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 and keep others calm (residents, family and whānau, visitors)**

OBSERVE

Risk factors

- Fast or slow heartbeat
- Irregular heart beats
- Heart attack
- Heart failure (HF)
- Hypotension (blood pressure lowers particularly on standing)
- Stroke/transient ischaemic attack
- Epilepsy/seizures
- Vestibular balance disorders – inner ear
- Shortness of breath (asthma, chronic obstructive pulmonary disease, 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 and keep others calm (residents, family and whānau, visitors)**

REPORT

Notify registered nurse of any changes

RECORD

Document in progress notes and 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