Acute deterioration | Te tere tauheke haere

Assessment steps

This tool is to help recognise acute change in older people and provides assessment steps for early intervention.

STOP AND WATCH/assess and review

STOP AND WATCH	
S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Participates less in activities
A	Ate less, difficulty swallowing medication
N	No bowel motion > 3 days, diarrhoea
D	Drank 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

Acute deterioration identified by STOP AND WATCH?

The registered nurse to perform the following assessment and review.

(Review Clinical Reasoning Guide on page 2.)

Then consult with NP/GP using the SBAR tool as a guide for reporting findings.

Clinical Reasoning Guide

Start with the STOP AND WATCH and then complete reversibility assessment steps 1–8.

- As per SBAR: History of the presenting problem. General appearance: pale, sweaty, distracted.
- Full set of obs T, P rates and rhythm, RR, BP, O_2 sats compare all with 'normal'.
- What is their medical history, and what medication are they on?
- Any recent labs, investigations, new medication?

Assessment	Review/action
Step 1	**Review what could be causing the change or decline overall** a) Review recent history, b) do observations, c) are there recent medication changes? Review acute deterioration clinical reasoning guide (see next page) and SBAR form to review possible causes of symptoms.
Step 2	**Take observations – review warning signs that indicate serious illness or sepsis (see sepsis screening tool)** **Take into account baseline observations:** • **Respiratory rate > 24/minute (see respiratory care guide).** • **Increased respiratory rate is one of the most sensitive indicators of acute illness** • SPO_2 < 90% • Temperature > 37.7°C or low temp < 36 °C • New heart rate > 100 bpm • New systolic BP < 100 mmHg
Step 3	**Assess for recent labs or other results (eg, X-rays)** Consider need for labs: CBC, CRP, electrolytes, creatinine, LFTs, MSU, BGL
Step 4	**Review hydration status** • Start input/output chart, ensure input/output equal in 24 hours • Offer fluids orally every 1–2 hours to increase oral fluid intake to 1,000–1,500/24 hours • **If unable to take oral fluids, consider normal saline SC (500 ml/12 hrs) and review diuretics (in consultation with prescriber)**
Step 5	**Assess for delirium** • Delirium screen: Neuro changes, increased falls, functional change and/or confusion. • Neuro assessment: pupils, extremity, power, face and body symmetry, weakness. See delirium care guide and 4AT delirium screen
Step 6	**Review pain status** Assess for pain location, type and severity. Review for pain intervention (use OLDCART)
Step 7	**Review for constipation or diarrhoea** Bowels not open for three days or watery bowels? Review available laxatives and clear bowels for constipation. Use loperamide and assess for dehydration for diarrhoea
Step 8	**Review goals of care** What does the resident/family/whānau want to happen now? **Review again after assessment goals of care** • For hospitalisation? Antibiotics? • How does the family/whānau feel about the situation? What would they like to happen now? • For comfort care only? If comfort care only, see palliative care guide – palliative care is an ACTIVE process • Develop a plan of care based on the above assessment

(Singer et al 2016; Dellinger et al 2011; Ouslander et al 2011; Boockvar & Lachs 2003)

Possible causes for specific clinical changes

Below is a tool to help narrow down the clinical causes for acute deterioration.

Symptoms	Possible causes	
Dizziness	• Neurological changes/CVA • Benign positional vertigo • Cardiac changes	• Dehydration • Medication side effects
Confusion, change in behaviour	• Medication side effects • Delirium • Stroke	• Uncontrolled diabetes • Electrolytes imbalance • Depression
Urinary dysuria, flank pain, lower abdominal pain	• Urinary tract infection • Urinary retention • Constipation	• Pylonephritis (kidney infections) • Medication
Sleepiness, fatigue, drop in consciousness level	• Hypoxia • BGL too low/too high • Hypoactive delirium • Medication	• Electrolyte imbalance • Dehydration Infection • Acute cardiac event or congestive heart failure Neurological change: CVA/TIA
Fall	• Cardiac changes • Dehydration • Urinary tract infection • Lower respiratory tract infection	• Neurological event – eg, TIA or CVA • Increasing frailty • Medication changes
Skin changes, rash or wound	• Infection – cellulitis? • DVT?	• Allergic/reaction • Bleeding (on warfarin?)
Shortness of breath (SOB)	• Respiratory: COPD or lower respiratory tract infection • Anaemia	• Acute cardiac event or congestive heart failure
Pain	• Complete OLDCART • Chest pain • Neurologic	• Musculoskeletal • Abdominal • Peripheral neuropathic pain

OLDCART Symptom evaluation tool

O	Onset
L	Location
D	Duration
C	Character
A	Aggravation or associated symptoms
R	Relievers
T	Treatment

Sepsis screening tool

Sepsis is a medical emergency

Known or suspected infection

↓ PLUS

Any two of the following

- Acute mental status change
- Hyperglycaemia
- Hyperthermia or hypothermia < 36 or > 37.5
- High white blood cell count (or low blood cell count)
- Tachycardia HR > 100 bpm
- Tachypnoea > 24 respiration/minute

May indicate sepsis – contact GP/NP

↓ POSSIBLE SHOCK

Indications of septic shock or organ dysfunction include

- Hypotension
- Increasing oxygen requirement (SPO_2 > 90%)
- Elevated creatinine (kidney impairment) or bilirubin level (liver impairment)
- Low platelet count
- Petechial rash (tiny purple, red or brown spots on the skin)

↓

Review again goals of care – for hospital or comfort measures?

Expected management/treatment of sepsis in aged care facility:

- Oral antibiotic
- Use oxygen to keep SPO_2 > 90% if not COPD
- Monitor hydration and urine output
- Pain management
- Monitor labs: CBC, renal function, CRP

Expected management/treatment of sepsis in hospital:

- IV fluids and antibiotics
- O_2 to keep sats > 90% if not COPD
- Bloods: cultures, lactate, renal function, CBC

(Singer et al 2016; Dellinger et al 2013; and bpac^{NZ} 2018 *Sepsis: Recognition, diagnosis and early management*: https://bpac.org.nz/guidelines/4/docs/Sepsis.pdf)

A template of the modified SBAR tool can be downloaded here: www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Modified_SBAR_tool_template_example_FCG_final.docx.

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Acute deterioration

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See the full range of frailty care guides here.