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Patient Assessment and Management in the Emergency Department Policy

1. Purpose

The purpose of this policy is to:

- ensure evidence based best practice standards for the triage, assessment, care and management of unplanned patient presentations to emergency facilities
- minimise unwarranted variation in clinical practice
- ensure each presentation is newly assessed as a unique episode of illness/injury
- ensure appropriate documentation and clinical handover
- ensure safe, effective and efficient health outcomes, minimising preventable harm and decreasing wastage therefore reducing health expenditure.

The scope of this policy relates to all medical, nursing, midwifery and allied health staff employed within WACHS.

Out of scope

- Planned outpatient presentations such as wound reviews or X-ray reviews are documented on the MR5 Outpatient Notes or identified in the Planned Return Visit field in webPAS or on the relevant digital medical record (DMR).
- When the Emergency Department (ED) is the provider of elective / planned testing e.g.: ECG, spirometry, asymptomatic COVID-19 testing etc. Refer to Emergency Department Acute and Outpatient Activity Guideline.

2. Policy

2.1 Communicating for safety in the Emergency Department

Partnering with consumers and carers

Staff must comply with the Consumer and Carer Engagement Policy to ensure that consumers and carers are welcomed and supported to participate in health care planning and delivery where decisions will impact on them. Staff are to actively facilitate a high level of consumer and carer engagement with the aim of providing positive health care experiences.

Staff must ensure measures are in place to maintain patient privacy and dignity, including offering the presence of a chaperone where appropriate to patient and clinician requirements (refer to the Chaperone Policy).

Staff must also provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements and support cultural input (refer to the Language Services Policy – MP 0051/17).

Minimising risks to patient safety

To minimise the risks to staff and patient safety:

- The triage area is to be as safe as possible, allowing for egress and duress, whilst aiming to maintain privacy.
- Each site is to have a local management plan for responding to armed and unarmed personal threats. Refer to Restraint Minimisation Policy and/or local Emergency Response Procedures (Code Black Personal Threat).
- Identifying and managing patients at risk of aggression, in accordance with Clinical Care of People with Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy – MP0101/18.
- It is mandatory for all ED clinicians to be aware of prevention and management of aggression and undertake training appropriate to their role. For de-escalation information refer to the De-escalation Techniques Information Resource.
- Identifying and responding to patients at risk of deliberate self-harm or suicide is in accordance with Safety Planning for Mental Health Consumers Policy – MP 018/24.
- Consider any additional visual observations for mental health patients, outlined in the Triage Procedure.
- Consider local management of ligature policies and procedures for patients at risk of self-harm (e.g. Great Southern Assessment and Management of Environmental Ligature in General Wards and Emergency Departments Procedure). Refer to the Working in Isolation – Minimum Safety and Security Standards for All Staff Policy.
- Where required, early notification of the Emergency Telehealth Service (ETS). Documentation of telephone conversation including handover of patient. See Appendix D: Emergency Telehealth Service Referral Process.
- Staff should be aware of the Aishwarya's CARE Call process and respond appropriately to any concerns. Refer to the Recognising and Responding to Acute Deterioration (RRAD) Policy and Recognising and Responding to Acute Deterioration Procedure.
- If patient is accompanied, the support person should be notified to raise any concerns of deterioration or patient safety. If the patient is unaccompanied, consider individual circumstances for risk assessment.

Clinical handover

In all cases clinical handover must include information exchange between all disciplines as per the National Safety and Quality Healthcare Service (NSQHS) Communicating for Safety Standard, and Clinical Handover Policy – MP 0095/18 using the iSoBAR format.

Consent to treatment

Patients undergoing procedures in the ED must be provided with full information and their consent documented as per Consent to Treatment Policy – MP 0175/22. The Adults with Impaired Decision Making Capacity Procedure and the Advance Health Care Directive and Enduring Power of Guardianship Guideline provide additional guidance regarding patients with impaired capacity to consent.

2.2 Presentation to the Emergency Department

WACHS assumes clinical governance for patient care on arrival to the ED irrespective of the mode of transport. Refer to the Transfer of Care in the Emergency Department for Patients Arriving by Ambulance Policy for further information.

Initial referral

The process for managing ED presentations is defined in Appendix A - Management of Presentations to ED in WACHS Facilities. All emergency patient contacts with the triage nurse must be documented on the MR1 WACHS Emergency Department Notes.

Telephone

Process:

- The receiving clinician is to quickly establish if the caller requires an emergency vehicle to attend
  - If **yes**, document the patients' name, phone and address details and transfer to or direct them to call '000' immediately
- If necessary, place hospital response teams on standby e.g. trauma team, local GP as per local procedure
- Consider early notification of ETS.

General call for non-emergency advice

Process:

- Redirect caller to HealthDirect – Telephone: 1800 022 222 or other specific numbers for:
  - hearing impairment – Hearing Impairment Text Telephone (TTY): 1800 022 226
  - maternity patients – the caller can be directed to the maternity service they are booked to give birth at
  - mental health - redirect caller to community mental health services within business hours or WA RuralLink (specialist after-hours mental health) – Telephone: 1800 552 002. Hearing Impaired Text Telephone (TTY): 1800 720 101.

Dead on arrival

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

Did not wait

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

Pregnant or postnatal women

Considerations:

- All women of child-bearing age are to be considered as pregnant until proven otherwise.
- There are no ATS categories specific to pregnancy related conditions. Some guidance is provided in Chapter 9 of the Emergency Triage Education Kit[1]

- An obstetric/maternity assessment of pregnant women who is more than 20 weeks gestation or six weeks postnatal is not within the scope of a nurse, however a nurse can conduct a primary assessment on the patient to identify life threats
- For women who are obviously in labour and birth appears imminent refer to the Imminent Unplanned Birth at Non-Birthing Site Policy.

Mental health

Considerations:

- The allocation of the ATS category must be based on clinical criteria that are consistent with ATS descriptors for mental health presentations. Refer to Triage Procedure.
- Where available, consider referral to the Clinical Liaison Team (CLT) and / or Psychiatric Liaison Nurse (PLN).
- Mental Health Emergency Telehealth Service (MH ETS) provides clinical staff and clients with access to support and assessment by specialist clinicians via video conferencing technology 24 hours a day, 7 days a week on 1800 422 190.
- At the discretion of a medical practitioner, emergency psychiatric treatment can be provided to a person — (a) to save the person's life; or (b) to prevent the person from behaving in a way that is likely to result in serious physical injury to the person or another person. (*Mental Health Act 2014*, s. 202). Emergency psychiatric treatment requires mandatory notification to the Chief Psychiatrist.

Paediatrics

Considerations:

- For the purpose of emergency presentations to ED, a paediatric presentation is any child under the age of 16 years.
- The clinical priorities and the principles of urgency for infants, children and adolescents are the same as those for adults.
- The value of parents, carers or significant others and their capacity to identify deviations from normal in their child's level of function is not to be underestimated
- Where applicable refer to WA Health Guidelines for Protecting Children 2020 and WebPAS Child at Risk Alert Procedure.
- Any infant presenting to a WACHS site should have their observations recorded on the age appropriate PARROT chart, including babies less than 28 days.

2.3 Triage – primary survey

All patients are to be assessed on arrival to the health care facility by an onsite triage nurse or with support from a triage nurse via video conference ETS. The process for Triage is outlined in the Triage Procedure.

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%

Table 1: Maximum waiting time for assessment and treatment according to ATS category

Time to treatment

Following allocation of an ATS category:

- All patients who have been triaged but not yet seen for assessment and treatment must be re-assessed once the triage time has expired (as per Table 1). Refer to the Transfer of Care in the Emergency Department for Patients Arriving by Ambulance Policy.
- Any patient who cannot be seen within the recommended ATS timeframes must be commenced on an age appropriate observation chart
- Clinical observations for patients awaiting assessment 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 (2) hourly
- Patients of concern including those who may be at risk of self-harm or suicide, should have strategies put in place to enhance safety and reduce risk, such an environmental risk assessment (e.g., ligature points), being in line of sight and/or increased visual observations.
- Escalation of abnormal observations and signs of deterioration are to be as per the age appropriate observation chart criteria and documented on the MR1 WACHS Emergency Department Notes, in accordance with the Recognising and Responding to Acute Deterioration Policy and Recognising and Responding to Acute Deterioration Procedure.
- Patient or carer concern can be escalated as per Aishwarya's CARE Call process
- For sites with a waiting room nurse role, refer to the Emergency Department Waiting Room Nurse Roles and Responsibilities Procedure.

2.4 Medical Officer or Nurse Practitioner notifications

Following completion of Triage assessment:

- An appropriately credentialed Medical Officer (MO) or ETS are to be **notified** of all patients categorised with an ATS category 1 or 2
- An appropriately credentialed MO, Nurse Practitioner (NP), or ETS are to be **notified** of all patients categorised with an ATS category 3
- An appropriately credentialed MO, NP, or ETS are to be **considered** for all patients categorised with an ATS category 4 or 5
- Other considerations for MO, NP or ETS notification include:
  - any patient who re-presents with 48 hours for the same condition
  - any presentation in which the provisional diagnosis is not clear
  - all patients who meet Trauma Team Notification criteria as per the trauma descriptors in the Triage Procedure - complete the MR2 WACHS Emergency Department Trauma Notes
  - any patient presenting under the *Mental Health Act 2014* or at risk of harm to self or others
  - additional triage indicators which require review by or discussion with a MO or NP are listed in Appendix B: Triage risk factor indicators for review or discussion with MO / ETS / appropriately credentialed NP / MOETS. Where a local MO, NP are not available, contact regional resource centre, MO or hub hospital (Wheatbelt), ETS or Acute Patient Transfer Coordination (APTC) Service
  - refer to local practice and ETS guidelines Appendix D: Emergency Telehealth Service Referral Process for referral process to ETS escalation of care.

2.5 Primary assessment

Following the Triage Primary Survey, a primary assessment must be undertaken, including:

- an ABCDE assessment
- a full set of physiological observations
- the patient's presenting complaint, past medical history, current medications and allergies.

Relevant clinical care pathways are to be implemented at this point; these may include:

- MR1B WACHS Chest Pain Pathway
- qSOFA (quick Sequential related Organ Failure Assessment) Tool Flowchart and MR1C WACHS Adult Sepsis Pathway
- WA Rural Acute Stroke Pathways (includes Clinical Guidelines for Stroke Management)
- Hip fracture clinical care as per WACHS Hip Fracture Clinical Care Policy and MR184H WACHS Rural Hip Fracture Aeromedical Retrieval Form

2.6 Secondary assessment

The secondary survey / assessment builds upon the primary assessment:

- once immediate life-threatening issues have been treated
- includes a system-based examination (e.g., respiratory assessment, mental health assessment, abdominal assessment)
- ensures that no injuries have been missed
- further assessments as indicated by clinical presentation.

Other considerations that may apply include ETS referral process, advance health directives (AHD), existing Goals of Patient Care form, webPAS risk alerts, cultural needs and next of kin.

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

NSQHS Clinical Care Standards

There are a number of clinical care standards that may be useful for ED presentations:

- Heavy menstrual bleeding
- Low back pain
- Opioid analgesic stewardship in acute pain
- Osteoarthritis of the knee.

Paediatric

WACHS endorses the use of the Perth Children's Hospital (PCH) Emergency Department Guidelines via the Perth Children's Hospital (PCH) Guidelines - EUCP Policy.

Mental health

For a mental health presentation consider:

- Mental health assessment is based on the patient's physical and mental state. Use the BACPAC Mental State Assessment to determine a baseline mental state. Refer to the Recognising and Responding to Acute Deterioration Procedure
- Refer for formal mental health assessment by Community Liaison team, Psychiatric Liaison Nurse or MH ETS
- For specific guidance on assessment and care for mental health presentations refer to Mental Health Care in Emergency Departments and General Wards Policy
- Where indicated complete an MR46 WACHS Suicide Risk Assessment and Safety Plan
- Identifying and managing patients at risk of deliberate self-harm or suicide will be in accordance with the Safety Planning for Mental Health Consumers Policy – MP 018/24. and the Principles and Best Practice for the Clinical Care of People Who May Be Suicidal. This includes the application of risk minimisation strategies such as placing the patient in a visual cubicle in the ED or considering a surveillance strategy for high-risk patients before they can be seen by a mental health clinician.

Pregnant or postnatal women

Nursing assessment of pregnant woman 20 weeks and over:
Triage in the emergency department and then contact midwifery service (for those sites who have one) or the Midwifery and Obstetric Emergency Telehealth Service (MOETS) via ETS for assessment of the pregnant woman.

MOETS inclusion criteria is:
- Over 12 weeks gestation
- Women up to 6 weeks postpartum
- Neonates up to 4 weeks corrected for gestational age

If MOETS is unavailable refer to Appendix C: Nursing history for a pregnant woman.

Fetal heart rate assessment in ED:
A single fetal heart rate by doppler does not constitute an assessment of fetal wellbeing and is not to 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, it may be distressing for the mother and possibly the staff
- 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 (CTG) monitoring must not be ordered by non-midwives and non-obstetric doctors.

Vaginal examinations of pregnant woman 20 weeks and over:
- vaginal examination must 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.
- assessment is to be made on the woman's presenting symptoms and vaginal examination must not influence management or decision making.
- 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 (RN) whom is not a midwife to undertake a vaginal examination in this context and any requests for the RN to undertake this procedure must be declined
- likelihood of preterm labour can be assessed by testing for Fetal Fibronectin (fFN) which can only to be performed by midwife or a MO. See Preterm Labour Policy.

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 E: Symptoms in the pregnant or postnatal woman requiring either Obstetric Medical Practitioner and/or Midwifery Consultation (via MOETS) 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. At non-maternity sites this consultation should occur via MOETS.

2.7 Implementing and evaluation of care

Following the secondary assessment an individualised management plan is to be developed with the patient and carer and documented, at a minimum, including:

- patient history and presence of comorbidities (MR1 WACHS Emergency Department Notes)
- differential diagnoses
- treatment for pre-existing and current condition
- including emulation of treatment by patient response
- 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, goals of care, or similar
- diagnostics undertaken and process of review.

Ongoing reassessment of the patient's condition and response to treatment is required. Any deterioration should be escalated as per the Recognising and Responding to Acute Deterioration (RRAD) Policy and Procedure.

2.8 Admission, Transfer and Discharge Planning and Disposition

Decision to admit

Ensure that a complete iSoBAR handover occurs between the ED and the ward. Refer to:

- MR184B WACHS Intra-hospital Clinical Handover form
- Clinical Handover Policy – MP 0095/18.

Decision to transfer

For patients requiring transfer:

- Refer to the Assessment and Management of Interhospital Patient Transfers Policy. The most senior WACHS clinician at the site, including WACHS Command Centre, is responsible for care and decision to transfer as per the policy.
- On decision to transfer and once acceptance of care and bed availability has been received from the accepting site, refer patient to APTC Service (1800 951 211) to begin transport booking.
- If the transfer is an ED to ED transfer, once care has been accepted by accepting ED, refer to APTC as above.
- Patients awaiting transfer must continue to receive planned treatment, regular observations and escalation of deterioration until care is handed over to the retrieval team.

- APTC will communicate transport plans and timeframes to the WACHS site.
- Contact the APTC to cancel transport request if the patient condition improves and the inter-hospital transfer is no longer required or if a private transport option is agreed by referring clinician as an appropriate option.
- The transfer of Mental Health Patients is to be in accordance with the *Mental Health Act 2014*, Chief Psychiatrist's Mental Health Bed Access, Capacity and Escalation Policy and the Interhospital Patient Transfer of Mental Health Patients Guideline.

Decision to discharge

For patients ready for discharge:

- A decision to discharge a patient from the emergency department can only be taken by a MO, NP, senior RN or midwife, 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 less than 2 years by a senior RN must be in consultation with a MO either onsite or by phone, ETS, or by an appropriately credentialed NP.
- Considerations must 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.
- The discharging clinician must ensure that patients and carers are provided with discharge advice, including consideration of written information and education for their condition and treatment (including medications) and information as to how to provide consumer experience feedback. Information available for use by clinicians include:
  - Emergency discharge information sheets for paediatric, adult, older adult and mental health (from WA Health)
  - Pain relief medications following surgery or injury – patient information (from WA Health)
  - Child Health Facts (from PCH)
- For specific mental health discharge considerations, refer to Mental Health Care in Emergency Departments and General Wards Policy.

2.9 Discharge against medical advice

Wherever possible, liaise with MO / ETS to review patient prior to patient leaving hospital. Refer to the Discharge Against Medical Advice Policy and the Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard.

3. Roles and Responsibilities

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.

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

Duty Doctor

- Will be assigned each shift at sites where MOs are employed.
- Is responsible for medical leadership and situational awareness.
- Will have a visible form of identification (e.g. arm band or sash) to make the shift clinical leadership available to patients, staff and ambulance crew.

Nurse ED Shift Coordinator

A dedicated Senior ED Nurse Shift Coordinator role, without a patient load, is to be rostered for sites managing more than 30,000 ED presentations per annum.

Sites that experience 20,000 to 30,000 presentations per annum will be reviewed by the WACHS Executive Director Nursing and Midwifery and recommendations made to WACHS Executive for a dedicated ED Nurse Shift Coordinator role at these sites.

Refer to the Shift Coordinator Procedure for general duties. Key aspects of the **ED Nurse Shift Coordinator** role are:

- they must be clearly identified on the roster and/or staff allocation plan and be clearly identifiable and visible to patients, staff and ambulance crew (e.g. arm band or sash)
- collaborate with the Duty Doctor to ensure situational awareness and proactive management of patient flow
- ensure regular contact and awareness across all areas of the department (including patients awaiting transfer of care) to provide an accurate picture of patient acuity and numbers
- escalating to most senior person on site (Coordinator of Nursing or Operations Manager) when department capacity is reached and /or exceeded
- be allocated a dedicated mobile/cordless phone and number for ease of consistent contact.

Triage Nurse

- Sites that roster two nurses per shift must ensure that triage is within the scope of one of those nurses, where possible.
- An enrolled nurse (EN) **must immediately notify** an appropriate triage RN (including ETS) or NP on the patient's arrival. An EN may be the first person to document an initial assessment of the patient.

- The RN or NP is then required to attend the patient to complete a triage assessment.
- Refer to the Triage Procedure for further information.

Waiting Room Nurse

Refer to the Emergency Department Waiting Room Nurse Roles and Responsibilities Procedure.

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

4. Monitoring and Evaluation

4.1 Monitoring

Monitoring of compliance with this document is the responsibility of Regional Nursing and Midwifery Directors and Regional Medical Directors.

Compliance, performance and evaluation is monitored through site, regional and central level governance processes including:

- WACHS Emergency Department Recognising and Responding to Acute Deterioration (RRAD) audit (includes review of triage processes)
- Review indicators within the Health Service Performance Report (HSPR):
  - Percentage of emergency department patients seen within recommended times by triage category
  - WA Emergency Access Target (WEAT)
- Review of clinical incident data

4.2 Evaluation

The Executive Director Nursing and Midwifery Services is responsible for ensuring that evaluation of this procedure is completed 5 yearly or sooner if indicated. Policy expert/s or leader in best practice will be asked to provide an opinion of WACHS capacity in meeting legislation, regulation, recommendations, strategies or framework obligations.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to Section 26 of the *Health Services Act 2016* and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies and procedures is mandatory.

6. References

1. Australian Government: Department of Health and Ageing. Emergency Triage Education Kit. Canberra ACT: Commonwealth of Australia; 2009 [cited 27 July 2022]
2. Government of Western Australia: Child and Adolescent Health Service Guidelines for Protecting Children 2020. Perth; Statewide Protection of Children Coordination Unit [Accessed 27 July 2022]
3. Government of Western Australia: WA Country Health Service [HealthPoint] Recognising and Responding to Acute Deterioration (RRAD) Policy. 2021 [Accessed 27 July 2022]
4. Government of Western Australia: WA Country Health Service [HealthPoint] Emergency Department Acute and Outpatient Activity Guideline. 2018 [Accessed 27 July 2022]
5. Government of Western Australia. Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance). WA Country Health Service [HealthPoint]2017 [Accessed 27 July 2022]
6. Government of Western Australia. Credentialing and Defining Scope of Clinical Practice Policy – MP 0084/18. Perth WA: Department of Health; 2019 [Accessed 27 July 2022].
7. Government of Western Australia. Clinical Governance, Safety and Quality Policy Framework. Perth WA: Department of Health; 2022. [Accessed 27 July 2022]
8. Government of Western Australia. Information Management Policy Framework. Perth WA: Department of Health; 2022. [Accessed 27 July 2022]
9. Australian Commission on Safety and Quality in Health Care [Internet] Canberra ACT: 2021. National consensus statement: Essential elements for recognising and responding to acute physiological deterioration (third edition) [Accessed: 27 July 2022]

7. Definitions

Term	Definition
Ambulance crew	All ambulance staff including paramedic, medic, patient transport officer, transport nurse, emergency medical technician and/or volunteer ambulance officer
Paediatric presentation	For the purpose of emergency presentations to ED, a paediatric presentation is any child under the age of 16 years
Postnatal woman	Postnatal women include those who present up to six weeks after giving birth
Triage	A triage system is the basic structure in which all incoming patients are categorised into groups using a standard urgency rating scale or structure1
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 injury1

8. Document Summary

Coverage	WACHS-wide
Audience	All medical, nursing, midwifery and allied health staff employed within WACHS.
Records Management	Non Clinical: Corporate Recordkeeping Compliance Policy Clinical: Health Record Management Policy
Related Legislation	• *Carers Recognition Act 2004* (WA) • *Children and Community Services Act 2004* (WA) • *Guardianship and Administration Act 1990* (WA) • *Health Practitioner Regulation National Law (WA) Act 2010* • *Medicines and Poisons Act 2014* (WA) • Medicines and Poisons Regulations 2016 (WA) • *Mental Health Act 2014* (WA)
Related Mandatory Policies / Frameworks	• Consent to Treatment Policy – MP 0175/22 • Clinical Care of People with Mental Health Problems Who May Be at Risk of Becoming Violent or Aggressive Policy – MP 0101/18 • Clinical Handover Policy – MP 0095/18 • Language Services Policy – MP 0051/17 • Mental Health Emergency and Follow Up Information on Discharge from Hospital Emergency Dept Policy - MP 0070/17 • Safety Planning for Mental Health Consumers Policy – MP 018/24
Related WACHS Policy Documents	• Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard • Adults with Impaired Decision Making Capacity Procedure • Assessment and Management of Environmental Ligature in General Wards and Emergency Departments Procedure – Great Southern • Assessment and Management of Interhospital Patient Transfers Policy • Advance Health Care Directive and Enduring Power of Guardianship Guideline • Care of the Deceased Policy • Chaperone Policy • Clinical Observations and Assessments Clinical Practice Standard (physiological (vital signs), neurovascular, neurological and fluid balance) • Consumer and Carer Engagement Policy • Discharge Against Medical Advice Policy • Documentation Clinical Practice Standard • Emergency Department Acute and Outpatient Activity Guideline • Emergency Department Waiting Room Nurse Roles and Responsibilities Procedure

	• Interhospital Patient Transfer of Mental Health Patients Guideline • Management and Review of "Did Not Wait" Patients that Present to Emergency Services Policy • Mental Health Care in Emergency Departments and General Wards Policy • Perth Children's Hospital (PCH) Guidelines - EUCP Policy • Preterm Labour Policy • Child Protection Holding Order: Power to Detain a Child Under the Age of Six in Hospital Procedure • Recognising and Responding to Acute Deterioration (RRAD) Policy • Recognising and Responding to Acute Deterioration Procedure • Restraint Minimisation Policy • Shift Coordinator Procedure • Transfer of Care in the Emergency Department for Patients Arriving by Ambulance Policy • Triage Procedure • WebPAS Child at Risk Alert Procedure • Working in Isolation - Minimum Safety and Security Standards for All Staff Policy
Other Related Documents	• Child Health Facts (PCH) • Emergency discharge information sheets (WA Health) • Guidelines for Protecting Children 2020 (CAHS) • Mental Health Bed Access, Capacity and Escalation Policy (State wide) • Patient Transfer Envelope Checklist • Principles and Best Practice for the Clinical Care of People Who May Be Suicidal (WA Health) • qSOFA (quick Sepsis related Organ Failure Assessment) Tool Flowchart • Safe Transport and Transfer of Country Mental Health Patients Flowchart
Related Forms	• MR1 WACHS Emergency Department Notes • MR1B WACHS Chest Pain Pathway • MR1C WACHS Adult Sepsis 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 Newborn Observation and Response Chart (N-ORC)

	• MR140E Paediatric Acute Recognition and Response Observation Tool (PARROT) – Age less than 3 months • MR140F Paediatric Acute Recognition and Response Observation Tool (PARROT) – 3-12 months • MR140G Paediatric Acute Recognition and Response Observation Tool (PARROT) – 1-4 years • MR140H Paediatric Acute Recognition and Response Observation Tool (PARROT) – 5-11 years • MR140I Paediatric Acute Recognition and Response Observation Tool (PARROT) – 12 years and above • 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 WACHS Tenecteplase Checklist • MR111 WACHS Nursing Admission, Screening and Assessment Tool • MR111P WACHS Paediatric Nursing Admission/Discharge Assessment form • MR184 WACHS Inter-hospital Clinical Handover form • MR184B WACHS Intra-hospital Clinical Handover • MR2 WACHS Emergency Department Trauma Notes • MR36 WACHS Discharge Against Medical Advice Form • MR46 WACHS Suicide Risk Assessment and Safety Plan
Related Training Packages	RRAD: Recognising and Responding to Acute Deterioration eLearning (RRAD EL1)
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2588
National Safety and Quality Health Service (NSQHS) Standards	2.01, 5.04, 6.01, 8.01, 8.04, 8.05, 8.08, 8.09 and 8.10
National Standards for Disability Services	Standards 1, 5 and 6
Aged Care Quality Standards	Standards 1, 2, 3, 5 and 8
National Standards for Mental Health Services	10.3, 10.4 and 10.5

9. Document Control

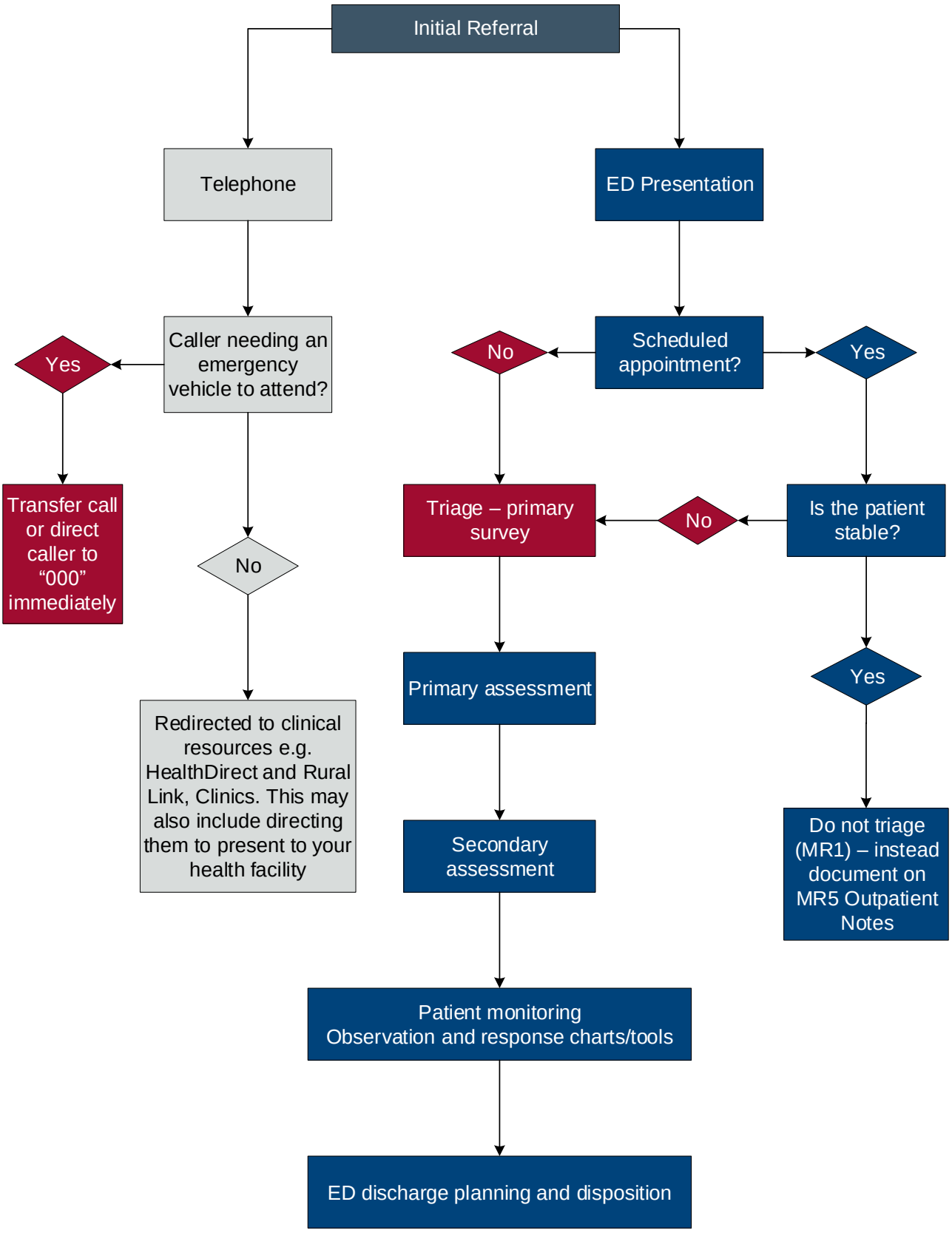
Version	Published date	Current from	Summary of changes
4.00	18 Sept 2023	18 Sept 2023	• dividing the former version (Assessment and Management in the Emergency Department CPS) into two separate documents; a Patient Assessment and Management in the ED Policy and a Triage Procedure • Significant changes related to consumers • changes to the 'Medical Officer or Nurse Practitioner Notifications' section: • Medical Officer, Nurse Practitioner or ETS referral are to be considered for ATS category 4 or 5s rather than being a mandatory notification. • appropriately credentialled Nurse Practitioners may be consulted in the decision to discharge children under 2 years. • significant mental health considerations in the ED environment. • appendices updated • inclusion of information about the Waiting Room Nurse and Shift Coordinator roles • references to the new Transfer of Care in the Emergency Department for Patients Arriving by Ambulance Policy (under development).
4.01	6 Dec 2023	18 Sept 2023	• Added link to the recently published Transfer of Care in the Emergency Department for Patients Arriving by Ambulance Policy and fixed typo.
4.02	12 April 2024	18 Sept 2024	• MP 0074/17 superseded by MP 018/24 – link replaced in this policy.
4.03	21 January 2025	18 Sept 2024	• Removed 'DRAFT' watermark from 2 pages in appendices.

10. Approval

Policy Owner	Executive Director Nursing and Midwifery Services
Co-approver	Executive Director Clinical Excellence
Contact	WACHS Coordinator of Nursing
Business Unit	Nursing and Midwifery
EDRMS #	ED-CO-16-73455

This document can be made available in alternative formats on request.

Appendix A: Management of patient presentations to ED in WACHS facilities



Appendix B: Triage risk factor indicators for review or discussion with MO / ETS / NP / MOETS

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.

Airway / Breathing	Cardiovascular	Neurosensory	Trauma
• **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**	• Irregular pulse rate, that is not normal for the patient • Unexplained drop in urine output (< 10ml in 3 hrs)	• First convulsion • Seizure activity-intermittent • Collapse • Loss of sensation in any body part • Decreased / loss of movement or weakness in any body part	• Any head or eye injury • Injury to chest, abdomen or neck • Alleged / suspicion of physical and / or sexual assault

Paediatric	Medical History	Infection

• **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**
	• 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
		• Oedema of bony areas around facial sinuses

Appendix C: 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

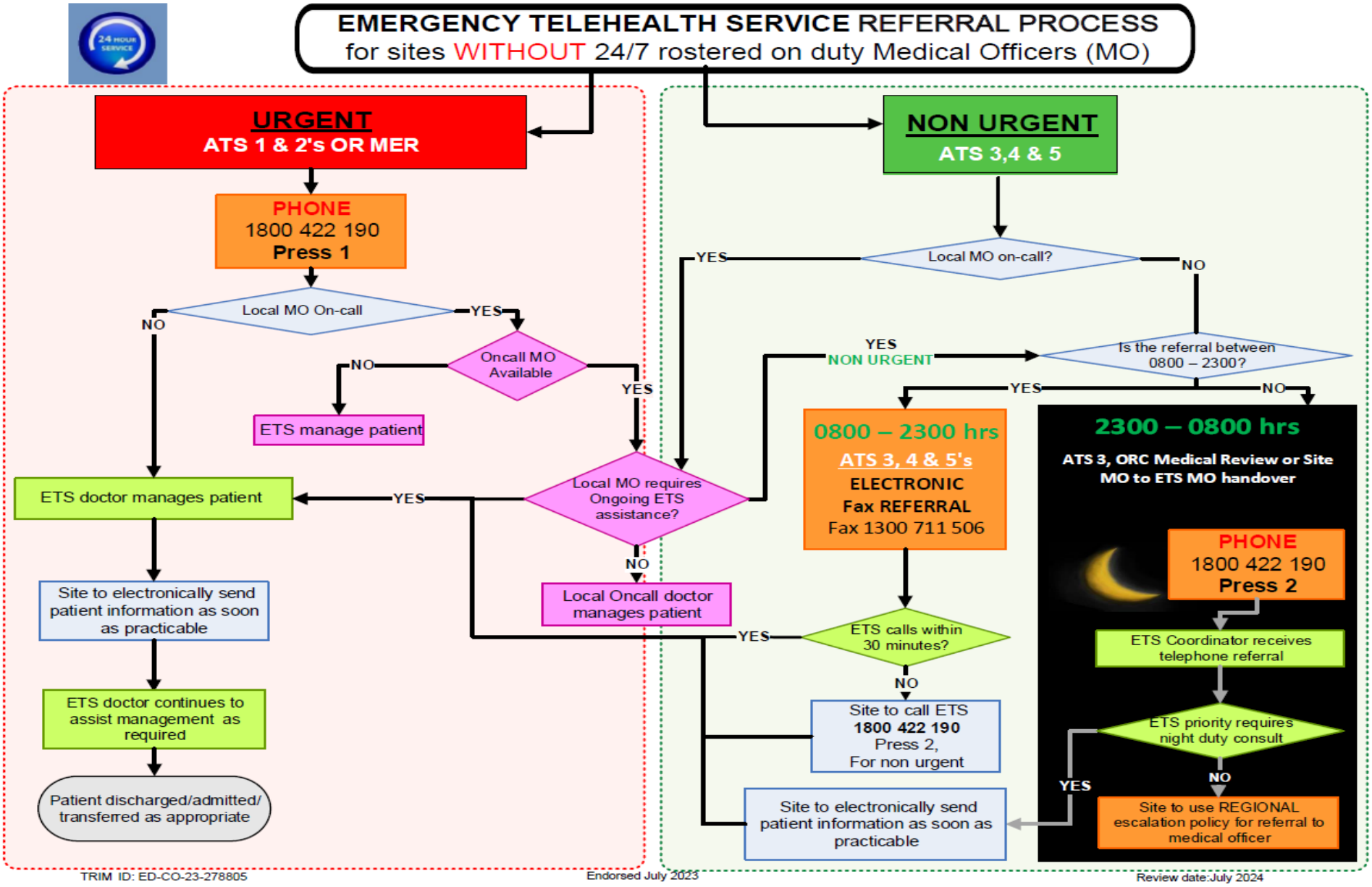
6. **Have you had any abdominal pain?**

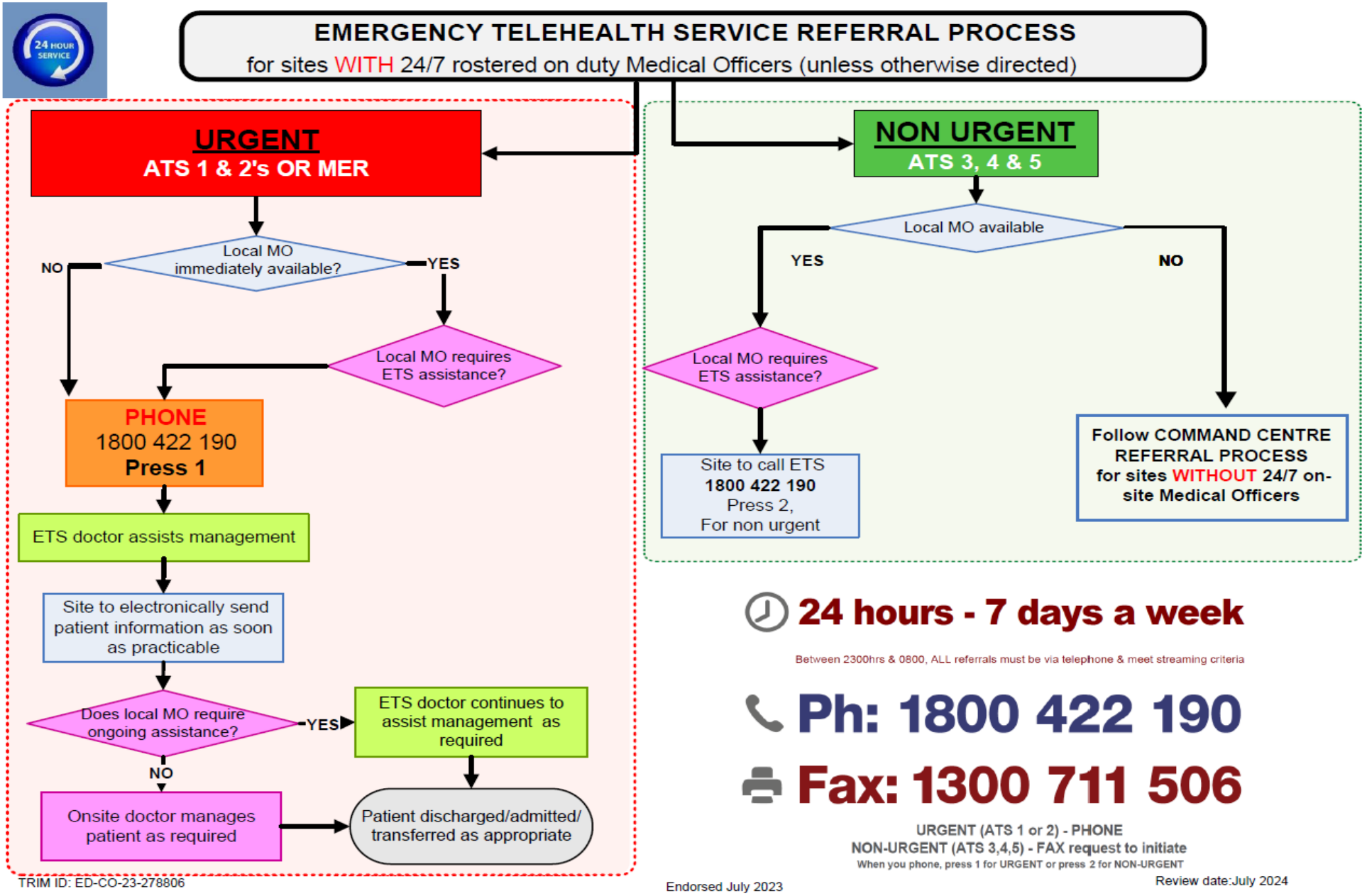
- Is the pain constant?
- Is the pain intermittent or crampy? Is there a pattern to the pain? Tell me when a pain comes and when it goes (time the frequency of the pain while assessing the woman)?
- If they have had a labour / birth before – does it feel like pains in your last labour?

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

Appendix D: Emergency Telehealth Service (ETS) referral process




EMERGENCY TELEHEALTH SERVICE REFERRAL PROCESS
for sites WITH 24/7 rostered on duty Medical Officers (unless otherwise directed)
URGENT
ATS 1 & 2's OR MER
Local MO immediately available?
NO
YES
Local MO requires ETS assistance?
PHONE
1800 422 190
Press 1
ETS doctor assists management
Site to electronically send patient information as soon as practicable
Does local MO require ongoing assistance?
YES
ETS doctor continues to assist management as required
NO
Onsite doctor manages patient as required
Patient discharged/admitted/ transferred as appropriate
NON URGENT
ATS 3, 4 & 5
Local MO available
YES
NO
Local MO requires ETS assistance?
Site to call ETS
1800 422 190
Press 2,
For non urgent
Follow COMMAND CENTRE REFERRAL PROCESS
for sites WITHOUT 24/7 on-site Medical Officers
24 hours - 7 days a week
Between 2300hrs & 0800, ALL referrals must be via telephone & meet streaming criteria
Ph: 1800 422 190
Fax: 1300 711 506
URGENT (ATS 1 or 2) - PHONE
NON-URGENT (ATS 3,4,5) - FAX request to initiate
When you phone, press 1 for URGENT or press 2 for NON-URGENT
TRIM ID: ED-CO-23-278806
Endorsed July 2023
Review date:July 2024

Appendix E: Symptoms in the pregnant or postnatal woman requiring either obstetric medical practitioner and/or midwifery consultation (via MOETS) 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**
Woman complains of reduced (less than normal or change in type) or absent fetal movements	• Unwell fetus • Requires biophysical profile by obstetric sonographer

Presenting symptoms (pregnant)	Possible complications
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 blood pressure (BP): • Headache, or • Blurred vision / visual disturbance, or • Epigastric pain, or • Hyper-reflexia / hypertonus, or • Swelling of hands, face or legs, or • Proteinuria BP 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)
History 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 38ºC or more	Epidural haematoma or epidural abscess • **Discuss with Anaesthetist**
Unwell with temperature greater than 38 ºC **or** less than 35.5ºC 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)
Any signs of endometritis – mild fever or lower abdominal pains	

Presenting symptoms (pregnant)	Possible complications
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