



**OBSTETRICS AND GYNAECOLOGY
 CLINICAL PRACTICE GUIDELINE**

Emergency Centre (EC)

Scope (Staff): WNHS Obstetrics and Gynaecology Directorate staff

Scope (Area): Emergency Centre KEMH

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

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Triage and observation in EC

Figure 1: The Australasian triage scale (ATS) categories¹

ATS category	Treatment acuity (maximum waiting time)	Performance indicator threshold
ATS 1 (red)	Immediate	100%
ATS 2 (orange)	10 minutes	80%
ATS 3 (green)	30 minutes	75%
ATS 4 (blue)	60 minutes	70%
ATS 5 (white)	120 minutes	70%

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

Key points

1. All persons who present to the Emergency Centre (EC) should be triaged on arrival. All patients presenting to the EC at KEMH will have primary assessment at triage to rapidly determine threat to life or limb and be allocated an Australasian Triage Scale (ATS) based on the primary assessment.
2. It is not appropriate for triage to be undertaken by an Enrolled Nurse, Midwife (who is not also a Registered Nurse), or administration staff (Only dual registration registered nurse/midwife shall undertake the role of triage not including graduates).
3. The triage assessment is not intended to make a diagnosis.
4. Any adverse signs or symptoms identified throughout the assessment process must be reported to the EC Coordinator and escalated as required.
5. The triage assessment and ATS category shall be recorded on the MR021. The most urgent clinical feature determines the ATS category, with consideration of the mechanism of injury and co-morbidities. Once a high-risk feature is identified, a response equal to the urgency shall be initiated.
6. The triage nurse is responsible for ensuring that the documentation of all episodes of care at triage is timely, accurate and comprehensive.

7. Recurrent presentations:

- Any patient that re-presents with the same condition within 24-48 hours is to be referred to a senior Medical Officer for review.
- If a patient has presented to any emergency department/ centre on three or more occasions with the same acute problem, the case should be either discussed with, or reviewed by, a Senior Registrar or Consultant.

[Recommendation Mar 2019]. Previous presentations can be seen across Metropolitan ED in EDIS Prior Registrations.

8. Persons presenting with a potential life threatening condition e.g. chest pain, severe haemorrhage or birth is imminent are **assessed** in the Emergency Centre. Non gynaecological / obstetric presentations should be stabilised and transferred to another adult facility as appropriate.
Document the management (assessments and methods used to stabilise) that occurs prior to transfer.
9. If a patient is being actively treated by another team (at another hospital) then the treating team are consulted and management discussed prior to admission.
[Recommendation Feb 2019]
10. At triage/ presentation the appropriateness of admission to this service is considered. **[Recommendation Feb 2019]**
11. Medical opinion must be sought by Emergency Centre staff prior to discharging patients who present with medical problems.
12. A chaperone is offered during any intimate physical examinations and documented to patient records. See NMHS Chaperone Policy.

Triage

Any person presenting to EC should be triaged

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

Triage nurse roles and responsibilities

- On presentation the triage nurse / midwife must assess the following:
 - Chief complaint
 - General appearance
 - Airway
 - Breathing
 - Circulation
 - Disability
 - Environment
 - Limited history
 - Co-morbidities
- Perform a quick evaluation to assess whether the patient is clinically stable.

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

Observations

- ATS Category 1, 2 and 3 patients shall be moved directly into the Emergency Centre clinical area prior to their observations being performed.
- Category 4 and 5 patients may have their initial observations performed in the waiting area. Checking of PV loss should occur in the clinical area of EC.
- Documentation of observations- as per WNHS Policy: [Recognising and Responding to Acute Physiological \(Clinical\) Deterioration](#): Observation and Response Chart (ORC): Emergency Centre
- All patients presenting to the Emergency Centre following triage must be commenced on an Adult, Antenatal, Postnatal or Neonatal ORC.
- Assess the patient's skin while taking and recording the pulse.
- All patients presenting to Emergency Centre with abnormal bleeding should have a speculum/ vaginal examination to assess the cervix and cause for the bleeding. If the Registered Nurse / Midwife or Medical Officer is unable to visually assess the cervix, then the Registrar, Senior Registrar or Consultant must be contacted to complete the vaginal examination.

Frequency of observations

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

Patient transfers

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

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

Telephone advice***NEW**

Documentation must be completed for all incoming calls where clinical advice is given (e.g. to patients) on the 'Documentation of Incoming Calls-Emergency Centre' (MR040.02)

Recording of clinical care commencement date / time

Procedure

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

NB: The commencement of care **is not** the triage and assessment of the patient. The triage and primary assessment time should be accounted for and documented accurately on EDIS.
- Commencement of clinical care must meet at least one of the following principles:
 - Add to the patient assessment (maternal or neonatal)– visual inspection of vaginal loss, postnatal wound or perineal inspection, HVS, specimen collection, wound swab collection, breast / nipple examination, collection of Expressed Breast Milk (EBM) specimen etc.
 - Mitigate clinical risk e.g. patient is considered at risk of falls or pressure injury due to their condition on presentation.
 - The provision of definitive therapy to the patient (maternal or neonatal) e.g. hyperemesis - the insertion of an intravenous cannula and commencement of fluids resuscitation, analgesia for pain.
 - In the opinion of the nurse / midwife the patient should be transferred to a cubicle in the EC for increased observation.
- The commencement of care and time must be documented on the EC Assessment form (MR 021) and in EDIS by the staff member who performed the care. All care and investigations performed should be recorded in EDIS system as appropriate in a timely manner.
- If clinical status changes in a way that will impact upon the triage category, if additional information becomes available or the commencement of clinical care will impact upon the triage category or influence the urgency* then re-triage must occur and the medical officer must be notified. The reason for re-triage must be documented. For more details refer to Department of Health Australia: [Emergency Triage Education Kit \(E TEK\)](#).

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

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

Procedure

- Any member of the public (including KEMH staff member or hospital visitor) who presents at the EC should be triaged by the Triage Nurse/Midwife in EC.
- **It is inappropriate to triage any person by telephone including staff members. If an internal call is received about a patient in the MBU, KEMH staff member, hospital visitor / client asking for advice, the person must be advised to present at the EC and documentation of incoming calls- Emergency centre MR040.02 must be completed**
- **Under no circumstances are internal requests to be made to EC for prescriptions for outpatient attendees to occur.** If an outpatient requires medication (even if it is obstetric or gynaecology related) they must be advised to present to their GP or the EC where they will be triaged and assessed appropriately.
- MBU patients who have been assessed by a medical practitioner in the MBU and referred to KEMH EC for admission shall be assessed and triaged as outlined in the previous [triage](#) chapter. If the referring medical practitioner has recommended admission to KEMH this shall occur.
- MBU patients who are unable to present at the EC / return to the MBU without assistance must be transferred via a non-urgent ambulance from the MBU to EC. If their clinical condition dictates urgent review (i.e. unable to wait for SJA) a code blue (55) must be called.
- Identify those patients who have evidence of, or are at high risk of physiological instability.
- Assign an appropriate ATS category in response to the clinical assessment data.
- Provide immediate care of life threatening conditions, provide patient comfort measures and arrange transfer to the appropriate facility.
 - The mode of transfer will be dependent on the presenting complaint and the clinical status of the patient.
 - **Document** the management (assessments and methods used to stabilise) that occurs prior to transfer.

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

Purpose

To advise on the management of patients alleging a recent sexual assault after hours in the KEMH Emergency Centre (EC) in the event that SARC is unable to see the patient (code yellow/disruptions to the Business Continuity Plan- BCP)

Procedure

1. SARC aims to provide emergency medical/forensic services 24 hours a day, 7 days a week. Service provision limitations exist.
2. In the event that the on-call SARC senior medical practitioner (SMP) is unavailable to attend to a patient in person for any reason, a phone advisory service will be available.
3. Depending on the clinical scenario, female clients who require an after-hours service may be asked by the SARC counsellor to attend the Emergency Centre at KEMH.
4. Where general physical injury, non-genital bleeding, non-fatal strangulation, suicidal ideation or suspected fracture is identified, the patient will be advised to attend their nearest Emergency Department (not the KEMH EC).
5. Male clients will be advised to attend their nearest local Emergency Department.
6. SARC services include telephone access to a counsellor who can provide advice and support to the client and the KEMH EC staff. The counsellor will assist in liaison with other services if this is required. Emergency Centre staff should call 6458-1828 to access the SARC after-hours services.
7. Prior to a patient attending EC, SARC staff will have conducted a triage, forensic prioritisation and planning for service delivery.

8. Medical care

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

- Provide a private room if available and allow access to a support person.
- **General well-being:** assess and treat as per patient presentation (life-threatening emergencies should go to the nearest ED as above).
- **Genital injuries and bleeding:** discuss with the on-call SARC SMP. An external genital examination (visual inspection only) may be conducted if there are symptoms of bleeding or pain (avoid speculum use). If heavy genital bleeding, examine and treat as medically indicated. This may involve the use of a speculum. If time permits, discuss with the on-call SARC SMP.

- **Emergency contraception:** Assess the need for emergency contraception and administer if no contra-indications.
- **Pregnancy:** Determine if the patient is pregnant and assess viability and fetal well-being if necessary.

9. Forensic care

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

- **DNA contamination:** if the patient is required to change into a hospital gown for any reason, wipe the examination bed and cover with a sterile theatre drape. Collect relevant items of clothing as discussed with SARC staff.
- **Showering:** Advise the patient not to shower or wash to avoid loss of forensic evidence.
- **Collect Early Evidence Kit (EEK)** (wee and wipe, blood and urine for toxicology, clothing as appropriate) as advised by SARC staff:
 - Use an EEK, located in the SARC box in the cupboard in cubicle 4
 - Instructions for use are also located in this box
 - Obtain informed consent from the patient using the enclosed consent form
 - Store the sealed forensic evidence specimen bag in a fridge
 - Clothing can be placed individually into clean paper bags and sealed i.e. each item of clothing in a single separate bag. Bags are in the EEK kit
 - This EEK will be collected by SARC the following day
 - The SARC box is to be checked and re-stocked by staff of SARC every six months or earlier if used

10. A full clinical forensic medical examination including sexually transmitted infection (STI) and BBV screening will be provided at SARC as soon as possible, generally the following morning.

High vaginal swab (HVS) collection in EC

Indications for HVS collection

- STI screen
- Vaginal symptoms
- Suspected PID

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

For opportunistic testing of asymptomatic women- See Silver book [Opportunistic testing](#)

Collection

Refer to KEMH Clinical Guideline: Obstetrics and Gynaecology:

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

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

IV morphine administration by nurses / midwives in EC

Aim

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

Key points

1. Administration of opioids via the intramuscular route may be inappropriate in the EC due to the possible delay in the action of the analgesia and the inability to titrate the amount of opioid required for patient comfort.
2. Only EC nurses / midwives who have been assessed as competent in the administration of IV morphine may administer it. See Pharmacy Adult Medication Guideline: [Morphine](#) and [DNAMER Competencies](#): IV Morphine
3. The medication must be prescribed by a Medical Officer on the Medication Chart MR 810.05
4. Respiratory depression is a side effect of the administration of an opioid medication. Attending Registered Nurses / Midwives must be aware of this and be competent to manage this complication.
5. Older persons may require lower doses of opioids to achieve an equivalent analgesic effect and the duration of analgesia is often longer.
6. Escalate observations as per relevant adult or postnatal ORC. This may require a Code Blue Medical call.
7. If the patient is not being admitted as an inpatient, they must remain in the EC for **two hours** following the last dose of an opioid.
8. When IV Morphine is prescribed, staff should ensure that they have access to Naloxone and are familiar with the indications & administration of the medication.

Procedure

- Assess the patient to establish their level of pain by asking the patient to rate the pain out of 10 or rate as mild / moderate / severe.
- Perform respiratory rate, oxygen saturation, pulse rate, blood pressure and temperature prior to administration.
- The patient should have a sedation score < 2 with a respiratory rate > 12 / minute.
- The medication must be prescribed by a Medical Officer.
- For the checking and administration see KEMH Clinical Guideline, Pharmacy: [Medication Administration](#) (available to WA Health staff via HealthPoint)
- For Schedule 8 Administration see KEMH Clinical Guideline, Pharmacy: [Medication Administration](#) (available to WA Health staff via HealthPoint)

- The medication is only to be administered at a rate of 2.5mg every 5 minutes to a maximum of 10mg.
- RN/RM must stay with medication solution and patient and **two** authorised health professionals must be involved in every step of the handling process as per [Medication Administration](#) guideline.
- Following administration the nurse / midwife must:
 - Perform and record oxygen saturations, respiratory rate, pain score and sedation level as a baseline and 10mins post each dose. Recorded on the relevant adult or postnatal ORC.
 - Following the final bolus an additional two sets of observations of respiratory rate, conscious state and pain score at 10 minutes and 20 minutes
 - Solution must be discarded in S8 liquid Waste with two RN/RMS.

Reversal

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

References and resources

1. Department of Health Australian Government. Emergency Triage Education Kit [webpage]: Department of Health, Australia; 2013. Available from: <https://www1.health.gov.au/internet/main/publishing.nsf/Content/casemix-ED-Triage%20Review%20Fact%20Sheet%20Documents>

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Curtis K, Murphy M, Hoy S, Lewis MJ. The emergency nursing assessment process – A structured framework for a systematic approach. *Australasian Emergency Nursing Journal*; 2009; 12:130-136.

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

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

Related policies

Department of Health, Australia

- [Emergency Triage Education Kit \(E TEK\)](#)

Department of Health, WA:

- [MP 0086/18 - Recognising and Responding to Acute Deterioration Policy](#)
- [MP 0164/21 - Patient Activity Data](#)
- [WA Health Consent to Treatment Policy](#) 2016

Related WNHS and NMHS policies, guidelines and forms

WNHS Clinical Guidelines:

O&G:

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

Pharmacy:

- [Medication Administration](#) (available to WA Health staff via HealthPoint), includes

Schedule 8 Controlled Medications Administration

- A-Z Adult Monograph: [Morphine](#); [Naloxone](#)









Additional related policies (for SARC section):

- WNHS policy: [Child Protection and Child Sexual Abuse \(Mandatory Reporting\)](#)
- Legal Requests for Medical/Clinical Reports- direct requests to Medico Legal Services
- Medical record and patient information (confidentiality of): [WNHS policy: Patient Information \(Management of\)](#) and [NMHS policy- Healthcare Record – Access and Document Release](#)
- Department of Health WA: [Guidelines for Protecting Children 2015](#); [MP 0166/21 - Mandatory Reporting of Child Sexual Abuse Training Policy](#)

Forms

- MR021 Emergency Centre Assessment
- MR040.02 Documentation of Incoming Calls - Emergency Centre
- MR810.05 WA Hospital Medication Chart

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Version history

Version number	Date	Summary
1	Sept 2017	First version History: In Sept 2017 amalgamated seven individual guidelines on care in EC dating from Feb 2012. <ol style="list-style-type: none"> 1. Triage and Observation in the Emergency Centre 2. Recording of Clinical Care Commencement Date and Time in EC 3. Admission of a patient to the Emergency Short Stay Unit 4. After hours management of emergency sexual assault resource centre(SARC) clients 5. High Vaginal Swab Collection in EC 6. Presentation and Management of Staff and Visitors(including patients from the MBU) with Non Gynaecological or Obstetric Conditions 7. IV Morphine Administration in the Emergency Centre
2	Feb 2018	Full review by guideline pod
3	May 2018	SARC section amended. <ul style="list-style-type: none"> • SARC continue to attempt to provide emergency medical/forensic 24 hour service. • The SARC box is to be checked and re-stocked by staff of SARC every six months or earlier if used. • Removed section regarding exceptions / priority 1 cases
4	Feb 2019	<ul style="list-style-type: none"> • If a patient is being actively treated by another team (at another hospital) then the treating team are consulted and management discussed prior to admission (p. 2) [RCA recommendation] • At triage/ presentation the appropriateness of admission to this service is considered (p.2) [RCA recommendation]
5	Mar 2019	<ul style="list-style-type: none"> • Recurrent presentations: If a patient has presented to any emergency department/ centre on three or more occasions with the same acute problem, the case should be either discussed with, or reviewed by, a Senior Registrar or Consultant. [RCA recommendation]

6	Oct 2021	<ul style="list-style-type: none"> • Document clinical advice given by telephone (e.g. to patients) on the 'Documentation of Incoming Calls- EC' MR form • Document all assessments and methods used to stabilise patients that occurs prior to patient transfer to another hospital • Only dual registration registered nurse/midwife shall undertake the role of triage not including graduates • Any member of the public who presents to the EC are triaged by the Triage Nurse/Midwife in the EC • Presentations with non-gynaecological or obstetric conditions- Provide immediate care of life threatening conditions, provide patient comfort measures • Observations- refer to escalation and response processes on relevant ORC. All patients are commenced on the relevant ORC after triage. • 'Admission to the short stay unit' chapter removed- no longer used • SARC chapter (contacts, medical and forensics) updated • HVS section- added indications and now links to relevant guidelines for collection and opportunistic testing • ATS appendix removed- print copies available at triage desk • IV morphine administration section updated: <ul style="list-style-type: none"> ➢ Must be prescribed by a Medical Officer on the Medication Chart MR 810.05 ➢ Time to stay, if not admitted after dose, changed to 2 hours ➢ RN/RM must stay with medication solution and patient; ➢ Frequency of observations changed (baseline and 10mins post each dose)- record on relevant ORC ➢ Solution must be discarded in S8 liquid waste with two RN/RMs ➢ Reversal- Indications updated, Escalate as per relevant adult or postnatal ORC which may require a Code Blue Medical call)
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