H&H Care SA Pty Ltd	**Form12.** Recognising Deterioration and Emergency Response **Australian Government Support at Home Program**	
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Policy and procedure 12
H&H Care SA Pty Ltd | Support at Home services

This policy explains how H&H Care SA recognises changes in a client's physical, cognitive or psychological condition, obtains timely help and maintains safe care. In an emergency call 000 first. Do not wait for a manager, family member or registered provider to give permission.

Document control	Details
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Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Managers, nurses, coordinators, workers and approved contractors delivering home and community services

1 Purpose and scope

Deterioration is a change that may indicate worsening health, function or wellbeing. It may be sudden or gradual, physical, cognitive or psychological. Workers must notice changes from the person's usual condition, take concerns seriously and escalate within their role. A client's or carer's concern that something is wrong can itself justify review.

This policy applies to Support at Home services delivered on behalf of The Fig Trees and other approved registered providers. It supports their clinical governance and emergency arrangements without assuming their statutory responsibilities. It does not replace first aid training, authorised clinical instructions, medication procedures or professional judgement.

2 Responsibilities

Workers observe, seek consent, provide first aid within training, call for help and document actual events. They must not diagnose, prescribe or change treatment independently. The RN assesses and advises within scope, establishes individual clinical triggers and referrals, and confirms delegation and supervision. EN practice requires appropriate RN supervision. The Coordinator ensures contact cover, continuity and direct communication with the registered provider.

The Director provides resources, training, competent staffing, verified escalation cover and oversight. Agree The Fig Trees' clinical, after-hours and incident contacts in writing. A management title, past medical experience or family relationship does not confer current clinical authority or replace emergency services.

Baseline assessment and early recognition

3 Establish the person's usual condition

At assessment and after relevant changes, record usual communication, cognition, mobility, intake, continence, breathing, mood, skin, pain and daily function as relevant to the service. Obtain current clinical plans, allergies, medication support role, emergency contacts and client preferences. Record sources and dates rather than assuming an old referral remains accurate.

The RN or relevant treating practitioner specifies any required observations, equipment, frequency, expected ranges, escalation thresholds and contact sequence. Use clinical tools only where appropriate to the setting and staff competence. Do not invent universal vital-sign limits or assume an apparently normal reading overrides concerning symptoms.

4 What workers should notice

Area	Examples of change requiring attention
Breathing and circulation	New breathlessness, altered breathing, chest discomfort, paleness, sweating, unusual fatigue or swelling.
Brain and communication	Sudden confusion, drowsiness, fainting, new speech difficulty, weakness, seizure activity or reduced responsiveness.
Function and mobility	New inability to stand or transfer as usual, falls, reduced walking, increased assistance or marked decline in daily activity.
Intake and elimination	Reduced eating/drinking, vomiting, diarrhoea, difficulty swallowing, reduced urine or change in bowel pattern with other concerns.
Pain skin and infection	New or worsening pain, feverishness, shivering, wound changes, skin damage, bleeding or a new rash.
Mood and behaviour	New withdrawal, agitation, severe distress, unusual beliefs or behaviour, threats of harm or concern about immediate safety.
Client or carer concern	The person says they feel different, unwell or unsafe; a carer reports a meaningful change from usual condition.

These are prompts, not diagnostic criteria or an exhaustive list. Older people may become seriously unwell without typical symptoms or fever. New confusion is not automatically dementia or a urinary infection; arrange clinical assessment. Do not dismiss decline as ageing, attention seeking or a challenging personality.

5 Check and act within competence

Pause the activity, speak to the client and note onset, symptoms, usual condition and current safety. Obtain only observations you are trained and authorised to take. Do not delay help while completing a full assessment or obtaining equipment. Ask the RN for review when uncertain; call 000 for serious danger or rapid worsening.

Emergency signs and escalation levels

6 Call 000 for an emergency

Examples requiring immediate emergency response include:

- Unresponsiveness, absent or abnormal breathing, collapse, severe breathing difficulty or inability to speak because of breathlessness.
- Suspected stroke: sudden face weakness, arm weakness or speech change; note when the person was last known well, even if symptoms improve.
- Suspected heart attack or other serious chest symptoms, particularly pressure or pain with sweating, breathlessness, nausea or collapse. Do not wait for a fixed duration when concerned.
- Severe bleeding, serious injury, suspected major head/spinal injury, severe allergic reaction, choking with inability to breathe effectively, suspected poisoning or overdose.
- A seizure lasting five minutes, repeated seizures without recovery, a first seizure, serious injury or breathing difficulty; follow an individual plan that may require earlier escalation.
- An immediate threat of serious harm to self or others, severe mental distress with danger, or another rapidly worsening or life-threatening situation.

This list is not exhaustive. If you believe there is an emergency, call 000 and describe the facts. Do not postpone because family says to wait, the RN is unavailable, the client cannot pay, the visit is almost over or funding approval is unclear.

7 Urgent and non emergency changes

For new concerning symptoms without immediate emergency signs, directly contact the RN or designated clinician promptly and arrange review at the urgency advised. New confusion, significant reduction in intake or urine, possible infection, worsening pain or loss of function should not be left until a routine future review. The RN determines the clinical response, including urgent GP or emergency referral.

For a gradual, stable change without urgent concerns, notify the Coordinator and RN as appropriate during the same service period and arrange a documented review and follow-up. If symptoms worsen or you cannot obtain timely clinical advice, escalate to the next contact or emergency services according to risk. Do not leave an unwell person without an agreed safe arrangement.

The healthdirect nurse advice line, 1800 022 222, is available 24 hours for non-emergency advice if the usual clinical pathway is unavailable or advice is needed. It does not replace 000 for an emergency or H&H Care's management responsibilities. An unattended voicemail, app alert or email is not a completed urgent escalation.

Immediate emergency response and first aid

8 Emergency response procedure

- Check for danger to yourself, the client and others. Stop unsafe tasks and call 000 for ambulance, police or fire as needed. Give the exact location, access details, client condition and callback number; use speakerphone where practical.
- Follow dispatcher instructions and current first aid training. Send another person for assistance or an AED if available without delaying essential care. Do not leave the person alone simply to fetch equipment.
- If unresponsive and not breathing normally, start CPR and use an AED if available, subject to a clearly applicable lawful treatment limitation. Do not delay CPR to search for records or seek routine permission. If unable or unwilling to give breaths, provide chest compressions and follow dispatcher advice.
- If unresponsive but breathing normally, maintain the airway and use appropriate positioning under first aid or dispatcher guidance, considering injury. Continue checking breathing; abnormal gasps are not normal breathing.
- Notify the H&H manager and RN after emergency help is activated, or ask another person to notify them. The Coordinator promptly alerts the registered provider and appropriate client contact on a lawful, safe basis.
- Stay with the client where safe, provide reassurance and monitor within competence until a competent responder accepts handover or a safe alternative is agreed. Arrange support for other dependent people if needed.
- Give responders relevant current information, confirm handover and document times, observations, actions, advice, outcome and remaining responsibilities.

9 Condition specific boundaries

For seizures, protect from injury, time the event, do not restrain and do not put anything in the mouth. Follow the individual seizure plan and current first aid training. Emergency rescue medicine may be given only under valid instructions, appropriate authority and demonstrated competence; it must not delay an emergency call when indicated.

For swallowing or consciousness concerns, do not give oral food, drink or medicines unless appropriate under authorised instructions and first aid guidance. Treat severe choking under current training and dispatcher directions. Do not perform blind finger sweeps or improvise an untrained procedure.

For falls, do not automatically lift the person up. Check immediate safety and obtain appropriate assessment; call 000 for serious injury or emergency concerns. Use the assessed transfer plan and suitable equipment, not an unsafe manual lift. For diabetes, allergy or other conditions, follow the current individual action plan and emergency directions rather than making up doses or treatment.

Workers must not independently give oxygen, change medication doses, administer injections or use other clinical interventions outside their authorised role, plan and competency. This policy is not a clinical prescription or complete first aid manual.

Consent advance care planning and continuing care

10 Consent refusal and advance care documents

Explain the concern and proposed help in accessible language and support the client's decision. A capable person may refuse assessment or treatment. Do not force care; promptly seek RN or emergency advice, explain material risks without coercion, document the discussion and agree the safest available follow-up. Sudden confusion or impaired communication requires decision-specific assessment, not an assumption that family may decide everything.

At intake, ask about advance care directives, clinician treatment or resuscitation plans and palliative arrangements where relevant. The RN verifies current documents and obtains clarification from the treating team, including how workers locate and apply them in an emergency. Record the actual scope, source, date and accessibility. Do not create a no-resuscitation instruction from age, diagnosis, family preference or a general care plan.

Respect a valid and applicable treatment refusal or limitation under South Australian law and authorised clinical guidance. A limitation on CPR does not automatically mean no symptom relief, no treatment or no ambulance. If applicability or instructions are unclear, call 000, explain the uncertainty and provide appropriate first aid while obtaining urgent clinical guidance; do not delay help searching for documents.

11 Palliative and expected deterioration

A planned end-of-life pathway requires current clinical instructions, symptom and escalation plans, authorised medicines, available professional support and clear after-hours contacts. Workers support comfort and choices within role. Expected deterioration must not become a reason to ignore new distress, unsafe care or a treatable problem. Use the planned clinical pathway when clearly appropriate, with 000 for an emergency not adequately addressed by the plan or when urgent help is unavailable.

12 Handover documentation and review

Use structured handover: identify the client and current situation; give relevant baseline, diagnoses and allergies; state onset, last known well where relevant, actual observations and actions; request the required response and confirm who accepts follow-up. Send current plans and verified medication information as appropriate, not a list reconstructed from memory.

Record symptoms and onset, observation times and values actually taken, contact attempts, advice and read-back, emergency arrival, transfer destination and client response. Notify the registered provider promptly and follow Policy 9 for incident/SIRS assessment where relevant. Deterioration or hospital transfer is not automatically a reportable incident, but care omissions, neglect or other qualifying circumstances may be.

After discharge or significant change, obtain updated clinical instructions, reassess risks and confirm staffing, equipment and medication information before affected services resume. Assign and track follow-up; a referral or phone message alone does not verify care occurred. Review the event with the client and professionals, update the plan and use open disclosure if something went wrong.

Deterioration observation and escalation record

EMERG F01 | Record facts and actual observations. Do not delay emergency assistance or direct contact while completing this form.

Client and identifier: _____
Date location and worker role: _____
Current care or clinical plan reference: _____
Usual condition relevant to concern: _____
_____
Change observed or reported and source: _____
_____
Onset/time first noticed and last known well if relevant: _____
Client's words and wishes: _____

Actual observations within competence

Time	Observation value units and method	Action or change
_____	_____	_____
__	_____	_____
_____	_____	_____
__	_____	_____
_____	_____	_____
__	_____	_____

Emergency signs and immediate response: _____
_____
000 called/time/reference if available: _____
RN or clinician contacted and time: _____
Advice instructions read-back and implementation: _____
_____
If no response escalation and outcome: _____
Manager and registered provider notified/time: _____
Client contact informed or reason not appropriate: _____

Handover and outcome

Receiving professional role and time accepted: _____
Transfer destination or safe ongoing arrangement: _____
Client condition/outcome: _____
Outstanding action owner and required time: _____
Incident/case note reference: _____
Author authentication and entry time: _____

Individual deterioration and emergency plan

EMERG F02 | Complete with the client, Clinical Lead RN, treating professionals and registered provider as appropriate. Clinical thresholds and treatment instructions require qualified authorisation; this blank form is not a treatment order.

Client name identifiers and address: _____
Plan author role date/version: _____
Communication needs and chosen supporter: _____
Baseline condition and relevant diagnoses: _____
Allergies and current clinical plan references: _____

Change or trigger	Required response and timing	Responsible contact and backup
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____

Required observations frequency equipment and authorised role: _____
_____
Individual medication/rescue plan reference if applicable: _____
Advance care or resuscitation document location and verification: _____
_____
Emergency access and hazards: _____
Essential care or equipment outage contingency: _____

Verified contacts and cover

Emergency ambulance police or fire: 000
RN/clinical contact and hours: _____
Clinical backup if unavailable: _____
GP/treating service: _____
H&H manager/on-call and coverage hours: _____
The Fig Trees/provider and after-hours contact: _____
Client-chosen emergency contact and agreed role: _____
Palliative/specialist contact if relevant: _____

Client involvement consent or authority: _____
Clinical approval and role: _____ Date: _____
Coordinator readiness check: _____ Date: _____
Provider coordination confirmed: _____
Workers briefed and current copy location: _____
Review date and earlier triggers: _____

Call 000 for an emergency. Do not wait for manager approval. Read this plan alongside current clinical documents and applicable lawful treatment limitations.

Readiness training governance and references

13 Service readiness and training

Before accepting relevant care, confirm client-specific emergency plans, staff competence, safe equipment and clinical cover. Maintain first aid and CPR training appropriate to duties, current competency evidence and practice in calling for help, structured handover, falls, seizure and deterioration scenarios. Workers must know where instructions and backup contacts are held during an app or power outage.

The RN sets any client-specific observation requirements and validates that workers can use devices and interpret escalation instructions within role. Maintain equipment according to instructions and check availability and function. A written policy or training attendance alone does not establish competence for clinical tasks.

14 Monitoring and improvement

As internal controls, the Coordinator checks unresolved urgent escalations each service day and more frequently according to risk, confirming professional receipt and action. Management reviews emergency events, delayed recognition, unanswered contacts, transfers and client feedback monthly and audits a risk-based sample quarterly. Test contact and downtime arrangements at least annually and after significant changes.

Use incident review to identify delays, communication gaps, task omissions, missing plans or inadequate cover. Assign actions, owners and due dates and verify effectiveness. Share relevant lessons and plan changes with workers and The Fig Trees while protecting confidentiality. Review this policy annually and after serious events or changes to guidance or service scope.

15 References and related policies

Policies 1 to 11; clinical governance, medication, condition-specific plans, falls/manual handling, first aid, infection prevention and business continuity. Apply the Aged Care Act 2024 and Rules 2025, relevant professional standards, South Australian consent and advance care law, privacy and WHS requirements, and the current brokerage agreement.

- Commission — Standard 5 Clinical care, including recognition and response to deterioration. https://www.agedcarequality.gov.au/strengthened-quality-standards/clinical-care
- Australian Commission on Safety and Quality in Health Care — Recognising and Responding to Acute Deterioration Standard. Use as practice guidance adapted to home care, not a claim that H&H is hospital-accredited. https://www.safetyandquality.gov.au/national-standards/nsqhs-standards/recognising-and-responding-acute-deterioration-standard
- ANZCOR — Guideline 8 Cardiopulmonary Resuscitation. https://www.anzcor.org/home/basic-life-support/guideline-8-cardiopulmonary-resuscitation-cpr
- healthdirect — Calling triple zero and health advice. https://www.healthdirect.gov.au/healthcare-and-services/emergency-and-urgent-care/calling-triple-zero
- Epilepsy Foundation — Seizure first aid. https://epilepsyfoundation.org.au/understanding-epilepsy/seizure-first-aid/
- SA Government — Advance care directives. https://www.sa.gov.au/topics/family-and-community/planning-ahead/advance-care-directives

Official guidance and advice contacts checked 24 October 2026. Confirm current first aid guidance and client-specific instructions. This policy does not replace accredited practical training or authorise independent treatment.

Director approval: _____ Clinical Lead RN approval: _____
Effective date: _____ Next review: _____
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