



Emergency - Quality, Education and Safety Teleconference

E-QuEST

18th July 2018

Dr Nicholas Lelos | Advanced Trainee | Emergency Care Institute

Thanks for joining



House rules

Confidentiality

Respect

AGENDA

- Case reviews
- Underlying causes
- Clinical context
- NSW Health guidance

Participation encouraged throughout

(But please turn off camera & mute mic when not talking)

Case

- 70 yr old male, admitted for large pleural effusion
- Triage Obs: HR 83 BP 156/88 Sats 95% on RA, RR 24
- PMHx:
 - Mild COPD
 - HTN
 - Obese
- Medx: Seretide, atorvastatin, amlodipine

Case - continued

Smokes 20/day PY 55, no alcohol

Admission under respiratory physician – diagnostic and symptom relief
drainage of R pleural effusion

Team came, pigtail Seldinger chosen – wire and dilator used

20 mins after → patient agitation, restless

Obs: 98% with nasal prongs BP 160/89 RR 28

THOUGHTS ON THE CASE?

Confidentiality
Respect

Causes

→ ?Pain

→ ?Anxiety

→ ?Organ injury

→ ?Behavioural issues

→ ?Withdrawal

→ ?Tension pneumothorax

Case - continued

Senior doctor review

Plan:

iv ketamine 30 mg

→ Patient trashes around, disoriented and agitation increases

THOUGHTS?



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CLINICAL
INNOVATION

Case 1 - continued

90 kg man

2.5 + 2.5 +2.5 mg iv midazolam and 30 + 30 mg iv ketamine fast bolus

Result:

Large man at 45 degrees covered in drapes with chest drain and respiratory rate dropping to apnoea

Thoughts?

Ketamine administration speed

Symptom management



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Case 1 - continued

Patient laid flat – commenced bag ventilation

Proceeded to intubation

Given suxamethonium

Successful size 8 ETA uneventful

Obs sats 99% on air HR 80 BP 160/80

Ventilator set up

Case 1 - continued

Settings?

Tidal Volume 500 ml

10 minutes in – Blood pressure dropping: systolic of 120 → 110 → 90

25 mins – systolic 75; Sats 99% Heart rate 140

THOUGHTS?



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Case 1 - continued

TENSION TYPE PNEUMOTHORAX

Hypovolaemia

Cardiogenic

Meds – no propofol used

Case 1 - Review

Second senior review – inspected patient, penetrating chest wound found (previous drain insertion site!)

→ 12 gauge dwellcath in 4th intercostal space anterior axillary line placed
→ serosanguinous fluid drained

Haemodynamic stability returns post iv bolus

Formal drain → 2 L of fluid drained

Intensive Care admission

DISCUSS

- What went well?
- What could have been improved?
- How can this help local management?

Learning points - improvements

Preparation is key for any procedure – anticipation of issues facilitates dealing with them if they occur

Painful procedure even with analgesia – always choose agents and doses, be prepared to use them

Ketamine in awake patients – even small doses can have unexpected effects

→ Small amount of midazolam can help

→ Rapid bolus induces apnoea – can be bagged, not laryngospasm

CHEST DRAINS



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Different Techniques

Breathing – Needle Thoracostomy

Indications

Suspected pneumothorax with low saturations or hypotension (tension pneumothorax)

Contraindications

Pneumothorax excluded (sliding present on ultrasound)

No haemodynamic compromise (normal saturations and blood pressure)

Alternatives

Chest drain (trauma tube or pigtail catheter)

Thoracostomy

Informed consent

Emergency procedure (consent generally not required)

Potential complications

Failure to decompress (risk increased with shorter catheter)

Failure after decompression with recurrence of tension pneumothorax

Vascular, visceral and pulmonary parenchymal damage (risk increased with longer catheter)

Procedural hygiene

Micro Aseptic Non-Touch Technique

PPE – Non-sterile gloves, Surgical Mask, Eye protection, Gown

Procedure

Area

Resus bed if possible

Staff

Procedural clinician

Equipment

Long 14-16G Catheter (9 cm Dwellcath) or

Large bore IV cannula

5-10 ml Syringe (optional)

Positioning

Sitting up or Supine

Medication

Nil

Sequence

Palpate medial and lateral head of the clavicle and find the mid-point

Place 2 fingers below clavicle at mid-point (mid clavicular line)

The Space below second finger is the second intercostal space

Insert needle over the top of the third rib perpendicular to skin

Advance needle until air is aspirated into a syringe full of water, then remove syringe or

Advance needle without syringe until gush of air noted

Consider Longer needle (8cm) with failure to decompress or

Place needle in safe triangle in axilla

Post procedure care

Repeat procedure if haemodynamic compromise recurs

Follow immediately with chest drain

Documentation (later): Insertion site, attempts and any immediate complications

Tips

A normal 4.5 cm cannula does not reach pleural space anteriorly in 50% of trauma patients

Insert standard cannula at site of chest drain insertion to increase success

Cannulas often kink, and block and the procedure may need to be repeated



Different Techniques

Breathing – Thoracostomy Open

Indications

Failed needle decompression with suspected tension pneumothorax (low saturations or hypotension)
Traumatic cardiac arrest (Bilateral)

Contraindications

Pneumothorax excluded (sliding present on ultrasound)
No haemodynamic compromise (normal saturations and blood pressure)
Spontaneous ventilation

Alternatives

Needle Thoracostomy followed by formal Large Chest drain (32F)

Informed consent

Emergency procedure (consent generally not required)

Potential complications

Occlusion (requiring re-fingering)
Infection
Vascular, visceral and pulmonary parenchymal damage

Procedural hygiene

Macro Aseptic Non-Touch Technique
PPE – Sterile gloves and Gown, Surgical Mask, Eye protection

Procedure

Area

Resus bed

Staff

Scout nurse and Procedural clinician

Equipment

Scalpel
Haemostat or Forceps

Positioning

Supine or semi-erect with head of bed elevated to 45 degrees
The ipsilateral arm is abducted and externally rotated as much as possible
Safe triangle: lateral to pec major, Medial to lat dorsi, Axilla, 5th ICS, anterior to mid-axillary line (LT nerve)

Locate triangle of safety, anterior to mid-axillary line at fourth to fifth intercostal space
Palpate and mark site

Medication

10 ml Lignocaine 1% with Adrenaline
IV Morphine 5-10 mg (Adjusted to co-morbid status)
IV midazolam 1-2 mg (Adjusted to co-morbid status, consider procedural sedation)

Sequence

Aim for 4th ICS just below armpit hair
Make a confident 4 cm incision into subcutaneous tissue/muscle
Advance closed Haemostat into pleura (with 4 cm exposed from fingers to reduce chance of lung injury)
Push through muscle and open slightly (possible hiss or gush of blood)
Rub haemostat side to side on superior margin of rib below to bluntly dissect a hold large enough for a chest drain
Palpate for lung through incision (unless sharps risk from possible rib fractures)

Post procedure care

Follow immediately with formal chest drain (unless intubated, ventilated and heading immediately to theatre)
Analgesia
Antibiotics (1g Cefazolin)
Document attempt and any immediate complications

Tips

It is common to incisions to be too low in the chest.
A thoracostomy incision should be at a level superior to the nipple line, in the axilla.
A good guide is one fingers breadth below inferior margin of the axillary hairline
Place 1-2 intercostal spaces higher in pregnant patients due to elevated diaphragm.

Breathing – Thoracostomy Formal (Size 24-32 Fr)

Indications

Pneumothorax (Traumatic)
Traumatic Haemothorax (Visible on CXR)
Empyema

Contraindications

Coagulopathy/Thrombocytopenia
Loculated effusion/pleural adhesions
Bullous disease
Overlying skin infection

Alternatives

Open thoracostomy
Smaller intercostal catheter inserted with Seldinger technique

Informed consent

Emergency procedure (consent generally not required)

Potential complications

Pain
Failure
Bleeding
Re-expansion pulmonary oedema
Infection
Neurovascular, visceral, and pulmonary parenchymal damage
Tension pneumothorax

Procedural hygiene

Macro Aseptic Non-Touch Technique
PPE – Sterile gloves and Gown, Surgical Mask, Eye protection

Procedure

Area
Resus bed

Staff
Scout nurse and Procedural clinician

Equipment
Chest drain kit
Suture and suture kit

Different Techniques

Dressing
Underwater sealed drain

Positioning

Patient semi-erect with head of bed elevated to 45 degrees
The ipsilateral arm is abducted and externally rotated as much as possible placed behind their head and restrained
Safe triangle: lateral to pec major, Medial to lat dorsi, Axilla, 5th ICS, anterior to mid-axillary line (LT nerve)
Palpate and mark site

It is common to incisions to be too low in the chest.
A thoracostomy incision should be at a level superior to the nipple line, in the axilla.
A good guide is one fingers breath below inferior margin of the axillary hairline
Place 1-2 intercostal spaces higher in pregnant patients due to elevated diaphragm.

Medication

10 ml Lignocaine 1% with Adrenaline
IV Morphine 5-10 mg (Adjusted to co-morbid status)
IV midazolam 1-2 mg (Adjusted to co-morbid status, consider procedural sedation)

Sequence formal

Anesthetise skin, soft tissue, muscle, periosteum, and pleural space with lignocaine
Discard Trocar and insert curved forceps through distal side hole of chest tube
Incise 2.5 cm parallel along upper border of lower rib at insertion site
Blunt dissection through muscle with curved clamp to rib
Angle over the rib and push until enter the pleural space with 'give' or 'gush' of air or blood
Open the clamp and pull it out with the clamp still open to create a larger tract
Inserts finger into pleural cavity and performs finger sweep (unless rib fracture suspected)
Inserts 28-32F ICC loaded on needle holders above rib to avoid neurovascular bundle
Once inserted rotate through 360 degrees and directs tip superiorly and posteriorly
Inserts until all eyelets within pleural cavity (approx. 6cm + subcutaneous tissue depth)
Clamp tube prior to underwater seal drain attachment if large volume blood
Attach to underwater sealed drain without suction (with air vent open)
Identify fogging of chest tube and swinging of underwater sealed drain
Suture with 2-0 non-absorbable interrupted sutures, tying tube with a few loops near skin with last suture
Apply Mesenteric dressing to keep clean and sealed
Secure drain to chest tube using Elastoplast strips allowing visualisation of attachment.
Pad tube and secure with Elastoplast mesentery

Different Techniques

Breathing – Thoracostomy Seldinger (Size 8-14 Fr)

Indications

Pneumothorax 8-14 Fr (Secondary spontaneous and Iatrogenic)
Pleural effusion

Contraindications

Coagulopathy/Thrombocytopenia
Loculated effusion/pleural adhesions
Bullous disease
Overlying skin infection

Alternatives

Open thoracostomy
Larger formal chest [drain](#)

Informed consent

Level 2 – written or verbal consent

Potential complications

Pain
Failure
Bleeding
Re-expansion pulmonary oedema
Infection
Neurovascular, visceral, and pulmonary parenchymal damage
Tension pneumothorax

Procedural hygiene

Macro Aseptic Non-Touch Technique
PPE – Sterile gloves and Gown, Surgical Mask, Eye protection

Procedure

Area

Resus bed

Staff

Scout nurse and Procedural clinician

Equipment

Intercostal Catheter kit
Suture and suture kit
Dressing

Underwater sealed drain

Positioning

Patient semi-erect with head of bed elevated to 45 degrees
The ipsilateral arm is abducted and externally rotated as much as possible placed behind their head and restrained
Safe triangle: lateral to pec major, Medial to lat dorsi, Axilla, 5th ICS, anterior to mid-axillary line (LT nerve)
Locate triangle of safety, anterior to mid-axillary line at fourth to fifth intercostal space
Palpate and mark site

It is common to incisions to be too low in the chest.

Intercostal catheter insertion should be at a level superior to the nipple line, in the axilla.
A good guide is one fingers breath below inferior margin of the axillary hairline
Place 1-2 intercostal spaces higher in pregnant patients due to elevated diaphragm.

Medication

10 ml Lignocaine 1% with Adrenaline
IV Morphine 5-10 mg (Adjusted to co-morbid status)
IV midazolam 1-2 mg (Adjusted to co-morbid status, consider procedural sedation)

Sequence seldinger

Anesthetise skin, soft tissue, muscle, periosteum, and pleural space with lignocaine
Place larger needle for guidewire along the same tract, aspirating until you withdraw pleural fluid
Remove syringe and thread guidewire through needle, removing needle after wire placement
Use scalpel to lance a tract next to the guidewire
Thread dilator over wire into the pleural space
Thread the catheter over the wire, making sure you can always see and hold the guidewire
Place catheter at 10cm + soft tissue depth
Take samples if required
Attach to underwater sealed drain without suction (with air vent open)
Identify swinging of underwater sealed drain
Suture with 2-0 non-absorbable interrupted sutures, tying tube with a few loops near skin
Apply Mesenteric dressing to keep clean and sealed
Secure drain to chest tube using Elastoplast strips allowing visualisation of attachment.
Pad tube and secure with Elastoplast mesentery

Post procedure care

Analgesia (oral, or IV considering PCA)
Confirm position with CXR
Documentation insertion with depth, function of underwater sealed drain and ongoing management

Tips

There is no evidence to recommend suction on initial placement of a chest drain in the ED.
Antibiotics reduce the incidence of pneumonia and empyema after trauma requiring chest drain
ICC's should generally not be clamped due to the risk of air leak causing tension pneumothorax.
ICC clamping for 30 mins after drainage of 1 litre chronic air/fluid may reduce re-expansion pulmonary oedema
ICC's should not be clamped in massive haemothorax, tamponade is not possible.

CLINICAL TOOLS → PROCEDURES

https://www.aci.health.nsw.gov.au/networks/eci



Emergency Care Instl | ACEM - Member Hor | Clinical Information A | NSW eHealth NSW Confer



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Upcoming Events

September 2017						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
27	28	29	30	31	1	2

What's New

ECI Events

Videos and presentations are now available from the 2017 [Research Symposium, Nursing Leadership Forum](#) and the first [ED Leadership Forum](#) on 9 June

Clinical tools

Latest evidence based

[CLICK HERE »](#)

Transcutaneous Pacing

Transcutaneous pacing in the ED



Chest Drains, Catheters and Urgent Decompression

We look at various ways to drain and access the chest cavity.



Lumbar Puncture



OneDrive-2018-07-....z... ^



Chest drain EQU...do... ^



E-QuEST June 18.pptx ^



2018.06.30_capitat....doc ^

Show all



Chest Drains, Catheters and Urgent Decompression

[Home](#) > [Courses](#) > [ECI](#) > [Procedures](#) > [Chest Drain](#)

 [Browser Advice](#)

Urgent Chest Decompression

 [Chest decompression movie \(6 minutes\)](#)

 [Step by Step Guide](#)

Seldinger Chest Drain

You might know this as the pigtail chest drain, which ever brand you have the principles of insertion are the same.

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(No announcements have been)

 [Seldinger Chest Drain from the ACI \(6 minutes\)](#)

 [Step by Step Guide](#)

Formal Chest Drain

We are trending away from using very large chest drains and should aim for the smallest size to get the job done. Larger drains have more complications.

Formal chest drains are used in trauma and draining purulent effusions.

 [Short Chest Drain Movie \(60 seconds\)](#)

Just a quick aide memoire, watch the full video as well.

 [Formal Chest Drain long movie](#)

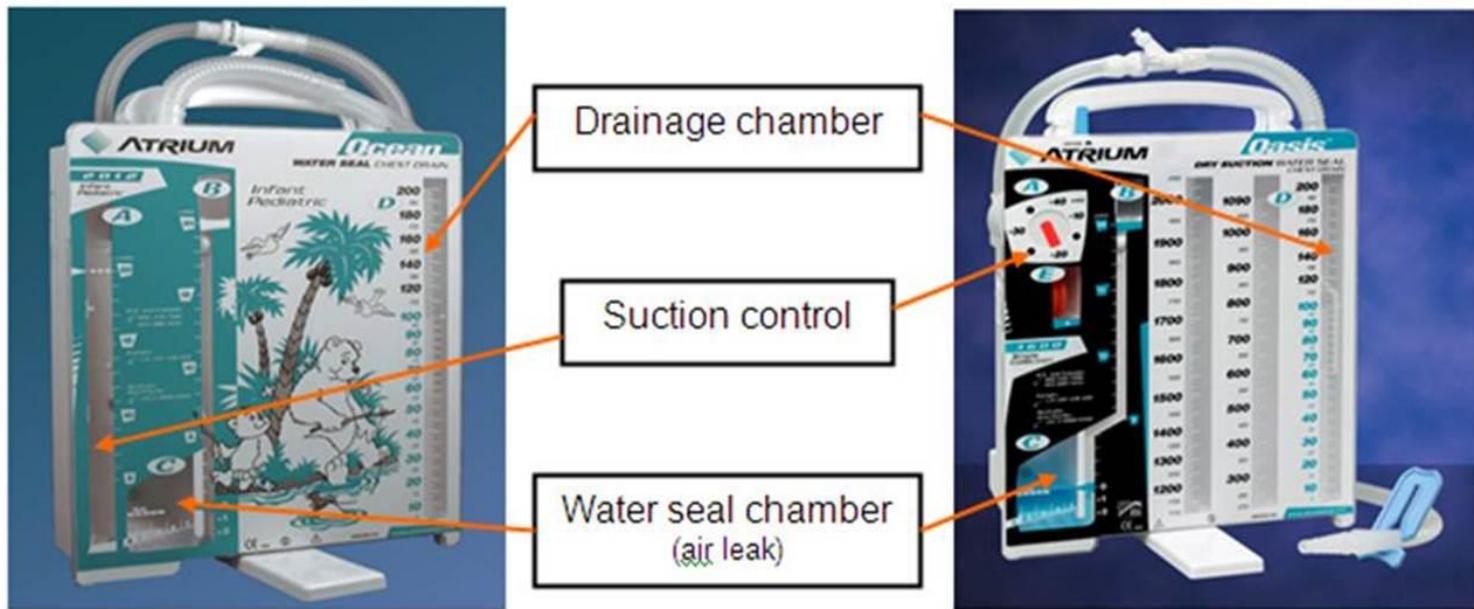
 [Step by Step Guide](#)

Quiz and certificate

 [Chest Decompression and Drainage Quiz](#)

Chest Drain systems

Chest drain system



Common Oversights

When leaving the ICC in → still connected to a Under Water Seal Drain (UWSD) that the airvent cap is left on .

The airvent cap on the UWSD circuit (has blue cap) must be removed (OFF) if the drain is not to be on low wall suction as can cause tension tension tension if left on

Fixing of dressing around chest drain if sutures are not stable – can fall off if heavy items (i.e. forceps to clamp) are still hanging off the tube.

EVIDENCE-BASED TIPS

There is no evidence to recommend suction on initial placement of a chest drain in the ED.

Antibiotics reduce the incidence of pneumonia and empyema after trauma requiring chest drain

Chest tubes > 32Fr demonstrate diminished benefit with increased discomfort

Trocars are associated with organ injury and should not be used

Purse string suture leaves worse scars than simple interrupted sutures

ICC's should generally not be clamped due to the risk of air leak causing tension pneumothorax.

ICC clamping for 30 mins after drainage of 1 litre pneumothorax may reduce re-expansion pulmonary oedema

ICC's should not be clamped in massive haemothorax, tamponade is not possible



DEMONSTRATION



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Online ECI Resources

Moodle procedures <https://aci.moodlesite.pukunui.net/course/index.php?categoryid=22>

The chest drain page is here <https://aci.moodlesite.pukunui.net/course/view.php?id=87>

ECI UPDATES ON PROCEDURES: IMPROVING EFFICIENCY/ OUTCOMES

- Procedural hygiene
- Consent
- New resources and links

Procedural Hygiene

Infection Prevention During Procedures

Standard Precautions

Universal measures to prevent infection to the patient and proceduralist → “Standard Precautions”; otherwise, providing sub-standard infection

Following components of standard precautions are fixed for all procedures:

Routine environmental cleaning

Hand hygiene

Respiratory hygiene and cough etiquette

Safe handling and disposal of sharps

Reprocessing of reusable medical equipment and instruments

Waste management & appropriate handling of linen

clean area

exposed surface of hands and wrists should be cleaned/ washed

The proceduralist is responsible for the safe use and disposal of all sharps.



From Imaging Pathways Health – WA available at

<http://www.imagingpathways.health.wa.gov.au/index.php/imaging-pathways/neurological?id=64#teaching-points>

Two components of standard precautions are
variable between procedures:

Aseptic Non-Touch Technique (ANT technique)
Personal Protective Equipment (PPE)

Aseptic Non-Touch Technique (ANT Technique)

Asepsis means ‘freedom from infectious material’.

→ Aseptic technique aims to prevent pathogenic organisms, in sufficient quantity to cause infection,

Sterile conditions, meaning ‘free from microorganisms’, are not possible to achieve typical hosp: ‘sterile technique’ → inaccurate

Our aim → aseptic technique, preventing contamination of susceptible open or broken wounds, surgical or intravenous access sites (“Key Sites”) and parts of the procedure equipment or solutions that must remain aseptic throughout clinical procedures (“Key Parts”). Key parts and sites should only come into contact with each other during the procedure (“Non-Touch”).

Intact patient skin should be prepared with 60%-80% ethanol (or locally recommended antimicrobial) and all wounds should be irrigated with running tap water (aseptic but not sterile) or sterile saline.

2 Aspects; Micro and Macro

Micro ANT Technique

For many procedures no key parts or only small (“micro”) key parts which are protected by sterile syringe caps, sheathed needles, covers or packaging.

A clean area and non-sterile gloves are sufficient for these procedures. Sterile micro key parts form micro aseptic fields and if non-touch technique of key parts is applied aseptic technique is simplified. (e.g. Back slab application, Cannula insertion).

Macro ANT Technique

Procedures that are technically complex may include large open key sites or numerous key parts which must be touched by hand.

To counter these risks, the working field must be managed as a key part and a formal aseptic field (sterile drape) and sterile gloves are required.

Hand hygiene is also increased to surgical scrub with running water (mechanical and antimicrobial cleaning). Micro aseptic fields and non-touch technique should still be utilised where practical to do so. (e.g. Central venous access).

Aseptic fields provide working space ensuring the integrity of asepsis during procedures. Aseptic fields large enough to come contact the proceduralists body require a sterile gown. Aseptic fields increase in size; complexity of the procedure and the proficiency of the provider performing the procedure.

Personal Protective Equipment

Personal Protective Equipment (PPE) refers to barriers used to protect mucous membranes, airways, skin and clothing from contact with infectious agents. PPE provides protection for the proceduralist and patient.

Protecting yourself (Proceduralist)

Non-sterile gloves: all procedures due to risk of exposure to blood, body substances, secretions and excretions

Aprons: if increased risk of contamination of clothing with blood, body substances, and infectious material

Surgical mask: procedures that generate splashes or sprays of blood, body substances, secretions or excretions

Protective eyewear/shield: procedures that generate splashes or sprays

P2 respirator mask: procedures that may aerosolise particles when the patient's infectious status is unknown

Protecting the patient

Sterile gloves: In Macro ANT Technique (hand contact with sterile parts or sites is possible during asepsis)

Sterile surgical gown: In Macro ANT Technique (body contact with sterile parts or sites is possible during asepsis)

Surgical mask: In Macro ANT Technique (Prevent proceduralist respiratory droplets in aseptic field)

Sterile US cover and gel: If probe contact with sterile parts or sites is possible during asepsis)

Emergency procedures

For time critical emergency procedures, the increased risk to the patient from infection using non-aseptic technique may be small compared to the risk of delaying the procedure for even a few seconds (e.g. Surgical cricothyroidotomy, Thoracotomy in cardiac arrest from penetrating chest trauma).

However, the risks of sharps injuries and exposure to body fluids to the proceduralist increases in high pressure situations.

In these situations, cleaning and the preparation of sterile fields should be avoided but the important of PPE and Safe handling, disposal and communication of sharps increases in importance.

CONSENT

Procedural Consent

Emergency Consent

Level of procedures

Advance Care directives

Inability to obtain consent

Minors



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CONSENT: GENERICS

Obtaining consent for procedures is a specific legal requirement and an accepted part of good medical practice. A competent patient is entitled to refuse a medical procedure. Treating a competent patient who has validly refused treatment could constitute assault or battery.

Excluding medical emergencies, patients must be provided with adequate information about a procedure to enable them to make informed decisions. This includes the benefits, possible adverse effects or complications, alternatives, and the likely result if the procedure is not performed.

For a patient's consent to be valid the following criteria must be met:

The person must have the capacity to give consent

Consent must be freely given

Consent must be specific to the procedure

The patient must be informed in a way the patient can understand

In an emergency, where the patient is unable to give consent a procedure may be carried out immediately to save the person's life, to prevent serious injury, or to prevent the patient from suffering significant pain and distress.

LEGAL ASPECTS

The law does not require consent in writing. Consent is a process (not a signature) which may be provided orally or implied by body language, however, consent obtained in writing will assist practitioners in any subsequent legal proceedings as it will support the view that treatment had been discussed with the patient and that consent has been obtained. NSW Health's policy mandates written consent using a prescribed consent form for major procedures including intravenous sedation and procedures with significant risks.

FACILITATION

Pre-prepared material (translated where relevant) about a procedure or treatment may be useful if given to the patient as a means of stimulating discussion and for guiding the medical practitioner when informing the patient. Interpreters should be used for any non-English speaking patients.

LEVEL OF PROCEDURES (NSW HEALTH POLICY)

Level 1 procedure

Usually requires a single proceduralist

Does not require written consent

Does not involve procedural sedation or general / regional anaesthesia.

Level 2 procedure

Requires a proceduralist, often supported by an assisting proceduralist/s

Written or verbal consent

Does not involve procedural sedation or general / regional anaesthesia

Level 3 procedure

Requires at least one proceduralist for sedation and a separate procedural team

Always requires written consent

Involves procedural sedation or general / regional anaesthesia



Advance Care Directives

A medical practitioner should not provide treatment or perform a procedure where there is a valid direction by the patient that such treatment is not to be provided in any circumstances.

Should a patient provide such a written direction, a medical practitioner can assume a signed Advance Care Directive will have been made by a competent patient to be used when they are not competent.

We should comply with an Advanced Care Directive provided it applies to the current situation.

Patient incapable of providing consent

A person is incapable of giving consent if they are not “competent”, meaning they are unable to comprehend and consider the information in order to reach a decision. It is possible that a patient could be competent to make some, but not all decisions concerning their treatment.

Common reasons a patient may lack competency include:

Temporary factors such as the patient’s medical condition (e.g. intoxicated, unconscious)

Intellectual impairment, dementia, or brain damage

Mental illness currently impairing decision making

Children (Generally aged 14 or less)

In an emergency, where the patient is unable to give consent a procedure may be carried out immediately to save the person’s life, to prevent serious injury, or to prevent the patient from suffering significant pain and distress.

If a person is 16 years of age or over and incapable of giving consent for a non-emergency procedure, the consent of the patient’s “person responsible” will be required. The person responsible for a patient will often be the patient’s spouse or de facto. It may also be a parent, guardian, guardianship board or local authority.



Special situation: Minors

Emergency medical treatment to save a life or to prevent serious damage to health (including any procedure, operation or examination) may be provided without the consent of the minor (under 18) or a parent or guardian.

Children are given autonomy based on their level of maturity. A competent child aged 14 and above may consent to their own treatment. However, where the child is 14 or 15 years of age, it is prudent for practitioners or hospitals to also obtain the consent of the parent or guardian, unless the patient objects. For non-emergency treatment under the age of 14 years, the consent of the parent or guardian is necessary.

Children cannot refuse life-saving or health saving treatment until they are 18 years or older. The protective powers of the state override a minor's refusal of life saving treatment. This is in contrasts to adults (18 years and over) who can refuse life-saving treatment even if that refusal results in their death.

SUMMARY

- Chest drains common procedures, several aspects to look out for
- Various techniques; simplified step-by-step instructions available
- Video format currently available too
- ECI is providing this for all procedures common in Eds – watch this space!
- Shift towards a more rationalised approach to consent and hygiene as per NSW Health policy

E-QuESTs so far

- Atypical Chest Pain - ACS
- Sepsis in the elderly
- Abdominal pain in the elderly - AAA & Ischaemic gut
- Scrotal emergencies
- Headaches Part I: Deadly headaches
- Paediatric deterioration
- Head injuries
- Ophthalmological emergencies
- Pediatric emergencies and bronchiolitis
- Headaches Part II: undifferentiated headaches
- Chest Drains – procedural insights



Looking to next month, please...

- Share your cases
- Share your patient safety actions
- Spread the word with your colleagues

(or send me their email: Nicholas.lelos@health.nsw.gov.au)

What would you like to see / hear about?



Level 4, 67 Albert Avenue
Chatswood NSW 2067

PO Box 699
Chatswood NSW 2057

T + 61 2 9464 4666
F + 61 2 9464 4728

aci-info@health.nsw.gov.au
www.aci.health.nsw.gov.au

Many thanks!

Next E-QuEST

Wednesday 15th August 08:00

Look out for our email survey
We need your responses to guide future
work

