Assessment and Management in the Emergency Department - Clinical Practice Standard

1. Purpose

The purpose of this policy is to:

- Ensure evidence based minimum practice standards for the triage, assessment, care and management of unplanned patient presentations to emergency facilities.
- Minimise unwanted variation in clinical practice (overuse, misuse and underuse).
- Ensure safe, effective and efficient health outcomes, minimising preventable harm and decreasing wastage therefore reducing health expenditure.one1
- Ensure each presentation is newly assessed as a unique episode of illness/injury.
- Ensure appropriate documentation and clinical handover.

2. Scope

The scope of this policy relates to all medical, nursing and midwifery staff employed within WACHS. All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility and the scope of their professional registration as documented by the Australian Health Practitioner Regulation Agency.

2.1 Out of scope:

- Planned outpatient presentations such as wound or X-ray reviews are documented on the MR5 Outpatient Notes or identified in the Planned Return Visit vs Emergency attendance field in webPAS.
- When the ED is the only provider of **elective testing** i.e. ECG, spirometry etc. Refer also to WACHS Emergency Department Acute and Outpatient Activity Guideline.
- Pregnant women 20 weeks gestation or more, presenting to the ED at a hospital with a maternity ward with a pregnancy related condition should be sent straight to maternity for midwifery assessment. Refer to Appendix 6 – Pregnant Women 20 Weeks or More Presenting to a Maternity Site.

3. Communicating for Safety in the Emergency Department

To minimise the risks arising from patient aggression:

- The triage area should be as private as possible for easy staff egress and duress capability.

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- Refer to local Code Black procedure. Each site should have a local management plan for identifying and managing patients know to be at risk of aggression towards hospital staff.
- It is mandatory for all ED clinicians to be trained in aggression management.
- Refer to the Chief Psychiatrist of Western Australia, DOH Principles and Best Practice for the Care of People Who May be Suicidal.
- Refer to the WACHS Working in Isolation – Minimum Safety and Security Standards for All Staff Policy.
- Early notification of the Emergency Telehealth Service (ETS). Documentation of telephone conversation including handover of patient.

3.1 Clinical Handover

In all cases clinical handover must include information exchange between all disciplines as per the National Safety and Quality Healthcare Service (NSQHS) Standard- Communicating for Safety, and MP 0095/19 Clinical Handover Policy using the iSoBAR framework.

3.2 Consent to Treatment

Patients undergoing procedures in the ED must be provided with full information and their consent documented as per MP 0657/18 Consent to Treatment Policy. The policy provides guidelines for those unable to provide consent on their own behalf and for life-threatening emergency situations.

3.3 Partnering with Consumers

Ensure measures are in place to maintain patient privacy and dignity. Offer the presence of a chaperone where appropriate to patient and clinician requirements, refer to the WACHS Chaperone Policy. Provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements.

4. Triage Process

4.1 Triage Competency

Registered Nurses performing triage must:

- be employed at a minimum Registered Nurse level 1.2
- be endorsed by their Primary Supervisor / Line Manager to perform the role of Triage
- Compete the Triage Continuing Professional Development (CPD) Declaration (NEDT 001-1) in the WACHS Learning Management System annually, acknowledging completion of least one of the following elements each year:
    - 1 year full-time equivalent in an Emergency Department setting with Triage capacity

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    - Minimum of 3 shifts at a Regional Resource Centre (RRC) Emergency Department supervised in the Triage role. The RRC may be substituted by a similar or equivalent facility that is endorsed by the regional Nurse Educator or line manager (SNR 3 or above)
    - Complete WACHS Triage Theory Assessment (NEDT EL2)
    - Attend CRANA Plus Triage Emergency Care Course
    - Performs in a minimum of 5 case reviews, discussing findings within the workplace team. Maintains evidence using WACHS Triage Case Review template.
    - Completion of at least one Peer Review by endorsed WACHS Triage Assessor. Evidence to be maintained on WACHS Peer Review template.
- Demonstrate annual competency in all of the following:
    - Basic Life Support (adult & child) competency (REABL/ REPBL 003).
    - Advanced Life Support - Adult competency (REALH 003).
    - Advanced Life Support - Paediatric competency (REP 003).
- Must have successfully completed, (minimum once only or as directed by line manager) all of the following:
    - WACHS Triage Theory Assessment (NEDT EL2)
    - WACHS Triage Practical Assessment (NEDT 003).

    Nb. Staff may apply for Recognition of Prior Learning (RPL) of an accepted triage education program as described in the WACHS Learning & Development Program Catalogue

Registered Nurses facilitating Triage competency of others must have:

- Current Triage competency as described above
- Be recommended as an Competency Facilitator by their Primary Supervisor
- Participate in Quality Improvement Activities including:
    - involvement in the audit of MR1 documents
    - development of action plans and improvement strategies based on audit results
- Completed the Triage Competency Facilitator Declaration (NEDT 004) annually, including Reflective Practice Activity for Assessors.

Note: Sites which roster two nurses per shift are to ensure one holds a current triage competency as listed above. A staff member who is yet to achieve triage competency must seek guidance from either the triage competent nurse onsite or through WACHS Command Centre Emergency Telehealth Service (ETS). All nursing staff at ETS must be triage competent.

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4.2 Initial Referral

Regardless of referral or mode of transport to the ED, all patient contacts with the triage nurse must be documented on the MR1 WACHS Emergency Department Notes. The process for managing emergency department presentations is defined in Appendix 2 - Management of Patient Presentations to ED throughout WACHS.

4.3 Telephone

The receiving clinician should quickly establish if the caller requires an emergency vehicle to attend.

- If yes, document the patients' name, phone and address details and transfer them to '000' immediately.
- Do not hang up until they are connected to the emergency vehicle provider.
- If necessary place hospital response teams on standby e.g. trauma team, local GP as per local procedure.
- Consider early notification of ETS (Emergency Telehealth Service)

4.4 General call for non- emergency advice

Redirect caller to HealthDirect – Telephone: 1800 022 222, Hearing Impaired Text Telephone (TTY): 1800 022 226.

4.5 Mental Health Call for non-emergency advice

Redirect caller to WA ***RuralLink*** (specialist after-hours mental health) – Telephone: 1800 552 002, Hearing Impaired Text Telephone (TTY): 1800 720 101.

Child and Adolescent Acute Response Team 1800 048 636.

5. Emergency Triage and Immediate Management

5.1 Triage – Primary Survey

- All patients are to be assessed on arrival to the health care facility, according to the ATS guidelines.
- Rapid visual survey of Airway, Breathing, Circulation, Disability and Exposure (ABCDE) assessment is to occur.
- The most urgent and high risk clinical features determine the ATS category, with consideration of mechanism of injury and co-morbidities. Relief of pain is a legitimate reason for a higher ATS category.
- Triage does not require formal physiological observations. Palpation of pulses can ascertain quality and rate of heart rate, condition of skin (cool, dry etc.).
- Commence nurse-initiated care activities i.e. first-aid, pain relief, or escalation of care as indicated.

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ATS Category	Maximum waiting time for assessment and treatment	Performance indicator threshold
1	Immediate	100%
2	10 minutes	80%
3	30 minutes	75%
4	60 minutes	70%
5	120 minutes	70%

Refer to Appendix 3 - Australasian Triage Score Categories and Appendix 4 - Triage Clinical Descriptors.

5.2 Nursing documentation

The triage assessment and ATS code allocated must be recorded on the MR1 WACHS Emergency Department Notes. Refer also to the OD 0590/15 Recording and Reporting of Clinical Care Commencement Date and Time in the Emergency Department.

5.3 Nursing observations

A Nurse is to be notified of:

- Any patient who cannot be seen within the recommended ATS timeframes must be commenced on a MR140A WACHS Observation and Response Chart series, appropriate to age – (Adult Chart for 16 years and over if deemed mature / appropriate).
- All patients in the waiting room must be re-assessed once the triage time has expired as per the table above.
- Observations in the waiting room are done as per ATS criteria unless the patient's clinical condition dictates more frequent observations:
  - ATS 3 - every 30 minutes
  - ATS 4 - every 60 minutes (1 hourly)
  - ATS 5 - two hourly.

Escalation of abnormal observations should be as per the ORC criteria and documented on the MR1.

5.4 Medical Officer or Nurse Practitioner Notifications

A Medical Officer (MO) is to be notified of:

- All patients categorised as ATS category 1-2.

A Medical Officer (MO) or Nurse Practitioner (NP) is to be notified of:

- All patients categorised as ATS category 3-5.
- Any patient who re-presents with 48 hours for the same condition.
- Any presentation in which the provisional diagnosis is not clear.

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- All patients who meet Trauma Team Notification criteria as per the trauma descriptors in Appendix 4 - Triage Clinical Descriptors and complete the MR2 WACHS Emergency Department Trauma Notes.
- Additional triage indicators which require review by or discussion with a MO or NP are listed in Appendix 5 - Triage Risk Factor Indicators or Review or Discussion with Medical Officer (MO) / ED Nurse Practitioner (NP).
- Where a local MO or NP are not available, contact Regional Resource Centre (RRC) MO or hub hospital (Wheatbelt), Emergency Telehealth Service (ETS) or Royal Flying Doctor (RFDS).
- Refer to local practice and ETS guidelines Appendix 11 - Emergency Telehealth Service Referral Process for referral process to ETS escalation of care.

5.5 Mental health considerations

Key considerations for triage of mental health presentations:

- The usual primary-survey approach to assessing all incoming patients is to be complete prior to commencing mental health assessment. The higher ATS (general or mental health specific) is documented and acted upon to expedite appropriate review and treatment.
- Mental health triage is based on assessment of observed and reported clinical features and undertaking WACHS BACPAC Mental State Assessment.
- The allocation of a triage code must be based on clinical criteria that are consistent with ATS descriptors for mental health presentations. Refer to Appendix 4 - Triage Clinical Descriptors.
- Refer to WACHS Mental Health Care in Emergency Departments and General Wards Policy.
- Where indicated complete an MR46 WACHS Suicide Risk Assessment and Safety Plan.
- Adult and paediatric community mental health links for Child and Adolescent Acute Response Team and RuralLink (free call 1800 552 002 or [TTY] 1800 720 101).
- People presenting with mental health problems and associated risk to self or others may be treated under Duty of Care, or by reference to the MH Act 2014: "Emergency Psychiatric Treatment (EPT)". Refer to Appendix 1 - Definitions.

5.6 Paediatric presentations

For the purpose of emergency presentations to ED a paediatric presentation is any child under the age of 18 years. Key considerations for triage of paediatric presentations:

- The clinical priorities and the principles of urgency for infants, children and adolescents are the same as those for adults.
- Determining the urgency will require recognition of serious illness, some features of which may be different in infants and children. Refer to Appendix 4 - Triage Clinical Descriptors and Appendix 5 - Triage Risk Factor Indicators for Review or Discussion with Medical Officer / ED Nurse Practitioner. Where

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applicable refer to OD 0606/15 Guidelines for Protecting Children and WACHS WebPAS Child at Risk Alert Procedure.

- The value of parents, carers or significant others and their capacity to identify deviations from normal in their child's level of function should not be underestimated.
- Infants that are preterm must be placed on the age adjusted appropriate MR 140 Paediatric Observation and Response Chart. Refer to section 15. Related Forms.

5.7 Dead on arrival

Refer to WACHS Care of the Deceased Policy and the related suite of procedures and forms.

5.8 Did not wait

Refer WACHS Management and Review of “Did Not Wait” Patients that Present to Emergency Services Policy.

5.9 Primary Assessment

Primary Assessment must involve:

- A systematic physiologic assessment.
- A full set of physiological observations.
- The patient's presenting complaint, past history, current medications and allergies.

Relevant clinical care pathways should be implemented at this point.

5.10 Secondary Assessment

The secondary survey/assessment builds upon the primary assessment:

- Once immediate life-threatening issues have been treated.
- Includes a further complete physical examination to ensure that no injuries have been missed.

Other considerations that may apply include Emergency Telehealth Referral Process, Advanced Health Directives (AHD), WebPAS risk alerts, cultural needs and Next of Kin.

A clinician working within their scope of practice may commence specific clinical care using established protocols, procedures or endorsed guidelines.

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6. Management of Pregnant or Postnatal Women

6.1 Principle of triage assessment for pregnant and postnatal women

- There are no ATS categories specific to pregnancy related conditions. Some guidance is provided in Chapter 9 of the Emergency Triage Education Kit and the following:
  - For presentations to ED with a maternity service – Refer to Appendix 7 – ED Obstetric Triage Pathway.
  - For presentations to ED with a no maternity service – Refer to Appendix 8 – ED Obstetric Triage Pathway for Non-maternity Service Sites.
  - The triage nurse must confirm the gestation using Estimated Due Date (EDD); this is calculated from the first day of the Last Normal Menstrual Period (LNMP) or an EDD by first trimester ultrasound scan.
  - All pregnant women 20 weeks or more need to be triaged and then follow Appendix 7 – ED Obstetric Triage Pathway and commenced on a MR140B WACHS Maternal Observation & Response Chart.
  - Assessment of pregnant women who are more than 20 weeks or postnatal is not within the scope of a nurse.
  - Postnatal women include those who present up to six weeks after giving birth.
  - For women who are obviously in labour and birth appears imminent refer to the WACHS Management of Imminent Unplanned Birth at Non-Birthing Service Sites Policy.
  - All women of child-bearing age are to be considered to be pregnant until proven otherwise.

6.2 Clinical telephone advice

If the caller does not require an emergency vehicle, either direct the caller to:

- The maternity service they are booked to give birth at, OR
- HealthDirect as per 'General Medical' telephone referrals.

6.3 Nursing assessment of pregnant woman 20 weeks and over

- Triage in the emergency department.
- Refer to Appendix 9 – Nursing History for a Pregnant Woman.
- A single fetal heart rate by Doppler does not constitute an assessment of fetal wellbeing and should not be routinely undertaken by non-midwives and non-obstetric doctors as:
  - They may not know normal /abnormal parameters.
  - There is no ability to act on an abnormal fetal heart.
  - If the fetal heart cannot be found, which may be due to inadequate technique rather than absence of a fetal heart, is may be distressing for the mother and possibly the staff.

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    - A single fetal heart rate tells you only that the baby is alive at the time it is taken and an ill baby can still die shortly thereafter.
- Cardiotocograph monitoring should not be ordered by non-midwives and non-obstetric doctors.

6.4 Vaginal examinations of pregnant woman 20 weeks and over

- Assessment should be made on the woman's presenting symptoms and vaginal examination should not influence management or decision making.
- Vaginal examination should not be undertaken by non-midwives and non-obstetric doctors, as the assessment is very likely to be inaccurate and therefore misguide appropriate management / transfer.
    - Cervical status can change rapidly so may be falsely reassuring.
    - Risks of introducing infection to the mother and/ or fetus.
    - Risks of causing rupture of membranes.
    - Risks of increasing likelihood of preterm labour /birth.
    - Risks of causing haemorrhage if placental location is not known.
    - Unnecessary discomfort and exposure to the woman.
- It is outside the scope of practice for a Registered Nurse whom is not a Registered Midwife to undertake a vaginal examination in this context and any requests for the Registered Nurse to undertake this procedure must be declined.

6.5 Symptoms requiring obstetric / midwifery consult:

- Pregnant women can present with symptoms that may appear to a non-midwife nurse and non-obstetric doctors to be unrelated to the pregnancy.
- Refer to Appendix 6 – Symptoms in the Pregnant or Postnatal Woman Requiring Obstetric MP and/or Midwifery Consultation before Discharge from the ED.
- These symptoms can be associated with significant maternal or fetal complications and as such require consultation with either an obstetric medical practitioner or midwife.
- Refer to Appendix 8 – Pathway for Obstetric or Midwifery Advice for ED / ETS Staff at a Non-maternity Site.

7. Implementing and Evaluation of Care

7.1 Planning

Following the secondary survey / assessment an individualised management plan is to be documented, at a minimum, including:

- Patient history and presence of comorbidities (MR1).
- Differential diagnoses.
- Treatment for pre-existing and current condition.
- Including emulation of treatment by patient response.

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Medications (MR170 series).

- Frequency and type of observations.
- Psychosocial and cultural factors that could influence patient care planning and treatment.
- Patient education and consent.
- Any limits on interventions associated with AHDs or similar.
- Diagnostics undertaken and process of review.
- Refer to the General, Paediatric and Mental Health General Management Principles e.g. actions and considerations - Appendix 10 - General Management Principles.

8. Admission, Transfer and Discharge Planning and Disposition

8.1 Decision to admit

- Ensure that a complete iSoBAR handover occurs between the ED and the ward. Refer to MP0095/19 Clinical Handover Policy.

8.2 Decision to transfer

- Refer to the WACHS Assessment and Management of Interhospital Patient Transfers Policy. The most senior WACHS clinician at the site, including ETS, is responsible for care and decision to transfer as per the policy.
- WACHS Link is a model for transferring emergency and urgent patients requiring tertiary level care.
- Patients awaiting transfer must continue to receive regular observations, escalation and treatment until care is handed over to the retrieval team.

8.3 Decision to discharge

- A decision to discharge a patient from the emergency department in rural facilities can only be taken by a MO, NP or senior Registered Nurse, after a comprehensive secondary assessment.
- If the patient has ongoing significant symptoms and the diagnosis is unclear, the patient must be discussed with a MO/NP prior to discharge.
- Discharge of children aged < 2 years by a NP or senior Registered Nurse must be in consultation with a MO either onsite, by phone or by ETS.
- Considerations should include the suitability of the patient's proposed residence, the availability of safe transport and the availability of supervision or carer support according to the identified discharge needs.
- Patients and carers must be provided with a ED discharge summary, written information and education for their condition and information as to how to provide consumer experience feedback.

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8.4 Discharge against medical advice

Wherever possible, liaise with MO to review patient prior to patient leaving hospital. Refer to WACHS Admission, Discharge and Intra-hospital Transfer CPS.

9. Staffing Requirements

Refer to the WACHS Emergency Care Capability Framework Report and Emergency Care Minimum Requirements Matrix for minimum medical and nursing staffing requirements in emergency departments.

9.1 Triage Nurse

- The triage nurse is to be a qualified and experienced registered nurse level 1.2 or above and competent as documented in Section 4 Triage Process.
- Sites which roster two nurses per shift must ensure one nurse is triage competent.
- The enrolled nurse may be the first person to document an initial assessment. The enrolled nurse **must then immediately notify** an appropriate triage competent registered nurse or nurse practitioner of the patient's arrival and the findings of the initial assessment.
- The registered nurse or nurse practitioner is then required to attend the patient to complete a triage assessment.

10. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System. Refer to WACHS Records Management Policy and Health Record Management Policy.

11. Evaluation

Monitoring of compliance with this document is to be carried out by Regional Nursing and Midwifery Directors and Regional Medical Directors. Refer to the facility audit schedule WACHS Recognising and Responding to Acute Deterioration Audit specific to Emergency Department patients.

12. Standards

National Safety and Quality Health Service Standards: 2.1, 5.4, 6.1, 8.1, 8.4, 8.5, 8.8, 8.9, 8.10

Aged Care Accreditation Standards: 1, 2, 3, 5, 8.

National Standards for Mental Health Services: 10.3, 10.4, 10.5.

National Standards for Disability Services: 1, 5, 6.

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13. Compliance Monitoring

Performance and evaluation of triage practices are to be monitored through site, regional and central level governance processes including:

- Clinical audit of triage using the agreed WACHS audit tool and process http://wachs.hdwa.health.wa.gov.au/?id=3136
- Review of key performance indicators such as Percentage of emergency department patients seen within recommended times by triage category and WA Emergency Access Target (WEAT) within the Health Service Performance Report (HSPR)
- Review of any clinical incidents involving triage.

14. Legislation

(Accessible via: Western Australian Legislation or ComLaw) sites)

- *Carers Recognition Act 2004*
- *Children and Community Services Act 2004*
- *Civil Liability Act 2002*
- *Criminal Code Act Compilation Act 1913*
- *Disability Services Act 1993*
- *Equal Opportunity Act 1984*
- Equal Opportunity Regulations 1986
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Mental Health Act 2014*
- *Occupational Safety and Health Act 1984*
- Occupational Safety and Health Regulations 1996
- *Pharmacy Act 1964*
- *Poisons Act 1964*
- Poisons Regulations 1965
- *Privacy Act 1988*
- *Public Sector Management Act 1994*
- *State Records Act 2000*

15. References

Department of Health and Ageing Emergency Triage Education Kit

DOH Guidelines for Protecting Children

WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response policy (2018)

WACHS Emergency Department Acute and Outpatient Activity Guideline

WACHS Clinical observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance)

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WA health system Credentialing and Defining Scope of Clinical Practice Policy

WA health system Clinical Governance, Safety and Quality Policy Framework

WA health system Information Management Policy Framework

16. Related Forms

MR1 WACHS Emergency Department Notes

MR1B Chest Pain Pathway – All patients presenting with chest pain are to be commenced on the MR1B chest pain pathway. At any stage of the ED episode, if the MO or NP deems that the patient does not need to continue on the pathway, they can be discharged from the pathway.

MR140 WACHS Medical Emergency Response / Code Blue Record

MR140A Adult Observation and Response Chart (A-ORC)

MR140B Maternal Observation and Response Chart (M-ORC)

MR140C Additional Maternal Observation Chart

MR140D Paediatric Observation and Response Chart (N-ORC)

MR140E Paediatric Observation and Response Chart (P-ORC - under 3 months)

MR140F Paediatric Observation and Response Chart (P-ORC - 3-12 months)

MR140G Paediatric Observation and Response Chart (P-ORC - 1-4 yrs)

MR140H Paediatric Observation and Response Chart (P-ORC - 5-11 yrs)

MR140I Paediatric Observation and Response Chart (P-ORC - 12+ yrs)

MR170.1 Medication History and Management Plan

MR170A National Inpatient Medication Chart - Adult Short Stay

MR170C Anticoagulant Medication Chart

MR170D National Inpatient Medication Chart - Paediatric Short Stay

MR170E National Inpatient Medication Chart - Paediatric Long Stay

MR172A and B - Tenecteplase forms – Any patient who presents with an acute myocardial infarction requiring thrombolysis is to have their treatment assessed and managed as per the MR172a and MR172b form

MR2 WACHS Emergency Department Trauma Chart (Adult) – All major trauma is to be documented on the MR2 trauma sheet

MR111 WACHS Nursing Admission, Screening and Assessment Tool or MR111P WACHS Paediatric Nursing Admission/Discharge Assessment form - As a minimum complete the comprehensive skin assessment, Braden score, malnutrition screening tool, and falls risk assessment.

MR184 WACHS Inter-hospital Clinical Handover form

Patient Transfer Envelope Checklist

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WACHS Safe Transport and Transfer of Country Mental Health Patients Flowchart.

MR36 WACHS Discharge Against Medical Advice Form

MR46 WACHS Suicide Risk Assessment and Safety Plan

17. Related Policy Documents

WACHS Mental Health Care in Emergency Departments and General Wards

WACHS Chaperone Policy

WACHS WebPAS Child at Risk Alert Procedure

WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy

WACHS Clinical observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance)

WACHS Mental Health Care in Emergency Departments and General Wards Policy

WACHS Working in Isolation - Minimum Safety and Security Standards for All Staff Policy

18. Policy Framework

Clinical Governance, Safety and Quality

Information Management

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19. Appendices

Appendix 1 Definitions

Appendix 2 Management of Presentations to ED in WACHS Facilities

Appendix 3 Australasia Triage Score Categories

Appendix 4 Triage Clinical Descriptors

Appendix 5 Triage Risk Factor Indicators for Review or Discussion with Medical Officer / ED Nurse Practitioner

Appendix 6 Symptoms Requiring Either Obstetric MP and/or Midwifery Consultation before Discharge from the ED

Appendix 7 Obstetric Triage Pathway for EDs in a Maternity Hospital

Appendix 8 Pathway for Obstetric / Midwifery Advice by ED or ETS Staff at a Non-maternity Site

Appendix 9 Nursing History for a Pregnant Woman

Appendix 10 General Management Principles - General, Paediatric and Mental Health - ATS 1 to 5

Appendix 11 Emergency Telehealth Service Referral Process

This document can be made available in alternative formats on request for a person with a disability

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Directorate:	Nursing & Midwifery Services	EDRMS Record #	ED-CO-16-73455
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Appendix 1 – Definitions

Term	Definition
Advanced Life Support	Involves the management of a cardiac arrest or other medical emergencies in a clinical setting, and includes recognition of the critically ill patient, airway management (including LMA at some sites), resuscitation procedures, defibrillation and basic drug therapy.
Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, 2015).
Close on call	Appropriate health practitioner available to attend site within 10 minutes.
Consumer	A person who uses, or may potentially use, health services. Depending on the nature of the health service organisation, this person may be referred to as a patient, a client, a consumer, a customer or some other term. Consumers also include families, carers, friends and other support people, as well as representatives of consumer groups.
Continuous visual surveillance	Patient is under direct visual observation at all times.
Direct supervision	Direct supervision is considered to be in the company of an RN or medical practitioner or visually via an emergency tele-health service.
Emergency psychiatric treatment	Sections 202 – 204 of the *MHA 2014* allow for emergency psychiatric treatment to be provided to a patient without informed consent: • where treatment needs to be provided to save the person's life, or • where treatment needs to be provided to prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person. The MO who provides emergency psychiatric treatment must make a record of that treatment (Form 9A). A copy of the form must be provided to the person, the Chief Psychiatrist and, if the person is a mentally impaired accused, to the Mentally Impaired Accused Review Board. (OD 0657/16).
Triage system	The process by which a clinician assesses a patient's clinical urgency.
Triage	A triage system is the basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure.
Urgency	Urgency is determined according to the patient's clinical condition 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. For example, patients may be triaged to a lower urgency rating because it is safe for them to wait for an emergency assessment, even though they may still eventually require a hospital admission for their condition or have significant morbidity and attendant mortality.

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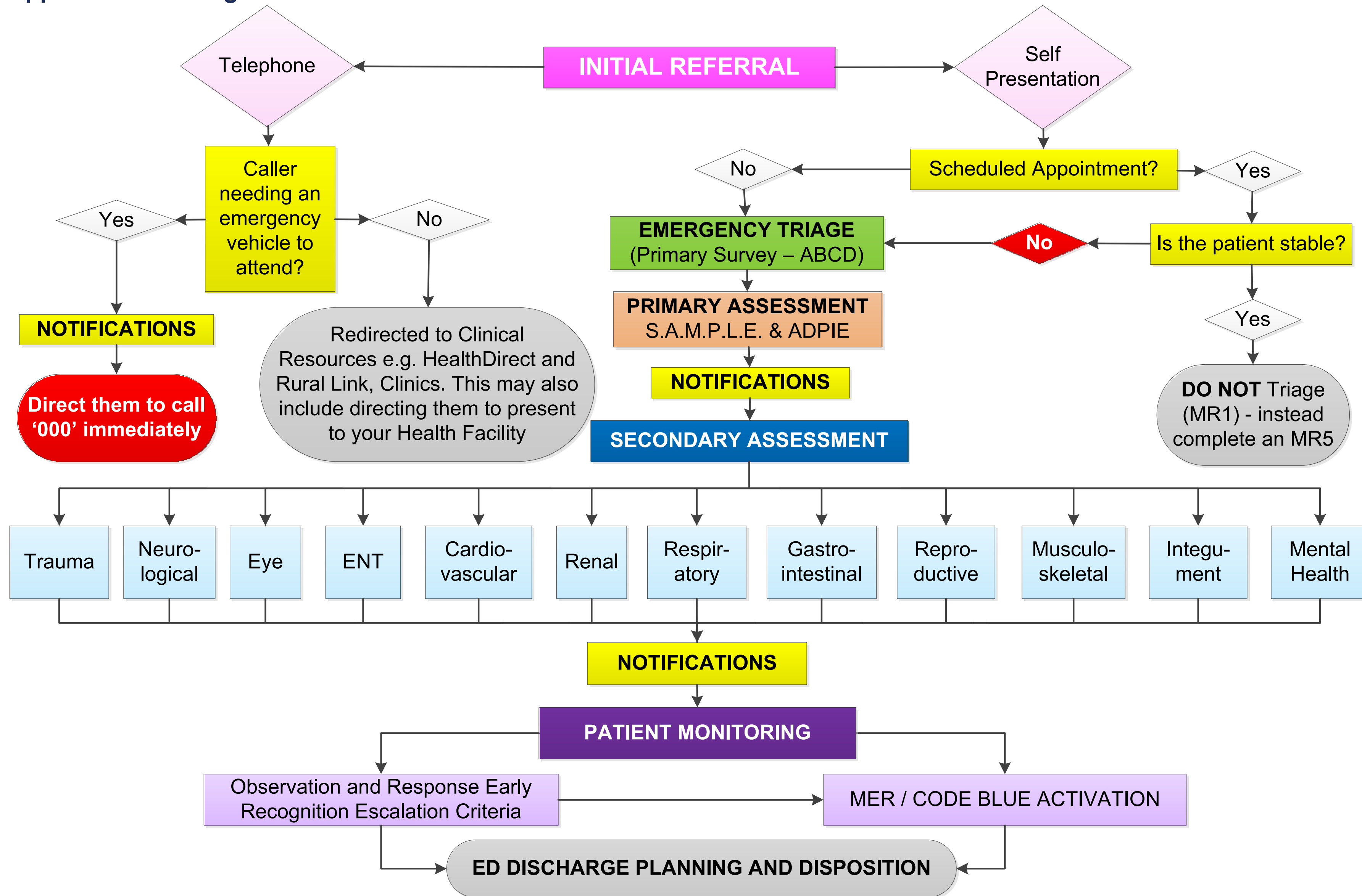
Appendix 2 - Management of Patient Presentations to ED in WACHS Facilities



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Appendix 3 - Australasian Triage Score Categories

The time allocated to each ATS category describes the maximum time a patient can safely wait for medical assessment and treatment (ACEM 2013 & 2016). All ATS 1-3 and any in **Appendix 5** must be reviewed by MO or NP.

ATS	DESCRIPTION OF CATEGORY	RESPONSE Key Performance Indicator	National Target Times
1	Immediately life-threatening - Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive treatment.	**Immediate -** Simultaneous assessment and treatment	100%
2	Imminently life-threatening condition or deteriorating so rapidly that there is the potential of threat to life/foetus/organ system failure or important time-critical intervention e.g. antidote, thrombolysis, or human practice mandates the relief of very severe discomfort/pain or distress. Pain score 7-10 (severe)	**Within 10 minutes** - Assessment and treatment	80%
3	Potentially life-threatening – may progress to life or limb threatening, or may lead to significant morbidity, or potential for adverse outcome or time-critical treatment; or human practice mandates the relief of severe discomfort or distress. Pain score 4-6 (moderate).	**Within 30 minutes -** Assessment and treatment	75%
4	Potentially life-serious condition may deteriorate, or possible adverse outcome or time-critical treatment; Symptoms moderate or prolonged or situational urgency or significant complexity or severity likely to require complex work-up and consultation and/or inpatient management or human practice mandates the relief of severe discomfort or distress. Pain score 1-3 (mild)	**Within 60 minutes** - Assessment and treatment start	70%
5	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 or clinic-administrative problems e.g. request for prescription only; results review; medical certificate. Pain score 0 (no pain)	**Within 120 minutes -** Assessment and treatment start	70%

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Appendix 4 - Triage Clinical Descriptors – Airway and Breathing

(Note: This list is not exhaustive; advice should be sought for any other concern relating to safety of a patient (ACEM 2016).

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
AIRWAY	ALL PATIENTS	Immediate risk to airway: • Completely obstructed • Partially obstructed • Threatened airway (swelling / facial burns) or airway management required	• Patent • Airway risk– severe stridor or drooling with distress • Partially obstructed with moderate respiratory distress	• Patent • Partially obstructed with mild respiratory distress • Able to verbalise	• Patent • Foreign body aspiration with no respiratory distress	• Patent
BREATHING	ADULTS	Extreme respiratory distress: • Absent respiration/respiratory arrest • RR<10 or >36 • Hypoventilation SpO_2 <85%	Severe respiratory distress: • RR <10 or >29-35 • SpO_2 85-90%	Moderate Respiratory Distress: • Moderate shortness of breath • RR 25-29 • SpO_2 91 – 94%	Mild or no Respiratory Distress: - RR 20-24 - SpO_2>94% • Chest injury without rib pain or respiratory distress • Difficulty swallowing, no respiratory distress	No respiratory distress • RR 10-20 $Sp0_2$>94%

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

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Appendix 4 - Triage Clinical Descriptors Breathing Continued

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
BREATHING	PAEDIATRIC	Extreme respiratory distress: • Absent respiration • Hypoventilation • Severe respiratory distress e.g. severe use accessory muscle, severe retraction, acute cyanosis • RR and SpO_2 dependant on parameters for ORC age range	Severe respiratory distress: • Moderate use accessory muscles, moderate retraction, skin pale • RR and SpO_2 dependant on parameters for ORC age range	Mild-moderate respiratory distress: • Mild use accessory muscles, mild retraction, skin pink • RR and SpO_2 dependant on parameters for ORC age range	No Respiratory Distress: • RR and SpO_2 dependant on parameters for ORC age range	No respiratory distress

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Appendix 4 - Triage Clinical Descriptors Circulation

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
CIRCULATION	ADULTS	Severe circulatory compromise: • Absent circulation/Cardiac arrest • SBP<90 • Heart rate<40 or >140 • Uncontrolled haemorrhage	Moderate circulatory compromise: • Clammy, mottled skin, skin pale, cool, poor perfusion • Heart rate <50 or 120-140 • Hypotension SBP<90 or Hypertension SPB 200+ • Severe blood loss • Chest pain • Fever 38° C+ with signs of lethargy (any age) • Suspected sepsis (haemo-dynamically unstable) • Febrile neutropenia-immunosuppressed, oncology or steroid therapy • Hypothermia <35.0°C	Mild circulatory compromise: • Palpable peripheral pulses, skin pale, warm • Mild tachycardia HR 110-119 • Severe hypertension SBP 160-200 • Moderately severe blood loss – any cause • Suspected sepsis (haemodynamically stable) • Persistent vomiting • Dehydration	No circulatory compromise: • Skin pink and warm, no alteration in vital signs • Mild haemorrhage • Vomiting or diarrhoea without dehydration	

Appendix 4 - Triage Clinical Descriptors Circulation Continued

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
CIRCULATION Paediatric signs and symptoms (s/s) of dehydration: - ↓LOC/activity - Cap refill> 2 secs - Dry mucous membranes - Absent tears - Sunken eyes/ fontanelles - ↓Tissue turgor - Deep respirations - Thready/weak pulse - Tachycardia - ↓Urine output / <4 wet nappies in 24hrs - Weight loss >4-5%	PAEDIATRIC	Severely Shocked Child: • Absent circulation • Significant bradycardia e.g. <60 in an infant • Severe haemodynamic compromise (absent peripheral pulses, skin pale, cold, moist mottled, significant tachycardia as per ORC for age range; capillary refill >4 seconds) • Uncontrolled haemorrhage	Moderate circulatory compromise: • Skin pale, cool, moderate tachycardia as per ORC for age range, capillary refill 2-4 seconds • >6 s/s dehydration • Fever with signs of lethargy/ increased irritability (any age) • Any neonate or corrected preterm age < 28 days • Age < 3 months and febrile (38.0°C) • Age < 5 years, febrile (38.5°C) and with signs of lethargy or increased irritability or rash or co-morbidities	Mild circulatory compromise: • Palpable peripheral pulses, skin pale, warm • Mild tachycardia as per ORC for age range • 3-6 s/s dehydration	No circulatory compromise: • Palpable peripheral pulses, skin pink warm and dry as per ORC for age range) • <3 s/s dehydration	• No s/s of dehydration

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

Appendix 4 - Triage Clinical Descriptors Disability

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
DISABILITY	ADULTS	• AVPU- Unresponsive • Glasgow Coma Score GCS< 8 • Ongoing/prolonged seizure • Pupils: fixed and dilated (Indication of possible drug overdose or head trauma) • IV drug overdose and unresponsive or hypoventilation	• AVPU- responds to pain only • GCS 9 – 12 • Drowsy, decreased responsiveness of any cause • Sudden severe headache with altered GCS • BSL <3 or >19 mmol • Suspected provisional diagnoses (Acute stroke, meningococcemia) • Significant sedative or other toxic ingestion • Significant or dangerous envenomation	• AVPU- responds to voice • GCS >13 • Sudden severe headache with normal GCS • BSL > 16-18 mmol • Head injury with short loss of consciousness, now alert • Seizure, now alert • Suspected stroke	• Normal GCS or no acute change to usual GCS • AVPU - Alert • Minor head injury, no loss of consciousness	• Normal GCS

Appendix 4 - Triage Clinical Descriptors Disability and Pain

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
DISABILITY	PAEDIATRIC	• GCS <8 • Ongoing / prolonged seizure	• GCS 9 – 12 • Severe decreases in activity (no eye contact, decreased muscle tone) • Significant sedative or other toxic ingestion • Significant / dangerous envenomation	• GCS >13 • Moderate decrease in activity (lethargic, eye contact when disturbed)	• Normal GCS or no acute change in usual GCS • Mild decrease in activity (quiet but eye contact, interacts with parents)	• Normal GCS • No alteration to activity (playing, smiling)

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Appendix 4 - Triage Clinical Descriptors Neurovascular and Trauma

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
PAIN	ALL PATIENTS		• Very severe pain (pain score 7-10) requiring analgesia, affecting physical capacity emotions and or behaviour. Including possible: cardiac cause, acute myocardial infarction, AMI, PE, aortic dissection, pulmonary embolus, aortic dissection, abdominal aortic aneurysm, ectopic pregnancy, ischaemic leg, ischaemic gut, renal colic, dislocated hip or shoulder	• Moderate severe pain (pain score 4-6) requiring analgesia • Chest pain likely non-cardiac • Abdominal pain without high risk features of moderate-severe pain or patient age >65 years	• Moderate pain (pain score 1-3) some risk features and/or requiring analgesia • Non-specific abdominal pain	• Minimal pain

For additional information on paediatric patients please refer to Emergency Triage Education Kit – Chapter 8: Paediatric Triage.

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Appendix 4 - Triage Clinical Descriptors Neurovascular and Trauma

		Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
NEUROVASCULAR	ALL PATIENTS		• Severe neurovascular compromise; pulseless, cold, nil sensation, nil movement, ↓ cap refill	• Moderate neurovascular compromise; pulse present or acutely absent, cool, ↓ sensation, movement and / or cap refill	• Mild neurovascular compromise; pulse present, normal/ ↓ sensation, movement and/or cap refill • Tight cast- with no neurovascular impairment • Swollen 'hot' joint/s	• No neuro-vascular compromise

Appendix 4 - Triage Clinical Descriptors Neurovascular and Trauma

TRAUMA ALL PATIENTS					
Major trauma criteria ATS1 or 2: - Penetrating injury - Fall > 3 metres (paediatric fall >1m) - MCA > 60kph; MBA / cyclist > 30kph; Pedestrian - Explosion - Ejection/rollover - Prolonged extrication (>30min) - Death in same vehicle	- Major multi trauma	• Major multi trauma (requiring rapid organised response) • Severe localised trauma – major fracture, amputation • Suspected testicular torsion	• Moderate limb injury – deformity, severe laceration, crush injury • Trauma – high risk history with no other high-risk features • Child at risk of abuse/suspected non-accidental injury	• Minor limb trauma – sprained ankle, possible fracture • uncomplicated laceration requiring investigation or intervention	• Minor wounds – small abrasions, minor lacerations (not requiring suturing)

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Appendix 4 - Triage Clinical Descriptors Ophthalmic and High Risk History or Clinico-Administrative

	Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
OPHTHALMIC ALL PATIENTS		• Penetrating eye injury • Chemical Injury (Acid or alkali splash to eye) – requiring irrigation • Sudden loss of vision or pain with or without injury • sudden onset of pain, blurred vision AND red eye • Suspected endophthalmitis post eye procedure (post cataract, post intravitreal injection)	• Sudden abnormal vision with or without injury • Moderate eye pain e.g. blunt eye injury, flash burns, foreign body	• Eye inflammation or foreign body with normal vision	• Low-risk history and now asymptomatic • Minor symptoms of existing stable illness or low risk condition. • Patient requesting medical certificates, prescriptions.

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Appendix 4 - Triage Clinical Descriptors Neurovascular and Trauma

HIGH RISK HISTORY or CLINICO-ADMINSTRATIVE ALL PATIENTS Age >65 or <1month Chemical exposure			• Child protection issues • No safe environment to discharge patient to • Stable neonate	• Patients presenting as worker's compensation • Any other reason for concern requiring MO review • Parental concern (mandatory MO or NP review)	•

Appendix 4 - Triage Clinical Descriptors Mental Health

	Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
MENTAL HEALTH ALL PATIENTS If in police custody or on Mental Health forms consider clinical escalation	Risk: Definite danger to life (self or others). Severe behavioural disorder. Immediate threat of dangerous violence. Observed: • Extreme or Violent behaviour • Possession of weapon • Self-destruction in ED • Displays extreme agitation or restlessness • Bizarre/disoriented behaviour Reported: • Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations)	Risk: Probable risk of danger (self or others) Observed: • Severe agitation/ restlessness • Physically/verbally aggressive • Confused/unable to cooperate • Hallucinations/delusions/ paranoia • Requires or has required restraint / containment • High risk of absconding and not waiting for treatment Reported: • Attempt at self-harm / threat of self-harm • Immediate threat of harm to others • Unable to wait safely	Risk: Possible danger to self or others; very distressed; risk of self-harm or has deliberately self-harmed Observed: • Agitated/restless • Intrusive behaviour • Confused • Withdrawn/ambivalence about treatment • Not likely to wait for treatment • Potentially aggressive Reported: • Suicidal ideation • Situational crisis Presence of psychotic symptoms: • Hallucinations • Delusions • Paranoid ideas	Risk: Under observation and/or no immediate risk to self or others. Observed: • No agitation/ restlessness • Irritable without aggression • Cooperative • Patient provides coherent history Reported: • Semi urgent mental health problem • Pre-existing mental health disorder • Symptoms of anxiety or depression, without suicidal ideation • Willing to wait	Risk: No danger to self or others. No acute distress or behavioural disturbance Observed: • Cooperative • Communicative and able to engage in developing management plan • Able to discuss concerns • Compliant with instructions Reported: • Pre-existing non-acute mental health disorder with chronic psychotic symptoms, social crisis, clinically well patient

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Appendix 4 - Triage Clinical Descriptors Mental Health Continued

	Category 1 (immediate)	Category 2 (10 minutes)	Category 3 (30 minutes)	Category 4 (60 minutes)	Category 5 (120 minutes)
MENTAL HEALTH ALL PATIENTS If in police custody or on Mental Health forms consider clinical escalation	Risk: Definite danger to life (self or others). Severe behavioural disorder. Immediate threat of dangerous violence. Observed: • Recent violent behaviour		Risk: Possible danger to self or others; very distressed; risk of self-harm or has deliberately self-harmed Observed: • Thought disordered • Bizarre/agitated condition • Presence of mood disturbance: • Severe symptoms of depression • Withdrawn/uncommunicative and/or anxiety • Elevated or irritable mood		Risk: No danger to self or others. No acute distress or behavioural disturbance Observed: • Request for medication • Minor adverse effect of medication

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Appendix 5 - Triage Risk Factor Indicators for Review or Discussion with Medical Officer / ED Nurse Practitioner

(Note: This list is not exhaustive and in addition to the items described, advice is to be sought for any other concern relating to the health or safety of a patient.)

<table>
<tr><th>Airway / Breathing</th><th>Cardiovascular</th><th>Neurosensory</th><th>Trauma</th></tr>
<tr>
<td>• Any patient on oxygen
• Apnoeic / cyanotic episode
• History of severe/anaphylactic allergy response and presenting with allergic reaction
• Asthma not relieved by actions outlined in the patient’s emergency / national asthma action plan
• audible wheeze, snoring in presenting complaint</td>
<td>• Irregular pulse rate, that is not normal for the patient
• Unexplained fall in urine output (< 10ml in 3 hrs)</td>
<td>• First convulsion
• Seizure activity-intermittent
• Collapse
• Loss of sensation in any body part
• Decreased / loss of movement or weakness in any body part</td>
<td>• Any head and eye injury
• Injury to chest, abdomen or neck
• Alleged / suspicion of physical and / or sexual assault</td>
</tr>
<tr><th colspan="2">Paediatric</th><th>Medical History</th><th>Infection</th></tr>
<tr>
<td colspan="2">• Seizure activity
• Decreased intake / output
• Red currant jelly stool
• Bile stained vomit
• Actual / potential effects of drugs / alcohol
• Age < 2 years any discharge
• Age <1 month (including corrected age) with:
▪ Febrile convulsions
▪ Acute changed to feeding pattern
▪ Acute change to sleeping pattern
• Any undifferentiated diagnosis</td>
<td>• Exacerbation of chronic condition, where the patient’s care plan identifies need for medical review.
• History rheumatic fever or prosthetic valve
• Representation with similar or same symptoms within 48 hours
• Age >65</td>
<td>• Oedema of bony areas around facial sinuses</td>
</tr>
</table>

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Appendix 6 – Symptoms in the Pregnant or Postnatal Woman Requiring Either Obstetric MP and/or Midwifery Consultation before Discharge from the ED

Presenting Symptoms (pregnant)	Possible Complications
Any symptoms below should prompt the triage RN to take a BP: • Headache, or • Blurred vision / visual disturbance, or • Epigastric pain, or • Hyper-reflexia / hypertonus, or • Swelling of hands, face or legs, or • Proteinuria	• Pre-eclampsia • Pregnancy Induced Hypertension • Eclampsia (seizure) • HELLP syndrome (haemolysis, elevated liver enzymes, low platelets) – can result in DIC (disseminated intravascular coagulopathy) **Diagnostic tests required:** • FBC • LFTs • Coag profile • PCR
Blood pressure 140/90 or more, or increase of 30/15 mmHg above pre-pregnancy BP	
Any abdominal pain: • Intermittent, **or** • Crampy, **or** • Constant, **or** • with or without back pain, **or** • Rigid abdomen, not relaxing • Epigastric pain	• Early labour including preterm • Placental abruption • Chorioamnionitis • Epigastric pain – can be a sign of severe pre-eclampsia
UTI symptoms under 37 weeks: • Frequency, **or** • Burning, **or** • Offensive urine, **or** • Cloudy urine	• UTI is the most common trigger of preterm labour • Preterm labour can only be excluded by Obstetric consult
Gastroenteritis associated with intermittent abdominal pain less than 37 weeks	• Sepsis (can be afebrile) • Gastro may trigger preterm labour
Any fluid loss per vagina (or loss suspected by the woman): • Spotting, **or** • Bleeding, **or** • Clear or coloured or offensive fluid	• Early labour (including preterm) • Ruptured membranes • Chorioamnionitis • Placental abruption – can trigger coagulopathy • Massive maternal haemorrhage
Woman complains of reduced (less than normal or change in type) or absent fetal movements	• Unwell fetus requires **biophysical profile by Obstetric Sonographer**

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Presenting Symptoms (pregnant)	Possible Complications
Woman complains of reduced (less than normal or change in type) or absent fetal movements	• Unwell fetus • Requires biophysical profile by obstetric sonographer
Any abdominal trauma, particularly arising from: • MVA / seatbelt • Fall • Assault	Placental abruption Potential outcomes: • Concealed massive maternal haemorrhage • Unwell fetus / death • Preterm labour • Severe coagulopathy
Umbilical cord prolapsed from the vagina	
Postnatal up to 6 weeks	**Possible Complications**
Any symptoms below should prompt the triage RN to take a BP: • Headache, or • Blurred vision / visual disturbance, or • Epigastric pain, or • Hyper-reflexia / hypertonus, or • Swelling of hands, face or legs, or • Proteinuria Blood pressure 140/90 or more, or increase of 30/15 mmHg above Pre-pregnancy BP	• Hypertension due to pre-eclampsia can re-bound after birth (generally on the 3rd of 4th day within the first week)
Hx of epidural or spinal for birth: • Pain or inflammation at the epidural / spinal site, **or** • Sensory or motor deficits in the lower limbs (one or both), **or** Fever 38 or more	Epidural haematoma or epidural abscess • **Discuss with Anaesthetist**
Unwell with temperature greater than 38 **or** less than 35.5 twice	• Sepsis
Changes to vaginal loss: • Increased bleeding or clots since birth, **or** Offensive vaginal discharge	• Retained products of conception • Endometritis • Retained vaginal pack (if required perineal suturing)

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Presenting Symptoms (pregnant)	Possible Complications
Any signs of endometritis – mild fever or lower abdominal pains	
Any symptoms of urinary retention / incontinence: • Dribbling **or** • Urge incontinence **or** • Small volumes **or** • Bladder pain **or** • Dysuria **or** • Frequency **or** • Haematuria.	• Bladder over-distension injury (particularly if Hx Epidural) • Birth trauma (particularly if Hx instrumental vaginal birth or caesarean) • UTI

Pregnant or Postnatal up to 6 weeks	
Symptoms of postnatal depression	• 1 in 5 women at risk
Red **or** hot **or** tender spots on calves	• Deep vein thrombus
Red **or** hot **or** tender spot/s on breast/s +/- Fever **or** flu like symptoms	• Mastitis **or** breast abscess

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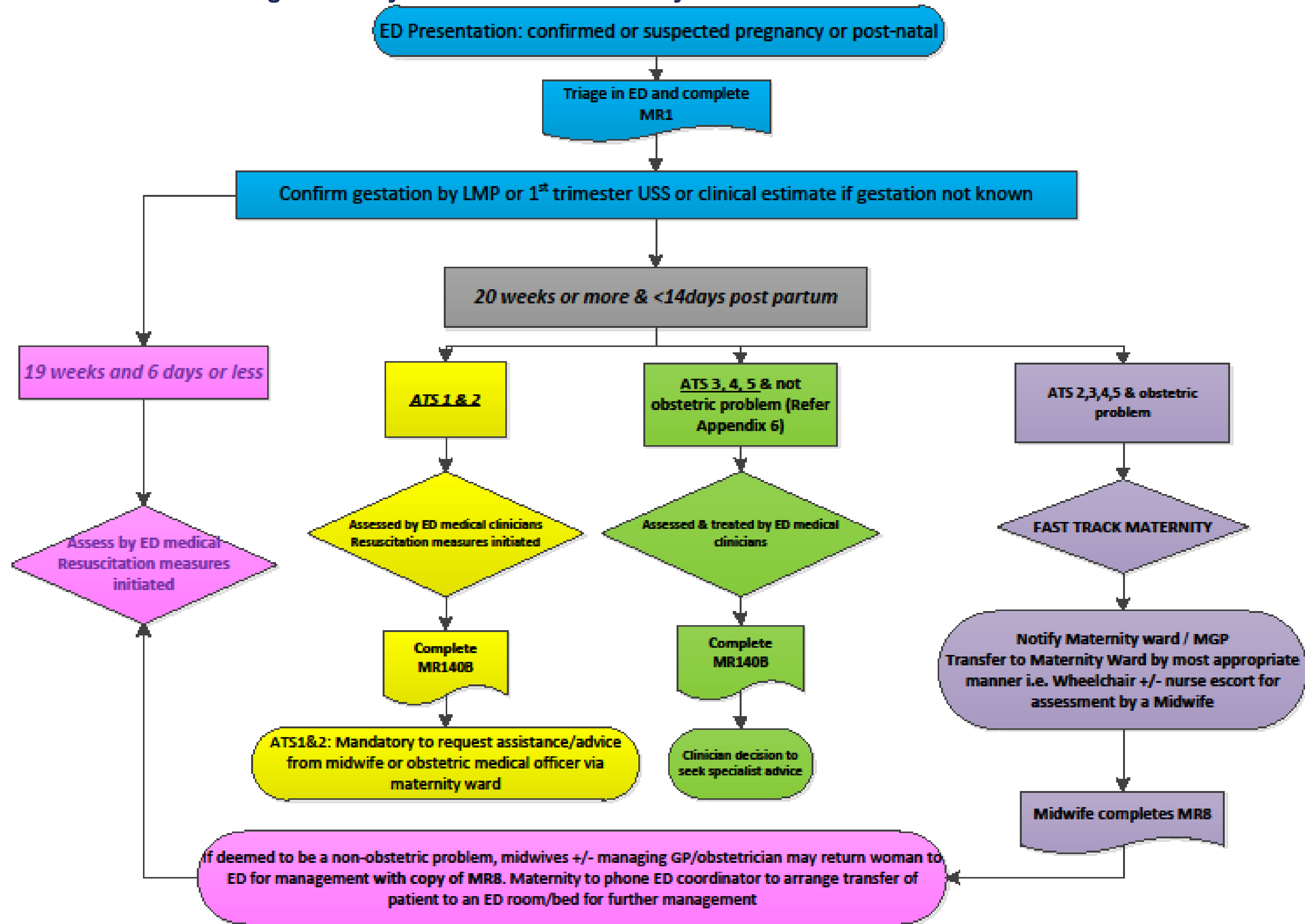
Appendix 7 - Obstetric Triage Pathway for EDs with a Maternity Service



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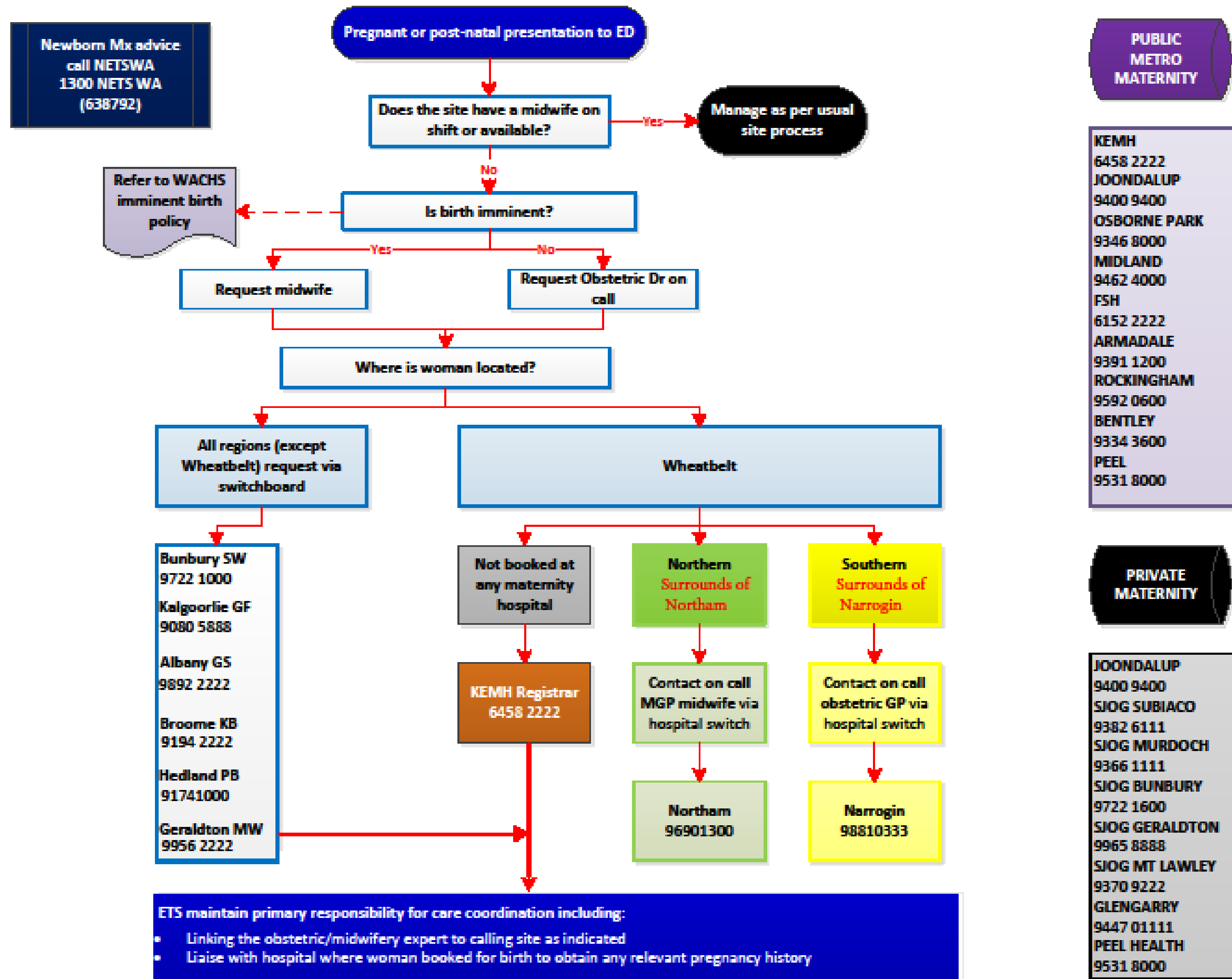
Appendix 8 – Pathway for Obstetric / Midwifery Advice by ED or ETS Staff at a Non-maternity Service Sites



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Appendix 9 – Nursing History for a Pregnant Woman

1. **What date is your baby due?**
   - If due date known – use a pregnancy wheel to calculate gestation based on due date and current date
   - If due date not known –
     - If date that last menstrual period started is known then use a pregnancy wheel to determine due date and current gestation
     - Has she seen a doctor or midwife this pregnancy
     - Has she had an ultrasound done anywhere?
     - Assess abdomen (if normal BMI),
       - fundus felt above umbilicus = more than 20 weeks
       - Fundus felt below umbilicus = less than 20 weeks
2. **How many pregnancies have you had (Gravida)? How many births have you had after 2O weeks (Parity)?**
   - If they have had a baby before,
     - did they have any complications in pregnancy or during birth
     - have they had any caesarean births
3. **Have you had any antenatal visits in this pregnancy?**
   - Where was your antenatal care?
   - Where are you booked to have your birth?
   - Have you had any problems with this pregnancy
4. **If more than 26 weeks – have you felt your baby moving today?**
5. **Have you had any blood or fluid leaking from your vagina?**
   - Describe how much?
   - Can you show me?
   - If yes, place a pad in situ and **reassess after lying down for 30 minutes**
6. **Have you had any abdominal pain?**
   - Is the pain constant?
   - Is the pain intermittent or crampy? Is there a pattern to the pain? Tell me when a pain comes and when it goes (time the frequency of the pain while assessing the woman)?
   - If they have had a labour / birth before – does it feel like pains in your last labour?
7. **Do you have any of the following (if yes, requires a BP check)?**
   - Headache
   - Spots before your eyes
   - Swelling in face or hands
   - Pitting oedema of legs
   - Epigastric pain

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Appendix 10 - General Management Principles – ATS 1 – Adult & Paediatric – Mental Health

<table>
<tr><th>ATS Category</th><th>General (adult and paediatric)</th><th>Mental Health</th></tr>
<tr><td>1</td><td>Action:
• Continuous cardiac monitoring, SpO_2
• MET call activation
• Transfer the patient to the resuscitation area immediately
• Alert the resuscitation nurse and medical staff immediately for commencement of immediate simultaneous assessment and treatment
• Activate local emergency response protocols (If not on site immediately contact ETS/ RRC/RFDS for assistance/advice).

Consider:
• Alerting theatre Radiology and pathology for emergency intervention
• Alerting ambulance service / RFDS for emergency transfer dependent on local service capacity.</td><td>Supervision:
• Continuous visual surveillance

Action:
• Alert medical staff immediately
• Alert community mental health team / RuralLink (Free call 1800 552 002 – TTY 1800 720 101) Child and Adolescent Acute Response Team 1800048636 as appropriate to day, time and site.
• Provide safe environment for patient or others
• Alert senior nurse to prepare for personnel to assist with any required emergency psychiatric treatment.

Consider:
• Calling an emergency Code Black for assistance, as per local procedure, if required
• Calling police +/- security if staff or patient safety is compromised
• Intoxication by drugs and alcohol may cause escalation in behaviour that requires management
• Use of WACHS Sedation for mental health patients awaiting RFDS transfer from remote regions guideline.</td></tr>
</table>

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Appendix 10 - General Management Principles - ATS 2

ATS Category	General (adult and paediatric)	Mental Health
2	Action: • Transfer the patient to the resuscitation / treatment area immediately • Continuous cardiac monitoring, SpO2 • Triage nurse to weigh child/infant • Alert a registered nurse for commencement of immediate simultaneous assessment and treatment • Alert medical staff immediately for commencement of assessment and treatment • Activate local emergency response protocols. (If not on site immediately contact ETS/ RRC/RFDS for assistance/advice) Consider: • Alerting theatre for emergency intervention. • Alerting ambulance service/RFDS for emergency transfer dependent on local service capacity.	Supervision: • Continuous visual surveillance. Action: • Alert medical staff immediately, for prompt assessment for consideration of **referral** under the *Mental Health Act*. • Alert community mental health team/RuralLink/ (Free call **1800 552 002** – TTY 1800 720 101) Child and Adolescent Acute Response Team 1800048636 as appropriate to day, time and site • Provide safe environment for patient or others • Use defusing techniques (oral medication, time in quieter area) • Alert senior nurse to prepare for personnel to assist with any required emergency psychiatric treatment • Prompt assessment for patient recommended. Consider: • If diffusing techniques ineffective, escalate care • Police +/- security/ additional staff until patient sedated • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

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Appendix 10 - General Management Principles – ATS 3

ATS Category	General (adult and paediatric)	Mental Health
3	Action: • Transfer the patient to the treatment area as appropriate • Triage nurse to weigh child/infant. • Commence first aid and comfort measures (ice for pain and swelling, sling for arm) • Hand over patient to a nurse or MO for consideration of assessment and treatment • If patient able to remain in waiting room, triage nurse to observe patient and perform physiological observations and document at 30 minute intervals.	Supervision: • Close visual observation at a maximum of 10 minute intervals must be documented - do not leave in the waiting room without support person Action: • Alert community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) Child and Adolescent Acute Response Team 1800048636 as appropriate to day, time and site • Ensure safe environment for patient and others. Consider: • Clinical escalation if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress or threats of harm to self or others • Alert nurse coordinator / security that patient is in the department, for code black preparedness • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

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Appendix 10 - General Management Principles – ATS 4

ATS Category	General (adult and paediatric)	Mental Health
4	Action: • Patient may wait in the waiting room, advise patient may not to drink or eat anything until assessed (presentation dependent) • Triage nurse to weigh child/infant • Commence first aid and comfort measures e.g.: ice for pain and swelling, elevation of swollen limb, clean dressing and patient applied pressure • Hand over patient to a nurse or MO for prioritisation of assessment and treatment • If patient able to remain in waiting room, triage nurse to observe the patient and perform physiological observations and document at hourly intervals.	Supervision: • Intermittent regular observation at a maximum of 30 minute intervals, must be documented. Action: • Discuss with community mental health team/RuralLink (Free call 1800 552 002 – TTY 1800 720 101) Child and Adolescent Acute Response Team 1800048636 as appropriate to day, time and site. May not occur if patient's treating General Practitioner is the Visiting Medical Practitioner who assesses the patient • Referral information must be provided to consumer prior to discharge. Consider: • Clinical escalation if evidence of increasing behavioural disturbance, such as restlessness, intrusiveness, agitation, aggressiveness, increasing distress • Referral for follow-up with community mental health team on discharge / admission • Intoxication by drugs and alcohol may cause escalation in behaviour that requires management.

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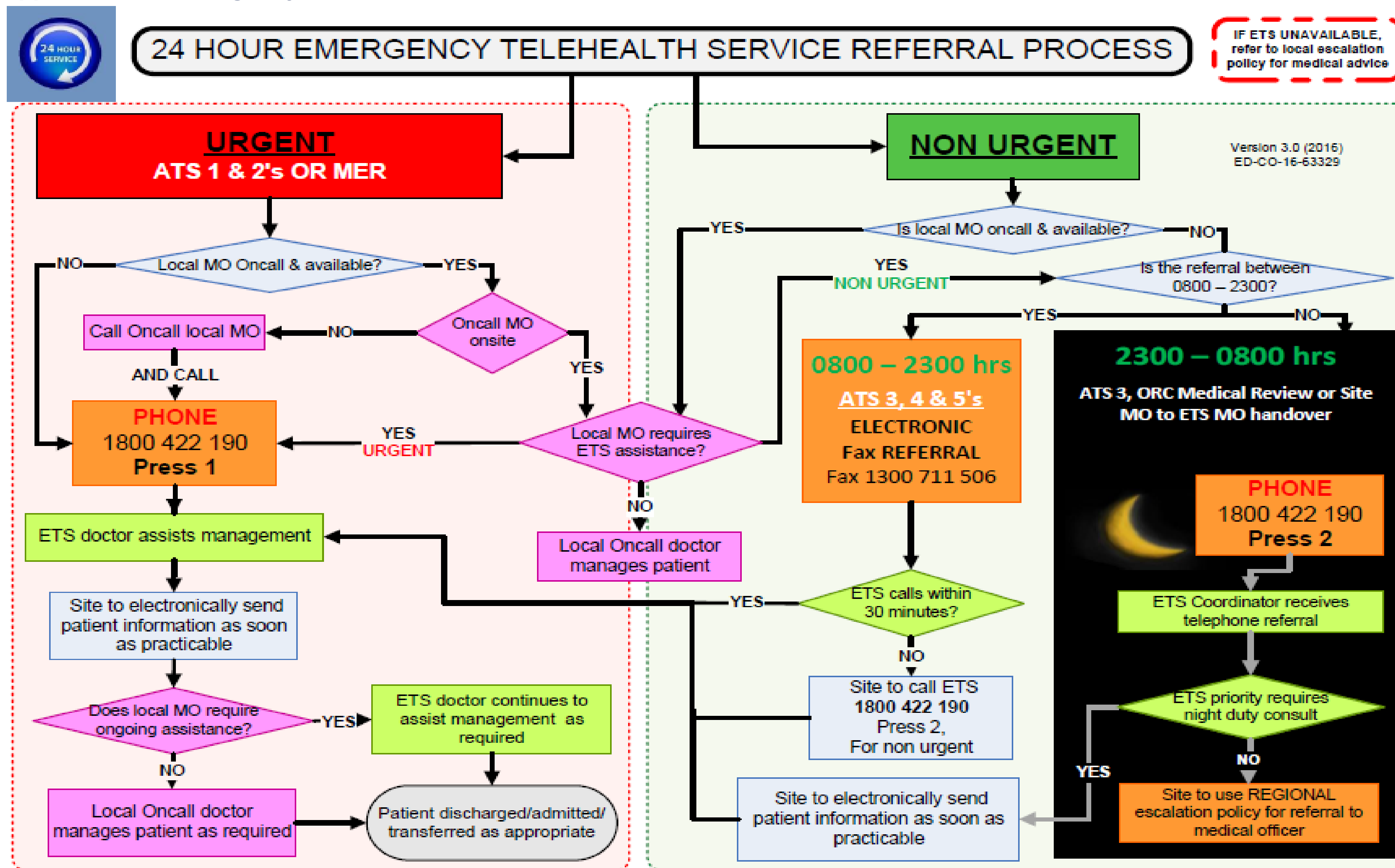
Appendix 10 - General Management Principles – ATS 5

ATS Category	General (adult and paediatric)	Mental Health
5	Action: • Patient may wait in the waiting room, advise patient may not to drink or eat anything until assessed (presentation dependent) • Triage nurse to weigh child/infant • Commence first aid and comfort measures e.g. ice for pain and swelling, elevation of swollen limb, clean dressing and patient applied pressure • Hand over patient to nurse or MO for prioritisation of assessment and treatment • If patient able to remain in waiting room, triage nurse to observe the patient and perform physiological observations and document at two hourly intervals observe the patient .	Supervision: • General observation -routine waiting room check at 30 minute intervals, must be documented Action: • Discuss with community mental health team/RuralLink (Free call **1800 552 002** – TTY 1800 720 101) Child and Adolescent Acute Response Team 1800048636 as appropriate to day, time and site • Refer to treating team if case-managed • Referral information must be provided to consumer prior to discharge.

Appendix 11 – Emergency Telehealth Service Referral Process



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