APAC 'SICK PATIENT' FLIPCHART
EMERGENCY DECISION INDEX

Has your resident one or a *combination* of the following?

Shortness of breath?	Chest Pain?	Unable to drink/ vomiting/ diarrhoea/has not passed urine for 12+ hrs	Confusion more than is 'normal' for them	Smelly, dark or cloudy urine	No Bowel action or diarrhoea for 2-3 days &/ or increasing abdominal pain	Blocked, broken, dislodged tube(s)	Recent or suspected fall or change in mobility
↓	↓	↓	↓	↓	↓	↓	↓
Respiratory?	Cardiac?	Dehydration	Confusion	UTI	Constipation	TUBES SPC / IDC or PEG	Falls

Is there an Advance Care Directive, Advance Care Plan documented in the resident's notes?

→ NO → Go to relevant **section** or **sections** above

→ YES → Requests **Intervention** go to relevant **sections** above

→ YES → Requests **Palliation, go to Palliation** or go to relevant section above

Flip cover sheet over for reference pages.

This chart is a guide, and needs to be supported by clinical judgement.

APAC 'SICK PATIENT' FLIPCHART FOR AGED CARE FACILITIES

This document is based on the NHHEDI document developed by GRACE and the Division of Rehabilitation and Aged Care at HKHS and Sydney North Primary Health Network

WHAT TO DO:

DO ACUTE ASSESSMENT

↓

FLIP TO THE SYMPTOM PAGE AND READ 'WHAT TO DO'

↓

CALL THE GP

↓

IF GP NOT AVAILABLE OR IF ISSUE NOT RESOLVED CALL THE Mona Vale BRACE Team 9998 6111 FOR ACCESS TO THE AGED CARE REGISTRAR OR APAC

↓

IF NOT AVAILABLE, CALL AMBULANCE 000

↓

INFORM RELATIVES

Mona Vale Hospital –
Beaches Rapid Access Care of the Elderly (BRACE) Team
Phone 9998 6111 Fax 9979 7876

ACUTE ASSESSMENT

D - Danger - Check for danger to yourself and the resident

R - Response - Is the resident alert or unconscious?

A - Airway - Is there noisy breathing or a blocked airway?

B - Breathing - Are they breathing? Is there trouble breathing?

C - Circulation - Is there a pulse? Is there bleeding?

D - Disability - Does the resident have new weakness in the arms or legs? Check the blood sugar and document

CALL THE RELATIVES OR PERSON RESPONSIBLE

IS THERE AN ADVANCE CARE DIRECTIVE?

IF THE PATIENT IS FOR PALLIATION, FOLLOW THEIR PALLIATIVE CARE PLAN

NOTE: THIS CHART IS A GUIDE ONLY AND DOES NOT REPLACE CLINICAL JUDGEMENT

Every effort has been made to ensure that the information contained on this resource package is correct at time of release. APAC/BRACE does not warrant the accuracy or completeness of the information. If anyone using this resource package becomes aware of any inaccuracy or incompleteness of the information, please notify BRACE immediately on phone: (02) 9998 6111 (Version 16 April 2016)

ACUTE ASSESSMENT: HOW TO USE THIS FLIPCHART

Doctor's Name	Doctor's Office Telephone No.	Doctor's Mobile No.	After Hours GP Service Phone No.

THE EMERGENCY TROLLEY IS LOCATED:

THE OXYGEN IS LOCATED:

Beaches Rapid Access Care of the Elderly Team (BRACE) Monday to Friday 8:00am – 4:30pm

9998 6111

IMPORTANT CONTACT DETAILS

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has a change in breathing AND one of the following is present: • Chest pain • Breathing rate is either below 8 breaths per minute or more than 30 breaths per minute • Can't say more than a few words due to breathlessness • Heart rate is more than 130 beats per minute • Systolic blood pressure (top reading) is below 90mmHg	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Increasing shortness of breath • Cough • Unexplained fever or sweats • Decreased food or fluid intake • Decrease in usual function or activities • Increasing confusion	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Give oxygen at 2 litres per minute via nasal prongs or 6 litres per minute by mask • Sit resident upright. Provide them with reassurance • Give resident any prescribed regular or PRN puffers or nebulisers • Review resident frequently and notify GP of any worsening in condition. Check observations again according to local policy or every 15 minutes if resident fits the red 'needs immediate action' description	

BREATHING DIFFICULTIES

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has new chest pain or tightness AND one or more of the following: • It is not relieved by up to 2 doses of their prescribed medication such as anginine or GTN spray • It is not relieved by antacid (e.g. Mylanta) • They are sweaty or clammy • They have left arm, shoulder or jaw pain • Their heart rate is greater than 130 or less than 40 per minute • Their blood pressure is less than 90 systolic • Their respiratory rate is greater than 30 per minute	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Increasing episodes of chest pain brought on by exertion which improve with medication or rest • New chest pain or tightness at rest which improves with medication	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Lay the patient down and encourage to rest • Give the resident oxygen at 6 litres per minute by mask or 2L per minute by nasal prongs • Give any prescribed GTN or anginine medication unless systolic BP is less than 100 • Monitor blood pressure, heart rate, temperature and respiration rate according to local policy, or every 15 minutes if resident fits the red 'needs immediate action' description	

CHEST PAIN

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has new or worsening confusion AND one or more of the following: • There is a risk of harm to themselves, staff or other residents • There is a change in level of consciousness • The systolic blood pressure is less than 90 • The heart rate is more than 130 or less than 40 per min • The respiratory rate is greater than 30 or less than 8 per minute • The temperature is greater than 38 or less than 36	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following new symptoms which suggest a delirium: • A decreased ability to focus attention (e.g. cannot count backwards from 10 to 1, cannot hold a simple conversation) • Increased agitation or aggression • A change in usual level of function	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Offer the resident frequent reassurance and re-orientation in a calm, quiet manner • Check the resident has their glasses and hearing aids, if applicable • Ensure any pain is well-controlled. Avoid mechanical restraints • Check patient has adequate oral intake and is opening bowels and passing urine • Check vitals sign, urinalysis, BSL and document results	

NEW OR WORSENING CONFUSION (DELIRIUM)

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has had a fall AND one of the following is present: • Severe or increasing pain or weakness on movement • Difficulty using a limb • A decreased level of consciousness/ increased drowsiness/ increasing agitation • Their heart rate is greater than 130 or less than 40 per minute • Their blood pressure is less than 90 systolic • Their respiratory rate is greater than 30 per minute	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Increased unsteadiness • Persistent pain • Features that make you concerned they may have another fall	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• If has any "needs immediate action" symptoms, bed rest until medical review • Check Glasgow Coma Scale (GCS) every 30 minutes for 4 hours, then 4 hourly for 24 hours See appendix for details of how to perform GCS. Notify doctor of any change in GCS • If no 'needs immediate action' symptoms, resident should be assisted in mobilising. Do not move resident if you suspect a fracture • Lower bed as close to floor as possible	

FALLS

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has not been opening bowels AND has any of the following: • Vomiting • Worsening abdominal pain • Decreased level of consciousness/drowsiness • Systolic blood pressure below 90 • Heart rate above 110 • Not passing wind • Increasing agitation or confusion • Temperature greater than 38 or less than 36 degrees	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Has not been opening bowels for over 48 hours despite usual aperients • Distended or bloated abdomen • Nausea • Decreased oral intake	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• If not passing wind, drowsy or vomiting, keep nil by mouth until medical review • If is passing wind and no other 'needs immediate action' symptoms, increase oral fluid intake and provide any prescribed aperients • Perform a per rectum (PR) examination, to be performed by registered nurse and GP's as per professional standards	

ABDOMINAL PAIN

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has not been drinking AND has one of the following: • Persistent vomiting or diarrhoea and not tolerating fluids orally for more than 8 hours • Little or no urine output for 12 hours • Decreased level of consciousness/drowsiness • Systolic blood pressure below 90 • Heart rate above 110 • Temperature greater than 38 or less than 36 degrees	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Reduced oral intake • Dark, concentrated urine • Increasing confusion, agitation or drowsiness • New swallowing difficulty	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• If the resident is alert, sit them upright and give small sips of water (20-30ml) every 10-15 minutes as tolerated. Thicken as appropriate for patient. **DO NOT ATTEMPT IF CHOKING ON FLUIDS** • If cannot tolerate sips, moisten mouth with mouth swabs dipped in water • Monitor blood pressure, heart rate, respiratory rate and temperature according to local policy, or every 15 minutes if resident fits red 'needs immediate action' description • Check the resident's blood glucose and document result	

DECREASED ORAL FLUID INTAKE

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If you suspect a urinary tract infection AND one of the following is present: • Their temperature is above 38 degrees Celsius or below 36 degrees • Their heart rate is greater than 130 or less than 40 per minute • Their blood pressure is less than 90 systolic • Their respiratory rate is greater than 30 per minute • Increasing confusion or agitation	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following symptoms: • Burning or stinging on passing urine • Blood-stained urine • Offensive-smelling, thick or dark urine • Passing urine more frequently • Appears in pain and rubbing groin or abdomen	1. Call the GP 2. Call BRACE if needed and GP agrees 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Take a clean urine sample and perform a urine dipstick test. Document results • Check resident's blood glucose • Offer oral fluids if able to swallow • Check observations according to local policy, or every 15 minutes if fits red 'needs immediate action' description	

URINARY SYMPTOMS

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If the resident has developed a new skin problem AND one or more of the following: • Difficulty breathing • Temperature is above 38 or below 36 degrees • The systolic blood pressure is less than 90 • The heart rate is more than 130 or less than 40 per min • The respiratory rate is greater than 30 or less than 8 per minute • Increasing agitation or confusion associated with a rash	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has developed any of the following skin problems: • A new rash or itchiness • A newly identified ulcer or large traumatic wound • Redness, heat or swelling of an area of skin • New discharge from, or redness surrounding an ulcer	1. Call the GP 2. Call BRACE if needed and GP agrees 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Check the resident's temperature and other observations • Replace skin flap over any skin tears. Apply a **non-stick** dressing example (silicone, Vaseline impregnated gauze) and crepe bandage to any open wounds. • For burns, immediately flush with cold running water for 20 minutes	

SKIN PROBLEMS

BRACE Monday to Friday 8am – 4:30pm 9998 6111

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	If there is a problem with the resident's tube AND one or more of the following: • Their temperature is above 38 or below 36 degrees • Their heart rate is greater than 130 or less than 40 per minute • Their blood pressure is less than 90 systolic • Their respiratory rate is greater than 30 per minute • Increasing abdominal pain or bloating • Vomiting • Worsening agitation or distress	1. Call the GP 2. If GP agrees call BRACE to access clinical support 3. Check for Advance Care Directive 4. If cannot call GP and no advanced directive Call ambulance 5. Read blue section 6. Notify relatives
NEEDS ACTION WITHIN 24 HOURS:	If the resident has any of the following problems related to their tube: • Redness, pain or itching of the skin around the tube insertion site or resident pulling at tube • Increasing ooze of fluid around the tube insertion site • Increasing resistance to flushing of PEG or decreased flow from SPC • Tube has fallen out	1. Call the GP 2. Call BRACE if needed and GP agrees 3. If GP not available follow local policy 4. Read blue 'While waiting for help' section 5. Notify relatives
WHILE WAITING FOR HELP:	• Check the tube is not kinked, tangled or clamped • If tube has fallen out and staff trained adequately, replace with similar sized sterile Foley catheter within 30 minutes to keep site open until replacement can be inserted	

GASTROSTOMY (PEG)/ SUPRA- PUBIC (SPC) TUBES

BRACE Monday to Friday 8am – 4:30pm 9998 6111

GLASCOW COMA SCALE (GCS)

Eye Opening (E):	
Spontaneous	4 points
Responds to verbal command	3 points
Responds to pain	2 points
No eye opening	1 point

Best verbal response (V):	
Oriented	5 points
Confused	4 points
Inappropriate words	3 points
Incomprehensible sounds	2 points
No verbal response	1 point

Best motor response (M):	
Obeys commands	6 points
Localises to pain	5 points
Withdraws from pain	4 points
Flexion to pain	3 points
Extension to pain	2 point
No movement	1 point

SCORING

To score GCS, check the resident's best response to each of the three categories and compare this to the resident's normal response.

Document the score for each of the **Eye Opening**, **Best Verbal Response** and **Best Motor Response** and add the total together.

The total score should be between 3 (lowest possible score) and 15 (highest possible score).

Example: A resident who is drowsy and responds only by opening their eyes to pain, making groaning sounds only to pain, and flexes (bends their arms) to pain has a GCS of **E2 V2 M3= 7.**

WHEN TO ACT	RESIDENT'S SYMPTOMS	WHAT TO DO
NEEDS IMMEDIATE ACTION:	Does the resident have an Advanced Care Plan/Directive? What level of care is the resident/family requesting? This will assist in decisions about treatment If the resident has any of the following symptoms • Expressed pain or pain suggested by facial grimace, knees pulled towards stomach or jaw clenched • Resident may also be anxious, agitated or restless • Increasing agitation confusion or hallucinations • Noisy breathing or respiratory distress • Mouth/tongue is dry, painful, red and/or white coating • Signs of developing pressure areas – back, heels, against oxygen tubing etc • Diarrhoea/constipation affecting comfort Consider friends and family for religious/spiritual support Keep the family/person responsible informed about decline in the resident's condition	1. Check Care Plan for directions 2. If no Care plan call the GP 3. If GP agrees call BRACE to access clinical support 4. If cannot contact GP, call BRACE for advice 5. Invite friends /family to sit by resident's bed
NEEDS ACTION WITHIN 24 HOURS:	If concern regarding new/worsening symptoms consider timely assistance from GP and advice from Palliative outreach team (24hrs 99983600)	1. Notify GP 2. Call BRACE for support as needed 3. Invite family and friends to be at the bedside as appropriate
WHILE WAITING FOR HELP:	• Reassure the resident that family is on the way/help is coming – even if the person is unconscious they can often hear and understand what you are saying • Check for urinary/faecal incontinence, consider bladder scan looking for urinary retention • Check the records – Are there any specific rituals that need to be completed before or soon after the death as in Jewish, Islamist and Buddhist religions	

PALLIATION

BRACE Monday to Friday 8am – 4:30pm 9998 6111

ISBAR COMMUNICATION TOOL

		Example
I	Introduction	Hi, my name is Jane and I am the RN at Sunnyside aged care facility tonight.
S	Situation	I have Mr Brown here and I am worried he may have a chest infection and might need to start antibiotics.
B	Background	Mr Brown is an 85 year old man. He has a background of ischaemic heart disease and COPD but he's normally quite fit and can mobilise to the dining room with no problems. He has been unwell for a few days with a cough, fever and shortness of breath. His exercise tolerance has reduced to around 5 metres in the last few days.
A	Assessment	His RR was 25 and oxygen saturations were 90% on air. His BP was 110/90 and his heart rate was 95 bpm. He had a fever of 38 degrees last night. He is sitting up in bed but looks out of breath and has a chesty sounding cough. On auscultation his chest, there was widespread wheeze.
R	Recommendation	I think he has a chest infection and may need some antibiotics. I'd be grateful if you could come out and assess him.

ACKNOWLEDGEMENTS

The following departments and committees contributed to the development of this tool:

Lower North Shore Residential Aged Care Directors of Nursing/Managers Committee

Northern Beaches Residential Aged Care Directors of Nursing/Managers Committee

APAC/GP Shared Care Steering Committees

GRACE Team and the Division of Rehabilitation and Aged Care at HKHS

Former Northern Sydney Medicare Local

The tool was localised with contributions from

BRACE Team

Northern Beaches Palliative Outreach Team

May 2016

NSW GOVERNMENT Health Northern Sydney Local Health District

SYDNEY NORTH Health Network phn NORTHERN SYDNEY