Remote Area Nurse Model of Consultation Quick Reference Cards

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INTRODUCTION

The remote area nurse (RAN) model of consultation provides a holistic, systematic and culturally safe framework for use with clients in remote primary care settings with high levels of morbidity and complex social, psychological, environmental, and cultural needs.

It is designed to guide a comprehensive general and **non-emergency** consultation.

The model has been developed by an expert panel of RAN and RAN educators. The principles are aligned to the four domains of the National Rural and Remote Nursing Generalist Framework 2023-2027:

Domain 1 Culturally safe practice
Domain 2 Critical analysis
Domain 3 Relationships, partnerships and collaborations
Domain 4 Capability for practice

If an emergency, follow DRSABCD

PRINCIPLES OF CONSULTATION

Culturally safe approach

- How can I make the client feel comfortable?
- Have I considered gender issues?
- Is there a need for an interpreter?
- Are appropriate family members present?

Holistic and comprehensive

- Consider 'whole-person' context
- Guided by population health principles
- Explore client's experience of their illness and expected outcomes
- Consider the pervasive impact of trauma

Systematic

- History before observations or physical examination
- Use a structured chronological approach

Shares power with the client

- Develops a partnership with the client
- Encourages the client to share in decisions
- Builds client's self-reliance and health literacy

PRINCIPLES CONTINUED

Provides coordination and continuity of care

- Recognise the importance of shared care
- Document accurate client records
- Coordinate complex care
- Collaborate with colleagues
- Activate recall system as required

Encourages clinical reasoning

- Consider age/place risk of client
- Consider what is most likely and what you cannot afford to miss
- Use a problem-solving approach

Promotes clinical safety and quality

- Work within scope of practice
- Consider strength-based approaches
- Use best practice treatment protocols and quality improvement processes and procedures

AVOIDING ERRORS

Build clinical knowledge including:

- Knowledge of atypical presentations
- Local epidemiology and populations at risk
- Use multiple sources of information

Apply clinical reasoning

- What else could it be?
- What finding does not fit with clinical thinking?
- Rule out the worst-case scenario
- Identify red flag symptoms
- Identify repeat presentations

Reduce reliance on memory

- Use relevant checklists, clinical guidelines and clinical decision support tools

Acknowledge emotions including:

- External demands and internal stresses
- Emotions arising from client interactions

Seek help

- Obtain a second opinion or medical consultation

RAN MODEL OF CONSULTATION STEPS

1. **Open consultation** – use empathy and build trust

2. **History** – listen carefully to the patient story

3. **Clinical examination** – look, listen and feel

4. **Examination findings** – summarise and discuss with client

5. **Negotiate management plan** – shared decisions lead to better outcomes

6. **Close consultation** – ask 'Do you have any questions?'

7. **Documentation** – accurate records safeguard patient care and accountability

8. **Reflection** – transform experience into growth

1. OPEN CONSULTATION

Before opening the consultation

- Review client records - note last visit, outstanding actions and past investigations
- Obtain more information if needed
- Ensure room is comfortable, well-lit, private
- Ensure you have appropriate equipment
- Consider your own and the client's safety

During the consultation

If not an emergency

- Greet the client and establish rapport
- Confirm identity with three identifiers – check name, chart number, DOB, nominated next-of-kin
- Note general impressions – appearance, speech, hearing, gait, posture, symmetry, tremors, odour, colour, skin, mental state
- Observe interaction with self and others
- Use appropriate language

2. HISTORY
Reason for presentation - acute / chronic disease review / screening
The story of why the client presented
Establish concerns and expectations
Use OLDCARTS mnemonic to explore the current presentation
Explain what you are thinking and doing and why you need to ask questions
Listen actively, encourage openness and do not interrupt
Respect silence and await a response.
Ask about any changes - travel, work or other activities
If the reason for the presentation is unclear, work backwards to further explore the client's concerns

2. HISTORY - OLDCARTS
Onset – when did it start?
Location – where is the pain or where is the problem?
Duration – how long, have they had it before, what happened?
Characteristics – description of symptom/s and severity (pain score)
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 - CURRENT HEALTH REVIEW

Current health status

- Assess appetite, nausea, changes in weight, sleep, energy, and physical activity
- Substance use – brief intervention
- Changes in urine, bowels, menstrual cycle, sexual health
- Emotional health including self-harm
- Ask ‘ Do you ever feel unsafe”

Medicines

- Prescribed – what, why, when, how long, any problems
- Does client take medications as prescribed
- Ask about over-the-counter, herbal, traditional, other people’s medications
- Contraception (if appropriate)

Allergies – what happens when exposed and how are allergies managed

Immunisations – review status

2. HISTORY - OTHER

Client's past history, if not known ask about:

- Past medical, surgical and psychiatric history
- Gynaecology/obstetric history (if appropriate)
- Accidents, injuries, admissions to hospital, treatment at other clinics
- Ask 'Is there anything else I need to know to look after you today?'

Family medical history, if not known ask about:

- Past medical, surgical and psychiatric history
- Current health complaints, age of onset
- Cause of death, age at death
- Update client's record as required

3. CLINICAL EXAMINATION OVERVIEW

Explain the purpose of the examination
Obtain client consent and ensure privacy
Conduct a rapid physical assessment – perform a head-to-toe assessment to identify signs of illness and injury
Review client's records to understand the client's health journey
Investigations as indicated including BGL, Hb, BMI, waist circumference, U/A, pregnancy test, ECG and other point-of-care tests
Systematic assessment of relevant systems – LOOK, LISTEN, FEEL
If client consents and timing allows, consider opportunistic screening as indicated by history, local epidemiology and age/place risk.

RAPID PHYSICAL ASSESSMENT

- Look at client – assess general appearance, gait, facial expression and speech
- Record temperature, pulse, respiration, blood pressure and oxygen saturation
- Examine nails, (clubbing) hands (tremor), and arms (cool peripheries)
- Inspect scalp, eyes and ears
- Inspect mouth, tongue and teeth
- Check neck and cervical lymph nodes
- Auscultate heart sounds and anterior breath sounds, palpate and percuss chest
- Lean patient forward and auscultate posterior breath sounds, palpate and percuss chest
- Lie patient flat and inspect, auscultate, percuss and palpate abdomen
- Inspect and palpate both legs for perfusion, pulses and oedema
- Inspect feet – colour, warmth, movement and sensation, pulses and lesions

EYE ASSESSMENT

SIGNS/SYMPTOMS

Changes in visual acuity	Blurred vision
Pain	Double vision
Discharge	Dryness/itching

EXAMINATION *Rapid Physical Assessment* plus systematic inspection of both eyes including:

- Lids/lashes/lacrimal system – check for normal anatomy, lesions or discharge
- Conjunctiva/sclera – check for dilated blood vessels, lesions and discharge
- Cornea – assess clarity. If indicated use Fluorescein stain to detect epithelial disruptions
- Anterior chamber – assess for depth, exudate and haemorrhage
- Pupil – test reactivity of both pupils. Check for relative afferent pupil defect
- Lens – assess colour (transparent)
- Extraocular movement/alignment – assess equal movement up, down, left, and right
- Visual acuity – use Snellen or Tumbling 'E' chart

Beware the single red eye – may be foreign body, trauma, corneal ulcer, iritis, or acute glaucoma. Do not assume conjunctivitis (usually bilateral)

EAR ASSESSMENT

SIGNS/SYMPTOMS

Hearing loss	Fever
Pain	Discharge

Swelling/redness behind the ear
Slow speech development in children

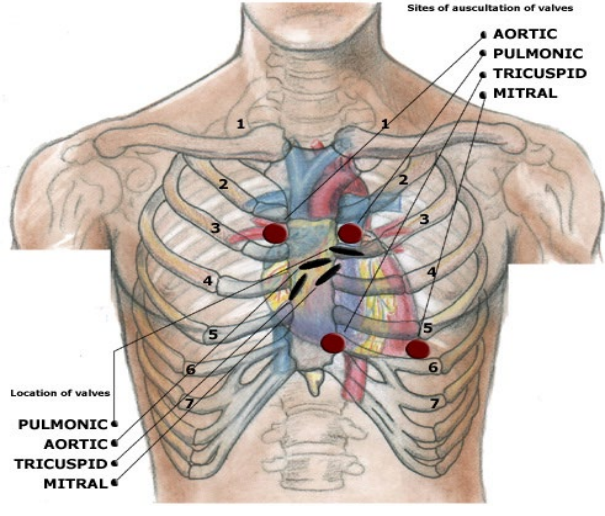
EXAMINATION *Rapid Physical Assessment* plus systematic inspection of both ears including:

- Check outside and back of ear – swelling, redness, scarring.
- Straighten ear canal by pulling pinna down for infants, back for children and up and back for adults.
- Use largest speculum as comfortable and insert carefully into ear canal.
- Inspect external auditory canal
- Visualise total tympanic membrane
- Inspect tympanic membrane for normal light reflex, inflammation, perforation, discharge
- Follow decision making matrix to diagnose middle ear status and determine treatment

CARDIOVASCULAR SYSTEM

SIGNS/SYMPTOMS

- Pain – severity, nature, duration, frequency, location and radiation, relieving and aggravating factors, associated features
- Breathing – dyspnoea on exertion, orthopnoea, paroxysmal nocturnal dyspnoea
- Check for peripheral oedema, palpitations, claudication, and syncope



CARDIOVASCULAR SYSTEM continued

EXAMINATION *Rapid Physical Assessment* plus:

Pulse – rate and rhythm and volume

Blood pressure – lying and standing

Heart

- Inspection – appearance, skin, extremities
- Auscultation
  - Heart sounds – normal/abnormal
  - Lung sounds – compare symmetrical auscultation points
- Palpation – locate apex beat

Peripheral Arteries

- Auscultation for bruits
- Palpation – brachial, radial, femoral, popliteal and pedal pulses

Peripheral veins

- Colour, temperature, capillary refill
- Varicose veins, ulcers
- Thrombosis – swelling, heat, redness and tenderness

Oedema – peripheral and sacral

RESPIRATORY SYSTEM

SIGNS/SYMPTOMS

- Cough
- Chest pain
- Added sounds – wheeze**,** crackles, stridor
- Sputum
- Dyspnoea

EXAMINATION *Rapid Physical Assessment* plus:

Inspection

- Respiratory rate and effort
- Movement – symmetrical or asymmetrical
- Shape – normal, barrel, pigeon/funnel chest
- Trauma – bruising, lacerations, scarring

Palpation

- Trachea – central or deviated left or right
- Tenderness
- Chest expansion
- Tactile fremitus/subcutaneous emphysema

Percussion

- Chest wall including apexes and axillae – normal, resonant, dull

Auscultation

- **Breath sounds**
  - **Pitch** (frequency)
  - **Amplitude** (loudness)
- **Added sounds** as above

GASTROINTESTINAL and GENITOURINARY

GASTROINTESTINAL SIGNS/SYMPTOMS

Nausea/vomiting
Reflux/dysphagia
Altered bowel habits
Pain/bleeding
Changes in appetite/weight

URINARY SIGNS/SYMPTOMS

Urinary frequency
Flank pain
Dysuria/discharge
Nocturia
Urinary incontinence
Haematuria

EXAMINATION *Rapid Physical Assessment* plus:

Inspection

- Distension, scars, masses, pulsations

Auscultation

- Assess bowel sounds

Palpation: Four quadrants

- Light, then deep palpation – tenderness, rigidity, rebound tenderness
- Organs – liver, spleen, kidneys, bladder,
- Masses – site/characteristics, pregnancy

Percussion

- Tenderness, ascites, organs, masses

MUSCULOSKELETAL SYSTEM

SIGNS/SYMPTOMS

Pain	Reduced movement
Loss of function	Instability

EXAMINATION *Rapid Physical Assessment* plus:

Inspection

- Symmetry – compare sides
- Wasting, scars, swelling and deformities
- Gait – smooth, symmetrical, ability to turn
- Posture

Palpation

- Tenderness
- Heat/coolness

Movement

- Perform movements without assistance
    - Abduction, adduction, extension, flexion, rotation, pronation and supination
    - Look for pain, restriction or abnormal movement patterns
- Passive movements – assess for stiffness and pain

NERVOUS SYSTEM

SIGNS/SYMPTOMS

Headache Weakness Motor changes
Seizures Cognitive changes
Problems with speech or memory
Loss of consciousness

EXAMINATION *Rapid Physical Assessment* plus:

- Mental status including level of consciousness, orientation and memory
- Cranial nerve (I-XII) assessment as appropriate
- Glasgow Coma Scale/Child Coma Scale
- Inspection – gait, muscle wasting, tremor
- Assess muscle tone – increased or reduced
- Assess muscle strength – grade resistance
- Assess coordination – finger-to-nose test
- Assess sensation – light touch and pain
- Assess perception of body position and movements
- Assess reflexes
- Tests for meningeal irritation – neck stiffness, Kernig's sign, Brudzinski's sign and high-pitched cry (in child < 2 years)

MENTAL STATUS EXAMINATION

Ask about person's usual behaviour

ASSESS

Appearance – grooming and hygiene

Behaviour – how the client is acting

Mood – emotions that client describes

Affect – observed client emotions

Speech – assess rate, volume, tone, quantity, and fluency

Thoughts

- Form – lose track of conversation, mixed-up talk, not making sense.
- Content – talking about hurting self or others, beliefs that are false and fixed (delusions), overly suspicious (paranoia)

Perception – altered sensory perception (hallucinations) hearing, seeing, tasting, smelling or feeling things that are not present

Cognition and sensorium – oriented to person, place and time, memory, level of consciousness.

Insight/judgement – does person understand what the problem is, are they behaving in a dangerous manner.

MENTAL HEALTH - RISK ASSESSMENT

Medical conditions – new or pre-existing, are they well managed, medications – any changes, any substance use.

Risk to self

- Suicide, self-harm, victim of violence
- Vulnerability – potential for exploitation, neglect, accidents, physical deterioration
- Risk of absconding or wandering
- Poor judgement and damage to reputation

Risk to others

- Violence, intimidation, sexual risk

Protective factors (things that keep client safe)

- Responsible person or carer
- Level of insight, ability to accept help, support and treatment
- No history of violence, self-harm, suicide attempts
- Community capacity to support client

Remember: If issue of personal/public safety follow organisation guidelines – contact police.

4. EXAMINATION FINDINGS

Consider

- Reason for the presentation
- Other health issues
- Age/place risk – what is this client at risk of considering their age and setting?
- What things are often missed that should not be overlooked?
- What is the most likely problem?
- Best practice treatment guidelines
- Seek further advice as required
- Summarise and discuss findings with client
- Explore client's knowledge and clarify misunderstanding – use 'teach-back' method as appropriate
- Discuss long and short-term goals
- Consider brief intervention and health promotion as appropriate

5. NEGOTIATE MANAGEMENT PLAN

- Always consider the context in negotiating a management plan.
- Discuss treatment goals and priorities with the client and significant others as appropriate including investigations, immunisation and referrals
- Confirm management plan is acceptable to client and family, including what to expect, what to do if the problem gets worse
- Plan follow-up and long-term management for identified risk factors, public health/preventive health issues and screening
- Advocate for the client as appropriate
- Ask if there are any questions, encourage and reassure the client
- Agree on follow-up

6. CLOSE CONSULTATION

- Check client's understanding and acceptance of the management plan
- Provide illustrated or written material

7. DOCUMENTATION

- Be clear, accurate, legible, and concise
- Include assessments, action taken, outcomes and reassessment if necessary
- Meet all medico-legal requirements

- Update client's record
  - Enter information into client's record
  - Follow organisation documentation style
- Refer for further investigations, support and management as required
- 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 or could have been done better?
- Identify own learning needs
- Consider your own self-care

RAN MODEL OF CONSULTATION FOR CHILDREN

For paediatric assessment follow the same steps as the RAN MoC

- A parent or guardian should always be present to provide consent, help with communication and on-going care
- Young children may be more comfortable sitting on a parent/carer's lap
- Initiate the assessment by first observing the child and follow with examination
- Check child's immunisation status
- Calculate REWS (or similar early warning score) by age
- Measure and record weight at each visit
  - Babies and children under 2 years – use baby scales, naked (no nappy or singlet)
  - 2-5 years – use adult scales, wearing dry nappy or underpants only
  - 5 years and over – use adult scales, wearing light clothing and no shoes

PAEDIATRIC ASSESSMENT TRIANGLE (PAT)

APPEARANCE

- Reflects child's age, stage of development and ability to interact with the environment
- Use 'TICLS' mnemonic to assess appearance

Tone	Child active or listless?
Interactivity and mental status	How alert is the child? Does child reach for and grasp a toy, or is the child disinterested in interacting or playing with the care giver?
Consolability	Can the child be comforted by the care giver?
Look/gaze	Does the child fix their gaze on an object or is there a glassy-eyed stare?
Speech/cry	Is speech or cry strong and vigorous or weak or high pitched?

- What is the child's state of consciousness?
- Does the child look ill?

WORK OF BREATHING

- Reflects adequacy of airway and ventilation
- Assess body position, movements of chest/abdomen and breathing pattern
- Listen for abnormal airway sounds (stridor, grunting, coughing, and wheezing)
- Look for visual signs of increased work of breathing such as abnormal position or posture (head bobbing), intercostal retractions, nasal flaring, grunting, gasping and tachypnea
- Are the airways obstructed? Is child short of breath?

CIRCULATION TO SKIN

- Reflects the adequacy of cardiac output and perfusion of vital organs
- Assess the skin and mucous membranes for abnormal colour (pallor, mottling and cyanosis)
- Capillary refill time, warmth of peripheries
- Non-blanching rash

An abnormality noted in any of the PAT segments denotes an unstable child

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