West Moreton Health

Registered Nurse Care Guide

Residential Aged Care

2018324

Version 1 | November 2018

Caring Better Together

Queensland Government

Care Guide Contents:

Welcome to the Registered Nurse Care Guides for Residential Aged Care

These Care Guides have been adapted, with permission, from the RN Care Guides for Residential Aged Care from the Residential Aged Care Integration Programme (RACIP), Waitemata District Health Board, New Zealand. They provide a quick reference for common conditions encountered when caring for older people in residential aged care. They are based on published guidelines and the best evidence available at the time of review. The Care Guides have been adapted by a group of subject matter experts, to ensure their relevance and alignment with to the Australian context of residential aged care.

These Care Guides are to be used as a guide only! They do not replace robust clinical judgement. They are designed to enhance the thoroughness of the Registered Nurse's assessment and assist with care planning to achieve the best outcome for the older person.

They are also designed to promote early intervention and communication with other members of multidisciplinary teams and particularly with the older person's GP.

We hope you find these Care Guides helpful for providing the best quality care available for older adults.

Dr Robyn Henderson
Executive Director – Nursing and Midwifery
West Moreton Health

Coral Niesler
Nurse Practitioner Nurse Navigator – Medical and Aged Care
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These RN Care Guides are printed and distributed on behalf of the West Moreton Health Residential Aged Care Facilities project 2018.

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Acknowledgements

These Care Guides were originally developed in 2007 under the leadership and vision of Helen Francis, General Manager and Dr Michal Boyd, Nurse Practitioner and Clinical Leader at Waitemata District Health Board, Auckland, New Zealand. They are the result of the collaboration between Waitemata District Health Board Gerontology Nursing Service, Older Adult and Home Health Services, and leaders and clinicians working and practicing in residential aged care. Without their support and hard work the development of these Care Guides would not have been possible.

These Care Guides have been adapted, with permission, from the RN Care Guides for Residential Aged Care from the Residential Aged Care Integration Programme (RACIP), Waitemata District Health Board, New Zealand for use by the West Moreton Health Residential Aged Care Facility (RACF) Project 2018-2019 team. The project team would like to thank all the contributors to the development of the Care Guides in New Zealand, particularly Dr Michal Boyd, University of Auckland and to Sue Skipper, Waitemata District Health Board for granting permission to adapt the Care Guides.

The RACF Project 2018-2019 team would like to thank the following for reviewing and adapting the Care Guides to the Australia context:

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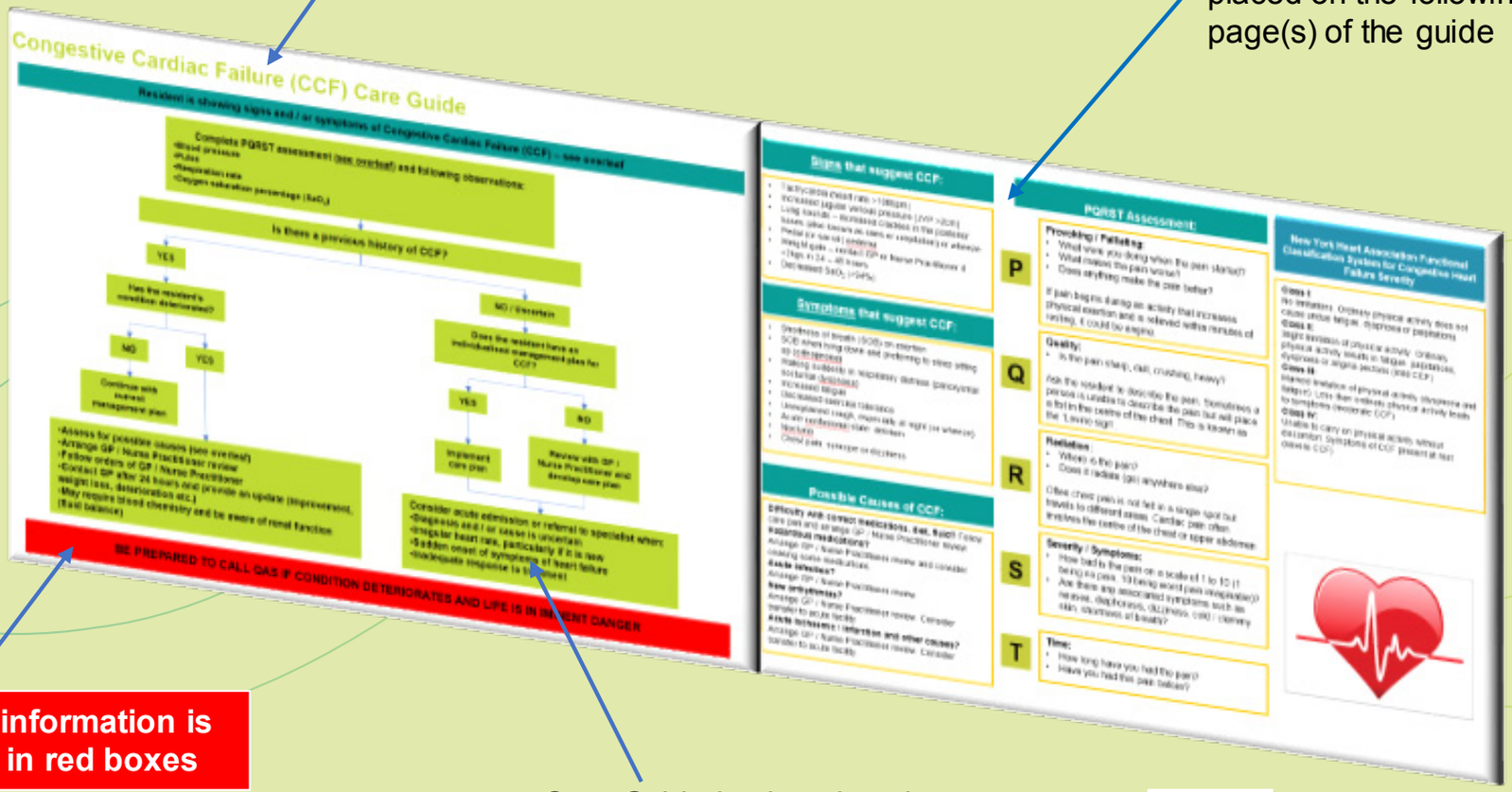
How to use these Care Guides:

Title of Care Guide

Detailed information is placed on the following page(s) of the guide



Critical information is placed in red boxes

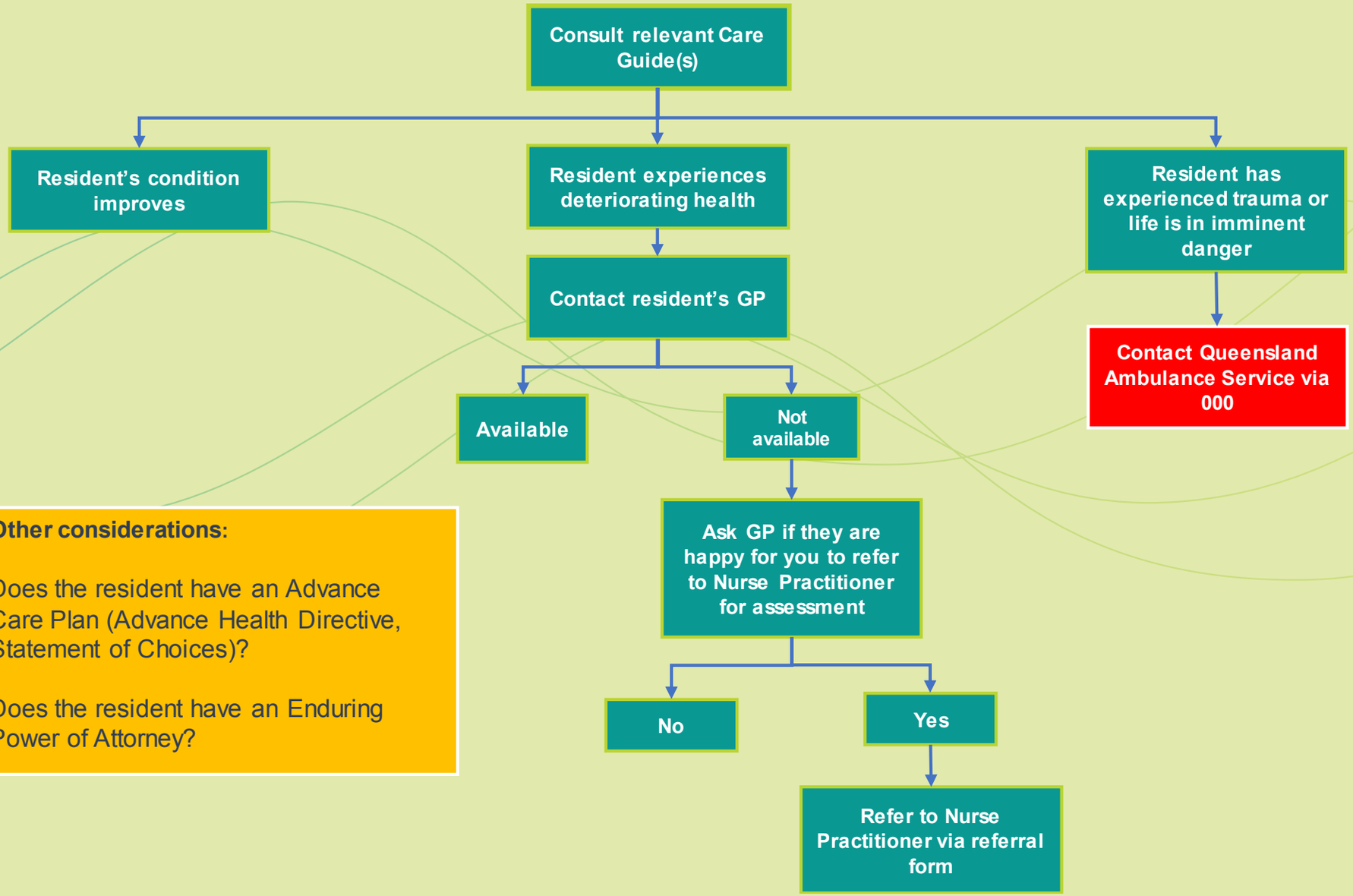
Care Guide is placed on the left hand page. This provides guidance regarding clinical actions/interventions

Remember:

These care guides do not replace clinical judgement. Individual Advanced Care Plans should be considered in conjunction with these care guides.

Nurse Practitioner Support

The West Moreton Health Nurse Practitioner for Medical and Aged Care is supporting the implementation of the Care Guides. The Nurse Practitioner is available for advice and assessment with permission from the resident's GP. The Nurse Practitioner does not replace the resident's GP, who has medical governance. Please follow the process below:



Other considerations:

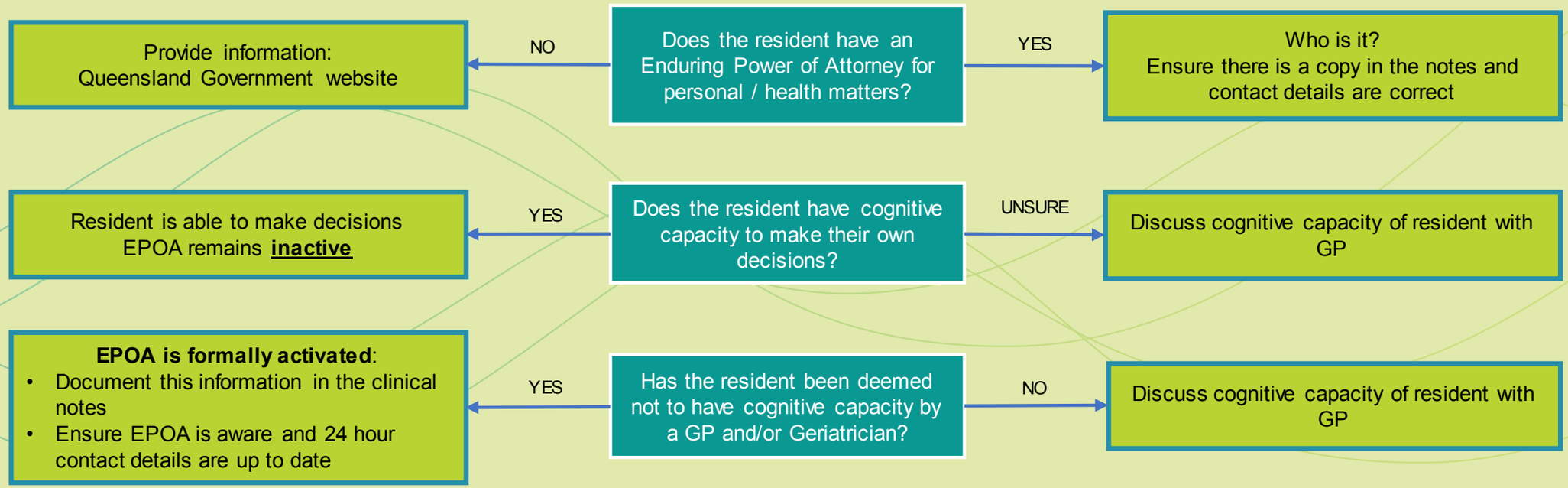
Does the resident have an Advance Care Plan (Advance Health Directive, Statement of Choices)?

Does the resident have an Enduring Power of Attorney?

Enduring Power of Attorney (EPOA)

An EPOA is somebody a resident appoints to make financial, personal (including health care), or both types of decisions on their behalf.

For financial decisions, the resident may nominate whether they want the attorney to begin making financial decisions straight away or at some other date in the future. The attorney's power to make personal decisions (including health care) only commences when the resident loses capacity to make those decisions.



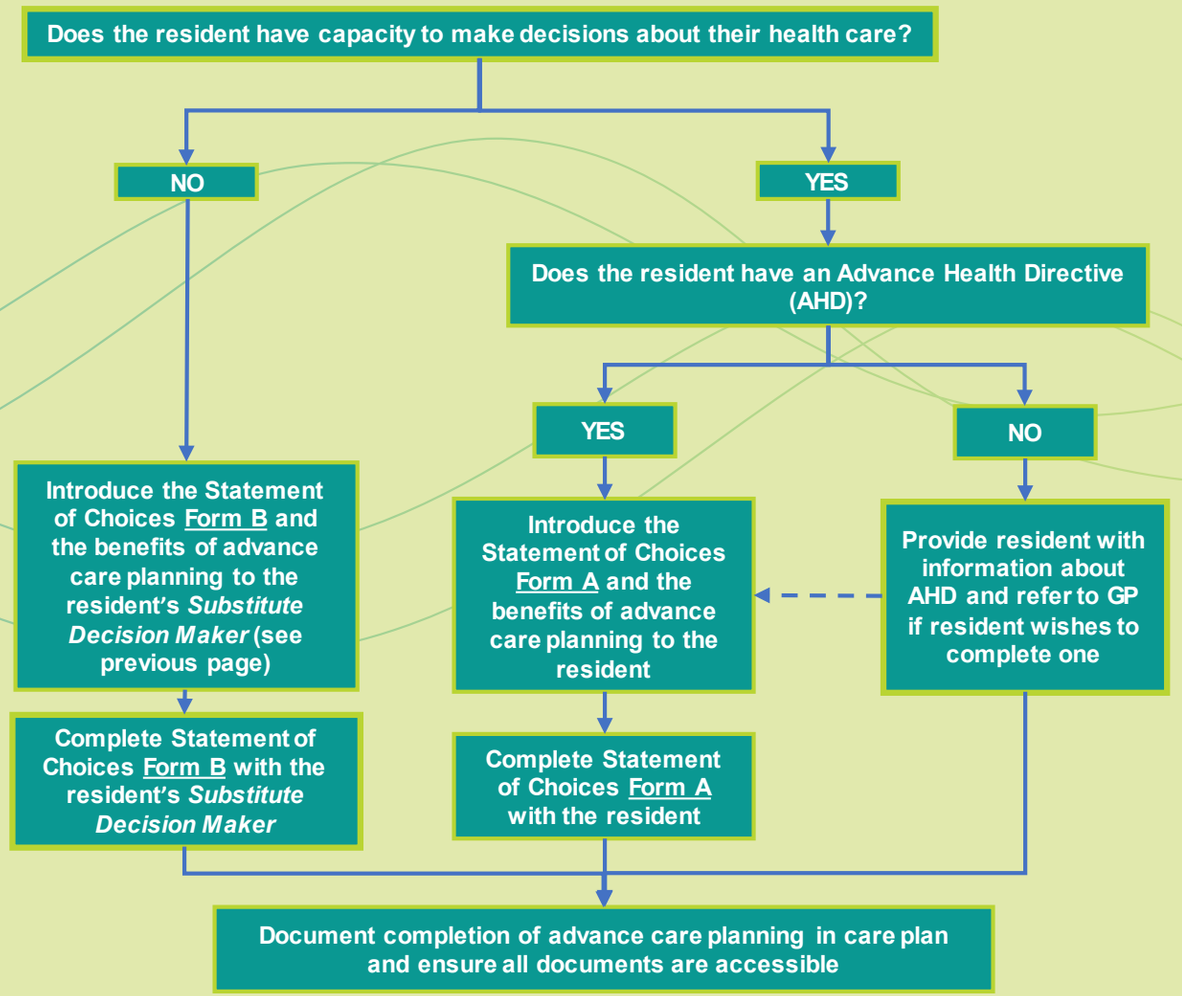
The resident can change or revoke (cancel) the EPOA at any time they are still have cognitive capacity
Every person is presumed to have capacity for a decision until proven otherwise. Loss of capacity must be confirmed by a health professional. If there is uncertainty the Civil and Administrative Tribunal (QCAT) will make a formal decision about capacity.
For more information, visit: https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/power-of-attorney-and-making-decisions-for-others/power-of-attorney

If there is no EPOA for personal / health matters please refer to the 'Decision-Making Hierarchy on page 8.

Advance Care Planning

Advance Care Planning is a process that gives the resident and their Substitute Decision Maker (SDM) / family the opportunity to plan for health care preferences. It is a way to ensure that the wishes of the resident, their SDM / family have been thoroughly articulated and are part of the care plan.
Advance Care Planning is an ongoing process that should be discussed on a regular basis. Review of advance care planning wishes should be completed every time there is a change in the resident's status or at least annually.

Initiating an Advance Care Planning (ACP) Discussion



Fast Facts:

- The Statement of Choices (SoC) document lets Substitute Decision Maker/s (SDMs) and clinicians know a person's individua preferences to inform medical treatment decisions made at a time when the individual does not have decision-making capacity.
- **Participation in any aspect of advance care planning (ACP) is voluntary**. Health professionals must not coerce or direct individuals to participate in ACP and complete documentation. They must not instruct a person to refuse or accept interventions or to limit or accept treatments against their wishes.
- All clinicians must act ONLY within their scope of practice when discussing ACP or helping complete a SoC.

Office of Advance Care Planning, Queensland 2018

Top Tips:

- Before introducing the SoC to others, familiarise yourself with the content of both Form A and Form B
- Allow people time to think and reflect. ACP and completing an SoC may take more than one discussion
- Explain that it is useful to complete all fields in the SoC, though not all fields are mandatory.

Office of Advance Care Planning, Queensland 2018

Advance care planning (ACP) is a process and ACP documents do not supersede good medical practice

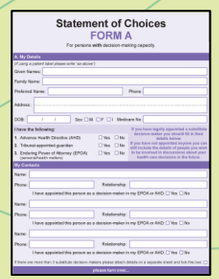
Advance Care Planning Documentation

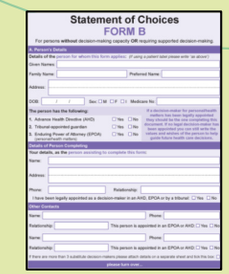

ADVANCE HEALTH DIRECTIVE

This form deals with your future health care.

Advance Health Directive (AHD):
In Queensland, an AHD is a legally binding advance care planning document stating a formal set of instructions for future health care. It is used to inform doctors about a person's choices for health care when they become unable to make health care decisions.

The AHD allows a person to record their wishes relating to a specific set of medical circumstances if they eventually lose the capacity to make decisions. It can only be completed by a person with capacity.


Statement of Choices
FORM A


Statement of Choices
FORM B

Statement of Choices (SoC):
The SoC is a document designed to help a person (or their significant other if the person does not have decision-making capacity) record their wishes, values and beliefs to guide those close to them to make health care decisions on their behalf if they are unable to make those decisions. The SoC has legal effect as a means of expressing a resident's wishes but is not a legally binding document.

SoC Form A is for residents with decision-making capacity.

SoC Form B is completed on behalf of residents who don't have decision-making capacity or who need support to make decisions

In the event of a conflict between a SoC and AHD, the AHD must be followed, in accordance with the decision-making hierarchy

Decision-Making Hierarchy in Queensland

The individual makes their own health care decisions for as long as they have capacity to do so

When the individual no longer has decision-making capacity, a <u>Substitute Decision Maker</u> is required

1. **Advance Health Directive**
2. **QCAT Appointed Guardian**
3. **Enduring Power of Attorney for personal (health) matters**
4. **Statutory Health Attorney**
5. **Public Guardian**

Queensland legislation governing end of life decision-making:

Powers of Attorney Act 1998

Guardianship and Administration Act 2000

Public Guardian Act 2014

End of Life Care Guide

RECOGNISING DYING

Would you be surprised if the resident dies in the next 12 months?

- **Yes** → Consider Advance Care Planning with resident and family
- **Not sure** → Discuss with GP or Nurse Practitioner
- **No** → Does the resident show the signs and symptoms listed in 'Signs and Symptoms of Final Days of Life' box?
  - **No** → Consider commencing palliative care plan
  - **Yes** → Review by GP or Nurse Practitioner to ensure no reversible cause. Commence end of life care plan if no reversible cause identified

Signs and Symptoms of Final Days of Life:

- Rapid day to day deterioration that is not reversible
- Requiring more frequent interventions
- Becoming semi-conscious with lapses into unconsciousness
- Increasing loss of ability to swallow
- Refusing or unable to take food, fluids or oral medications
- An acute event has occurred requiring revision of treatment goals
- Profound weakness
- Changes in breathing patterns

'People are approaching the end of life when they are likely to die in the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions, if they are at risk of dying from a sudden, acute crisis in their condition
- Life threatening acute conditions caused by sudden catastrophic events'

Australian Commission on Safety and Quality in Health Care (ACSQHC). National Consensus Statement: Essential elements for safe and high quality end of life care. Page 33). Sydney, ACSQHC, 2015.

ASSESSMENT AND MANAGEMENT OF SYMPTOMS

Pain:
- Acknowledge psychological, spiritual, cultural and social components of pain
- Assess for pain type, frequency, aetiology and location of each pain
- Assess and document effectiveness of pain relief after every intervention
- Request subcutaneous medications are charted in anticipation it may be required (via continuous infusion if necessary)
- If pain regimen is not effective, contact GP or Nurse Practitioner for review

Nausea and Vomiting:
- Administer regular antiemetic medications and PRNs as required
- If no symptoms of nausea and vomiting present, ensure PRN antiemetic medication is prescribed in anticipation of symptom(s)
- If symptoms persist, contact GP or Nurse Practitioner for review

Shortness of Breath:
- Offer psychological support and reassurance to resident and family to reduce distress
- Take your time – do not rush the resident
- Use a cool fan or open window to create air movement
- Administer prescribed medications as needed (for example, low dose morphine)
- If unable to swallow, consider continuous subcutaneous infusion
- If symptoms persist, contact GP or Nurse Practitioner for review

Respiratory Secretions:
- Offer psychological support and reassurance to resident and family to reduce distress
- Nurse the resident on their side, reposition every 3 – 4 hours
- If no secretions are present, ensure PRN medication is prescribed in anticipation of symptom
- Common medications include Hyoscine Hydrobromide, Buscopan and Glycopyrrolate
- If symptoms persist, contact GP or Nurse Practitioner for review

Agitation, Anxiety and Restlessness:
- Treat reversible causes (physical discomfort, pain, full bladder, pressure areas, constipation etc.)
- Provide psychosocial support – refer for counselling if required
- Administer medications as prescribed and as required
- Common medications include Haloperidol and benzodiazepines (Midazolam, Clonazepam etc.)
- If symptoms persist, contact GP or Nurse Practitioner for review

KEY COMFORT CARES

Family Support:
- Enable family to stay with resident if the gamily and resident wish to
- Offer culturally appropriate support to family
- Provide psychosocial and spiritual support as required
- Facilitate family's involvement in care if family and resident wish to be

Skin and Pressure Area Care:
- Keep skin clean
- Avoid products that dry or harm skin
- Balance the need for repositioning with the need for comfort (discuss with resident and family)
- Use a pressure relieving mattress (if resident can tolerate it)
- Wound care for comfort only – goal of wound care is not to heal wound
- Offer PRN analgesia prior to repositioning if required

Mouth Care:
- Keep mouth clean and moist (second hourly mouth cares)
- Avoid alcohol based agents for cleaning the mouth
- Use lip balm to keep lips feeling moist

Eye Care:
- Keep eyes clean and moist
- Eye washes as required
- Lubricate eyes if they are dry or resident reports discomfort

Micturition:
- Keep resident dry and comfortable, ensuring pads provide skin protection
- Consider indwelling urinary catheter for comfort of resident. Discuss with resident and GP.

Bowel Care:
- Optimal bowel care prior to last days contributes to overall comfort
- Constipation and diarrhoea can be a source of distress for the resident
- Bowel movements will decrease as end of life approaches
- When oral medication is no longer tolerated by resident, other bowel management agents are not usually used unless to reverse an identified problem.
- Exclude a full rectum if resident becomes agitated or restless

Other Therapies (if resident would like them):
- Music therapy
- Aromatherapy
- Hand massage

Acute Chest Pain Care Guide

TREAT ALL SEVERE CENTRAL CHEST PAIN AS CARDIAC UNTIL PROVEN OTHERWISE

Resident complains of acute (sudden onset) chest pain

↓

Position resident upright

↓

Complete PQRST assessment (see next page) and following observations:
- Blood pressure
- Pulse
- Respiration rate
- Oxygen saturation percentage (SaO_2)

↓

Instruct a colleague to call QAS via 000

↓

If SaO_2 is below 94% commence oxygen supplementation at 3L/min via nasal prongs

↓

Does the resident have an acute chest pain plan?

↓

Yes → Administer medications as per plan

No → Provide reassurance and support

↓

TRANSFER TO HOSPITAL VIA QAS

ASSESSMENT OF ACUTE CHEST PAIN

Complete the following assessment whilst awaiting the Queensland Ambulance Service – stay with the resident at all times.

P

Provoking / Palliating:
- What were you doing when the pain started?
- What makes the pain worse?
- Does anything make the pain better?

If pain begins during an activity that increases physical exertion and is relieved within minutes of resting, it could be angina.

Q

Quality:
- Is the pain sharp, dull, crushing, heavy?

Ask the resident to describe the pain. Sometimes a person is unable to describe the pain but will place a fist in the centre of the chest. This is known as the 'Levine sign'.

R

Radiation:
- Where is the pain?
- Does it radiate (go) anywhere else?

Often chest pain is not felt in a single spot but travels to different areas. Cardiac pain often involves the centre of the chest or upper abdomen

S

Severity / Symptoms:
- How bad is the pain on a scale of 1 to 10 (1 being no pain, 10 being worst pain imaginable)?
- Are there any associated symptoms such as nausea, diaphoresis, dizziness, cold / clammy skin, shortness of breath?

T

Time:
- How long have you had the pain?
- Have you had this pain before?

Use this assessment as a handover to paramedics on arrival – with clinical observations and details of any medications administered.

Congestive Cardiac Failure (CCF) Care Guide

Resident is showing signs and / or symptoms of Congestive Cardiac Failure (CCF) – see overleaf

Complete PQRST assessment (see overleaf) and following observations:
- Blood pressure
- Pulse
- Respiration rate
- Oxygen saturation percentage (SaO_2)

Is there a previous history of CCF?

YES

Has the resident's condition deteriorated?

NO

Continue with current management plan

YES

- Assess for possible causes (see overleaf)
- Arrange GP / Nurse Practitioner review
- Follow orders of GP / Nurse Practitioner
- Contact GP after 24 hours and provide an update (improvement, weight loss, deterioration etc.)
- May require blood chemistry and be aware of renal function (fluid balance)

NO / Uncertain

Does the resident have an individualised management plan for CCF?

YES

Implement care plan

NO

Review with GP / Nurse Practitioner and develop care plan

Consider acute admission or referral to specialist when:
- Diagnosis and / or cause is uncertain
- Irregular heart rate, particularly if it is new
- Sudden onset of symptoms of heart failure
- Inadequate response to treatment

BE PREPARED TO CALL QAS IF CONDITION DETERIORATES AND LIFE IS IN IMMINENT DANGER

Signs that suggest CCF:

- Tachycardia (heart rate >100bpm)
- Increased jugular venous pressure (JVP >2cm)
- Lung sounds – increased crackles in the posterior bases (also known as rales or crepitation) or wheeze
- Pedal (or sacral) oedema
- Weight gain – contact GP or Nurse Practitioner if >2kgs in 24 – 48 hours.
- Decreased SaO_2 (<94%)

Symptoms that suggest CCF:

- Shortness of breath (SOB) on exertion
- SOB when lying down and preferring to sleep sitting up (orthopnoea)
- Waking suddenly in respiratory distress (paroxysmal nocturnal dyspnoea)
- Increased fatigue
- Decreased exercise tolerance
- Unexplained cough, especially at night (or wheeze)
- Acute confusional state: delirium
- Nocturia
- Chest pain, syncope or dizziness

Possible Causes of CCF:

Difficulty with correct medications, diet, fluid? Follow care plan and arrange GP / Nurse Practitioner review
Hazardous medications?
Arrange GP / Nurse Practitioner review and consider ceasing some medications
Acute infection?
Arrange GP / Nurse Practitioner review
New arrhythmias?
Arrange GP / Nurse Practitioner review. Consider transfer to acute facility
Acute Ischaemic / Infarction and other causes?
Arrange GP / Nurse Practitioner review. Consider transfer to acute facility

PQRST Assessment:

P

Provoking / Palliating:
- What were you doing when the pain started?
- What makes the pain worse?
- Does anything make the pain better?

If pain begins during an activity that increases physical exertion and is relieved within minutes of resting, it could be angina.

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Severity / Symptoms:
- How bad is the pain on a scale of 1 to 10 (1 being no pain, 10 being worst pain imaginable)?
- Are there any associated symptoms such as nausea, diaphoresis, dizziness, cold / clammy skin, shortness of breath?

T

Time:
- How long have you had the pain?
- Have you had this pain before?

New York Heart Association Functional Classification System for Congestive Heart Failure Severity

Class I:
No limitations. Ordinary physical activity does not cause undue fatigue, dyspnoea or palpitations.
Class II:
Slight limitation of physical activity. Ordinary physical activity results in fatigue, palpitations, dyspnoea or angina pectoris (mild CCF)
Class III:
Marked limitation of physical activity (dyspnoea and fatigue). Less than ordinary physical activity leads to symptoms (moderate CCF)
Class IV:
Unable to carry on physical activity without discomfort. Symptoms of CCF present at rest (severe CCF)

Respiratory Care Guide

SHORTNESS OF BREATH (SOB) / DYSPNOEA

New/Unexpected Problem

ASSESS AND RECORD THE FOLLOWING:

- Temperature, pulse, respiration rate, heart rate and BP – monitor 6 hourly
- Lung sounds (crackles, rhonchi – record where heard on the chest)
- Oxygen saturation
- Change in mental status (delirium, confusion etc.)
- Physical and functional status changes
- Cough (productive, non-productive etc.)
- Sputum – amount and colour
- Is there a diagnosis of COPD, CCF or Diabetes?
- Level of relief from short acting bronchodilators (e.g. Ventolin, Bricanyl) if relevant
- Pain on breathing

ARE ANY OF THE FOLLOWING PRESENT?

- New or worsening cough
- Increased or newly purulent sputum, unable to expectorate
- New crackles or wheezes heard on chest exam
- Decline in cognitive, physical or functional status
- New agitation
- Fever or hypothermia (temperature up or down from baseline)
- Difficulty in breathing
- Chest pain (pleuritic – worse with breathing)
- Oxygen saturation <90% (new or worsening)
- Systolic blood pressure <20mmHg from baseline

Contact GP or Nurse Practitioner with new onset of symptoms

Resident expected to die in next few days

Initiate palliative measures for shortness of breath and / or anxiety

Worsening of an existing respiratory condition

Does resident have an individualised care plan?

NO

YES

Implement individualised care plan

Condition Resolved?

NO

YES

If the resident is experiencing significant respiratory distress, tachypnoea, hypoxia or is unarousable, transfer resident to hospital
Call QAS via 000

If hospital admission is recommended do the following:

- Copy advance care plans
- Discuss with family / EPOA
- Copy medications, medical history and recent nursing and medical assessment, including recent pathology results

Recommended Immunisation Guidelines

- Residents are vaccinated annually against influenza
- Some residents may need to be vaccinated against Streptococcus Pneumoniae – check the Australian Immunisation Handbook for current recommendations
- All employees of residential aged care facilities are vaccinated annually against influenza

Managing a COPD Exacerbation in Primary Care

Resident is feeling unwell and experiencing any of the following:

- More coughing
- More phlegm
- Thicker phlegm than usual

Recommend: Start using more short-acting bronchodilator (SABA) via spacer every 3 – 4 hours, titrated to response.

Resident is feeling worse:

- 3 – 4 hourly SABA not relieving symptoms adequately

Recommend: Commence oral prednisolone 30 – 50mg daily for 5 days

If clinical features of infection present (fever, change in colour / volume of phlegm)

Recommend: Also commence oral antibiotics for 5 days.

Resident is still unwell 2 – 5 days after treatment commences:

Recommend:
Review by GP or Nurse Practitioner
Review and reinforce the use of a COPD Action Plan

COPD-X Guideline Australia

Possible Indicators for Hospital Assessment in COPD Exacerbations

The following maybe indicators for hospital assessment or admission:

- Marked increase in intensity of symptoms, such as sudden development of resting dyspnoea
- Severe underlying COPD
- Onset of new physical signs (e.g. cyanosis, peripheral oedema)
- Failure of an exacerbation to respond to initial medical management
- Presence of serious co-morbidities (e.g. heart failure, newly occurring arrhythmias)
- History of frequent exacerbations

Lung Sound Basics

Crackles: (Rales) are fine rattling sounds. These are non-continuous, high pitched, fine crackles, like the sound of carbonated beverages. These sounds are usually caused by the presence of fluid in the alveoli and bronchioles (Bates 2007)
Wheezes: Wheezes are musical sounds like the high-pitched notes on a clarinet. Wheezes are produced by constricted or partially obstructed airways.

Dyspnoea in Palliative Care

Non- Pharmacological Management:

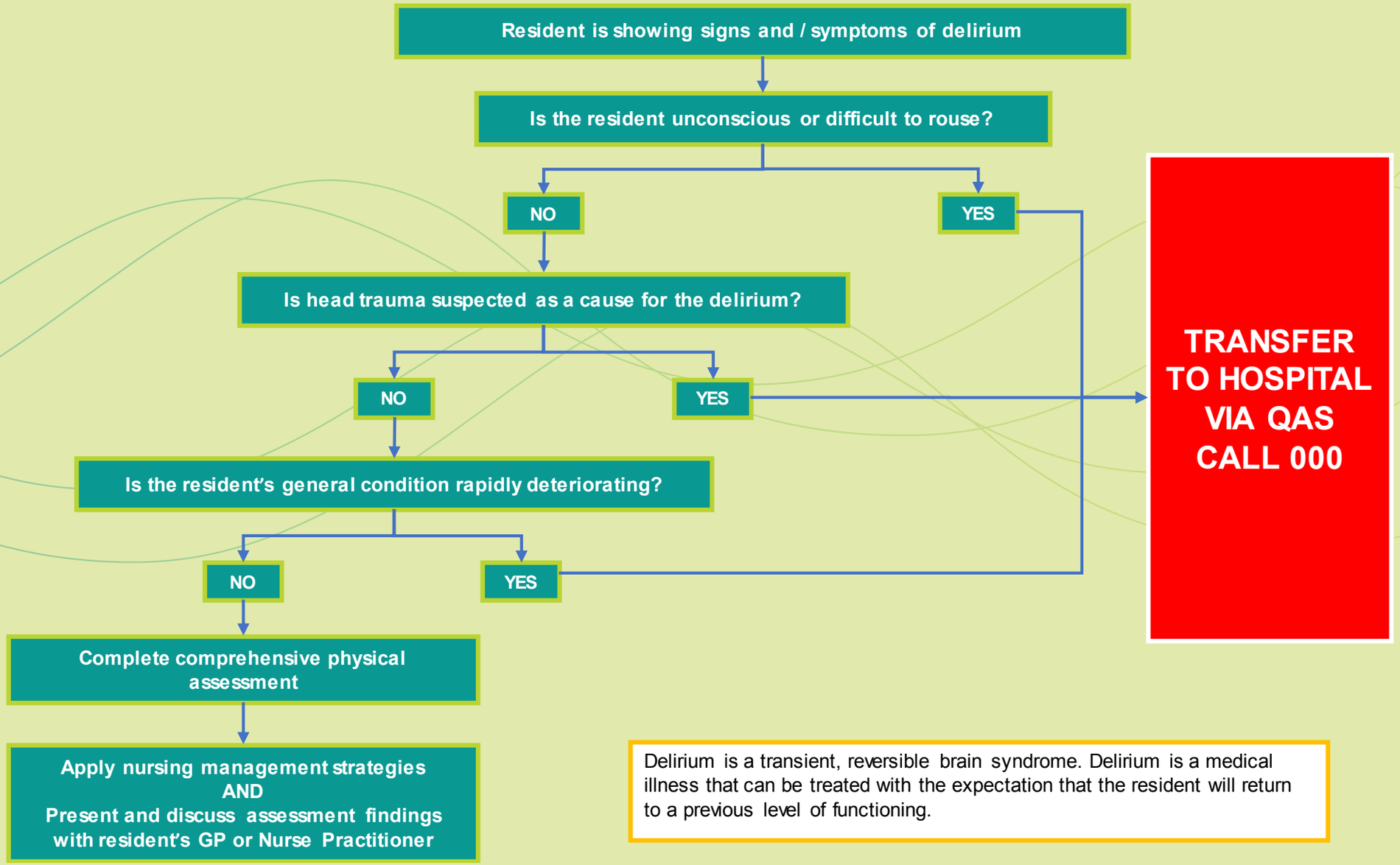
- Environmental strategies (increase air movement, prevent overheating, position appropriately, reduce exertion)
- Psychological (Listen empathetically to concerns, provide reassurance, provide advice to resident and family, provide counselling if needed)
- Targeted therapies (for cognitively intact residents only):
  - Specialist counselling for ongoing anxiety and panic
  - Counselling and relaxation techniques
  - Teaching breathing control exercises

Pharmacological Management:

- Opioids (oral or parenteral should be the first line pharmacological intervention)
- Benzodiazepines – consider short term use only when associated with acute anxiety or at the end of life
  - Anxiolytics (alprazolam, clonazepam and diazepam) can be used to alleviate anxiety or panic associated with dyspnoea
  - Midazolam can be useful for an acute episode when its amnesic effect may be beneficial
- Oxygen – few residents will benefit from oxygen

Delirium Care Guide:

DELIRIUM IS NOT A DIAGNOSIS – DELIRIUM IS A SYMPTOM AND HAS AN UNDERLYING CAUSE



Delirium is a transient, reversible brain syndrome. Delirium is a medical illness that can be treated with the expectation that the resident will return to a previous level of functioning.

Signs and Symptoms of Delirium

- KEY INDICATOR: Fluctuating level of consciousness (main difference from dementia or depression diagnosis)
- Acute onset (usually hours to days)
- Global impairment of cognitive functioning:
- Overall reduced level of functioning
- Disturbances of sleep-wake cycle; restlessness
- Hallucinations (particularly visual) and paranoid delusions

Comprehensive Physical Assessment:

Record vital signs:

- Temperature, pulse, respirations, blood pressure, oxygen saturation, blood glucose level, assess hydration and nutritional status

Assess for all possible causes:

- Your assessment should include pain assessment, cardiac examination, respiratory assessment, abdominal assessment

Neurological assessment:

- Glasgow coma scale
- Assess for obvious neurological deficits

Medication review:

- Is the resident taking anticholinergics, sedatives or opiates?
- Has a new medication been added?

Check for the following exacerbating factors:

- Previous episode or history of delirium
- Uncomfortable or too hot / cold e.g. incontinent, needing a position change
- Hungry / thirsty
- Non- English speaking
- Noisy environment
- Known to have a history of mental illness
- Recent environmental change

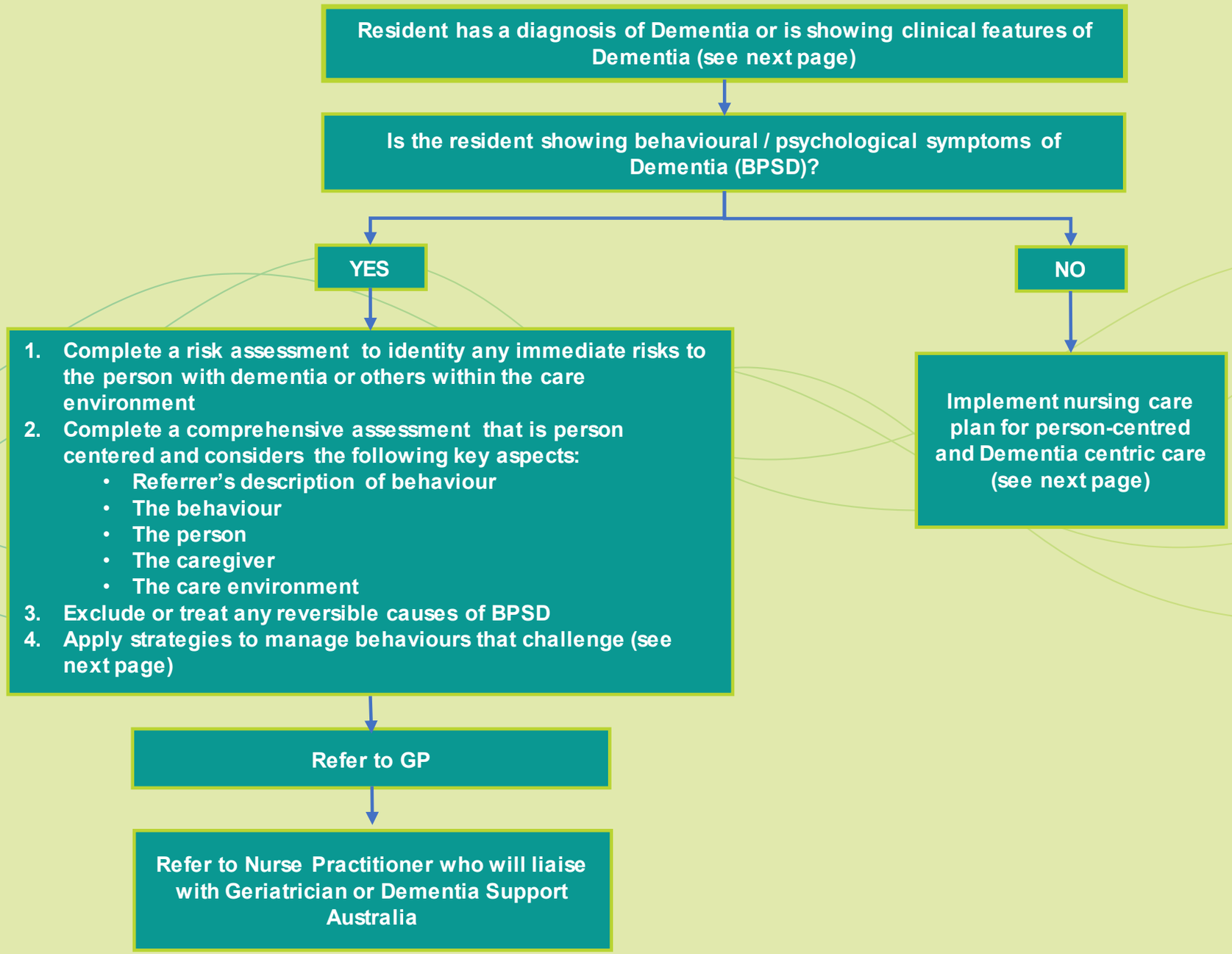
Nursing Management of Delirium:

- Maintain a low stimulus, calm and well lit environment
- Increase nursing supervision and monitoring
- Keep bed as low to the ground as possible
- Use firm but non-confrontational directions / do not argue
- Avoidance of all unnecessary medications
- Maintenance of food and fluid intake
- Re-orientation to time, place and person
- Regular monitoring of vital signs
- Education and reassurance of family and friends
- Document: behaviours clearly, management strategies that are working and those that are clearly ineffective
- Ensure resident has working hearing aids and glasses if appropriate
- Photographs of family, friends and significant others placed in the resident's room
- Clocks and calendars to help with orientation
- Regular exposure to sunlight

Causes of Delirium:

- Constipation
- Medications (adverse drug events, drug interactions etc.)
- Infections – respiratory, UTI, septicemia
- Metabolic – hypoxia, electrolyte imbalance, hyper / hypoglycaemia
- Neurological – sub arachnoid hemorrhage, tumor, trauma, CNS infection, seizure, alcohol/ drug withdrawal
- Vascular – TIA, stroke
- Urinary retention
- Pain
- Fatigue
- Anemia
- Sleep Deprivation
- Diseases – dementia, Alzheimer's disease, cardiac, pulmonary, hematological, oncological, renal, hepatic, metabolic, endocrinological and infections
- Environmental changes, e.g. move to a new room or facility

Dementia Care Guide



Clinical features of Dementia	
Onset	Generally insidious and depends on cause
Course	Long, no diurnal effects, symptoms progressive
Progression	Unpredictable, variable
Duration	Months to years
Awareness	Diminishing with occasional insight
Alertness	Generally normal
Attention	Generally normal
Orientation	Impaired
Memory	Short term memory loss. Longer retention of long term memory
Thinking	Difficulty with abstraction, thoughts impoverished, make poor judgements, words difficult to find, lack of cognitive cohesion
Perception	Misconceptions of themselves and others often observed. Physical depth perception affected

STRATEGIES TO MANAGE BEHAVIOURS THAT CHALLENGE:

- Know how to communicate with the resident
- Speak in a clear, simple manner, using gestures to supplement
- Do not argue with validity of delusions; rather try to understand the feelings being indirectly expressed
- Adjust personal cares to a later time if resident is resistant
- Assess and treat pain
- Assess the cause of wandering
- Decrease environmental stimuli that agitates the resident
- Remove the resident from the stressful situation – gently guide the resident from the environment while speaking in a calm and reassuring voice
- Allow a resident to wander if the environment is safe and secure
- Music
- Distraction and diversion – distract the resident with favourite food or activity
- Gentle physical touch to help calm the resident
- Massage

NURSING CARE PLAN

IMPLEMENT PERSON-CENTRED AND DEMENTIA CENTRIC CARE:

- Evaluate the environment for safety and appropriateness
- Structure the environment to enhance memory e.g. clocks, calendar, orientation board
- Place familiar objects in room
- Label important rooms, using pictures e.g. photos at a young age and present, for help with recognition
- Use photos of the resident at a young age and present to help with recognition of self
- Know the resident, know the background
- Ensure consistent daily routine and familiarity
- Call the resident by name, approach in clear view, make eye contact
- Give simple requests, substitute pictures if resident is experiencing aphasia
- Speak slowly, clearly and calmly
- Don't order the resident around or tell them what they can and cannot do
- Use simple instructions and repeat if necessary
- Ensure the resident has hearing aids and glasses if needed
- Encourage the resident to select his / her own clothes – but simplify the number of choices
- When assisting with personal cares ensure privacy: keeping doors closed and blinds pulled
- Scheduled toileting and prompted voiding to manage and reduce urinary and faecal incontinence
- Graded assistance and positive reinforcement to maintain functional independence for as long as possible
- Participation in structured group activities
- Music: particularly during meals and bathing
- Walking or other forms of light exercise
- Pet therapy
- Aromatherapy

DEMENTIA AND PALLIATIVE CARE

A palliative approach for dementia aims to improve the quality of life of those affected by this capacity-limiting syndrome through early identification, assessment, education and compassionate comfort care inclusive of physical, cultural, psychological, social and spiritual needs. Actively treat reversible conditions if this improves the quality of life.

Depression Care Guide

Note the number of symptoms, onset, frequency / patterns, duration, changes in normal mood, behaviour and functioning.
(Symptoms must be present pervasively for longer than two weeks to indicate possible depression).

SYMPTOMS:

- Depressed or irritable mood, frequent crying
- Loss of interest, pleasure (family, friends, hobbies, sex)
- Weight gain or loss (especially loss)
- Sleep disturbance (especially insomnia)
- Fatigue, loss of energy
- Psychomotor change
- Diminished concentration
- Feelings of worthlessness and guilt
- Suicidal thoughts or attempts, hopelessness

RISK FACTORS:

- Psychosis e.g. delusional/ paranoid thoughts, hallucinations
- History of depression, current substance abuse (especially alcohol), previous coping style
- Recent losses or crises e.g. death of a spouse, friend, pet, retirement, anniversary dates, move to another residence, changes in physical health status, relationships or roles
- In elderly persons, frequent somatic (physical) complaints may actually represent an underlying depression
- Chronic pain
- Diseases: e.g. respiratory, cardiac, stroke, cancer

ASSESSMENT:

- Obtain / review medical history and physical neurological; examination
- Assess for depressogenic medications (e.g. steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensive, histamin-2 antagonists, betablockers, antipsychotics, immunosuppressive, cytotoxic agents)
- Assess for related systemic and metabolic processes (e.g. infection, anaemia, hyponatraemia, hypo/hyperthyroidism, hypo/hypercalcaemia, congestive heart failure and renal failure)
- Assess for cognitive dysfunction
- Assess level of functional disability
- Do a Geriatric Depression Screen – short form (next page). For those with cognitive impairment use the Cornell Scale for Depression in Dementia (next page)

Refer to GP or Nurse Practitioner to ensure referral to Mental Health Services for Older Adults if assessment indicates depression.

INTERVENTIONS:

- Remove or control risk factors: consult with GP or Nurse Practitioner to avoid / remove / change medications that can worsen depression; work with GP or Nurse Practitioner to correct / treat physical / metabolic / systemic medical issues
- Monitor and promote nutrition, elimination, sleep / rest patterns.
- Physical comfort (especially pain control)
- Enhance physical function (e.g. structure regular exercise / activity; refer to Physiotherapy, Occupational Therapy, Recreational Therapy; develop a daily activity schedule)
- Enhance social support (e.g. identify / mobilise a support person, ascertain need for spiritual support and contact appropriate person / service)
- Maximise autonomy / personal control, self-efficacy (e.g. enable resident to actively participate in making daily schedules and setting short term goals)
- Identify and reinforce strengths and capabilities
- Structure and encourage daily participation in relaxation therapies, pleasant activities and music therapies
- Monitor and document responses to medications and other therapies; re-administer depression screening tool
- Provide practical assistance; assist with problem solving
- Provide emotional support e.g. empathic, supportive listening, encourage expression of feelings and hope instillation, support adaptive coping and encourage pleasant reminiscences
- Provide information about the physical illness and treatments(s) and about depression (e.g. that depression is common, treatable and not the person's fault)
- Ensure referral to Older Persons Mental Health Team; consider psychiatric, nursing home care intervention
- Institute safety precautions for suicide risk as per facility policy (ensure continuous surveillance of resident while obtaining an emergency psychiatric evaluation and disposition)

DEPRESSION SCREENING
CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

Scoring system:

A = Unable to evaluate 0=Absent 1=Mild to Intermittent 2=Severe

SCORE GREATER THAN 12 = PROBABLY DEPRESSION

A. Mood -Related Signs				
1. Anxiety; anxious expression, rumination, worrying	A	0	1	2
2. Sadness; sad expression, sad voice, tearfulness	A	0	1	2
3. Lack of reaction to pleasant events	A	0	1	2
4. Irritability; annoyed, short tempered	A	0	1	2
B. Behavioural Disturbance				
5. Agitation; restlessness, hand wringing, hair pulling	A	0	1	2
6. Retardation; slow movements, slow speech, slow reactions	A	0	1	2
7. Multiple physical complaints (*score 0 if GI symptoms only*)	A	0	1	2
8. Loss of interest; less involved in usual activities (*score 0 only if change occurred less than 1 month ago*)	A	0	1	2
C. Physical Signs				
9. Appetite loss; eating less than usual	A	0	1	2
10. Weight loss (*score 2 if greater than 2 kilograms in one month)*	A	0	1	2
11. Lack of energy; fatigues easily, unable to sustain activities	A	0	1	2
D. Cyclic Functions				
12. Diurnal variation of mood; symptoms worse in the morning	A	0	1	2
13. Difficulty falling asleep; later than usual for the person	A	0	1	2
14. Multiple awakenings during sleep	A	0	1	2
15. Early morning awakening; earlier than usual for this person	A	0	1	2
E. Ideational Disturbance				
16. Suicidal; feels life is not worth living	A	0	1	2
17. Poor self-esteem; self-blame, self-deprecation, feelings of failure	A	0	1	2
18. Pessimism; anticipation of the worst	A	0	1	2
19. Mood congruent delusions; delusions of poverty, illness or loss	A	0	1	2

Geriatric Depression Scale: Short Form *Choose the best answer for how you have felt over the past week:*	
1. Are you basically satisfied with your life?	YES / **NO**
2. Have you dropped many of your activities of interests?	**YES** / NO
3. Do you feel that your life is empty?	**YES** / NO
4. Do you often get bored?	**YES** / NO
5. Are you in good spirits most of the time?	YES / **NO**
6. Are you afraid that something bad is going to happen to you?	**YES** / NO
7. Do you feel happy most of the time?	YES / **NO**
8. Do you often feel helpless?	**YES** / NO
9. Do you prefer to stay at home, rather than go out and doing new things?	**YES** / NO
10. Do you feel you have more problems with memory than most?	**YES** / NO
11. Do you think it is wonderful to be alive now?	YES / **NO**
12. Do you feel pretty worthless the way you are now?	**YES** / NO
13. Do you feel full of energy?	YES / **NO**
14. Do you feel that your situation is hopeless?	**YES** / NO
15. Do you think that most people are better off than you are?	**YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.
A score >5 points is suggestive of depression and warrants follow up comprehensive assessment
A score >10 points is almost always indicative of depression

Anxiety can be a symptom of depression:

Anxiety is an arousal state. People experience anxiety in different ways, but the following three elements are considered to be common:

1. A conscious feeling of fear and danger without the ability to identify immediate objective threats that could account for these feelings;
2. A pattern of physiological arousal and bodily distress that may include miscellaneous physical changes and complaints such as heart palpitations, faintness, feeling of suffocation, breathlessness, diarrhoea, nausea or vomiting; and
3. A disruption or disorganisation of effective problem-solving and mental control, including difficulty in thinking clearly and coping effectively with environmental demands.

Nutrition and Hydration Care Guide

	DEHYDRATION ASSESSMENT	NUTRITION ASSESSMENT
Indicators for dehydration and poor nutrition	• Dark coloured urine and decreased urine output • Assess mouth, mucous membranes and skin • Thickened secretion • Postural hypotension • Cramps • Irritability • Delirium	• Weight loss >5% in past 3 months • MST 2 or more (see next page) • BMI 21 or above (see next page) • Resident is leaving 25% of food each meal / assess over 7 days (document on a food intake chart) • Patient acutely unwell – no food intake >5 days • **Assess nutrition risk (next page)**
1st Line Treatment	• Fluid balance chart for 3 days (input / output) • Minimum 1.6L/day (unless contra-indicated) • Offer fluids of choice 2 hourly • Offer non-ambulatory residents with fluids every 1.5hours • Encourage oral intake each medication round • Review medications • Reassess in 24 hours	• Notify GP or Nurse Practitioner • Treat contributing factors e.g. constipation • Implement basic oral nutrition support (small, nutrient dense, frequent meals and snacks) • Extra assistance to eat, food charts, fortified meals • Weekly weighs for 4 weeks • Reassess – if weight loss continues move to 2nd line treatment
2nd Line Treatment	• Contact GP or Nurse Practitioner (may order blood urea / creatinine levels, electrolytes • Continue fluids • Reassess in 24 hours	• Contact GP or Nurse Practitioner who may order thyroid / FBC / serum transferase / albumin • Speech Pathology referral if required • Dietician referral if required • Discuss at multidisciplinary meeting • Increase energy and protein intake with nutritious fluids • Reassess and if weight loss continues, move to 3rd line treatment
3rd Line Treatment	• Recontact GP or Nurse Practitioner • Consider subcutaneous fluids • Reassess in 24 hours and contact GP or Nurse Practitioner if no improvement	• Continue to monitor • Consider referral to medical specialist
Prevention	Explore fluids of choice and offer: • Jelly • Tea / coffee • Ice blocks • Soup	

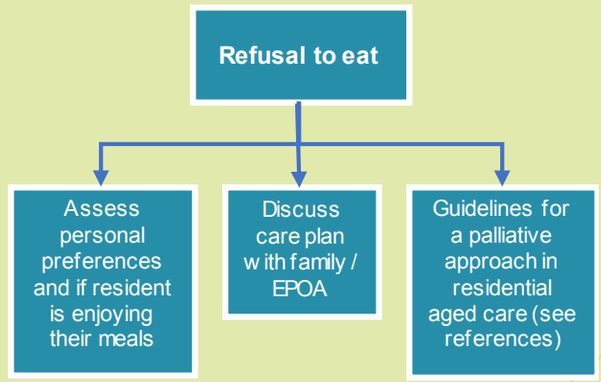
The D-E-N-T-A-L Self Report Questionnaire

Assessment Item	Point value
Dry mouth	2
Eating difficulty	1
No recent dental care within 2 years	1
Tooth or mouth pain	2
Alternation or change in food selection	1
Lesions, sores or lumps in the mouth	2

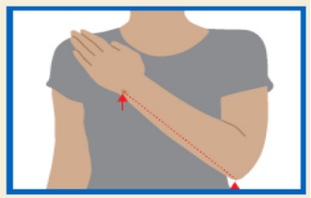
A score greater than 2 points indicates that a dental problem exists that might affect the resident's wellbeing

Identify and rule out contributing causes

- Environmental issues
- Food preferences – food and fluid choice
- Dentition and oral health
- Dysphagia / Speech Pathology referral
- Mental health – consider depression
- Faecal impaction
- Infection / UTI / URTI / GI
- Decline in ADLs / mobility
- Requires increased assistance
- Medication – iatrogenic causes
- Underlying pathology
- GI disturbance



Estimating height from ulna length



Measure between the point of the elbow (olecranon process) and the midpoint of the prominent bone of the wrist (styloid process) (left side if possible).

HEIGHT (m)															
	Men (<65 years)	1.94	1.93	1.91	1.89	1.87	1.85	1.84	1.82	1.80	1.78	1.76	1.75	1.73	1.71
	Men (≥65 years)	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67
	Ulna length (cm)	32.0	31.5	31.0	30.5	30.0	29.5	29.0	28.5	28.0	27.5	27.0	26.5	26.0	25.5
	Women (<65 years)	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.70	1.69	1.68	1.66
	Women (≥65 years)	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
	Men (<65 years)	1.69	1.67	1.66	1.64	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.49	1.48	1.46
	Men (≥65 years)	1.65	1.63	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48	1.46	1.45
	Ulna length (cm)	25.0	24.5	24.0	23.5	23.0	22.5	22.0	21.5	21.0	20.5	20.0	19.5	19.0	18.5
	Women (<65 years)	1.65	1.63	1.62	1.61	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47
	Women (≥65 years)	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40

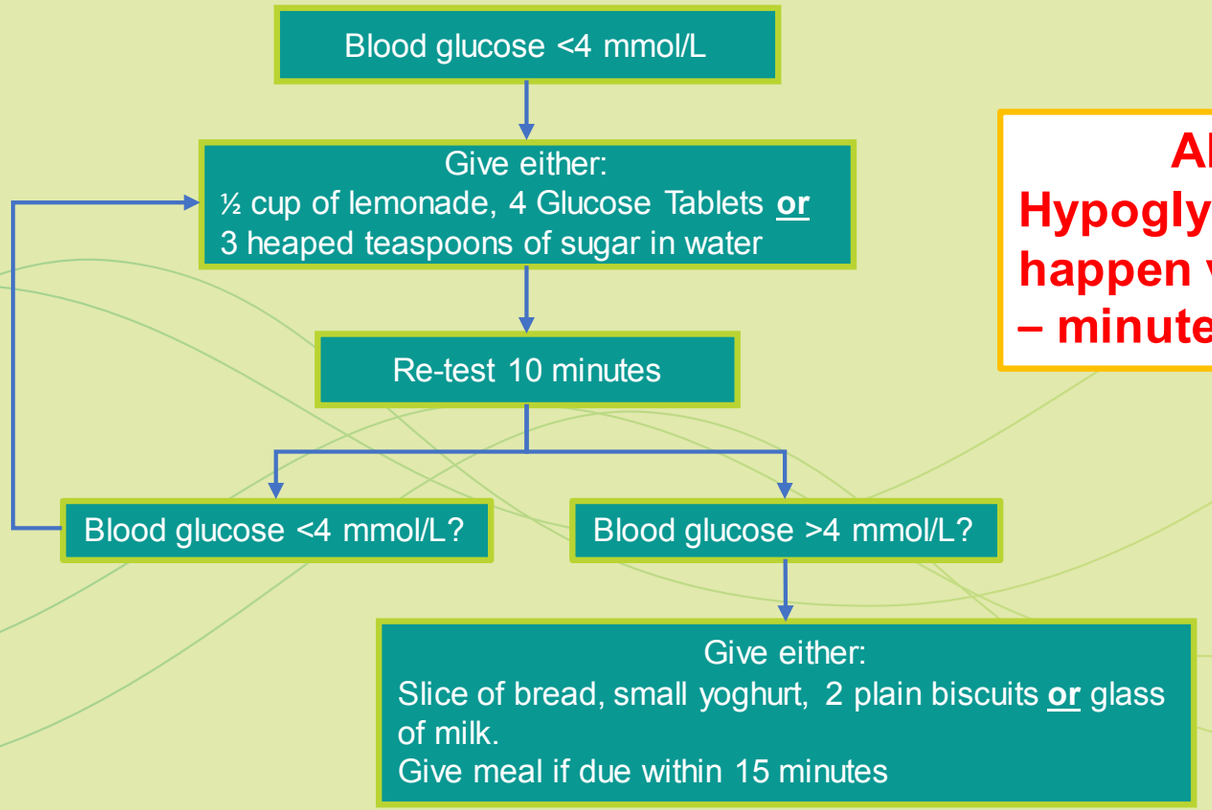
WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy						Overweight				Obese					Extremely obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 175.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Seek family involvement at meal time if possible and practical

Malnutrition Screening Tool (MST)

1	Has the resident lost weight in the last six months without trying? No 0 Unsure 2 Yes, how much (kg)? 1 – 5 1 6 – 10 2 11 – 15 3 >15 4 Unsure 2	
2	Has the resident been eating poorly because of decreased appetite? No 0 Yes 1	
	Total Score	

TREATMENT OF HYPOglycaemia IN THE CONSCIOUS RESIDENT:



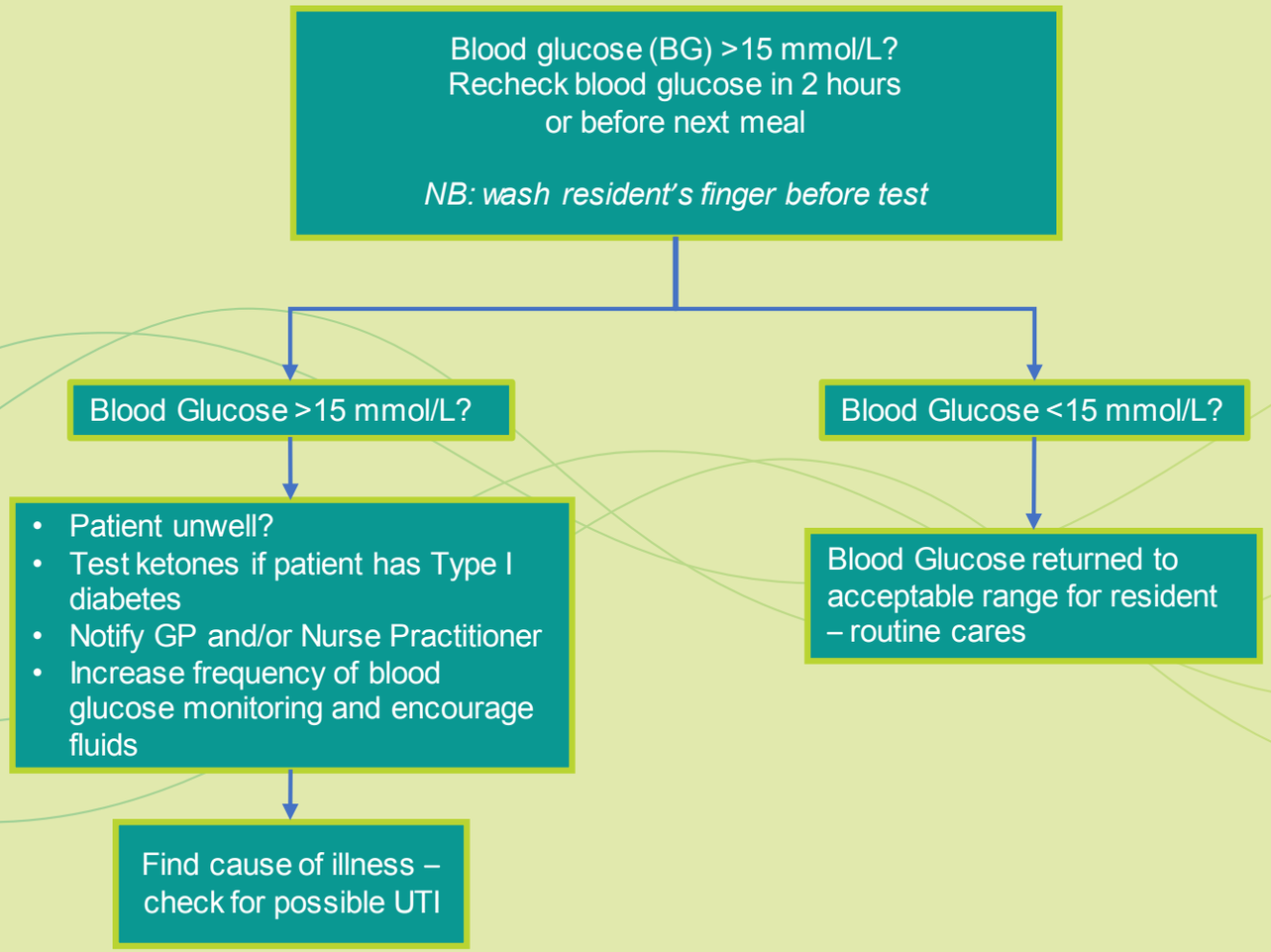
ALERT:
Hypoglycaemia can happen very quickly – minutes to hours

NB: Notify GP if blood glucose level is not 4 mmol/L within 30 minutes but continue with hypo treatment

Be wary of hypos in the elderly who are on sulphonylureas (Glipizide, Gliclazide or Glibenclamide). Glibenclamide is not recommended for use in the older adult due to its very long duration of action.
Re-check blood glucose again in 3 – 4 hours after treating the hypo as the action of these medications can cause blood glucose to fall again.

IF RESIDENT IS UNCONSCIOUS CALL QAS VIA 000 IF NO DOCTOR IS IMMEDIATELY AVAILABLE

TREATMENT OF HYPERglycaemia IN THE CONSCIOUS RESIDENT:

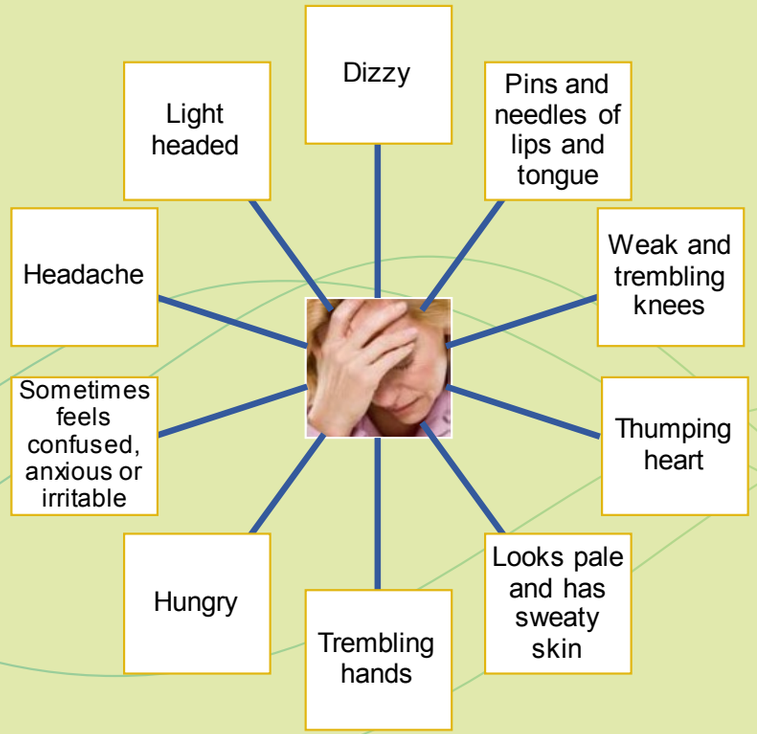


NB: A one off blood glucose reading after eating a sweet treat is not of concern provided the blood glucose has dropped again before the next meal. Continued high readings above 15 mmol/L are of concern and GP should be asked to review.

IF RESIDENT IS UNCONSCIOUS CALL QAS VIA 000 IF NO DOCTOR IS IMMEDIATELY AVAILABLE

Differentiating between HYPOglycaemia and HYPERglycaemia – Signs and Symptoms

HYPOglycaemia:



Other signs and Symptoms: nightmares, restless sleep, sweating, hangover in the morning.

Note: resident may be asymptomatic (hypoglycaemic unawareness) but still require treatment if the blood glucose is less than 6 mmol/L. If in doubt recheck capillary glucose level and ensure a drop of blood is obtained.

Hypoglycaemia can progress to stupor, seizure or coma and will become a medical emergency if not treated promptly.

HYPERglycaemia:

Signs and symptoms of HYPERGLYCAEMIA - Blood Glucose [BG] >15 mmol/L

Gradual onset of symptoms: Polydipsia (extreme thirst), polyurea (increased urination), weight loss, blurred vision, fatigue, and skin infections.

As hyperglycaemia progresses----lethargy and loss of alertness----rarely progresses to coma

Hyperosmolar Hyperglycaemic State (HHS):
Neurological symptoms are more common. Dehydration more common in the elderly.
Diabetic Ketoacidosis (DKA):
Hyperventilation with 'fruity' breath and abdominal pain, nausea less common in elderly.

Signs and volume depletion common in both HHS and DKA, including decreased skin turgor, dry axillae and oral mucosa, low jugular venous pressure and if severe, hypotension and tachycardia.

Both are medical emergencies

KEY RECOMMENDATIONS FOR TYPE 2 DIABETES

KEY MESSAGES:

NB: In the elderly most will have a high cardiovascular risk and individualised targets need to be **realistic and safe**.

- Screen for renal, retinal and foot complications
- Aim for HbA1c between 7.0% - 8.0% assuming no hypoglycaemia. HbA1c over 8% may still be acceptable in residents with no symptoms and life expectancy is less than 12 months.
- Aim for a blood pressure below 130 – 140 / 80 mmHg but this may need to be raised to avoid postural hypotension
- Annual cardiovascular risk assessment

- Diet focused on glycaemic, cardiovascular risk reduction, weight reduction if appropriate and tolerated
- Physical activity
- Monitor blood glucose level
- Nutritional assessment performed by a Accredited Practicing Dietician (APD)

- Retinal screening every 2 years to check for retinopathy
- Retinopathy is the major cause of vision loss.

- BP 130-140/80 mmHg
- HbA1c 7-8%
- Microalbuminuria: ACE inhibitor or $\acute{\alpha}_2$ receptor blocker (if not contraindicated) if BP allows
- Overt diabetic nephropathy or proteinuria: as above + refer to specialist

- Daily visual inspection and supportive well-fitting footwear
- Podiatry custom built footwear for high risk feet
- Annual diabetic podiatry review
- Contact GP immediately if cellulitis or osteomyelitis present or suspected
- Foot ulceration requires referral to specialist service

- Diabetes Annual Cycle of Care to promote early detection and intervention
- Treatment plan agreed for the resident
- Refer to specialist or other care when appropriate

REDUCE CARDIOVASCULAR RISK

Adults over the age of 60 years who have diabetes indicates greater than 15% risk of cardiovascular disease. The Guidelines for the Management of Absolute Cardiovascular Disease Risk (2012) recommend the following management plan:

Lifestyle	Pharmacotherapy	Monitoring
Frequent and sustained advice and support about diet and physical activity Smoking cessation – appropriate advice and support Advice given simultaneously with BP and lipid lowering drug treatment	Treat simultaneously with lipid lowering and BP lowering unless contraindicated or clinically inappropriate Aspirin not routinely recommended Consider withdrawal of therapy for people who make profound lifestyle changes	Review response 6 – 12 weekly until sufficient improvement or maximum tolerated dose achieved Adjust medication as required

For the elderly, individualise the target HbA1c

% Units	New Units (mmol/mol)	
<6%	<42	Non diabetic range
6-6.5%	42-48	? too low (if on insulin or sulphonylurea) check for hypos
6.5-7%	48-53	Excellent but still be mindful of hypos in older person
7-8%	53-64	Good
8-9%	64-75	? a bit high
9-10%	75-86	Too high – poor control
10% or>	86 or >	Exceptionally poor control

Gastrointestinal Care Guide

Resident is complaining of abdominal discomfort

Assess for the following:
- Acute abdominal pain and possible obstruction (see abdominal assessment)
- Delirium
- Impaction (see DRE pg 32)
- Rectal bleeding

Present assessment findings to GP or Nurse Practitioner

Resident has Diarrhoea

Assess for the following:
- Self-limiting, sudden onset diarrhoea
- Food poisoning
- Overflow related to constipation (see DRE guidelines pg 32)
- Pre-existing medical condition causing diarrhoea
- Nausea and / or vomiting
- Overuse of laxatives
- Clostridium Difficile (potentially serious)

Monitor and rehydrate

If symptoms persist (>24 hours) refer to GP or Nurse Practitioner

Abdominal assessment basics:

Listen for bowel sounds over each quadrant:

- Absent
- <2 – 3 per minute (hypoactive)
- 10-30 per minute (hyperactive)
- High, tinkling sounds in one area (possible obstruction)

Lightly feel (palpate) abdomen:

- Guarding with light touch

Deeper abdominal palpation:

- Masses?
- Tenderness
- Note location

Maintenance and Prevention

- Assess and treat haemorrhoids and fistulae
- Provide adequate privacy
- Ensure adequate body positioning
- Provide enough time, preferably after meals
- Ensure adequate hydration, dietary intake, fibre/fluid balance
- Review medications – reduce constipating medications

Constipation Care Guide

Establish resident's normal bowel pattern

Resident is constipated

Update care plan?

1st Line Treatment (day 1-3)

Assess:

- Physical environment
- Seating position favourable for bowel movement
- Non-invasive abdominal exam – bowel sounds, pain with light and deep touch, abdominal masses or lumps (notify GP if abnormal examination result)

Interventions:

- Dietary: Porridge, prunes, fruit, pear juice
- Increase fluid intake
- Laxatives: usually osmotic agent (Movicol – Coloxyl & Senna – OR combination of both)
- Complementary treatment can be considered: essential oils, massage, reflexology
- Maintenance: increase exercise (walking if possible) or stationary exercise

BM

No BM

2nd Line Treatment (day 4)

Re-assess:

- Non-invasive abdominal exam – bowel sounds, pain with light and deep touch, abdominal masses or lumps (notify GP if abnormal examination result)
- Digital rectal examination (DRE) to assess for impaction

Interventions:

- Follow facility protocol and discuss with GP and/or Nurse Practitioner (e.g. glycerine suppository, Ducolax, Movicol, Oral Fleet, enema, high enema, manual removal)

BM

No BM

3rd Line Treatment (day 5)

Re-assess:

- Non-invasive abdominal exam – bowel sounds, pain with light and deep touch, abdominal masses or lumps (notify GP if abnormal examination result)
- Digital rectal examination (DRE) to assess for impaction

Interventions:

- Follow facility protocol and discuss with GP and/or Nurse Practitioner (e.g. glycerine suppository, Ducolax, Movicol, Oral Fleet, enema, high enema, manual removal)

BM

Contact GP who may follow up with one or more of the following interventions:

- **Physical examination**
- **Rectal examination**
- **Abdominal x-rays**
- **Blood – FBC etc.**
- **Stool sample**

CONSTIPATIONS MEDICATIONS OVERVIEW

Types of medications used for constipation:

1. **Bulking agents** (i.e. psyllium (Metamucil), calcium polycarbophil (Fibercon) – good for maintenance
   - Must have adequate fluid intake
   - These agents need 2 – 3 days to exert their effect and are not suitable for acute relief
   - Avoid if peristalsis is impaired, such as for late stage Parkinson's Disease, Stroke, Spinal Injury and existing faecal impaction or bowel obstruction
2. **Osmotic agents** (Movicol) – maintain fluid content in the stool
   - Often the first choice for constipation because they are gentle with few side effects.
3. **Stool softeners** (docusate) – alter the surface tension of the faecal mass
   - Good for those with hard stools, excessive straining, anal fissures or haemorrhoids
   - Psyllium has been shown to be more effective than stool softeners for chronic constipation
   - Not a good choice for impaired peristalsis
4. **Stimulants** (Senna, bisocodyl, docusate sodium) – stimulate intestinal movement
   - Use sparingly – it can result in electrolyte imbalance and abdominal pain
   - Prolonged use can precipitate lack of colon muscle tone and hypokalaemia
   - Contraindicated in suspected intestinal blockages
5. **Suppositories: Medicated suppositories should be inserted blunt end first, Lubricant suppositories should be inserted pointed end first.**
   1. Lubricant (glycerine) – lubricate anorectum and have stimulant effect. Should be inserted in to the faecal mass to aid softening of the mass. No significant side effects.
   2. Stimulant (glycerol, bisocodyl) – must be inserted against mucous membrane of the rectum, and not in to the faecal mass
   3. Osmotic (rectal phosphates)
   4. Stool softening (docusate sodium) – side effects can include electrolyte imbalance and abdominal pain.

ENEMAS AND SUPPOSITORIES

Administration of enema:

- Obtain consent
- Lying left lateral with knees flexed if able
- Do digital rectal exam prior to administration
- Medicated suppositories: insert at least 4cm in to the rectum against rectal mucous membrane, administer blunt end first
- For lubricating suppository, administer pointed end in to faecal mass, allow 20 minutes to take effect

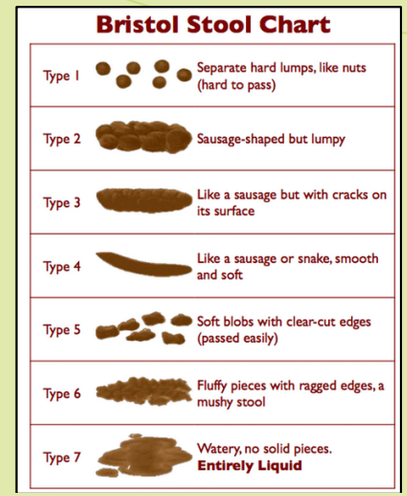
DIGITAL RECTAL EXAMINATION

- Obtain consent
- Lying left lateral with knees flexed is able
- Observe areas for haemorrhoids / rectal prolapse / tears
- Gloved index finger well lubricated
- Gently using one finger only

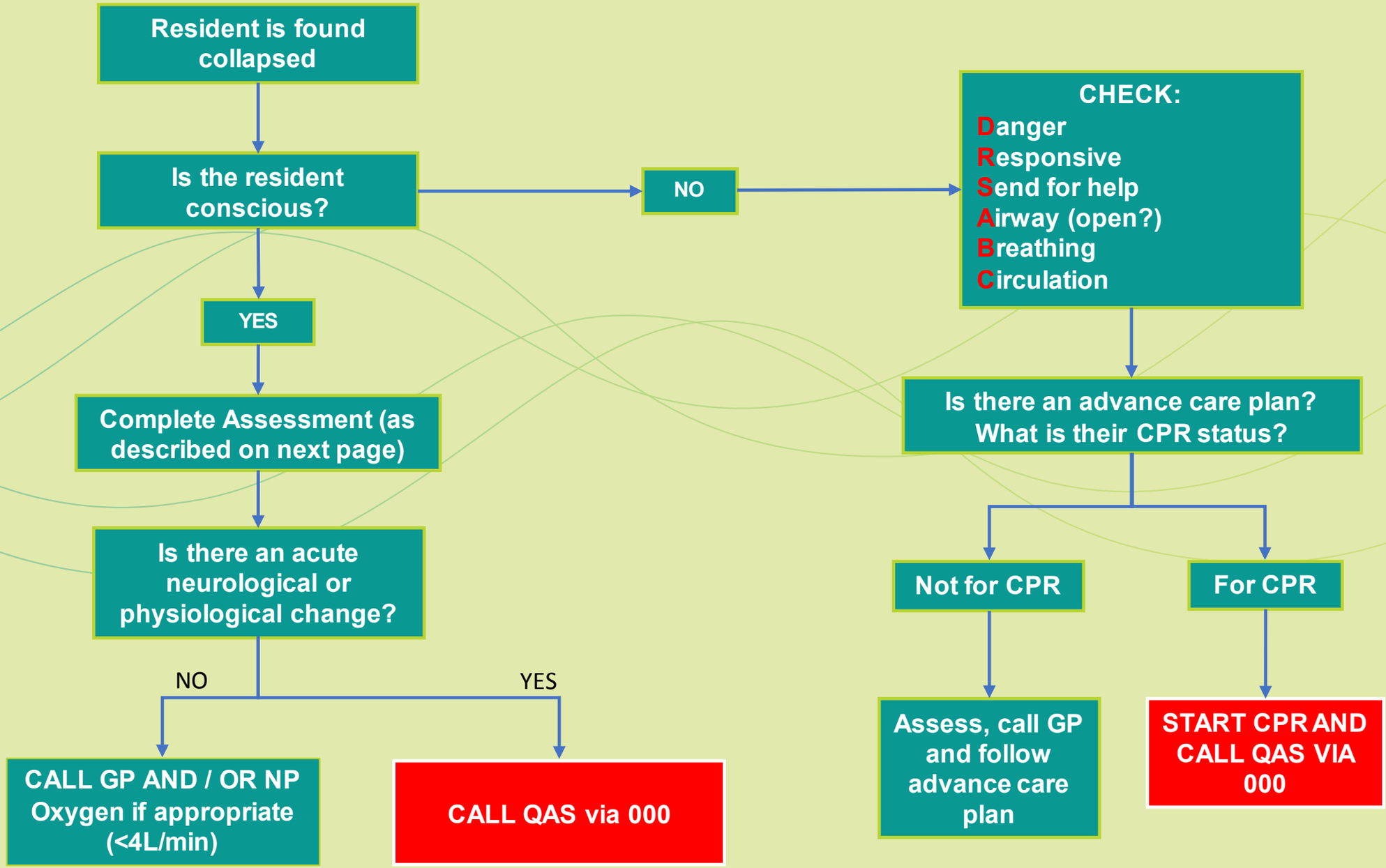
MANUAL REMOVAL

Should be avoided if possible and only used if all other methods have failed (or if part of the individual care plan)

- Obtain consent
- Lying left lateral with knees flexed if able
- Observe areas for haemorrhoids / rectal prolapse / tears
- Take pulse (baseline)
- Use a well lubricated, gloved finger
- Gently using one finger only
- Remove small amounts at a time
- Stop if distressed or pulse rate drops



Syncope and Collapse Care Guide



POSSIBLE CAUSES OF COLLAPSE

- Tachycardia, bradycardia, arrhythmia, heart defects, heart failure, heart attacks
- Vasovagal (common faint)
- Orthostatic hypotension
- Dehydration
- Hypo / hyperglycaemia
- Hypo / hyperthyroidism
- Stroke / TIA
- Epilepsy
- Anaemia
- Infection
- Medication / alcohol
- Panic / anxiety attack
- Heat stroke
- COPD, emphysema, SOB, excessive coughing
- Inner ear problem

ASSESSMENT

- Response to stimuli
- BP lying (and sitting if able), pulse, respiratory rate, Oxygen saturation if available
- Blood glucose
- Check for injury and treat: bleeding, cuts, grazes, limb deformity and swelling, palpate for pain, check for decreased range of motion (if conscious and able to actively move limbs)
- Temperature
- Orientation to time, place and person (compared to normal)
- Events and circumstances prior to episode if available e.g. position, activity, predisposing factors, precipitating events
- Symptoms prior to or at onset of episode e.g. nausea, sweating, chest pain
- Details of episode e.g. duration, breathing patterns, movements
- End of episode e.g. pain, confusion, muscle aches, colour, injury, incontinence
- Previous episodes
- Clinical history
- Medications

Revise care plan if frequent collapses – see Fracture Action Strategies pg 38

Falls Prevention Care Guide

Definition of a fall: "Unintentionally coming to rest on the ground, floor, or other level, but not as a result of syncope or overwhelming external force" (Agostini, Baker & Bogardus 2001)

KEY MESSAGES:

- Many falls can be prevented
- Best practice in fall and injury prevention includes identification of fall risk implementation of standard strategies and targeted individualised strategies that are adequately resourced, monitored and regularly reviewed
- The outcome of the falls risk assessment and identified preventative strategies are discussed with the resident, their family and all health care staff and incorporated in to the resident's individualised care plan
- The most effective approach to fall prevention is likely to be one that involves all staff and the use of a multifactorial fall prevention program

Falls Risk Factors

Environmental

- Unsuitable footwear
- Lighting – levels that cause glare or limit visibility
- Stairs
- Floors: surfaces that cause slips / trips / stumbling
- Patient rooms: clutter / furniture, lack of supports e.g. call bell
- Personal / frequently used items out of reach e.g. glasses, drink, reading material, television remote
- Beds: position, unlocked brakes
- Bathrooms: wet / slick floors, rugs / mats not properly secured
- Seating: not individualised to resident's needs / abilities
- Elevators
- Reduced access to use of assistive devices
- If new or ongoing issues (despite intervention) refer to GP or Nurse Practitioner for review

Request Occupational Therapy or Physiotherapy assistance

Person Centred

- Increasing age (especially >85years)
- 2 or more falls in previous 6 months
- Wandering behaviour
- Cognitive impairment
- Incontinence, urinary infections
- Independent transfers
- Hyper / hypotension (postural drop)
- Impaired balance or weakness
- Unsteady gait / use of mobility aid
- Impaired hearing or vision
- Fever / acute illness e.g. pneumonia
- Within 24 hours of surgery
- Depression / delirium / anxiety / confusion
- Primary cancer
- Dehydration / poor nutrition
- CHF, heart disease and / or arrhythmias
- Neurological disorders including seizures
- Dizziness, vertigo
- History of alcohol abuse and / or intoxication
- Diabetes

Medications

- Over the counter and / or prescribed polypharmacy
- Laxatives
- Diuretics and / or increase in dose
- Antiarrhythmic medications
- Anticoagulants
- Antihypertensive medications
- Vasodilators
- Sedatives, tranquilises, psychotropic medications
- Antidepressant medications
- Narcotics
- Hypoglycaemic agents
- Anaesthetics
- Antiseizure / antiepileptic medications

Request review from GP or Nurse Practitioner if new or ongoing issues suspected despite intervention

Highest Risk of Falls:

Residents who are:

- Able to stand but need assistance with transfers
- Incontinent
- Cognitively impaired
- New to the facility

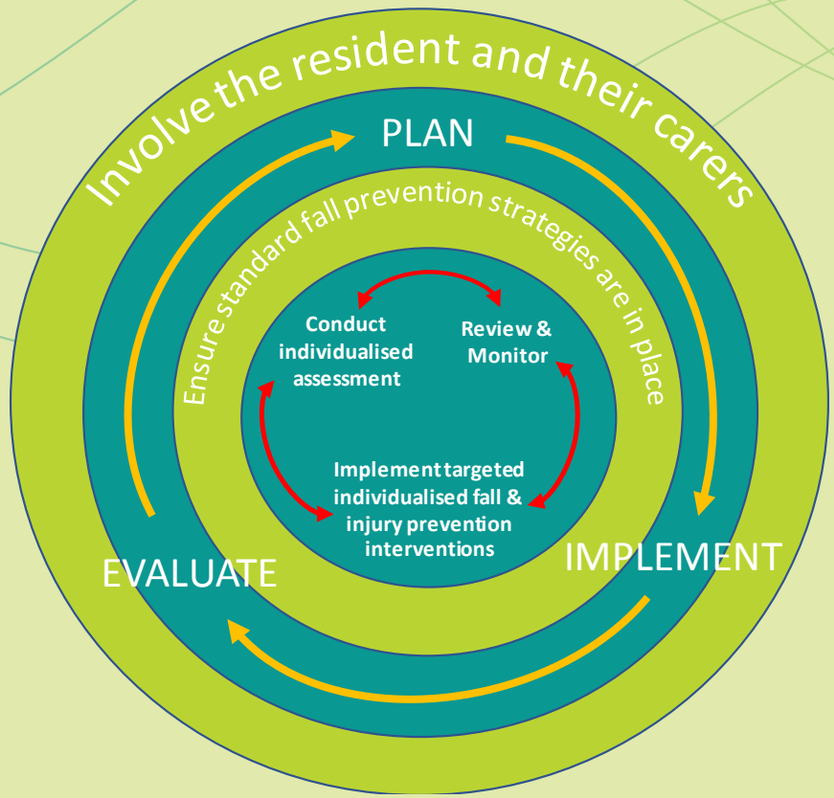
Comprehensive Multidisciplinary Falls Assessment (to be completed after ANY fall):

- Health history and functional assessment
- Medications and alcohol consumption review
- Vital signs and pain assessment
- Vision screening
- Gait and balance screening and assessment
- Musculoskeletal and foot assessment
- Continence assessment
- Neurological assessment
- Depression screening
- Depression scoring
- Walking aids, assistive technologies and protective devices assessment
- Environmental assessment

RESTRAINTS are not a method of fall prevention – DO NOT RESTRAIN

Components of a Fall Prevention Program

1. Initial assessment of all residents to identify their falls risk and develop a care plan with interventions for their individual risk factors
2. Risk assessment factors entered in to all resident's health records
3. Ongoing reassessment for causes, factors and falls as part of a 3-monthly clinical review or sooner if further falls, change in health status or change in environment
4. Appropriate prevention / intervention plan implemented for all residents
5. High risk residents may be identified at the bedside with a 'fall symbol' and will have the high risk interventions implemented as appropriate
6. Consider referral to specialist gerontology service
7. Documentation of all falls and completion of incident report
8. Measuring and monitoring of fall rates / injury rates
9. Monitor and audit uptake of falls program e.g. hip protection, vitamin D uptake, exercise program participation, staff education
10. Attention to the environment – lighting, flooring, furniture, bathrooms and toilets
11. Staff education programs



Fall Prevention Interventions for Individual Residents

Intervention	Description
Restraints	DO NOT USE
Staff education	Staff need a high level of awareness for each resident's fall risk
Individualised care plans	Including intervention programs
Attention to vision / visual aids	Annual review – use correct visual aids (e.g. glasses) for mobilising
Orientation and reorientation	Environmental orientation and how to obtain assistance (e.g. call bell)
Agitation, wandering and impulsive behaviour	Recognise and eliminate to reduce factors that precipitate these behaviours
Case conferences	Include all care givers, nursing, medical and allied health staff. Include family if appropriate
Medication review	Eliminate or reduce doses (aiming to maximise health benefits whilst minimising side effects e.g. falls
Resident participation	Work with high risk residents – increasing assistance as needed
Exercise	Encourage participation in exercise programs for improving balance
Footwear	Well fitting, non-slip footwear and treatment of any foot problems
Continence management	Manage bladder and bowels as required
Hydration and Nutrition	Ensure adequate nutrition and fluid available, and in reach
Environmental issues	General and individualised attention including: • Specialised advice on assistive and mobility devices • Correct use of moving and handling equipment • Multidisciplinary approach with management
Hip protectors	Consider use of hip protectors for clients assessed as high risk of fractures associated with falls
Vitamin D	Evidence suggests vitamin D is associated with reduction in falls and fall-related fractures

VALUE OF EXERCISE
Exercise to improve balance, strength and gait is a key component of fall prevention programs

Fracture and Contracture Care Guide

MANAGEMENT OF ACUTE FRACTURE

Acute Fracture Presentations:
- Acute pain
- Decreased mobility / weight non-bearing
- Deformity of limb, shortness, rotation
- Haematoma / oedema

Action Plan

- Treat shock
- Take vital signs
- Administer appropriate analgesia - Refer to pain management care guide
- Providing a calm and secure environment for the patient
- Monitor swelling, neurovascular observations
- Immobilisation of site (First Aid until QAS Paramedic arrives)
- Inform GP and/or NP of suspected fracture

Transfer resident to hospital
Call QAS via 000

MANAGEMENT OF CONTRACTURE

Contracture Presentations:
- Alternate anatomical presentation
- Reduced strength
- Reduced bone density
- Thinning of subcutaneous tissues
- Increased risk of pressure sore / ulceration development
- Increased skin moisture within contracted area

Action Plan

- Referral to physiotherapist for functional assessment EARLY for prevention and management of contracture
- Multidisciplinary team coordination for ongoing management of contracture – keeping skin dry and intact, comfort, pain control and handling techniques
- Advice on daily activities of living and promotion of independence
- Provision of individualised exercise plan for muscle strength, endurance and balance program
- Increase dietary intake to include high energy patient diet
- Provide pressure care aids and consider referral to Occupational Therapist for specialised pressure care aids.

One in three older people have a fall each year and 40% of older people have multiple falls.
Falls have significant physical and emotional impacts on older people.

General risk factors that should be reviewed

- People with significant cognitive impairment
- Osteoporosis
- Low BMI
- History of falls
- History of Cardiac disease/neurovascular disease
- History of Parkinson's or other motor sensory deficit
- High risk medications e.g. anti-convulsant, opioids, antiarrhythmics, sedatives
- Polypharmacy
- Smoking / Alcohol
- Sensory deficits e.g. visual, auditory
- Previous history of fracture
- Decreased mobility
- Environmental hazards e.g. loose rugs, lack of grab rails, unsteady furniture
- Poorly fitting footwear or no footwear

Action strategies

- Delirium/Dementia Care
- Lifestyle advice e.g. activity, diet, calcium rich foods, limit alcohol intake
- Sunlight or supplemental Vitamin D, (Vitamin D supplementation recommended for all mobile adults unless contraindicated)
- Undertake vision, hearing testing and wear aids
- Neurological/cardiovascular assessments
- Cognitive assessments
- Medication review
- Consider a bisphosphonate for all people with history of fractures, calcium and Vitamin D supplement if no cardiac risk / good dental care
- Falls assessment, Skin inspection, Cognition assessment, regular weights for all age/gender groups
- Consider hip protectors/appropriate footwear / non- slip socks
- Prevent dehydration
- Toileting regime / regular bowel function/bowel chart
- Environmental assessment – repair cracks in concrete, install hand rails,
- Remove clutter, adequate lighting etc
- Training staff to carry out assessments and recognise those at risk

General risk factors that should be reviewed

COGNITIVE

- Depression
- Delirium
- Dementia
- Medication reaction / issues
- Hallucinations / delusions
- Dehydration
- Disorientation
- Agitation

CARDIOVASCULAR / RENAL

- Low BP/High BP
- Electrolyte imbalance

- Endocrine disorders
- Infection / UTI
- Orthostatic Hypotension (stand at least 3 minutes prior to taking BP)

MUSCULOSKELETAI

- Poor gait
- Loss of balance
- Reduced muscle tone
- Reduced bone density
- Decreased muscle strength
- Thinning subcutaneous tissues

RESPIRATORY

- Shortness of breath
- Acute respiratory change
- Chest infection
- Reduced chest expansion & decreased oxygen levels
- Curvature of spine
- Calcification of thoracic region
- Chronic respiratory disease

Pain Assessment Care Guide

Pain is an individual, multifactorial experience influenced by culture, previous pain events, and ability to cope.
Pain is what the person says it is.

"Tell me about your pain"
Is this pain increased (an exacerbation of existing pain) or ongoing?

→ **ALERT**
If acute chest pain contact GP
refer to pg. 11

Does the resident have difficulty communicating e.g. advanced dementia, impaired, non-verbal?

YES → **Use Abbey Pain Scale**

NO

Provokes – what makes the pain better or worse?

Quality – what does it feel like? Is it sharp, dull, stabbing, burning, crushing?

Radiation – does the pain radiate, move anywhere?

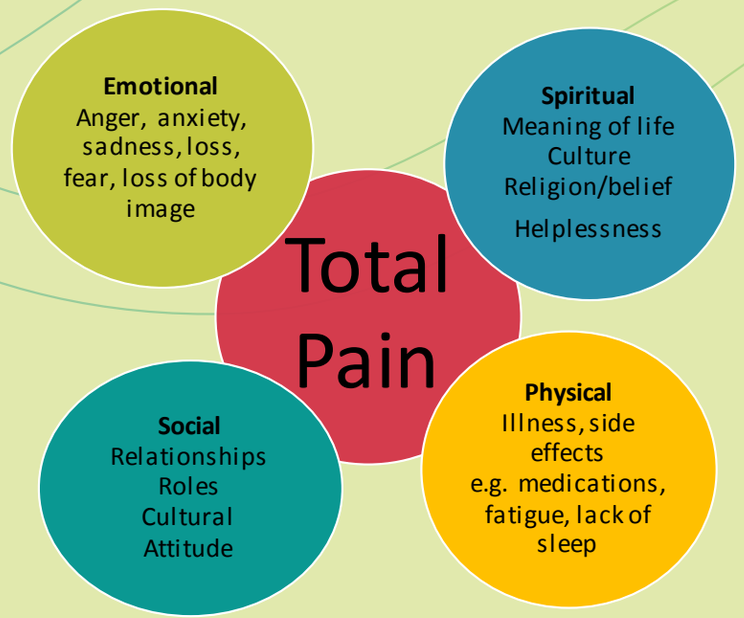
Severity – how bad is the pain, how severe is it?

Time – when does it occur, how long does it last?

What does the resident think is causing the pain?

REMEMBER:

- Reassess regularly
- Listen to caregivers and family
- Document in resident's clinical record
- Develop and implement an individualised care plan
- Resident may have more than one pain across multiple sites
- Resident may use different words to describe pain
- Identify and treat reversible causes (UTI, constipation, trauma)
- Discuss with GP or Nurse Practitioner
- Escalate pain concerns to the senior nurse



Abbey Pain Scale:

Vocalisation: whimpering, groaning, crying

Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

Facial expression: looking tense, frowning, grimacing or looking frightened

Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

Change in body language: fidgeting, rocking, guarding part of the body, withdrawn

Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

Behavioural change: increased confusion, refusing to eat, alteration in usual patterns

Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

Physiological change: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor

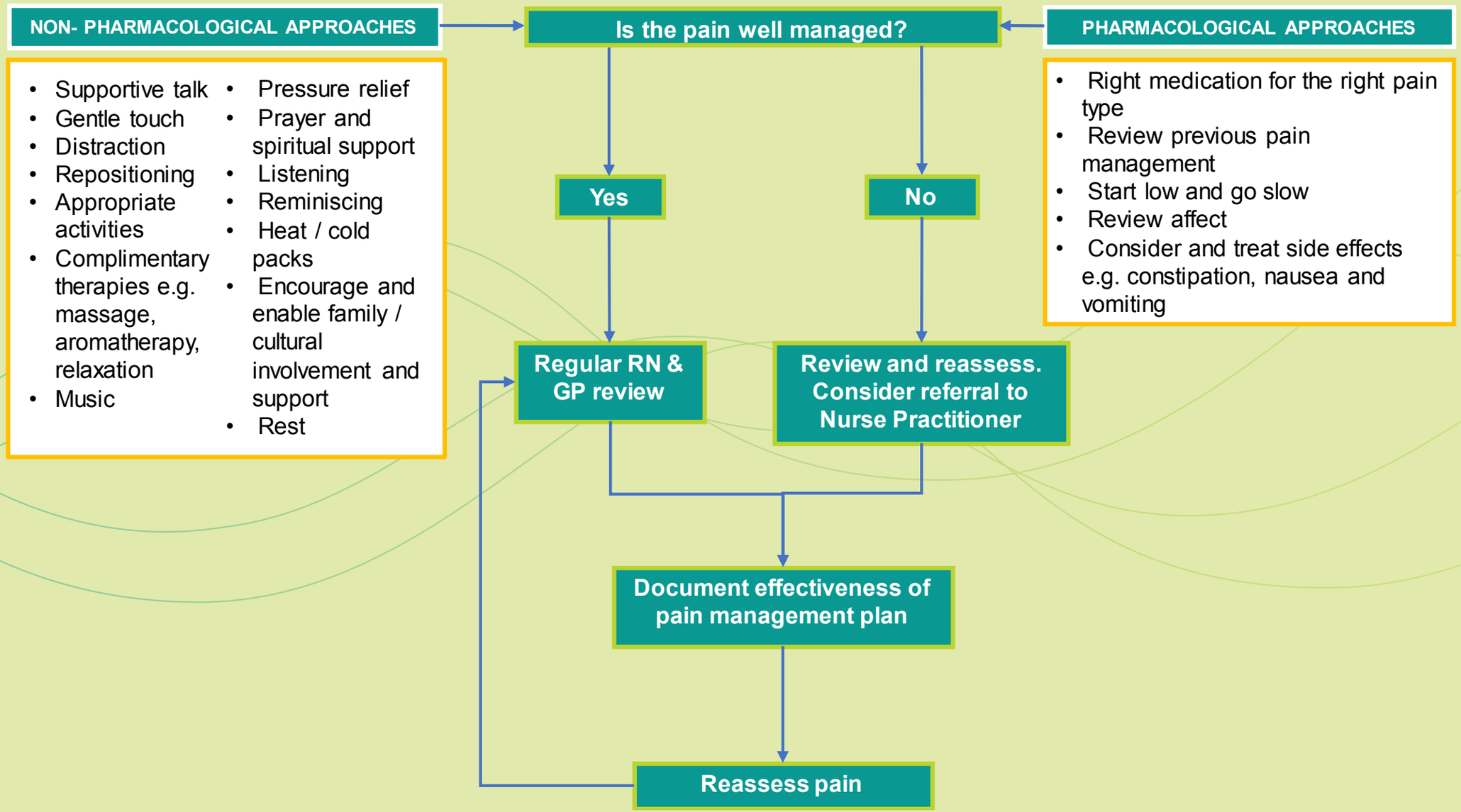
Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

Physical changes: skin tears, pressure areas, arthritis, contractures, previous injuries

Absent 0 Mild 1 Moderate 2 Severe 3 Score: ☐

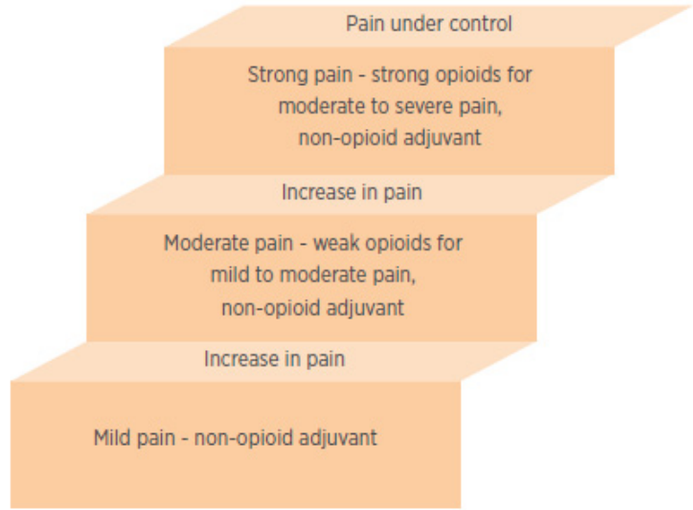
0-2	3-7	8-13	14+
No pain	Mild	Moderate	Severe

Pain Management Care Guide



	WHO Ladder Step	Score on pain scale (0 – 10)	Analgesics of choice
1.	**Mild pain**	<3 out of 10	Paracetamol Note: aspirin is not recommended for older people due to high risk of GI bleeding.
1.	**Mild to moderate pain**	3 to 6 out of 10	Weak opioids (codeine) + / - paracetamol
1.	**Severe pain**	>6 out of 10	Strong opioids (morphine, fentanyl, oxycodone + / - paracetamol)

World Health Organisation (WHO) analgesic ladder for pharmaceutical treatment of pain:



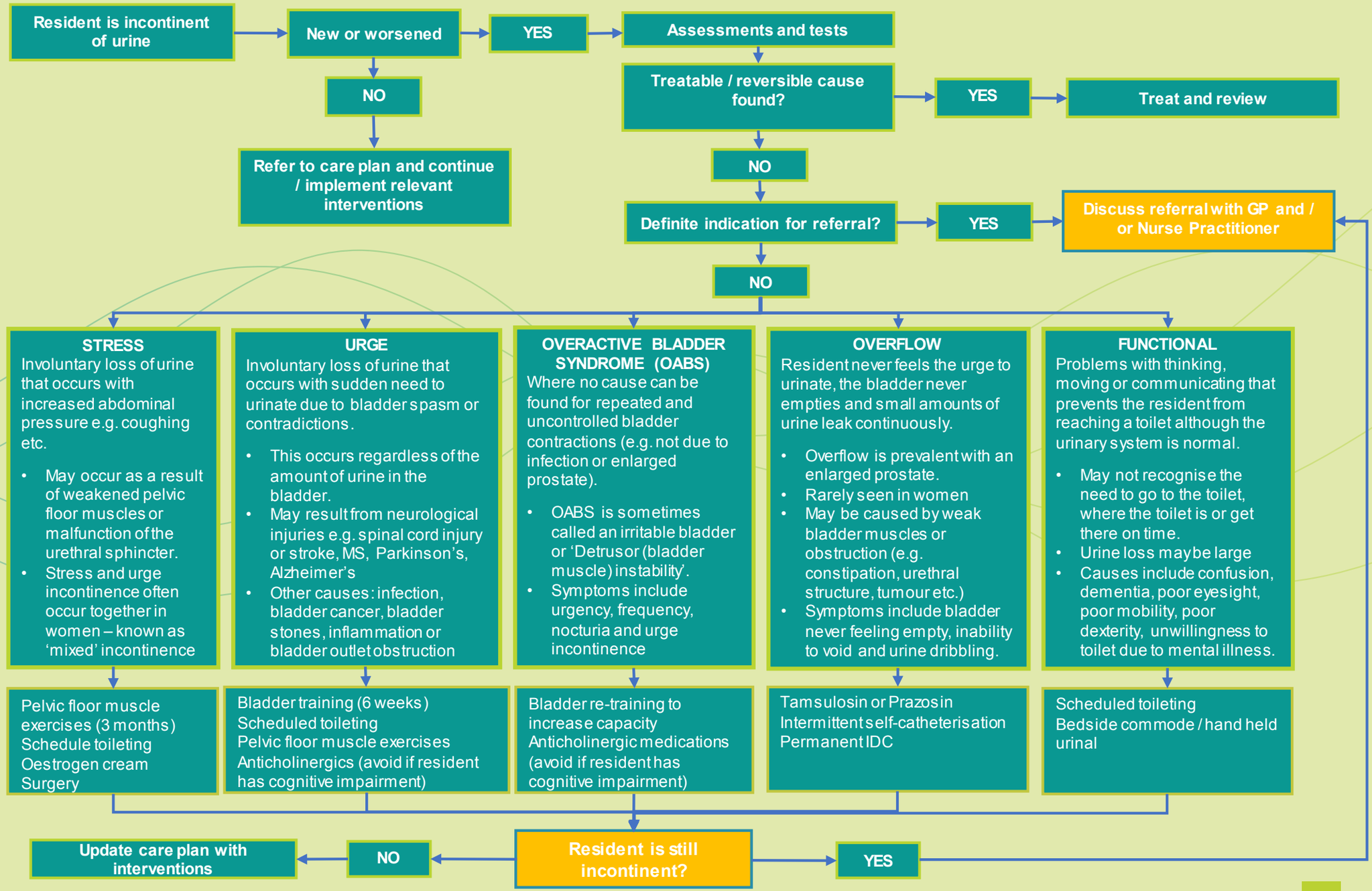
Successful pain management:

- Is resident centred and realistic
- Involves the resident and their families
- Is built on accurate pain assessment
- Uses a holistic approach
- Includes a multi-disciplinary approach

Note:

- Non Steroidal Anti Inflammatory Drugs (NSAIDs) are not recommended for the frail elderly.
- Use NSAIDs with caution for anybody with Chronic Renal Disease.

Urinary Incontinence Care Guide



Changes with Age:

- The maximum amount of urine the bladder can hold tends to decline
- The ability to postpone urination after feeling the need may decrease
- The amount of residual urine increases
- In women, the urethra shortens and the lining becomes thinner as the level of oestrogen declines in menopause (decreasing ability of urinary sphincter to close tightly
- In men, the rate of urine flow out of the bladder and through the urethra slows when the prostate gland is enlarged (common as men age)

Review History of Urinary Incontinence:

- Medical diagnoses
- Medications
- Characteristics of voiding: frequency, timing, volume
- Previous treatment for urinary incontinence and outcome
- Importance to resident
- Resident / family expectations
- Bowel habits
- Use of restraint
- Use of continence products

General Assessment:

- Mental status / motivation
- Mobility
- Environment

Targeted Physical Examination:

- Lower extremity oedema
- Neurological
- Abdominal
- Pelvic (women): external exam of labia, vagina for prolapse, atrophic vaginitis, skin changes

Tests:

- Urinalysis, urine culture and sensitivity if symptomatic
- Post void residual urine
- Stress cough test
- Supplemental blood work where indicated

General Considerations:

- Avoid caffeine (can irritate the bladder)
- Maintain fluid intake (concentrated urine can irritate the bladder)
- Timely administration of diuretics so the resident can be close to the toilet
- Alcohol may make symptoms worse

Potentially Reversible Conditions:

- Stool impaction
- Urinary tract infection
- Delirium
- Depression
- Decreased fluid intake
- Volume overload
- Congestive heart failure
- Venous insufficiency with oedema
- Medication side effects: rapid acting diuretics, anticholinergics, narcotics, calcium channel blockers, alpha-adrenergic agonists, psychotropic medications
- Irritation or inflammation in or around lower urinary tract
- Atrophic vaginitis or urethritis
- Metabolic (hyper / hypoglycaemia)
- Impaired ability or willingness to reach a toilet
- Illness, injury or restraint that interferes with mobility

Indications for Referral:

Always refer for:

- Microscopic haematuria
- Visible haematuria
- Recurrent or persisting urinary tract infection
- Suspected pelvic mass arising from the urinary tract
- Symptomatic prolapse visible at or below the vaginal introitus
- Palpable bladder after voiding
- Persisting bladder or urethral pain
- Clinically benign pelvic masses
- Associated faecal incontinence see pg. 29 Diarrhoea
- Suspected neurological disease
- Voiding difficulty
- Suspected urogenital fistulae

Urinary Tract Infections Care Guide

NON CATHETERSIED RESIDENT

IS THE RESIDENT SYMPTOMATIC?
(refer to next page)

→ NO → Prevention strategies (see next page)

YES

Assess and record baseline observations & new or worse signs and symptoms

Do signs and symptoms meet definition for urinary tract infection?

The resident has at least 2 of the following signs and symptoms:

- Fever (>38ºC) or chills
- New or increased burning or pain on urination, frequency or urgency
- Worsening of mental or functional status
- Chronic UTI may be asymptomatic until signs of renal failure become apparent

(see next page)

→ NO → Consider other causes

YES

Is there an individualised care plan that covers that scenario?

→ YES → Implement care plan

Initiate collection of MSU or clean catch urine specimen AND contact GP or Nurse Practitioner to discuss assessment

→ Discuss possible care pan with GP. Consider risks and resident goals (see next page)

RESULTS OF URINALYSIS?

Positive
Greater than 10^5 colony forming units / ml or pending

→ **Symptomatic? Meets definition for UTI**

→ YES → **Commence treatment**

→ NO → **Do not treat for UTI**

Negative
No growth or mixed bacterial growth

→ **No UTI**

Is the resident symptomatic?

Urinary tract infection (UTI) is the most common bacterial infection in residents in residential aged care facilities. Asymptomatic bacteriuria is not treated with antibiotics except in special circumstances e.g. prior to surgery where it may increase post operative risk. There is no discernible benefit to the resident (when there is bacteria in the urine without symptoms) and there are risks of antimicrobial resistance and medication reactions.

Surveillance of asymptomatic bacteriuria is not recommended as this represents baseline status for many residents.

Symptomatic UTI:
One of the following criteria must be met:

1. The resident does not have an indwelling urinary catheter and has at least **2** of the following symptoms:
   - Fever (>38°c) or chills
   - New or increased burning or pain on urination, frequency or urgency
   - New flank or supra-pubic pain or tenderness
   - Change in character of urine (colour, viscosity, smell etc.)
   - Worsening of mental or functional status
2. The resident has an indwelling urinary catheter and has at least **2** of the following signs and symptoms:
   - Fever (>38°c) or chills
   - New flank or supra-pubic pain or tenderness
   - Change in character of urine (colour, viscosity, smell etc.)
   - Worsening of mental or functional status

Care should be taken to rule out other causes of these symptoms.
If there are 2 or more symptoms of non-urinary infection, do not order urine culture.

Collection of Mid-Stream Specimen of Urine (MSU):
A urine specimen can take some time to collect. Alerting staff as soon as a UTI is suspected will assist in getting specimen before any treatment is started. A urine specimen should always be obtained prior to treatment because a negative urine culture is useful to exclude UTI.

A positive urine culture will show micro-organism's sensitivity to antibiotics, allowing for judicious prescribing. Antimicrobial resistance is becoming increasingly problematic in residential aged care increasing the importance of optimising antimicrobial therapy.

Treatment Options:

Treatment options need to be individualised for each resident. Deciding when to start antibiotics can be challenging. Possible treatment may include:

- **Resident is symptomatic but not unwell** → **Wait for urine result but continue to monitor**
- **Resident is symptomatic and unwell** → **Refer to GP or Nurse Practitioner for review**; **Eligible for a phone order**
- **Resident is critically unwell or deteriorating rapidly** → **Transfer to hospital via QAS (dial 000)**; **Treat serious infection as soon as possible**

Preventative strategies may include:

- Adequate hydration to meet daily requirements
- Attention to perineal hygiene and continence management
- Cranberry capsules to reduce E.Coli adherence to the bladder wall
- Void catheterisation
- Consider atrophic vaginitis and oestrogen cream treatment if resident continues to suffer multiple UTIs

Continue to monitor resident in all cases for change in status and act accordingly. Consider risks, care plan, previous allergies and treatment history, communication with EPOA, family member and / or representative.

Skin Care Guide

Skin at risk

Nursing assessment completed e.g. Waterlow score pg. 48, falls risk assessment pg. 35, nutrition/hydration status pg. 23

Prevention plan implemented?

Intact skin

Normal skin but at risk:
Thin, fragile, dry or previous history of ulcer, pressure sore or cancerous occurrence

Consider use of:
- Skin protectors
- Maintain nutrition/hydration levels
- Use of moisturisers
- Careful use of skin cleaners (pH balanced)
- Maintain hygiene

Compromised skin

Cracked, macerated, indurated, bruised, ashy, erythematous/ warm to touch

- Moisturise intact skin
- Pressure relieving devices e.g.. mattresses etc.
- Protect intact skin using foams, transparent films, heel/elbow protectors, appropriate footwear
- Keep intact skin cleansed, pH balanced

Broken skin

Skin tears, leg ulcers, cancerous occurrences, pressure sores, surgical incisions

- Provide warm, moist environment for optimal wound healing
- Absorb excess exudates by using foams, absorbent pads, hydrocolloids, alginates
- Prevent infection by keeping wound clean or using activated dressings
- Minimise pain/promote comfort
- Pressure relieving devices e.g. mattresses etc.

Arterial ulcer

- Doppler assessment
- Consult with GP regarding ischemia and planned treatment
- Protect extremity from trauma
- Assess for pain and provide pain relief
- Cleanse area
- Prevent contamination
- Moisturise and protect intact skin
- Do not over moisten wound bed
- Reduce bioburden through proper products

Venous ulcer

- Doppler assessment
- Compression therapy
- Leg elevation, exercise e.g. walking
- Weight management as needed
- Cleanse, moisturise and protect intact skin
- Moisture balance imperative
- Avoid contamination

Pressure ulcer

- Proper positioning, turning, patient support surface and/or wheelchair seat pressure cushions are essential
- Cleanse, moisturise and protect intact skin
- Avoid massage of bony prominences
- Pressure relieving devices e.g. cushions, mattresses, heel protection, gel pads

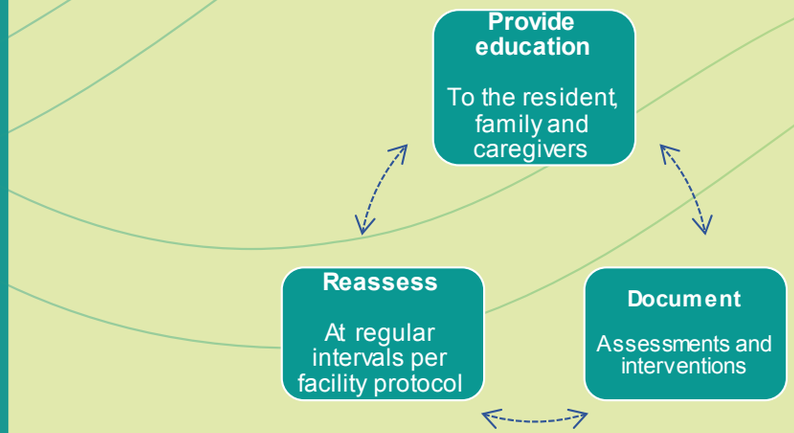
Neuropathic ulcers Diabetic or Rheumatoid

- Consult with GP or NP if ischemia exists
- Blood Glucose monitoring and balance
- Protect from injury with orthotics or other appropriate footwear
- Cleanse, moisturise and protect intact skin
- Avoid contamination
- Keep wound more dry than moist

Please Note: Certain skin conditions can arise when the skin is moist and warm, especially when other risk factors are present. Patients on antibiotic therapy or immunosuppressants are particularly susceptible to skin infections as are individuals with diabetes, AIDS, leukaemia, or lymphomas. Those with epithelial barriers are also at risk e.g. burns, maceration or those whom are undergoing radiotherapy.

Implement wound prevention protocols

- Provide skin inspection: at least daily based upon characteristics listed on the previous page
- Use good turning techniques: avoid stripping/shearing injury, use slide sheets as recommended in safe patient and manual handling education
- Use good positioning techniques
- Careful selection and removal of adhesives: use adhesive removal wipes or alternatives to tapes/adhesives
- Pressure Injury Risk screening tool: e.g. Waterlow, Braden, or similar
- Pressure relieving devices
- Assess for adequate nutritional intake and hydration
- Consider medication and other disease processes in care planning



WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

Ring scores in table, add total. More than one score/category can be used.

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS	
AVERAGE		HEALTHY	0
BMI = 20-24.9	0	TISSUE PAPER	1
ABOVE AVERAGE		DRY	1
BMI = 25-29.9	1	OEDEMATOUS	1
OBESE		CLAMMY, PYREXIA	1
BMI > 30	2	DISCOLOURED	
BELOW AVERAGE		GRADE 1	2
BMI < 20	3	BROKEN/SPOTS	
BMI=WT(KG)/HT (m2)		GRADE 2-4	3
CONTINENCE		**MOBILITY**	
COMPLETE/		FULLY	0
CATHETERISED	0	RESTLESS/FIDGETY	1
URINE INCONT.	1	APATHETIC	2
FAECAL INCONT.	2	RESTRICTED	3
URINARY + FAECAL		BEDBOUND	
INCONTINENCE	3	e.g. TRACTION	4
		CHAIRBOUND	
		e.g. WHEELCHAIR	5

SEX AGE	
MALE	1
FEMALE	2
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
81 +	5

MALNUTRITION SCREENING TOOL (MST)
(Nutrition vol.15, no.6 1999—Australia)

A - HAS PATIENT LOST WEIGHT RECENTLY
YES - GO TO B
NO - GO TO C
UNSURE - GO TO C AND SCORE 2

B - WEIGHT LOSS SCORE
0.5 - 5KG = 1
5 - 10KG = 2
10 - 15KG = 3
> 15KG = 4
UNSURE = 2

C - PATIENT EATING POORLY OR LACK OF APPETITE 'NO' = 0, 'YES' = 1

NUTRITION SCORE
IF > 2 REFER FOR NUTRITION ASSESSMENT/ INTERVENTION.

SPECIAL RISKS

TISSUE MALNUTRITION		NEUROLOGICAL DEFICIT	
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE		PARAPLEGIA (MAX OF 6)	4-6
(RESP, RENAL, CARDIAC)	5		
PERIPHERAL VASCULAR		**MAJOR SURGERY OR TRAUMA**	
DISEASE	5	ORTHOPAEDIC/SPINAL	5
ANAEMIA (HB < 8)	2	ON TABLE > 2 HR#	5
SMOKING	1	ON TABLE > 6 HR#	8

MEDICATION—CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY—MAX OF 4

SCORE
10 + AT RISK
15 + HIGH RISK
20 + VERY HIGH RISK

Scores can be discounted after 48 hours, provided patient is recovering normally.

Age related skin changes:

- Reduced pigmentation
- Fewer functional elastic fibres
- Reduced vascular blood
- Reduced skeletal muscle
- Slower replacement of hair and nails
- Reduced cellular shedding and replacement
- Thinner dermis

Perineal skin compromise

- Cleanse and protect skin tissue at frequent intervals
- Gently cleanse skin
- Frequent use of a moisturiser or barrier is recommended with incontinence
- Management of incontinence issues: scheduled toileting, pads, uridomes/uritips etc.

Wound bed preparation

TIME

T = tissue debridement to increase viability

I = Infection/inflammation, reduce bioburden of the wound

M = Moisture balance at wound bed

E = Edge of wound advancement, wound progressively healing and the circle is going inward

	Athlete's foot	Thrush	Ringworm	Scabies	Eczema	Psoriasis
Signs & Symptoms	• Intense itching • Pale skin • Redness around wound • Scaling • Maceration • Fissures in the skin	• Itchy burning rash • Purulent discharge of white curd-like discharge	• Circular slightly erythematous patches	• Scaling • Symmetrical rash • Excessively itchy rash, particularly at night	• Dryness • Deep seated itching • Inflammation & redness • Fungal/bacterial infections are common with eczema • Skin oedema • Blistering	• Chronic inflammation of skin/nails • Raised red scaly patches • Flaky skin • Excessive growth of reproduction of skin
Contributing factors	• Sharing communal bathing facilities • Wearing heavy footwear with no way for perspiration to evaporate • Wet footwear • Exposure to fungus	• Diabetes mellitus • Use of antibiotics • Changes in hormonal/ physiological status • Irritants such as detergents/talc • Excessive heat/humidity	• Exposure to fungus • Excessive heat/humidity • Cross contamination of surfaces e.g. toilets, towels, hair brushes	• Weakened immunity • Skin to skin contact • Also spread through bedding & carpets	• Allergic reactions to dust mites, detergents or dietary intake • Stress • Environmental factors	• Auto immune disorder related to excessive smoking, chronic alcohol consumption • Stress
Treatments	• Clean dry feet & footwear • Change footwear daily • Twice daily application of antifungal medication	• Treat with antimycotics (antifungal meds) • If able keep areas clean, dry and if able allow to air	• Treat with antimycotics (antifungal meds) • Mild cases can use tea tree oil	• Application of topical creams e.g. permethrin • Treatment of contacts • Environmental cleaning required	• Keep skin moisturised (twice daily) & avoid harsh soaps • Homeopathic sulphur creams/bath salts can aid in calming inflammatory episodes • Keep mite antigen levels down by regular dusting/vacuuming & changing of bedding • Antihistamines & steroidal therapy upon serious outbreaks	• Specialist bath/cream treatments such as coal tar creams, corticosteroids, vitamin D3 creams • Sunlight (UVA/UVB) therapy • Oral medications such as immunosuppressants and retinols

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Glossary:

Tachycardia – Rapid heart rate
Crackles/wheeze – See Lung Basics pg 16
Dyspnoea – Difficulty breathing/shortness of breath
Nocturia – The complaint that the individual has to wake at night one or more times for voiding
Diaphoresis – Excessive sweating (commonly associated with shock or other medical emergencies)
Arrhythmias – Improper beating of the heart
Hypoxia – Deficiency in the amount of oxygen reaching the tissues
Anaemia – Low red blood cell count
Psychomotor – relating to the origination of movement in conscious mental activity
Systemic – relating to a system, especially as opposed to a particular part
Hyponatremia – Low blood sodium level
Orthopnoea – Difficulty breathing/shortness of breath when lying down
Cardiac Cachexia – Severe weight loss/wasting due to chronic heart failure
Dysphagia – Difficulty swallowing
Hypoxaemia – Low blood oxygen level
Paroxysmal nocturnal dyspnoea – Sudden episodes of difficulty breathing/ shortness of breathing at night

Care Guide Abbreviations:

ACP – Advanced Care Planning
ADL – Activity of Daily Living
AHD – Advanced Care Directive
APD – Advanced Practising Dietician
BG – Blood Glucose
BMI – Body Mass Index
BP – Blood Pressure
BPSD – Behavioural/Psychological Symptoms of Dementia
CCF – Congestive Cardiac Failure
CNS – Central Nervous System
COPD – Chronic Obstructive Pulmonary Disease
DKA – Diabetic Ketoacidosis
DRE – Digital rectal exam
ECG – Electro Cardio Gram
EPOA – Enduring Power of Attorney
FBC – Full Blood Count
GI – Gastrointestinal
HbA1c – Glycosylated Haemoglobin, Type A1C
HHS – Hyperosmolar Hyperglycaemic State
IDC – Indwelling Catheter
MS – Multiple Sclerosis
MST – Malnutrition Screening Tool
MSU – Mid-Stream Specimen of Urine
OABS – Over Active Bladder Syndrome
PRN – as required
QAS – Queensland Ambulance Service
SABA – Short Acting Beta Antagonist
SDM – Substitute Decision Maker
SOB – Shortness of Breath
SoC – Statement of Choices
TIA – Transient Ischemic Attack
URTI – Upper Respiratory Tract Infection
UTI – Urinary Tract Infection
WHO – World Health Organisation

Caring Better Together