EDDIE+

Researching Early Detection of Deterioration in Elderly residents

April 2022

RN & EN Education

AusHSI AUSTRALIAN CENTRE FOR HEALTH SERVICES INNOVATION

QUT

Acknowledgement of Country

We acknowledge the First Nations owners of the lands on where we gather today and pay our respects to the Elders, lores, customs and creation spirits of this country.

For thousands of years, the First Nations owners have gathered to share their knowledge and stories.

We pay our respects to all Aboriginal and Torres Strait Islander peoples and acknowledge the important role they play within our communities.

We recognise their long and continuing connection to country, the lands, winds and waters throughout Australia.

We recognise that these lands have always been places of teaching, researching and learning.

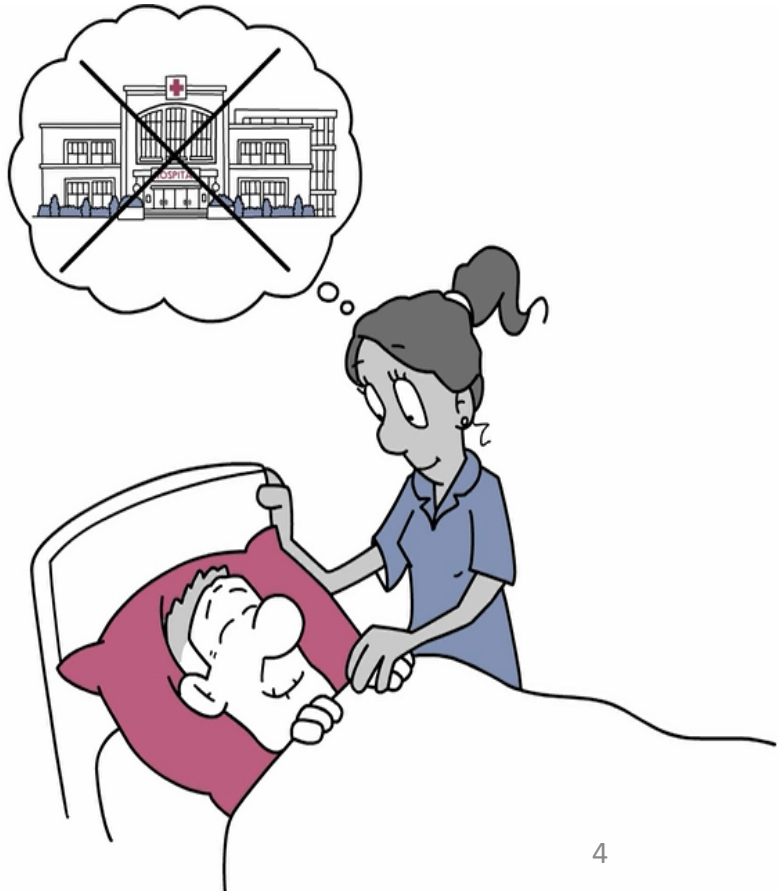
Learning outcomes

Aged Care Quality Standards

1	2	3	4	5	6	7	8	
✓	✓	✓				✓	✓	Review physical, psychological or cognitive changes in residents that may indicate a risk profile for deterioration
	✓	✓	✓			✓	✓	Identify key clinical assessments, care and referral/review pathways for residents at risk of deterioration
✓	✓	✓						Use reporting processes and communication tools to support early escalation of resident deterioration

Why avoid hospital?

- Increased risk of healthcare associated complications
- Loss of independence
- Deconditioning
- Distress
- Worse or extended illness, delayed recovery
- Decreased quality of life and shortened life span



Residents at higher risk of deterioration

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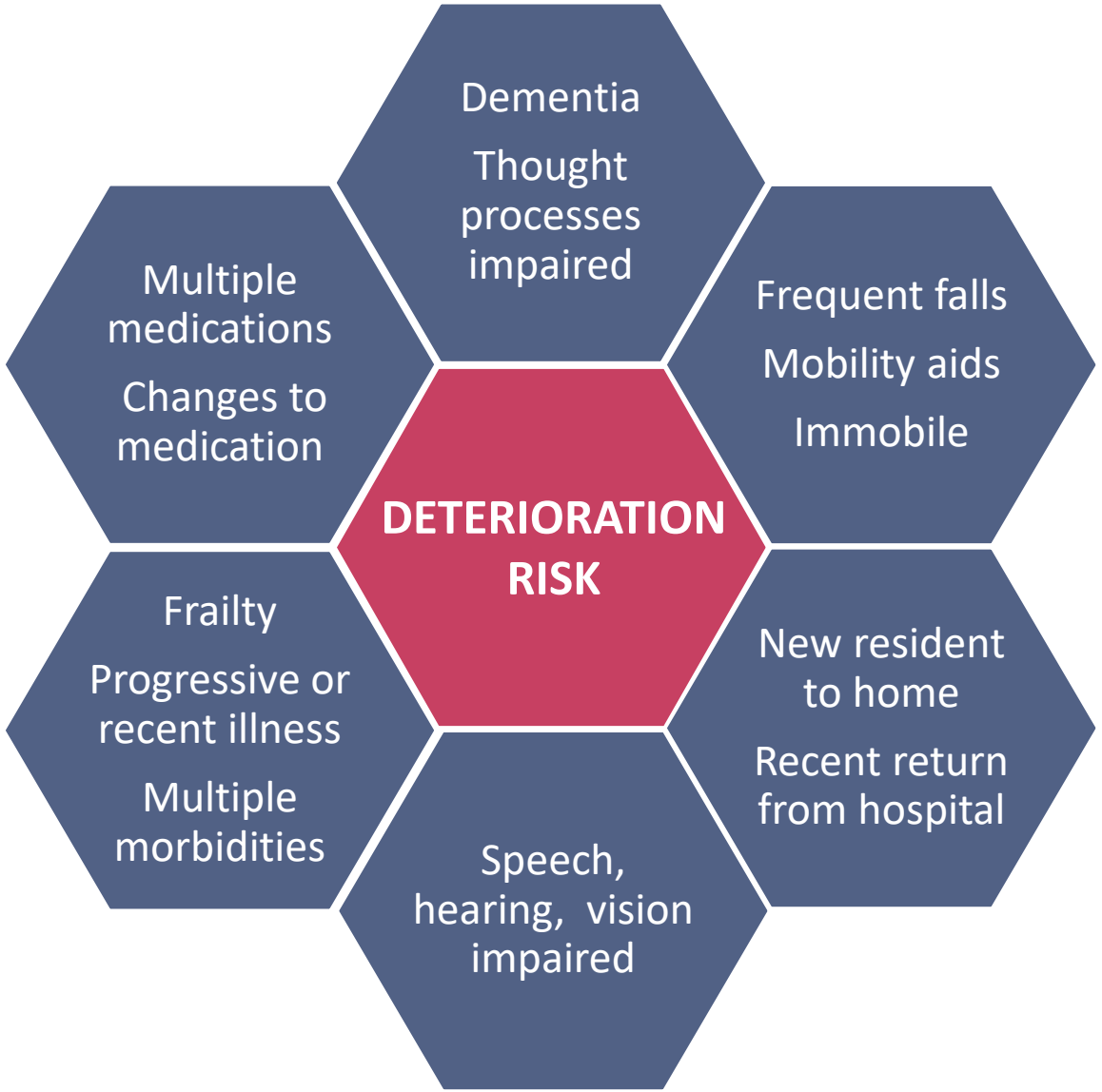


Noticing changes

How are they responding to you?

Aggressive, not talking, tired?

Has a family member/ carer/advocate told you of a change?

Are they in pain, distressed, confused?

Is this behaviour normal for them?

How is their eating drinking, toileting and sleep?

Are they less active or overactive?

Unsteady on feet?

ALL staff encouraged to report <u>early</u> changes in a resident's condition

Barriers to early reporting

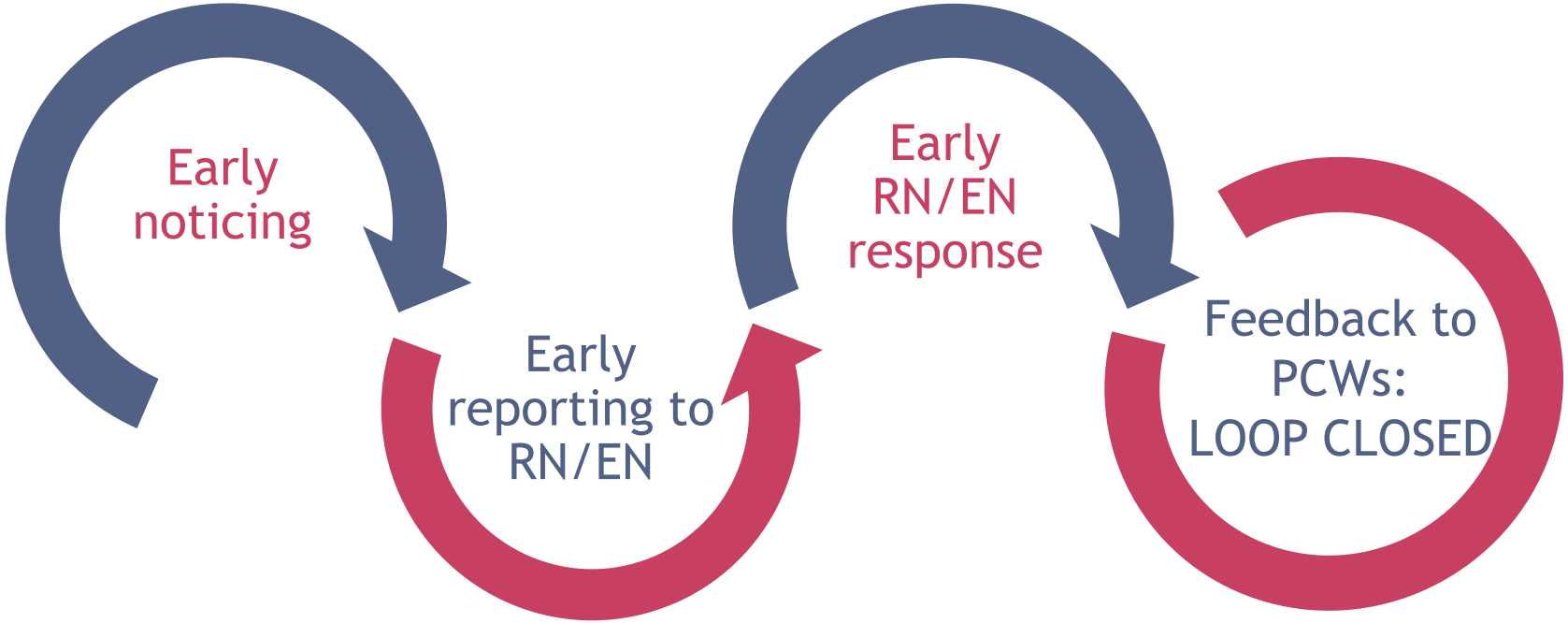
Timing: time needed to report, when to report, workload

Process: uncertain of whether to report, what to say, to whom, when and how?

Experiences of reporting: Follow up and feedback, unsure of outcomes in past, not listened to

RNs/ENs are to acknowledge and offer feedback to PCWs

Communication



LOOP CLOSED:

- ❑ PCWs concern & reporting acknowledged
- ❑ PCWs made aware of what follow-up action has been taken for the resident

Early Detection of the Deteriorating Resident

DELIRIUM

CHEST PAIN

DYSPNOEA

DEHYDRATION

UTIs

CONSTIPATION

FALLS

PALLIATIVE CARE

Clinical response

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Recognising

What's changed?

What's been reported?

Assessments

Signs/symptoms, history

Physiological effects

Apply clinical judgment and reasoning

Care

What actions to take?

Immediate care & longer term care

Clinical monitoring

Referral/ Review

Who to consult?

Reporting

Further review and referral

Check in with PCW

Delirium

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Recognising

- Disturbed cognition and consciousness
- Altered perception, attention deficit
- Abrupt onset
- Hyperactive, hypoactive or fluctuations of both

Assessments

- Vital signs
- CAM, 4AT, GCS
- Pain Assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- FBC & bowel chart
- Infection, UTI
- Medication review
- Use of aids
- Sleep patterns
- Head to toe assessment

Care

- Analgesia
- Hydration, aperient
- Reduce noise/distractions
- Reassurance/reorientation
- Promote sleep/rest
- Falls risk prevention

Referral/ Review

- GP
- Hospital outreach

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Chest pain

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Recognising

- Distress
- Central or tight chest pain, may radiate to jaw or left arm or back
- Heavy feeling on chest
- Nausea
- Sweating
- Reflux
- Dyspnoea
- Agitation

Assessments

- Vital signs
- Pain assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- Medication review
- 3 Lead ECG rhythm
- Head to toe assessment

Care

- Administer GTN & aspirin if not contraindicated
- Analgesia
- Oxygen therapy titrate to 95%< or COPD 88-92%
- Lie or sit person down, loosen clothing, reassure
- Review ACP status/ documentation

Referral/ Review

GP

Hospital outreach

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Dyspnoea

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Recognising

- RR ≥30 breaths/min
- Asthma, COPD, increased coughing and sputum
- Sweating, fever
- Agitation, confusion
- Difficult speaking, lying supine, use of extra-sternal muscles, SOB
- Noisy breathing, stridor
- Cyanosis
- Chest or pain on breathing

Assessments

- Vital signs: O_2 Saturations (resident dependent)
- Respiratory assessment: auscultation, palpation, observation
- Pain Assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- Borg dyspnoea scale
- Medication review
- Conscious level, GCS

Care

- Semi-Fowler's position, sit resident upright
- Administer prescribed medications: respiratory, diuretics, analgesia
- Oxygen administration: O_2 Saturations <92% or low for resident – aim for >92-96%
- COPD 0.5-2 l/min via NP – aim for O_2 Sat >88-92%

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Referral/ Review

- GP
- Hospital outreach
- Physiotherapist

Dehydration

Recognising

- Fatigue, weakness, delirium, agitation
- Dry, poor tissue turgor, sunken eyes
- Decreased thirst/poor oral intake
- Decreased or dark urine
- Constipation
- Fluid loss: fever, diarrhoea, vomiting, wound, infection

Assessments

- Vital signs, medication review
- CAM, GCS
- FBC & bowel chart
- Pain assessments: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- Oral intake: dysphagia, anorexia
- BGL (ketoacidosis)
- Use of sight/hearing aids
- Changes to mobility

Care

- Prompt resident to drink & assist with oral intake
- FBC
- Address fluid losses
- Mouth and skin care
- Hypodermoclysis: Subcutaneous fluid administration (1ml/minute up to 60ml/hour at one site)

Referral/ Review

- GP
- Hospital outreach

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

UTIs

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Recognising

- Dysuria
- Incontinence, retention, frequency & urgency
- Flank pain or suprapubic pain
- Haematuria, pyuria, turbid malodorous
- Delirium, agitation
- Fatigue, anorexia, malaise
- Fever: T° +1.5°C above baseline or > 38°C

Assessments

- Vital signs, medication review
- Pain Assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- MSU/ Urinalysis
- FBC & Continence changes
- CAM, cognition
- Criteria UTI met
- Risk profile assessment- CAUTI, diabetes, hospitalisation, catheter, Hx Renal calculi, cystocele, fistulas

Care

- FBC - increase fluids
- Use alkalisers
- Skin hygiene/pressure area care
- Falls risk prevention
- Fever care
- Analgesia
- Bladder scan (PVR)

Referral/ Review

- GP
- Hospital outreach
- Monitor antimicrobials

Monitor vital signs & cognitive state

Documentation, handover & inform resident representative

Constipation

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Recognising

- < 3 bowels open/week or > 2 days no bowel action
- Abdominal bloating, pain, cramps, nausea, vomiting
- Straining, incomplete evacuation, feeling of fullness/blockage in rectum
- Delirium
- Dehydration, anorexia

Assessments

- Vital signs
- Abdominal palpation
- Bowel sounds, flatus
- Pain Assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- FBC & bowel chart
- CAM
- Medication review
- Rectal and faecal examination
- Bladder scan- Uropathy

Care

- FBC & Bowel chart daily/shift
- Aperients/enemas/suppositories
- Increase dietary fibre/fruits/fluids
- Regular toileting/bowel training
- Abdominal massage (10min/day)
- Increase activity

Referral/ Review

- GP
- Hospital outreach

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Falls

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Recognising

- Bruising, laceration, physical injury, fractures
- Pain, agitation, guarding
- Cognitive changes
- Change in mobility (aids & footwear)
- Risk factors: delirium, dementia, dehydration incontinence, infection, frailty & impaired mobility
- Environmental: flooring, lighting, obstacles

Assessments

- Vital signs & BGL(hypo)
- CAM, GCS, AVPU
- Pain Assessment: PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- FBC & Medication review
- Infections, UTI
- Falls risk assessment (FRAT)
- Use of vision, hearing and mobility aids
- Head to toe assessment

Care

- Post Fall Management head injury or non-head injury observations
- Pain management, wound care, oxygen therapy
- Hip protectors, alarm mats
- Remain with resident

Referral/ Review

- GP
- Hospital outreach
- Physiotherapist
- Geriatric review
- Podiatrist, Optometrist, OT

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Palliative Care

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Recognising

- Changes in pain & comfort levels
- Evidence of existential distress
- Family/carer concerns or observations
- Increased frailty, weakness, illness progression, weight loss
- Decreased mobility, appetite, cognition, consciousness level
- Change in emotional and spiritual well being

Assessments

- Vital signs
- Pain Assessment PQRST, numerical, Abbey, M-RVBPI, PAINAD, McGill
- FBC, including swallowing & nutrition
- Medication review
- Head to toe assessment
- Clinical Frailty Scale
- SPICT

Care

- Facilitate resident and representative wishes and plans (ACD, AHD, ACP, EPOA)
- Implement end of life care planning & pathway
- Physical care and aids
- Organise and maintain cultural, spiritual, psychosocial support

Referral/ Review

- GP
- Hospital outreach
- Specialist palliative care services referral
- Allied health professionals

Monitor vital signs & cognitive state
Documentation, handover & inform resident representative

Clinical Parameters

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- **Serious/Life Threatening zone** - Do not leave the resident unattended; seek urgent medical review
- **Caution zone** - Increase frequency of monitoring- vital signs assessment; request a medical review
- **Normal zone** - Address any resident complaints or issues

Remember!

The parameters are a guide

They do not substitute for clinical judgment or reasoning

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Deterioration Parameters

CATEGORIES	NORMAL	CAUTION	SERIOUS / LIFE THREATENING
ACTIONS	Seek medical review of complaint or issue	Seek medical Increase frequency of monitoring	URGENT MEDICAL REVIEW Do not leave the resident unattended
HEART RATE (BEATS/MIN)	50 - 100	40 - 49 or 101 - 130	<40 or >130
SYSTOLIC (mmHg)	110 - 180 *(or range specified by GP for resident)*	90 - 109 or 181 - 200 *(or higher in well resident)*	<90 or >200 symptomatic
RESPIRATORY RATE (BREATHS/MINUTE)	10 - 24	6 - 9 or 25 - 30	<6 or >30
O2 SATURATIONS	92-100% with or without O2 *(or normal for resident)*	88-91% with O2 given	<88% with O2 given
RESPIRATORY EFFORT	Typical for resident	Abnormal, laboured or noisy Not typical for resident	Distress and/or cyanosis with O2 given
TEMPERATURE	35.6°C - 37.7°C	35°C - 35.5°C or 37.8° - 39°C Temperature Baseline +1.5°C	<35°C or >39°C
RESPONSIVENESS	Alert, cognition normal for resident	Not alert, but responds to voice	Responsive to pain only or Newly unresponsive or Sudden change in mental state
PAIN	Nil, or tolerable with or without analgesia	Observable discomfort with analgesia	Highly distressed with analgesia
BLOOD GLUCOSE (MMOL/L)	6 - 15 *(or range specified by GP for resident)*	4 - 5.9 or <4 responsive to treatment or Persistently >15 in well resident	< 4 AND unresponsive to treatment or Persistently >15 in unwell resident

Adapted from: Queensland Health (2020). Management of Acute Care Needs of RACF Residents: a suite of collaborative pathways for General Practitioners and Registered Nurses. Version 22

April 2022

PCW's- communication tools for reporting

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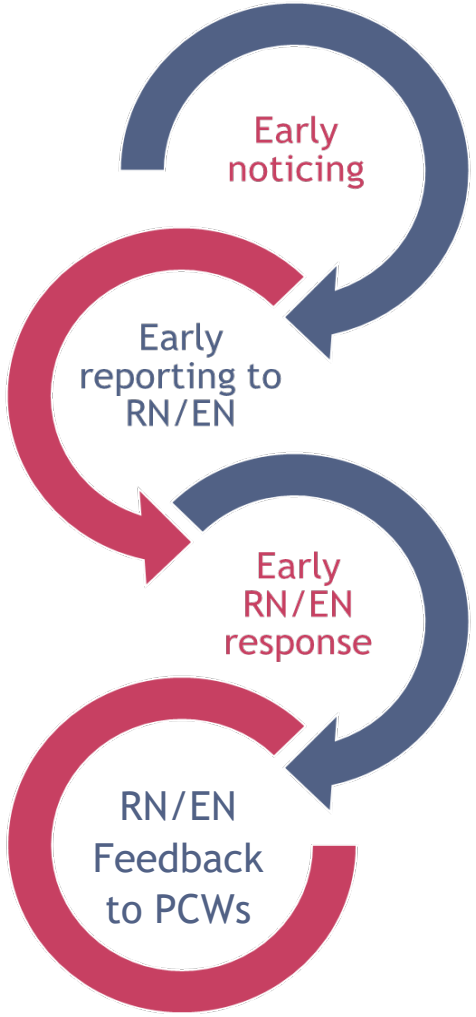
CUS
I am **C**oncerned about…
I feel **U**ncomfortable because…
This is a **S**erious/**S**afety issue, can you please…



From today I will…..