Revised RAN Model Of Consultation

Authors

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We acknowledge the traditional custodians of their lands upon which we walk, reside, and work. We pay our respects to First Nations peoples and to the traditional custodians of the lands we're meeting on today, Whadjuk people of the Nyoongar nation.

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Why a RAN Model of Consultation?

- Key difference between RANS and other nurses is the everyday client consultation
- Estimated at about 80-85% of a RAN role
- Was developed to ensure comprehensive, systematic and person-centred care and to mitigate risk to the client, the nurse and the health service.
- Designed to provide evidence based, culturally informed care, standardise RAN consultation best practice and improve the health outcomes of their clients.

Why a RAN Model of Consultation?

A 22-year-old Aboriginal woman taken into custody 2 August 2014 at South Hedland Police Station for unpaid fines totaling $3,622.00

- Reviewed at Hedland Health Campus
  - 2 August: Rib pain, assessed as "Behavioural problem"
  - 3 August: "Sore all over", tachycardic, afebrile, no CXR
- Died 4 August 2014 of overwhelming sepsis
  - Pneumonia and osteomyelitis of previous rib fracture

An 18-year-old Aboriginal woman presented at a remote clinic with a painful left ankle

- Assessed as having a sprained ankle.
- Treated with RICE protocol
- Later diagnosed with Rheumatic heat disease

Principles Mapped Against the Rural and Remote Nursing Generalist Framework 2023–2027

1.1 Safety and Quality
1.2 Critical Reflection
1.3 Advocacy

2.1 Culturally Safe Quality Care
2.2 Evidence-Based Ethical Practice
2.3 Technology Enabled Practice & Care

3.1 Effective communication
3.2 Collaborative Holistic Care
3.3 Professional Practice

4.1 Care of Self and Others
4.2 Lifelong Learning
4.3 Accountability to Self and the Profession

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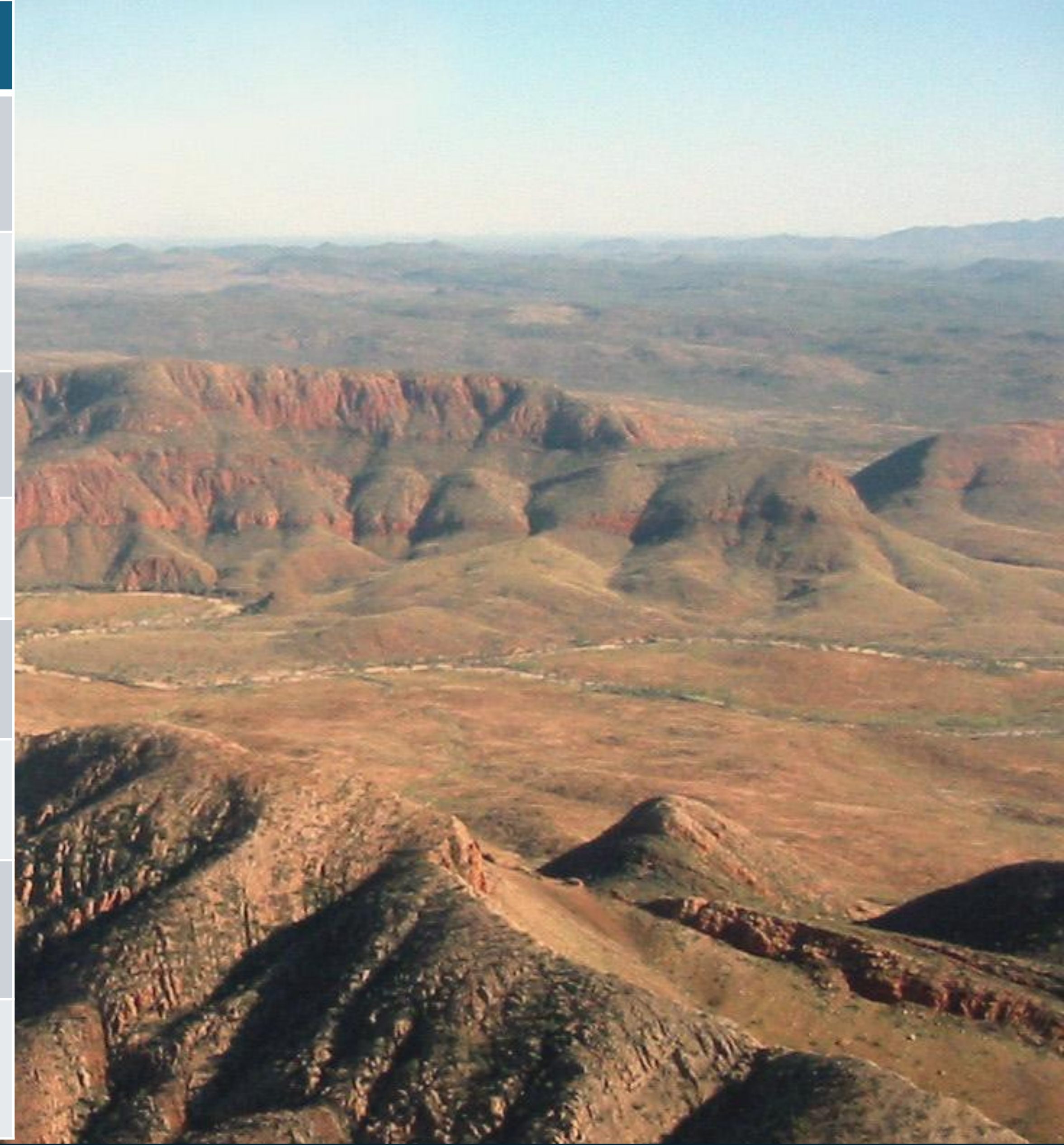
STEPS
1. Open consultation
2. History
3. Clinical examination
4. Assessment and Discussion
5. Negotiate a management plan
6. Close consultation
7. Documentation
8. Reflection



1. Open Consultation

Before seeing client

- Review clinic records, note last visit & outstanding actions and review past investigations
- Get more information if needed
- Ensure room is comfortable, well lit, private
- Ensure appropriate equipment
- Consider own & client's safety

Seeing client, If not an emergency

- Greet, establish rapport.
- Note general impressions - appearance, speech, hearing, gait, posture, symmetry, tremors, odour, colour, skin, hands, mental state
- Observe interaction with others
- Check name, chart number, DOB, next-of-kin, need three identifiers.
- Use appropriate language
- If appropriate
  - Offer interpreter if necessary
  - Gendered health professional if available
  - Involve family if appropriate

2. History

Reason for presentation Acute / chronic disease review / screening
Story of why the client presented today
Opening question “Why have you come in today?” Use silence appropriately to hear responses.
Establish concerns and expectations
OLDCARTS (onset, location, duration, aggravating / relieving factors, treatments, associated signs & symptoms)
Explain what you are doing/thinking, why you need to ask more questions
Listen actively, encourage openness, don’t interrupt.
Ask if they been doing anything differently lately, travel work, activities
If you can’t work it out – work backwards “what where they doing, what did they eat /drink that morning, last night, yesterday

2. History – OLDCARTS

Onset — when did it start?
Location — where does it hurt, where is the problem
Duration — how long, have they had it before, what happened then
Characteristics — description of symptom/s
Aggravating factors — what makes it worse
Relieving factors – what makes it better
Treatments — what have they tried and was it effective
Signs and symptoms (other)

2. HISTORY – OTHER

CURRENT HEALTH STATUS

- Appetite, nausea, change in weight.
- Sleep, energy, physical activity.
- Smoking/alcohol/other substance use - readiness to quit if indicated.
- Urine, bowels, menstruation, sexual health
- Interest in life, emotional health/anxiety, self-harm, ‘do you ever feel unsafe’.

MEDICINES

- Prescribed — what, when, how long, any problems.
- Do they take medications as prescribed.
- Over-the-counter, herbal, traditional, other people’s medications
- Contraception (if appropriate)
- Asks about any concerns about medications

ALLERGIES — what happens when exposed, and how are allergies managed

IMMUNISATIONS — review status

Past medical and surgical history, if not known ask

Family medical history, If not known ask.

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STEP 3. Clinical Examination

Rapid Physical Assessment

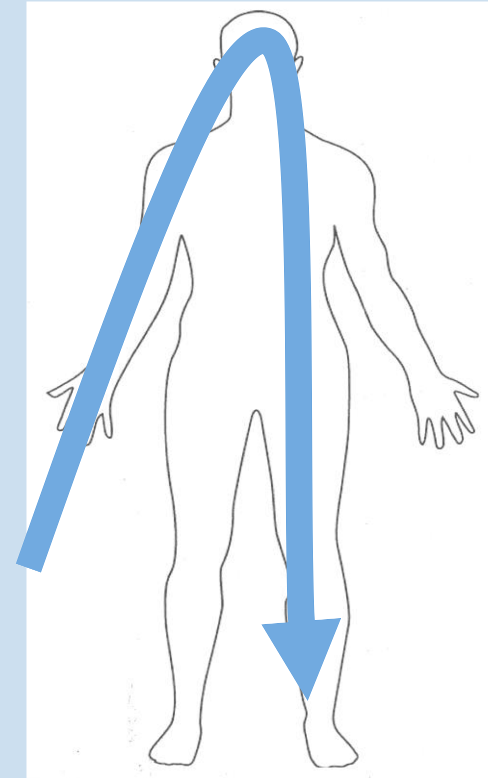
1. Look at client and determine general appearance, gait, facial expression and speech.
2. Record temperature, pulse, respiration, blood pressure and oxygen saturation rate.
3. Examine nails, (clubbing) hands (tremor), and arms (cool peripheries).
4. Inspect scalp, eyes and ears.
5. Inspect mouth, tongue and teeth.
6. Check neck and cervical lymph nodes.
7. Auscultate heart sounds, anterior breath sounds, palpate and percuss chest.
8. Lean patient forward and auscultate posterior breath sounds, palpate and percuss chest.
9. Lie patient flat and inspect, auscultate, percuss and palpate abdomen.
10. Inspect/palpate both legs for perfusion, pulses and oedema.
11. Inspect feet – check colour, warmth, movement and sensation, pulses and lesions

Incorporate Targeted system examination LOOK, LISTEN FEEL

Ear / Eye / Cardiovascular / Respiratory / Gastrointestinal and Genitourinary / Musculoskeletal/ Nervous / Mental Health

Screening tests as indicated including BGL, Hb, BMI, waist circumference, U/A, pregnancy test, ECG and other point-of-care tests

If client consents and timing appropriate, consider screening investigations as indicated by history, local epidemiology and age/place/risk.



- Smooth execution
- Patient comfort
- Start with least invasive part of body i.e., hands and move on

4. Assessment & Discusssion

<table>
<tr><td>Make an assessment for
• Reason for presentation</td><td colspan="3">• Other Health Problems</td></tr>
<tr><td colspan="4">Consider - Age / place / risk
eg Remote Indigenous population common conditions: Acute rheumatic fever (ARF), bronchiectasis, anaemia, diabetes, chronic kidney disease (CKD), cardiovascular disease</td></tr>
<tr><td>Red flags: What can't I afford to miss?
Important, but (perhaps) uncommon
Rule in / rule out</td><td colspan="3">Serious infection Meningococcal disease / Septicaemia Cardiovascular / Cancer / Ectopic pregnancy / ARF</td></tr>
<tr><td>What is often missed?
• Endocarditis
• ARF</td><td colspan="3">• Early pregnancy
• Anaemia
• Post-streptococcal glomerulonephritis (PSGN)</td></tr>
<tr><td colspan="4">What is most likely?</td></tr>
<tr><td>Is the patient trying to tell me something?</td><td>• Domestic Violence</td><td>• Child Abuse</td><td>• Stress.....financial / family</td></tr>
<tr><td colspan="4">Consult best practice treatment manuals</td></tr>
<tr><td colspan="4">Seek further advice remote medical practitioner or more experienced team member</td></tr>
<tr><td colspan="4">Summarise and reflect findings with client</td></tr>
<tr><td colspan="4">Explore client's knowledge and clarify misunderstanding—use 'teach-back' method as appropriate</td></tr>
<tr><td colspan="4">Discuss long-and short-term goals</td></tr>
<tr><td colspan="4">Assess and use opportunities for brief intervention and health promotion</td></tr>
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Critical Thinking

- Ability to critically think, analyse data and demonstrate clinical reasoning.
- History (including past history) informs examination.
- Considers what is most likely, clinically significant conditions and what you cannot afford to miss.
- Rules in and out as required, including worst case scenario or what you can't afford to miss.
- Identify red flags.
- Recognises risk and the deteriorating patient.

Avoiding Diagnostic Errors

- Premature closure—once you think you have the answer you stop looking.
- Failure to consider all diagnostic possibilities.
- Affective error—personal feelings (positive or negative) about a patient to affect clinical decisions.
- Focusing on the presenting complaint and ignoring other health issue

"More is missed by not looking than by not knowing"
Thomas McCrae (1870 – 1935), Canadian physician

5. Negotiate Management Plan

Important to negotiate, not just tell
Review best practice treatment manuals for management guidelines
Discuss goals/priorities including immunisation, negotiate management including referrals with client and significant others as appropriate
Confirm management plan is acceptable to client and family, including what to expect, what do if gets better or gets worse
Advocate for client as appropriate with health and other services
Consider context and environment in negotiating management plan
Plan follow- up and long- term management for identified risk factors, public health/preventive health issues and screening
Ask if there are other questions, encourage and reassure
Agree on follow- up

STEPS

6. Close Consultation

- Check client's understanding and agreement of management plan / Provide appropriate illustrated or written material

7. Documentation

- Be clear, legible, concise, contemporaneous, progressive and accurate
- Include information about assessments, action taken, outcomes, reassessment processes (if necessary), risks, complications and changes
- Meet all necessary medico-legal requirements for documentation
- Update client record / Enter information as appropriate into items in electronic system
- Follow the documentation style required by your organisation
- Refer as necessary for further investigations, support & management
- Update recall system / Make use of Shared Electronic Health Record as appropriate and with consent

8. Reflection

- How did the consultation go? What went well? / well? What could have been done better?
- Identify own learning needs in relation to this condition/management, etc / Consider your own self-care and other colleagues

Case Scenario

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