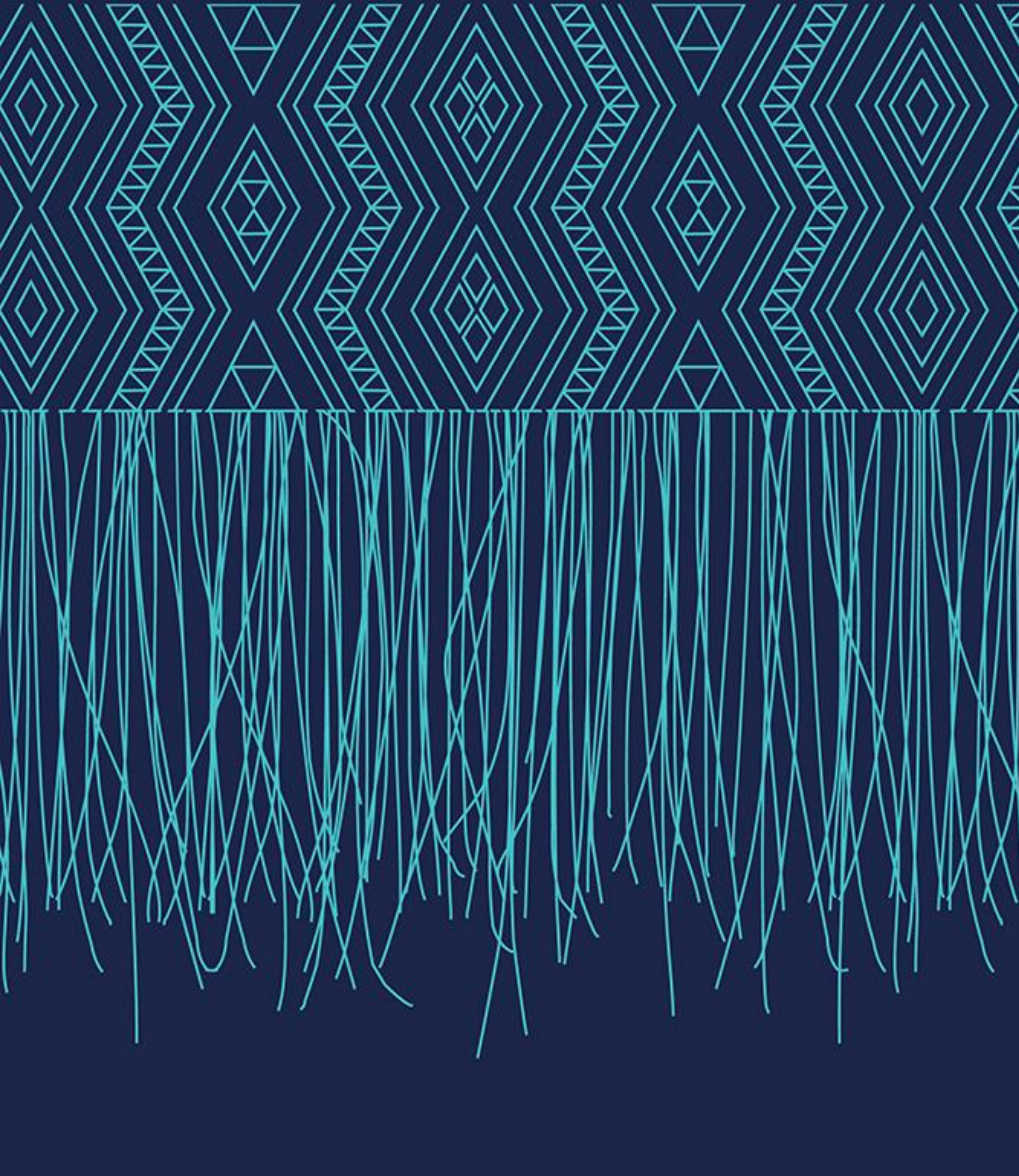

Detection of Acute Deterioration for the Elderly

Aloha Sison, NP

Older People make up a significant part of our society

Largest group of consumers of health and disability support services

Their needs are increasing steadily

People are living longer…

- **Life expectancy in most developed countries is increasing.**

- **Around 10 years longer on average than someone born in 1950**

Age-related Residential Care Facility

- When one can no longer manage in their own home, they move to a rest home or hospital – Generally called as an Age-related Residential Care (ARRC) facility.
- ARRC provide support through long-term and short-term care beds. Long-term care beds are the most common type in the industry.
- Four levels of care: rest home, hospital, dementia and psychogeriatric as well as short term (respite and convalescent care) ARRC certified beds.

Aged Care Nursing Staff play a key role in detecting and managing deterioration.

What is acute deterioration?

- **Sudden, clinically important rapid change in the person’s BASELINE cognitive, behavioral, functional or physical health domains.**
- **’Clinically important’ - No intervention in that change, may result to death of the person.**
- **Acute deterioration includes all causes of acute illness includes NEW or an EXACERBATION to a chronic illness.**

Aged Care Nursing **Staff Members** play a key role in detecting and managing deterioration.

Different trajectories of deterioration

Short period of evident decline

these residents may have good function for a long period followed by a few weeks or months of rapid decline prior to death

Long-term limitations with intermittent serious episodes

gradual decline in function. During each acute episode, the resident is at risk of dying but they may not. However, function will continue to decline.

Prolonged dwindling

long-term progressive disability and reduction in function. Death may be caused by infections, falls or fractures

What is the first step of critical thinking?
Problem Identification

What is ASSESSMENT?

- Evaluation of a patient using selected skills of history-taking, physical examination using tools or framework in order to address needs and achieve goal/s.

- A **standardized approach to identifying and responding to acute deterioration is recommended.**

- Numerous Tools are available that but not specific to ARC nurses

Rapidly and immediately consider life-threatening issues before completing a full assessment of acute deterioration.

Chest Pain Assessment

Sepsis Screening Tool

Approach to Dyspnea/ Acute breathlessness

Syncope/ Collapse

New HQSC guidelines are now available.

Acute deterioration

- 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, diarrhea
- D –drank less
- W – weight change
- A –agitated or more nervous than usual
- T – tired, weak, confused or drowsy
- C- change in skin color or condition
- H –more help walking, transferring and toileting

Acute Deterioration
Assessment Steps

1) History of Presenting Complaint

O-nset
L-ocation
D-uration
C-haracteristics
A-ssociated Symptoms
R-elieving or Aggravating Factors
T-reatment
I-mpact
C-oping mechanism
E-xpectations:what do they want

- Resident is the primary source
- Use available resource for collateral information including staff, family/whanau and notes

2) Concern

How well do you know the resident?

How concerned are you of the changes for this resident?

- Important note: Family concern is considered a ‘vital sign’.

3) Delirium

- **New or increased confusion**
- **Inability to concentrate**
- **Change in level of consciousness**
- **Hallucinations – Tactile, Visual, Auditory**

- Consider hyper- and hypo-active delirium.
- A person that has gone ‘quiet’, ’letahrgic’, ‘drowsy” maybe having hypo-active delirium.

4)Observed change in behavior

- **Are behaviors inconsistent with person's usual routine/ habit?**
- **Unusually withdrawn or not wanting personal cares? Aggression?**
- **Reduced eating and drinking?**

- Reduced eating and drinking – Consider staring food/fluid balance chart to trigger close monitoring by all staff members
- Withdrawn behavior- take a holistic approach.

5) Functional symptoms

- Is there evidence or recent history of a fall?
- Is there evidence of weakness or fatigue?
- A change in ADLs?
- A change in mobility?

6) Physical symptoms

Review of Systems:

Cardiorespiratory:

Gastrointestinal:

Genitourinary:

Skin:

Pain Status

- Breathlessness, cough, edema
- Nausea, vomiting
- Bowels: Constipation, diarrhea, overflow -Review Bowel chart
- Change in urinary frequency, urgency, color, urine
- Skin: Breakdown, Wound, IAD
- Pain: review pain status

7) Vital sign and examination

Vitals Signs: Compare with baseline

RR: >25 or <10 bpm

O2 sats: <93%

SBP: <100 mmhg

PR: >100 or <50 bpm

Temp: 37.2℃ or 1℃ above baseline or <35℃

- Neurological: Unilateral weakness, balance, facial changes
- Respiratory: breath sounds and work of breath
- Cardiac: heart sounds, pulses, edema
- Abdomen: tenderness or masses, bowel, bladder, kidney
- Musculoskeletal: strength, pain range of movement
- Skin, wound, rash, infection

8) Consider in context of person

Recent changes to medication or treatmen?

Recent investigation or laboratory tests?

Does this appear to be something new?

Does an ACP apply?

Can a person reliably make a decision? (Acute confusion affects the decision-making ability of the person)

- Does this appear to be an exacerbation of a chronic condition?
- An expected end of life process?
- A new clinical issue? Needs a diagnosis
- Is it a worsening situation

9) Contact GP, NP or urgent care with details in line with facility protocol

*** Use ISBARR to provide a complete but concise clincial picture.**

*** Establish the urgency of the situation**

- Treatment plan with expected improvement
- Treatment with expected dignified end of life - Discuss anticipatory medications as necessary
- Monitor frequency and when to call for urgent care

10) Update family/whanau, staff members, DOCUMENT

Ensure to use explicit words when discussing with family about assessment current intervention, monitoring and escalation plan.

- Document conversations with family
- Ensure to update care plan (short-term and long-term care plan)
- Handover to care staff members

11) Monitor

Monitor and escalated to NP, GP or urgent care if person deteriorates in 24-48 hours.

What do you do with the information you have?

When health professionals do not communicate properly, patients are at risk.

- MISCOMMUNICATION IS AN ONGOING ISSUE IN THE
- HEALTH CARE INDUSTRY – All MDTs are trained differently
- Utilize communication tool that is available in the facility
- GOOD COMMUNICATION SAVE LIVES

HANDOVER

“the transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another person or professional group on temporary or permanent basis”

It is a skill – if done well it provides clear communication and accountability and strengthens the capacity to plan and manage the care required by the patients.

Currently the quality of handover (regardless of the situation) is reliant on the person rather than process.

ISBAR

https://www.youtube.com/watch?v=T9D3h3DFd1c

I	**Identify**	**Introduce yourself (facility; which area in facility)** **Patient (name, DOB, age, gender, location)**
S	Situation	Why are you calling? Briefly state the problem, what, when, how severe? Principal problem, reason for call. OLDCART

B	**Background**	**Information related to the patient, medical history.** **List of current relevant medication, allergies.** **Resuscitation status.** **Relevant social information, family/ NOK to be informed.**
A	Assessment	Most recent vital signs. BGL if appropriate. Neuro-vital signs if post-fall. Any information that has not been captured in the OLDCART

R	**Recommendation/ agree a plan**	**Given the situation, what needs to happen?** **What are you wanting (advice, orders or transfer). What is the level of urgency?** **What is the plan ?**
R	Read back	Clarity and check for shared understanding. Who is responsible for what and by when? Confirm shared understanding Who is doing what and by when?

DOCUMENTATION – If it is not documented, it was not done.

- Be clear, legible, concise, contemporaneous, progressive and accurate
- Include information about assessments, action taken, outcomes, reassessment processes (if necessary), risks, complications and changes
- Meet all necessary medico-legal requirements for documentation.

Reference:

https://www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea-2023-edition