# NDIS LWB 5631 Spinal Injury – Autonomic Dysreflexia - Plan

- This Autonomic Dysreflexia Plan must be developed with the person we support and their Health Practitioner.
- The Autonomic Dysreflexia Plan 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 Plan should be read in conjunction with the relevant policies and procedures.

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

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

| **Risks and Emergency Response** |
|---|
| **Risks** |
| **When to call an ambulance** |
| **When to seek medical assistance** |

| **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)<br>☐ kidney stones<br>☐ urinary tract infection<br>☐ constipation or administration of enema | ☐ faecal impaction or administration of enema<br>☐ pressure injuries<br>☐ haemorrhoids<br>☐ Other: |
| **Symptoms and signs specific to me** *(Completed by Health Professional)* | |
| ☐ sudden hypertension (high blood pressure)<br>☐ pounding headache<br>☐ bradycardia (slow heart rate)<br>☐ flushing or blotching of the skin above the level of the spinal cord injury<br>☐ profuse sweating above the spinal cord injury level<br>☐ sense of apprehension or anxiety | ☐ shivering and chills with no temperature<br>☐ nasal congestion<br>☐ blurred vision<br>☐ shortness of breath<br>☐ pale skin tone and goose bumps below the level of spinal cord injury<br>☐ 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 the NDIS LWB 5411 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 plan:** *(Completed by the Health Professional )*

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

☐ Modifications are required as follows:

**After 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** | | | |

**Plan developed by:** *(completed by Health Professional(s))*

| | | | |
|---|---|---|---|
| **Name:** | | **Profession:** | |
| **Contact details:** | | **Date:** | |
| **Name:** | | **Profession:** | |
| **Contact details:** | | **Date:** | |

**Review of plan** *(completed by Health Professional)*

| | | |
|---|---|---|
| ☐ **Set review:** | **Date:** | |
| **Signature:** | | |

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

- a problem being identified while following this plan
- 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 plan 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** | | |

## 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 Plan > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD