ACUTE DETERIORATION

Acute deterioration means the resident is experiencing and exhibiting signs and symptoms that are of new onset and have occurred over minutes, hours or 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

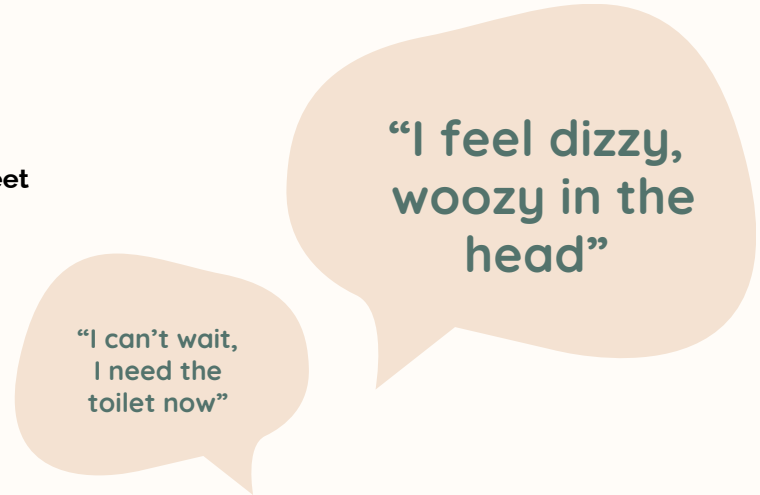
- **Shoulders, back, hips, knees, ankles, feet**

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

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

REPORT

Notify registered nurse of any new signs and symptoms to the registered nurse and/or general practitioner

RECORD

CARE PLAN/RESIDENT MANAGEMENT PLAN

- The registered nurse/senior health care assistant will **notify family and 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