BENDIGO HEALTH
EMERGENCY DEPARTMENT

CLINICAL GUIDELINES FOR NURSING STAFF

BENDIGO HEALTH

Excellent Care. Every Person. Every Time.

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Documenting the
Primary and Secondary Survey

Primary Survey

A = AIRWAY (along with simultaneous cervical spine immobilization)
Patency, assesses vocalisation, stridor, assesses artificial airway position, airway security, cuff pressure/air leaks

B = BREATHING
Rate, rhythm, work of breathing, skin colour, breath sounds, chest wall movement, SpO2, O2 flow

C = CIRCULATION
Colour, warmth, cap refill, pulse rate and integrity, BP, cardiac rate & rhythm, haemorrhage control, IV access

D = DISABILITY (neurological status)
Neurological status- assesses conscious state with AVPU or Glasgow Coma Scale, assess pain level

E = EXPOSE / ENVIRONMENTAL CONTROL
Appropriate removal of patient clothing for assessment purposes, Initiation of temperature control strategies eg. patient gown, warmed blankets

NB: Consider MAC to escalate care of the deteriorating patient and initiate if patient breaching MAC criteria (see policy on PROMPT)

Secondary Survey

F = FULL SET OF VITAL SIGNS
RR, P, BP, SpO2, T°, Further interventions (eg. ECG, SpO2, IDC, naso-gastric tube, lab tests including BSL), Facilitate family presence

G = GIVE COMFORT MEASURES
Pain management, position, provide privacy, explain, reassure, communicate

H = HISTORY AND HEAD-TO-TOE
Obtain past and presenting history, include baseline/chronic health status, vaccination status, record patient weight and assess fluctuations, Precipitating events/factors leading to admission, Acute symptoms and onset of duration, Usual treatments/medications

Systems Assessment including neurological, cardiovascular, respiratory, gastrointestinal, renal/genitourinary, integumentary, musculoskeletal, metabolic and immunological systems and psychosocial assessment.

I = INSPECT POSTERIOR SURFACES
Obtain extra help for a log roll if required

ABDOMINAL PAIN

1. Change the patient into a hospital gown, ensure patient privacy.

2. Perform Primary Survey (ABCDE) and document.

3. Obtain ECG & **get it reviewed immediately** by senior doctor. Consider continuous cardiac monitoring if indicated/severe pain.

4. Undertake Vital Signs 1/24.

Consider MAC criteria and initiate if patient breaching.

(Report to ANUM/Duty Consultant if patient breaching MAC criteria).

5. For stable patients obtain blood sample via venepuncture. Send CRP, FBE, U&E, LFT & Lipase. Consider BSL.

NB: If patient has severe pain or otherwise clinically indicated– insert IVC (eg deranged vital signs). (If unsure, check with treating doctor)

(Collect X-match & Coagulation profile – Await treating doctor before sending).

6. Administer analgesia & anti-emetics.

   (Obtain written order from treating doctor).

7. Collect urine FWT & BHCG

   (for females of reproductive age).

8. Keep the patient NBM.

CHEST PAIN

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
4. Obtain ECG & **get it reviewed and signed off immediately** by Duty Consultant. Connect continuous cardiac monitoring.
5. Repeat ECG when pain free AND with new episodes of chest pain.
6. For stable patients, obtain blood sample via venepuncture. Send FBE, U&E, Troponin. Consider BSL
   If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC. (If unsure, check with treating doctor).

   (Collect X-match and coagulation profile as part of pathology screening- await treating doctor before sending).
7. Administer Aspirin 300mg – If not given pre-hospital.
8. Record pain score & give Anginine 300mcg S/L - if BP > 90 systolic. (Repeat this step every 5 minutes as required for pain management – maximum 3x doses (900 mcg total).
9. If pain persists, give incremental Morphine 2.5mg IV until pain free or to a maximum dose of 10mg. Obtain written order from treating doctor & ensure the pain score is documented and the patients - BP > 90 systolic prior to administration.

10. Administer anti-emetic if required.
    (Obtain written order from treating doctor).

URINARY SYMPTOMS

(UTI & PYELONEPHRITIS - ADULT)

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
4. **IF SIGNS OF SEPSIS ONLY** obtain blood sample via venepuncture. Send FBE, U&E and VBG. (NB: Not necessary if sepsis criteria not met).

   If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) – insert IVC. (If unsure, check with treating doctor)
5. Collect urine sample for urine dipstick & BHCG (for females of reproductive age). Consider urine MCS if fits Urine MCS Flowchart.
6. Give simple analgesia as indicated

NB: For stable patients, blood tests are not required

VOMITING/DIARRHOEA

(ADULT)

1. Commence infection control procedures.
   (Contact Precautions)
2. Change the patient into a hospital gown, ensure patient privacy.
3. Perform Primary Survey (ABCDE) and document.
4. Undertake Vital Signs 1/24.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
5. For stable patients, obtain blood sample via venepuncture. Send FBE, U&E. Consider BSL. If patient is in pain, add LFT's & lipase. **If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC.** (If unsure, check with treating doctor).
6. Administer anti-emetic.
   (Obtain written order from treating doctor).
7. Commence oral hydration & Consider IVT N/Saline order from treating doctor.
8. Collect urine sample for FWT & BHCG (for females of reproductive age).

PV BLEEDING

(IN EARLY PREGNANCY)

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
4. Assess amount & type of PV bleeding. **NB: Staff must have a chaperone for this.**
   (Colour, Clots, tissue, products of conception).
5. For stable patients, obtain blood sample via venepuncture. Send FBE, U&E, BSL, BHCG & Group & Hold. Consider BSL.
   If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC. (If unsure, check with treating doctor).
6. Consider IVT if hypovolemic.
   (Obtain written order from Duty Consultant).
7. Obtain pain score out of 10 & administer analgesia if required.
   (Obtain written order from treating doctor).
8. Prepare patient for PV exam.
9. Ensure the patient maintains a full bladder for possible U/S scan.
10. Collect mid-stream urine sample for FWT & BHCG **after bedside ultrasound is done** (check with senior doctor if ultrasound is required, bladder must be full for this procedure).

CELLULITIS

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24.

   (Report to ANUM/Duty Consultant if breaching MAC criteria).

4. For stable patients, obtain blood sample via venepuncture. **Blood only needs to be collected if signs of sepsis, diabetic patient or extensive cellulitis.** If indicated, send FBE and U&E. Consider BSL.

   If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC. (If unsure, check with treating doctor).

5. Consider patient for SSOU or HITH.

PAEDIATRIC PRESENTATIONS

(GENERAL ASSESSMENT)

A - Check patency

B - Rate/Effort/Use of accessory muscles

C - Skin pallor/temperature/central return

D - Assess conscious state & activity

E - Rash/haematomas/cuts/grazes

F - Record intake/output over past 48hrs

(Consider amount of vomiting & diarrhoea. If dehydrated, consider insertion of NGT and/or application of EMLA cream. If unsure, refer to treating doctor).

- Weigh ALL paediatric patients
  (<1year should have a bare weight)
- Obtain urine sample (clean catch) for FWT/MCS if signs of sepsis, fever, lower abdominal pain or dysuria
- Assess level of pain – record a pain score and give simple analgesia as indicated with patient/caretaker consent

See RCH Clinical Guidelines for Pain Assessment and Measurement Tools including FLACC and Wong-Baker

SHORTNESS OF BREATH

(ASTHMA & COPD - ADULT)

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24 including WOB.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
4. Auscultate chest – Assess air entry/wheezes/crepitations.
5. Apply oxygen as indicated and aim for SPO2>92%
   (Consider previous respiratory history when applying – SpO2 of 88-92% acceptable in patients with a history of COPD).
6. Administer Salbutamol 5mg & Ipatropium 500mcg via volumatic spacer if indicated – If unsure discuss with senior nursing staff
   (Obtain written order from treating doctor)
7. For stable patients, obtain blood sample via venepuncture. Send FBE and U&E. **If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC.** (If unsure, check with treating doctor).
8. Obtain ECG & **get it reviewed and signed off immediately** by Duty Consultant. Connect continuous cardiac monitoring if abnormal heart rate.
9. Re-assess respiratory status post Salbutamol and Ipatropium & repeat if necessary (burst therapy).
10. Consider High Flow Oxygen if required.

SPRAINS, STRAINS & SOFT TISSUE INJURIES

1. **Mechanism of injury** (How).
2. **Age of injury** (When).
3. **Neurovascular status of affected limb.**
   (Colour/warmth/movement/sensation/pulses)
4. **First aid** (RICE).
5. **Assess pain using pain scale.**
6. **Administer oral analgesia. Consider IV/IN for severe pain after discussion with a doctor** (Obtain written order from treating doctor)
7. **Nurse initiated Xray** (where appropriate)

TIA

(Resolved Neurological Symptoms)

1. Change the patient into a hospital gown, ensure patient privacy.
2. Perform Primary Survey (ABCDE) and document.
3. Undertake Vital Signs 1/24 **including GCS/Neurological obs**.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
4. Apply oxygen therapy only if SpO2 <92%.
5. For stable patients, obtain blood sample via venepuncture. Send FBE, U&E and BSL with glucometer.

   If patient is high risk, has severe pain or otherwise clinically indicated (eg deranged vital signs) insert IVC. (If unsure, check with treating doctor).
6. Obtain ECG & **get it reviewed and signed off immediately** by Duty Consultant. Connect continuous cardiac monitoring if abnormal heartrate/rhythm.
7. Obtain history of time of onset, duration & when symptoms resolved.

CVA/STROKE

1. Activate Stroke Call (Dial 2222 and report Stroke Call to Cubicle #)

*Please note: Prioritise getting these patients to CT ASAP

2. Change the patient into a hospital gown, ensure patient privacy.
3. Perform Primary Survey (ABCDE) and document.
4. Undertake Vital Signs 15/60 until stable including GCS/Neurological observations.
   (Report to ANUM/Duty Consultant if breaching MAC criteria).
5. Apply oxygen therapy if SpO2 <92%.
6. Obtain history of time of onset of symptoms or time last seen "well".
7. **Insert IVC 18G R) CF.** Send bloods for FBE, U&E and BSL using glucometer. (Collect group & hold and coag profile – discuss with treating doctor before sending).
8. Prepare for CTB (Urgent if symptoms < 9hrs).
9. Obtain ECG and continuous cardiac monitoring.
10. Prepare VST Cart for neurologist Consult.
11. Keep patient NBM – Until speech assessment (or perform dysphagia screening/assessment if competency completed).