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