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 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

*SoB = shortness of breath

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 resident 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 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, WHICH 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
- Keeping call bell available to resident at all times
- Identify any medication prescribed that may provide relief, eg, inhalers
- Undertaking regular, frequent assessment to monitor for deterioration or improvement

Temperature <35.5˚C or >37.2˚C - 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

REPORT

Notify registered nurse of any changes. If an emergency — call 111

RECORD

Document in progress notes and 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 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/Shared Goals of Care Plan for this resident? Familiarise yourself with the plan for this resident
- Document all actions, interventions and responses to interventions