Rationale

This procedure aims to guide staff in the early identification, assessment, documentation and communication about changes in the health status of residents to ensure that deterioration is recognised early and appropriate action is taken to escalate care. This promotes better health and quality of life for residents and reduces the need for transfer to acute settings. This procedure specifically relates to a sudden and acute change in resident health status.

Standard Operating Procedure

Stage	Responsibility	Description
1.	Medical Officer and Residential Care Staff	**Identify goals of clinical care** Establish what observations are to be taken, including frequency and reportable limits. Record in ManAd™ (Management Advantage), resident details on the clinical tab **Complete and Document Advance Care Plan** A copy of the Advance Care Plan should also be easily accessible in hard copy in the residents file (refer Advance Care Planning (ACP) Procedure
2.	Residential Care Staff	**'Stop and Watch' Early Warning** Staff observing a change in resident's behaviour or health status using the 'Stop and Watch" algorithm should discuss their concern with the Registered Nurse in charge of the shift The **"Stop and Watch" algorithm** **S**eems different than usual **T**alks or communicates less than usual **O**verall needs more help than usual **Pain – new or worsening** **A**te less than usual (Not because of dislike of food) **N**o bowel movements in three days/ diarrhoea/change in regular bowel habits **D**rank less than usual **W**eight change **A**gitated or nervous more than usual **T**ired, weak, confused, or drowsy **C**hange in skin colour or condition **H**elp with walking, transferring, toileting more than usual In the absence of limits set by the medical officer, the following will be the **reportable limits**: **BSLs** – below 3.5mmol/L, above 20mmol /L **BP** – systolic above 180 mmHg, or below 90mmHg; diastolic below 50mmHg **Pulse** – below 50 or above 100 **Temperature** – below 35.5°C or above 38°C Observations are to be verified/rechecked using manual and automatic BP machines before reporting to the medical officer

Stage	Responsibility	Description
3.	Residential Care staff	**Clinical care when deterioration identified** Care will vary dependent on the clinical condition at the time from emergency treatment (refer Code Blue procedure ensuring care provision is consistent with the resident's Advance Care Directive, if present) to planned care coordination in consultation with a medical officer. Care to be provided will be documented and communicated including increase in observation/BSL regime, increase in fluid intake monitoring, and any other additional clinical monitoring that may be required dependent on the condition. Clinical deterioration identified by a resident, next of kin or external carer must be communicated to the registered nurse in charge for action.
4	Residential Care staff	**Review of Risk Assessments when deterioration identified** Review the following assessments in order to manage any emerging risks, as appropriate in the individual situation: • Falls Risk • Mobility & Transfers • Braden Skin Assessment • Behaviours • Swallowing – including any required modified consistency for food or fluids • Hygiene needs – including oral care in particular All changes in care interventions and management should be communicated promptly to all care staff allocated to the care of the deteriorating resident. Always ensure that the handover sheet is correctly amended to maintain consistency with prescribed interventions. Update care plans as appropriate.
5.	DONRAC / NUMs	**Rostering** Ensure that there is always a rostered clinician who has proficiency in basic life support on site.
6.	Residential care staff / ANUM / AHM	**Communication - clinicians** Staff identifying changes in a resident's condition are to report the change to the RN in charge or the AHM. The RN in charge will undertake assessment, including a full set of vital sign observations, and make a determination about further action and document all actions in ManAd™. Communication is given following the structured handover mnemonic ISBAR: refer Appendix 1 for example. Actions taken and responses to interventions must be documented in the progress notes. Formal daily handover will incorporate verbal communication of clinical concerns to the next shift.

Stage	Responsibility	Description
7.	ANUM/ /AHM	**Communication – resident/next of kin/carer** On admission: Residents' families and carers are informed of recognition and response systems through information contained in the Resident Information Booklet (available from Residential Aged Care Administration) and can contribute to the processes of escalating care through being encouraged to communicate any concerns regarding clinical condition to staff, via REACH. Ongoing: Care plan review discussions will encourage the resident/MTDM (Medical Treatment Decision Maker) to communicate any concerns regarding clinical condition When a resident's condition deteriorates – staff are to inform the resident/ MTDM /carer and document the communication in the ManAd™.

Additional Information

Referring Policy
Residential Aged Care Policy

Other References

Buist M, Bernard S, Nguyen TV, Morre G, Angerson J. Association between clinical abnormal observations and subsequent in-hospital mortality :a prospective study. *Resuscitation 2004*;62:137-141
Interact – Stop and Watch
The National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration. ASCHC
Advanced Care Plan Procedure
InterAct Version 4 Tool, 2011 Florida Atlantic University

Compliance
Observation audit >80% of residents have observations recorded minimum of 3 monthly.

Author/Contributors

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J Bulten	Nurse Practitioner	4 November 2010 (approval date), 7 November 2013

APPENDIX 1

REQUEST FOR MEDICAL ATTENTION - ISBAR FORMAT

Prior to contacting the GP, have pathology results and the resident's drug chart at hand.

IDENTIFY:
- yourself,
- the resident
- where the resident currently is

SITUATION:
- provide the GP with the resident's admission diagnosis
- inform the GP why you are calling (resident deteriorating)

BACKGROUND:
- provide the relevant medical history
- remind GP of any allergies
- inform of any other medical or allied health consultations
- discuss any other diagnostic results (blood tests) or other interventions
- does the resident have an advance care plan?

ASSESSMENT:
Provide information relating to the resident deteriorating such as:
- how many days the resident has been unwell
- food or fluid intake changes or weight loss
- change in ability to tolerate food or fluids
- nausea or vomiting
- increasing weakness
- observations
- urinary output
- bowel issues
- pain assessment results
- signs of agitation/ restlessness, hypoxia/disorientation
- skin integrity
- other symptoms including infection, oral health, drowsiness, fatigue, semi consciousness
- resident's response to nursing interventions related to these issues

RECOMMENDATIONS & RESPONSIBILITY:
- Family conference regarding the initiation of Advance Care Plan discussion
- Required nursing interventions
- Further orders, ie subcutaneous medications due to the inability to swallow oral medications
- GP visit and when you would like them to visit, ie urgent visit required, later in the day or next day
- Document in ManAd™ progress notes the conversation and response from the GP, including the time GP will attend