Appendices
Best possible medication history (BPMH) 3-4

- 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/

### 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
- Where there are discrepancies, ask patient ± advise the MO/NP
- Check a medication reference if unsure about a medicine

### Step 4

**Record the information on the medical record**
- On the designated form or in the electronic medical record
- Document allergies + any recent change(s) 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

- Prescription medicines
- Sleeping tablets
- Inhalers, puffers, sprays, sublingual 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
- Social and recreational drugs
- Intermittent medicines eg weekly or twice weekly
- Refrigerated medicines

**High risk medicines** - Anti-infectives, Potassium and other electrolytes, Insulin, Narcotics and other sedatives, Chemotherapeutic agents, Heparin, enoxaparin, warfarin and 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
- If neonatal death or stillbirth - MO will advise. Also see Qld Clinical Guideline Stillbirth care https://www.health.qld.gov.au/qcg/publications#maternity

Background
- Also see Information for health professionals (Qld) https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/92868/m-osc-fs-information-for-health-professionals.pdf

Confirm deceased by checking all the following $^{1,2}$
- 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

Is this a reportable death
See Life extinct form for full definitions

No
- Contact MO + local clinic management, who will advise ongoing management

Yes or unsure
- Offer condolences to the family + consider/support their needs/wishes about viewing the body$^3$

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

Immediately report to local Police + contact MO:
- Until advised do NOT: $^{1,3}$
  - move the body. Note: if in public place cover body with sheet + protect dignity of the deceased
  - remove medical equipment eg IVCs, catheters
- Notify local clinic management + next of kin (if known/appropriate)
- 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

| Primary Clinical Care Manual 11th edition |

#### A
Alert

#### V
Responds to voice

#### P
Responds to painful stimuli

#### U
Unresponsive

<table>
<thead>
<tr>
<th>Glasgow Coma Scale (GCS)(^1,2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eyes open</strong></td>
</tr>
<tr>
<td>Spontaneous</td>
</tr>
<tr>
<td>To speech</td>
</tr>
<tr>
<td>To pain</td>
</tr>
<tr>
<td>No response (C= eyes closed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Child/infant</strong></th>
<th><strong>Non verbal person (child/infant/adult)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientated</td>
<td>5</td>
</tr>
<tr>
<td>Alert, babbles, coos, words to usual ability</td>
<td>Spontaneous normal facial/oro-motor activity</td>
</tr>
<tr>
<td>Confused</td>
<td>4</td>
</tr>
<tr>
<td>Less than usual words, spontaneous irritable cry</td>
<td>Less than usual ability/response to touch only</td>
</tr>
<tr>
<td>Inappropriate words</td>
<td>3</td>
</tr>
<tr>
<td>Cries only to pain</td>
<td>Vigorous grimace to pain</td>
</tr>
<tr>
<td>Incomprehensible sounds</td>
<td>2</td>
</tr>
<tr>
<td>Moans to pain</td>
<td>Mild grimace to pain</td>
</tr>
<tr>
<td>No response (T=tracheostomy)</td>
<td>1</td>
</tr>
<tr>
<td>No response to pain</td>
<td>No response to pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Child/infant/non verbal person</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Obeys commands</td>
</tr>
<tr>
<td>Spontaneous or obeys verbal commands</td>
</tr>
<tr>
<td>Localises to pain</td>
</tr>
<tr>
<td>Withdraws from pain</td>
</tr>
<tr>
<td>Flexion to pain (decorticate)</td>
</tr>
<tr>
<td>Extension to pain (decerebrate)</td>
</tr>
<tr>
<td>No response</td>
</tr>
</tbody>
</table>

#### GCS total/15

- Always act on: score ≤ 15 or drop of ≥ 2
- If ≤ 8 requires secured airway. Consider LMA, p. 56 until patient can be intubated
Injection pain

HMP Managing injection pain

Non-pharmacological strategies

- 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
    - CoolSense® - use Buzzy® for 60 seconds first, then CoolSense® for 10 seconds, then Buzzy® as above
    - other device eg Shot Blocker® - piece of plastic shaped to fit around the injection site and press the skin with multiple, small, blunt bumps to ‘saturate sensory nerves’
- Distraction techniques eg electronic games, videos
- Refrigerate needle prior to injection
- Allow the syringe to reach room temperature before use
- Injecting slowly eg over 2–3 minutes - be guided by the patient

Pharmacological strategies

- 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 highly distressed consider consulting MO/NP/RHD (Qld) 1300 135 854 or state/territory RHD control program for other options
- Note: The Australian ARF/RHD guideline provides guidance for lidocaine (lignocaine) injected with Bicillin LA® as an option. This is not currently supported in Qld

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<table>
<thead>
<tr>
<th>S2</th>
<th>Lidocaine (lignocaine) + prilocaine Emla®</th>
<th>Extended authority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NIL</td>
</tr>
</tbody>
</table>

MID, RIPRN and RN may proceed

<table>
<thead>
<tr>
<th>Form</th>
<th>Strength</th>
<th>Route</th>
<th>Dose</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cream</td>
<td>Lidocaine 2.5% / Prilocaine 2.5%</td>
<td>Topical</td>
<td>Adult and child &gt; 6 months</td>
<td>Leave on skin for 1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Squeeze about 3.5 cm from tube onto intact skin and cover with an occlusive dressing OR apply 1 patch</td>
<td>Remove prior to injection</td>
</tr>
</tbody>
</table>

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. 82
**Ventrogluteal injection**

**Injection site**

- Anterior superior iliac spine
- Iliac crest
- Gluteus medius
- Greater trochanter

**Technique**

- 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:
  - with the palm of your hand, locate the greater trochanter of the femur
  - place your index finger towards the front or anterior superior iliac spine + fan the middle finger as far along the iliac crest as you can reach. The thumb should be pointed towards the front of the leg
- The injection site is in the middle of the triangle between the middle and index fingers
- Remove your fingers prior to inserting the needle
- See video - *Ventrogluteal injection technique*
  [https://www.youtube.com/watch?v=BlO_hojT5ik&feature=youtu.be](https://www.youtube.com/watch?v=BlO_hojT5ik&feature=youtu.be)