ACUTE DETERIORATION

Acute deterioration means the resident is experiencing and exhibiting signs and symptoms that are of new onset and has occurred over hours to days.

Alert

Resident is unconscious?

- Call registered nurse immediately and ring for an ambulance
- Check airway, breathing and start CPR
- Trauma (ie, bleeding) – deliver first aid

Stroke symptoms

REMEMBER, RECOGNISE AND ACT FAST

F	A	S	T
Face drooping	Arm weakness	Speech difficulties	Time to call

If an admission to hospital is required:
Prepare admission letter and transfer form and send copy of medication chart

OBSERVE

Look out for any of these signs:

S	Seems different from usual
T	Talks or communicates less
O	Overall needs more help
P	Participates less in activities
A	Ate less, difficulty swallowing medications
N	No bowel motion for more than 3 days, diarrhoea
D	Drinking less
W	Weight change
A	Agitated or more nervous than usual
T	Tired, weak, confused or drowsy
C	Change in skin colour or condition
H	More help walking, transferring, toileting

IDENTIFY

WHAT DO YOU SEE?

Abnormal vital signs

- Respiratory rate > 25 or < 10
- Oxygen saturations SPO2 < 93%
- Temperature > 37.2˚C or > 1˚C above baseline or < 35˚C
- Heart rate > 100 bpm or < 50 bpm
- New systolic BP < 100 mmHg

Neurological

- Facial droop
- Arm/leg weakness
- Changes in speech
- Loss of consciousness
- Choking

Cardiac

- Hand on chest/clutching chest
- Sweaty and pale
- Collapse
- Loss of consciousness
- Swollen feet, ankles and legs
- Rapid increase in weight

Personal care

- The resident is having difficulty showering, dressing and managing their grooming

Respiratory

- Short of breath when sitting
- Short of breath when dressing or walking
- Short of breath when lying down
- Has a dry or moist cough
- Purple colour to mouth/hands
- Wheezing

Abdominal

- Abdominal tenderness – holding stomach
- Distended abdomen
- Decreased fluid and food intake
- Vomiting/retching/nausea
- Diarrhoea
- Bowels not open for 3-plus days

Urinary

- New urinary symptoms: frequency and incontinence
- Frequently passing urine at night
- Blood in urine/dark urine
- No urine passed
- Smelly urine
- Suprapubic/lower stomach tenderness

Skin integrity

- Change in colour
- Open wound
- Redness and warmth
- Oozing wound
- Bleeding

Cognition/behaviour

- Increased confusion
- Disorientation
- Sleepy and lethargic – difficult to wake
- Agitated and angry
- Depressed/sad/crying

IDENTIFY

Musculoskeletal

- Swollen, red, warm joint – hip, shoulder, knee, elbow, wrist
- New back pain
- Pain on movement
- Joint deformity

Mobility

- Unsteady and balance poor
- The resident has fallen today or during the past few days
- Increased weakness – one or both sides
- Leaning to one side
- Limping
- Shuffling

SYMPTOMS REPORTED BY PERSON

The resident is experiencing these symptoms and may say:

Neurological

- **Dizziness** – sitting or standing – "I feel dizzy, woozy in the head"
- **Headache**
- **Changes in vision/hearing**
- **Numbness/tingling**

Cardiac

- **Palpitations** – "My heart is racing"
- **Chest pain** – "My chest hurts"

Respiratory

- **Resident states they are breathless**

Pain/discomfort

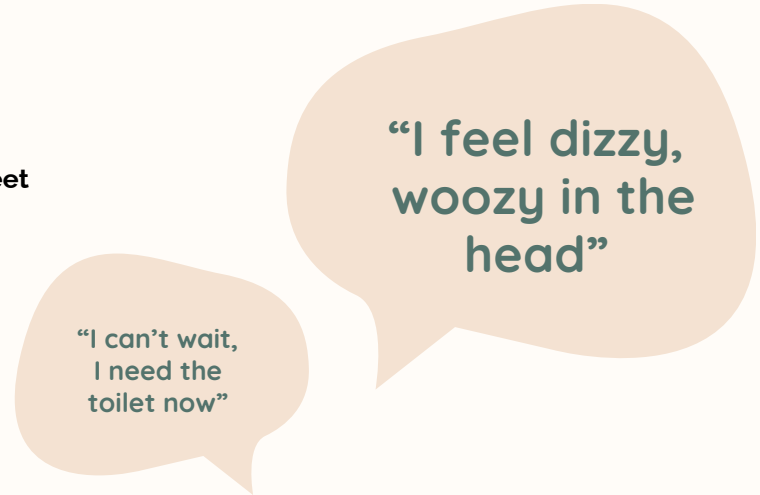
- **Shoulders, back, hips, knees, ankles, feet**

Abdominal

- **Pain** – "My stomach is sore"
- **Nausea** – "I feel sick"
- **Difficulty moving bowels**

Urinary symptoms

- **Frequency** – "I am always needing the toilet"
- **Urgency** – "I can't wait, I need the toilet now"
- **Pain when passing urine** – "It hurts when I go to the toilet"
- **Abdominal/suprapubic tenderness**



ACTION

Take vital signs	Normal range
Pulse	60–90 bpm
Blood pressure	120/80 mmHg
Respiratory rate	14–20 bpm
Oxygen saturations	95–100%
Temperature	36–37.5˚C
Blood sugar level	4–7 mmol

REMEMBER

Observe: the resident's behaviour
Identify: any changes in health status or any abnormalities

Report: new signs and symptoms to the registered nurse and/or general practitioner

Record: record and document changes in health status, for example, new signs and symptoms in the progress notes

Handover: to the next shift

RECORD

Document in progress notes/update care plan

RECORD

CARE PLAN/RESIDENT MANAGEMENT PLAN

- **Notify family/whānau** and enduring power of attorney (EPOA) (welfare) – document this clearly
- **Document in resident's notes** – accurately and thoroughly – what you observed, who you reported to, intervention and action carried out
- **Continue to monitor resident** – vital signs, level of alertness, comfort
- **Maintain nutrition and hydration** – food diary and fluid balance chart
- **Pain management**
- **Monitor bowels and bladder**
- **Monitor skin integrity** for signs of pressure areas – regular positioning
- **Increased supervision** and monitoring of resident to ensure care needs are maintained