



CLINICAL PRACTICE GUIDELINE

Emergency Centre (EC)

This document should be read in conjunction with the [Disclaimer](#)

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Triage and observation in EC

Aim

To ensure the best outcome for the patients who present to the Emergency Centre (EC) at KEMH.

Key points

1. All patients who present to the emergency centre should be triaged on arrival. All patients presenting to the EC at KEMH will have primary assessment at triage to rapidly determine threat to life and be allocated an Australasian Triage Scale (ATS) based on risk analysis.
2. Only senior Registered Nurses/ Midwives shall undertake the role of triage nurse RN Level 1.3 and above once completed triage training. It is not appropriate for triage to be undertaken by an Enrolled Nurse, Midwife (who is not also a Registered Nurse), or administration staff.
3. The triage assessment is not intended to make a diagnosis.
4. Any adverse signs or symptoms identified throughout the assessment process must be reported to the appropriate staff and escalated as required.
5. The triage assessment and ATS category shall be recorded on the MR 021. The most urgent clinical feature determines the ATS category, with consideration of the mechanism of injury and co-morbidities. Once a high-risk feature is identified, a response equal to the urgency shall be initiated.
6. The triage nurse is responsible for ensuring that the documentation of all episodes of care at triage is timely, accurate and comprehensive.
7. Recurrent presentations (except patients representing for booked Early Pregnancy Assessment Service (EPAS) appointments who have no change in their clinical status):
 - Any patient that re-presents with the same condition within 24-48 hours is to be referred to a senior Medical Officer for review.
 - If a patient has presented to any emergency department/ centre on three or more occasions with the same acute problem, the case should be either discussed with, or reviewed by, a Senior Registrar or Consultant.

[Recommendation Mar 2019]
8. Women presenting with a potential life threatening condition e.g. chest pain, severe haemorrhage or birth is imminent are assessed in the Emergency Centre. Non gynaecological / obstetric presentations should be stabilised and transferred to another adult facility as appropriate.
9. If a patient is being actively treated by another team (at another hospital) then the treating team are consulted and management discussed prior to admission.

[Recommendation Feb 2019]

10. At triage/ presentation the appropriateness of admission to this service is considered. **[Recommendation Feb 2019]**
11. Medical opinion must be sought by Emergency Centre staff prior to discharging patients who present with medical problems.
12. A chaperone is offered during any intimate physical examinations and documented to patient records. See NMHS Chaperone Policy.

Triage

Emergency triage is a unique practice that deals with unstable, undiagnosed patients presenting to an emergency centre / department. The process of triage involves the application of high level assessment skills and theoretical knowledge, to assess a patient and make a decision about the degree of urgency to see a treating clinician. It is important that the level of urgency assigned is appropriate and reflective of individual presentations.

Triage nurse roles and responsibilities

- Undertake initial patient assessment and allocate the ATS category. Complete a visual assessment with the whole patient being surveyed prior to focussing on the specific area of concern.
- Rapidly assess the patients for Danger, Response, Seek help and Airway, Breathing and Circulation (DRSABC).
- Activate the medical emergency alarm if life threats are identified (Code Blue Medical).
- Undiagnosed patients can rapidly deteriorate so ongoing assessment and re-evaluation of their presenting findings should occur throughout their presentation. 30 minutely documentation of their condition in the waiting area must occur.
- Re-triage will be indicated if the patient's condition deteriorates. Reasons for the re-triage must be documented and communicated to the Registrar/Consultant
- Obtain a history from the patient. Document all findings on the MR 021
- Initiate appropriate nursing intervention to improve patient outcomes and secure the safety of patients and staff.
- In the waiting area the type of observations required should be dictated by the patient's clinical presentation.
- Act as a liaison for members of the public and other health care professionals.

Figure 1: The Australasian triage scale

ATS Category	Treatment Acuity (Maximum waiting time)	Performance Indicator Threshold
ATS 1 (red)	Immediate	100%
ATS 2 (orange)	10 minutes	80%
ATS 3 (green)	30 minutes	75%
ATS 4 (blue)	60 minutes	70%
ATS 5 (white)	120 minutes	70%

Please refer to [Appendix 1](#): Australasian triage scale: descriptors for categories

Observations

- Vital signs are measured at triage consist of Temp,HR, RR, SaO2
- Any patient identified as ATS Category 1, 2 and 3 should be taken immediately into an appropriate assessment and treatment area.
- All patients who present to EC shall have a full set of vital signs performed according to their triage category at the time of assessment and treatment (with the exclusion of EPAS patients and other follow up patients e.g. Postnatal women)
- The following observations are generic for all presentations once triaged to the EC
 - Respiratory rate
 - Oxygen saturation
 - Blood pressure (manual preferred)
 - Pulse (manual check)
 - Temperature
 - Conscious state
 - Pain score
 - Blood glucose level (in diabetic presentations or those with altered mental state)
 - PV loss
 - Urinalysis (+ UHCG if appropriate)
 - AVPU (see Figure 2):

Figure 2: AVPU scale

A = Alert

V = Responds to voice

P = Responds to pain

- Purposefully
- Non-purposefully
 - Withdrawal/flexor response
 - Extensor response

U = Unresponsive

- Assess the patient's skin while taking and recording the pulse.
- Category 1, 2 and 3 patients shall be moved directly into the emergency centre clinical area prior to their observations being performed.
- Category 4 and 5 patients may have their initial observations performed in the waiting area. Checking of PV loss should occur in the clinical area of EC.
- All patients presenting to Emergency Centre with abnormal bleeding should have a speculum/ vaginal examination to assess the cervix and cause for the bleeding. If the registered nurse / midwife or medical officer is unable to visually assess the cervix then the Registrar, Senior Registrar or Consultants must be contacted to complete the vaginal examination.

Frequency of observations

- Observations shall be performed as frequently as determined by the patient's clinical status.
- All patients admitted to a ward shall have a full set of observations performed and documented on the MR 285.01 Observation chart prior to the actual transfer. This will ensure that the patient's condition is satisfactory and also assist in determining what level of escort is appropriate.
 - A Registered Nurse/Midwife shall escort all patients to ward or theatre unless vital signs are in the Red/Medical Review section of the observation chart, which requires a Medical Officer and a Registered Nurse/Midwife escort. An Anaesthetist /anaesthetic registrar and anaesthetic technician should escort patient's that are unstable and have triggered a Code Blue (Purple Area) of the observation chart. Also see Clinical Guideline, O&G: Admission, Transfer & Discharge: [Transfer of a Critically Unwell Patient to an ICU at Another Hospital](#)
 - No woman should be discharged without a vaginal/speculum examination if presents with vaginal bleeding. Document in the patient medical record- MR 021/022.

Recording of clinical care commencement date / time

Purpose

To provide guidance on the recording of the commencement of clinical care by nurses and midwives in the Emergency Department Data Collection (EDIS)

Procedure

- The commencement of clinical care time may be either
 - When the patient is first seen by a Medical Officer or
 - When the patient is first seen by a nurse or other health professional.

NB: The commencement of care **is not** the triage and assessment of the patient.

The triage and assessment time should be accounted for and documented accurately on the MR 021 Emergency Assessment form.

- Commencement of clinical care must meet at least one of the following principles:
 - Add to the patient assessment (maternal or neonatal)– visual inspection of vaginal loss, postnatal wound or perineal inspection, HVS, specimen collection, wound swab collection, breast / nipple examination, collection of Expressed Breast Milk (EBM) specimen etc.
 - Mitigate clinical risk e.g. patient is considered at risk of falls or pressure injury due to their condition on presentation.
 - The provision of definitive therapy to the patient (maternal or neonatal) e.g. hyperemesis - the insertion of an intravenous cannula and commencement of fluids resuscitation, analgesia for pain.
 - In the opinion of the nurse / midwife the patient should be transferred to a cubicle in the EC for increased observation.
- The commencement of care and time must be documented on the EC Assessment form (MR 021) and in EDIS by the staff member who performed the care. All care and investigations performed should be recorded in EDIS system as appropriate in a timely manner.
- If clinical status changes in a way that will impact upon the triage category, if additional information becomes available or the commencement of clinical care will impact upon the triage category or influence the urgency* then re-triage must occur and the medical officer must be notified. The reason for re-triage must be documented.

*Urgency is determined according to the patient's clinical status and is used to 'determine the speed of intervention that is necessary to achieve an optimal outcome'. Urgency is **independent** of the severity or complexity of an illness or injury.

Admission to the emergency short stay unit

Aim

To provide best practice requirements for the Short Stay Unit within the KEMH EC, for women who require interim management to relieve symptoms and to stabilise and treat presenting problems prior to discharge.

Key points

1. A discharge letter must be completed and given to the patient on discharge.
2. Patients likely to be admitted or awaiting a bed on the ward do not satisfy the criteria for admission to the Short Stay Unit.
3. Consultants attending the daily board round must be notified of all admissions to the Short Stay Unit.

Criteria for admission

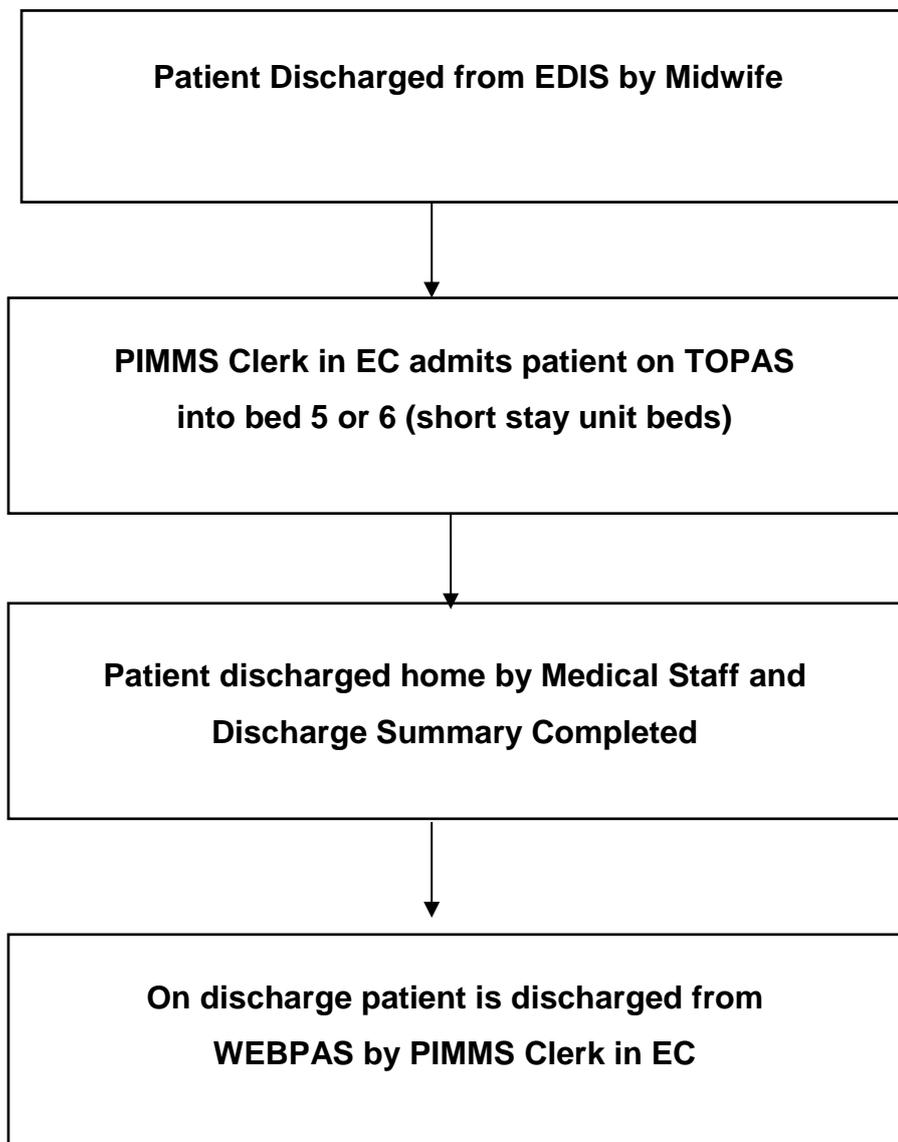
1. The patient must have one of the following:
 - Medical condition that warrants short term stay for stabilisation of their symptoms. For example: rehydration management for Hyperemesis, Medical management of ectopic pregnancy requiring administration of methotrexate etc.
 - Drowsiness following a procedure in the EC
 - Intoxication or affected by substances requiring observation as there is concern for their wellbeing.
2. There must be a reasonable expectation that the patient will be discharged from the KEMH Short Stay Unit within 6 hours.

Procedure

As soon as the decision to admit to the Emergency Centre Short Stay Unit has been made, administrative processes should occur to support the transfer of patient information from EDIS to TOPAS, whilst acknowledging that the patient's location remains within the Emergency Centre. The attached flowchart outlines the required steps for ensuring this occurs in a timely manner.

See next page for flowchart.

Process for admission to the EC Short Stay Unit



Staff and visitors (including MBU patients) with non-gynaecological or obstetric conditions

Purpose

To appropriately triage and provide initial care to staff, visitors and patients from the Mother Baby Unit who present at the EC with non-gynaecological or obstetric conditions. Timely access to emergency care can improve patient outcomes.

Procedure

- A staff member, visitor or patient from the Mother Baby Unit who presents at the Emergency Centre shall be assessed by the triage nurse / midwife in the unit. **It is inappropriate to triage any person by telephone including staff members. If an internal call is received about a staff member, visitor / client, or patient in the MBU asking for advice the person must be advised to present at the EC.**
- **Under no circumstances are internal requests to be made to EC for prescriptions for outpatient attendees to occur.** If an outpatient requires medication (even if it is obstetric or gynaecology related) they must be advised to present to their GP or the EC where she will be triaged and assessed appropriately.
- MBU patients who have been assessed by a medical practitioner in the MBU and referred to KEMH EC for admission shall be assessed and triaged as outlined below. If the referring medical practitioner has recommended admission to KEMH this shall occur.
- MBU patients who are unable to present at the EC / return to the MBU without assistance must be transferred via a non-urgent ambulance from the MBU to the Emergency Centre. If their clinical condition dictates urgent review (i.e. unable to wait for SJA) a code 55 must be called.
- On presentation the triage nurse / midwife must assess the following
 - Chief complaint
 - General appearance
 - Airway
 - Breathing
 - Circulation
 - Disability
 - Environment
 - Limited history
 - Co-morbidities.
- Perform a quick evaluation to assess whether the patient is clinically stable.

- Identify those patients who have evidence of, or are at high risk of physiological instability.
- Assign an appropriate ATS category in response to the clinical assessment data.
- Provide immediate care as per the ATS category and arrange transfer to the appropriate facility. The mode of transfer will be dependent on the presenting complaint, the clinical status of the patient and availability of appropriate transport.

Emergency sexual assault resource centre (SARC) clients: After hours management (2200-0900 hours)

Purpose

To provide guidance on the management of emergency SARC clients after hours (2200-0900 hours) at the Emergency centre KEMH in the event that SARC is unable to provide full after hours care (code yellow/disruptions to the Business Continuity Plan- BCP)

Procedure

1. SARC will continue to attempt to provide emergency medical/forensic services 24 hours a day, 7 days a week.
2. In the event that medical/forensic service delivery is interrupted, a phone call advice service with a SARC medical officer will be available after 2200 hours. However the medical officer will not attend the emergency case.
3. Female clients who require a service 2200 – 0900 hours will be advised by the SARC counsellor to attend the Emergency centre at KEMH.
4. Where physical injury, bleeding or suspected fracture is identified, the counsellor will liaise with the duty SARC medical officer and advise the client to attend the nearest Emergency Department (not the Emergency Centre at KEMH).
5. Male clients shall be advised to attend their nearest local Emergency department.
6. After 2200 hours, a counsellor may attend the emergency case at the Emergency Centre at KEMH. This decision will be made following liaison with the SARC medical officer (consultation between the medical officer and the police may also be required).
7. The role of the counsellor is to:
 - Provide support to the victim of the sexual assault.
 - Provide liaison with the police and other services.
 - Provide liaison within the EC and support to EC staff, and provide containment of the situation.
 - Triage the case for the provision of forensic services by a SARC medical officer the next morning at the SARC premises.
8. Medical / forensic urgency prioritisation is undertaken by the duty medical officer (SARC) and the police.
9. The following care may be provided by the KEMH staff in consultation with the SARC medical officer:

Safety

Ensure medical safety and exclude any life threatening emergencies – these cases should have been referred to the **Emergency Department of their nearest local hospital** (See point 5).

Location

Consider prevention of DNA cross contamination. All patient contact surfaces should be wiped with trigene and then covered with a fresh paper sheet (blue). Refer to NMHS policy on the [Management of Chemicals and Hazardous Substances](#)

Provide a private area whenever possible with access to a support person.

- Consider any immediate physical, mental or substance use issues as for all patients.
- Consider the presence of an existing pregnancy.
- Offer emergency contraception as required.

Forensic

- Consider forensic specimen collection using the Early Evidence Kit (wee and wipe specimens). This is located in the SARC box in the cupboard in cubicle 4. Instructions for use are also located in this box.
- The SARC box is to be checked and re-stocked by staff of SARC every six months or earlier if used.
- Ensure informed consent is obtained prior to collecting forensic specimens.
- Avoid loss of forensic evidence by requesting that the client does not wash, shower or defecate (if anal assault has occurred).
- Clothing can be collected by police or placed individually into clean paper bags and sealed i.e. each item of clothing in a single separate bag.
- An external genital examination (visual inspection only) may be conducted if there are symptoms of bleeding or pain, but generally a speculum examination should be delayed until seen at SARC.
- A full medical forensic examination will be provided at SARC as soon as possible, generally the following morning.

High vaginal swab (HVS) collection in EC

Purpose

To identify those situations when a high vaginal swab (HVS) should be collected in the EC.

Procedure

High Vaginal Swabs are often used to diagnose causes of vaginal discharge but they are of limited value.¹

HVS may be used to aid the diagnosis of bacterial vaginosis, vulvovaginal candidiasis and *Trichomonas vaginalis*.

Indications for HVS collection

- Sex workers
- Sexually active women < 25 years of age and not in a stable long term relationship
- Substance users (especially IVDU)
- Women who have recently changed their sexual partner.
- Women with multiple sexual partners
- Women travelling away from home
- Women from a high incidence STI area.
- Vaginal discharge with malodour, itch or pain
- Vaginal or cervical inflammation
- Coital pain and post coital bleeding
- Contact bleeding of the cervix
- Lower abdominal pain indicating Pelvic Inflammatory Disease (PID).

Collection

Refer to KEMH Clinical Guideline: Obstetrics and Gynaecology: [Vaginal Procedures: Swabs](#)

NB: The indication for collection **must** be documented on the Pathology Request form.

IV morphine administration by nurses / midwives in EC

Aim

The timely, appropriate and safe administration of intravenous morphine in the EC.

Key points

1. Administration of opioids via the intramuscular route may be inappropriate in the EC due to the possible delay in the action of the analgesia and the inability to titrate the amount of opioid required for patient comfort.
2. Only EC nurses / midwives who have been assessed as competent in the administration of IV morphine may administer it.
http://kemh.health.wa.gov.au/services/nccu/guidelines/drug_protocols/MorphineSulphate.pdf
3. The medication must be prescribed by a medical officer on the MR021 Emergency Centre Assessment form.
4. Respiratory depression is a side effect of the administration of an opioid medication. Attending Registered Nurses / Midwives must be aware of this and be competent to manage this complication.
5. Older women may require lower doses of opioids to achieve an equivalent analgesic effect and the duration of analgesia is often longer.²
6. If the following occurs inform the EC Medical Officer immediately
 - Sedation score > 2

0= awake and alert
 S= normal sleep, responds to stimuli
 1= mild, occasionally drowsy, easy to rouse
 2= moderate, rousable but not able to stay awake
 3= severe, difficult to rouse or unrouseable

 - Resting respiratory rate less than 8 per minute
 - SaO₂ < 95%
 - Systolic blood pressure < 80mmHg
7. If the patient is not being admitted as an inpatient, she must remain in the EC for 4 hours following the last dose of an opioid. Consider admission to the EC Short Stay Unit.
8. When IV Morphine is prescribed, staff should ensure that they have access to Naloxone and are familiar with the indications & administration of the medication.

Procedure

- Assess the woman to establish her level of pain by:
 - Asking the patient's verbal (0-10) or rating as mild / moderate / severe.
 - Observing the woman's vital signs for evidence of high levels of pain e.g. elevated blood pressure and pulse (NB vital signs do not necessarily alter in the presence of pain). Perform respiratory rate, oxygen saturation, pulse rate, blood pressure and temperature prior to administration.
 - The patient should have a sedation score < 2 with a respiratory rate > 12 / minute.
 - The medication must be prescribed by a Medical Officer.
 - For the checking and administration see KEMH Clinical Guideline, Pharmacy: [Medication Administration](#) (available to WA Health staff via Healthpoint)
 - For Schedule 8 Administration see KEMH Clinical Guideline, Pharmacy: [Medication Administration](#) (available to WA Health staff via Healthpoint)
- The medication is only to be administered at a rate of 2.5mg every 5 minutes to a maximum of 10mg.
- Following administration the nurse / midwife must:
 - Perform and record oxygen saturations , respiratory rate, pain score and sedation level every 5 minutes for 20 minutes
 - Following the final bolus an additional two sets of observations of respiratory rate, conscious state and pain score at 10 minutes and 20 minutes.

Reversal

- Naloxone is the drug of choice.
- Naloxone is available in 400mcg/ml Ampoules.
- The drug can be administered Intravenously: 1ml every 2-3minutes to a maximum dose of 10mg.
- IV infusion may be considered.
- Patients who are suspected to have opioid over dose will need to be reviewed by a senior medical officer and the anaesthetic team should be informed immediately if altered consciousness/ airway compromise is observed.
- For the checking and administration see KEMH Clinical Guideline, Pharmacy: [Naloxone](#)

Appendix 1: Australasian triage scale: descriptors for categories

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	Immediately Life Threatening Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway – impending arrest Respiratory rate <10/min Extreme respiratory distress BP < 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS < 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence
Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	Imminently life threatening. The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival or Important time critical treatment The potential for time critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED or Very severe pain Humane practice mandates the relief of	Airway risk: severe stridor or drooling with distress Severe respiratory distress Circulatory compromise: Clammy or mottled skin, poor perfusion HR < 50 or > 150 (adult) Hypotension with haemodynamic effects Severe blood loss Chest pain of likely cardiac nature Very severe pain any cause Suspected sepsis (physiologically unstable) Febrile neutropenia BSL < 3 mmol/l Drowsy, decreased responsiveness any cause (GCS < 13) Acute stroke Fever with signs of lethargy (any age) Acid or alkali splash to eye

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
		very severe pain or distress within 10 minutes	requiring irrigation Suspected endophthalmitis Post eye procedure (post cataract, post intravitreal injection), sudden onset pain, blurred vision and red eye. Major multi trauma (requiring rapid organised team response)
Category 3	Assessment and treatment start within 30 mins	<p>Potentially Life Threatening The patient's condition may progress to life or limb threatening, or may lead to significant morbidity, if assessment and treatment are not commenced within thirty minutes of arrival or</p> <p>Situational Urgency There is potential for adverse outcome if time critical treatment is not commenced within thirty minutes or</p> <p>Humane practice mandates the relief of severe discomfort or distress within thirty minutes</p>	Severe hypertension Moderately severe blood loss any cause Moderate shortness of Breath Seizure (now alert) Persistent vomiting Dehydration Head injury with short LOC now alert Suspected sepsis (physiologically stable) Moderately severe pain any cause requiring analgesia Chest pain likely non cardiac and mod severity Abdominal pain without high risk features mod severe or patient age >65 years Moderate limb injury deformity, severe laceration, crush Limb altered sensation, acutely absent pulse Trauma High risk history with no other high risk features Stable neonate Child at risk of abuse/suspected non-accidental injury Behavioural/Psychiatric: very distressed, risk of self Harm acutely psychotic or thought disordered situational crisis, deliberate self Harm agitated / withdrawn potentially aggressive

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 4	Assessment and treatment start within 60 mins	<p>Potentially serious The patient's condition may deteriorate, or adverse outcome may result, if assessment and treatment is not commenced within one hour of arrival in ED. Symptoms moderate or prolonged or Situational Urgency There is potential for adverse outcome if timecritical treatment is not commenced within hour or Significant complexity or Severity Likely to require complex work up and consultation and/or inpatient management or Humane practice mandates the relief of discomfort or distress within one hour</p>	<p>Mild haemorrhage Foreign body aspiration, no respiratory distress Chest injury without rib pain or respiratory distress Difficulty swallowing, no respiratory distress Minor head injury, no loss of consciousness Moderate pain, some risk features Vomiting or diarrhoea without dehydration Eye inflammation or foreign body normal vision Minor limb trauma sprained ankle, possible fracture, uncomplicated laceration requiring investigation or intervention Normal vital signs, low/moderate pain Tight cast, no neurovascular impairment Swollen "hot" joint Non-specific abdominal pain Behavioural/Psychiatric: Semi urgent mental health problem Under observation and/or no immediate risk to self or others</p>

ATS Category	Response	Description of Category	Clinical Descriptors (indicative only)
Category 5	Assessment and treatment start within 120 minutes	Less Urgent The patient's condition is chronic or minor enough that symptoms or clinical outcome will not be significantly affected if assessment and treatment are delayed up to two hours from arrival or Clinico-administrative problems Results review, medical certificates, prescriptions only	Minimal pain with no high-risk features Low risk history and now asymptomatic Minor symptoms of existing stable illness Minor symptoms of low risk conditions Minor wounds small abrasions, minor lacerations (not requiring sutures) Scheduled revisit e.g. wound review, complex dressings Immunisation only Behavioural/Psychiatric: Known patient with chronic symptoms Social crisis, clinically well patient

References and resources

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Related policies

Department of Health WA:

- [MP 0086/18 - Recognising and Responding to Acute Deterioration Policy](#)
- [OD 0590/15 - Recording and Reporting of Clinical Care Commencement Date and Time in the Emergency Department](#)
- [OD 0657/16 - WA Health Consent to Treatment Policy](#)

Related WNHS policies, procedures and guidelines

KEMH Clinical Guidelines:

O&G:

- [Pregnancy Care \(First Trimester\) Complications](#)
- [Transfer of a Critically Unwell Patient to an ICU at Another Hospital](#)
- [Vaginal Procedures](#): Speculum Examination; Swabs: Low vaginal, High Vaginal, Endocervical and Rectal

Pharmacy:

- [Medication Administration](#) (available to WA Health staff via Healthpoint), includes Schedule 8 Controlled Medications Administration
- A-Z Adult Monograph: [Morphine](#); [Naloxone](#)

WNHS Policies (for SARC section):

- [Child Sexual Abuse and Child Protection \(Mandatory Reporting of\)](#)
- Legal Requests for Medical/Clinical Reports- direct requests to Medico Legal Services
- [Medical Records and Patient Information \(Confidentiality of\)](#)

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