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Appendices

Best possible medication history (BPMH)[1-4]

- Get an accurate and complete list (or as close as possible) of medicines the patient is currently taking at presentation, or as early as possible in care
- Online course ***Get it right! Taking a best possible medication history*** https://learn.nps.org.au/

Step 1

Review sources of available medicines information eg:

- Medication containers, blister packs
- Community pharmacist list, GP referral letters
- Medical record(s), *My Health Record* https://www.myhealthrecord.gov.au/
- The Viewer, QScript (Qld), or if outside of Qld local sources

Step 2

Interview the patient ± carer/family if possible

- Names of all medicines patient is taking
- Prescription, over-the-counter, complementary - dose, strength, form, concentration, frequency, duration and why taking:
  - use **Medication history checklist** (below) to guide interview
- Any difficulty taking medicines, how often missed
- Recent change to medicine(s) or doses
- Allergies/bad reaction to any medicines in past, what/when/has it happened since

Step 3

Verify the history with one or more sources of information

- Check that these match up/any inconsistencies
- If any discrepancies, ask patient ± advise MO/NP
- Check a medication reference if unsure about a medicine eg AMH, eMIMS

Step 4

Record the information on the medical record

- On the designated form, in the electronic medical record or *Enterprise-wide Liaison Management System* (eLMS) (Qld)
- Document allergies + any recent changes to medicines and why
- Give list of medicines when care transferred eg retrieval team, to patient/carer when discharged, at clinical handover

Medication history checklist[4]

- ☐ Prescription medicines
- ☐ Sleeping tablets
- ☐ Inhalers, puffers, sprays, subling tablets
- ☐ Oral contraceptives, hormone replacement therapy
- ☐ Over-the-counter medicines
- ☐ Anticoagulants/antiplatelets
- ☐ Analgesics
- ☐ Gastrointestinal medicines (for reflux, heartburn, constipation, diarrhoea)
- ☐ Topical medicines eg creams, ointments, lotions, patches
- ☐ Complementary medicines eg vitamins, herbal or natural therapies
- ☐ Inserted medicines eg nose, ear, eyes, pessaries, suppositories
- ☐ Injected medicines
- ☐ Recently completed courses of medicines
- ☐ Other people's medicines
- ☐ Smoking history eg tobacco, vapes, NRT
- ☐ Social and recreational drugs
- ☐ Intermittent medicines eg weekly or twice weekly
- ☐ Refrigerated medicines

High risk medicines - 'APINCH' - **A**nti-infectives, **P**otassium, other electrolytes, **I**nsulin, **N**arcotics, other sedatives, **C**hemotherapeutic agents, **H**eparin, enoxaparin, warfarin, other anticoagulants

Patient death in absence of medical officer

Recommend

- Follow HHS/local policy + procedures. If outside of Qld, refer to local policy + procedures
- Death in community can be very emotional + distressing. Be guided by local health workers + clinic management. See *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying* https://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf
- If suspected death by suicide, support services for family/friends and staff include StandBy Support After Suicide https://standbysupport.com.au and Thirrili's Postvention Suicide Support https://thirrili.com.au/
- If neonatal death or stillbirth - MO will advise. Also see Qld Clinical Guideline *Stillbirth care*

Resources

- *Life extinct form* (Qld Health intranet only) https://qheps.health.qld.gov.au/__data/assets/pdf_file/0034/2446477/mr41.pdf
- *Information for health professionals* (Qld) https://www.coronerscourt.qld.gov.au/for-health-professionals

Confirm deceased by checking all the following[1]

- No palpable carotid pulse
- No heart sounds heard for 30 seconds
- No breath sounds heard for 30 seconds
- No response to centralised stimuli
- Fixed dilated pupils

- Contact MO + local clinic management, who will advise ongoing management
- **Is this a reportable death, see** *Life extinct form* for full definitions

No

- Offer condolences to the family
- Family will advise cultural wishes/requirements

The **death is reportable** to the coroner if:[1,2]

- Unknown person
- Violent or unnatural, including trauma
- Happened in suspicious circumstances
- Death was healthcare related
- A cause of death certificate not likely to be issued (cause unknown)
- Death in care
- Death in custody or as a result of police operations

Yes or unsure

Immediately report to local Police

- Until advised:[2,3]
  - **DO NOT** move the body. **Note:** if in public place cover body with sheet + protect dignity of the deceased
  - **DO NOT** remove medical equipment eg IVCs, catheters
- Notify local clinic management + next of kin (if known/appropriate)[4]
- Police or MO will report the death to the coroner + advise ongoing management which may include completing *Life extinct form*
- Refer to HHS/local policy + procedure

Glasgow Coma Scale/AVPU

A	Alert
V	Responds to voice
P	Responds to painful stimuli
U	Unresponsive

Glasgow Coma Scale (GCS)[1,2]

Eyes open	Spontaneous	**4**		
	To speech	**3**		
	To pain	**2**		
	No response	**1**	If eyes closed by swelling, write **C**	
			Child/infant	**Nonverbal person** (child/infant/adult)
Best verbal response	Orientated	**5**	Alert, babbles, coos, words to usual ability	Spontaneous normal facial/oro-motor activity
	Confused	**4**	Less than usual words, spontaneous irritable cry	Less than usual ability/ response to touch only
	Inappropriate words	**3**	Cries only to pain	Vigorous grimace to pain
	Incomprehensible sounds	**2**	Moans to pain	Mild grimace to pain
	No response	**1**	No response to pain	No response to pain
			Child/infant/nonverbal person	
Best motor response	Obeys commands	**6**	Spontaneous or obeys verbal commands	
	Localises to pain	**5**		
	Withdraws from pain	**4**		
	Flexion to pain *decorticate*	**3**		
	Extension to pain *decerebrate*	**2**		
	No response	**1**		
	GCS total/15			

ALERT always act on **score ‹ 15 or drop of ≥ 2**
If ‹ 8 consider airway adjunct eg LMA, p. 54. Patient may require intubation

Injection pain

HMP Managing injection pain - adult/child

- Do not rush or force injection on patient. Staff or family must not restrain patient to give injection

Non-pharmacological strategies[1]

- Patients of all ages should have control over how and where they receive their injection
- Short wait time for injection
- Pain blocking techniques - applied to site prior to injection eg:
  - ice pack for 5 minutes
  - firm pressure for 10 seconds
  - ice and vibration:
    - Buzzy® - ice pack for 5 minutes then Buzzy® for 60 seconds and move Buzzy® directly above the site of insertion during injection keeping in contact with skin
    - Exocool®/CoolSense® - use Buzzy® for 60 seconds first, then Coolsense® for 10 seconds, then Buzzy® as above
    - other device eg Shot Blocker® - piece of C shaped plastic to fit around the injection site and press the skin with multiple, small, blunt bumps to 'saturate sensory nerves'. Inject through U shaped opening
- Distraction techniques eg electronic games, videos
- Refrigerate 'needle' prior to injection
- Allow the 'syringe/barrel' to reach room temperature before use
- Injecting slowly eg over 2–3 minutes - be guided by the patient

Pharmacological strategies[1]

- Paracetamol before injection and at appropriate intervals after. See Acute pain, p. 32
- Anaesthetic spray/cream before injection eg Emla®. **Note:** only anaesthetises skin, not lower layers
- Nitrous oxide + oxygen (Entonox®) during injection. See Acute pain, p. 32
- **If Bicillin L-A®:**
  - may be given with lidocaine to reduce the pain of the injection (see next page)[2]
  - if still highly distressed consider consulting MO/NP or if for ARF, QH RHD Program ✆ 1300 135 854 or local RHD control program for other options

S2	**Lidocaine + prilocaine** Emla®			**Extended authority** ATSIHP/IHW/IPAP
ATSIHP, IHW, IPAP, MID, RIPRN and RN may proceed				
Form	**Strength**	**Route**	**Dose**	**Duration**
Cream Patch	Lidocaine 2.5% Prilocaine 2.5%	Topical	**Adult and child › 6 months** Squeeze about 3.5 cm from tube onto intact skin and cover with an occlusive dressing OR apply 1 patch	Leave on skin for 1 hour Remove prior to injection
Offer CMI: Effect lasts for 30 minutes to 2 hours after removal. May cause temporary blanching and swelling of the skin				
Contraindication: Methaemoglobinaemia. Use with caution if taking medicines that may cause methaemoglobinaemia eg sulfonamides, nitrates				
Management of associated emergency: Consult MO/NP. See Anaphylaxis, p. 80 [3]				

S4	Lidocaine			Extended authority ATSIHP/IHW/IPAP/RIPRN/SRH
ATSIHP, IHW, IPAP, MID and RN must consult MO/NP (or administer on current medication order)				
RIPRN and SRH may proceed				
Form	**Strength**	**Route**	**Dose**	**Duration**
Injection	1% 50 mg/5 mL	IM	0.5 mL	stat To reduce injection pain of Bicillin L-A
Preparation: Transfer the Bicillin L-A® dose to a 3 mL syringe then draw up 0.5 mL of lidocaine 1%. Do not mix, to allow the lidocaine to be injected first. For detailed instructions, see *ARF and RHD guidelines* https://www.rhdaustralia.org.au/arf-rhd-guidelines				
Offer CMI: It will hurt as it goes in. Report drowsiness, dizziness, blurred vision, vomiting or tremors				
Management of associated emergency: Ensure resuscitation equipment readily available. Consult MO/NP. See Anaphylaxis, p. 80 [1,2]				

Ventrogluteal injection

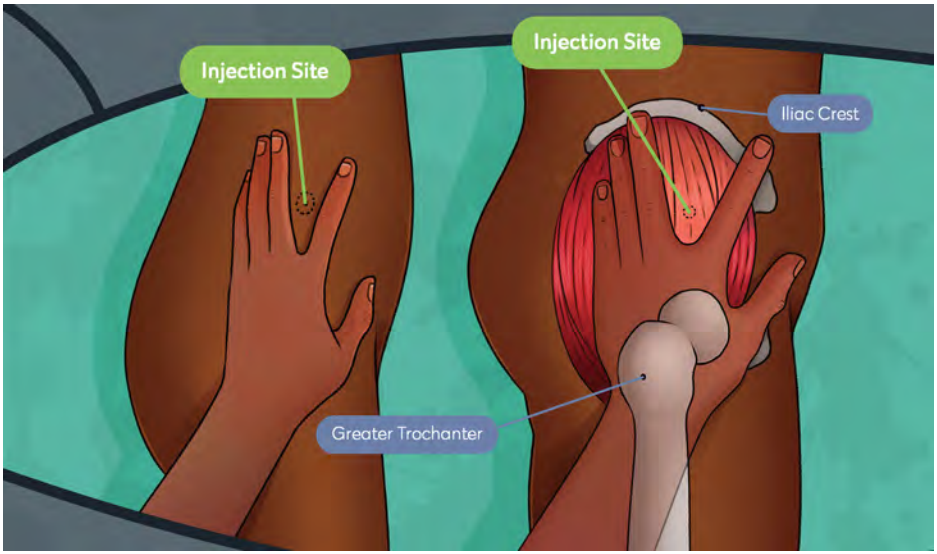

Image used with permission of Rheumatic Heart Disease Program, Qld Health

Technique[1,2]

- Place patient in a side-lying position
- Use your right hand on the patient's left hip; or left hand on the patient's right hip:
  - place palm of your hand on the greater trochanter, thumb towards pelvis/abdomen
  - place your index finger towards the front (anterior superior iliac spine) + fan the middle finger as far along the iliac crest as you can reach
- The injection site is in the middle of the triangle between the middle and index fingers
- See video - *Ventrogluteal injection technique* https://www.youtube.com/watch?v=BlO_hojT5ik&feature=youtu.be