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| EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | Professor Gordian Fulde  
SESLHD Clinical Stream Director – Emergency and Critical Care |
| AUTHOR | SESLHD ED Clinical Nurse Consultant, Clinical Nurse Educator Working Group |
| POSITION RESPONSIBLE FOR THE DOCUMENT | Andrewina Piazza-Davies, SESLHD Clinical Stream Nurse Manager – Emergency and Trauma Services  
Andrewina.Piazza-Davies@health.nsw.gov.au |
| 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. |
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 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 [http://www.ecinsw.com.au/CIN](http://www.ecinsw.com.au/CIN).

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.

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.

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.
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.

6.1 **Documentation of radiology request**

1. The order must be completed electronically in FirstNet utilising the 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 – PD2013.043 Medication Handling in NSW Public Health Facilities*, 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 Quality Use of Medicines Committee (DQUM). 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 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 - PD2013_043 Medication Handling in NSW Public Health Facilities.*

### 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.
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).
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 Nurse Protocols (ENP) 2014
- SESLHD Emergency Department Standing Orders
- Australian College of Emergency Medicine (ACEM) Guideline on Pathology Testing in the Emergency Department
- NSW Ministry of Health Policy - PD2013_043 Medication Handling in NSW Public Health Facilities

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
Emergency Clinical Stream CNC/NE Working Group Members

Ms Leanne Horvat  Clinical Stream Nurse Manager, Critical Care/Emergency  SESLHD
Ms Bernadine Romero  ED Clinical Nurse Consultant  St George Hospital
Ms Alana Clements  ED A/Clinical Nurse Consultant  St George Hospital
Ms Lauren Neuhaus  ED Nurse Educator  St George Hospital
Ms Kelly Wright  ED Clinical Nurse Consultant  Sutherland Hospital
Ms Samantha Connelly  ED A/Clinical Nurse Consultant  Sutherland Hospital
Mr Ray Hunt  ED Clinical Nurse Educator  Sutherland Hospital
Ms Kulvir Kaur  ED A/Clinical Nurse Educator  Sutherland Hospital
Mr Wayne Varndell  ED Clinical Nurse Consultant  Prince of Wales Hospital
Ms Kylie Howes  ED Nurse Educator  Prince of Wales Hospital
Ms Rhonda Wainwright  ED Clinical Nurse Consultant  Sydney Hospital

Consultation Members:
Ms Ann Brown  eMR Firstnet Manager  SESLHD / ISLHD
Ms Julie Thompson  Pharmacist - Drug & QUM Committee Coordinator & eMEDs  SESLHD

12. REVISION AND APPROVAL HISTORY

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<td>Leanne Horvat, Clinical Stream Nurse Manager Critical Care / Emergency &amp; Clinical Redesign. SESLHD Emergency Stream CNC/NE Working Group</td>
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<td>Approved by Drug and Quality Use of Medicines Committee</td>
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Appendix 1: SESLHD Adult Standing Order Analgesia Flowchart

Is the adult patient in pain from any cause? Assess and document pain score

Is the cause of the pain likely to cause injury or is life threatening if not treated urgently?
Immediately refer to ED Senior Medical Officer (SMO)

Has the patient had any pain relief prior to presenting to ED?
Check allergy status, contraindications and document medication history

How severe is the patient’s pain? Use verbal numerical rating scale and document

Mild pain (1-3/10)
If no paracetamol in the last four hours consider stat dose:
Paracetamol 1gram PO/PR
Or
Ponadione 1gram PO
And/Or
(16-65yrs) ibuprofen 400mg PO

Moderate pain (4-6/10)
If no paracetamol in the last four hours consider stat dose:
Paracetamol 1gram PO/PR
And
Oxycodone Hydrochloride PO
Adult (16-65yrs) 5-10mg
Elderly (>65yrs) 2.5-5mg
And/Or
(16-65yrs) ibuprofen 400mg PO

Severe pain (7/10)
Initiation of morphine sulphate or fentanyl ONLY if patient:
• GCS 15 and/or sedation ≤ 1
• HR >50 and <140/min
• SBP >100 and <200mmHg
• RR ≥ 10 and <30/min
• SpO2 >92%
Refer to ED SMO if outside these parameters

Adult (16-65yrs)
Oxycodone Hydrochloride: Maximum 10mg PO or
Morphine Sulfate: Maximum 10 mg IV or
Intranasal Fentanyl: Maximum 100 micrograms IN

Elderly (>65yrs)
Oxycodone Hydrochloride: Maximum 5mg PO or
Morphine Sulfate: Maximum 5mg IV or
Intranasal Fentanyl: Maximum 100 micrograms IN

Refer to each specific standing order for indications / contraindications & dosage

Check and document pain score within one hour

If further analgesia is required discuss with ED SMO

Treating ED MO to co-sign within four (4) hours

Record vital signs and pain score every 15mins for the first hour.

Is the cause of the pain likely to be life-threatening and unreolved with narcotics?
Immediately refer to ED SMO

NB: All 54 and 58 standing order medications must be administered in accordance with the SESLHD Emergency Department Standing Orders Procedure.

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Trim No. T14/38375
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Appendix 2: Emergency Nurse Approved Protocol (eMR Downtime Form)

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**EMERGENCY NURSE APPROVED PROTOCOL**

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**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) tool for arrhythmia
- Spirometry / Peak Flow
- Urinalysis:

**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%:

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

**Symptomatic Treatment:**
- Antimetic:
- Analgesia:
- IV Fluids Sodium Chloride 0.9%:
- Pain Assessment / Pain Score
- PV Chart
- RiCE / Splinting
- Stool Chart
- Trial of Fluids
- Wound Irrigation
- Wound Adhesive
- Plaster of Paris (POP)

**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

**Escalation & Referrals:**
- ASET Nurse
- Clinical Initiatives Nurse
- Clinical NUM / AHNM
- Drug & Alcohol CNC
- Infection Control CNC
- Team Consult / Review
- Mental Health CNC

**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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Appendix 3: Pathology Requesting for Adult Patients in the ED

**APPENDIX 2: MATRIX (SIDE A)**

### Pathology Requesting for Adult Patients in the Emergency Department - Suggested tests for common conditions

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<th>WBC</th>
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<th>Cr</th>
<th>Na</th>
<th>K</th>
<th>Ca</th>
<th>Urea</th>
<th>Cre</th>
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**Key**
- 考虑 (Consider or Ask Supervisor)
- 不适用于本病 (Not Currently Indicated)

This image is a guide for clinical staff when deciding pathology tests. Clinical judgment should be exercised. Some patients may not need any tests or have had those performed recently. If in doubt consult with senior ED doctor. Some tests may not be immediately available.

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