SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Critical Care and Emergency Medicine
KEY TERMS	Emergency Nurse Protocol, Emergency Nurse, Nurse Protocol, Standing Orders
SUMMARY	The purpose of this document is to provide a district-wide procedure for the use of Emergency Nurse Protocols and Standing Orders across SESLHD Emergency Departments.

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SESLHD PROCEDURE

Framework for Emergency Nurse Protocols and Standing Orders in SESLHD

SESLHDPR/369

1. POLICY STATEMENT

This Procedure outlines the correct process for using the Emergency Nurse Protocols (ENP) and Standing Orders (SO) within SESLHD Emergency Departments (EDs) in line with the following NSW Ministry of Health Policy Directives: PD2009_071 - Emergency Department Data Dictionary; PD2018_010 - Emergency Department Patients Awaiting Care and PD2013_047 - Triage of Patients in NSW Emergency Departments.

2. BACKGROUND

The management of patients presenting with acute medical and surgical emergencies relies upon focused assessment, diagnosis and appropriate management to reduce morbidity and mortality. The emergency nurse is often one of the first persons to assess the patient, and therefore finely tuned assessment skills are required. Those patients who have been assessed by triage and found to have no immediate life-threatening clinical signs may be asked to wait until a bed and medical officer is available. This wait can be a distressing time for the patient, their carer and/or family. Patients waiting to be seen by a medical officer or nurse practitioner are appropriate for review by an experienced Advanced Clinical Nurse (ACN) or Clinical Initiatives Nurse (CIN).

The purpose of this document is to provide a district-wide procedure for implementation of the Adult Emergency Nurse Protocol (ENP) and Standing Orders (SO) usage across SESLHD Emergency Departments. Emergency Nurse Protocols are to formalise emergency nursing practice with appropriately educated and experienced RNs. The nurse protocols are not intended as diagnostic tools. The protocols are to be utilised to the individual nurse's level of knowledge and skills. e.g. A RN1 or RN2 would be expected to complete a primary survey, relevant history and basic investigations (i.e. ECG) as detailed within the protocol; however, may not be able to complete some areas within the toolkit such as: initiating relevant medication standing orders / further investigations and interventions requiring venepuncture or cannulation / or completing facets of physical examination that they have not yet been taught. Those nurses able to initiate extended practice skills and administer medication standing orders must be working in an Advanced Clinical Nurse (ACN) capacity must have at least a minimum of two years emergency / critical care experience and be able to work in all aspects of the ED i.e. resuscitation, triage, clinical initiatives nurse, acute / subacute, fast track and paediatrics, or as considered clinically skilled and appropriate by the ED Nurse Manager.

Implementation of the ENP allows for the early implementation of appropriate clinical care and to commence assessment and treatment on a patient within their scope of practice. Patient's clinical conditions often rapidly change and the nurse is able to escalate care as necessary to a Senior Medical Officer (SMO) prior to being seen by a treating medical officer or nurse practitioner. The medical officer will continue to be involved in the patient management until discharge and will see the patient as soon as possible. These approved Adult Emergency Nurse Protocols will be implemented across SESLHD with appropriate training and education in line with the NSW Ministry of Health Clinical Initiatives Nurse Program Clinical Initiatives Nurse | Emergency Care Institute.

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3. RESPONSIBILITIES

3.1 Emergency Advanced Clinical Nurses will:

- Demonstrate an advanced level of clinical competency in the care of patients, using theoretical knowledge and clinical judgment at an advanced level
- Effectively assess patients on presentation to ED and independently initiate investigations based on this assessment
- Utilise advanced skills in emergency nursing including advanced assessment skills, the ability to initiate diagnostics including radiology, pathology and nurse initiate analgesia based on these assessment skills and to implement patient care using advanced clinical skills i.e. wound assessment and fracture management, plastering/splinting
- Determine, prioritise and justify clinical decisions using best practice utilising the ENP for patients that meet the inclusion criteria of the protocol
- Utilise effective interpersonal and communication skills to interact positively with patients and families
- Demonstrate collaborative practice as a member of a multidisciplinary team together with an ability to work within scope of practice
- Ensure that the needs of the patients are being met by providing adequate care and continuing to advocate for the patient with any concerns
- Comply with all Ministry of Health Policy Directives and SESLHD policies and procedures, and report non-compliance to their line manager
- Escalate any **Red Flags** identified from the primary survey, history or systems assessment to the Clinical Nurse Unit Manager (CNUM) and Senior Medical Officer (SMO)
- Document all nursing care and investigations / diagnostics and treatment provided to patients under the ENP / SO.

3.2 Clinical Nurse Unit Managers (CNUM) will:

- Oversee correct use of ENPs and SOs
- Ensure appropriate nursing assessments are being conducted by nursing staff
- Escalate any ongoing **Red Flags** identified by the assessing nurse from the primary survey, history or systems assessment to the SMO
- Escalate any ongoing clinical concern for the patient by the assessing nurse to the SMO
- Document escalations that are made and any medical orders given.

3.3 Senior Medical Officer (SMO) will:

- Review all patients that have commenced on the ENP if **Red Flags** are identified by nursing staff and escalated
- Document escalations made and any treatment or interventions attended/to be attended in response to escalations
- Review any investigations, diagnostics and treatments commenced by nursing staff.

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4. PROCEDURE

4.1 Nursing Assessment

- All appropriate basic nursing assessments and interventions must occur before commencing any investigations or treatment relevant to the ENP
- Correct identification of patient's symptoms who meet the assessment criteria of the ENP
- Each ENP contains a description of the assessment criteria or patients signs and symptoms that is specific to that protocol
- One or more of the signs and symptoms described in the assessment criteria are necessary to implement a specific ENP
- Nurses must follow ENP instructions on assessment, investigations and diagnostics appropriate to the patients presenting problem
- In making clinical decisions the nurse should remain cognizant of their level of expertise and take advantage of the expertise of all members of the emergency team
- Nurses are responsible for practicing in a safe manner and maintain a safe care environment for themself and others.

4.2 Escalation Criteria

- The nurse should have a low threshold to escalate care of patients urgently to an ED SMO and CNUM as soon as the patient's condition deteriorates or presents itself as urgent.
- The nurse will refer all patients who meet the following escalation criteria **Red Flags** to an ED SMO:
  - Patients who meet PACE / Between The Flags (BTF) criteria
  - Neurological compromise
  - Neurovascular compromise
  - Trauma Call Criteria
  - Non-accidental Injury
  - Compound fractured limb
  - Severe pain of any cause
  - Abdominal tenderness and/or guarding
  - Pregnancy > 12 weeks gestation
  - Acute confusion / poor historian e.g. dementia, acute delirium
  - Substance use / abuse - which has altered the persons responses
  - Co-morbidities compromising presentation
  - Any patient in whom you have ongoing concerns
- Escalation criteria or **Red Flags** are recorded in the ENPs and identify any immediate life-threatening presentations that require escalation and referral to a SMO
- Immediately notify CNUM and SMO if any **Red Flags** are identified from the primary survey, history or systems assessment
- Implementation of these protocols must not delay the patient being placed in an appropriate treatment area bed
- The sequence of carrying out the ENP is linear. If a nurse is involved in caring for the patient simultaneously with another nurse then steps may occur concurrently.

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4.3 Handover of Care

- If the ENP commenced is not completed, then the nurse must handover the appropriate investigations and/or treatment required immediately to another treating RN or medical officer to complete ongoing care
- Implementation of these ENPs and SOs must not delay medical staff attending to these patients.

4.4 Dispute Resolution

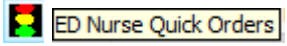
Where disagreement occurs between the nurse and the treating medical officer regarding the protocol or standing order the following procedure shall apply:

- The SMO and nursing team leader shall be informed. If the SMO deems it appropriate he/she shall sign off the SO
- The SMOs decision is final, as he/she is responsible for patient care in the ED. Disputed decisions may be followed up at an appropriate time with the Director of Emergency Medicine. In keeping with ED policy any individual staff member at their discretion may raise incident reports via the IIMS
- If the ED Medical Director in consultation with the Senior Nurse Manager / CNC feels there has been un-authorised use of medications or procedures outside of or in a manner contravening a ENP or SO then the matter will be reviewed with the nurse involved and appropriate action taken.

5. SENSIBLE TEST ORDERING PROTOCOLS (STOP) – PATHOLOGY

There are a variety of opinions and a variable evidence base for appropriate pathology test requesting. Expert panel opinion has been sought for current and reasonable practice and these are summarised in Appendix 3 as a matrix for common emergency presentations. The Australian College of Emergency Medicine (ACEM) Guideline on Pathology Testing in the Emergency Department matrix is designed as a rapid reference guide for junior medical and nursing staff for the treatment of adult patients attending the ED. It is acknowledged that some tests may not be immediately available on-site in all locations. Senior clinicians should provide education and support to junior doctors and other nursing staff in the ED to assist with appropriate test selection.

5.1 Documentation of Pathology requests

Pathology orders are placed electronically via FirstNet utilising the ED Nurse Quick Orders 

icon available in FirstNet. Green coloured nurse protocols can be ordered by any RN according to the protocol with Orange being conditional nurse protocols and may require discussion with a senior medical officer prior to ordering.

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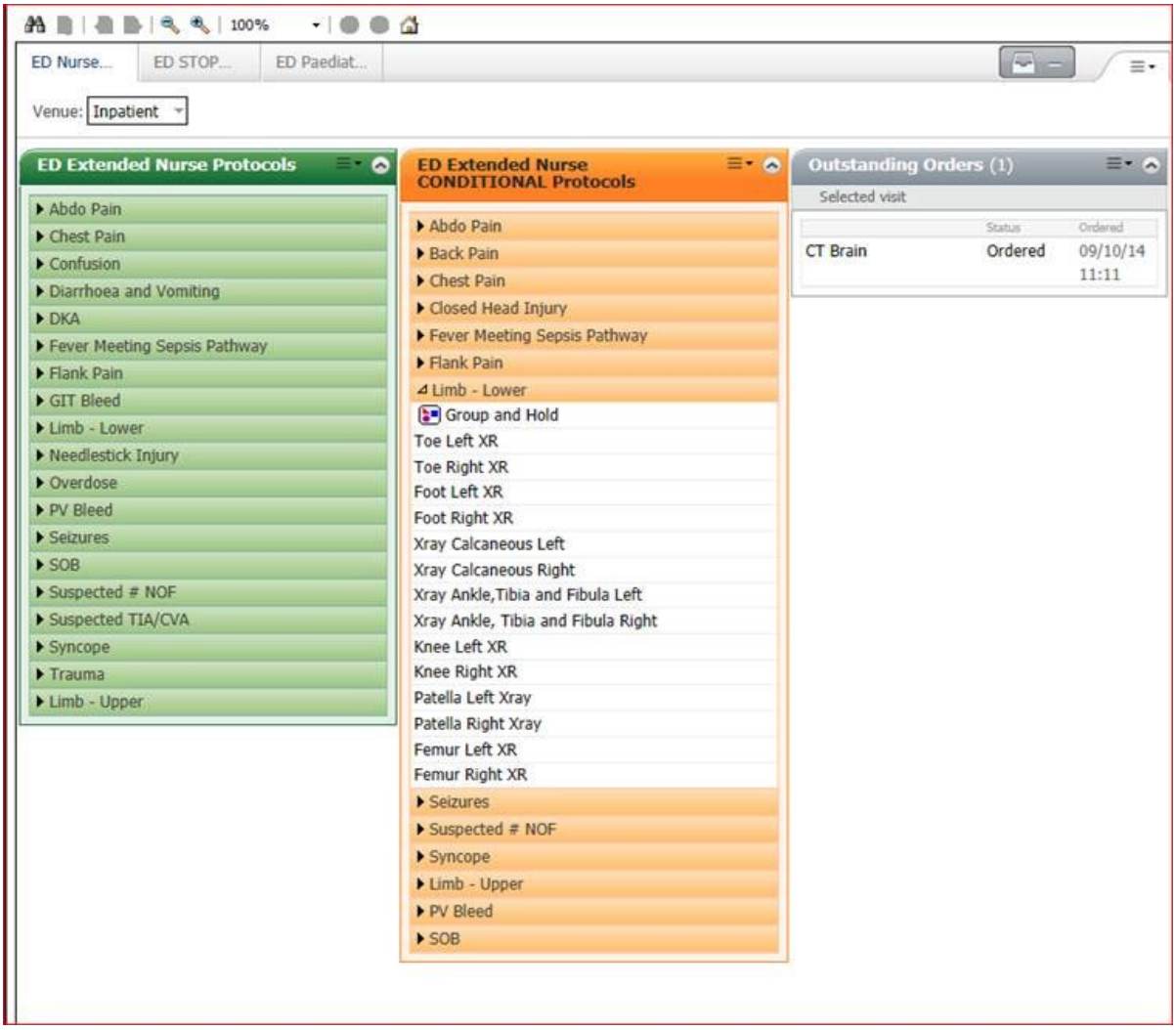

6. SENSIBLE TEST ORDERING PROTOCOLS (STOP) – RADIOLOGY

Nurse initiated x-ray provides framework for appropriate ordering of radiological investigations for adult patients >15 years presenting to the ED with isolated distal limb injuries.

This section compliments the protocols and should only be utilised by accredited emergency registered nurses who have completed the appropriate training for the initiation of radiological investigations for isolated limb injuries. Patients should be advised against leaving the ED prior to being reviewed by a medical officer (MO) or Nurse Practitioner (NP). If patients choose to leave the department they should be advised to follow up with the Local Medical Officer (LMO) in order to obtain results for any radiological investigations undertaken.

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6.1 Documentation of radiology request

1. The order must be completed electronically in FirstNet utilising the ED Nurse Quick Orders  ED Nurse Quick Orders icon. In the event of a written request; the form is to be completed legibly, including patient details, the person requesting must be clearly documented followed by 'Nurse Initiated'.

2. Minimum documentation of order should include:
   - Succinct and specific description of mechanism of injury
   - Points of maximal bony tenderness, swelling or deformity are to be described anatomically
   - A provisional diagnosis (e.g.? # distal radius).

3. Examination requested should specify:
   - Side of injury (i.e. Left or right)
   - Any specific views required (e.g. scaphoid, patella, calcaneal).

7. STANDING ORDERS

Timely access to analgesia not only decreases physical discomfort but also allows adequate physical assessment of the patient's condition thus facilitating timely diagnosis. This procedure should be utilised in conjunction with NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling, which outlines the medico-legal requirements of Standing Orders (SO):

- Standing orders provide authorisation by an authorised prescriber for the administration (or supply for administration where applicable) of medication without a patient-specific written order in specific clinical and emergency situations
- Nurses may only administer according to current ED approved standing orders as published at: Standing Orders
- An authorised prescriber i.e. ED treating medical officer must confirm the administration by countersigning the record of the administration as soon as possible, and within four hours
- All ED standing orders must be approved by the SESLHD Drug and Quality Use of Medicines Committee (DQUM) and be in the form of a written instruction, signed and dated by an appropriate Clinical Stream Medical Director
- A standing order must be consistent with the respective medication's approved product information, evidence-based clinical practice guidelines and other relevant NSW Health policies and directives
- Each standing order must be reviewed every 12 months and re-approved as appropriate.

Emergency Nurses must complete the *SESLHD Nurse Initiated Pharmacology Emergency Department Standing Orders Learning Package* and only administer the specific standing orders approved by the SESLHD Drug and Therapeutics Committee (DTC). These can be found on the intranet at Standing Orders.

This resource package is to provide education and support, setting solid foundations for the safe practice and effective administration of Nurse Initiated Analgesia and other

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pharmacotherapies utilised in the ED. An *Analgesia Flowchart* is provided in Appendix 1 which outlines the recommended medications based on numerical pain scale rating for each of the approved standing orders.

7.1 Documentation of Standing Orders

- Document patient observations including the patient's pain score on the Emergency Department observation chart and/or electronically within FirstNet.

Paper-based National Inpatient Medication Chart (NIMC)

- The administering nurse must record the administration in ink on the 'once-only' section of the NIMC as Emergency Department Standing Order (i.e. "ED STO") plus print and sign their name
- The ED Standing order must be countersigned by the medical officer that subsequently assesses and treats the patient within four hours.

Electronic Medication Chart (eMEDs)

- The administering nurse must order the medication through the FirstNet 'orders' tab
- The *Physician name* must be populated to the ED Medical Director's name and the *Communication* type as 'Protocol'
- Accountable Drug Register documentation must be completed i.e. when documenting in the S8 drug book, the ED Medical Director's name followed by 'EDSO' next to it to indicate this is a standing order
- The signatures of the administering nurse and nurse checking the medication must be clearly documented both in the Accountable Drug Register and on the NIMC/eMEDs and this includes completing the date, time, drug, dose, route and time of administration sections
- The administering nurse must record in the patient's progress notes or electronically in FirstNet the administration and effect of the medication
- Drugs must be checked and ordered according to hospital policy and adhering to the NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling.

8. DOCUMENTATION

Collecting information on nursing interventions and first seen by times is vital in the analysis of the effectiveness of the ACN or CINs role. ED nurses are all responsible for appropriate timely and accurate documentation of all patient care and/or nursing interventions. For any patient on which the ED nurse performs any assessment or intervention, including education on ED processes and reassurance, will require the nursing assessment to be completed in the ED Pathway / Protocol screen in FirstNet.

Documentation of the use of ENP and SOs will be initially recorded electronically by clicking on the icon  Approved Protocol which opens the FirstNet ED Approved Protocol screen. This will '*stop the clock'* and identify that a nurse protocol has been initiated. Once this information has been entered no additional information can be added by another nurse into the protocol screen.

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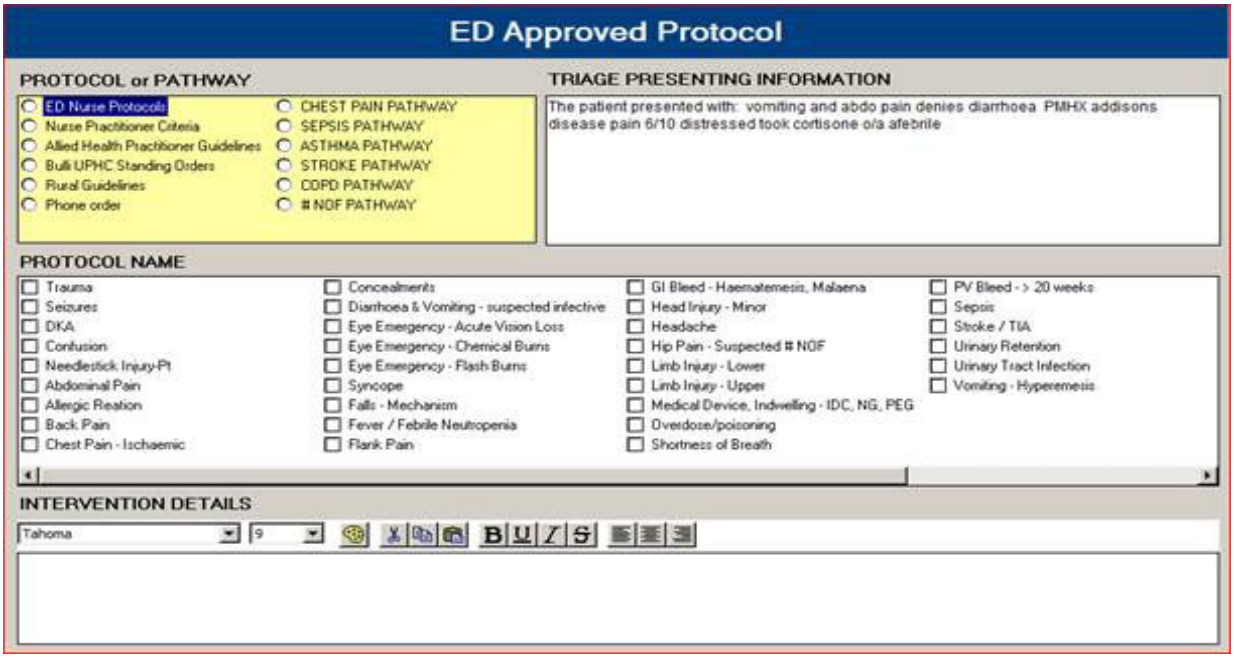
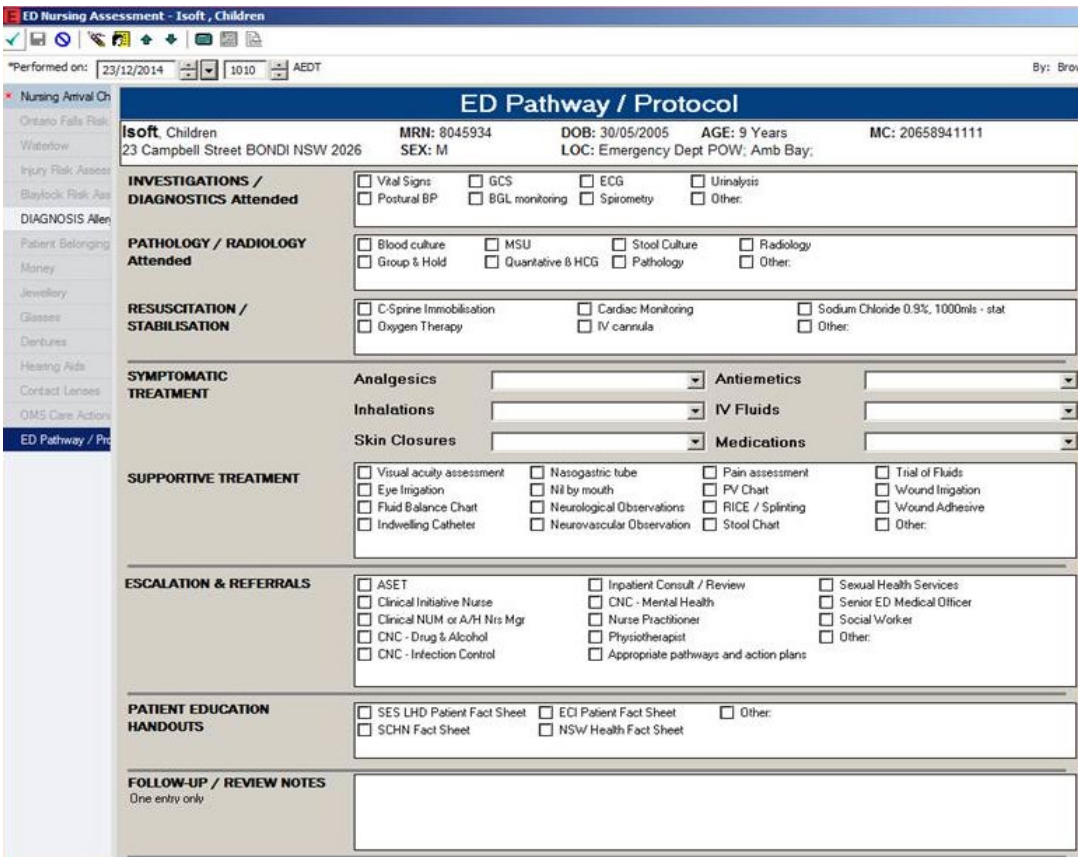


Further management of the patient's ongoing nurse protocol care should be documented contemporaneously in the ED Nursing Assessment Form under documentation and includes information regarding investigations and diagnostics initiated, symptomatic or supportive treatment, escalations and referrals, patient education and handouts as well as any follow-up or reviews required *(see screen shot below)*.



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During periods of FirstNet downtime, ED nurses should document all approved protocol interventions on the ***Emergency Nurse Approved Protocol (eMR DOWNTIME FORM)*** in Appendix 2 so that these can be entered into FirstNet at a later time period.

9. AUDIT

The mechanism for monitoring the use of ENPs and SOs will be bimonthly audits of at least 10 patient's notes, where ENPs and/or SOs have been implemented. Facility ED Nurse Educators (NE) or Clinical Nurse Consultant (CNC) will be responsible for carrying out these audits. Reports of these audits will be reviewed both locally at facility Emergency Department Meetings and reviewed bimonthly at the District Emergency Clinical Stream Committee.

Any concerns arising from the use of these ENPs or SOs should be communicated to the Nurse Manager and Director of Emergency Medicine and/or, if appropriate documented as an incident within IIMS. These will be formally reviewed with the notes audit.

10. REFERENCES

- SESLHD Adult Emergency Nursing Protocols
- SESLHD Emergency Department Standing Orders
- Australian College of Emergency Medicine (ACEM) Guideline on Pathology Testing in the Emergency Department
- Clinical Initiatives Nurse (CIN) Role Clinical Initiatives Nurse | Emergency Care Institute (nsw.gov.au)
- Clinical Initiatives Nurse in Emergency Departments – Educational Program - Resource Manual 2011
  NSW Ministry of Health Policy Directive PD2022_032 - Medication Handling

11. ACKNOWLEDGEMENTS

- Prince of Wales Hospital *Emergency Department Advanced Clinical Nurse Standing Orders,* 2009.
- Prince of Wales Hospital *Emergency Department Extended Practice Nurse Treatment Guidelines,* Clinical Business Rules, 2012
- Prince of Wales Hospital *Emergency Department Assessment Toolkits*, 2011.
- St George Hospital *Emergency Department Extended Practice Nurse Guidelines, Protocols & Orientation Package,* 2011.
- St George Hospital *Emergency Department Clinical Initiatives Nurse (CIN) Management, Clinical Business Rule*, June 2012
- ISLHD *Standing Orders for Clinical Treatment by ISLHD Emergency Department Advanced Clinical Nurses*, 2013
- SESLHD ED Clinical Stream Clinical Nurse Consultant /Clinical Nurse Educator /Nurse Educator working group
- SESLHD ED Clinical Stream Committee

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12. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
August 2014	0	Samantha Connelly, A/CNC TSH ED
August 2014	1	Leanne Horvat, Clinical Stream Nurse Manager Critical Care / Emergency & Clinical Redesign. SESLHD Emergency Stream CNC/NE Working Group
November 2014	2	Revised following feedback from Julie Thompson (DQUMC) and SESLHD Emergency Stream CNC/NE Stream Working Group.
November 2014	3	Approved by SESLHD Emergency Stream Committee on 11 December 2014
February 2015	4	Endorsed by SESLHD District Drug & QUM Committee on 12 February 2015
March 2015	5	Endorsed by Clinical and Quality Council on 11 March 2015
March 2018	6	Minor review endorsed by Executive Sponsor and submitted to Executive Services
March 2018	6	Processed by Executive Services prior to progression to SESLHD DQUM
May 2018	6	Approved by Drug and Quality Use of Medicines Committee
May 2023	7	Minor review. Amended Section 11; removed Emergency Clinical Stream CNC/NE Working Group Members and added SESLHD ED Clinical Stream Clinical Nurse Consultant /Clinical Nurse Educator /Nurse Educator working group. Appendix 3 updated. References updated. Approved by Executive Sponsor.
June 2023	7	Approved by SESHD Drug and Therapeutics Committee.

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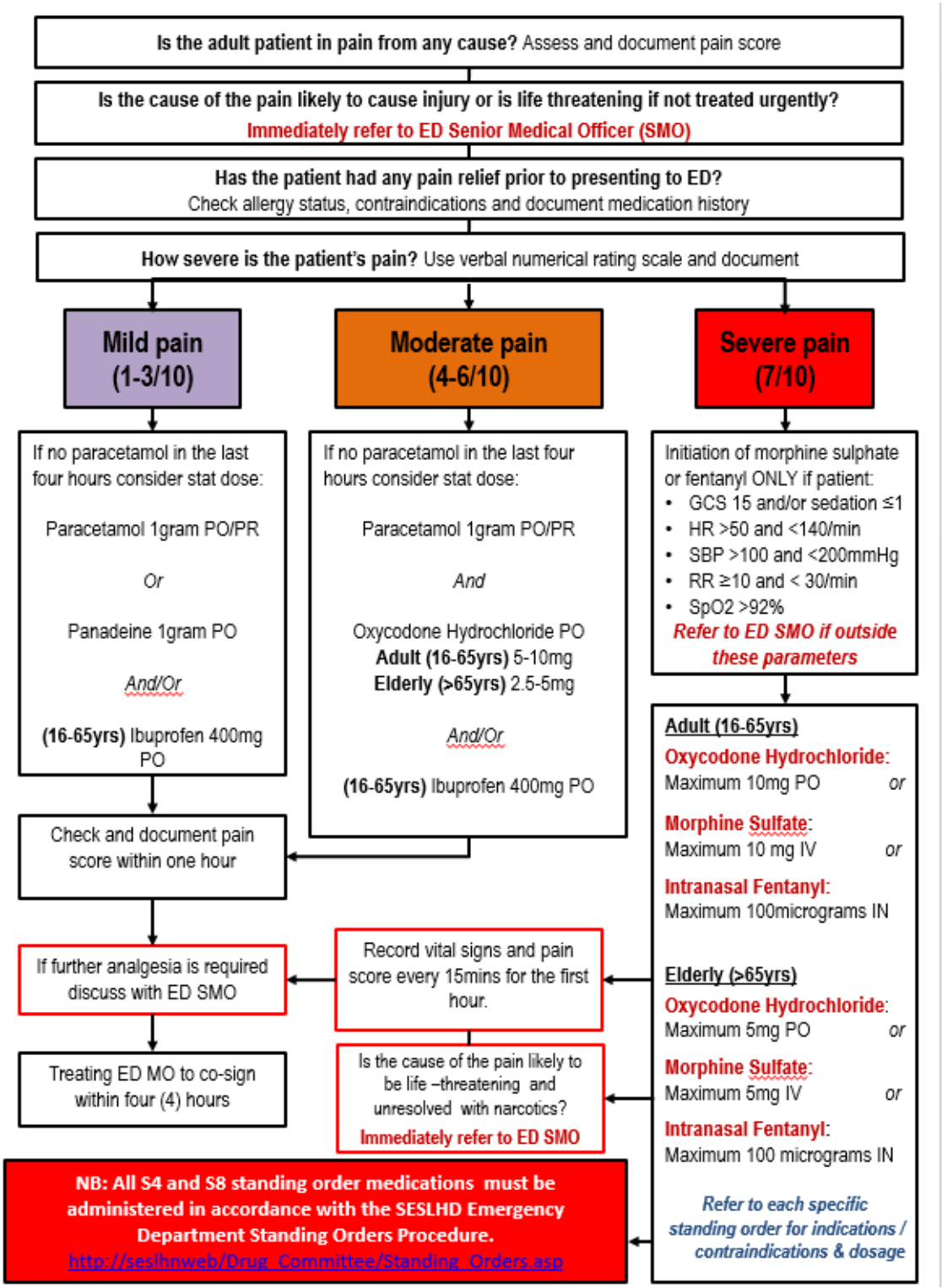
Appendix 1: SESLHD Adult Standing Order Analgesia Flowchart



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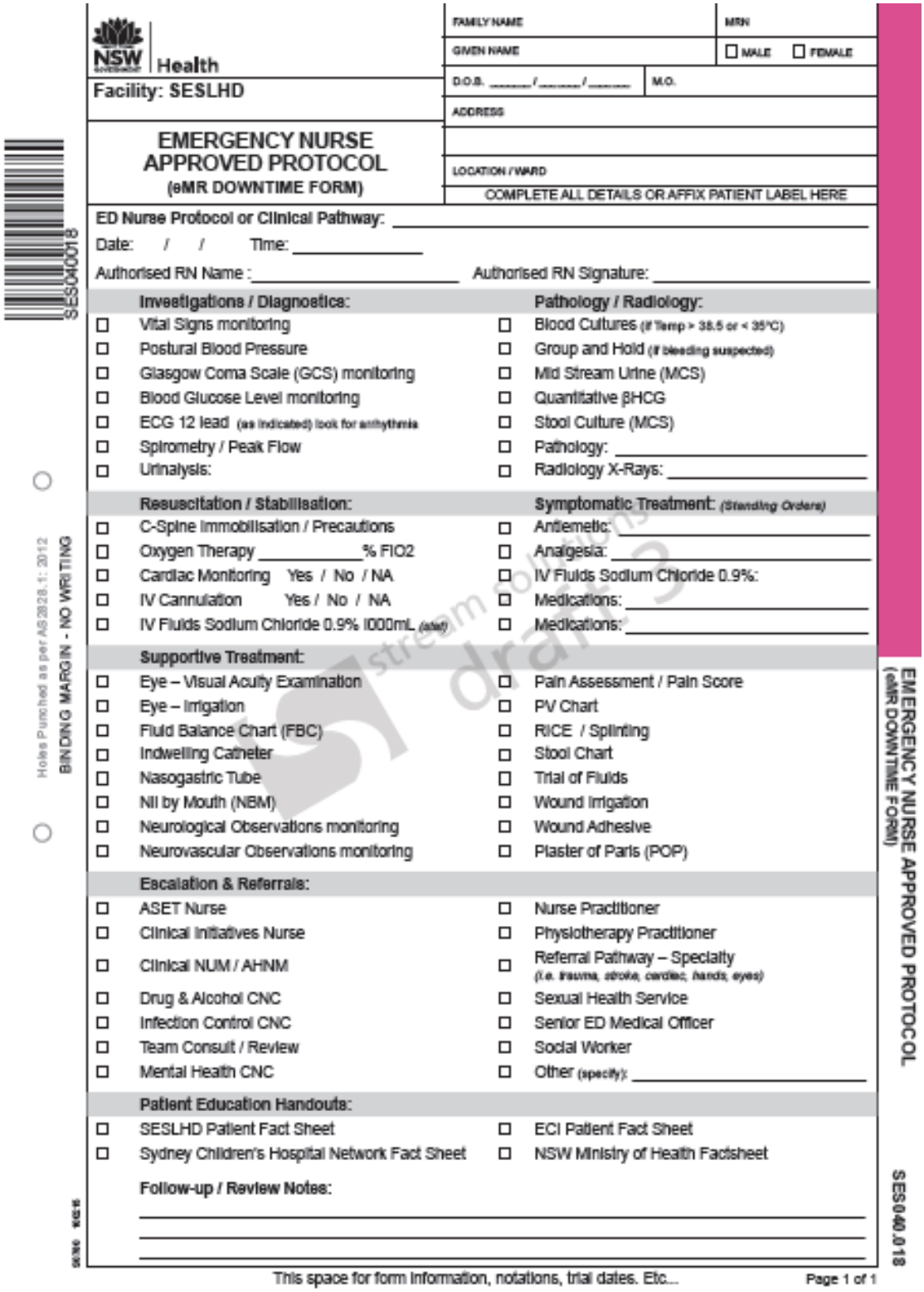
Appendix 2: Emergency Nurse Approved Protocol (eMR Downtime Form)



NSW Health

Facility: SESLHD

EMERGENCY NURSE APPROVED PROTOCOL
(eMR DOWNTIME FORM)

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ED Nurse Protocol or Clinical Pathway: _____

Date: / / Time: _____

Authorised RN Name :_____ Authorised RN Signature: _____

Investigations / Diagnostics:

- ☐ Vital Signs monitoring
- ☐ Postural Blood Pressure
- ☐ Glasgow Coma Scale (GCS) monitoring
- ☐ Blood Glucose Level monitoring
- ☐ ECG 12 lead (as indicated) look for arrhythmia
- ☐ Spirometry / Peak Flow
- ☐ Urinalysis:

Pathology / Radiology:

- ☐ Blood Cultures (if Temp > 38.5 or < 35°C)
- ☐ Group and Hold (if bleeding suspected)
- ☐ Mid Stream Urine (MCS)
- ☐ Quantitative βHCG
- ☐ Stool Culture (MCS)
- ☐ Pathology: _____
- ☐ Radiology X-Rays: _____

Resuscitation / Stabilisation:

- ☐ C-Spine Immobilisation / Precautions
- ☐ Oxygen Therapy _____% FIO2
- ☐ Cardiac Monitoring Yes / No / NA
- ☐ IV Cannulation Yes / No / NA
- ☐ IV Fluids Sodium Chloride 0.9% 1000mL (stat)

Symptomatic Treatment: (Standing Orders)

- ☐ Antiemetic: _____
- ☐ Analgesia: _____
- ☐ IV Fluids Sodium Chloride 0.9%:
- ☐ Medications: _____
- ☐ Medications: _____

Supportive Treatment:

- ☐ Eye – Visual Acuity Examination
- ☐ Eye – Irrigation
- ☐ Fluid Balance Chart (FBC)
- ☐ Indwelling Catheter
- ☐ Nasogastric Tube
- ☐ Nil by Mouth (NBM)
- ☐ Neurological Observations monitoring
- ☐ Neurovascular Observations monitoring
- ☐ Pain Assessment / Pain Score
- ☐ PV Chart
- ☐ RICE / Splinting
- ☐ Stool Chart
- ☐ Trial of Fluids
- ☐ Wound Irrigation
- ☐ Wound Adhesive
- ☐ Plaster of Paris (POP)

Escalation & Referrals:

- ☐ ASET Nurse
- ☐ Clinical Initiatives Nurse
- ☐ Clinical NUM / AHNM
- ☐ Drug & Alcohol CNC
- ☐ Infection Control CNC
- ☐ Team Consult / Review
- ☐ Mental Health CNC
- ☐ Nurse Practitioner
- ☐ Physiotherapy Practitioner
- ☐ Referral Pathway – Specialty (i.e. trauma, stroke, cardiac, hands, eyes)
- ☐ Sexual Health Service
- ☐ Senior ED Medical Officer
- ☐ Social Worker
- ☐ Other (specify): _____

Patient Education Handouts:

- ☐ SESLHD Patient Fact Sheet
- ☐ ECI Patient Fact Sheet
- ☐ Sydney Children's Hospital Network Fact Sheet
- ☐ NSW Ministry of Health Factsheet

Follow-up / Review Notes:

_____
_____
_____

This space for form information, notations, trial dates. Etc...

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EMERGENCY NURSE APPROVED PROTOCOL (eMR DOWNTIME FORM)

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stream solutions draft 2

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Appendix 3: Pathology Requesting for Adult Patients in the ED

Appendix 1 Matrix: Side A

Pathology Requesting for Adult Patients in the Emergency Department - Suggested Tests for Common Conditions

Fill tubes to correct level and identify, label and sign at BEDSIDE as per local protocol. Ensure CORRECT ORDER of draw →	Aseptic collection	Na Citrate	Depending on instrument type and chemistry methodology different hospitals will have a local protocol to follow. The following gel tube colours are a guide only CHECK WITH YOUR LOCAL LABORATORY ■ ■ ‖ =white top ■ = Gold top ■ =Orange										K EDTA ■ or ■	Blood Bank EDTA ■	Syringe BG ■	Only send M/C/S if clinical concern UTI	Other Appropriate Investigations
Presentation	BC [1]	Coags [2]	UEG [3]	LFT	Ca/Phos/Alb	Urate	Troponin	Lipase	hCG [4] (female)	CRP	CK	Drug level	FBC	Group/Antibody screen [5]	Blood Gas [6]	Dipstick Urinalysis	
Abdominal pain severe (upper/epigastric)	Consider			Plus LDH	Consider		Consider										Consider Lactate
Abdominal pain severe (lower)	Consider				Consider									Female			Consider Lactate
Back pain atraumatic (requiring admission)	Consider				Consider			Consider		Consider							
Cellulitis (requiring admission)	Consider			Consider													M/C/S if infected lesions
Chest pain - suspected Ischaemic Heart Disease				Consider													
Chest pain - suspected Pulmonary Embolism		Consider D-Dimer		Consider			Consider										
Confusion/Syncope	Consider			Consider	Consider		Consider										Consider CSF investigations
Cerebrovascular Accident		Consider															
Diabetic Ketoacidosis	Consider																
Fever for Investigation (include returned travellers)										Consider							Consider malaria, dengue and other illness investigations relevant to Hx
Fractures Neck Of Femur/Major Long Bone																	
Fractures Minor for Theatre >55yo																	
Gastrointestinal Bleed		Consider															
Jaundice For Investigation					Consider												Consider relevant viral serology
Liver Disease					Consider												Consider relevant viral serology
Oncology patients (febrile neutropenia)					Consider									Consider		Plus M/C/S	
Overdose (significant)											Consider	Consider	Consider		Consider		Consider paracetamol
Per Vaginal Bleed - 1st trimester									Quantitative								Consider PCR for chlamydia & gonorrhea
Pneumonia (requiring admission)																	Recommend sputum M/C/S, respiratory virus PCR and urinary antigen
Pyelonephritis (not simple cystitis)	Consider															Plus M/C/S	
Renal Colic (1st episode)																	
Renal Disease																	
Seizures (1st episode)			Plus bedside glucose		Plus Mg												Consider CSF investigations relevant to Hx
Seizures (recurrent)			Consider									Consider	Consider				
Septic Joint - suspected				Consider		Consider				Consider							Joint Fluid M/C/S
Sepsis																Plus M/C/S	Lactate + other relevant cultures
Snake Bite [7]				LDH only									Plus film				
Short Of Breath - Asthma (requiring admission)			Consider										Consider		Consider		Nasopharyngeal swab for respiratory virus PCR
Short Of Breath - suspected Acute Pulmonary Oedema															Consider		
Short of Breath - Chronic Obstructive Pulmonary Disease															Consider		Consider Sputum M/C/S
Trauma (Major)																	
Warfarin therapy		INR only	Consider if over anti-coagulated	Consider if over anti-coagulated									Consider	Consider			

Key	This form is a guide for clinical staff initiating pathology tests. Clinical judgment should be exercised. Some patients may not need any tests or have had them performed recently. If in doubt consult with senior ED doctor. Some tests may not be immediately available locally.
Perform test	1. BC = Blood Cultures. History of immunocompromise, fever and/or clinical syndrome suggesting sepsis is a more important indicator to collect BC than whether the patient is febrile at the time of examination/collection.
Not Generally Indicated	2. Coags = Standard Coagulation Panel (includes INR/PT, APTT, fibrinogen).
Consider or Ask Supervisor	3. UEG = Urea, creatinine, electrolytes and glucose.
	4. hCG is usually required prior to drug treatment and radiological investigations in women of child bearing age
	5. There are very specific requirements relating to requests and specimen collection/labelling for transfusion. Please ensure requests and specimens fully comply with local requirements
	6. Blood gas: Venous blood gas is often acceptable. Arterial sample required for assessment of oxygen status.
	7. Snake bite: FBC + film, INR +aPTT, UEG, CK, consider fibrinogen + d-Dimer (false negatives occur with point of care devices), consider LDH

RCPA The Royal College of Pathologists of Australasia

From 'Guideline on Pathology Testing in the Emergency Department' developed by the Australasian College for Emergency Medicine (ACEM) and the Royal College of Pathologists of Australasia (RCPA) 2018

Please refer to full guideline document for further information

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY
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