NDIS LWB 5631 Spinal Injury – Autonomic Dysreflexia - Protocol

- This Autonomic Dysreflexia Protocol must be developed with the person we support and their Health Practitioner.
- The Autonomic Dysreflexia Protocol must be overseen by the Health Practitioner.
- **Staff members must be appropriately trained to administer or dispense medication and undertake any Autonomic Dysreflexia Procedures.**
- This Autonomic Dysreflexia Protocol should be read in conjunction with the relevant policies and procedures.

Personal Details *(to be completed by staff & person we support)*			
Name:		**CIRTS ID:**	
Date of Protocol:		**Review Date:**	

My Support includes (tick all that apply) and who undertakes this:				
Procedure	**Me**	**LWB DSW**	**Health Professional**	**Other**
☐ Blood Pressure Monitoring	☐	☐	☐	
☐ Emergency medication administration (refer to PRN Protocol)	☐	☐	☐	
☐ Catheter	☐	☐	☐	
☐ Bowel Care	☐	☐	☐	

Specific Autonomic Dysreflexia Information (*completed by a Health Professional*)			
Neurological location of Injury:			
Baseline Blood Pressure Rate of the person we support:			
Baseline Body Temperature of the person we support:			
Note regarding Blood Pressure:	20mm to 40mm Hg above baseline in adults may be a sign of Autonomic Dysreflexia	15mm to 20mm Hg above baseline in adolescents may be a sign of Autonomic Dysreflexia	15mm Hg above baseline in children may be a sign of Autonomic Dysreflexia

Common causes specific to me *(Completed by Health Professional)*	
☐ bladder can be blocked (urinary catheter) ☐ kidney stones ☐ urinary tract infection ☐ constipation or administration of enema ☐ faecal impaction or administration of enema	☐ pressure injuries ☐ haemorrhoids ☐ Other:

Symptoms and signs specific to me *(Completed by Health Professional)*	
☐ sudden hypertension (high blood pressure) ☐ pounding headache ☐ bradycardia (slow heart rate) ☐ flushing or blotching of the skin above the level of the spinal cord injury ☐ profuse sweating above the spinal cord injury level ☐ sense of apprehension or anxiety	☐ shivering and chills with no temperature ☐ nasal congestion ☐ blurred vision ☐ shortness of breath ☐ pale skin tone and goose bumps below the level of spinal cord injury ☐ irritability or change in behaviour

Checking Blood Pressure intervals *(Completed by Health Professional)*

If symptoms persist, monitor Blood Pressure every minutes and record on the NDIS LWB 5595 Blood Pressure Monitoring - Recording Chart.

Administer Emergency Medication *(Completed by Health Professional)*

Administer Emergency Medication as per PRN Protocol when Blood Pressure is at

Details about any specific changes or preferences staff must know in order to support the person with this procedure: *(Completed by the Health Professional)*

☐ Not Applicable, the person's supports do not require any modification.

☐ Modifications are required as follows:

In the event of an emergency call an ambulance immediately on triple zero (000)

<u>After</u> calling an ambulance, call the following emergency contacts *(Completed by the person we support or their support network)*:			
Name:		**Contact Number**	
Relationship			
Name:		**Contact Number**	
Relationship			

Protocol developed by: *(completed by Health Professional(s))*			
Name:		**Profession:**	
Contact details:		**Date:**	
Name:		**Profession:**	
Contact details:		**Date:**	

Review of protocol *(completed by Health Professional)*		
☐ **Set review:**	**Date:**	
Signature:		

☐ **As needed review:** This protocol will be reviewed following

- a problem being identified while following this protocol
- a new risk being identified
- advice from the person's GP/ Allied Health Professional

Consent and Authorisation

I consent to the support requirements detailed in this protocol to be implemented to assist in the management of my health supports or receive general emergency response as required. If I am unable to give consent, LWB will seek consent from my guardian/person responsible.

Name	**Relationship**	**Signature**	**Date**
	Self		

	Guardian / Person Responsible		
	LWB Line Manager		

Staff Declaration

All staff who work with this person to sign along with AQHP conducting Skills Assessment					
I have read and understood this Protocol and have received training relevant to the person's support needs and I agree to implement the attached protocol.					
Staff Name	Signature	Date	AQHP Name	Signature	Date

Upload to CIRTS as follows:
Plans & Assessments > New Plan > Service Type = the service providing the HIDPA > Plan name – [select from drop down] Autonomic Dysreflexia Management Protocol > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD