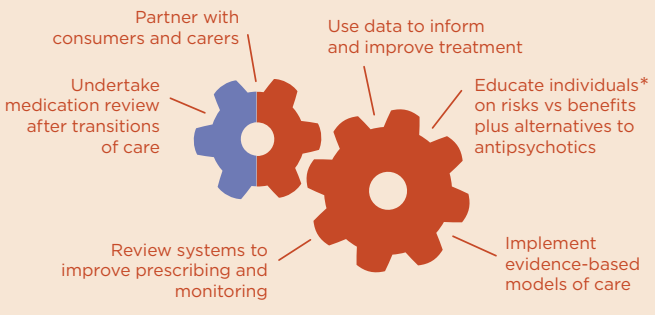
Only one antipsychotic (risperidone) is approved for BPSD
on the PBS, and only to be used:

- on authority script for 12 weeks
- for dementia of Alzheimer's type with psychosis and aggression, and
- after non-pharmacological interventions have failed.

We can reduce inappropriate use



For individuals
*Prescribers, healthcare managers and workforce, consumers and carers



At organisational and systems level

www.safetyandquality.gov.au and cognitivecare.gov.au #BetterWayToCare

Dementia Training Australia

Optimising antipsychotic medication management for responsive behaviour

* This guide is not intended to be used for the management of patients with acute severe behavioural disturbance.

Stage One
Identify the target responsive behaviour and **liaise with the prescriber**

1. **Exclude delirium/depression, adverse drug effects or interactions, infection or pain by liaising with the prescriber**. Consider a medication review. Refer to appropriate guidelines to manage any identified causes.
2. If available, contact your in-house dementia specialist for advice regarding **first-line non-pharmacological** interventions. For further advice contact Dementia Support Australia (DSA) on **1800 699 799**.
3. **Review** and **amend** the current care plan, ensuring a focus on individualised, person-centred care strategies.
4. Should these measures adequately manage the responsive behaviour, **maintain** care provision using the amended care plan, with regular **monitoring** and **review**.

Unresolved responsive behaviour

If modification of care provision does not adequately manage the behaviour, **liaise with the prescriber**.
Whilst pharmacological management **may** be considered at this time; **non-pharmacological** approaches should be maintained throughout.

An antipsychotic medication should only be considered for use in a person with dementia for:

a. Distressing psychosis or

b. A behaviour that is harmful/severely distressing to the individual or puts others at risk.

Most other symptoms are unlikely to respond to treatment with an antipsychotic medication.

Stage Two
Suggested Plan: If an antipsychotic is to be trialled

1. Commence antipsychotic medication using a **regular low dose** (refer to ***FOR PRESCRIBERS: STARTING A REGULAR ANTIPSYCHOTIC*** card).
2. **Monitor** for ongoing response and **potential side-effects** (refer to ***POTENTIAL SIDE-EFFECTS*** card):
   a. If **side-effects** develop **at any stage**, immediately contact the prescriber.
   b. **Maintain non-pharmacological** approaches.
3. **Review** after **2 to 4 days** for effectiveness:
   a. If no/inadequate response, contact prescriber and consider increasing the dose.
   b. If tolerated and effective, continue treatment.
4. At **1 to 2 weeks**, prescriber to **review** for response and **side-effects**:
   a. If the antipsychotic is ineffective/not tolerated, **cease** it. Should an alternative antipsychotic be trialled, return to Step 1.
   b. If the antipsychotic is tolerated and effective, continue treatment. **Monitor** for response and **side-effects**, **maintain non-pharmacological** approaches.
   c. Discuss and develop a **withdrawal** plan with the prescriber. Prescriber to initiate **withdrawal** plan; aiming to cease no later than **12 weeks** (refer to ***WITHDRAWAL PLAN*** card).
5. At **6 weeks**, prescriber to **review** for response and **side-effects**. Repeat Step 4a and 4b. Consider **withdrawal** if not already initiated.
6. At **12 weeks**, prescriber to **review** suitability for resolution of the target responsive behaviour.
7. If the target responsive behaviour reoccurs after dose reduction or cessation refer to ***WITHDRAWAL PLAN*** card.

* **REMINDER STICKERS** are available to assist; place them in the Communication Book or Resident Notes as appropriate.

This resource was originally produced by the Western Australian Dementia Training Study Centre, and is now distributed by Dementia Training Australia.
Dementia Training Australia is supported by funding from the Australian Government under the Dementia and Aged Care Services Fund.
Please visit www.dta.com.au

F.A.S.T. Stroke Assessment

How to identify respiratory outbreaks and what to do next

1. Identify – 3 or more residents/staff within a period of 72 hours with symptoms of influenza like illness (ILI) – fever, cough, sore throat, fatigue, SOB & headache (occasionally in the elderly fever MAY NOT be evident)
2. Implement – Infection Control see – http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-flu-guidelines.htm
   - Use masks, gloves and gowns
   - Isolate residents in individual rooms, or cohort in multi-bed rooms
   - Use hand rubs and increase cleaning of surfaces
3. Notify all staff and avoid moving staff between wards
4. Review and Collect information on
   - vaccination status of residents and staff
   - heighten surveillance for further cases
   - start a case list (daily line listing separating staff and residents)
5. Notify your local Public Health Unit (PHU) – 1300 066 055
6. Arrange testing of cases – Ask your GP to order viral and bacterial swabs: Contact the PHU for advice
7. Signage – place appropriate signage around facility to warn and restrict visitors
8. Review group activities and cancel where considered appropriate
9. Monitor the outbreak – daily communication with your PHU
10. Declare outbreak over (8 days from the onset of symptoms of the last resident case)

GEN

NSW GOVERNMENT

SHPN (HPNSW) 180172

RECOGNISING AND MANAGING GASTROENTERITIS

Australian Government
Department of Health and Ageing

Activity	What to do
Gastroenteritis suspected?	• **A gastroenteritis outbreak is defined as 2 or more cases of vomiting or diarrhoea over a 24 hour period** • Inform your Senior Nursing staff on duty
Nominate an Outbreak Coordinator	Name: ..... Ph: Pager: .....
Implement infection control precautions immediately	• Seek advice of an expert in infection control – internal or external (your PHU may be able to advise) • Increase hygiene measures: especially hand hygiene & environmental cleaning • Isolate infected residents if possible • Notify families & other residents
Restrict contact & prevent spread	• Strict hygiene measures, eg. hand hygiene, PPE • Isolate or cohort residents if possible • Limit staff & visitor movement into restricted area • Infected staff off work • Suspend all group activities
Notify	• Your State/Territory Population Health Dept • Your State/Territory office of Commonwealth Department of Health and Ageing • Resident's GP, all staff, all visiting GPs, allied health workers, volunteers, or anyone in contact with your facility
Collect specimens	• Observe standard infection control practices and wear personal protective equipment, eg. gloves, gown, mask • Collect faecal or vomit specimens in specimen jars (faecal specimens preferable) • Label specimens & complete pathology request form • Store specimens in refrigerator – **not in a food fridge!** – until collected by pathology lab.
Document	List cases – up-date daily: • Details of residents, staff with symptoms • Onset date of symptoms of gastroenteritis for each • Their contacts – to identify "at risk" groups
Complete your legislative requirements	• Refer to your State/Territory public health legislation for your on-going responsibilities & reporting requirements for the duration of the outbreak

WASH AND DRY HANDS BEFORE & AFTER CONTACT WITH AFFECTED RESIDENTS

Further copies of this poster are available from National Mailing and Marketing at NMM@nationalmailing.com.au

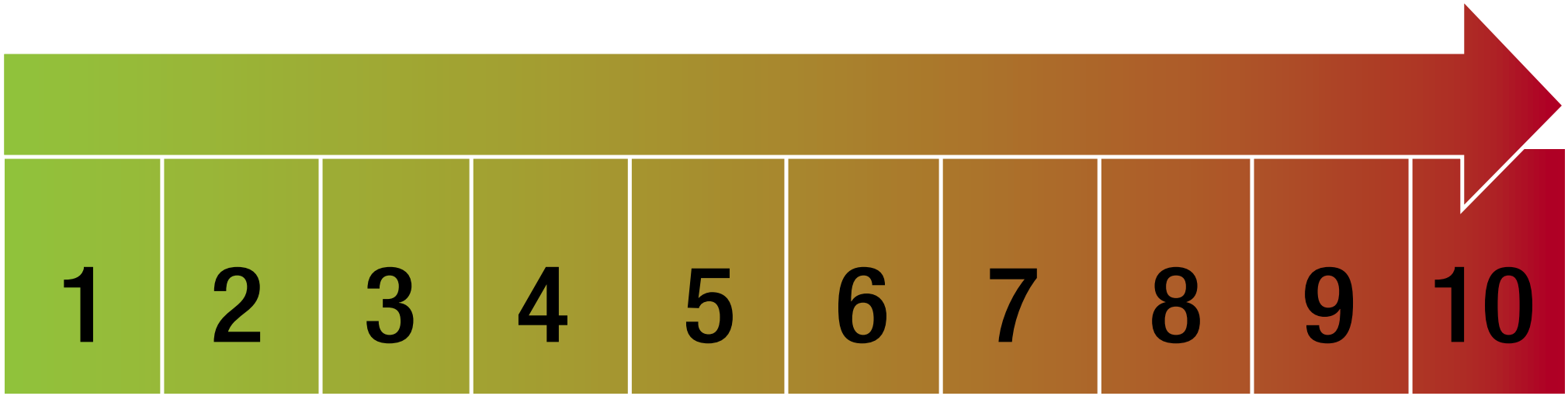
PAIN - PAINAID ASSESSMENT TOOL

PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD)				
ITEMS	**0**	**1**	**2**	**SCORE**
BREATHING Independent of Vocalisation	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respiration	
NEGATIVE VOCALISATION	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
FACIAL EXPRESSION	Smiling or inexpressive	Sad. Frightened. Frown	Facial grimacing	
BODY LANGUAGE	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
CONSOLABILITY	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
Reference: Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. J Am Med Dir Assoc. 2003; 4:9-15.				**TOTAL**

PAIN ASSESSMENT

NO PAIN

WORST IMAGINABLE



Abbey Pain Scale

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

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

Name of resident: ……...

Name and designation of person completing the scale: ……..

Date: ……**Time:** ……

Latest pain relief given was……..……..……..**at** ……..**hrs.**

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

Q2. **Facial expression**
eg: looking tense, frowning grimacing, looking frightened **Q2** ☐
Absent 0 Mild 1 Moderate 2 Severe 3

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

Q4. **Behavioural Change**
eg: increased confusion, refusing to eat, alteration in usual patterns **Q4** ☐
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. **Physiological change**
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor **Q5** ☐
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. **Physical changes**
eg: skin tears, pressure areas, arthritis, contractures, previous injuries. **Q6** ☐
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 – 6 and record here ⇨ **Total Pain Score** ☐

Now tick the box that matches the Total Pain Score ⇨

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

Finally, tick the box which matches the type of pain ⇨

Chronic	Acute	Acute on Chronic
☐	☐	☐

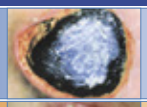
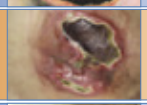
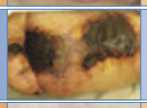
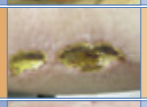
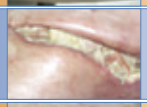
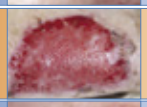
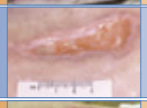
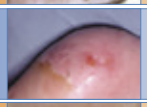
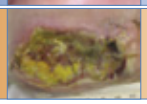
Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

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

A Guide to Dressing Options based on Wound Type

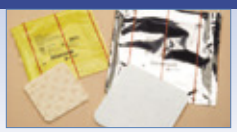
Factors affecting wound healing:
- Medications eg. steroids etc
- Altered nutrition
- Impaired immunity
- Age
- Infection
- Foreign body eg. sutures, debris
- Mechanical stress
- Oxygenation
- Smoking, alcoholism, diabetes

Remember:
1. Document your assessment and management plan
2. Trace all wounds for progress
3. If wound is failing to heal reassess causative factors e.g infection, pressure etc
4. Avoid using hydrocolloids on people with diabetes especially those who have plantar ulcers
5. If using tape apply like a window frame
6. Be sure to get approval prior to debriding a wound on a patient with diabetes or vascular disease from the patient's Consultant or CNC/Wound specialist

Tissue Type		Aim	Product
Black dry eschar (no arterial insufficiency)		Rehydrate[1] Autolytic debridement[1] Loosen eschar[1]	Hydrogel Foam[6] Polymem[6] Prontosan wound solution or gel
Black dry eschar (with arterial insufficiency)		Keep dry and trim Protect	Foam Dry dressing Non-adherent dressing
Black wet eschar (no arterial insufficiency)		Absorb exudate Autolytic debridement[1] Protect	Antibacterial[4] Foam[5] Antimicrobial[4] Hydrofibre
Yellow dry slough		Rehydrate Autolytic debridement[1]	Hydrogel Hydrocolloid[2] Prontosan wound solution or gel
Yellow moist slough		Autolytic debridement Absorb exudate	Hydrofibre[4] Polymen[5] Prontosan wound solution or gel
Red, dry granulation		Protect Maintain moisture	Foam[7] Hydrocolloid Hydrogel
Red, moist granulation		Protect Manage exudate	Foam Hydrocolloid, (depending on level of exudate) Alginate (if bleeding[5])
Hypergranulation		Protect Decrease hypergranulation	Foam with pressure Calcium alginate Consider antimicrobial
Epithelisiation		Protect	Film Foam Hydrocolloid[7]
Infection		Treat Infection Protect	Antibacterial[5] Antimicrobial[5] (frequent r/v of wound progress required)[5] Prontosan wound solution or gel

Foams

Biatain
Lyofoam
Polymem
Allevyn
Mepilex



Films

Opsite 3000
Tegaderm
Bioclusive
Cutifilm

Hydrocolloids

Comfeel Plus Ulcer/
Transparent
Duoderm thin/CGF

Alginates

Kaltostat
Sorbsan

Hydrofibre

Aquacel
Versiva xc

Hydrogels

Wound aid
Intrasite
Aquaclear
Solosite
Prontosan

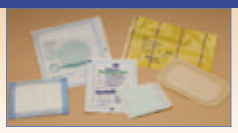
Antimicrobial \ Antibacterial

Actisorb
Aquacel Ag
SSD Cream
Atrauman Ag
Medihoney
Polymem Ag
Flaminal
Prontosan
AMD

Acticoat
Contreet
Bactigras
Flagyl
Iodosorb
Wound aid

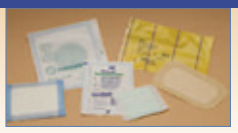
Highly Absorbent

Mesorb
Zetuvit plus
Alione
Dry Max



Silicone based

Mepilex border
Mepitel
Allevyn gentle
border



1. Please check arterial sufficiency prior to debriding. 2. Dressing choices could also include polymem. 3. Hypertonic saline solutions can also be used. 4. Cadoxemer iodine (iodorsorb) has also been effective in autolytic debridement. 5. Consider highly absorbents for secondary dressing. 6. Other products such as silvazine and acticoat can be considered. 7. Consider silicone dressing.

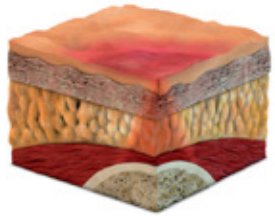
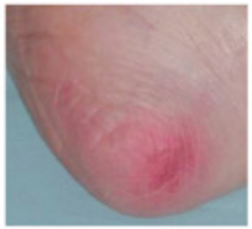
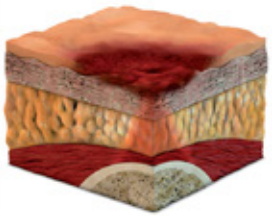
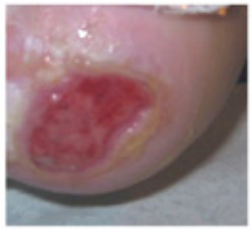
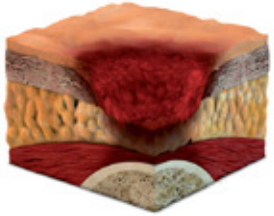
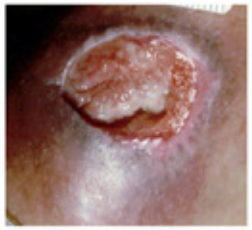
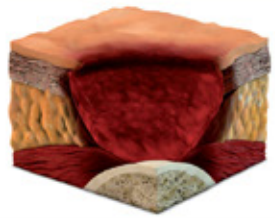
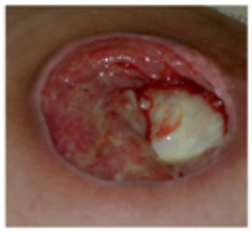
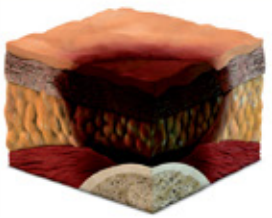
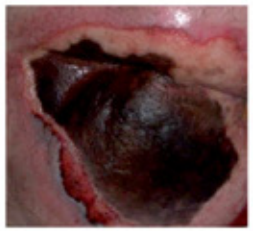
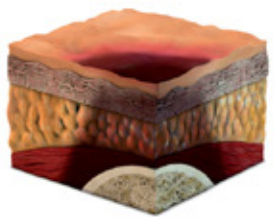
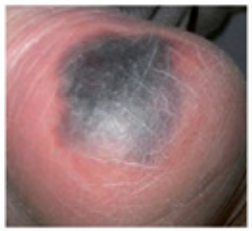
NB. Prontosan Solution for soak and rinse
Prontosan wound gel is for antimicrobial & autolytic debridement.

AVS 71203

By SSW wound advisory group 2011.
For more information contact Michelle Barakat-Johnson on 9395 2171

Health
Sydney
Local Health District

Table 7.1 NPUAP/EPUAP pressure injury classification system[4]

Stage I pressure injury: non-blanchable erythema	Stage II pressure injury: partial thickness skin loss	Stage III pressure injury: full thickness skin loss
• Intact skin with non-blanchable redness of a localised area usually over a bony prominence. • Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. • The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. • May be difficult to detect in individuals with dark skin tones. • May indicate "at risk" persons (a heralding sign of risk).	• Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough. • May also present as an intact or open/ruptured serum-filled blister. • Presents as a shiny or dry, shallow ulcer without slough or bruising (NB bruising indicates suspected deep tissue injury). • Stage II PI should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	• Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. • The depth of a stage III PI varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III PIs can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PIs. Bone or tendon is not visible or directly palpable.
 	 	 
Stage IV pressure injury: full thickness tissue loss	**Unstageable pressure injury: depth unknown**	**Suspected deep tissue injury: depth unknown**
• Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. • The depth of a stage IV pressure injury varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these PIs can be shallow. Stage IV PIs can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone or tendon is visible or directly palpable.	• Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed. • Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.	• Purple or maroon localised area or discoloured, intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Deep tissue injury may be difficult to detect in individuals with dark skin tone. • Evolution may include a thin blister over a dark wound bed. The PI may further involve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
 	 	 

All 3D graphics designed by Jarrad Gittos, Gear Interactive. http://www.gearinteractive.com.au
Photos stage, I,IV, unstageable and suspected deep tissue injury courtesy C. Young, Launceston General Hospital. Photos stage II and III courtesy K. Carville, Silver Chain. Used with permission.

Skin Tear Management Flow Chart

Assessment

- All clients should have a risk assessment for skin tears on admission
- Assess and document skin tears using a recognised assessment and classification system e.g. STAR[1]
- Assess the surrounding skin for swelling, discolouration or bruising

If skin flap is pale, dusky or darkened:

- Reassess in 24-48 hours or at the first dressing change

* *Assessment should only be undertaken by trained staff*

[1] Carville et al. 2007

Management

- Control bleeding
- Cleanse the wound gently with warm water or normal saline, pat dry
- Realign edges if possible
  - do not stretch the skin
  - use a moist cotton-tip to roll skin into place
- Apply a low adherent, soft-silicone dressing to wound, overlapping the wound by at least 2 cm
- Draw arrows on the dressing to indicate the direction of dressing removal
- Mark the date on the dressing
- Apply limb protector

Prevention

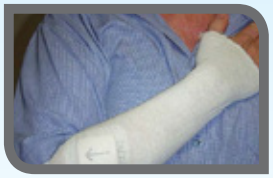
- Assess skin regularly and implement a prevention protocol for those at risk
- Use soap-free bathing products
- Apply moisturiser twice daily
- Use correct lifting and positioning techniques
- Avoid wearing rings that may snag the skin
- When repositioning use assistive devices such as slide sheets
- Protect fragile skin with either limb protectors or long sleeves or pants
- Pad or cushion equipment and furniture
- Avoid using tapes or adhesives, use tubular retention bandages to secure dressings

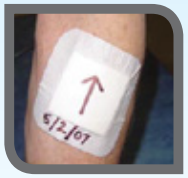
Document

- Level of risk and risk factors present
- Prevention strategies
- Management strategies
- Category of skin tear/s, size, location, tissue type, exudate, surrounding skin
- Progress and outcome of interventions

Risk factors for a Skin Tear

- History of previous skin tears
- Bruising, discoloured, thin or fragile skin
- Cognitive impairment / dementia
- Impaired sensory perception
- Dependency
- Multiple or high risk medications e.g. steroids, anticoagulants
- Impaired mobility
- Poor nutritional status
- Dry skin / dehydration
- Presence of friction, shearing and/or pressure





References:

Ayello E, Sibbald R, *Preventing pressure ulcers and skin tears, in Evidence-based geriatric nursing protocols for best practice*, E Capezuti, et al., Eds. 2008, Springer: New York. • LeBlanc K, Baranoski S, *Skin tears:* Adv Skin Wound Care, 2011. 24(9S): 2-15 • Ratliff C, Fletcher K, *Skin Tears:* Ostomy Wound Management, 2007. 53(3) http://www.o-wm.com/article/6968 • Carville K et al., *STAR: A consensus for skin tear classification.* Primary Intention, 2007. 15(1): 18–28 • Joanna Briggs Institute, *Topical skin care in aged care facilities. Best Practice*, 2007. 11(3) • Wounds UK. *Best Practice Statement: Care of the Older Person's Skin Wounds* UK 2012 , 2nd ed.

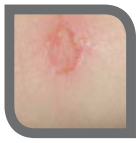
promoting healthy skin

Champions for Skin Integrity

QUT ihbi Institute of Health and Biomedical Innovation

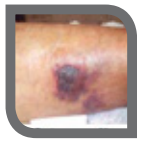
CRICOS No. 00213J

STAR classification system



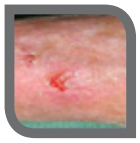
Category 1a

A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is not** pale, dusky or darkened.



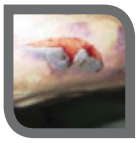
Category 1b

A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour **is** pale, dusky or darkened.



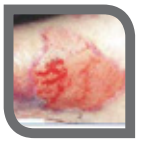
Category 2a

A skin tear where the edges can not be realigned to the normal anatomical position and the skin or flap colour **is not** pale, dusky or darkened.



Category 2b

A skin tear where the edges can not be realigned to the normal anatomical position and the skin or flap colour **is** pale, dusky or darkened.



Category 3

A skin tear where the skin flap is completely absent.

Skin Tear Audit Research (STAR). Silver Chain Nursing Association and School of Nursing and Midwifery, Curtin University of Technology. Revised 4/2/2010

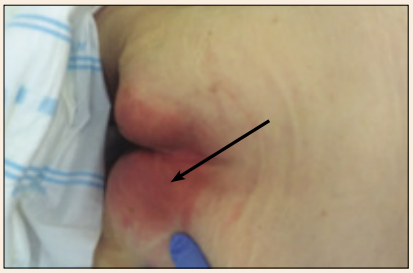
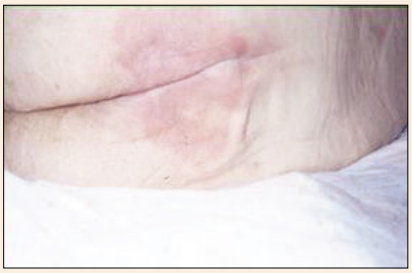
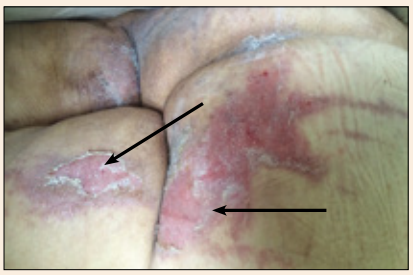
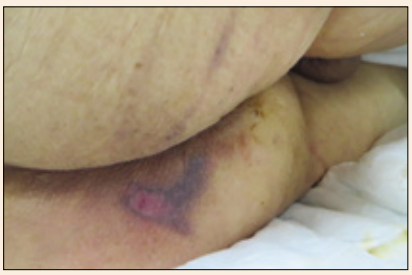
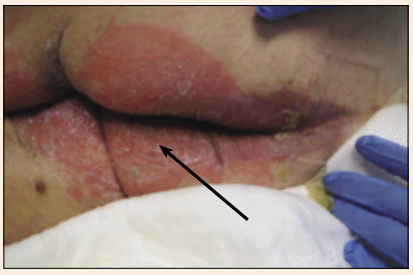
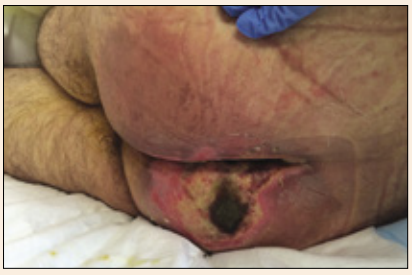
This project is funded by the Australian Government Department of Health and Ageing under the Encouraging Better Practice in Aged Care (EBPAC) program

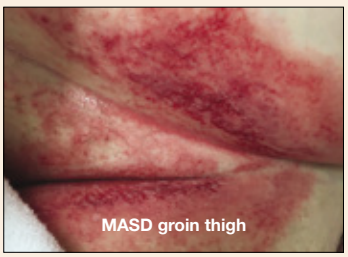
Pressure injury versus Incontinence associated Dermatitis: Know the difference

KNOW THE DIFFERENCE

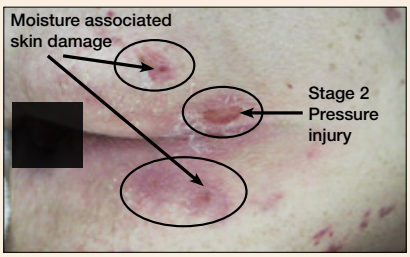
Health
Sydney
Local Health District

Pressure Injury and Incontinence Associated Dermatitis (IAD), Moisture Associated Skin Damage (MASD)

Moisture Associated Skin Damage		Pressure Injury	
	IAD – Category 1 (skin intact)		Pressure injury Stage 1
	IAD – Category 2 (Broken skin)		Pressure injury Stage 2
	IAD – Category 2		Pressure injury Unstageable


MASD groin thigh

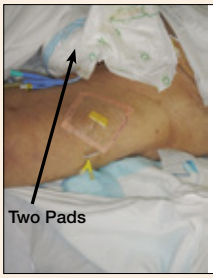
Use comfort shield barrier cloths



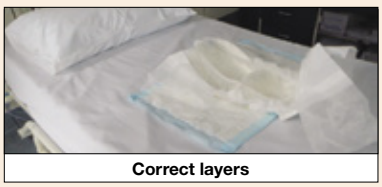
Moisture associated skin damage and stage 2 pressure injury

IAD and Moisture Associated Skin Damage (MASD)

- Use comfort shield barrier cloths
- Minimise layers between mattress and patient
- Assess patient risk factors for developing a pressure injury
- Use the correct sized incontinent pad



Too many layers increases moisture, heat and impairs microclimate


Correct layers

Contact your pressure injury champion or wound CNC if unsure

Pressure Injury Prevention and Management

- Conduct a risk assessment within 2 hours of admission. Repeat as required by patient's acuity
- Reposition frequently
- Assess skin daily and everytime you reposition
- Assess nutrition – refer to a dietitian
- Use pressure relief equipment eg mattress, heel wedges

Compiled by Michelle Barakat-Johnson (District pressure Injury prevention and management and Ashleigh Dolton (A/CNC wound RPAH) Photos courtesy of Michelle Barakat-Johnson and Thomas Leong and used with permission 2015/16

Audio Visual Services 78656

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FACT SHEET

Authorised Care Plans

The purpose of NSW Ambulance Authorised Care Plans is to strengthen systems to support paramedic decision-making in meeting the needs of individual patients with specific medical conditions, as well as respecting predetermined and agreed palliative and end-of-life wishes.

Authorised care encompasses palliative care treatment and end-of-life decisions through the application of standardised Advanced or End-of-Life Care Plans. These plans authorise paramedics to provide care outside their usual scope of practice, whilst putting the patient's wishes first by providing the right care in the most appropriate setting.

Based on NSW Ambulance experience, Authorised Care Plans have been successful in meeting the goals for end-of-life wishes for patients and ensuring they receive care at the location of their choosing wherever possible, thereby reducing unnecessary and avoidable Emergency Department (ED) admissions.

In this program, NSW Ambulance liaises with Local Health Districts (LHDs), Primary Health Networks and the treating clinicians. The plans are registered with NSW Ambulance and uploaded into the computer aided dispatch (CAD) system, enabling a real-time automated alert to be provided to responding paramedics that an endorsed plan is in place.

The three core elements of NSW Ambulance Authorised Care Plans are:

Authorised Paediatric Palliative Care Plan
for children under the care of the Children's Hospital Network or their treating clinician. This plan gives the family and/or enduring guardian the opportunity to discuss treatment and transport options for the patient, namely to remain at home with support services in place for the length of care, or to be transported directly to a predetermined health facility.

Authorised Adult Palliative Care Plan
for adult patients under the care of their treating clinician where treatment and/or transport options have been discussed and noted in the Authorised Care Plan.

Authorised Care Plan
for patients with specific medical conditions under the care of their treating clinician. This plan enables paramedics to administer pre-authorised medications and procedures outside of NSW Ambulance's normal practice.

Qualified paramedics are authorised to administer the medication, and/or procedures listed on the Palliative or Authorised Care Plan.

NSW Ambulance

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FACT SHEET – AUTHORISED CARE PLANS

Patient-centred

This model of care increases confidence and understanding of the paramedic role specific to end-of-life care and the promotion of care plans. Paramedics complement existing services and the support being provided by in-situ facility staff, carers and family, as well as specialist and primary health providers.

This program also strengthens processes, enabling paramedics to support and respect the patient's palliative wishes where an authorised care plan has been collaboratively written and agreed between them and their general practitioner. This plan is developed in consultation with the palliative care team, family and/or a residential aged care facility.

The Impact of an Authorised Palliative Care Plan in Place

Our experience shows 50 per cent of patients attended by NSW Ambulance who have an Authorised Palliative Care and End-of-Life Care Plan in place, are not transported to the ED. In part, this reflects that NSW Ambulance is called for reasons differing to symptoms related to the palliative plan or the patient has reconsidered their decision about remaining at home. The overall impact for the hospitals is that less patients are occupying a bed in the ED or being admitted beyond the ED. For the patient, it means they have a choice to remain at home for their care and NSW Ambulance is able to contribute to the wishes of the patient. There are cost savings for the ED based on the average cost of an ED encounter. In addition, the benefit to NSW Ambulance is less patient presentations to the ED, as well as the benefit to the patient of having their wishes respected.

For more information, email integratedcare@ambulance.nsw.gov.au

Clinical Handover Form

Attention Hospital Triage / Admission staff:

This envelope should remain with the ***Patient Record*** and used at ***Discharge***.

Checklist for Transfer-to-Hospital Clinical Handover

Residential Aged Care Facility to complete and send with resident to hospital

Resident name			
Pension/ DVA number		**Medicare number**	
Name of facility			
Address			
Phone		**Fax**	
General Practitioner		**Phone**	
		Fax	
Person Responsible – notified of transfer?	**Name**	**Relationship**	
	Phone		☐ Y ☐ N ☐ N/A
Pharmacy name		**Phone**	
		Fax	

RACF Outreach Team/ Geriatric Flying Squad currently involved in the management of this resident?	☐ Y ☐ N ☐ N/A

Included documentation		
Transfer summary?	☐ Y ☐ N ☐ N/A
Copy of medication chart?	☐ Y ☐ N ☐ N/A
Blank medication chart (for use at discharge if required)?	☐ Y ☐ N ☐ N/A
Copy of Advance Care Directive / Advance Care Plan?	☐ Y ☐ N ☐ N/A
Doctors letter (if available)?	☐ Y ☐ N ☐ N/A
Behaviour Management Chart?	☐ Y ☐ N ☐ N/A
"Top 5" list or similar?	☐ Y ☐ N ☐ N/A
ISBAR communications tool?	☐ Y ☐ N ☐ N/A
Swallowing concerns?	☐ Y ☐ N ☐ N/A
Visual impairment?	☐ Y ☐ N ☐ N/A
Hearing impairment?	☐ Y ☐ N ☐ N/A
Valuables?	☐ Glasses ☐ Dentures ☐ Hearing aid Other:

Specific reason for hospital transfer?	

CESPHN gratefully acknowledges the financial and other support from the Australian Government Department of Health September 2016

Clinical Handover Form

Checklist for hospital to complete and send with resident on discharge

Patient's MRN sticker	Discharge ward direct contact

1. Discharge summary		
Discharge summary to GP (ensure current GP)?		☐ Y ☐ N ☐ N/A
Name:		☐ Faxed ☐ Electronic
Discharge summary faxed to RACF?		☐ Y ☐ N ☐ N/A
Discharge summary sent with resident to RACF?		☐ Y ☐ N ☐ N/A
Copy of Wound Chart included?		☐ Y ☐ N ☐ N/A
Copy of Behavioural Management Chart included?		☐ Y ☐ N ☐ N/A
Referrals, reports, follow-up appointments included?		☐ Y ☐ N ☐ N/A
Valuables returned?		☐ Y ☐ N ☐ N/A
Follow up by RACF Outreach/ Geriatric Flying Squad arranged?		☐ Y ☐ N ☐ N/A
NSW Ambulance Authorised Adult Palliative Care Plan initiated?		☐ Y ☐ N ☐ N/A

2. Medications			
Medication supply sent with resident? ( ) days	☐ Blister packed	☐ Not packed	☐ N/A
Medication list/ script faxed to pharmacy?			☐ Y ☐ N ☐ N/A
Prescription sent with resident?			☐ Y ☐ N ☐ N/A

3. Transportation details				
Person Responsible	Name		Phone	
	Notified of discharge/ transfer?			☐ Y ☐ N ☐ N/A
RACF staff name		Notified of discharge/ transfer?		☐ Y ☐ N ☐ N/A
Transport organised?	☐ Y ☐ N ☐ N/A	Time		
		Date		

Important issues or concerns

CESPHN gratefully acknowledges the financial and other support from the Australian Government Department of Health September 2016

SLHD Services for Residential Aged Care Facilities (RACFS)

RACF staff or GP:
Have you concerns about the condition of your resident?

1. **Medical Emergency?**
   Call **000**

2. Contact
   GP

3. Contact
   ACT
   1300 722 276

Access Care Team (ACT)

- Provides clinical telephone triage: support and advice.
- Experienced Registered Nurses (RN) will work with RACFs to achieve the best outcomes for residents.
- ACT is a single point of contact providing referral and information for community aged care services.

RACF Outreach

RACF Outreach Nurses
Aged care nurses provide assessment, support and consultation for RACF residents in their RACF: e.g. Comprehensive Geriatric assessment, Wound care, Falls, Behavioural issues, Advanced Care Planning and Education.

Geriatricians
Provide Comprehensive Geriatric Assessment for those unable to attend outpatient services and clinical governance for the RACF Outreach team.

Other SLHD services

Sydney District Nurses (SDN)
Specialist Nursing Palliative Care Consultants

Hospital In The Home
Provides acute care treatments for residents who would otherwise require treatment in hospital in their RACF or in clinic.

Continence Nurses
Specialist Nursing Continence Care consultation.

Access Care Team (ACT)		
Phone: 1300 722 276	**Fax:** 9767 7026	**Email:** SLHD-ACTCallCentre@health.nsw.gov.au

24 hours 7 days a week *(Including public holidays)*
After hours calls 8pm – 8am will be answered by RPA Virtual Hospital

For more information visit us at *(or scan the barcode for access)*:
www.slhd.nsw.gov.au/acrs/findaservice.html

AVS 85824

Sydney Local Health District (SLHD) Clinical Support Guidelines for Residential Aged Care Facilities (RACFs)

AVS 85824