Introduction

Aged Care Emergency Service Overview

The Aged Care Emergency (ACE) service is an initiative between insert local area, Residential Aged Care Facilities (RACFs), insert your local medicare local name (if possible), and General Practitioners (GPs). The service provides triage, consultancy, clinical support, and advice for RACF staff and GPs, so that care for patients can be delivered in the facility where appropriate, and transfer to hospital is avoided.

The ACE service can provide information, and where appropriate assist with the coordination of outreach or outpatient services for clinical issues such as wound management, continence problems, behavioural issues, IV antibiotic therapy, and the management of some acute and chronic conditions. If the patient does need to be transferred to hospital, the ACE clinicians can facilitate the process and provide information about the patient to hospital staff prior to admission.

The Residential Aged Care Facility staff can contact the service by telephone on insert local phone number. The senior Registered Nurse will discuss the clinical issues of the patient and when indicated, will use the ACE manual (page 17) as a guide to troubleshoot and advise on the most appropriate management.

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

Guide to this Manual

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

The Aged Care Emergency Manual (page 17) contains clinical information and flow charts to guide RACF and ACE clinicians to determine the clinical needs of the acutely unwell patient.

It is divided into sections related to body systems and each section has a number of clinical issues identified. The flowcharts will assist staff in delivering care; however it should always be used in conjunction with clinical judgement.

The Aged Care Emergency (ACE) clinicians are available for advice and will discuss the clinical concerns for the patient and refer to the manual as appropriate.
Before Making a Call Regarding an Unwell Patient

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

Next, read the following steps and collect all documentation required.

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Done?</th>
<th>Relevant Documentation included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collect the patient file and have a copy of the ACE manual, either online or on-paper.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Complete the ISBAR 4 Aged Care Form.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Make sure a full set of current observations have been attended and all relevant clinical information is available. This includes:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Temperature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Pulse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- BP (where possible, a lying and standing BP is valuable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Respiratory rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Blood Sugar Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- When bowels were last opened</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oxygen saturation (where possible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Any available recent pathology or X-ray reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does the patient have any known allergies? List</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Confusion Assessment Method score (page 97)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Latest GP summary or notes (ensure correct GP is on transfer form)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Make sure the following information is available:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Patient's regular medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Signing sheets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Any additional stat medications or prn medications administered for the patient's current condition</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Check the patient's immunisation status, including pneumovax and fluvax.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Action

<table>
<thead>
<tr>
<th></th>
<th>Done?</th>
<th>Relevant Documentation included?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Inform the patient's GP and relatives of the patient's current condition, and let them know that you are calling the ACE service. If the patient is being transferred to ED, encourage the family to assist with the assessment and support the patient's needs.</td>
<td>☐</td>
</tr>
</tbody>
</table>
| 7. | Make copies of the following:  
  - Current Advance Care Directive or Plan  
  - Any MOLST forms  
  - Other information that will assist with determining appropriate care for the patient, such as the name and contact details of the person responsible.  
  - Latest GP summary or notes (ensure the correct GP name is on the transfer form).  
  - RACF contact name and phone number | ☐ | ☐ |
| 8. | Complete the patient hospital transfer form | ☐ | ☐ |

### Transfer to hospital

If the ACE nurse recommends transfer to hospital, they will advise you of the destination hospital. This is normally the ED that most of your patients go to.

*Book the ambulance transfer* (page 11) through the normal processes. An appropriate time frame for transfer is required.
Recognition of a Deteriorating Patient

Any rapid deterioration in condition should be treated with suspicion.

Check medical orders for life sustaining treatment (MOLST)/ACP before commencing or calling for urgent assistance.

<table>
<thead>
<tr>
<th>Observation</th>
<th>Green (usual)</th>
<th>Yellow (caution)</th>
<th>Red (danger)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Respiratory Rate</strong></td>
<td>10 - 24 /min</td>
<td>Less than 9/min</td>
<td>Less than 5/min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 25/min</td>
<td>More than 30/min</td>
</tr>
<tr>
<td><strong>Respiratory Effort</strong></td>
<td>Typical for this patient and SpO₂ normal</td>
<td>Unusually laboured or noisy breathing for this patient</td>
<td>Obvious distress and/or cyanosis (despite oxygen)</td>
</tr>
<tr>
<td><strong>Pulse Oximetry (SpO₂)</strong></td>
<td>95-100% (with or without oxygen) typical for this patient</td>
<td>Less than 95% (despite oxygen) for this patient</td>
<td>Less than 90% (despite oxygen)</td>
</tr>
<tr>
<td>Beware of the COPD patient who may normally have low saturations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
<td>100 – 180 mmHg (systolic = top measurement) typical for this patient</td>
<td>Less than 100 mmHg</td>
<td>Less than 90 mmHg</td>
</tr>
<tr>
<td>Caution: If a patient's BP is normally 160 mmHg and is now 100 mmHg, this is not normal for this patient</td>
<td>More than 180 mmHg</td>
<td>More than 200 mmHg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(systolic = top measurement) For this patient</td>
<td>(systolic = top measurement)</td>
</tr>
<tr>
<td><strong>Heart Rate</strong></td>
<td>50 – 120/min</td>
<td>Less than 50/min</td>
<td>Less than 40/min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 120/min</td>
<td>More than 140/min</td>
</tr>
<tr>
<td><strong>Response and Cognition</strong></td>
<td>Alert (A)</td>
<td>Verbal (V)</td>
<td>Pain (P) or (U)</td>
</tr>
<tr>
<td>Or cognition normal for this patient</td>
<td>Or cognition normal for this patient</td>
<td>Unresponsive to Pain or sudden change to mental state</td>
<td></td>
</tr>
<tr>
<td><strong>Temperature</strong></td>
<td>35.6 - 38.4°C</td>
<td>Less than 35.5°C</td>
<td>More than 38.5°C</td>
</tr>
<tr>
<td>With or without anti-pyretic medication</td>
<td>More than 38.5°C</td>
<td>Despite anti-pyretic medication</td>
<td></td>
</tr>
<tr>
<td>If over 37.5 monitor patient and check with RN</td>
<td>Without anti-pyretic medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>Nil or tolerable</td>
<td>Obvious discomfort</td>
<td>Obviously distressed</td>
</tr>
<tr>
<td>With or without pain medication</td>
<td>Despite recent pain medication</td>
<td>Despite recent pain medication</td>
<td></td>
</tr>
<tr>
<td><strong>Blood Glucose</strong></td>
<td>5 – 7 mmol/L or in range for this patient</td>
<td>Less than 4 mmol/L</td>
<td>Less than 4 mmol/L and unresponsive to treatment (oral glucose)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More than 14 mmol/L</td>
<td>More than 28 mmol/L</td>
</tr>
</tbody>
</table>

(adapted from ASNSW BTF)
Advance Care Planning Guidelines

When assessing a medically unwell patient, it is important that any Advance Care Plans/Directives are considered if decisions are to be made about treatment. Follow the guidelines below to help in decision-making and care.

1. **Can the resident make their own decisions about their care?** If the patient is capable of making their own decisions about their care, it is important that you involve them, their general practitioner, and their family/person responsible (if requested by the patient) in discussions.

2. **Does the patient have an Advance Care Plan/Directive?** If a patient cannot make their own decisions about their care, check if the patient has an Advance Care Plan/Directive.
   - If the patient has **no** Advance Care Plan/Directive:
     - Discuss with the patient's person responsible/family what they believe the patient would have wished.
     - Involve the patient's general practitioner in all discussions.
   - If the patient **does have** an Advance Care Plan/Directive:
     - Consider if the content of the plan is relevant to the current clinical situation.
     - Consider if the documents are current and reflect recent discussions.
     - Involve the patient's general practitioner in discussions.
     - Involve the patient's person responsible/family in discussions.

**Transfer to hospital required**

*If a patient needs to be transferred to hospital, call ACE* (page 11). Make sure copies of ACP/ACD documents are sent with the patient to hospital.

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

**Transfer not required**

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

- Make sure there is a clear and comprehensive plan of management in the event that the patient's condition deteriorates further. This plan should include attending to any relevant referrals needed as part of this plan, such as palliative care or other (ACE may be able to assist).
- Keep the patient's general practitioner informed.
- Keep all staff informed about the management plan and make sure they are resourced to carry it out.

**In all cases**

- Make decisions that best reflect the patient's wishes and quality of life.
- Provide clear feedback to the patient (if applicable) and person responsible/family about care decisions.
- Provide information and support to the patient (if applicable) person responsible/family as required.
Aged Care Emergency Flowchart

Before deciding to send any patient to an Emergency Department, first determine if the patient has an ACP/ACD. Some ACPs/ACDs specifically request that the patient is NOT to be transferred to hospital or ED, even if they are experiencing a life threatening emergency. Others may be more detailed about when to send and what treatments they may consent to. If an ACP/ACD states "do not send me to hospital if..." then it is not appropriate to do this without further discussions with the patient's general practitioner and family. See Advance Care Planning Guidelines (page 8).
Aged Care Emergency Manual

Aged Care Emergency Flowchart

RACF patient unwell

Is it life threatening?

No

Refer to RACF ACE Clinical Resource Manual and inform GP

Problem resolved?

No

Notify GP for advice or review by RACF staff if ACP/ACD requests intervention

Yes

Does ACP/ACD specifically indicate do not transport to hospital?

Yes

(ACP/ACD specifies do not transfer to hospital)

(No ACP/ACD or it states intervention)

In an emergency, phone 000

No

GP available?

Yes

RACF Staff:
Phone 131233 to book transfer and nominate timeframe

ACE Clinician:
Give receiving ED relevant information. Where available, case manage resident in ED

No

• Contact ACE service (insert local number) who will provide clinical support over the phone and establish goals of care
• Inform GP when able

Yes

Patent for transfer to ED?

No

Patient is managed in RACF with ACE phone support or referrals, i.e., ECPs, clinics, or other services

ACE Clinician:
• Collaborate with GP and RACF staff about the patient action plan
• Document the plan and recommendations and send a letter to the GP and RACF staff

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Calling an Ambulance Flowchart

Assumptions:
1. All callers who ring the 131233 number are either a Registered Nurse or general practitioner, OR
2. If not a Registered Nurse, they have a referral name (i.e., GP or the Specialist Nurse) on the ACE line.
3. Life-threatening includes, but is not limited to: cardiac arrest, unconscious patients, severe unrelieved chest pain, severe shortness of breath, severe haemorrhage.

See also: Transferring a Patient to Hospital (page 13)
Calling an Ambulance

Is it life threatening?

Yes

Phone 000

Caller will be asked:
- Address
- Telephone number of the emergency

Caller will be triaged via ProQA and be asked a series of questions about the patient and their condition

ProQA will determine the correct ambulance response based on the answers given to the questions

For life threatening cases as defined, there will be a lights and sirens response

No

Phone 131233

Caller will be asked:
- Patient demographic details

Caller will be asked the location where the patient is being picked up from and transported to

Caller will be asked:
- The diagnosis of the patient
- Whether they are a stretcher patient or can ambulate
- The infection status of the patient

Caller will be asked for a referring GP’s name (can be an RN)

Caller will be asked when the transport is required, i.e., urgent, 1 hour, 2 hours, etc
Transferring a Patient to Hospital

When transferring a patient to hospital, send the following:

- Copy of the medication chart and any sign sheets.
- Advance Care Directive/Palliative Care Plan/MOLST.
- Transfer form.
- GP summary (if available).
- Full set of observations.
- Copy of the completed ISBAR 4AC form

Please advise if the carer or family have been notified.
**ACE Manual Consultation and Clinical Editors**

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

### Aged Care and Rehabilitation Services

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning, HNE Intensive Care Senior Staff Specialist JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Network Manager HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Network Clinical Lead, Director of Geriatrics HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>CNC ASET / AARCS HNE</td>
<td>25/11/2013</td>
</tr>
</tbody>
</table>

### Aged Care Services in Emergency Teams (ASET)

At hospitals where ACE is currently operational.

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Hunter Hospital (JHH), Tamworth Rural Referral Hospital (TRRH). Armidale Hospital, Belmont District Hospital (BDH) and Calvary Mater Hospital Newcastle (CMH)</td>
<td>25/11/2013</td>
</tr>
</tbody>
</table>

### Anaesthesia and Pain

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>A&amp;P Stream Clinical lead HNE, Senior Staff Specialist &amp; Director Hunter Integrated Pain Service (HIPS)</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>A&amp;P Stream Coordinator, Acting CNC Acute Pain Service</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Operations manager and CNC HIPS</td>
<td>25/11/2013</td>
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</table>

### Cardiac Stream

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Cardiac Stream Coordinator HNE and CNC Cardiology HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Cardiac Stream Clinical Lead and Cardiac Liaison Officer (Southern)</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Cardiac Stream Clinical Lead &amp; Cardiology Staff Specialist JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Cardiac Assessment Nurse JHH</td>
<td>25/11/2013</td>
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</tbody>
</table>
### Chronic Disease Network

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease Network Clinical Lead HNE, Director Respiratory and Sleep Medicine JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Chronic Disease Network Manager HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Nurse Manager SMHSOP (Specialist Mental Health Services for Older Persons)</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>HealthPathways Project Officer</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Career Medical Officer (CMO) Stras Unit, Belmont Hospital HNE, General Practitioner (GP)</td>
<td>25/11/2013</td>
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</table>

### Dementia/Delirium

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Dementia / Delirium CNC JHH</td>
<td>25/11/2013</td>
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</table>

### Diabetes Network

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Clinical Lead Diabetes Network HNE, Director Endocrinology JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Diabetes Network Coordinator HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>CNC/CDE Adult Diabetes Service JHH</td>
<td>25/11/2013</td>
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### Emergency Stream

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>CMH Emergency Department Service Manager &amp; ED stream Coordinator HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>ED Stream Clinical Lead HNE, Director of Emergency Medicine CMH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Senior Staff Specialist Clinical Governance HNE, Emergency Medicine JHHED &amp; ACE Clinical Lead HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Senior Staff Specialist Emergency Medicine JHHED</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Acting CNC JHH Emergency Department (ED)</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Chronic and Complex Care Coordinator JHH ED</td>
<td>25/11/2013</td>
</tr>
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</table>
## Gastrointestinal

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Clinical Lead Gastroenterology HNE, Director of Gastroenterology and Endoscopy JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Gastro-liaison Nurse JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Gastro-liaison Nurse JHH</td>
<td>25/11/2013</td>
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</table>

## New South Wales Ambulance

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Liaison Officer</td>
<td>Station Officer</td>
</tr>
</tbody>
</table>

## Palliative Care

<table>
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<tr>
<th>Position or Title</th>
<th>Review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care Network Clinical Lead HNE Director Palliative Care Calvary Mater Newcastle(CMN)</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Palliative Care Network Coordinator HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Senior Staff Specialist Palliative Care CMN</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Palliative Care CNC CMN</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Nurse Practitioner(NP) Palliative Care Community Aged Care Services</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Population Health Unit Director Hunter Population Health HNE</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Senior Staff Specialist Neurology JHH</td>
<td>25/11/2013</td>
</tr>
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</table>

## Respiratory Network

<table>
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<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Respiratory Network Clinical Lead HNE, Senior Staff Specialist Department Respiratory and Sleep Medicine JHH</td>
<td>25/11/2013</td>
</tr>
<tr>
<td>Respiratory Network Coordinator HNE, Respiratory CNC JHH</td>
<td>25/11/2013</td>
</tr>
</tbody>
</table>

## Urology

<table>
<thead>
<tr>
<th>Position or Title</th>
<th>Review date</th>
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</thead>
<tbody>
<tr>
<td>Urology CNC HNE</td>
<td>25/11/2013</td>
</tr>
</tbody>
</table>
Guidelines

Cardiology

Heart Failure Issues

Patients with known heart failure who are receiving active treatment should have a Clinical Management Plan in place to manage exacerbations.

- Standing orders for oxygen, diuretics, and morphine may be helpful for patients who have frequent exacerbations.
- Acute infections from any source may exacerbate symptoms.

Shortness of breath (rate > 26-28/min)

Usual cause:
- Excess fluid in the lungs.
- Left ventricular failure or pump failure.

Treatment:
- Rest when needed.
- Oxygen if necessary.
- Extra pillows to sleep if needed.

Ankle swelling

Usual cause:
Ankle swelling is usually caused by fluid leaking out of the blood vessels into the tissues. This is called oedema.

Treatment:
- Inform the GP.
- Review fluid intake, diet (especially sodium intake), and medications (e.g., diuretics).
- Elevate legs.

Weight gain

Usual cause:
Fluid build-up may cause rapid weight gain.

1 litre fluid = 1 kg weight.

Treatment:
- Weigh every morning before breakfast.
- Monitor fluid.
- Restrict sodium.
Tiredness

**Usual cause:**
Tiredness can be caused by decreased blood flow to the major organs and muscles.

**Treatment:**
- Adequate rest.
- Use energy conservation techniques.

Loss of appetite

**Usual cause:**
- Build-up of fluid in the digestive organs.
- Decreased circulation.

**Treatment:**
Eat smaller meals, more often.

Dizziness

**Usual cause:**
- Decreased blood flow to the brain.
- Changes in heart rate and rhythm.

**Treatment:**
- Mobilise slowly.
- Sit or lie down when needed.
- Inform the GP.
- Check pulse. If over 120 or below 40, contact the GP.

Chest pain

**Usual cause:**
Chest pain is occasionally caused by reduced blood flow to the heart muscle.

**Treatment:**
See the Managing Chest Pain Flowchart (page 20).
Confusion

Usual cause:
Confusion can be caused by decreased blood flow to the brain.

Treatment:
- Rest as needed.
- Oxygen if required.
- Clear communication.

Aspirin

Contraindications
- Bleeding disorders.
- Severe hepatic, renal impairment.
- Erosive gastritis.
- Peptic ulcer.
- Concomitant - already on aspirin or other anticoagulants.
Managing Chest Pain Flowchart

Important:

- ** Sig drop (significant drop) in BP is > 20 mm Hg ** Always wait 5 minutes after administering GTN (glyceryl trinitrate) before taking a BP.
- For further advice and support Call ACE.
- Check expiry date on GTN spray: GTN tablet expires 90 days from opening

*GTN tablet/spray is a suggested medication. Suggest standing order for this medication.*
Management of Chest Pain

Initial Actions:
- Provide reassurance to the patient
- Assess and document full set of observations, noting any diaphoresis (sweating), dizziness, change to skin colour

Assessment:
- Identify when the pain started, the location and duration of pain (where is the pain?) and if the resident has had this pain before

Never had these symptoms before

With patient lying or sitting with legs elevated, give ½ GTN tablet and 300 mg aspirin chewed as per standing order

Wait 5 minutes and wait for GTN to dissolve then reassess pain and check BP

Contact GP for advice/review

Yes

Pain resolved?

No, and this is new onset pain

Phone 000 for an ambulance

No, and known angina

Sig BP drop?

Yes

Give second dose of ½ GTN tablet or subling spray

If pain persists 5 min after second dose of GTN and no sig BP drop, give 3rd half subling GTN

If pain not resolved after 15 min or 3 doses GTN...

No

With patient lying or sitting with legs elevated, give ½ GTN tablet or subling spray as per standing order or as per patient management plan
Managing Hypertension Flowchart

Management of Hypertension

Assessment:
- Systolic ≥ 180
- Observe full set of vital signs – Check for unusual BP levels
- Check if medication has been given

Patient has mild (or no) headache and no new neurological signs or new weakness

- Allow patient to rest quietly and ensure normal medications are given
- Check for UTI, urinary retention, constipation
- Carry out Pain Score

Patient has one or more of:
- Severe headache
- New neurological signs
- Agitated or distressed
- New weakness
- And ACP requests intervention

- Phone 131233 to arrange transfer to hospital

Yes

Pain Score zero?

- Allow patient to rest and trend BPs hourly over 4 hours
- Document in notes
- If no improvement, contact GP or ACE for further advice

No

- If any pain, follow Pain Pathway

Reassess pain after analgesia
- Allow patient to rest and trend BP and pain hourly for 4 hours
- Document in notes

References


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

**Management of an Allergic Reaction**

**Assessment:** Is the reaction **mild/moderate** or **severe**?

**Mild/Moderate**
- Hives, redness, rash, itch, swelling or tingling in the face/eyes, cough, slight tightness in throat or chest, nausea, slight dizziness or confusion

**Take Action – Mild to Moderate**
- Remain calm and sit patient down
- Quickly identify the cause and remove it if possible
- Give antihistamine if required (standing order)
- Give reliever inhaler 4 puffs via spacer
- Assess:
  - Vital signs (give oxygen if required)
  - Skin colour
  - Appearance
- Monitor response and escalate to anaphylaxis treatment if needed
- Notify GP of incident, document in notes, and handover to next shift

**Severe**
- Difficult noisy breathing, swelling of tongue, swelling or tightness in throat, difficulty talking/hoarse voice, wheezing or persistent cough, persistent dizziness or collapse, pale

**This is anaphylaxis**

**Take Action – Severe**
- Lay the person down if appropriate
- Administer epiPen IMI
- Phone 000 for an ambulance
- Make sure copies of all medications given and observations taken are recorded and given to ambulance officers
- Follow the anaphylaxis pathway
- Stay with the patient
**ACTION PLAN FOR Anaphylaxis**

for use with EpiPen® or EpiPen® Jr adrenaline autoinjectors

**MILD TO MODERATE ALLERGIC REACTION**

- swelling of lips, face, eyes
- hives or welts
- tingling mouth
- abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

**ACTION**

- For insect allergy, flick out sting if visible. Do not remove ticks
- Stay with person and call for help
- Give medications (if prescribed) ..........................................................
dose: ........................................................................................................
- Locate EpiPen® or EpiPen® Jr
- Contact family/emergency contact

**ANAPHYLAXIS (SEVERE ALLERGIC REACTION)**

- difficult/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- persistent dizziness or collapse
- pale and floppy (young children)

**ACTION**

1. Lay person flat, do not stand or walk. If breathing is difficult allow to sit
2. Give EpiPen® or EpiPen® Jr
3. Phone ambulance - 000 (AU), 111 (NZ), 112 (mobile)
4. Contact family/emergency contact
5. Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)

**If in doubt, give EpiPen® or EpiPen® Jr**

EpiPen® Jr is generally prescribed for children aged 1-5 years.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

**Additional information**
## Behaviour and Confusion Management

### Behaviour Management Identification Tool

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

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

Delirium

Multi-factorial aetiology. Common causes of delirium include:

- General illness and infections.
- Pain.
- Constipation.
- Dehydration.
- Medication and alcohol use.
- Poly-pharmacy and environmental factors.

Assessment:
The Confusion Assessment Method (CAM) (page 27) can assist in making a diagnosis of delirium.

Management:
Pharmacological interventions are considered as a last resort for management of delirium.

Medication

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

Assessment:
Specific to the desired result of either reducing the psychotic experience or assisting rest.

Management:
Some causes of delirium require specific medication treatment. The patient may benefit from GP referral for community pharmacy review.

Communication

- Patients with delirium may have verbal and non-verbal cues.
- Don’t take insults personally.
- Speak slowly and clearly.
- Always stay close to a exit area.
- Don’t argue with an aggressive patient.

Behaviour Management Plan

An ongoing plan can assist with continuity of care and identification of any new issues.

When writing a plan, highlight the behaviour of concern, identify any triggers or signs of escalation, and document management. Remember to have ongoing evaluation of the plan.
CAM (Confusion Assessment Method)

**CAM (Confusion Assessment Method)** (page 97) can assist in the diagnosis of delirium.

1. Acute onset and fluctuating course
2. Inattention
3. Disorganised thinking
4. Altered level of consciousness

Patients need to have **1 and 2 and either 3 or 4.**
Managing Challenging Behaviour Flowchart

Always attend a full set of observations, including U/A, skin inspection, BSL, and pain score. Consider, could pain be an issue?

**Managing Challenging Behaviour**

**Assessment:** Is this a new behaviour or an exacerbation of known behaviours? Does the patient have an Advanced Care Plan?

*New behaviour*  
Consider possible reversible causes and manage as per New Confusion Flowchart

**Exacerbation of known behaviour**  
Seek advice from DBMAS on 1800 699 799

**Follow the patient’s individualised management plan.**  
Find further help

**Is the person a danger to themselves or others?**

- **Yes**
  - Use team approach and keep communication clear and simple
  - Safety here is essential, in line with the Mental Health Act the patient may require a schedule order. Contact the GP or if GP unavailable ASNSW and Police for assistance.

- **No**
  - Consider the environment – Has anything changed?
  - Keep a behaviour record, i.e., ACFI 6 or 9
  - Medication as a last resort – see issues

**Contact GP. If GP unavailable, contact ACE**

**Consider outreach visit**  
If transfer to hospital required, phone 131 233 and nominate time for transfer

**Note:** All mental health referrals must go through the insert your local Mental Health Contact Centre name.
Patient is a risk to themselves or others

The premise of Mental Health care is to provide care in the least restrictive environment so if the patient is at risk of harm to themselves or others a schedule can be written by the GP and the patient will be transported to hospital.

If the GP is unavailable the ASNSW can enact a schedule with police involvement.

Where to find help

A patient residing in a RACF can access further assessment in the following ways:

- The GP can either refer to Geriatrician or the Specialist Mental Health Service for Older Persons (SMHSOP) via the insert local Mental Health Contact Centre details.
- If there is no known or suspected diagnosis of dementia the team at insert local Mental Health Contact Centre details have multi-disciplinary expertise in assisting RACFs to develop management plans for patients with challenging behaviours associated with dementia.
  - For patients with a diagnosis of dementia, you can refer to insert local Mental Health Contact Centre details, especially if the primary reason for referral is challenging behaviours that are becoming a problem to manage in the residential setting. These referrals will require a GP referral.
  - The patient/family will be seen for a one-off multi-disciplinary consultation (Psychogeriatrician, Social Worker, and Psychologist).
  - There must be a detailed GP referral outlining initial assessment, investigations, and results (to rule out the obvious causes of delirium), clear description of the intrusive and or inappropriate behaviours or other distressing or psychotic features, as well as any known triggers. This is essential as this team is not responsible for the ongoing care of the patient.
  - Assessments are very comprehensive and appointments can take up to 3 hours to complete.
  - The patient may also need neuropsychological testing if the team consider this necessary.
- RACF patients with a diagnosis of dementia and behavioural and psychological symptoms in dementia with escalating behaviours - The RACF can also get the GP to make a referral.
- Delirium is an urgent situation. The cause needs to be identified and managed. This would generally be managed by the GP in the first instance, but geriatricians and insert local Mental Health Contact Centre details can also give advice for more complex cases, particularly where it is prolonged.
Managing New Confusion or Suddenly Worsening Confusion Flowchart

1. Look for signs of infection – Vitals, urinalysis, skin inspection, see issues.
2. Assess: Look for an address any potentially reversible causes.
   - Attend full set of observations: T, P, BP, R, SaO2, UA, BSL, Skin inspection – could this be cellulitis?
   - Note any cough or rapid breathing that is not normal for this patient.
   - Have there been any medication changes in the previous 7 days?
   - Is there any new facial droop, slurring of speech, or limb movement deficits that are not normal for this patient?
3. See Challenging Behaviours flowchart: Contact GP for review.
4. CAM positive for delirium?
   - Yes
     - Contact GP to discuss treatment if cause cannot be resolved
     - Address the cause and any precipitating factors
     - Patient at risk for pressure damage and falls
     - Manage delirium through supportive care: Use environmental strategies, Prevent complications
     - Educate family and carers
     - Behaviour settling?
       - Yes
         - Continue to monitor and document behaviour management plan
       - No
         - Contact GP, if GP unavailable, contact ACE
5. Cause found?
   - Yes
   - Contact GP to discuss other assessment required and treatment plan
   - No
6. Possible causes:
   - Pain from any source
   - Urinary retention
   - Constipation
   - Other – new injury, pressure wound, skin tear, etc.
Decreased Level of Consciousness Flowchart

Patient has Decreased Level of Consciousness

Assessment: Can the patient be roused easily?
Is this decreased level of consciousness an expected part of the illness trajectory?

No, cannot be easily roused

Danger Response Airway Breathing Circulation AVPU? (see below)

If no Advanced Care Plan

Lie patient on left side

Monitor GCS, ECG (if available)

Contact GP
Contact ACE

If GP feels it is appropriate

If transfer to hospital required, phone 131233

Yes, can be roused easily

Baseline AVPU (see below), Vitals, Delirium Screen, i.e., obs. U/A, BSL

Contact GP
Contact ACE

Commence resuscitation as required

Phone 000

Treatment any underlying condition

AVPU:
A = Alert
V = responding to verbal stimuli
P = responding to painful stimuli
U = unconscious
Seizure

Seizure Issues

First seizure

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

**Assessment:**
- Urinalysis, MSU, routine bloods.
- AVPU (Alert, Verbal - patient responds to voice stimulation, Pain - patient responds to pain, Unresponsive). Every 30 minutes for 2 hours, then every hour until reviewed.
- Observations (T,P Respiratory rate, BP, O2 sats BGL).
- Imaging (CT head or MRI).

**Intervention:**
- Treat underlying cause (e.g., may need antibiotics to treat infection).
- Will need specialist referral and review to rule out stroke, SDH, and brain tumour.
Seizure documentation

Consideration:
- Need to consider whether it is a partial seizure (with or without secondary generalisation) or a generalised seizure.
- Document a detailed description of the seizure, attack, or event and document in residents notes.

Assessment:
If a partial seizure:
- Assess patient's ability to speak during a seizure.
- Assess patient's ability to obey commands during a seizure.
- Assess patient's ability to recall memory after the seizure.

If a generalised seizure:
- Assess patient for any lateralising signs such as do they have jerking movements on one side of their body (which side) and which limbs are affected?
- Has patient become cyanotic (bluish in colour) or flushed?
- Does the patient have any head and/or eye deviation (that is: turned their head and/or eyes to one side only and document which side).
- Has patient bitten their tongue or the inside of their mouth (blood noticed in the mouth)?
- Has patient been incontinent of urine or faeces?

Intervention:
If the patient does not fully recover because:
- The patient has been prolonged to seizure(s) of longer than 5 minutes, or
- The patient has had 2 or more complex partial seizures less than 2 hours apart, or
- The patient has 2 seizures without any recovery from the post-ictal state.
- The patient may be in Status Epilepticus, which is a medical emergency and thus the resident will need to be reviewed by a specialist or transferred to the nearest Emergency Department for further treatment and management.
Post ictal monitoring

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

Consideration:
- Consider patient's recovery. Is the patient recovering? (Keep in mind some patients can remain post ictally confused or inappropriate for up to 30 to 60 minutes.)
- Provide oxygen therapy.

Assessment
- Assess patient's AVPU (Alert, Verbal - patient responds to voice stimulation, Pain - patient responds to pain, Unresponsive) every 30 minutes until fully recovered (to patient's pre-seizure state).
- Assess routine observations, BP, HR, respiratory rate, and oxygen saturation.

Intervention
- Will need GP or specialist referral and review of an anti-epileptic medications (AEDs).
- If patient is known to have epilepsy and on AEDs, will need to check the therapeutic drug level of that AED.
Managing Seizures Flowchart

Seizure

Administer oxygen on resident and place in left lateral position and monitor

Assessment

Seizure lasting longer than 5 min, or 2 seizures in close succession (< 1 hr apart), or The patient is not showing an increase in their level of consciousness within 30 min

Complete a full set of obs T P R SaO2 BP including BGL

Yes

Phone 000 for an ambulance

Contact ACE

No

Is this the first seizure?

Yes

Contact GP
Initiate investigations and observations
Consider referral to neurology

No

If patient has known seizures, the patient should have a Clinical Management Plan

Monitor post ictal and call GP to review medication levels
Diabetes

Diabetes Issues

- Insert Local Diabetes contact details
- Australian Diabetes Council 1300136588 - You can talk to a diabetes educator/ dietitian/ exercise physiologist. Mon - Fri 9 - 5pm.

Type 1 diabetes

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

Guidelines for management:

- Ensure the patient has regular carbohydrate intake.
- Test urine for ketones if BGL is >15.
- Do not withhold insulin.

Type 2 diabetes

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

Guidelines for management:

- Ensure the patient has regular carbohydrate intake.

Blood glucose monitoring

Daily blood glucose monitoring is required, according to the following guidelines:

- Frequency of Blood glucose monitoring should follow the recommended guidelines by Diabetes Australia or an individually tailored clinical management plan as recommended by the patient's Endocrinologist or GP.
- Test more frequently if the patient is unwell or if suspected hypo/hyper glycaemia.
- The aim is 4 - 6 mmol before meals, and 6 - 8 mmol two hours after a meal. However, these levels may vary in the elderly, so diabetic patients should be individualised on a diabetic management plan.

Guidelines for management:

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

Hypoglycaemia is a blood glucose level below 4. See the Hypoglycaemia Management (page 38) flowchart.

Guidelines for management:
Do not try to give an oral replacement to an unconscious/drowsy patient.

Hyperglycaemia

Hyperglycaemia is a blood glucose level above 11.1 mmol.

Guidelines for management:
- Report symptoms - Polyuria, polydipsia
- Follow an individual diabetic Clinical Management Plan.

Insulin

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

Guidelines for management:
- Store insulin unopened, in the fridge.
- Once opened, insulin can remain at room temperature for one month.
- Each patient must have their own, clearly labelled vial.
- Do not use insulin if it has turned cloudy, it's past the expiry date, or if the vial has been open longer than 1 month.

Foot care

Foot care is important for patients who have diabetes.

Guidelines for management:
- Patients who have a history of ulcers should be referred to a podiatrist or high risk foot clinic.
- Practice good pressure area care.
- Do not use poor fitting shoes (always check inside the shoe before putting it on a patient).
- Do not cut toenails unless you have been trained for this.
Residents who have known diabetes should have a diabetes Clinical Management Plan.

*For those with Type 1 diabetes, it is advisable to have a standing order of IM Glugagon in case of severe hypoglycaemia.*
Management of Hypoglycaemia
Suspected low blood glucose level (BGL)

Signs and Symptoms:
Pale, sweating, shaky, palpitations, light-headed, dizzy, irritable, speech, confusion, fitting, change in consciousness or behaviour
Patient may show some, all, or none of the above symptoms

Assessment:
Test BGL < 4 mmol

Hypoglycaemia
Patient conscious

Step 1
Give quick acting carbohydrate:
• 1 lbs honey, jam, or sugar, or
• 1/3 can soft drink (not diet), or
• 7 small or 4 large jelly beans, or
• 1 fruit juice “Popper”

Step 2
Give slower acting carbohydrate (=15 grams)
• Glass of milk, or
• Slice of bread, or
• 2 – 3 plain biscuits

Step 3
Wait 15 min then recheck BGL

Severe hypoglycaemia
Patient unconscious or unable to tolerate oral glucose

Is IM Glucagon ordered & available?

Yes
Give IM Glucagon as ordered by GP
Patient should respond within 10 min

Has patient regained consciousness?

Yes
No

No
Phone 000

BGL > 4?

Yes
Continue to monitor BGL

No
Repeat Step 1 and Step 3

After 15 min, check BGL again

BGL > 4?

Yes
Repeat Step 1 and contact GP

No

If transfer to ED required, RACF staff phone 131233

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Falls

Management of a Fall (Head Injury) Flowchart

Patients on anticoagulants, for example, warfarin, one of the new oral anticoagulants (dabigatran, rivaroxiban, apixaban) and/or clopidogrel, ticlopidine, or plasugrel have a high risk of significant bleeding as a result of trauma. A patient on anticoagulants who sustains a fracture, soft tissue injury, or large laceration should be observed closely. If a large haematoma develops anywhere on the body, consult the general practitioner or Medical Officer. General Practitioners (GPs) should carefully consider the risk versus benefit of anticoagulants in high risk fallers.
Management of a Fall with Evidence of a Head Injury

Danger Response
Arrest Breathing Circulation
Does the patient have an Advance Care Plan?

Loss of consciousness?

No

Assess for injuries and attend vital signs

Patient on anticoagulants?

No

Phone 131233 for transfer to hospital for assessment and head CT

Yes

Assessment

One or more of the following:
- Abnormal behaviour from baseline
- Large hematoma
- Altered neurological signs from baseline
- Vomiting
- Severe headache
AND patient has an ACP/ACD requesting intervention

If change in LOC or neurological observations or bleeding unable to be controlled

If change in LOC or neurological observations or bleeding unable to be controlled

Simple head laceration requiring closure via sutures or glue:
- Control bleeding with pressure and dress appropriately
- Monitor neurological observations for 4 hours
- Inform GP. If GP unavailable, call ambulance service and state ECP appropriate
- Notify GP of fall and document in notes
- Continue to monitor and implement falls prevention strategies

Observe patient over next 7 days for changes in behaviour or LOC (even if patient has been assessed in an ED)

Send the patient to ED if any of the following develop:
- Severe persistent vomiting
- Drowsiness, giddiness or confusion (new or worse than patient’s normal)
- Severe or persistent headache
- Bleeding from the ears or nose
- Drowsy or difficulty in waking up (new or worse than patient’s normal)
- Feeling or acting as though drunk without consuming alcohol or drugs
- Confusion or not acting normally
- Convulsions (fits) or persistent twitching of face or limbs (new or worse than patient’s normal)
- Blurring or loss of vision
- Seizing or double

GP to review patient

Yes

Place in left lateral position
If ACP requests intervention, apply oxygen and monitor

Phone 000
References

- Institute of Trauma and Injury Management (www.itim.nsw.gov.au)
Management of a Fall (No Head Injury) Flowchart

Patients on anticoagulants, for example, warfarin, one of the new oral anticoagulants (dabigatran, rivaroxiban, apixaban) and/or clopidogrel, ticlopidine, or plasugrel have a high risk of significant bleeding as a result of trauma. A patient on anticoagulants who sustains a fracture, soft tissue injury, or large laceration should be observed closely. If a large haematoma develops anywhere on the body, consult the general practitioner or Medical Officer. General Practitioners (GPs) should carefully consider the risk versus benefit of anticoagulants in high risk fallers.
**Gastroenterology**

**Constipation Flowchart**

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

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

**References:**

**Acknowledgements:**
- Dr Carolyn Hullick JHIED Senior Staff Specialist, Sheridan Briggs ED Pharmacist HNELHD, Bernadette Stewart
Managing Constipation

Day 2 – Bowels not opened

- Increase regular aperients, monitor for signs of obstruction
- Increase oral fluids (if no vomiting)

Day 3 – Bowels not opened

- Digital PR by RN

Result:
- Rectum empty and collapsed
  - Usually indicates bowels have opened
  - Continue to monitor
- Soft faeces in rectum
  - Suppository required – 2 Microlax or Bisacodyl
  - 8 sachets Movicol® in 1 litre water and consumed within 6 hours
  - Coloxyl and senna tabs x2. Repeat in 12 hours
- Hard faeces in rectum
  - Morning – Glycerine suppository x 2
  - Evening – Increased oral aperient
  - Digital disimpaction
  - 8 sachets Movicol® in 1 litre water and consumed within 6 hours
  - Coloxyl and senna x2. Repeat in 12 hours
- Rectum empty and dilated
  - Rule out bowel obstruction
  - Abdominal X-ray if not nauseous

Day 4 – Bowels not opened

- Suggested medications only – you must consult a GP
- Contact GP for medication orders as appropriate

8 sachets Movicol® in 1 litre water and consumed within 6 hours (if not nauseated)
GP may consider Fleet® enema or similar

Repeat Day 3 process and contact GP
Managing Gastroenteritis

**Important**: If two or more cases of gastroenteritis are found in the facility, you must contact the Public Health Unit (insert local Public Health Unit phone number) who will send a Gastro Information Pack by fax or email.

**Signs of dehydration include:**
- Reduced urine output
- BP - Top reading below 90
- HR above 110/min

A gastro kit is available from:
Gastrostomy Tubes

Gastrostomy Tube Issues

Aspiration

Consider:
Feeding position at least 45 degrees from horizontal.

Assessment:
- Chest sounds
- Cough.
- Feed in mouth.

Intervention:
Monitor for signs of pneumonia. If present, stop feeds.

Nausea and vomiting

Consider:
- Feeds running too fast.
- Formula too cold.
- Constipation.

Assessment:
Note colour of emesis.

Intervention:
- Sit at 45 degrees from horizontal.
- Stop feed if vomiting. May need S/C fluids (page 53).

Hyper-granulation (proud flesh)

Assessment:
Check tube is fixed correctly - Not too loose or tight.

Intervention:
Contact ACE (page 5) who will liaise with Gastro CNC.
Dehydration

Consider:
- Insufficient fluid intake.
- Persistent diarrhoea/vomiting.

Assessment:
- Skin turgor.
- Decreasing fluid intake.

Intervention:
- Increase water via tube.
- Contact ACE (page 5), Dietician.

Constipation

Consider:
- Fibre in feed.
- Medication.
- Fluid intake.
- Change in physical activity.

Assessment:
- Abdominal bloating.
- Bowels not opening.
- Hard, difficult to pass stool

Intervention:
- Increase H2O flushes.
- Consider use of aperients.
- Contact Dietician.
**Diarrhoea**

**Consider:**
- Medication.
- Formula too cold.
- Formula contaminated.

**Assessment:**
Monitor hydration.

**Intervention:**
- Give formula at room temperature.
- May need extra fluids/flushes.
- Ensure preparation of formula is hygienic.
Managing Gastrostomy Tubes Flowchart

Insert local contact details for Gastro-liaison Nurse.

Gastrostomy Tube Issues

**Blocked**
- Check the tube for kinks
- Use a gentle push and pull action with a 50 ml syringe to dislodge blockage using 20 – 30 ml warm water or soda water (½ teaspoon sodium bicarbonate in 50 ml water)
- Gently massage tube between fingers

**Leaking**
- Ensure balloon is adequately inflated
- If irritation occurs, wash around the tube with warm soapy water and dry well
- Consider barrier create +/- dressing

**Dislodged**
- Established tube?
  - Yes: Tube was initially inserted within the last 10 weeks
  - No: Phone 131233 to arrange transfer to hospital
- Replace gastrostomy tube if available
- If no gastrostomy tube available, insert a new same sized Foley’s catheter and secure the tube well

**Phone ACE**
- ACE to contact CNC Gastro or ACE
  - May need to consider suction therapy
Subcutaneous Fluids

Subcutaneous Administration Issues

Fluid not running or leaking at site

Possible causes:
- Tube kinked.
- Cannula dislodged.
- Safety.
- Burette empty.

Interventions:
- Check line and site.
- Adjust height of fluid.
- Cannula may need to be resited.

Needle site inflamed

Consider:
- Cellulitis.
- Systemic symptoms.

Possible causes:
Infection due to cannula.

Interventions:
Monitor site.

Large swelling over site

Possible causes:
Infusion not being absorbed at fast enough rate.

Interventions:
- Slow infusion rate down.
- If doesn’t subside, reinsert cannula at new site.
**Cellulitis at site**

Swelling, redness, and heat over and around insertion site

**Consider:**
- Pain/tenderness.
- Fever.
- Systemic symptoms.

**Possible causes:**
Infection.

**Interventions:**
- Stop infusion immediately and notify GP.
- Reinsert cannula in new site.

**Undecided what fluid to give**

**Interventions:**
- 0.9% Saline Chloride.
- 4% Dextrose and 1/5 Sodium Chloride.

**Undecided what rate to run fluids**

**Consider:**
Consider the patient’s condition and co-morbidities.

**Interventions:**
- Not faster than 83 mls an hour (1 litre over 12 hours).
- No more than 2 litres a day.

**Cannula insertion**

**Consider:**
Monitor site each shift.

**Interventions:**
Change cannula if inflamed and leave in situ no longer than 72 hrs.
Managing Subcutaneous Fluid Administration

Subcutaneous fluid administration is not appropriate for:
- Shock
- Severe dehydration
- Cardiac failure (page 17)
- Pulmonary oedema
- Some skin disorders
- Lymphoedema
- The management of malnutrition
- Fluid resuscitation
- Terminal care (page 63)

Subcutaneous fluid administration is appropriate for:
- Mild dehydration
- Poor oral intake
- Dysphasia
- Confusion/delirium (page 26)
- Mild hypothermia
- Nausea and vomiting
- Impaired venous access
- Gastroenteritis (page 46)

Procedure for subcutaneous fluid administration

1. **General Practitioner (GP)** - Order isotonic fluids for administration (0.9% sodium chloride or 4% dextrose 1/5 sodium chloride).

2. Insert the subcutaneous device to a non-oedematous position (shown below). Secure with a firm dressing.

   ![Subcutaneous Fluid Administration Diagram](image)

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

3. Prime the IV giving set, attach to a S/C device and run the infusion. The rate must be no greater than 2 litres a day.

4. Monitor the site. If you have any concerns, contact the GP. See also: Subcutaneous Administration Issues (page 51).

5. Monitor the patient’s hydration:
   - If the patient is stable, discontinue fluid administration and recommence it when needed.
   - If there is no improvement, the patient is unstable or the patient deteriorates, contact the GP.

6. GP - Call 131233 to arrange transfer to hospital (page 11).
Pain

Identifying Pain

Pain identification and assessment

**Verbal:**
- Individual's report of presence and intensity.
- Numerical pain rating scale, verbal descriptor scale, brief pain index (BPI).

**Non verbal:**
- Facial expression, vocalisation (moaning, calling out), body movements, changes in interpersonal interactions, mental status change.
- Assessment tools may include, PAINAD, ABBEY pain scale.

**The resident with dementia:**
- Detection of pain often reduced.
- Reports of pain should be accepted.
- Those unable to communicate look for cues (as above).

**Type of pain**

**Nociceptive – Superficial:**
- Burning, stinging or sharp.
- Well localised.
- Lesions, ulcers, pressure areas

**Deep:**
- Aching, gnawing pain, well localised.
- Osteoarthritis, fractures.

**Visceral:**
- Deep, cramping squeezing pain, pressure, diffuse, not localised.
- Bowel obstruction, abdominal colic.

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

- May be non-verbal.
- End stage disease progression.

See [palliative section](#) (page 63)

Managing Pain Flowchart

Adapted from the Australian Pain Society Pain Management flowchart, "Pain in residential Aged Care Facilities management strategies".
Respiratory

Shortness of Breath (SOB) - New Onset

Important! If the patient has one or more of the following, and their ACP (page 8) (Advanced Care Plan) states intervention, phone 000.

- Lips are blue.
- Nail beds are blue.
- Respiratory rate <12 or >40.
- Sudden pain on breathing.
- Unable to speak or only in words.
- Temperature <34 or >38.
- A new, debilitating cough.

Immediate actions

1. Sit the patient upright or in a comfortable position. Give reassurance and assess the severity of the shortness of breath (SOB).

2. Check/assess:
   - Respiratory and heart rates.
   - Temperature.
   - Pallor, colour (cyanosis).
   - Presence of wheeze.
   - Ability to talk (long or short sentences or words only).
   - Chest expansion.
   - Cough.
   - Sputum.
   See assessment below.

3. Apply oxygen:
   - If patient has COPD, use 2L/min via nasal prongs.
   - If patient has asthma or the cause is unknown, use 6L/min via mask.

Important: Excessive oxygen may be dangerous. Maintain SaO2 90-94%.
Assessment and next steps

Consider the multiple causes of SOB:

- **Congestive heart failure** - Waking at night with SOB, difficulty lying down, cough at night or when lying down, swelling or the ankles or lower limbs, weight gain. See [Heart Failure Issues](#) (page 17).
- **COPD** - Gradual onset, cough, decreased exercise tolerance. Patient may already have a diagnosis of COPD.
- **Asthma** - Acute onset, expiratory wheeze, unable to speak in whole sentences.
- **Pneumonia** - Pain, localised to one side of the chest, fever, cough, audible crepitations in the chest. If pneumonia is suspected, contact the GP who may contact ACE and/or arrange transfer to hospital.
- **Pulmonary Embolism** - Rapid heart and respiratory rate, history of immobility, recent surgery, cancer, current or previous DVT, new sudden pain on breathing. If pulmonary embolism suspected, contact the GP who may contact ACE and/or arrange transfer to hospital.
- **Acute Coronary Syndrome/Myocardial Infarction** - Dull heavy tight anterior chest pain, pain in throat, jaw, back, and arms, pallor, sweating, and nausea. If acute coronary syndrome/myocardial infarction suspected, contact the GP who may contact ACE and/or arrange transfer to hospital.
- **Palliative** - Terminal phase of illness, anxiety - Contact the Palliative Care team if the patient is known to them, or contact ACE and the GP. Consider standing order for anxiolytic.

Notes

- If three or more cases of influenza-like illnesses within 72 hours are identified, notify the Public Health Unit ([insert local Public Health Unit phone number](#)).

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Acute Shortness of Breath Flowchart

PFU - Insert local phone number.
Rapid Access Clinic - Insert local phone number.
Managing Acute Shortness of Breath

**Symptoms** — Increased shortness of breath and decreased exercise tolerance, breathlessness, wheeze, cough, sputum production, chest tightness, tachycardia, increased use of accessory muscles (e.g., abdominal), difficulty speaking in full sentences

**Assessment:**
Sit patient in comfortable position and reassure. Assess severity of symptoms

**Moderate**
- Increased breathlessness, increased cough, sputum
- No altered LOC, no physical exhaustion, variable wheeze, able to talk in sentences

Give reliever asthma medication — Give 4 puffs of blue/grey reliever (e.g., Ventolin, Asmol, or Airomir)
- Use a spacer if available
- Give 1 puff at a time with 4 breaths after each puff
- Use the person’s own inhaler if possible
- If no improvement, repeat. Continue to reassure patient.

**Severe**
- Fever/chills, +/- ankle swelling, extremely short of breath at rest, difficulty speaking, increased sputum or changes in colour (green or yellow), increased cough (dry or productive), no relief from inhalers, chest pain, agitated or drowsy, physical exhaustion, HR > 120, cyanosed around lips, wheeze if quiet, talks in words only, may be hypotensive, cool peripheries

**Treatment effective?**

**Treatment effective**
Continue reliever medication 4 hourly for 24 – 48 hours and contact GP

**Return of symptoms**
- Continue reliever medication. Contact GP
- Consult patient’s action plan

**Unchanged or symptoms worsening**
Phone 000 for ambulance
- Give oxygen if available
- While waiting for ambulance, continue giving reliever medication — 4 puffs every 4 minutes

Contact ACE

**Warning! Excessive oxygen can be dangerous. Maintain SaO2 90-94%**
- If pulse oximetry is not available, administer oxygen at no more than 2 litres per minute via nasal prongs, or where available, follow the patient’s individualised management plan with regards to oxygen
Tracheostomy Issues

Excessive secretions

Possible causes:
- Infection.
- Fluid overload.

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

Dry secretions

Possible causes:
Inadequate humidification.

Interventions:
- Regular normal saline nebuliser.
- Provide warm air humidifier.
- Ensure inner cannula is clean and free of crusty sputum.
Blood stained sputum

Possible causes:
- Irritation.
- Insufficient humidification.
- Suction Issues – Too vigorous, deep, frequent, or high pressure.
- Infection.
- Excessive coughing.

Interventions:
- Monitor.
- Review suctioning technique, educate staff.

Follow up required:
- Phone 000 if excessive.
- Phone ACE if unsure.

Excoriation to skin surrounding stoma

Possible causes:
- Excessive moisture.
- Exposure to contaminated secretions.
- Infected sputum.

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

Follow up required:
- GP review.
- Tracheostomy care provider.
Tracheostomy Flowchart

Tracheostomy Troubleshooting

Assessment

Tube displaced

- Patient breathing +/- distress?
  - No
    - If no advanced care directive
    - Commence CPR
  - Yes
    - Position patient with neck extended
    - Attempt to insert clean tracheostomy tube of the same size or one size smaller if assessed to do so
    - Successful?
      - No
        - Phone 000 for ambulance
          While waiting for ambulance, occlude stoma site and apply O2 by mask to face
          If laryngectomy patient, Do not occlude stoma – Place O2 tubing in stoma
      - Yes
        - Monitor patient
          Contact GP and Trachy care provider

Tube blocked

- Apply oxygen to trachy
  - Encourage patient to cough out secretion
  - If successful, remove inner cannula and clean
  - Suction resident, short durations, twice
  - Successful?
    - No
      - Phone 000 for ambulance
        While waiting for ambulance, occlude stoma site and apply O2 by mask to face
        If laryngectomy patient, Do not occlude stoma – Place O2 tubing in stoma
    - Yes
Palliative Care

Palliative Care Issues

The aim of Palliative Care

**Consider:**
Neither to hasten nor prolong life.

**Assessment:**
- Patient comfort is most important.
- Family acceptance.

**Intervention:**
- Palliative approach to care.
- Educate and support the family.

Restlessness/agitation/terminal delirium

**Consider:**
- Terminal phase.
- No reversible causes to the delirium.

**Assessment:**
- Moaning, grunting, crying out.
- Agitation.
- Restlessness.
- "Plucking", resistant to care.
- Aggression, hallucinations.

**Intervention:**
Benzodiazepines/haloperidol.
Hydration

Consider:
Subcut fluids (page 51) may be considered, although are not usually appropriate (extremely rare)- may interfere with the dying process and may cause more harm than good.

Assessment:
Resident comfort.

Intervention:
- Small sips of water.
- Mouth care.
- Cease oxygen if possible.

Mouth care

Consider:
- Thrush.
- Medication.
- Dehydration.
- Thirst.

Assessment:
Inspection of oral mucosa and tongue.

Intervention:
- Small sips of water.
- Mouth care.
- Soft toothbrush or impregnated swabs and mouth moisturiser.
- Oral balance.

Myoclonus

Consider:
Opioid toxicity.

Assessment:
Involuntary jerking, muscle twitching.

Intervention:
- Benzodiazepines.
- Consider opioid rotation – Contact Palliative care.
Terminal secretions

**Consider:**
Family/carer/patient distress.

**Assessment:**
Noisy rattling breathing "death rattles".

**Intervention:**
- Repositioning.
- Anticholinergics (hyoscine, glycopyrrolate).
- Gentle oral pharyngeal suctioning (using soft Nelation® catheter).
- Cease any artificial hydration.

**Palliative Care Crisis Pack**
For end of life management. See [Palliative Care Crisis Pack](#) (page 66).

**Palliative Care Service**
Contact for any issues/advice or for any persistent symptom.
Insert local Palliative Care Service phone numbers.

**Bereavement**

**Consider:**
Services for relatives.

**Intervention:**
Available through palliative care services [insert local phone number](#).
# Palliative Care Crisis Pack

The palliative care crisis pack is to be used as a guide for the care of residents in the terminal phase of life. The medications are suggested drugs only and should be used under the supervision and direction of the patient's general practitioner or palliative care team.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Variable</td>
<td>Subcut</td>
<td>PRN</td>
<td>Pain</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>10 mg</td>
<td>Subcut</td>
<td>4 hourly, PRN</td>
<td>Nausea</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>0.5–1 mg</td>
<td>Subcut</td>
<td>2-4 hourly, PRN</td>
<td>Confusion restlessness Terminal delirium</td>
</tr>
<tr>
<td>Midazolam</td>
<td>2.5–5 mg</td>
<td>Subcut</td>
<td>hourly PRN</td>
<td>Acute agitation myoclonus</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>0.5 mg (0.2 mL) drops</td>
<td>Sub-lingual</td>
<td>6 hourly PRN</td>
<td>Agitation convulsions</td>
</tr>
<tr>
<td>Glycopyrrolate</td>
<td>0.2–0.4 micrograms</td>
<td>Subcut</td>
<td>4–6 hourly, PRN</td>
<td>Conscious resident, for increased secretions</td>
</tr>
<tr>
<td>Hyoscine</td>
<td>0.4–0.8 micrograms</td>
<td>Subcut</td>
<td>2–4 hourly, PRN</td>
<td>Unconscious resident for increased secretions</td>
</tr>
<tr>
<td>Mouthcare</td>
<td></td>
<td>Oral mucosa, tongue and lips</td>
<td>4 hourly and PRN</td>
<td>Dry mouth</td>
</tr>
</tbody>
</table>

See also: [Palliative Care on HealthPathways](http://hne.healthpathways.org.au/17434.htm)  
Urology

Indwelling Catheter Issues

Difficulty inserting Foley® urethral catheter (males)

Enlarged prostate, urethral stricture, previous prostate surgery:
- Check medical history.
- Check catheter size.
- **Intervention**: GP may consider referral to an Urologist for assessment. Choose a larger gauge catheter e.g., 16G.

Inadequate lubricant:
- Anaesthetic lubricant should always be inserted into the urethra prior to inserting the catheter. Allow time for the anaesthetic lubricant to work i.e., 2 minutes.
- **Intervention**: Change the angle of the penis, and rotate the catheter gently whilst inserting the catheter.

Patient is anxious:
- **Intervention**: Ask patient to breathe slowly if possible to help relax the muscle below the prostate. This may assist with catheter insertion.

Constipation:
- Check recent bowel movement.
- Do PR check for faecal impaction.
- **Intervention**: As above and treat constipation (page 44).

Retracted penis:
- **Intervention**: Ask patient to breathe slowly if possible to help relax the muscle below the prostate. This may assist with catheter insertion

Difficulty inserting Foley® urethral catheter (females)

Urethral orifice is difficult to visualise:
- Light source - Ensure adequate lighting.
- Unable to open legs adequately e.g. arthritis:
  - Check for most comfortable position, e.g., on her left side, pillow under buttocks.
  - **Intervention**: Aim the catheter in an upward direction during insertion to avoid entry into the vagina.
- Atrophic vaginitis (Vulva pale looking and bleeds easily when labia separated):
  - **Intervention**: GP may consider topical oestrogen.
  - **Intervention**: GP may consider referral to an Urologist for insertion of SPC.

Obesity:
- Undertake staff / patient risk assessment.
- **Intervention:** GP may consider topical oestrogen. GP may consider referral to an Urologist for insertion of SPC.

### Constipation:
- Check recent bowel movement.
- **Intervention:** Do PR to check for faecal impaction. [Treat constipation](#) (page 44).

### Difficulty removing suprapubic catheter (SPC)

#### Consider:
Ridge forming on catheter when the balloon is deflated.

#### Assessment:
- Check catheters on removal and consider changing catheter brand.

#### Intervention:
- Allowing the balloon to self-deflate will minimise the ridging, i.e., attach the syringe to inflation valve and allow the water to fill the syringe.
- Re-inflating the balloon with 0.1 mL of water and removing syringe may reduce the ridging, then rotate the catheter whilst removing.

### Difficulty with reinserting (changing) a SPC

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

#### Ridge forming on catheter when the balloon is deflated:
- Check catheters on removal and consider changing catheter brand.
- **Intervention:**
  - Allowing the balloon to self-deflate will minimise the ridging, i.e., attach the syringe to inflation valve and allow the water to fill the syringe.
  - Re-inflating the balloon with 0.1 mL of water and removing syringe may reduce the ridging, then rotate the catheter whilst removing.

#### Ensure the bladder is full prior to catheter change if possible:
- Not applicable for patients with autonomic dysreflexia i.e., spinal cord injury above T10.
- **Intervention:** Clamp the drainage system (not the catheter) several hours.

### Gauge 16 Nelaton® Catheter:
If unable to reinsert the catheter try inserting the Nelaton® catheter to establish the tract (firmer catheter). Once inserted remove and insert the Foley® catheter.
Catheter is pulled out (by patient or by accident)

**Trauma:**
- Check for bleeding from the urethra.
- **Intervention:** Inform GP, re-catheterise or refer to ED.

**Securing catheter:**
- Check that the balloon is intact.
- **Intervention:** Inform GP if balloon not intact. Secure catheter with a securing device e.g., catheter strap.

**Patient confused:**
- Suitability for catheter valve/SPC. Assess for alternate management.
- **Intervention:** Inform GP.

**Blocked catheters**

40% of patients with catheters are "blockers". This is more common in immobile patients due to calcium leeching from bones into the urine. 100% silicone catheters have a larger lumen compared to latex/coated catheters and encrust less frequently.

**Hydration:**
- Monitor fluid intake.
- Maintain 2–3 litre fluid intake per day.
- **Intervention:** Consider subcutaneous fluids where appropriate.

**Constipation:**
- Assess bowels.
- **Intervention:** [Treat constipation](#) (page 44) - A full bowel can compress the urethra and block the catheter.

**Catheter size, type, and material:**
- Review catheter size and material.
- **Intervention:** Increasing the catheter size can improve drainage. However, the size for urethral catheters should not exceed G14 for females or G18 for males. 100% silicone catheters, especially Supracath™ (for suprapubic use only) provide the best drainage.

**Drainage bag:**
- Assess size of bag tubing.
- **Intervention:** Large bore tubing provides better drainage.

**Drainage system:**
- Assess patient’s bladder capacity. Consider catheter valve.
- **Intervention:** Attach a Simpla® catheter valve and drain the bladder every 4 hours. This has been shown to increase the time taken to become blocked compared to continuous drainage.

**UTI:**
- Collect urine specimens from a newly inserted catheter.
- **Intervention:** Only treat symptomatic infections. GP may consider referral for insertion of SPC, as larger catheters can be used.

**Leakage around the catheter (bypassing)**

**Catheter blocked:**
- Check for:
  - Kinks /loops in the catheter/drainage system.
  - Debris blocking catheter.
- **Intervention:** Ensure unobstructed flow.

**UTI:**
- Perform urinalysis for +ve nitrites.
- **Intervention:** Contact GP if +ve.

**Constipation:**
- Check bowels.
- **Intervention:** [Treat constipation](page 44).

**Bladder Spasms:**
- UTI catheter movement.
- **Intervention:** As above secure catheter to minimise movement.

**Catheter/ balloon size catheter movement:**
- Check catheter and balloon size.
- **Intervention:** Change to a smaller size if possible.
Indwelling Catheter Flowchart

Indwelling Catheter Troubleshooting

Assessment: What is the problem?

Blocked
- Check for kinks
- Milk the tube
- Encourage oral intake
  - If still no drainage, repeat milking the catheter
  - Remove catheter and replace:
    - size smaller for leaking catheter
    - size larger for blocked catheter
  - Anchor catheter without tension
  - If symptoms persist...

Leaking around catheter
- Check volume in the balloon
- Check for signs of constipation, pain, and UTI

Difficultly removing catheter
- Address location, duration, severity
  - Inspect insertion site for discharge or erythema
- Add 2 ml water back into the balloon then release syringe to allow independent drainage
- Slightly rotate and steady catheter
- Attempt to remove catheter again, asking patient to bear down
  - Use mild traction
  - Repeat the above procedure

Contact ACE

Pain

Haematuria
- Dipstick, U/I, contact GP
- Urine colour?
  - Rose coloured, with infrequent clots
  - Bright red to port coloured +/- clots present, poor output

Arrange outreach visit
If not available, phone 131233 to arrange transfer to hospital
Suprapubic Catheter Troubleshooting

What is the problem?

**Blocked**
- Check for kinks
  - Milk the tube
  - Encourage oral intake
- If unsuccessful, check vol of H2O in balloon and decrease to 6 mls
  - Remove catheter and replace
  - GP to consider Oxybutynin 2.5 mg bd +/- smaller SPC

**Bypassing (leaking around catheter)**
- Check for signs of constipation and UTI
- If unsuccessful, attempt to insert one size smaller catheter
  - If unsuccessful...

**Difficulty with reinsertion**
- Insert sterile Xylocaine gel 2% into SPC stoma
  - Try to reinsert prescribed catheter again
  - If unsuccessful...

**Balloon not deflating**
- Check for constipation
  - Add 2 ml water into 10 ml syringe, place into balloon then release syringe to allow independent drainage
  - Attempt to remove catheter again
  - If unsuccessful...

**Haematuria**
- Dipsick, U/A to check for UTI, contact GP
  - Urine colour?
    - Rose coloured, with infrequent clots
    - Bright red to port coloured +/- clots present, poor output
    - Increase fluids, treat UTI as appropriate
    - Monitor output and colour
    - Continue to liaise with GP if further concerns...

**Contact ACE**

Arrange outreach visit
- If not available, call 131233 to arrange transfer to hospital

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Urinary Tract Infection - Female - Flowchart

Urinary Tract Infection - Female

New/increased incontinence +/- urgency +/- increased confusio +/- fever

U/A

+ve for leukocytes +/- blood + nitrates

MSU for MC&S

Antibiotics if >10^5 CFU/ml

-ve for leukocytes +/- blood + nitrates

Palpate bladder to check for post-void residual

Palpable bladder

Referrals to consider:
- Continence CNC – to manage urinary symptoms
- Dementia CNC – to manage delirium
- Consider non-urological infection source, i.e., URTI

Contact ACE

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Urinary Retention Flowchart

Urinary Retention

Decreased urine output or no urine output

Assessment:
- Physical assessment
- Palpate bladder
- PR observations (temp, HR, BP)
- Intake
- Attend bladder scan if available

Contact GP

Consider possible cause

Dehydration

Encourage oral intake
Consider S/C fluids if appropriate

Constipation

Insert catheter

Treat constipation

Once constipation resolved, wait 24 hours then...

Do Trial of Void (TOV) in consultation with GP

Bladder dysfunction

Insert IDC if in retention
- If more than 1 litre drains, clamp catheter for 1/2 hour and inform GP

If more than 300 ml drains, leave catheter in situ

After 2 weeks

If unable to insert IDC, contact GP

Prostate related

Call 131233 to arrange transfer to hospital

Contact ACR
Wound Care

Management for Various Types of Wounds

Venous leg ulcer

Assessment:
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Patient history - Previous VLU, VV, DVT, and dilated and distorted veins.
- Dilated veins, ankle flare, location lower third of leg, presence of pulses, pedal dorsum and posterior tibial and popliteal.
- Compression for ABPI 0.8-1.2.
- Ankle brachial index (ABI) prior to compression therapy (>0.8 compressible).
- Location (generally malleolus area).
- Wound edges (irregular).
- Calf circumference (baseline).
- Moderate Pain.
- +/- Cellulitis.
- Pigmentation.
- Capillary refill.

Goal of treatment:
- Promote venous return
- Reduce oedema
- Prevent infection

Intervention:
- Management with T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Autolytic debridement, range of movement passive exercisers at ankle, bed elevation, diet and nutrition, regular exercise and weight control, skin care and hygiene to prevent infection, exudate management for protection of peri wound breakdown.
- Long term management compression hosiery with replacement 6-12 months.
- Skin care.
- Leg elevation.
- Adequate regular pain relief.
- +/- sharp wound debridement.

**Arterial leg ulcer**

**Assessment:**
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Severe pain.
- Reported calf pain nocte and claudication with ambulation and exercise.
- Cold toes and numb toes.
- Absence of pulses or diminished.
- Painful legs.
- Rest pain at night.
- Location (tips of toes).
- Punch out appearance.
- Shiny skin.
- Hairless.
- Diminished or absent pulses.
- Dry desiccated edges.
- +/- gangrene.
- Dependent rubor.

**Goal of treatment:**
- Prevent Infection.
- Promote Comfort and arterial perfusion.

**Intervention:**
- Vascular Consult if in-operable – dry non-adherent dressings.
- +/- antimicrobial.
- Protect from pressure.
- Avoid extreme temperature.
- Skin care.
- Remove non-viable tissue only under vascular supervision if boggy or infected.
- Management - Stop smoking.

**Diabetic foot ulcer**

**Assessment:**
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non-viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Location (plantar)
- Punch out appearance,
- Round, dry
- BGL, circulation

**Goal of treatment:**
- Off load plantar Pressure
- Prevent infection
- Avoid amputation

**Intervention:**
- Foam dressings to off load pressure.
- Education on foot / nail care
- Podiatry referral
- Correct foot wear

**Malignant wound**

**Assessment:**
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non-viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Biopsy.
Goal of treatment:

- Promote comfort and quality of life.
- Decrease odour.
- Control exudate.
- Decrease bleeding.

Intervention:

Metronidazole gel, medihoney gel.

Complex draining wound

Assessment:

- Level of drainage, colour, consistency.
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Goal of treatment: Contain exudate.

Intervention:

- Use of ostomy appliances.
- NPWT when wound has been debrided.
- Absorbent dressings.

Pressure Injuries

Assessment:

- Location, Grade.
- Size, Time frame.
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Risk assessment score.
- Support surface required.
- Nutrition.
Contamination risk.

**Goal of treatment:**
- Reduce pressure.
- Prevent infection.
- Promote healing, position to keep off area/ reduce pressure.

**Intervention:**
- Pressure relieve devices.
- +/- debridement.
- Moist wound dressings.
- +/- antimicrobial.

**Skin tears**

**Assessment:**
- Location Star classification:
  - Category 1a tear without tissue loss normal colour
  - Category 1b tear without tissue loss, pale, dusky or darkened
  - Category 2a Tear with partial tissue loss normal colour
  - Category 2b Tear with partial tissue loss, pale, dusky or darkened
  - Category 3 Tear with complete tissue loss
- Measure all wounds as a reference.
- Use T.I.M.E.:
  - Tissue management: healthy or non viable: may require debridement (episodic or continuous).
  - Infection or inflammation control: remove infected foci, topical/systemic antimicrobials.
  - Moisture balance: avoid desiccation and maceration; apply moisture balancing dressing, compression, NPWT.
  - Epithelial edge advancement: non-advancing or undermining, reassess cause or consider corrective therapies.
- Goal of treatment:
- Promote wound healing.
- Prevention of further skin damage.
- Prevent of Infection.

**Intervention:**
- Stop bleeding - apply pressure.
- Cleanse.
- Approximate skin flap immediately without over stretching (no steri strips).
- Silicone products for comfort and conformability.
- Local wound management – consider silicone dressings and mark dressing with arrow to show direction of dressing removal.
- Dress as appropriate – mark dressing with arrow to show direction of dressing removal consider silicone.
- Limb protection – for prevention as well.
- Documentation.
- Tetanus status.
Monitor.

**Chronic Wound Management Issues**

### Wound exudate

**Consider:**
- Amount.
- Consistency, colour, odour.

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

**Intervention:**
- Hydrogels, semi-permeable films, hydrocolloids.
- Silicone.
- Hydrogels, hydrocolloids, calcium alginates.
- Silicone.
- Calcium alginates, hydrofibres, hydrocolloid/paste powder/sheet, foams, silicone.
- Hydrofibres, foam sheet/cavity, extra absorbent dry dressings, wound/ostomy bags.

### Secondary dressing

**Consider:**
Dependant on exudate levels.

**Assessment:**
- As for Wound exudate (page 80).

**Intervention:**
- Telfa - Combines – Mesorb, Zenivit, foam.

### Odour

**Consider:**
- +/- infection.
- Location (groin, skin folds).

**Assessment:**
- Swabs.

**Intervention:**
- Charcoal.
- Consider use of antimicrobial dressings, medical honey debridement.

**Topical anti-microbials**

**Consider:**
- Positive swab results.

**Assessment:**
- Clinical infection.
- Inflammation / erythema.
- Increase pain, exudate, oedema.

**Intervention:**
- Silver impregnated dressings.
- Wound medical honey, cadexomer iodine powder/paste/sheet.
- Antiseptics, and tulle gras with soft paraffin and 0.5% chlorhexidine acetate.
Chronic Wound Management Flowchart

Managing Chronic Wounds

Assessment:
Document wound assessment

Inflammation
Heat, swelling, erythema, pain/itching

Goal – Restore optimal inflammatory response
Optimal wound coverage, cleansing, reduce mechanical trauma

Sloughy/necrotic wound base
Yellow to black tissue

Goal – Debridement
Autolytic CSW (conservative sharp wound) Mechanical, chemical

Critical colonisation
Inflammation, Hyper granulation, bleeding, increased exudate, rolled wound edges

Goal – Restore bacterial balance

Infection
Purulent wound, erythema increase exudate, swelling, heat, pain, malaise, fever

Wound swab, medical review with appropriate antibiotic treatment
Thorough wound cleansing, exudate management, topical anti-microbials if required

Wound bed preparation – Promote granulation, wound contraction and epithelialisation

Dry Wound
Minimal exudate
Moderate exudate
Heavy exudate

Secondary dressing if required for absorption and protection
If no improvement, contact ACE – consider outreach
Document the regime and progress
Pressure Ulcers Flowchart

Managing Pressure Ulcers

At Risk – As identified by risk assessment
- Maintain skin integrity
- Eliminate pressure, shear, and friction
- Initiate positioning, turn schedule, and support surface
- Document and communicate

Existing pressure ulcer
- Stage 1 - Non-blanching erythema, skin intact
- Alternating overlay +/- seating device

Stage 2 - Broken Epidermis, can be blister
- Stage 3 - Broken, dermis down to fascia
- Stage 4 - Cavity, through fascia, muscle, to bone
- Unstageable pressure injury, depth unknown (treated as Stage 4)
- Suspected deep tissue injury, depth unknown (treated as Stage 4)

See Pressure Injury Stages

Manage wound as per Chronic Wound Management
Pressury Injury Stages

Stage I pressure injury: non-blanchable erythema
- Intact skin with non-blanchable redness of a localised area usually over a bony prominence.
- Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area, may be difficult to detect with dark skin tones.
- The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue. (May indicate “at risk” persons (a heralding sign of risk).)

Stage II pressure injury: partial thickness skin loss
- Partial thickness loss of dermis presenting as a shallow, open wound with a red-pink wound bed, without slough.
- May also present as an intact or open/ruptured serum-filled blister.
- Presents as a shiny or dry, shallow ulcer without slough or bruising (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.

Stage III pressure injury: full thickness skin loss
- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed.
- Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling. The depth of a stage 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.

![Wound Example](image)

**Stage IV pressure injury: full thickness tissue loss**

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed.
- The depth of a stage 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, tendon visible or directly palpable.

![Wound Example](image)

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

- Full thickness tissue loss in which the base of the PI is covered by slough (yellow, tan, grey, green or brown) and/or eschar (tan, brown or black) in the PI bed.
- Until enough slough/eschar is removed to expose the base of the PI, the true depth, and therefore the stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural biological cover and should not be removed.
Suspected deep tissue injury: depth unknown (treated as stage 4)

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

Stoma Management Issues

Appliance not adhering/leakage/

**Consider:**
Peri-stomal skin damage due to leakage.

**Assessment:**
Skin reddened, broken, weeping, painful.

**Intervention:**
Contact stomal therapy clinic for appointment.

Colostomy inactive

**Consider:**
Number of days.

**Assessment:**
Pain, nausea, vomiting abdominal distention, interventions i.e., aperients. Digital examination, abdominal x-ray.

**Intervention:**
Contact stomal therapy clinic for appointment.
Para-stomal hernia

**Consider:**
Size.

**Assessment:**
- Hernia history.
- Pain.
- Stoma function.
- Hernia management.

**Intervention:**
- If stoma is non functioning and associated with pain, nausea, and vomiting, contact the Emergency Department.
- Contact stomal therapy clinic for appointment.

Stomal prolapse

**Consider:**
When occurred.

**Assessment:**
- Pain.
- Reducible?
- Colour of stoma – contact Emergency if dusky/purple/black.

**Intervention:**
Contact stomal therapy clinic for appointment.

Wound care

**Consider:**
Wound type/location.

**Assessment:**
Colorectal / surgical wounds.
Exudating wounds.
Entero-cutaneous fistula management.

**Intervention:**
Contact stomal therapy clinic for appointment.
Managing a Burn Injury

Immediate actions:
Provide immediate first aid - Cold running water for 20 minutes (no ice or cold packs).
Avoid hypothermia. For example, if the patient's leg is injured, keep a blanket over the rest of their body.

Assessment:
1. Determine the type of injury:
   - Scald:
     - Splash - cup, soup, shower.
     - Immersion - bath, foot bath.
   - Chemical burn:
     - Body fluids - naso-gastric or PEG tube leaking.
     - Spills - betadine, metho, asceitc acid
2. Assess and document the following:
   - Mechanism of injury:
     - Temperature of source - hot tea, tea cooled with milk, clear or thick soup.
     - Time of exposure - how long was the skin exposed to the heat source.
     - Cooling - was first aid provided?
   - Burn wound assessment:
     - Anatomical location.
     - Surface area %.
     - Grade (superficial, partial thickness, full thickness)
     - T - tissue management.
     - I - inflammation and infection control.
     - M - moisture balance.
     - E - epithelial (edge).

Management:
1. Discuss the burn injury with the general practitioner and/or ACE.
2. Continue monitoring the burn site. If there are any changes or deterioration to the burn site, contact the GP and/or ACE (page 5).
3. If appropriate, phone 131233 to arrange transport to hospital, (page 11)
4. Investigate circumstances leading to the burn injury and ensure that the patient is safe from further injury. Inform Management or follow your organisation's policies.
Education Resources

Contact Hunter Medicare Local (mailto:info@hunterml.com.au) to request access to various education resources.
Other Resources

Acronyms

- ABS - Antibiotics
- ACFI - Aged Care Funding Instrument
- ACT - Aged Care Triage
- AEDs - Anti-epileptic drugs
- BD - Twice a day
- BGL - Blood Glucose Level
- BP - Blood Pressure
- BPI - Basic Personality Inventory
- Ca - Cancer
- CAM - Confusion Assessment Method
- CNC - Clinical Nurse Consultant
- CNP - Clinical Nurse Practitioner
- COPD - Chronic Obstructive Pulmonary Disease
- JHH - John Hunter Hospital
- CSW - Conservative Sharp Wound
- CT - Computed Tomography
- DVT - Deep Vein Thrombosis
- ED - Emergency Department
- GCS - Glasgow coma scale
- GP - General Practitioner
- GTN - Glyceryl Trinitrate
- HITH - Hospital in the home
- HR - Heart Rate
- Hx - History
- IDC - Indwelling Catheter
- IM - Intra-muscular
- IV - Intravenous
- LOC - Level of Consciousness
- Mane - Morning
- Nocte - At night
- NP - Nasal Prong
- NPWT - Negative Pressure Wound Therapy
- MC & S - Microscopic Culture and Sensitivity
- MRI - Magnetic Resonance Imaging
- MSU - Mid stream urine
- PAINAD - Pain assessment in advanced dementia
- PEG - Percutaneous Endoscopy Gastrostomy
- PRN - As necessary
- RACF - Patiential Aged Csre Facilities
- SDH - Sub-dural haematoma
- Sig - Significant
- SOB - Shortness of Breath
- SPC - Supra-pubic Catheter
- S/L - Sub-lingual
- TNP - Treatment Notification Plan
- TOV - Trial of void
- T,P,R - Temperature, Pulse, Respiration
- Trachy - Tracheostomy
- U/A - Urinalysis
- URTI - Upper Respiratory Tract Infection
- UTI - Urinary Tract Infection
- # - Fracture
References

- "Guidelines and Using Advance Care Directives (NSW)" can be downloaded through NSW Health websites: [www.health.nsw.gov.au/pubs](http://www.health.nsw.gov.au/pubs) or obtained from:
  Better Health Centre
  Locked Mail Bag 5003
  Gladesville NSW 2111
  Tel (02) 9816 0452 Fax (02) 9816 0492


- Australian health Ministers’ Advisory Council (AHMAC), October 2006. Clinical Practice Guidelines for the Management of Delirium in Older People


- Concord Repatriation General Hospital. Nursing Services Protocol (S4). Protocol N°:19A Subcutaneous Fluid administration (Hyperdermoclysis)


- GMCT – Urology Network – Nursing


- Home Enteral Nutrition Cards: HEN – Troubleshooting, Feeding Plan, Nutrition Plan, Tubes – Care and Management, Feeding Tubes – Troubleshooting, Equipment, Organising ongoing supplies


- NSW Department of Health, 2003. *Care of patients with Dementia in General Practice*
- QE11 Hospital Health Service District, Brisbane South Community Health Service, November 2006 *Residential Aged Care Facility Clinical Resource Manual*.
- Sydney South West Area Health Service. *Pressure Ulcer Prevention and Management Policy*
- Sydney South West Area Health Service (Eastern Zone). Patient Information Booklet. *Chronic Obstructive Pulmonary Disease*
- Therapeutic Guidelines:
  - Palliative Care, 2012 version 3
  - Cardiovascular guidelines version 6 2012
  - Respiratory, version 4 2009
  - Gastrointestinal version 5 2011
  - Endocrinology version 4 2009
- [18/02/2014](#)
Other Contacts and Resources

Diabetes
- Insert Local Diabetes contact details
- Australian Diabetes Council 1300 136588. Info line - Can talk to Diabetes educator/ Dietitian/ Exercise Physiologist. Mon - Fri 9-5pm

Palliative Care
- Insert Local Palliative care details
- The PIG link is currently not active, however copies of the PIG and information/resources for GPs in UK can be accessed from http://www.rcgp.org.uk/clinical-and-research/clinical-resources/end-of-life-care-resources-for-gps.aspx
- PCOC – palliative care outcomes collaboration webpage

Respiratory
Insert Local respiratory Contact Details
Acknowledgements

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