Care Guide

for Health Care Assistants

Improving the care of frail older people

Ka hei ki te marae

Te Tāhū Hauora
Health Quality & Safety Commission

Te Kāwanatanga o Aotearoa
New Zealand Government

Contents

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Background

The Care Guides were first developed in 2010 by the Residential Aged Care Integration Programme (RACIP) Work Group to support caregivers in their practice. These guides were available online at Te Whatu Ora, Health New Zealand and Waitematā DHB websites. They were used across the Waitematā district aged residential care (ARC) facilities.

In September 2024, Te Tāhū Hauora was approached by the Aged Care Residential Quality leads to create a national resource by reviewing, refreshing and redesigning these Guides. Additionally, there was a call to bring a te ao Māori perspective to the design and to add a chapter on caring for kaumātua, thus aligning it with the RN Frailty Care Guides (edition 2023).

This Guide replaces the original guides. It includes guidance on an array of 20 topics to improve quality of care for our older adults. It is designed to:

- prompt Health Care Assistants to look for early warning signs of deterioration in the resident's health status
- report concerns to the Registered Nurse
- document concerns clearly
- provide evidence-based interventions for Health Care Assistants.

The Care Guide is to be used as guidance only. It does not replace the Registered Nurse assessment, oversight and intervention. Instead, it aims to enable the Registered Nurse to provide early intervention for residents in care.

Acknowledgement

The Care Guide is a collaborative endeavor, involving the input, support and advice from many health professionals in the residential care and secondary care sector and non-government organisations.

Te Tāhū Hauora acknowledges the significant work and feedback from all those involved in the creation of this national resource. In particular, to the project team and the Gerontology nurse specialists/practitioners from Waitematā community gerontology nursing service who imparted their expertise and gave us their valuable time to put this guide together.

Special acknowledgment must go to the 25 Health Care Assistant pioneers who participated in the very first focus groups held in 2019 in Waitematā DHB.

Our whakataukī

Ka hei ki te marae

An ornament of the marae

Rākau papa pānga, ka hei ki te marae

This kōrero serves as a kōrero whakarite (metaphor) which highlights the enduring value of our kaumātua who may no longer be active in their former roles but continue to contribute through the provision and maintenance of wisdom and guidance. This whakataukī presents kaumātua as taonga integral to society, just as whakairo, tukutuku and raranga are integral to the operation of the marae.

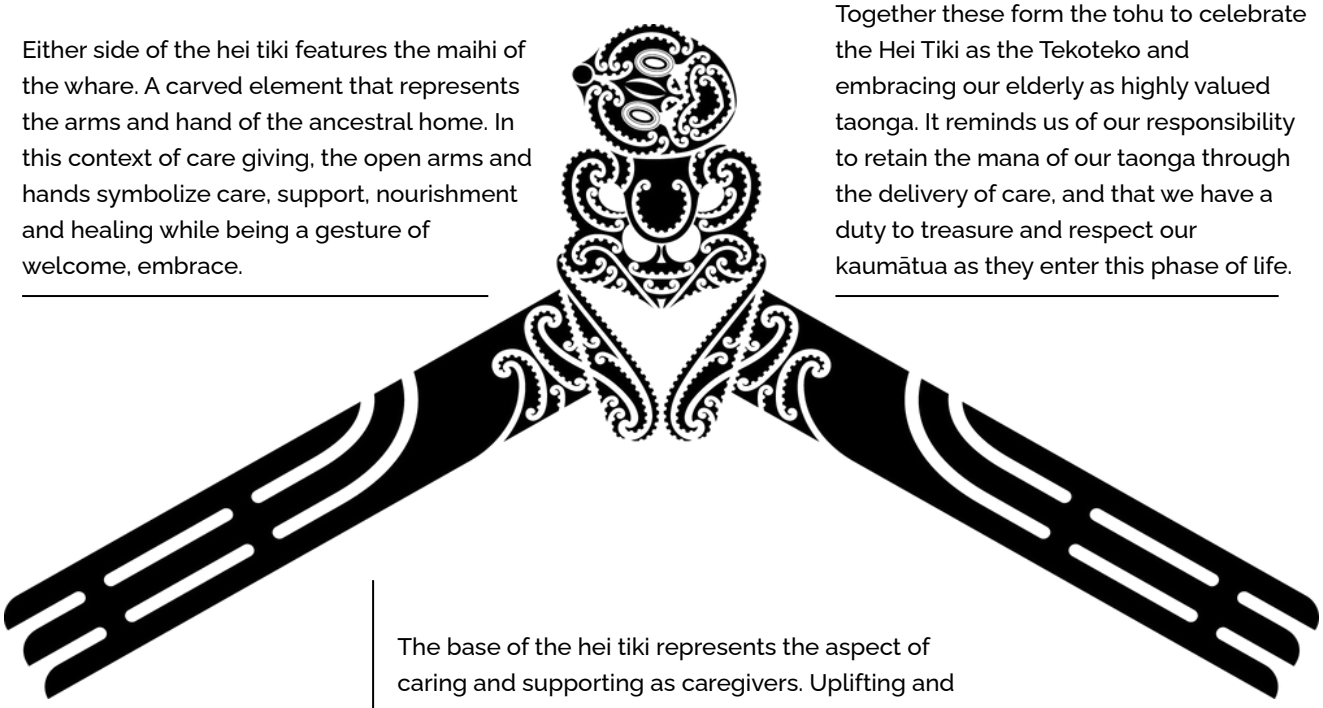
Whakataukī by Turei Ormsby (Tūhoe, Ngāti Porou, Ngāti Kahungunu)

Our tohu

Our tohu design features the figurative form of a hei tiki, being a literal expression of the whakataukī. It reflects the style of pītau a Manaia (painted artform). The combination of pītau, koru and ngutu kākā forms the overall hei tiki. Pītau represents the young shoots of a fern referring to whakapapa, whānau, handing down knowledge, new life and growth. In this content it means the transition from you to elderly, it's a new life and a new role. The open hands of the tiki represent the provision and maintenance of wisdom and guidance.

Either side of the hei tiki features the maihi of the whare. A carved element that represents the arms and hand of the ancestral home. In this context of care giving, the open arms and hands symbolize care, support, nourishment and healing while being a gesture of welcome, embrace.

Together these form the tohu to celebrate the Hei Tiki as the Tekoteko and embracing our elderly as highly valued taonga. It reminds us of our responsibility to retain the mana of our taonga through the delivery of care, and that we have a duty to treasure and respect our kaumātua as they enter this phase of life.



The base of the hei tiki represents the aspect of caring and supporting as caregivers. Uplifting and supporting the mana and mauri of our elderly. The left side (taha wāhine) represents care and the right side (taha tāne) being supported. Like the Hei Tiki, the base is created using the pītau with free flowing forms shaped like a necklace (Hei).

Tohu by Manukorihi Winiata (Ngati Raukawa, Te Āti Awa, Ngati Awa, Tūwharetoa)

COMMUNICATION

If required, always make sure the resident has their glasses on, hearing aids and teeth in place so they can see you, hear you and talk to you.

IDENTIFY

Care of communication aids and tools

Hearing aids

Check they are clean and the batteries are charged every morning

Glasses

Clean them each day

ACTION

EFFECTIVE COMMUNICATION

The acronym SOLER is used to summarise important behaviours, as follows.

S

- **Squarely** face the person
- Facing them in this way makes your posture say "I am ready to listen to you"
- Talk in a place free of distraction

O

- Keep an **open** posture – it shows you are being attentive
- Crossed arms and legs can represent less involvement

L

- **Lean** toward the other person. This shows you are listening
- Look directly, ensure you have their attention

E

- Maintain **eye** contact
- As you listen, use your eyes to show you are looking at the person. This lets them know you are listening to what they are saying

R

- **Relax** while attending
- It is entirely possible both to concentrate and be relaxed. In turn, this helps the other person to feel comfortable and relaxed

GOOD COMMUNICATION IS...

- Good communication begins with an introduction and establishing a rapport
- Allowing time for the resident to express themselves
- Having a respectful attitude
- Displaying attentive body language
- Choosing timing and place to talk
- Being aware of the cognitive status of the resident
- Listening, being attentive
- Respecting cultural differences – making connections with kaumātua, using whanaungatanga, if necessary
- Using interpreters and communication aids

ACTION

BE MINDFUL OF YOUR VERBAL AND NON-VERBAL BODY LANGUAGE

Verbal cues

- Speak slowly, clearly, precisely

Non-verbal cues

- Posture and body language
- Eye contact
- Facial expressions
- Gestures

Communicating with the resident's family/whānau/friends

- Maintain confidentiality and privacy
- Shared decision-making with family/whānau
- Concerns expressed from family/whānau are directed to the registered nurse/manager

RECORD

DOCUMENTATION

Writing progress notes

- Clear handwriting
- Designation
- Time, date and signature
- Content, concise, relevant and informative
- Document conversations with family
- Consider including:
  - appearance
  - comfort
  - nutrition/hydration status
  - mental health status
  - bowels/bladder
  - skin integrity

KAUMĀTUA **AND KUIA**

Tikanga Māori for Health Care Workers

This tikanga guide aims to help the aged care health care worker to provide culturally responsive care to Māori. This guide is underpinned by Māori values, protocols, concepts and Te Tiriti o Waitangi.

Tikanga Māori refers to the customary practices, principles, values and spirituality that guide Māori behaviour and social interactions. It encompasses a wide range of aspects, from protocols and etiquette to cultural beliefs and spiritual practices. Essentially, Tikanga Māori is the "right way" to do things, ensuring respectful and harmonious relationships within Māori communities and with the natural world.

Tikanga includes Māori beliefs that are inherited values and concepts practised from generation to generation. Values include the importance of te reo (language), whenua (land) and in particular whānau (family and extended family group).

Māori views on health are framed by a holistic approach that encompasses four key elements - wairua (spiritual), hinengaro (psychological) tinana (physical) and whānau (extended family). Karakia (blessing or prayer) are an essential part in protecting and maintaining these four key elements of health care.

In some instances, behaviour and practices that are not consistent with Māori beliefs and values can cause distress and result in a lack of confidence and participation in health care services by Māori.

Where possible it is best to involve a Māori clinician in the care of whānau Māori. Kaimahi providing mana enhancing support and whānau centred approach ensure that kuia are supported by female carers (HCA's) and kaumātua by male carers (HCA's).

Tapu, Noa and Mana

Tapu refers to prohibitions or restrictions
Noa means ordinary, unrestricted or free of tapu.

Tapu and Noa are opposing or balancing concepts. They must remain separated and balanced.

Tapu and Noa exist in a delicate balance. They are essential for understanding Māori culture and tikanga (customs).

Tapu protects the sacredness of places, certain objects and people. Personal tapu is a person's most important spiritual attribute.

Mana refers to prestige, authority, control, power, influence, status, spiritual power and charisma. Mana is a supernatural force in a person, place or object.

Whakamā – shy, sense of shame, embarrassed, maybe include Whakamana – to empower, to give authority

- There may be instances where things go wrong and a breach of tapu and or dignity occurs, or mana is not upheld. This may result in whakamā.
- May occur when there is a sense of loss of rangatiratanga (independence, autonomy and self-sufficiency), such as when their mobility, continence (loss of control of urine/stool) or cognition (memory, thinking and understanding) changes.
- When kaumātua experience whakamā, they may respond with withdrawal behaviours, and impact on their holistic wellbeing will be evident.

To uphold mana and tapu consider the following actions:

- the head and the sexual organs are most tapu. A person's head and body are considered tapu
- items that make physical contact with a person. A person's hei tiki, pounamu, whakakai, taonga tuku iho (heirlooms) are considered sacred and can be important for the mana of spiritual connection to their ancestors. Consent to touch, or remove must be sought from the kaumātua first. Storing of taonga needs to be considered, as you just can't put it anywhere!

Examples of how to avoid breaching tapu

- Always introduce yourself, say what you need / want to do, and ask for permission before any physical interactions.
- Do not pass anything especially food over a person's head.
- Do not put items that have touched the head or body or have been used to clean, on surfaces meant for food, drink or medications.
- Do not place bedpans, urinals etc on areas where food is placed and kept.
- Do not put items that have touched the head (eg, pillows, hats, hairbrushes) on chairs or anywhere other than the head of the bed. These items should be kept off surfaces and equipment used for the rest of the body.
- Do not take food into the room of a tūpāpaku (deceased person's body). Have a whānau room for whānau to access where they can wait, rotate sitting with tūpāpaku and eat and drink.

It is common practice after the burial of tūpāpaku to lift the tapu from the room where the deceased was lying, as well as from their home and possessions, through a ceremony called 'takahi whare'.

Glossary of terms

Aroha
translated as love but it encompasses compassion, kindness, empathy, caring and affection.

Wairua
providing care that recognises the importance of wairua, the spirit / soul of the person. Understanding the healing extends beyond the physical body. Healthy wairua must be in balance with hinengaro (mind), tinana (body) and whānau (family)

Whakamana
ensuring the residents autonomy and tino rangatiranga / self-determination is maintained. Empowering residents and whānau to be involved in care.

Manaakitanga
providing care in a mana enhancing way. Residents, whānau and staff are welcomed, names are pronounced correctly, people are treated without prejudice and with kindness, dignity and respect

Whanaungatanga
care that builds relationships / connections with residents and whānau. Understanding that the resident is part of a larger group, that we are all interdependent.

Kaitiakitanga
providing care that acknowledges our role as healers and guardian of the wellbeing of those we care for. Providing care that recognises we are part of the natural world in healing and wellbeing. Respecting the need to care for Papatuanuku (the earth), and Ranginui (the sky).

Āta Whakarongo
To listen and reflective deliberation. This requires patience, tolerance, giving time to listen and communicate to the heart, mind and soul of the person. It requires the conscious participation of all the senses, trust, integrity and respectfulness

Āta Haere
To be intentional. To approach reflectively, moving with respect and integrity. It signals the act of awareness of relationships, their significance and requirements

STANDARDS OF CARE
FOR THE DEPENDENT RESIDENT

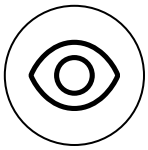
Residents at the end of life and resident's dependent for necessities of life.

Alert

Recognising dying

Signs may include:

- the patient becoming weak, sleepy, disinterested in getting out of bed or seeing anyone other than close family/whānau, less interested in surroundings and food, confused or agitated
- changes in ability to swallow (no longer able to take tablets, only taking sips of fluid or unable/unsafe to take fluids)
- symptoms becoming more obvious, and physical changes suggesting the body is closing down (skin colour changes, skin temperature changes, slowing of breathing rate or long pauses between breaths, involuntary twitching or moaning)
- the resident, family/whānau state they are dying



OBSERVE

Signs and symptoms

Presentation	changes to alertness, refusing care, hallucinations (seeing or hearing things that are not there)
Communication	speech changes, check if what they say makes sense
Breathing	patterns, cough, wheeze, sputum colour
Hydration and nutrition	difficulty or pain swallowing, reduced intake, coughing and choking, drooling
Mobility	ability to move in bed, transfer, weight bear
Skin	pressure injuries, wounds, bruising, rashes, sweating, dryness
Mood	low mood, anxiety, sadness
Head	Eyes: vision, discharge, redness, yellowness
Nose	discharge, bleeding
Ears	discharge, hearing
Mouth	dryness, odour, state of teeth, tongue and gums
Bowels	loss of continence, changes in amount, type, colour
Urine	loss of continence, changes to colour, smell, amount, frequency, pain
Behaviour	restlessness, aggression, resisting care, withdrawn
Pain	on movement, consistent, intermittent, at rest, non-verbal clues, for example, grimacing
Family/whānau	tensions, disagreements, aggression, distress

ACTION

ACTION PLAN OF CARE -

What do we expect the health care assistant to do?

Presentation

- Note any changes from the resident's usual presentation

Communication

- Allow time for the resident to communicate
- Recognise their communication whether it's verbal, facial or behavioural
- Use communication aids, if available
- Ensure hearing aids and glasses are in place, if required
- Avoid baby talk
- Show respect in the tone of your voice and content of your speech and actions

Behaviour

- Recognise cues that may communicate unmet needs or deterioration, for example, restlessness, aggression, distress, anxiety. Follow the behaviour care plan
- Remain calm because the resident may react to your emotions

Skin

- Follow care plan for pressure area care, wounds, rashes and trauma
- Ensure correct use of pressure-relieving equipment
- Ensure all skin folds are washed and thoroughly dried and skin is adequately moisturised. If using more than one cream product, allow 20 minutes between applications

ACTION

Mobility

- Support safe transfers and safe positioning
- Ensure regular changes are made to resident's position if their ability to move alone is limited
- Frequent repositioning prevents skin breakdown and pressure injury as well as further contractures
- Wheelchair positioning should maintain normal sitting position
- Ensure the call bell is within reach
- Undertake regular checks to ensure safety and comfort of position

Breathing

- Position upright to help breathing
- Ensure airflow through room
- If on oxygen, ensure correct use of nasal prongs/mask (see Respiratory Care Guide, for more detail)

Pain

- Pain can take many forms and be expressed in a variety of ways (facial grimacing, guarding, moaning or verbalising)
- Pain is what the resident says it is
- Follow pain management care plan
- Pain management can be supported by gentle massage, appropriate topical creams, positioning, distraction, a cup of tea and a chat, talking to family/whānau
- See Pain Guide, for more information

ACTION

Hydration and nutrition

- Eating and drinking is a social activity and a pleasure
- Ensure resident is in an upright position to support safe swallowing
- Record the amount of food and fluids taken accurately and regularly throughout each shift
- Allow time for the resident to eat and drink
- Note if resident is refusing to take food or fluids and ask why

Continence

- **Bowel care:** Provide privacy, correct positioning and enough time. Note when, amount and type accurately; ensure to note if no bowel motion. Hygiene care after each bowel motion and moisturise
- **Urine:** Assist resident to toilet regularly if resident maintains some or full continence. If incontinent, ensure regular hygiene and moisturising of skin. Note if not passing urine and report as soon as able

Mouth care

- Dentures should be regularly cleaned: frequency will vary according to secretions, food and so on. The more unwell the resident the more often mouth care should be undertaken, as often as every 2–4 hours
- The mouth should be rinsed regularly, where possible. If not possible, wipe out gently with a mouth swab soaked in warm water
- Lips should be kept moist to avoid cracking

ACTION

Grooming

- Grooming should be in line with the resident's preferences
- Clean eyes following practice guidelines and the care plan; keep eyes clean and moist. Ensure glasses are clean and available, if used
- Clean ears (never clean further than you can see) and apply hearing aids with working batteries, if used
- Clean nose (never clean further than you can see) and moisturise, if required
- Hair, beard, moustache are washed and combed or brushed, to keep in a clean and tidy state
- Nails should be clean and safe. Arrange trimming when required.

Mood

- Dependent residents and those at end of life can experience a wide range of emotions
- Show empathy and patience through tone of voice and body language, allow time
- Follow mood care plan

Family/whānau

- Involve the family/whānau in the care as much as they want
- Show empathy and patience; give them time to talk
- Allow privacy

RECORD

CARE AND MANAGEMENT OF THE RESIDENT

Use your clinical skills to identify:

- changes to presentation
- changes required in approach and care plan

Always remember to:

- communicate all changes to the registered nurse or whoever is in charge
- document all changes and actions you have taken
- maintain the resident's dignity at all times
- be aware of, and practise the 10 basic rights of the health care consumer as set out in the Code of Rights
- allow time to adequately complete care
- remain calm and reassuring
- look for opportunities to improve the resident's quality of life
- recognise that the family/whānau need your care and attention too

DELIRIUM

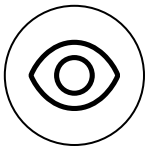
Delirium is an acute disturbance in mental state and awareness that results in confused thinking and altered awareness. Delirium is a medical emergency.

Alert

Early recognition is vital. Delirium is a medical emergency

REPORT to registered nurse, clinical manager or general practitioner or nurse practitioner

- **Delirium is acute.** It can occur when a resident is unwell or injured.
- Delirium is regarded as acute brain failure meaning the resident's brain does not work the way it usually would.
- Delirium is a potentially reversible condition. It needs immediate medical attention.
- Recognising delirium is essential, so appropriate interventions can be implemented.



OBSERVE

Acute onset – changes can occur over hours to days

- Agitation
- Altered alertness - more restless or sleepier
- Resident behaves differently from usual
- Changes to usual sleeping–waking pattern
- Changes can come and go, get better or worse over a 24-hour period
- Easily distracted or difficulty concentrating
- Increasing confusion or disorientation
- New hallucinations or abnormal thoughts or beliefs
- Change to usual function

IDENTIFY

Manage modifiable risk factors

- Walk, sit in chair for meals
- Monitor bowels
- Monitor skin – look for changes to skin, including pain, swelling or redness
- Get up, get dressed, get moving. Try to encourage a normal routine
- Monitor vital signs
- Monitor fluid intake –aim for at least 1.2 litres every 24 hours unless otherwise indicated
- If there are further changes, that is, resident is more sleepy or agitated, let the registered nurse and/or general practitioner know
- Monitor pain (see Pain Guide)

ACTION

Early recognition is vital.
Delirium is a medical emergency

- **REPORT** to registered nurse, clinical manager or general practitioner or nurse practitioner
- Get help and advice
- Look for causes (see Acute Deterioration Guide)
- Assess – **STOP AND WATCH**
- Any behaviour change could indicate delirium
- Use behaviour chart
- Document any changes to behaviour or alertness
- Check vital signs (if this is part of your role)
- Look for triggers such as toileting or pain
- Feedback from family/whānau

Maintaining safety, security and comfort

Residents with delirium are at **high risk** of falls, physical deterioration, developing infections or pressure injuries. Care is aimed at:

- maintaining dignity and/or privacy
- correcting sight and hearing problems – using glasses/hearing aids, if required
- ensuring basic needs are being met by supporting continence, nutrition and mobility
- monitor bladder and bowel function
- encouraging family/whānau to support with care if able
- reducing confusion, disorientation and agitation
- provide a quiet, calm, well-lit environment
- encouraging food and drinks
- complete behaviour chart – look for patterns or triggers
- preventing complications such as pressure areas, dehydration and falls
- falls precautions
- consider regular checks or constant observer
- treating pain
- maintaining a good sleep pattern

ACTION

Non-pharmacological strategies

- **Reorientation** – clocks, calendars, newspapers
- **Consider communication barriers**, that is, level of understanding and language
- **Use general conversation**, that is, "It's breakfast time"
- **Use environmental cues**, for example, open curtains during day and close at night
- **Maintain and restore sleep**–wake cycle patterns
- **Ensure visual and hearing aids** are used where possible
- **Encourage time in natural lighting**
- **Try to keep to familiar staff and environments**
- **Monitor behaviour**, including what works well and what is a trigger. Report to registered nurse
- **Distraction** – consider including what works fiddle mitts, sensor mats, photos, music and so on
- **Keep communication simple** – one step instructions

RECORD

Document in progress notes/update care plan

DEMENTIA

Dementia is an umbrella term for several diseases affecting memory, cognitive abilities and behaviour that interfere with a person's ability to maintain their activities of daily living (World Health Organization). Many types of dementia exist. The most common are: Alzheimer's, vascular dementia, Parkinson's dementia, Lewy body dementia and frontotemporal dementia.

OBSERVE

Signs of dementia

- Memory problems, particularly remembering recent events
- Disorientation in new environments, getting lost
- Not recognising loved ones or family/whānau members
- Increasing confusion about time and place
- Difficulty or loss of ability to do everyday or familiar tasks – managing personal care, preparing and cooking meals, managing finances
- Reduced concentration
- Changes in personality, mood or behaviour
- Difficulty making decisions, planning or solving problems
- Socially inappropriate behaviours - yelling, physical and verbal aggression, racist or sexual remarks
- Hallucinations: seeing things (animals, people, objects that is not visual to others), auditory (hearing noises), tactile depression
- Apathy, lack of motivation, withdrawal or depression
- Delusions, for example, thinking that someone has stolen an item
- Problems speaking or writing
- Difficulty understanding visual information, losing the ability to read
- Withdrawal from socialising
- Misplacing things

OBSERVE

LOOK OUT FOR

Remember: your resident may not be able to tell you if they are unwell, uncomfortable or need help

- **Increased confusion** (sudden) - refer to Delirium
- **Signs of pain and discomfort**, such as body language, facial expression, distress, pacing, quiet, agitated
- Not eating, not drinking, weight loss
- **Mobility:** unsteady, changes in walking, increased falls
- **Bowel and bladder:** changes in bowel and bladderhabits, increased incontinence, difficulty moving bowels

IDENTIFY

DIAGNOSIS

Dementia is diagnosed by a general practitioner, specialist doctor or nurse practitioner who reviews the following:

- results of cognitive testing, investigations such as blood tests, urine tests and brain scans
- information from the resident and family/whānau around signs, symptoms and timeframe

Dementia is a life limiting disease and, over time, a resident's mental and physical health status and level of function will decline. It is important to identify the signs and symptoms of deterioration – are they gradual or acute?

Gradual decline

If you notice a gradual decline in your resident's level of function then identify the areas of increasing need and alter the resident's care plan. Report your findings to the registered nurse

Acute deterioration

Decline in health and functional status occurs over hours/days – see the Acute Deterioration Care Guide. This may be something that can be treated

ACTION

KNOW YOUR RESIDENT

- **Who are they?** Family/whānau, previous occupation, personality, hobbies, interests, likes, dislikes
- **Know their health history**

Respect, dignity, compassion and patience are what your resident needs from you

RECORD

Document in progress notes/update care plan

Behaviours of concern

- New or increased
- Start a behaviour chart – see Behaviours of Concern Care Guide

Communication

- Clear, simple, concise instructions.
- Talk at eye level, smile and give the resident time to process the information and respond
- Encourage and praise often
- Don't keep correcting
- No arguing
- Don't be bossy or rush them

Personal care

- Encourage independence but assist when required

BEHAVIOURS **OF CONCERN**

Definition: Behavioural and psychological symptoms of dementia (BPSD) are defined by the International Psychogeriatric Association as "symptoms of disturbed perception, thought content, mood, and behaviour frequently occurring in residents with dementia".

Alert

Report

- Are these new behaviours?
- **OR** have these behaviours got worse in their intensity?
- **IF YES** — see the Acute Deterioration and Delirium care guides.

Alert/respond now

- Is the health and welfare of this resident, other residents or staff, at risk?
- **IF YES** — call the registered nurse, clinical manager or an ambulance immediately.

Assessment

- **Check vital signs** – heart rate, blood pressure, respiratory rate, oxygen saturations and temperature Identify potential triggers
- **Remember:** the resident has a brain failure due to disease. They cannot help their behaviour
- Don't judge the resident

OBSERVE

Signs and symptoms

- Screaming, calling out, crying
- Inappropriate undressing
- Resistance in allowing others to help with personal care
- Excessive wandering and pacing
- Physical and verbal aggression
- Verbal abuse
- Fidgeting
- Inappropriate sexual behaviour
- Sleeping patterns change, day–night reversal
- Paranoid thoughts
- Common delusions in people with dementia are theft and infidelity
- Hallucinations: seeing or hearing people, animals or objects due to brain failure
- Misidentification of staff for family/whānau members is also common
- Wandering and intrusiveness (AWOL risk)
- Repetitive/obsessive behaviours
- Apathy
- Anxiety

IDENTIFY

CAUSE OF BPSD*

Physical causes

- Acute illness – delirium due to illness, urinary tract infection, chest infection, stroke, heart attack
- Side effects of medication
- Impaired vision or hearing
- Dehydration
- Hunger
- Constipation
- Fatigue
- Pain/discomfort

Environmental causes of BPSD*

- Too large an environment
- Too much clutter
- Excessive stimulation – too much noise, too many people
- No orientation information or cues
- Poor sensory environment
- Unstructured environment
- Unfamiliar environment

Behaviours related to tasks

- The task is unfamiliar, too complicated or too many steps are involved in the task for the resident to manage

*Behaviours and psychological symptoms of dementia

ACTION

ACTION PLAN

De-escalate the situation

Use a quiet approach, good communication, reassure, comfort and listen, walk away

Take action

Look for and identify a potential unmet need, is the resident hungry, thirsty, in pain, wants to go to the toilet or is just lost and disoriented?

Be mindful of your own body language, voice and tone. Quiet non-threatening interaction is required

Immediate steps in BPSD* management

For a few moments observe resident from a distance because they may settle on their own accord without intervention

- Acknowledge distress and reassure the resident
- Do not argue or correct
- Remove resident to a quiet environment
- Distraction – exercise; walk, music, food, snack, touch, massage
- Search for belongings if resident considers them lost or stolen
- Consider potential fear of people or noise
- Consider gender or cultural issues
- Consider physical distance and your safety

Know your resident

- Who are they? Family/whānau, previous occupation, hobbies, interests, likes and dislikes.
- Know their health history

*Behaviours and psychological symptoms of dementia

RECORD

- **Communication needs to be concise** - give simple instructions, make eye contact, face the resident, smile and maintain a calm manner
- **Make sure the resident is wearing glasses and hearing aids, if required**
- **Understand your resident's previous fears and triggers**
- **Environment** – quiet; reduce noise and personalise your resident's bedroom
- **Food and fluid charts** – know resident's likes and dislikes
- **Bowel management** – monitor for signs of constipation
- **Socialisation** – involve your resident in regular activities; music, exercise, crafts
- **Personal care** – showering, dressing and grooming. Don't rush the resident. If able, let them choose when, what clothes to wear, if appropriate
- **Review medications with registered nurse, nurse practitioner, general practitioner**
- **Involve family/whānau**
- **Review by general practitioner**
- **Behaviour monitoring chart**

Behaviour charts

- What time the incident occurred
- What happened before the event
- Who else was involved
- Who was affected
- Staff response
- What worked and what did not work in managing the resident's behaviour

Documentation

- Be complete and accurate in what you write
- Describe what actually happened or what you observed
- Record your successes or failures
- Avoid making assumptions
- Update resident care plan

DEPRESSION

Depression is one of the most common psychiatric disorders in older people. It is not a normal part of ageing. It is a serious disabling mood disorder that can affect the way a person feels, behaves and thinks. It causes distress and anxiety, impacts on functional ability, reduces physical activity and can cause memory problems. Depression induces thoughts of worthlessness, helplessness and suicidal ideation (World Health Organization 2023; Zenebe et al 2021)

Alert

IMMEDIATE ACTION

If the resident states they want to die, end their life or hurt themselves, the registered nurse, nurse practitioner and general practitioner must be contacted immediately. **Do not leave the resident alone.**

A resident who is severely depressed and has expressed thoughts of self-harm and/or suicide will need to have constant monitoring and close supervision.

OBSERVE

Mental signs and symptoms

- Depressed mood most of the day, nearly every day
- Expressions of worthlessness or excessive guilt
- Isolation
- Resident expresses wish to die/suicidal thoughts
- Remaining in bed
- Loss of interest in activities
- Anxiety and/or panic attacks
- Crying and tearfulness
- Irritable and/or agitated
- Anger
- Psychotic symptoms – agitation, anxiety, hallucinations, paranoia
- Cognitive impairment

Physical signs and symptoms

- Not sleeping so well or sleeping too much
- Changes in weight
- Restlessness and/or agitation
- Changes in appetite
- Changes in communication
- Frequent reports of feeling unwell
- Loss of energy and tiredness

IDENTIFY

RISK FACTORS

Abnormal vital signs

- Family/whānau history
- Recent significant change or life event (ie, bereavement)
- Residing in residential care
- Substance abuse history (alcohol)
- Chronic pain
- Poor physical health
- Post-traumatic stress disorder (PTSD)
- Poor mobility
- History of mental health disorder
- Chronic medical conditions
- Dementia
- Multiple medications – beta blockers

Know your resident

Know your resident's previous medical history.
Have they experienced depression in the past?

Assessment

1. Rule out physical illness – check vital signs, report findings to registered nurse
2. Rule out suicidal and self-harm thoughts

ACTION

IMMEDIATE ACTION

If the resident states they want to die, end their life or hurt themselves, the registered nurse, nurse practitioner and general practitioner must be contacted **immediately**. **Do not leave the resident alone.**

A resident who is severely depressed and has expressed thoughts of self-harm and/or suicide will need to have constant monitoring and close supervision.

REPORT

Notify registered nurse of any changes

RECORD

Document in progress notes/update care plan

RECORD

CARE AND MANAGEMENT OF RESIDENT

- Spend time talking and engaging with the resident
- Listen to the resident's concerns
- Involve the resident in social activities
- Ensure the resident's spiritual needs are being met
- Involve and encourage your resident to exercise
- Monitor food and fluid intake, encourage treats and snacks
- Identify and manage pain and discomfort
- Encourage resident to do as much for themselves as they are able
- Involve family/whānau
- Praise frequently
- Reassurance and encouragement
- Smile and hugs, if appropriate

SEXUALITY AND INTIMACY

Sexuality and intimacy are a NORMAL part of life for all adults. Enjoyment does not cease just because someone is older or lives in residential aged care. It is a basic human right to be able to express sexuality. However, sexual expression by aged care residents can be uncomfortable for staff, other residents and families/whānau. It is important for facilities to have a sexuality policy. See RN Frailty Care Guides.

OBSERVE

Consenting to sexual relations

People with dementia in care homes may form new sexual relationships with other care home residents.

As long as both parties agree and have capacity to consent to these relationships, then care home staff should respect such relationships. But we need to be alert to prevent exploitation of either party.

Sexually disinhibited behaviour

It is not unusual for people with certain types of cognitive impairment to exhibit disinhibited sexual behaviour. It is important to be observant for any risks to others.

Risk levels

Risk level 1:
Kissing, hugging, hand holding, fondling, cuddling (not inclusive), consensual (implies awareness of actions)

Risk level 2:
Verbal sexual talk: flirting, suggestive language, sexually laden language

Risk level 3:
Self-directed sexual behaviours: masturbating, publicly exposing oneself

Risk level 4:
Physical sexual behaviour directed towards another resident with agreement

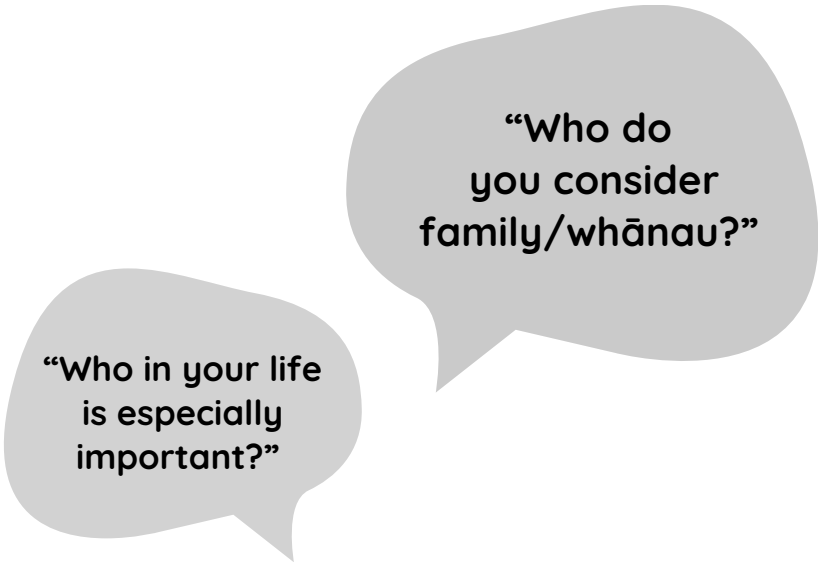
Risk level 5:
Non-consensual, overt physical sexual behaviour directed towards others

IDENTIFY

Sexual identity

Caring for sexual diversity: lesbian, gay, bisexual, transgender, intersex, queer/ questioning, asexual (LGBTIQA) and many other terms (such as non-binary and pansexual) people

- All staff should avoid making any assumptions about gender identity and sexual orientation, just as they should avoid assuming racial identity, age and other characteristics
- Providers should always work from the premise that they have LGBTIQA people in their service, even if no one has openly identified as LGBTIQA
- Create an opening for LGBTIQA residents to talk about any family/whānau members of choice by asking them open-ended questions, such as "Who do you consider family/whānau?" or "Who in your life is especially important?"
- Don't assume you can identify LGBTIQA individuals by appearances, experiences or external characteristics
- Be aware that a wide range of sexual and gender identities and expressions exist, and that these can change over time



RECORD

CARE AND MANAGEMENT OF RESIDENT

Sexual relations and behaviour

Health care assistants are the most likely to observe residents throughout the day. Please be aware of any changes in behaviour, both positive and negative, such as:

- **Positive:** happiness, smiling, singing
- **Negative:** tearful, withdrawing from activities, not wanting to leave their room, not wanting to be touched, bruising to skin, any blood in genital region

You must keep your own judgements neutral

- Report to registered nurse or manager
- Document behaviours observed

Sexual identity

See RN Frailty Care Guides – 'Sexuality and intimacy: Taeratanga me te pā taupiri'

- All health providers have a duty to deliver services that are respectful of our LGBTIQA community
- Use the resident's correct pronouns (he/him, she/her, they/them) and preferred name
- If you are not sure how the resident wishes to be addressed, politely ask rather than assuming

BOWELS AND **CONSTIPATION**

Constipation is common in older adults and occurs when stool travels too slowly along the digestive tract and is not effectively passed out the rectum.

Alert

RED FLAGS – signs

Need immediate attention

Notify registered nurse and general practitioner immediately if the resident is showing any of these signs:

- Bowels have not opened for three days – severe constipation with overflow
- Nausea and/or vomiting
- Abdominal pain
- Abdomen swollen and distended
- Loose stool, passing blood

OBSERVE

Signs and symptoms

SUBJECTIVE

RESIDENT REPORTS:

- feeling nauseous
- feeling like bowels haven't fully emptied and resident still needs to go after a bowel motion
- feeling like there is a blockage or obstruction in the rectum
- experiencing abdominal cramps, pain and/or discomfort

OBJECTIVE

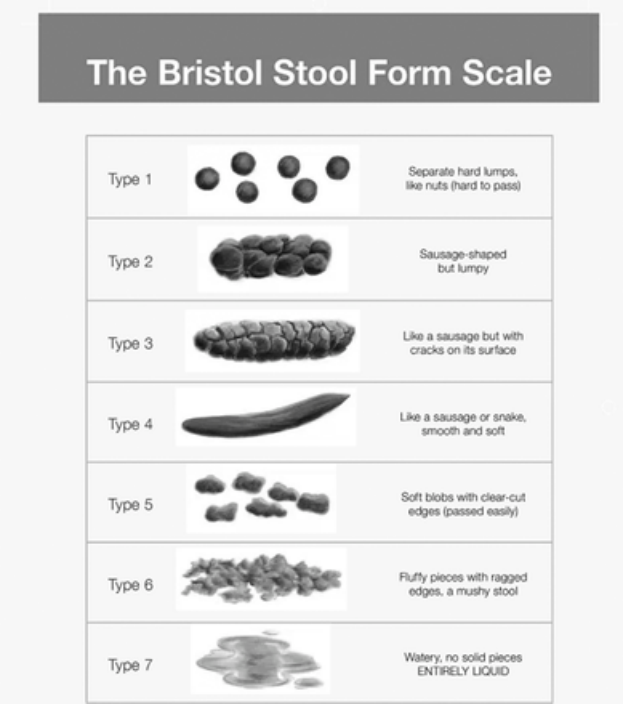
HEALTH CARE ASSISTANT STAFF OBSERVES:

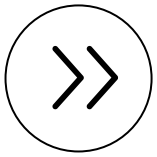
- vomiting
- decreased and/or loss of appetite
- dry, hard and lumpy stool that is difficult to pass (see Bristol stool chart)
- straining when passing stool
- infrequent passage of stools
- bloating in the abdomen
- lethargy or sluggishness
- rectal bleeding
- change in behaviour (eg, increase in confusion, irritability, decreased level of function)

IDENTIFY

Assessment

- **Check vital signs**
- **Check bowel chart** – noting: usual pattern, frequency and consistency of stool, evidence of bleeding and amount
- **Monitor food and fluid intake**
- **Inspect skin condition** (eg, redness) or presence of any abnormalities (eg, haemorrhoids or prolapse behaviour)
- **Monitor mood and behaviour** changes
  - presence of underlying delirium
- **Check current medications** and use of laxatives – monitor abuse and dependency





ACTION

Plan of care and intervention

DO

- Report clinical findings to registered nurse
- Offer high-fibre foods in diet (eg, including fruits, vegetables, bran, whole grain cereals and prunes)
- Encourage resident to drink plenty of fluids (aim 1.5–2 litres a day, unless contraindicated). Offer alternative fluids (eg, jelly, ice blocks, soup)
- Encourage resident to engage in exercises and physical activity
- Provide a regular schedule for toileting, especially after a meal
- Provide adequate time and privacy
- Position (proper sitting position with knees flexed)
- Monitor mood and manage stress
- Review medications – any changes, current medication usage that may lead to constipation, account for use of laxatives but give regularly if required
- Offer to toilet after breakfast to promote bowel movement

DO NOT

- Ignore the resident when they have the urge to move their bowels

RECORD

DOCUMENT IN THE BOWEL CHART EACH SHIFT

- Bowels did not open
- Bowels opened
- Record type, colour and size of stool - using Bristol stool chart
- Closely monitor the bowel habit of residents with dementia as they may not reliably report their bowel movements.

CARDIAC

Common conditions include heart failure, atrial fibrillation (irregular heartbeat) or angina. A myocardial infarction (heart attack) is a MEDICAL EMERGENCY. The most common sign of a heart attack is chest discomfort not relieved after following an action plan or the resident's care plan. It can also present as indigestion, sudden or severe shortness of breath, sweating, fainting, nausea and vomiting.

Alert

Chest discomfort needs to be reported to a registered nurse as soon as possible. Ask the resident to sit/lie down and rest. Chest discomfort can be frightening

If resident is unwell and a cardiac event is suspected, call 111, if no registered nurse, general practitioner or nurse practitioner is available

OBSERVE

Signs and symptoms

- Swelling of ankles, lower legs or stomach
- Unexplained cough, especially at night
- Increasing weight
- Getting up to the toilet more frequently at night
- Decreased appetite, feeling full sooner or nausea
- An irregular or racing heartbeat
- Shortness of breath when resting or more breathless/tired after usual activities such as showering, dressing or walking
- Increasing fatigue or weakness
- Dusky or blue feet/fingers/lips
- Sweating
- Needing more pillows to sleep
- Increased confusion
- Collapse

CHEST PAIN/DISCOMFORT

- Resident may report discomfort in the centre of the chest, jaw, back and or arms
- Discomfort may be described as crushing, tightness, heaviness or burning that does not go away and gets worse
- Pain may be associated with breathing changes, like shortness of breath, nausea or vomiting, sweating and/or dizziness

Chest discomfort needs to be reported to a registered nurse as soon as possible. Ask the resident to sit/lie down and rest. Chest discomfort can be frightening

IDENTIFY

Assessment

- **Vital signs.** If no registered nurse is available, note changes from baseline
- **Assessment of chest pain**, if no registered nurse is available
- **Know your resident.** Is this a new condition or a deterioration of an existing condition?

ACTION

Action plan

- **Report signs and symptoms immediately** to the registered nurse and document all observations and action in resident's notes
- **If previous history of chest pain**, then follow the action plan or resident's care plan (administer GTN/oxygen if standing order)
- **Refer to Cardiac RN Frailty Care Guide** for further information

RECORD

Document in progress notes/update care plan

If resident is unwell and a cardiac event is suspected, call 111, if no registered nurse, general practitioner or nurse practitioner is available

RECORD

CARE AND MANAGEMENT OF RESIDENT

Follow the care plan for management. This may include the following.

- Daily or regular weight check (for fluid status):
  - resident's weight should be checked at the same time each day with resident wearing similar clothing
  - a 2 kg gain or loss over a few days needs to be reported because this is likely due to fluid retention or loss rather than actual weight
  - recognising weight loss or gain as early as possible is important
- Note if the resident has any changes to their breathing
- Note if the resident has any extra swelling, especially around ankles, legs and tummy
- Resident may need additional assistance with activities of daily living when unwell
- If resident's fluids are restricted, monitor fluid intake accurately (include all fluids, soup and so on)
- Monitor food intake
- Manage urinary incontinence and monitor bowels
- Undertake skin checks and pressure injury prevention
- Ask if the resident has an Advanced Care Plan
- Undertake palliative care for residents with end stage cardiac disease
- Ensure the call bell is within reach

SYNCOPE AND **COLLAPSE**

Collapse means a sudden loss of strength, consciousness or body function resulting in the resident falling down becoming unresponsive and needing urgent help.

Alert

- **In an emergency, call 111 for an ambulance**
- **Call registered nurse and/or manager**
- **Start resuscitation, if appropriate (what is resident's wish/resuscitation status?)**
- **Comfort resident – keep calm (residents, family/whānau, visitors)**

OBSERVE

Risk factors

- Fast or slow heartbeat
- Irregular heart beats
- Heart attack
- Heart failure (CHF)
- Hypotension (blood pressure lowers particularly on standing)
- Stroke/TIA
- Epilepsy/seizures
- Vestibular balance disorders – inner ear
- Shortness of breath (asthma, COPD, excessive coughing, breathing disorders)
- Fainting or panic and/or anxiety attacks
- Dehydration
- Low or high blood sugar (diabetes)
- Fatigue or exhaustion
- Situational syncope – having a bowel movement, urinating, coughing, swallowing or after a meal
- Anaemia – often associated with chronic disease
- Infection
- Medications – polypharmacy – prescribed or over the counter medications, new or changed medications

IDENTIFY

Assessment

- **Check area for safety**
- **Do not move resident**
- **Call registered nurse**

BODY ASSESSMENT

A **Airway**

B **Breathing**

C **Circulation**

IF RESIDENT UNCONSCIOUS:

- **Resident for resuscitation** – start CPR
- **Resident NOT for resuscitation** – place in recovery position

Head injury? Cardiac failure? Fracture?

STROKE? ASSESS WITH FACE, ARM, SPEECH, TIME

F Face drooping

A Arm weakness

S Speech difficulties

T Time to call

- **Vital signs and blood glucose level**
- **Look for bleeding**
- **Assess for injuries**

ACTION

- **In an emergency, call 111 for an ambulance**
- **Call registered nurse and/or manager**
- **Start resuscitation, if appropriate (what is resident's wish/resuscitation status?)**
- **Comfort resident – keep calm (residents, family/whānau, visitors)**

RECORD

Document in progress notes/update care plan

RECORD

History of event

- What occurred at the time of the event?
- What symptoms occurred just before or at onset of event?

DOCUMENT TIMELINE

- Before episode, that is, nausea, sweating, pain, position, activity and so on
- Onset of episode, that is, duration, breathing, skin colour, behaviour
- Details of episode, that is, what occurred and how did it occur?
- End of episode, that is, incontinence, jerking, confusion, tongue biting, skin colour

Care and management of resident

CONTINUE TO MONITOR AS PER REGISTERED NURSE INSTRUCTIONS

Monitor vital signs, conscious or unconscious, bleeding, choking, major burn, fracture

CALL GENERAL PRACTITIONER

- Document syncope risk and management plan in resident's care plan
- Resident education (if appropriate)
- Adequate fluid and nutrition
- Medication management

ALL ASSESSMENTS TO BE ONGOING

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

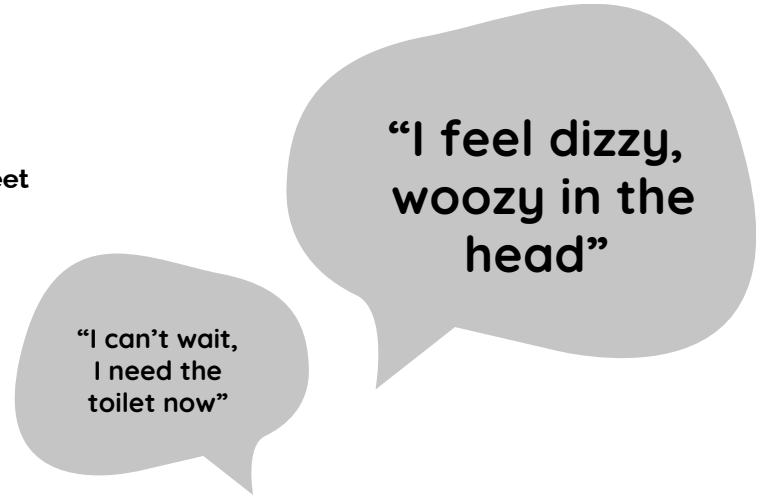
- **Shoulders, back, hips, knees, ankles, feet**

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

DIABETES

Type 1 diabetes mellitus (DM) is when the pancreas produces little or no insulin.

Type 2 DM is a chronic condition that affects how the body processes blood sugar.

It is important to know your resident who has diabetes and their medication-taking treatment.

OBSERVE

Signs and symptoms

Hyperglycaemia

Capillary glucose (CG) > 15 mmol/L
Happens gradually over hours to days

- Polydipsia (extreme thirst)
- Lethargy
- Loss of alertness
- Polyuria (increased urination)
- Rarely progresses to coma
- Weight loss
- If severe, hypotension (low blood pressure) and tachycardia (fast heart rate)
- Blurred vision
- Fatigue
- Slow wound healing
- Dehydration

Hypoglycaemia

Capillary glucose (CG) < 4 mmol/L
Happens suddenly in minutes to hours

- Confusion/ drowsiness/ sleepiness/ disoriented
- Dizzy/headache / light headed
- Hunger, nausea (feeling sick)
- Changing behaviour: anxious, nervous, irritable
- Rapid/fast heartbeat
- Shakiness/weakness/fatigue
- Looks pale, with sweaty skin and clamminess
- Slurred speech
- Blurred vision
- Unconscious if not treated
- Pins and needles of the lips and tongue or numbness

Resident can become unconscious if not treated - this is a medical emergency

ACTION

Action plan

Hyperglycaemia

- Report to registered nurse to identify acute illness
- Detailed fluid balance chart
- Encourage fluid intake to prevent dehydration
- Avoid sugary food or sweet drinks
- Increase frequency of CG If high, administer insulin as prescribed by doctor (competency assessment for insulin administration is required)
- Monitor vital signs closely
- Monitor level of consciousness

Hypoglycaemia

- Report to registered nurse
- Check CG - If low, then follow the care plan
- If a person is under 70kg - Give one of the following:
  - 5 Dextro or Vita glucose tablets
  - 3 BD glucose tablets
  - 15 g glucose powder
  - 175 ml fruit juice or non-diet soft drink
  - 9 jellybeans
  - 1 tablespoon honey
  - 1½ tablespoons jam
  - 1 Hypo-Fit gel
- Recheck after 15 minutes
- Stay with the resident and make sure they are safe
- Observe signs of improvement or deterioration
- If remains hypoglycaemic, urgently inform the registered nurse
- If not conscious, call an ambulance and stay with resident, check airway and place in recovery position
- When CG is greater than 4 mmol, provide a snack containing carbohydrate, eg, a slice of toast or 2 biscuits and crackers

RECORD

Document in progress notes/update care plan

RECORD

CARE MANAGEMENT OF A RESIDENT WITH DIABETES

- Monitor food intake, for example if family/whānau brings in food
- Encourage fluid intake
- Monitor weight
- Administer diabetic medications on time
- Encourage exercise
- Monitor moods
- Prevent infections, for example, UTIs and skin infection
- Monitor skin daily and treat any skin lesion promptly
- Check feet daily and make sure shoes are well-fitting to prevent injury. Refer to podiatrist if needed
- Check teeth and gums for signs of infection
- High risk for falls when diabetes is poorly controlled
- Rotate insulin needle sites
- Monitor alcohol intake
- Closely monitor glucose levels if resident is unwell, for example, vomiting, diarrhoea, not eating
- See the care plan and facility policy and procedures, for example medication administration

FALLS

A fall is any unintentional change in position where the person ends up on the floor or another level lower than their previous position.

It includes slips, trips and falls that occur while others are helping.

Alert

An emergency call 111 for an ambulance

OBSERVE

IDENTIFY

FALL RISK FACTORS

Environmental

- **Poor fitting footwear and clothing**
- **Poor lighting**
- **Floor surfaces** – wet or slippery
- **Clutter**

Medication

- **Polypharmacy** – too many prescribed or over the counter medications
- **New or changed medication**
- **Change of health status/weight requiring** change of medication dose
- **Diabetes and hypoglycaemia**

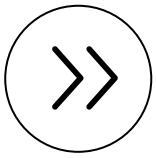
Resident centred

- **Frailty**
- **Past history of falls**
- **Pain**
- **Three Ds –** dementia, depression, delirium
- **Poor health,** for example, cardiac, diabetes, neurological disorders
- **Infection or acute health issue,** for example, respiratory or UTI
- **Multiple health issues**
- **Impaired function,** for example, vision, hearing, mobility
- **Dehydration/reduced nutrition**

REPORT

Assessment

- Check area for safety
- Do not move resident. Make comfortable
- Call registered nurse
- Body assessment
  - **A**—Airway, **B**—Breathing, **C**—Circulation
  - Head injury, stroke, cardiac failure, fracture?
  - Vital signs and blood glucose level
  - Medications – is resident on any blood thinners?
  - Assess for all injuries
  - Pain/discomfort assessment
  - Neurological assessment
- Cause of fall – how, when and why?



ACTION

Action plan

An emergency call 111 for an ambulance

- Call registered nurse and/or manager
- Start resuscitation, if appropriate (what is resident's wish?)
- Reassure resident (other residents, family/whānau, visitors)
- Assess and record:
  - **Minor injury** – first aid, observation, treatment, ongoing assessment – neuro/obs
  - **Major injury** – first aid, ambulance, observations, ongoing assessment and report
- Inform registered nurse, relatives, next of kin, enduring power of attorney, complete incident form and follow facility protocol

RECORD

CARE MANAGEMENT OF RESIDENT

Continue to monitor as per registered nurse instructions.

Monitor

- Observations
- Skin integrity
- Delirium
- Bowels and urine output
- Cognition – depression/dementia
- Hydration and nutrition
- Medication effects

Fall prevention

- Document fall risk and management plan in resident's care plan
- Resident education (if appropriate)
- Environmental assessment
- Visual and hearing aids
- Footwear and clothing
- Exercise – strength and balance
- Continence management
- Adequate fluid and nutrition
- Medication management –/+ vitamin D
- Hip protectors, sensor mats, and so on

MOVING AND TRANSFERRING (HANDLING)

Moving and transferring refers to the safe techniques and procedures used for lifting, carrying, pushing, pulling and generally moving objects or people. It involves proper manual handling of loads to prevent injury and ensure safety (Caringforcare.co.uk). Health care workers are at risk of musculoskeletal injury when their work involves moving and handling residents. Incorrect, unsafe moving and handling practices can cause musculoskeletal injuries, pain and loss of function, which in turn can lead to absenteeism, burnout, staff turnover and early retirement. Moving and transferring also puts residents at risk of skin tears, broken limbs and bruising.

Alert

STOP – THINK – ASK

The most physically demanding tasks that carers perform involve repositioning residents in bed/chair and transferring them from the bed to a stretcher. Repositioning residents can appear to be a straightforward activity, but it can lead to injuries to staff and residents if undertaken incorrectly.

IDENTIFY

Handling tasks associated with injuries to carers

- Transferring resident between bed and chair
- Transferring between chair and toilet
- Supporting in shower
- Making lateral transfers between bed and stretcher
- Repositioning in bed
- Repositioning in a chair
- Helping resident move from sitting to standing
- Preventing resident from falling

Know and follow your facility policy and procedures

Have you been trained? Do you know how to use the equipment provided?

All staff should receive specific education and training on moving and handling residents safely

- Be responsible and accountable for your own moving and handling practice.
- Ensure equipment is safe and clean before and after use. Store it correctly, eg, hoist on charge, brakes on.
- Use the appropriate equipment for the task, eg, equipment with a safe working load for bariatric patients.
- Report all incidents, concerns and potential hazards to the registered nurse, clinical nurse manager or facility manager promptly. Don't use equipment if you are not trained in using it.

IDENTIFY

Assess the environment

An environmental assessment includes assessing the physical space, equipment available, floor surfaces, clutter, lighting, noise and temperature.

Do remove any clutter and check that there are no trip hazards, you have adequate lighting and you have enough space to move.

Assess the resident (load) – know your resident

Before you move a resident – STOP and review resident's care plan – THINK safety first and ASK questions for risk assessment

Resident characteristics that can affect moving and transferring risks include (but are not limited to) their size, height and weight, level of dependency and mobility, as well as the extent of their compliance (ability to understand and follow instructions).

RISK ASSESSMENT

Before you move a resident, first refer to their care plan to determine their ability to move, sit, balance, stand, transfer and walk.

1. How alert or sleepy is the resident today?
2. Are they showing signs and symptoms that suggest a delirium or acute deterioration?
3. What is their current mobility? Do they have impaired mobility? Do they mobilise with walking aids and appropriate footwear?
4. Do they have a risk or history of falls? If yes, this may suggest some impaired balance or unsteadiness.
5. Do they have sensory deficits – hearing/vision impairments? If so, ensure the resident can hear and see you before you move them.
6. What is their weight? A higher body mass index (BMI) increases risk.
7. What is their level of fatigue and weakness? Greater frailty increases risk.
8. Are they in pain or discomfort? This can impact on their desire to move, bear weight and walk.
9. Do they understand what you are asking of them? Can they follow instructions?
10. Are there language and cultural differences you need to consider?

See care guides: Delirium; Acute deterioration; Falls; Dementia overview; Syncope and collapse

Check the hoist slings each time before using the hoist – pull the straps, check for fraying. Ensure hoists slings are on the resident correctly and attached to the hoist correctly. Ensure the resident has the correct sling and that it is the correct size for them.

ACTION

Before you move a resident

STOP to review resident's care plan
THINK safety first and ASK yourself

- How do I do this safely to protect myself and the resident?
- What are the potential risks of this move?
- Has someone shown me how to do this correctly?
- Do I need more staff to help? How many staff are needed for this task?
- Do I need specialised equipment? What equipment should I use? Do I know how to use this equipment (hoist, Molift Raiser, transfer belt, sliding sheet)?
- Have I been trained in how to use the equipment?
- Is the equipment appropriate for this transfer and for this resident? What does the resident's care plan say?
- Review previous moving and handling instructions from the physiotherapist. Review care plan, if available.

Do not go ahead with the transfer unless you know what to do.

NUTRITION AND **HYDRATION**

NUTRITION

OBSERVE

Look for

- Changes to usual eating habits
- Slower to eat
- Holding or pooling food in the mouth
- Refusing to eat
- Leaving food on the plate
- Difficulty chewing food
- Difficulty swallowing food

Signs of poor nutrition

- Lack of appetite or interest in food
- Tiredness and irritability
- Always feeling cold
- Loss of fat and muscle mass
- Higher risk of getting sick
- Longer healing of wounds
- Weight loss
- Constipation and/or diarrhoea

NUTRITION

IDENTIFY

Risk factors for poor nutrition

- Older age
- Prolonged hospital admission
- Dislike of eating and drinking
- Texture modification, for example, pureed, minced, moist, soft food
- Requiring assistance with food or fluids
- Cognitive impairment and/or confusion
- Impaired function and requiring increased assistance
- Decreased appetite
- Depression
- Multiple medicines
- Chronic pain
- Mouth hygiene issues
- Gastrointestinal issues, for example, nausea, vomiting, diarrhoea, abdominal discomfort

Assessment

- Check if resident is having the correct diet – normal, soft, pureed food
- Any coughing when swallowing food
- Food preferences, intolerances and/or allergies
- How much food is being eaten
- Are bowels regular
- Any weight loss or gain, for example, are clothes fitting, belt in a few notches
- Do dentures fit well, good mouth care
- Are glasses and/or hearing aids being used
- Any behaviour and/or mood changes
- Any change in level of function

NUTRITION

RECORD

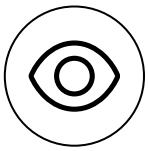
Plan of care

- Check care plan and progress notes
- Follow dietitian and speech language care plans
- Ensure use of food and bowel charts
- Weigh regularly
- Provide assistance and support as needed
- Correct positioning
- Use of correct utensils
- Consider cultural needs

REPORT

Notify registered nurse of any changes

HYDRATION



OBSERVE

Observe for...

- Changes to usual drinking habits
- Very thirsty
- Refusing to drink
- Leaving drinks unfinished
- Unable to reach or hold cup or water jug
- Difficulty swallowing
- Coughing or choking when drinking

Signs of dehydration

- Dry mouth, lips, tongue
- Reduced sweating
- Sunken eyes
- Low blood pressure
- Confusion and irritability
- Fast heart rate
- Needing more help with care
- Drowsiness and/or fatigue
- Constipation
- Reduced urine and/or darker urine

IDENTIFY

Risk factors for dehydration

- Older adults often have decreased thirst
- Requiring assistance with food and fluids
- Incontinence
- Cognitive impairment and/or confusion
- Impaired function and requiring increased assistance
- Depression
- Multiple medicines, includes diuretics, for example, frusemide
- Poor swallowing
- Acute illness, diarrhoea, vomiting and/or nausea
- Fluid restriction
- Dislike of water, preference for tea or coffee
- Fluid restriction

Assessment

- Check lips, tongue, mouth
- Check vital signs
- Urine output and how much
- Urine concentration and what colour
- Level of fluid intake
- Any coughing when drinking
- Any behaviour or mood changes

HYDRATION

ACTION

Plan of care

- Check care plan and progress notes
- Follow the SLT plan – thickened/thin fluids
- Accurate fluid balance chart
- Monitor hydration – lips, tongue, mouth
- Regular vital recordings
- Regular mouth care
- Monitor urine output and bowels
- Offer fluids of choice 2 hourly
- Use the right cup for the resident's needs – sipper cup or straw
- Encourage and assist with fluid intake

REPORT

Notify registered nurse of any changes

RECORD

Document in progress notes/update care plan

PAIN

Definition: Pain is a personal experience influenced by biological, psychological and social factors (such as culture and coping strategies). Pain is what the person says it is. It is possible to have more than one pain over multiple sites and for it to be more than physical.

OBSERVE

Signs and symptoms

People use different words to describe pain – sharp, dull, shooting, stabbing, burning, crushing, heavy, aching, pulling, tender, cramping, tight, throbbing, punishing, frightening

Behaviour change

- Increased confusion
- Declining to eat/drink
- Resistant to care

Physical change

- Sweating, flushed or pale skin, change in mobility
- Check vital signs (temperature, pulse, blood pressure, respiration, oxygen saturations)

IDENTIFY

Non-verbal responses to pain

BREATHING
Changes – loud, heavy, fast

VOCALISATION
Sighing, moaning or groaning, calling out, crying

FACIAL EXPRESSION
Frightened, sad, frowning, grimacing, clenched teeth

BODY LANGUAGE
Quiet, worried, distressed, anxious, agitated, fidgeting, pacing, holding, rubbing or guarding a body part, rocking, clenched fists, pulling or pushing away, striking out

Types of pain

EMOTIONAL
- Anger/anxiety sadness/loss
- Fear
- Loss of body image

SPIRITUAL
- Meaning of life
- Culture
- Religion/beliefs
- Helplessness

SOCIAL
- Relationships
- Roles
- Cultural
- Attitude

PHYSICAL
- Illness
- Side effects of medication, fatigue, lack of sleep

ACTION

Assessment

- **Tell me about your pain** (listen to the resident's story and note the language used)
- **Where is it?** Get the resident to show where the pain is on their body. "Is this new pain or old pain? What does it feel like?"
- **How bad is the pain?** Use the pain rating tool in your facility to assess and document pain
- **Does the resident have communication problems** (eg, language barrier, hearing or speaking difficulties, dementia) that mean they cannot tell you about their pain? Use your facility's non-verbal pain tool
- **What makes the pain better or worse?**
- **Ask family/whānau about previous pain episodes**

RECORD

Document in progress notes/update care plan

RECORD

CARE AND MANAGEMENT OF RESIDENT

- Check care plan for pain management
- Is there a cause for the pain that can be treated (eg, UTI, constipation, recent fall)?
- Has there been a new injury (eg, bruises, skin tears, recent fall)?
- Check pain medication has been given
- Assess if medication has worked

NON-MEDICATION TECHNIQUES

- What has helped ease pain in the past?
- Supportive talks/reassurance/validation
- Distraction; music, TV, talking therapy
- Gentle touch
- Keep the person moving: Repositioning and pressure relief
- Dim lights and reduce noise
- Rest and support sleep
- Heat or cold packs – check with the registered nurse
- Massage, aromatherapy, relaxation, breathing techniques, pet therapy or rongoā (traditional Māori medicine)
- Offer spiritual support or prayer (if appropriate)
- Comfort extras (eg, fiddle mitt, comfy blanket)

RESPIRATORY

This guide will help the health care assistant to identify residents with shortness of breath (dyspnoea) or difficulties with breathing.

Alert

If an emergency — call 111

Report to registered nurse

OBSERVE

Signs and symptoms

- New onset or worsening shortness of breath (SoB)
- Difficulty speaking due to SoB
- SoB at rest or when lying down
- Waking up short of breath at night
- Use of accessory muscles (neck and shoulder) or nasal flaring
- Prefers to sit upright rather than lie flat due to SoB
- Cyanosis – changes in colour of lips and fingernails (bluish tint in light-skinned or grey/whitish tint in dark-skinned people)
- Pain or discomfort with inspiration or on coughing
- Decline in physical functional level due to difficulty with breathing
- Changes in mental function, confusion (delirium)
- Poor relief from prescribed inhalers

OBSERVE

Changes in respiration

- Increase or decrease rate from resident's usual baseline
- Increased/decreased depth of respirations
- Altered rhythm of respirations
- Noisy/wheezing sound when breathing

New onset or worsening cough

- Is the cough productive or dry?
- Is there a new onset or worsening production of sputum? If so, note colour, consistency, odour and amount.
- Colour: Yellow/green indicating infection?
- Blood: Fresh red blood or pink discolouration? Frothy, foamy with bubbles?
- Does the resident have difficulty coughing up the sputum?

IDENTIFY

Assessment

- Does this resident need immediate attention? Is this an emergency? Does this resident need an ambulance?
- Notify registered nurse immediately if person is in distress
- Know your resident. Is this a new condition or a deterioration of an existing condition?
- Is there new or increased ankle/leg swelling?
- **Complete assessment of vitals:** temperature, respiratory rate, pulse, oxygen saturations, blood pressure
- **Note changes from baseline vitals:** fever or hypothermia, respiratory rate: RR > 25 rpm or 10 rpm over baseline, oxygen saturations < 93% on room air, heart rate > 100bpm, systolic blood pressure <100 mmhg
- Is resident more confused, sleepy or agitated which might suggest a delirium?
- Notify registered nurse; document observations and actions in notes

ACTION

Action plan

If an emergency — call 111 and report to registered nurse.

INITIATE CARE PLAN (IF ONE), THIS MAY INCLUDE:

- Reassuring resident to help reduce anxiety
- Positioning resident to ease breathing, for example, sitting upright, loosening tight clothing, opening windows, using a fan to give sense of air flow
- Placing a cool sponge on face, hands, neck
- Encouraging sips of fluids
- Keep call bell available to resident at all times
- Is there any medication prescribed that may provide relief? e.g. inhalers
- Regular, frequent assessment to monitor for deterioration or improvement

Temperature <35.5 or >37.2 - Use a fan facing the resident to provide direct airflow to their face. A hand held fan is ideal as the resident can hold it against their face and something for them to focus on.

RECORD

Document in progress notes/update care plan

RECORD

CARE AND MANAGEMENT OF RESIDENT

Encourage the resident to slow down their rate of breathing, to breathe in through the nose and out through the mouth.

- Follow care plan for worsening of respiratory condition (if available)
- Continue to monitor as per registered nurse instructions to identify any deterioration in condition
- Increase assistance with Activities of Daily Living (ADL) while resident is unwell
- Encourage regular food and fluids (resident may only be able to tolerate small amounts, offer frequently)
- Position resident with head of bed elevated or in sitting position to assist breathing
- Support with pillows to aid comfort
- Cool sponge as needed for comfort
- Use a fan
- Ensure resident has easy access to reliever inhaler
- Call bell to be available at all times
- Limit unnecessary visitors, to reduce distress and reduce the risk of spread of possible infection
- Is there an Advanced Care Plan for this resident? Familiarise yourself with the Plan for this resident
- Document all actions, interventions and responses to interventions

SKIN INTEGRITY

Alert

Pain and discomfort

Wounds and pressure injuries can be extremely painful.
Good pain management, both pharmacological and non-pharmacological, is important

SKIN ASSESSMENT

OBSERVE

Look, listen, feel

- Colour changes
- Temperature changes - hotter or colder than surrounding skin
- Pain, sensitivity
- Swelling, oedema, blisters
- Lumps, bites
- Fragile skin
- Sweating, oozing, moisture
- Itching, rashes
- Bruises
- Odour
- Dryness, flaking, cracking
- Skin tears, broken skin, wounds and pressure injury

CHECK

- Hair, ears, nose, mouth, breast, groin and all skin folds
- Feet, between toes, nails

ACTION

Action plan

Care plan may include

See Pressure Injury Guide

General skin care plan could include:

- frequent skin inspection
- keeping skin clean and dry
- use of PH friendly cleansers and soap substitutes
- use of moisturisers, barrier creams and prescribed creams
- resident wearing protective clothing, such as long sleeves, trousers, knee-high socks, skin protectors
- correct manual handling, regular position changes and use of sliding sheets and hoists when appropriate
- individualised continence management and appropriate toileting
- wound care
- appropriate equipment, such as pressure-relieving mattresses, appropriate seating and pressure-relieving devices
- good nutrition and fluid intake, may require food and fluid chart. Consideration of family/whānau involvement and personal preferences
- dietician input and supplements
- physiotherapy input and exercise plan
- soft well-fitting shoes
- pain management (including music, massage and repositioning

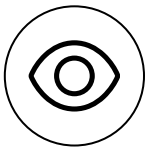
Important considerations

- Undertake hand hygiene, as per infection control protocols
- Ensure clear documentation
- Involve resident and family/whānau
- Handle gently – avoid pulling or tugging of the skin, remove accessories such as rings, watches and so on
- Ensure safe use of equipment, such as sliding sheets, hoists and off-loading devices
- Avoid adhesive tape on fragile skin. If removing, do with care
- Ensure a safe, clutter-free environment
- Ensure ongoing updates and communication with registered nurse

RECORD

Document skin assessment, findings and interventions in progress notes and resident care plan.

PRESSURE INJURIES



OBSERVE

Look, listen, feel

- Erythema/redness (may look like a bruise/skin discolouration in residents with darker skin)
- Blanching response- no change in colour when skin is pressed (darker skin makes this more difficult to detect)
- Localised heat
- Microclimate, for example, sweating
- Oedema/swelling
- Skin breakdown/erythema on bony prominences, such as heels, ankles, bottom, tailbone, hips, elbows
- Skin breakdown under medical devices, for example, under indwelling catheters, oxygen masks and tubing
- Pain
- The darker the skin. the more difficult pressure injuries are to detect

Be on the lookout for change in risk status

IDENTIFY

Assessment

Assess nutritional status – food and fluid, weight changes

Check for general changes in health status:

- level of mobility
- exacerbation of chronic conditions
- bowel and urinary changes
- level of consciousness
- agitation
- behaviour changes
- mood
- shortness of breath and/or shortness of breath on exertion

PRESSURE INJURIES

ACTION

Important considerations

- Clear documentation
- Family/whānau involvement. Involve and educate the individual and family/whānau about pressure injury risk and risk-reduction interventions
- Regular monitoring for change in condition
- Report changes early

S **Surface**
Make sure your residents have the right support

S **Skin inspection**
Early inspection means early detection. Show family/whānau, caregivers and colleagues what to look for

K **Keep** your residents moving and change position regularly

I **Incontinence/moisture**
Your residents need to be clean and dry

N **Nutrition/hydration**
Help residents to have the right diet and plenty of fluids

RECORD

Document in progress notes/update care plan

PRESSURE INJURIES

RECORD

ACTION PLAN

Report to registered nurse with assessment. Initiate care plan. This may include the following.

- Full head to toe skin check each shift including checking under medical devices and protective dressings, such as silicone foam dressings
- Avoid positioning on red areas or broken skin
- Use of pressure relieving devices and equipment, such as pressure-relieving mattress, heel protectors, cushions, sliding sheets
- Regular position changes. Choose frequency of turning based on support surface in use, tolerance of skin for pressure and individual preferences
- Consider lengthening position changes at night to promote uninterrupted sleep
- Encourage independence and mobility as much as possible
- Consider length of time sitting in chair
- Reposition immobile and weak residents in chairs hourly
- Discourage elevation of head above 30 degrees for more than one hour
- Manage continence. Cleanse skin promptly after episodes of incontinence
- Use substitute soaps
- Use barrier creams as required
- Moisturise skin daily
- Avoid rubbing fragile or reddened areas
- Ensure good nutrition and fluid intake. May require food and fluid chart. Consider assistance and support to increase oral intake, family/whānau involvement and personal preferences
- Give supplements as prescribed
- Pain management

URINARY

Alert

Report immediately to the registered nurse

Resident who displays these signs and symptoms

- Increased respiratory rate
- A resident who is shivering and cold
- A resident who is aggressive, agitated and/or at risk of harming themselves or others
- Increased heart rate, above 90 bpm

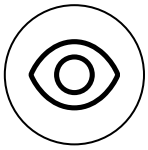
URINARY INCONTINENCE

The complaint or observation of involuntary leakage of urine at any time

URINARY TRACT INFECTIONS

A urinary tract infection (UTI) is an infection in any part of your urinary system (kidneys, ureter, bladder and urethra).

INCONTINENCE



OBSERVE

Signs and symptoms

- Frequent wet underwear
- Dribbling/leaking or flooding on standing
- Frequent passing of urine at night
- Regular trips to the toilet and leaking urine on the way (urge incontinence)
- Frequent falls in or accessing the toilet
- Current continence products not absorbent enough

INCONTINENCE

IDENTIFY

TYPES OF INCONTINENCE

Stress incontinence

The leaking of urine that may occur during exercise, coughing, laughing and lifting. The leakage of urine occurs due to the pressure on the bladder causing it to leak urine. This is more common in women, although it can occur in men. In women, pregnancy, childbirth, menopause and being overweight are the main contributors. In men, this is often caused by prostate issues.

Urge incontinence

A sudden and strong need to urinate with involuntary urine leakage. The bladder muscle becomes irritable and leakage occurs on the way to the toilet. It is associated with frequency day and night, and is often due to having an over-active or unstable bladder, neurological conditions, constipation, enlarged prostate or a history of poor bladder habits.

Mixed incontinence

A combination of stress and urge incontinence and is most common in older women.

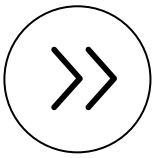
Overflow incontinence

A result of bladder outflow obstruction or injury. Constipation, an enlarged prostate and some neurological conditions can cause an increase in the number of bladder accidents.

Functional incontinence

Associated with limitations in thinking, moving and communicating about the need to reach the toilet.

INCONTINENCE



ACTION

Assessment

- **New or worsened urinary incontinence** – report to the registered nurse
- **Dipstick for urinary tract infection**
- **Bowel chart** – constipation can cause urinary retention, overflow and urgency by aggravating bladder function
- **Vital signs.** See Delirium Guide

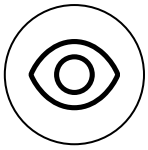
Assess mobility, resident can take themselves to the toilet or requires assistance and supervision

RECORD

RESIDENT CARE PLAN

- **Skin integrity** – cleaning and monitoring of skin integrity to prevent skin breakdown
- **Scheduled toileting regime** (reduces the frequency, urgency and thereby the level of incontinence)
- **Ensure call bell is always in easy reach**
- **Reduce caffeine intake** – this can irritate the bladder
- **Maintain good fluid intake** – concentrated urine can irritate the bladder
- **Easy access to the toilet**, commode or urinal; improve access to and provide supervision or assistance, if required
- **Monitor** for constipation and report to registered nurse

URINARY TRACT INFECTIONS



OBSERVE

Signs and symptoms

RED FLAGS

1. **Acute dysuria** – pain passing urine
2. **Fever** > 37˚C
3. **Flank pain** – lower back pain
4. **Suprapubic pain** – location – lower stomach
5. **Haematuria** – blood in the urine
6. **New/increased incontinence**, urgency and frequency

GENERAL

- Confusion and disorientation
- Increased difficulty with showering, dressing, grooming
- Aggression – verbal and physical
- Weakness
- Sleepiness
- Nausea/vomiting
- Smelly urine, discoloured urine, visible blood
- Mobility – falls, unsteady
- Fever/cold

RESIDENT COMPLAINS OF THESE SYMPTOMS

- "I don't feel well"
- Burning and stinging when passing urine
- Pain in back or stomach

IDENTIFY

Assessment (suspected UTI)

- Dipstick urine – only to rule out UTI – report results to registered nurse
- Vital signs – pulse, blood pressure, respiratory rate, temperature, oxygen saturations

URINARY TRACT INFECTIONS

ACTION

Report immediately to the registered nurse

RESIDENT WHO DISPLAYS THESE SIGNS AND SYMPTOMS

- Difficult to wake, sleepy
- Temperature below 35˚C and/or 37˚C
- Low blood pressure
- Increased heart rate, above 90 bpm
- Increased respiratory rate
- A resident who is shivering and cold
- A resident who is aggressive, agitated and/or at risk of harming themselves or others

INTERVENTIONS

- Close supervision and monitoring of resident who has delirium due to a UTI
- Monitor urine output, report if resident is not passing urine or urine is cloudy
- Encourage fluids, record on fluid chart
- Ensure residents with an indwelling catheter have the catheter emptied each shift and amount is recorded as per infection control standards

URINARY TRACT INFECTIONS

RECORD

CARE AND MANAGEMENT

- **Hydration** – good fluid intake each day – aim for 1.5 litres a day unless on a fluid restriction
- **Good hygiene** – thorough washing and rinsing around the genital area, regular changing of underwear
- **Good cleaning after an episode** of urinary and/or faecal incontinence
- **Good cleaning practice** after moving bowels – women wipe from front to back to avoid contamination
- **Avoid constipation**
- **Good nutrition**
- **Regular two hourly toileting** regime if reliant on health care assistants to help to and from the toilet
- **Prompt toileting assistance**

Observe the resident's behaviour

Identify any changes in health status or abnormalities

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

Record and document changes in health status – new signs and symptoms in the progress notes

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