

The Emergency Decision Guidelines are only a guide to assist you with your decision making for a resident

# Emergency Decision Guidelines

A guide for the acutely unwell, deteriorating resident.

The headings assist to direct clinical assessment and action required.

## Know the:

- **goals of care** for the resident:
  - treatment and hospital transfer if required, or
  - treatment but not for transfer to hospital if further deteriorates, or
  - palliative treatment
- resident's and family's **wishes**
- resident's **care plan** and **advance care directive**

## Know what is normal for the resident.

Follow **first aid** response requirements:

- **Danger:** remove yourself / the resident from danger
- **Response:** check the resident's Response and then
- **Airway, Breathing and Circulation:** continue with your acute assessment

**Assess and Document.** Note time of onset of symptoms



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The medical information provided in this guideline is intended as a guide for the management of the acutely unwell and deteriorating resident. The use of this guideline is not intended to provide a substitute for medical advice on the diagnosis and treatment of certain medical conditions. Any resident requiring medical advice or treatment must be referred to their treating General Practitioner or Nurse Practitioner. While the author/s of this guideline takes every precaution to ensure the currency and accuracy of all medical information contained in the guideline, the author/s does not offer any warranties as to the currency of information in this guideline. The author/s are not responsible for any loss or damage, including consequential loss, suffered in connection with reliance of information obtained from the use of this guideline or the reliance of any information provided.

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Developed by Southern Tasmania Area Health Service Nurse Practitioner - Aged Care and General Practice South, July 2011.

# Service Contact Details

Service Name	Contact numbers - Office Hours	Mobile	After Hours Service
Aged Services Southern Area Team Nurse Practitioner Aged Care Clinical Nurse Consultant / Geriatrician	Phone: 6222 7893    Fax: 6222 8476 Phone: 6222 8318    Fax: 6222 8476 Phone: 6222 7893    Fax: 6222 8476	0417 151 575 0437 006 486	nil
Community Palliative Care Service	Phone: 6224 2515    Fax: 6224 2451		Only if individual assessed and approved for AH services by Community Palliative Care
Continence Nurse Consultant, Royal Hobart Hospital	Phone: 6222 8327 (Tues-Fri)	0437 242 669 (Tues-Fri)	nil
Dementia Behaviour Management Advisory Service Older Persons Mental Health Service Nurse Practitioner, Older Person Mental Health Service	Phone: 6230 7541    Fax: 6230 7542 Phone: 6230 7702    Fax: 6230 7542 Phone: 6230 7541    Fax: 6230 7542	Nil Nil 0400 545 666	24hr DBMAS Assistance Line 1800 699 799 24hr Mental Health Help Line 1800 332 388 nil
Emergency Multidisciplinary Assessment Team, Royal Hobart Hospital (for general phone advice)	Phone: 6222 7024 7am till 7pm (staffing dependent 5-7pm)		Sat & Sun: 8 am—3 pm
PEG Nurse Consultant, Royal Hobart Hospital	Phone: 6222 8784	0438 026 464	nil

The **Emergency Trolley** is located at: \_\_\_\_\_

The **Oxygen Cylinder** is located at: \_\_\_\_\_

# The acutely unwell resident in the Aged Care Facility

## Guide to ringing the GP or Nurse Practitioner

This guide is for aged care residential staff to help you provide enough clinical information over the telephone for the GP or Locum or Nurse Practitioner to decide the course of action for the acutely unwell resident. It does not replace clinical care protocols within your facility. The guide may also be useful if you need to ring an ambulance or hospital.

### BEFORE phoning have in front of you:

- Drug chart and allergies + resident's notes**
  - **Tell the doctor / nurse practitioner**
    - Who you are and title (e.g. RN, EN, etc.) and the resident's name
    - Main reason for phoning e.g. change in cognitive status / alertness, chest pain, abdominal pain, resident had a fall, suspected UTI, palliative care etc.
    - Main symptoms e.g. distress, pain, difficulty breathing
    - Main physical signs e.g. alert, pale, sweating, dry mouth and tongue
    - How long the problem has been present and whether it is recurrent
    - Resident's wishes / advance care directive / family or person responsible's wishes
    - Who assessed the resident (name and title) and at what time
    - Who requested the doctor be rung (ACF staff / resident / family)
    - What action has been taken already eg. pain relief, anginine etc.

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### If you have to leave a message, leave:

- Name of Aged Care Facility, telephone number and time of call
- Name of resident
- Your name and title
- Main reason for ringing
- Urgency / how soon you need the doctor or nurse practitioner to ring back

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### AFTER the phone call, document ...

- Name and phone number of GP / locum / nurse practitioner and time phoned
- Whether the GP / locum / nurse practitioner will attend and date and time expected
- Immediate instructions / action

### ... and implement

- Immediate action / instructions e.g. medication order, monitor resident, call locum, call ambulance etc.
- Contact family as required

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# Vital Information for GP / NP

Residents Name: ..... Staff Member: ..... Date: .....

Date & Time	Clinical Indicators	Comments
	Temperature:	
	Pulse: .....beats / min Regular / Irregular ( <i>circle one</i> ) ECG:	
	Respiratory rate: .....respirations / min	
	Blood pressure: ...../.....Lying ...../.....Standing	
	Change in cognitive status:	
	Oxygen Therapy: usual / for current symptoms ( <i>circle one</i> )	
	Blood glucose level:	
	Bowels last opened: stool consistency / colour	
	Vomitus amount / type / colour	
	Urinalysis (if clinically indicated)	
	Medications given to help relieve problem	
	Other:	

## Abdominal Problems

Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If one or more of the following is present:

- Severe abdominal pain
- Distended or bloated abdomen and has not been able to pass wind 12-24 hours
- Persistent vomiting
- Heart rate more than 110 beats per minute or less than 50 beats per minute
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act  
Within  
12 hours**

- Bowels not open within 48 hours of expected motion
- Bowel motions hard or pellet-like
- Streaking of blood on the resident's motions
- If bowels not opened for 48 hours and has nausea or decreased oral intake

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- Consider starting nil by mouth until GP contacted or transferred to hospital
- If vomiting call GP / NP Aged Care as subcutaneous / intravenous fluids may be required
- Refer to facility documentation for bowel action & changes observed
- Medication as prescribed (with sips of fluid)
- Look for a change in pain or bowel medication & document

**TIPS:**

- **Position as comfortable**

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## **Airway and Breathing:** Obstructed? Noisy? Problem with Tracheostomy tube or laryngectomy stoma? Choking? Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If resident is increasingly breathless **AND** if one or more of the following is present:

- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Can't say more than single words or phrases due to breathlessness
- Blood pressure has fallen below 90 mmHg systolic (top reading)
- Heart rate more than 110 beats per minute or less than 50 beats per minute
- Bluish coloured lips, finger nails
- If Choking, 5 back blows if person can't cough up obstacle (see choking section page 9)
- If the tracheostomy / laryngectomy tube is blocked, remove the tube and replace with clean tracheostomy tube

Chest Pain – See Chest Pain section page 8

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act  
Within  
12 hours**

If the resident has any of these symptoms:

- Increasing breathlessness
- Increasing confusion
- Dry or moist cough
- Can't do usual activities due to breathlessness

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- Give oxygen at 2 litres / minute via nasal prongs (including residents with COPD)
- If using mask, give oxygen at 6 litres / minutes (excluding residents with COPD)
- Give residents their regular and / or prn respiratory medications: puffer / inhaler / nebuliser
- Monitor effectiveness of oxygen / medications
- Sputum / phlegm: note colour. Collect sputum sample if discoloured

**TIPS:**

- **Sit upright (if able)**
- **Fan can be useful for comfort**

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## Chest Pain:

### Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If the resident has any of these symptoms:

- Chest pain or tightness pain not relieved by their prescribed medications such as anginine or nitrolingual spray (check expiry date)
- Pain / discomfort in left arm, shoulder or jaw
- Sweaty, clammy, nauseated
- Heart rate more than 110 beats per minute or less than 50 beats per minute
- Blood pressure has fallen below 90 mmHg systolic

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act  
Within  
12 hours**

If the resident has any of these symptoms:

- Increasing frequency of chest pain brought on by activity which goes away with rest or medication
- New chest pain at rest which goes away with medication

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- Give oxygen at 2 litres / minute via nasal prongs (including residents with COPD)
- If using mask, give oxygen at 6 litres / minutes (excluding residents with COPD)
- Sit resident upright
- Loosen tight clothing
- Document: pain type eg sharp, dull, burning, heavy pressure, deep, superficial, aching.  
What caused the pain? What time the pain started, eased or stopped? Radiation or spread of pain?  
What makes the pain worse?

#### TIPS:

- **Reassuring presence**
- **Encourage the resident to rest until reviewed by GP / NP**

## Choking:

A choking person will usually clutch their throat, cough, wheeze or gag, have trouble speaking or swallowing, and make violent attempts to breathe. Face, neck, lips, ears and fingernails will become increasingly blue and the resident can become unconscious. (Reference: St John's First Aid for Choking *Adult / Child over one year*)

**Act  
Now**

- Ask resident to cough- to remove object. If unsuccessful call Ambulance.
- Bend resident well forward and give up to 5 sharp blows between shoulder blades.  
If unable to bend forward, roll onto side and give up to 5 sharp blows between shoulder blades.
- If still unsuccessful, give up to 5 chest thrusts, checking to see if the object is removed after each chest thrust.
- If unsuccessful, alternate between 5 back blows and 5 chest thrusts until medical aid arrives or blockage clears.

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

This information is not a substitute for first aid training.

## Circulation and Neurovascular

Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If the resident has any of these symptoms:

- Unrelieved bleeding
  - Any limb or area that is moderate-severe pain or increasing pain
- With one or more of these other symptoms:
- change in temperature - becomes cold to touch, or hot to touch
  - Slow to blanch – greater than 3 seconds or whitish or bluish in colour and no pulse palpable
  - Sudden reduction in sensation
  - Sudden swelling of limb or other part of body
- Heart rate more than 110 beats per minute or less than 50 beats per minute
  - Blood pressure has fallen below 90 mmHg systolic

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act  
Within  
12 hours**

If the resident has any of these symptoms:

- New changes in sensation eg pins and needles, stabbing, shooting sensation
- Unrelieved Pain
- Gradual swelling of limb

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- Document for the pain: pain type eg sharp, dull, deep, superficial, pins and needles, burning, aching. What caused it, or contributed to it? How long it lasted? What time the pain started, eased or stopped? Any radiation or spread of pain?

**TIPS:**

- **Reassure**
- **Encourage the resident to rest until reviewed by GP / NP**

## Confusion: Delirium / Infection

Check the Goals of Care: active or palliative treatment?

### Tips to check:

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

**Act Now**

If level of confusion is increasing OR change in level of consciousness AND one or more of the following:

- They pose an immediate risk to themselves, to other residents or to staff because of their behaviour
- Heart rate more than 110 beats per minute or less than 50 beats per minute
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Persistent temperature above 38°C or below 35.5°C
- Blood pressure has fallen below 90 mmHg systolic
- Blood glucose level less than 4 mmol / litre or 'Hi' on the glucometer
- Moderate – severe pain (following the use of breakthrough / nurse initiated pain relief)

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act Within 12 hours**

If the resident has any of these symptoms:

- Increase or fluctuations in confusion; increased night-time confusion
- Behavioural changes eg anxiousness, wandering, calling out, aggressiveness
- Hallucinations eg auditory, visual such as seeing something that isn't there

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While Waiting for help**

Avoid over sedating; Offer emotional support; Falls / Harm Prevention Program

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## Dehydration

### Check the Goals of Care: active or palliative treatment?

**Act  
Now**

Unable to drink AND one or more of the following:

- Persistent vomiting and or diarrhoea for more than 8 hours
- Passed no or little urine for 12 hours
- Blood pressure has fallen below 90 mmHg systolic
- Heart rate more than 110 beats per minute or less than 50 beats per minute

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act  
Within  
12 hours**

- Decreased intake of food or fluid
- Decreasing urine output and concentrated urine
- Dry mouth and tongue
- Listlessness and decreased appetite

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- If the resident is choking / coughing when sipping water, DO **NOT** give fluids
- If not choking, try half a glass of water every 30 minutes or ice blocks to suck
- Take pulse, blood pressure, respiratory rate and temperature

#### **TIPS:**

- **Mouth Care**
- **Keep resident warm but not too hot**

## Falls

### Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If the resident has had a fall AND if one or the more of the following is present:

- Fluctuating confusion / consciousness / inability to make sensible conversation compared to normal mental / conscious state
- Associated unresolving or increasing pain, including pain on movement
- Unable to lift limb off the bed and / or rotate limb as usual
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Blood pressure has fallen below 90 mmHg systolic

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act Within  
12 hours**

If resident has any of these symptoms:

- History of increasing pain and / or reducing movement / use of limb

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

If unwitnessed falls or head injury is suspected – do neurological observations:

- Keep immobile until reviewed by GP, ambulance or hospital
- If not on bed rest, staff to supervise / assist walking / transfers
- Consider asking GP to review medications. Has there been any recent changes of medications?
- Check observations: blood pressure, respiratory rate, urine & blood glucose levels
- Review for pain / analgesia effect
- Lying and standing BP if able to stand safely
- Implement falls risk strategies
- If appropriate check family availability if someone is needed to sit with the resident

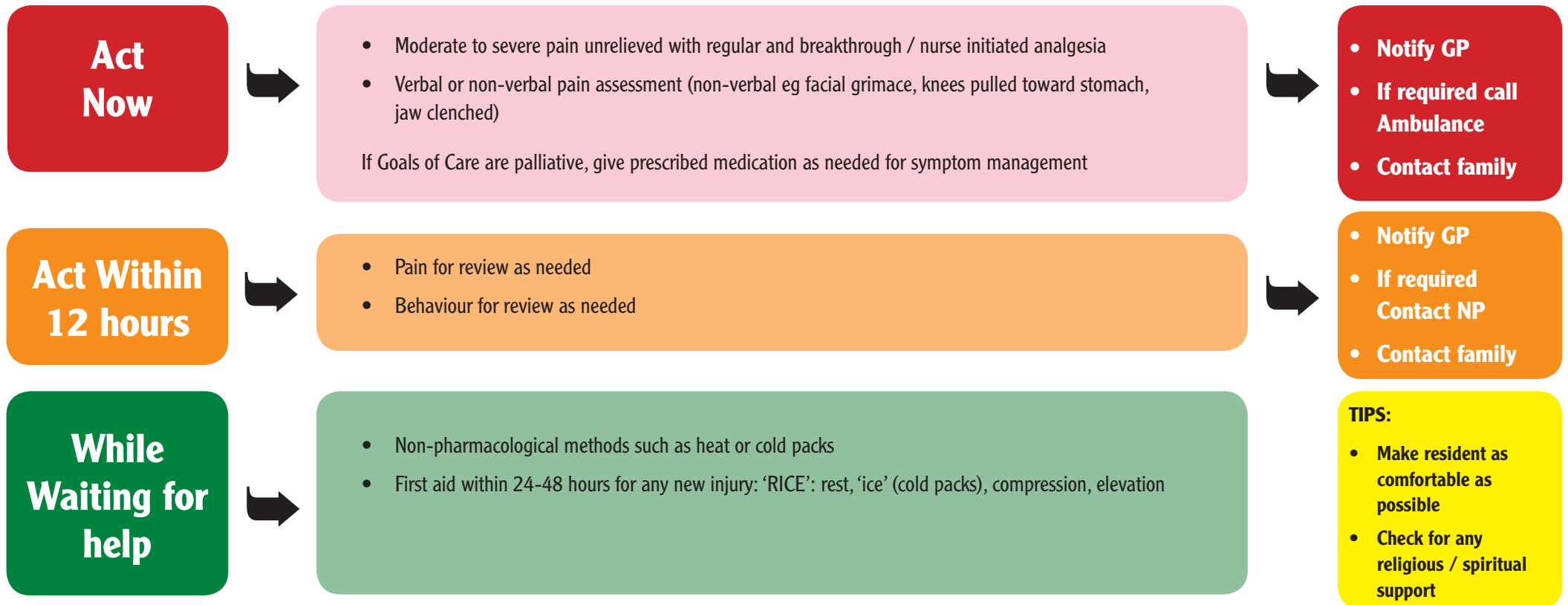
#### TIPS:

- **Discuss strategies to reduce falls risk with family e.g. check footwear**

# Pain

## Check the Goals of Care: active or palliative treatment?

- Note for the pain:
  - Pain type eg sharp, dull, burning, shooting, pins and needles, deep, superficial, aching, heaviness
  - What caused it? What contributed to it? For example: pain on walking, pain when at rest
  - What time the pain started? How long it lasted?
  - Radiation of pain / spread of the pain
  - What eased or stopped the pain? What makes it worse?
- Consider Palliative Care Service or Nurse Practitioner/s or Aged Services Southern Area Team for assistance with pain management



# Seizures

## Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If any of the following is present:

- Repeated or prolonged seizures
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Blood pressure has fallen below 90 mmHg systolic
- Heart rate more than 110 beats per minute or less than 50 beats per minute

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act Within  
12 hours**

- New: single or short duration seizures - review of resident
- See confusion: delirium / infection section page 11

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- Do not restrain the resident
- Do not force anything into the resident's mouth
- If semi-conscious or unconscious - place in side-lying / coma position
- Pillow under head for comfort and any other surrounding cushioning if seizure action is likely to cause harm

**TIPS:**

- **Reassure resident**

# Stroke

## Check the Goals of Care: active or palliative treatment?

**Act  
Now**

If any of the following is present:

- (Think FAST: Face - Arms - Speech / Swallow - Time it occurred and lasted)
- New facial weakness or has the resident's face / mouth drooped
- New changes in speech eg slurred. Does the resident understand you?
- New swallowing difficulties, coughing on saliva, fluids / food; gurgling or changed voice after swallowing
- Change in pupil reactions: use Glasgow Coma Scale
- Any reduction in Glasgow Coma Scales by 1 to 2 points
- Changed conscious level eg drowsy, less responsive
- Respiratory rate less than 8 breaths per minute or more than 25 breaths per minute
- Blood pressure has fallen below 90 mmHg systolic
- Heart rate more than 110 beats per minute or less than 50 beats per minute

- **Notify GP**
- **If required call Ambulance**
- **Contact family**

**Act Within  
12 hours**

- See confusion: delirium / infection section page 11

- **Notify GP**
- **If required Contact NP**
- **Contact family**

**While  
Waiting for  
help**

- If new swallowing difficulties, coughing on fluids / food; gurgling or changed voice after swallowing - then place resident on nil orally while awaiting assessment of swallow (No food, liquid, or medications administered orally)
- Ensure any weak limb is placed in normal body alignment and supported to prevent subluxation, chronic shoulder pain or other limb / joint problems

**TIPS:**

- **Reassure resident**
- **Mouth care**
- **Contact family**

# Tubes

## Check the Goals of Care: active or palliative treatment?

Indwelling Urinary Catheter (IDC); Suprapubic catheter (SPC); Percutaneous Endoscopic Gastrostomy (PEG) tube

- **Immediately replace** SPC or PEG if the tube is pulled out or broken. Use Foley catheter of same size as SPC or PEG tube to keep hole open until correct replacement tube can be put in.
- If the tube appears obstructed, for example: nothing going in / coming out: check patency. Flush IDC / PEG / SPC



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## References

**Australian Resuscitation Council**

<http://www.resus.org.au/>

**Royal Hobart Hospital Medical Emergency Team protocol 2006**

**St John's First Aid for choking**

[http://www.stjohnnsw.com.au/mc/fs/fs\\_choking1.html](http://www.stjohnnsw.com.au/mc/fs/fs_choking1.html)

**National Stroke Foundation Australia**

<http://www.strokefoundation.com.au/clinical-guidelines>

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