OFFICIAL

OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Emergency Centre (EC): Patient management

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Emergency Centre KEMH

This document should be read in conjunction with this Disclaimer

Contents

Triage and observation in the Emergency Centre (EC)

Figure 1: The Australasian triage scale (ATS) categories[1]

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%

* Refer to ATS at triage desk for detailed descriptors for categories.

Key points

1. The Emergency Centre Triage desk will be attended 24 hours a day by a Triage competent Midwife and/or Registered Nurse.
2. It is not appropriate for triage to be undertaken by an Enrolled Nurse, Midwife (who is not also a Registered Nurse), or administration staff (Only dual registration registered nurse/midwife shall undertake the role of triage not including graduates).
3. All persons who present to the Emergency Centre (EC) 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 or limb and be allocated an Australasian Triage Scale (ATS) based on the primary assessment.
4. The triage assessment is not intended to make a diagnosis.
5. Any adverse signs or symptoms identified throughout the assessment process must be reported to the EC Coordinator and escalated as required.
6. The triage assessment and ATS category shall be recorded on the Emergency Centre Assessment form MR021. 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.
7. The triage nurse is responsible for ensuring that the documentation of all episodes of care at triage is timely, accurate and comprehensive.
8. Recurrent presentations:
   - Any patient that re-presents with the same condition within 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]**. Previous presentations can be seen across Metropolitan ED in EDIS Prior Registrations.

9. Persons presenting with a potential life threatening condition e.g. chest pain, severe haemorrhage or birth is imminent are **assessed** in the EC. Non gynaecological / obstetric presentations should be stabilised and transferred to another adult facility as appropriate. **Document the management (assessments and methods used to stabilise) that occurs prior to transfer**.
10. Notify the Gynae-Oncology Senior Medical Officer (Fellow or Consultant) of any gynae-oncology patient presentations in EC. **[RCA recommendation Dec 2023]**
11. 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]**
12. **If a patient is known to a gynaecology, obstetric, gynae-oncology or paediatric treating team at the Women and Newborn Health Service or is post-operative,** the treating team should be made aware of the patients emergency presentation via email (to the Consultant, Senior Registrar and Registrar) before the patient leaves EC**.**
13. At triage/ presentation the appropriateness of admission to this service is considered. **[Recommendation Feb 2019]**
14. Medical opinion must be sought by Emergency Centre nursing and midwifery staff prior to discharging patients who present with medical problems.
15. A chaperone is offered during any intimate physical examinations and documented to patient records. See NMHS Chaperone Policy.

Triage

Any person presenting to EC should be triaged

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

- 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

- 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 patient for Danger, Response, Seek help and Airway, Breathing and Circulation (DRSABC)
- Activate medical emergency alarm if life threats are identified (Code Blue Medical)
- Undiagnosed patients can rapidly deteriorate, therefore, patients who remain in the waiting room remain the responsibility of the Triage Midwife and/or Registered Nurse and waiting room Assistant in Nursing, who will continue to monitor these patients and document 30 minutely **visual observations** for 'eyes in the waiting room'. **Vital sign observations** (see heading below) will be done in the department, or in the waiting room depending on their triage score and EC capacity.
- Re - triage is not advocated. Patients on reassessment in the waiting room whose condition has deteriorated must be escalated immediately to the Emergency Centre Coordinator and/or Emergency Centre Consultant.
- Obtain a brief history from the patient. Document all findings on the MR 021 Emergency Centre Assessment Form.
- Initiate appropriate nursing intervention to improve patient outcomes and secure the safety of patients and staff.
- Act as a liaison for members of the public and other health care professionals.

Triage Competency

Registered Nurse and Midwife or Registered Nurse performing the triage role must:

- Be employed at a minimum Registered Nurse level 1.3.
- Be endorsed by the Emergency Centre Clinical Nurse Midwife Consultant and Nurse Manager.
- Registered Nurse and Midwife minimum of 3 months full-time equivalent in the Emergency Centre.
- Registered Nurse minimum 1 year full-time equivalent in the Emergency Centre.
- Complete the Emergency Centre Triage Competency within 3 months of commencement of initial competency.
- Complete the Triage Continuing Professional Development (CPD) Declaration annually, acknowledging completion of at least two of the following elements each year:
    - **1 YEAR FULL-TIME** equivalent in the Emergency Centre completing the triage role a minimum of 3 shifts a fortnight.
    - Advance Life Support 1 completion.
    - Completion of the WNHS Triage Study Day.
    - Completion of PROMPT/Mini PROMPT/Emergency Simulation professional development activities.

  - Participates/attends a minimum of 3 WNHS Emergency Centre Triage in-services annually.
  - Completion of Emergency Triage Education Kit (ETEK) modules
  - Complete College of Emergency Nursing Australasia (CENA) Triage Emergency Course or eLearning activity.
  - Performs a minimum of 3 case reviews, discussing findings within the workplace team. Maintains evidence using WNHS Triage Case Review template.
  - Completion of at least one Peer Review/PDR meeting with Clinical Nurse Midwife Consultant (CNMC)/Staff Development Nurse Midwife (SDNM).
  - Evidence to be maintained on WNHS PDR Emergency Centre Triage Review template.
- Maintain annual Hospital Basic Life Support (HBLS) eLearning and Practical training
- Maintain annual Neonatal Resuscitation eLearning and Practical Training.

Observations

- ATS 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.
- Documentation of observations- as per WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health) to Observation and Response Chart (ORC): Emergency Centre
- All patients presenting to the Emergency Centre following triage must be commenced on an Adult, Antenatal, Postnatal or Neonatal ORC.
- Assess the patient's skin while taking and recording the pulse.
- 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 Consultant 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 and the relevant ORC escalation and frequency criteria. Any abnormal observations should be escalated as per WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health).
- Visual observations of patients within the EC department must occur at a minimum of hourly and documented on the MR021 Emergency Centre Assessment form. Note: See triage role section for 30 minutely **visual observations** for 'eyes in the waiting room'. **Vital sign observations** will be done in the department, or in the waiting room depending on their triage score and EC capacity.

- **Prior to transfer:** All patients admitted to a ward shall have a full set of observations performed and documented on the appropriate ORC within 30min prior to the actual transfer. This will ensure that the patient's condition is satisfactory / stable and also assist in determining what level of escort is appropriate.

Patient transfers

A Registered Nurse/Midwife shall escort all patients to the ward or theatre.

- For transfer of patients who are **unstable** or with observations in the **red, purple/code blue** zones on the ORC, there are **additional medical escort** requirements; see section '11. Transfers' within the WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health).
- See also principles within the Clinical Handover policy and guideline.

Did not wait / Left at Own Risk

Refer to NMHS Policy Management of 'Did Not Wait' and 'Left at Own Risk' Patients at Emergency Department/Centre

Telephone advice

Clinical advice should not be given to patients over the phone. Patients who phone with clinical enquiries should be redirected to contact Health Direct, attend a General Practitioner (GP) or make their way to the EC in person or their nearest Emergency Department dependent on their level of concern.

Phone calls received from other clinical agencies such as GP, other hospitals, or St Johns Ambulance, must be recorded on MR040.02 – 'Documentation of Incoming calls – Emergency Centre'.

Recording of clinical care commencement date/time

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 Registered Nurse/Midwife or other health professional

  NB: The commencement of care **is not** the triage and assessment of the patient. The triage and primary assessment time should be accounted for and documented accurately on EDIS.
- 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 Emergency Centre 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.
- Re-triage is not advocated. Patients on assessment within the Emergency Centre whose condition has deteriorated must be escalated immediately as per WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health).

Staff, visitors, patients with non-gynaecological or obstetric conditions

- Any member of the public (including KEMH staff member or hospital visitor) who present at the EC shall be triaged by the Triage Nurse/Midwife in Emergency Centre.

- **It is inappropriate to triage any person by telephone including staff members.** If an internal call is received about a patient in the MBU, KEMH staff member, hospital visitor / client asking for advice, the person must be advised to present at the EC and documentation of incoming calls by health professionals will be as per previous section Telephone Advice.
- **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 they will be triaged and assessed appropriately. Note- For WNHS Lactation Consultants- see relevant medication Structured Administration and Supply Arrangements (SASAs)
- 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 in the previous triage chapter. 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 EC. If their clinical condition dictates urgent review (i.e. unable to wait for St Johns Ambulance) a code blue (55) must be called.
- Refer to SARC section for sexual assault presentations.
- 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 of life-threatening conditions, provide patient comfort measures and arrange transfer to the appropriate facility.

- The mode of transfer will be dependent on the presenting complaint and the clinical status of the patient.
- **Document** the management (assessments and methods used to stabilise) that occurs prior to transfer.

Emergency sexual assault resource centre (SARC) clients: all hours management

Purpose

To advise on the management in KEMH EC of patients alleging a recent sexual assault.

When SARC staff attending with the patient

In rare situations, SARC will request the use of a room in the EC, in which to conduct a forensic examination. Two SARC staff members will accompany the patient throughout the examination.

Triage at EC: Relevant triage details are communicated to EC staff to minimise repeat questioning of the patient.

Room use: If EC cannot accommodate the patient, the Hospital Clinical Manager's (HCM) office is to be contacted to assist with location.

- Location options are:
  - EC
  - Early Pregnancy Assessment Service (EPAS) room (if room available)
  - Ward 6 procedural room
  - Maternal Fetal Assessment Unit (MFAU)

Notes: The room may be needed for 2-4 hours. The above list is not exhaustive and the HCM's office may consider suitability of rooms, case mix and trauma informed care principles in their decision. A private examination room with access to a bathroom is essential; an ensuite is preferred but not essential.

When SARC staff unable to attend initially

This section is used in the event that SARC is unable to see the patient initially (e.g. code yellow / disruptions to the Business Continuity Plan (BCP)).

Procedure

1. SARC aims to provide emergency medical/forensic services 24 hours a day, 7 days a week. Service provision limitations exist.
2. In the event the on-call SARC senior medical practitioner (SMP) is unavailable to attend a patient in person for any reason, a phone advisory service will be available.
3. Depending on the clinical scenario, female clients may be asked by the SARC counsellor to attend the EC at KEMH.
   - Where general physical injury, non-genital bleeding, non-fatal strangulation, suicidal ideation or suspected fracture is identified, the patient will be advised to attend their nearest Emergency Department (not the KEMH EC).
   - Male clients will be advised to attend their nearest local Emergency Department.

4. SARC services include telephone access to a counsellor who can provide advice and support to the client and the KEMH EC staff. The counsellor will assist in liaison with other services if this is required. EC staff should call 6458-1828 to access the SARC after-hours services. See also SARC website resources.
5. Prior to a patient attending EC, SARC staff will have conducted a triage, forensic prioritisation and planning for service delivery.
6. **Medical care**

   The following medical care should be provided by the KEMH staff in consultation with SARC staff

   - Provide a private room if available and allow access to a support person.
   - **General well-being**: assess and treat as per patient presentation (life-threatening emergencies should go to the nearest ED as above).
   - **Genital injuries and bleeding**: discuss with the on-call SARC SMP. An external genital examination (visual inspection only) may be conducted if there are symptoms of bleeding or pain (avoid speculum use). If heavy genital bleeding, examine and treat as medically indicated. This may involve the use of a speculum. If time permits, discuss with the on-call SARC SMP.
   - **Emergency contraception**: Assess the need for emergency contraception and administer if no contra-indications.
   - **Pregnancy**: Determine if the patient is pregnant and assess viability and fetal well-being if necessary.
7. **Forensic care**

   The following forensic care should be provided by the KEMH staff in consultation with SARC staff:

   - **DNA contamination**: If the patient is required to change into a hospital gown for any reason, wipe the examination bed and cover with a sterile theatre drape. Collect relevant items of clothing as discussed with SARC staff.
   - **Showering**: Advise the patient not to shower or wash to avoid loss of forensic evidence.
   - **Collect Early Evidence Kit** (EEK) (wee and wipe, blood and urine for toxicology, clothing as appropriate) as advised by SARC staff:
     - Use an EEK, located in the SARC box in the cupboard in cubicle 4
     - Instructions for use are also located in this box
     - Obtain informed consent from the patient using the enclosed consent form
     - Store the sealed forensic evidence specimen bag in a fridge
     - Clothing can be placed individually into clean paper bags and sealed i.e. each item of clothing in a single separate bag. Bags are in the EEK kit
     - This EEK will be collected by SARC the following day
     - The SARC box is to be checked and re-stocked by staff of SARC every six months or earlier if used
8. A full clinical forensic medical examination including sexually transmitted infection (STI) and blood-borne virus (BBV) screening and a psychosocial assessment will be provided at SARC as soon as possible, generally the following morning/shift. SARC follows its own processes for follow-up of these patients and their results.

See also Department of Health (2021) Coordinated medical and forensic and counselling response to patients who experience a recent sexual assault and present to an emergency department and resources on the SARC website.

High vaginal swab (HVS) collection in EC

Indications for HVS collection

- STI screen
- Vaginal symptoms
- Suspected PID

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

Opportunistic testing of asymptomatic women

- Opportunistic testing of asymptomatic men and women (external website – WA Health).

Collection

Refer to WNHS Clinical Guidelines: Obstetrics and Gynaecology:

- Vaginal Procedures: Swabs- LVS, HVS, ECS & rectal
- Sexually Transmitted Infections (STI): Vaginal discharge

See also Silver book – STI/BBV management guidelines (external website) - including STI screening recommendations for priority populations, opportunistic testing of asymptomatic women, and patient presentation and specimen collection.

Minor procedure pain relief

Some procedures in EC (e.g. cervical biopsy, removal of intrauterine device) may require consideration for inhalation pain relief. For pain relief inhalation options in EC, see Pharmacy Methoxyflurane (Penthrox®) medication monograph.

Intravenous opioid administration in EC

This section includes intravenous (IV) fentanyl and morphine.

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 narcotics may administer them. See Pharmacy Adult Medication Guidelines: Fentanyl and/or Morphine, and DNAMER Competencies: IV Opioid Administration
3. The medication must be prescribed on the WA Short Stay Medication Record MR810.05.

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 persons may require lower doses of opioids to achieve an equivalent analgesic effect and the duration of analgesia is often longer.
6. Escalate observations as per relevant adult or postnatal ORC. This may require a Code Blue Medical call.
7. If the patient is not being admitted as an inpatient, they must remain in the EC for **two hours** following the last dose of an opioid.
8. When IV narcotics are prescribed, staff should ensure that they have access to Naloxone and are familiar with the indications and administration of the medication.

Medication

Drug	Diluent	Final solution concentration	Dose / bolus	Time between doses/ bolus	Maximum	Peak
Morphine 10 mg/mL	Dilute with 0.9% sodium chloride to 10 mL	10 mL = 1 mg/mL	2.5 mg (**2.5 mL**)	**5 min increments**	**10 mg**	20 mins
Fentanyl 100 microg/ 2 mL	Dilute with 0.9% sodium chloride to 10 mL	10 mL = 10 microg/mL	<70 years: 30 microg (**3 mL**) ≥70 years: 20 microg (**2 mL**)	**3 min increments**	*100 microg	Rapid. Several minutes

* Fentanyl- 100 microg maximum then medical review prior to consideration to further. Can give up to 200 microg in total.

Procedure

- Perform baseline observations (respiratory rate, oxygen saturation, heart rate, blood pressure, temperature, conscious level, pain score) prior to administration.
    - Patient should have a sedation score < 2 with respiratory rate > 12 / minute
- The medication is to be handled and administered in line with medication administration policies and site requirements.
    - The medication must be prescribed by a Medical Officer.
    - For checking, labelling and administration see WNHS Clinical Guideline, Pharmacy: Medication Administration (available to WA Health staff via HealthPoint)
    - For Schedule 8 Administration see WNHS Pharmacy guidelines: Medication Administration and Schedule 4 Restricted (S4R) and Schedule 8 (S8) Medications and NMHS Procedure: Administration of

Schedule 8 (S8) and Schedule 4 Restricted (S4R) Medicines Policy and Procedure (available to WA Health staff via HealthPoint)

- RN/RM must stay with medication solution and patient and **two** authorised health professionals must be involved in every step of the handling process as per WNHS Pharmacy Medication Administration guideline.

- **During administration**
  - The administering staff member must give the minimal amount prescribed. Remain with the patient and monitor response to the medication. If the patient's pain is not relieved, titrate subsequent doses according to the prescribed order.
  - Schedule 8 medications must not be left at the bedside.
  - Perform and record respiratory rate, oxygen saturation, pain score and sedation level before each bolus dose, and document each increment as given on the Emergency Centre Assessment form (MR021).
  - The total dose administered should be recorded and signed for next to the valid prescription on the medication chart.
- **Following administration:**
  - Repeat observations (respiratory rate, oxygen saturation, heart rate, blood pressure, conscious state and pain score) 10 and 20 minutes after last increment given. Further observations determined as per clinical condition and ORC.
  - Solution must be discarded in S8 liquid waste with two authorised persons and documented as per pharmacy and S8 policies.
  - Advise the prescribing officer of any adverse effects

Reversal (opioid)

- Patients who are suspected to have opioid overdose will need to be reviewed by a Senior Medical Officer and the Anaesthetic Team should be informed immediately if altered consciousness or airway compromise is observed. Escalate as per relevant adult or postnatal ORC. This may require a Code Blue Medical call.
- Indications include:
  - Complete or partial reversal of opioid-induced respiratory or CNS depression
  - Suspected acute opioid overdose
  - Opioid-induced pruritus
- Naloxone is the drug of choice. Administer intravenously: 400microg (1mL) every 2-3 minutes to a maximum dose of 10mg. IV infusion may be considered.
- See Obstetrics and Gynaecology guideline: Adult Resuscitation Drug Protocols: 'Naloxone' (available to WA Health staff through HealthPoint).
- For checking and administration see Pharmacy Adult Medication Monograph: Naloxone

Emergency Centre Administration Clinic (GYN561)

- Patients that have been reviewed in the Emergency Centre or post operative patients from the Emergency Theatre list may require follow up in terms of histopathology and/or general results.
- The GYN561 clinic is staffed with a rostered registered medical officer (RMO), with supervision provided by the Consultant rostered to EC for the duration of the session.
- The clinic and runs Monday – Friday 0800-1600hrs.
- Patients with results requiring follow up should be referred to GYN 561 Clinic using the referral slips provided in EC and given to EC clerk for processing.
- No patient should be given results over the phone or by text. GYN561 clinic will offer a letter to the patient or to their GP if that is their preference. If care is urgent or requires escalation, a face to face appointment is offered.

Compliance, monitoring and evaluation

The Health Services Performance Report (HSPR) monitors and reports monthly on WNHS compliance with key targets including unplanned hospital readmissions, EC patients who did not wait and EC extended length of episode. In addition, the EC Clinical Nurse Midwife Consultant monitors EDIS for recurrent presentations and Datix CIMS trends, escalating concerns to relevant key stakeholders.

Further compliance auditing may be undertaken at the direction of the Recognising and Responding to Acute Deterioration Committee (Standard 8), with any concerns escalated to the Clinical Governance Committee and / or relevant organisational committees.

References and resources

1. Department of Health Australian Government. Emergency Triage Education Kit [webpage]: Department of Health, Australia; 2013. Available from: https://www.health.gov.au/resources/collections/emergency-triage-education-kit

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Lvovschi, V, Aubrun, F, et al. Intravenous morphine titration to treat severe pain in the ED, The American Journal of Emergency Medicine; 2010; 676-686.

Silver book – Guidelines for managing sexually transmitted infections and blood-borne viruses http://ww2.health.wa.gov.au/Silver-book

Sir Charles Gairdner Osborne Park Health Care Group [SCGOPHCG]. Narcotic analgesia policy: Sir Charles Gairdner Hospital ED Area Specific Guideline. SCGOPHCG. 2019.

Related policies (external websites)

Department of Health, Australia

- Emergency Triage Education Kit (E TEK) (2024)

Department of Health, WA:

- MP 0171/22 - Recognising and Responding to Acute Deterioration Policy
- MP 0164/21 - Patient Activity Data
- MP 0175/22 Consent to Treatment policy
- Coordinated medical and forensic and counselling response to patients who experience a recent sexual assault and present to an emergency department

Related WNHS and NMHS policies, guidelines and forms

WNHS Policy:

- Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental health)
- Transfer Policy and Procedure- including Transfer of a critically unwell patient to an ICU at another hospital

WNHS Clinical Guidelines:

Obstetrics and Gynaecology:

- Pregnancy: First Trimester Complications
- 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
- Obstetrics and Gynaecology (Adult) Medication guidelines: Methoxyflurane (Penthrox®); Morphine; Naloxone
- Structured Administration and Supply Arrangements (SASA): Lactation Consultants: Cabergoline ; Domperidone

Additional related policies and resources (for SARC section):

- WNHS policy: Child Protection and Child Sexual Abuse (Mandatory Reporting)
- Legal Requests for Medical/Clinical Reports- direct requests to Medico Legal Services
- Medical record and patient information (confidentiality of): WNHS policy: Patient Information (Management of) and NMHS policy- Healthcare Record – Access and Document Release
- Department of Health WA: Guidelines for Protecting Children 2020; MP 0166/21 - Mandatory Reporting of Child Sexual Abuse Training Policy
- SARC website resources

Forms

- Emergency Centre Assessment - MR021
- Documentation of Incoming Calls - Emergency Centre - MR040.02
- SARC Emergency Care History and Checklist - MR6.2

- WA Short Stay Medication Record - MR810.05

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Version history

Number	Date	Summary
1.0	Sept 2017	First version **History**: In Sept 2017 amalgamated seven individual guidelines on care in EC dating from Feb 2012. 1. Triage and Observation in the Emergency Centre 2. Recording of Clinical Care Commencement Date and Time in EC 3. Admission of a patient to the Emergency Short Stay Unit 4. After hours management of emergency sexual assault resource centre (SARC) clients 5. High Vaginal Swab Collection in EC 6. Presentation and Management of Staff and Visitors(including patients from the MBU) with Non Gynaecological or Obstetric Conditions 7. IV Morphine Administration in the Emergency Centre
2.0	Feb 2018	Full review by guideline pod
3.0	May 2018	SARC section amended. • SARC continue to attempt to provide emergency medical/forensic 24 hour service.

		• The SARC box is to be checked and re-stocked by staff of SARC every six months or earlier if used. • Removed section regarding exceptions / priority 1 cases
4.0	Feb 2019	• 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 (p. 2) **[RCA recommendation]** • At triage/ presentation the appropriateness of admission to this service is considered (p.2) **[RCA recommendation]**
5.0	Mar 2019	• Recurrent presentations: If a patient has presented to any ED/EC 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.**[RCA recommendation]**
6.0	Oct 2021	• Document clinical advice given by telephone (e.g. to patients) on the 'Documentation of Incoming Calls- EC' MR form • Document all assessments and methods used to stabilise patients that occurs prior to patient transfer to another hospital • Only dual registration registered nurse/midwife shall undertake the role of triage not including graduates • Any member of the public who presents to the EC are triaged by the Triage Nurse/Midwife in the EC • Presentations with non-gynaecological or obstetric conditions- Provide immediate care of life-threatening conditions, provide patient comfort measures • Observations- refer to escalation and response processes on relevant ORC. All patients are commenced on the relevant ORC after triage. • 'Admission to the short stay unit' chapter removed- no longer used • SARC chapter (contacts, medical and forensics) updated • HVS section- added indications and now links to relevant guidelines for collection and opportunistic testing • ATS appendix removed- print copies available at triage desk • IV morphine administration section updated: ➢ Must be prescribed by a Medical Officer on Short Stay Medication Record MR810.05 ➢ Time to stay, if not admitted after dose, changed to **2** hours ➢ RN/RM must stay with medication solution and patient; ➢ Frequency of observations changed (baseline and 10mins post each dose)- record on relevant ORC ➢ Solution must be discarded in S8 liquid waste with two RN/RMs ➢ Reversal- Indications updated, Escalate as per relevant adult or postnatal ORC which may require a Code Blue Medical call)
7.0	July 2023	• Telephone advice section changed- Clinical advice should not be given to patients over the phone. Patients who phone with clinical enquiries should be redirected to contact HealthDirect, attend a GP or make their way to the EC in person or their nearest Emergency Department dependent on their level of concern • SARC chapter expanded to 'all hours' and process added to contact HCM office if EC unable to accommodate • Added link to Lactation Consultant SASAs
8.0	Dec 2023	• Requirements for notification to Gynae-Oncology senior medical officers (Fellow or Consultant) of any gynae-oncology patient presentations in EC [**RCA recommendation**] • Clearer timeframe (within 48hrs) associated with ED/EC re-presentations **[RCA recommendation]**

		• Narcotic chapter now includes fentanyl administration in EC • New section for compliance, monitoring and evaluation added. Includes roles and responsibilities associated with monitoring and escalating multiple ED/EC presentations **[RCA recommendation].**

9.0	May 2025	• Addition of Key Points, to the Triage in the Emergency Centre section:
		  • "The Emergency Centre Triage desk will be attended 24 hours a day by a Triage competent Midwife and/or Registered Nurse." **[CIMS Recommendation]**
		  • "If a patient is known to a gynaecology, obstetric, gynae-oncology or paediatric treating team at the Women and Newborn Health Service or is post-operative, the treating team should be made aware of the patients emergency presentation via email (to the Consultant, Senior Registrar and Registrar) before the patient leaves EC." **[CIMS Recommendation]**
		  • Inclusion nursing and midwifery staff must be consulted for medical opinion prior to discharging patients from the Emergency Centre. **[CIMS Recommendation]**
		• Patients in the waiting room are the responsibility of the Triage midwife and or Registered Nurse and waiting room Assistant in Nursing, with 30 minutely **visual observations** for 'eyes in the waiting room'. **Vital sign observations** will be done in the department, or in the waiting room depending on their triage score and EC capacity.
		• Re-triage is not advocated. Patients on reassessment in the waiting room whose condition deteriorates must be escalated immediately to the Emergency Centre Coordinator and/or Emergency Centre Consultant.
		• Inclusion of Triage competence criteria for midwives and registered nurses who work in the Triage role in the Emergency Centre. **[CIMS Recommendation]**
		• Observation frequency and escalation referred to the WNHS Policy Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health); patients to be visually observed at a minimum of hourly, and documented on the Emergency Centre Assessment Form.
		• New "Did not wait/Left at own risk" section. Content refers to the NMHS Policy : Management of 'Did Not Wait' and 'Left at Own Risk' Patients at Emergency Department/Centre.
		• New "Emergency Centre Administration Clinic (GYN561)" section. Content added, to ensure Emergency Centre and post operative patients' histopathology and general results are followed up by a registered medical officer, with supervision provided by the consultant. **[CIMS Recommendation]**
		• No patient should be given results over the phone or by text. GYN561 clinic will offer a letter to the patient or to their GP if that is their preference. If care is urgent or requires escalation, a face to face appointment is offered.

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