Contents

Acknowledgements .................................................. iv
Program Overview .................................................. 1
  Program Outcomes ................................................ 1
  Facilitators Guide to the Educational Program .......... 3
  Program Evaluation ................................................ 5
Section 1
  1.1 Introduction to the Clinical Initiatives Nurse Role .......... 7
  1.2 CIN Communication and the Waiting Room .......... 9
  1.3 Management of the Waiting Room ..................... 11
  1.4 Pain and Overview of CIN Pharmacology .............. 15
  1.5 Musculoskeletal Assessment of Limbs and Principles of Radiological Examination .......... 22
  1.6 Wound Care ................................................ 26
Section 2
  Care of Special Population in the Waiting Room
  2.1 Care of the Patient with a Mental Health Presentation ........ 27
  2.2 Care of the Trauma Patient .......................... 32
  2.3 Care of the Patient with a Possible Sepsis Presentation ........ 39
  2.4 Care of the Patient with a Drug and Alcohol Related Presentation ...... 43
  2.5 Care of the Paediatric Patient ....................... 46
  2.6 Care of the Geriatric Patient .......................... 48
  2.7 Care of the The Pregnant Patient ...................... 51
Section 3
  3.1 CIN Documentation ........................................... 53

Appendices
  Appendix 1: Respiratory Assessment .................... 55
  Appendix 2: Abdominal Assessment ...................... 57
Assessment Documents
  Assessment Document 1:
    Exam Questions – multiple choice/short answer .......... 59
    Exam Answers – multiple choice/short answer .......... 63
  Assessment Document 2:
    Sample Questions – for application of commonly used Standing Orders for CINs – Adults & Paediatrics .......... 67
    Answers – for application of commonly used Standing Orders for CINs – Adults & Paediatrics .......... 71
  Assessment Document 3:
    Sample Competency for Mastery of Nurse Initiated Standing Orders .......... 74
  Assessment Document 4:
    Competency Assessment – Upper Limb .............. 76
  Assessment Document 5:
    Competency Assessment – Lower Limb .............. 81
  Assessment Document 6:
    Competency Assessment – Respiratory .............. 86
  Assessment Document 7:
    Competency Assessment – Abdominal .............. 88
Introduction

The Clinical Initiatives Nurse (CIN) Education Program

The CIN Role builds on knowledge and experience gained as the registered nurse progresses on their specialty career path and becomes proficient working in all areas of the Emergency Department (ED). However, there are several unique aspects to this role, in that it requires the nurse to holistically manage the waiting room which includes re-assessment, care initiation and provision of symptom management for undifferentiated patients. Hence, while the registered nurse in the CIN role may have well developed communication, assessment and care initiation skills, the CIN role will demand further expansion of these skills to meet the needs of the waiting room environment. This education program aims to provide the core knowledge base and skill set to prepare the RN to work confidently in this role.

The aims of the CIN role are to facilitate the following in the waiting room:
1. Patient Safety – through clinical re-assessment
2. Communication
3. Care Initiation – with an emphasis on pain management and diagnostics.

Thus the education program includes the following:
1. Communication in the waiting room and waiting room management
2. Pain assessment and management, limb assessment and radiological considerations, wound care and
3. The care of ‘special populations’ in the waiting room. This latter section alerts the CIN to the patient population that have been identified as most vulnerable for deterioration.

The abdominal and respiratory assessment sections have been included, as it has been recognised that these skills, which are specifically required, have historically not been well developed in contemporary emergency nurses. Developing competency with these skills is vital in the CIN role to enable the nurse to be confident in escalating care when required, commencing the right diagnostic tests and deciding if the patient remains clinically safe in the waiting room.
Acknowledgements

The CIN Education Program has been developed to align with the redesign of the CIN role in 2010. NSW Health would like to thank the following members of the CIN Education Working Party, who have been integral to the development and review of this document.

Editorial Team

Leanne Horvat  CNC SESLHN
Margaret Murphy  CNC WSLHN
Lea Kirkwood  Project Officer, Health Services
Performance Improvement Branch (HSPIB) NSW Health

CIN Education Working Party Members

Nerida Bell  ED CNC SYDLHN
Karen Braid  ED CNC NBMLHN
Andrew Burke  MH ED CNC SLHN
Alister Hodge  ED CNC SESLHN
Leanne Horvat  ED CNC SESLHN
Lea Kirkwood  Project Officer HSPIB
Matthew Lutze  ED NP SYD LHN
Jenny Major  ED NE SCLHN
Margaret Murphy  ED CNC WSLHN
Sharene Pascoe  ED CNC NLHN
Carlie Tighe  ED CNC SYDLHN
Tiana Trappel  ED CNE WLHN
Martin Ward  ED CNC NSLHN
Diana Williamson  ED CNC HNELHN
Ron Wilson  ED CNC SWSLHN
Nichole Woodward  ED CNC CCLHN

Other Acknowledgements

Diversity Health, Prince of Wales Hospital: SESLHN – In their Shoes
Centre for Training and Development SSWAHS – Limb Assessment DVD
Patient Carer Experience Team NSW Health HSPIB – CIN DVD

Vivienne Barratt  CNC NBMLHN
Kelly Dee  ED CNE NSLHN
Chris Henderson  ED CNE SWSLHN
Amanda Hooton  ED CNE SWSLHN
Joanne Reilly  MH ED SCLHN
Anne Starr  CNE NBMLHN
Program Overview

Program Outcomes

The CIN education program aims to enable the CIN to work confidently in the role. At the completion of this program the nurse will be able to:

- Discuss the role fundamentals and priorities
- Demonstrate a working knowledge of the communication needs of patients in the waiting room
- Demonstrate management of the waiting room
- Communicate effectively with the ED team to escalate care needs as required
- Undertake a pain assessment and develop a plan to manage the patient’s pain
- Demonstrate competency in limb assessment and decision to x-ray
- Demonstrate a wound assessment and develop a plan of care for initial wound management
- Demonstrate competency in abdominal and respiratory assessment
- Re-assess the patient with a Mental Health presentation in the waiting room and work collaboratively to meet their care needs
- Recognise the vulnerable populations in the waiting room and identify the specific care needs/risk profile for the following patient groups:
  - The Minor Trauma Patient
  - The Patient with Sepsis
  - The Patient with Drug and Alcohol Issues
  - The Paediatric Patient
  - The Elderly Patient
  - The Patient with Pregnancy Related Presentations.
- Document the CIN assessment, care plan and interventions in line with local documentation requirements.

Who is the Facilitator and what does that mean?

The facilitator may be a Clinical Nurse Educator, Nurse Educator, Clinical Nurse Consultant or at times the Nurse Manager, Clinical Nurse Specialist or a Nurse Practitioner. The term facilitator is used throughout to reduce repetition. The CIN participant must be clear about who is responsible in partnering with them to complete the program. This must be agreed at the local level.

What is in this Manual?

This manual is for the CIN program facilitator, it provides the following:

- The statement of purpose for each module
- The learning activities which are in the Participant Manual
- A guide to answers of the questions in the Participant Manual and suggested discussion points
- A guide to using the electronic media
- A guide to using the PowerPoint presentations
- A copy of the assessment documents.
What is not included in this Manual?

This program provides the core education that is required for the Emergency Nurse to be able to fulfil the CIN role. In many incidences there may be some additional local educational and/or assessment requirements, particularly where local guidelines are in place for Nurse Initiated X-ray, Nurse Initiated Analgesia and other medications under Standing Orders, and for skill sets that extend beyond the core role requirements. This is unavoidable, as policy dictates that standing orders are required to be signed off by ED Directors at the local facility level.

The CIN program does not address specific clinical pathways or CIN protocols; however the generic knowledge in this educational program will underpin developed CIN protocols and clinical pathways.

Course Pre-requisites

The CIN role description states that the CIN will be a ‘Registered Nurse with appropriate emergency nursing experience across a broad range of ED roles’. At a minimum it is expected that the CIN will have completed a Transition to Emergency Nursing Course (or equivalent), and fulfilled local requirements to confidently work in areas such as Acute, Resuscitation, Sub-acute, Paediatrics, +/- Fast Track & +/- Triage. Prior completion of the following is an expectation:

- Transition to Practice, Emergency Nursing (or similar)
- DETECT
- Paediatric Clinical Practice Guidelines E-Learning (in Paed or mixed EDs)
- +/- FLECC (Rural Nurses)
- Competence in intravenous cannulation and venipuncture.

Working knowledge of or access to, the following resources will aid completion of this course:

- Emergency Triage Education Kit 2007
- Mental Health for Emergency Departments 2009
- Maternity Emergency Guidelines for Registered Nurses 2007

CIN Accreditation Requirements

The requirements to successfully complete the CIN education program are:

1) Reading of the CIN Resource Manual and completion of the learning activities
2) Attendance and participation at the CIN face to face training sessions
3) Achievement of the required pass mark for the written exam on pain assessment and pathophysiology
4) Achievement of Competency in Musculoskeletal Assessment, Upper and Lower Limb
5) Achievement of Competency in Abdominal assessment and Respiratory assessment
6) Successful demonstration of waiting room communication and management, assessed during a preceptored day
7) Achievement of competency in wound assessment and initial management.

The assessment criterion is included at the end of each subject chapter in the Participant’s and Facilitators Manual.

1. All assessments are to be performed by a Clinical Nurse Educator or a nominated, accredited workplace assessor
2. Each assessment document requires the assessor to record and sign the mastery sheet in the Participant Manual, as well as record the assessment result electronically
3. To achieve accreditation the participant must achieve mastery in all elements and performance criteria.
Ongoing CIN accreditation is best maintained through currency of practice; therefore sites could request demonstration of this by the CIN. This may include documentation in a skills log, a structured reflective diary, peer review or may be directed at local site level.

**Recognition of Prior Learning (RPL)**

RPL will be accepted where the ED nurse has previously completed CIN (or other relevant) training and demonstrates working knowledge and competence in the required criteria. This will be organised locally with the Program Facilitator. In some cases modules that have not previously been included in CIN education will need to be completed to enable the CIN to work effectively in the ‘redesigned’ role.

Completion of the state wide CIN education program will be recognised if the CIN moves to a different ED within NSW Health, on presentation of evidence. There may be several modules which are not applicable to certain CIN roles (eg Care of the Geriatric patient in a Paediatric ED); this will be decided at the local level. Thus, if the CIN transfers to a new facility, they may be required to complete modules that were previously not required, to meet the needs of the role at the new facility.

The Participant Manual is provided for CIN participants to record notes and show evidence of completion of learning activities, as well as recording competencies. As such the manual provides evidence for Continuing Professional Development.

**Facilitators Guide to the Educational Program**

In a minority of EDs there are modules in the CIN education program which are not applicable (eg Care of the Geriatric patient in Paediatric ED). However, in the majority of EDs all modules will be useful. Prior to the commencement of the program facilitators and CIN participants should meet to agree on the following:

- the identified learning needs of the CIN
- the outcome of RPL applications
- the modules that need to be completed and
- the timeframe for completion of the modules.

The Resource Manual, PowerPoint presentations, learning activities and assessment requirements have been provided to promote a multimodal approach to the CIN education program. The program includes the following:

- Reading the Resource Manual, viewing the Limb Assessment DVD and completing the learning activities which will provide a basis of knowledge for the CIN
- Completion of group learning activities and demonstration/practice of skills in a face to face, interactive learning environment.
- Mentoring into the role in structured preceptored days with the course facilitator (including assessment of waiting room management and communication).

The program has been structured to enable the face to face learning component to be flexible. It may be delivered to groups at organised ‘study days’, or in small groups sessions at regular intervals at local sites (eg 1 - 2hr every week/fortnight for several weeks/fortnights), or use a mix of both approaches.
The written resource manual

Each module in the Resource Manual contains the following:

- Learning Objectives and Outcomes
- Core Knowledge Content
- Learning Activities.

It is expected that the CIN participant will work through the CIN Resource Manual, completing the learning activities and recording evidence of this in the CIN Participant Manual. However some of the learning activities require discussion or demonstration with the facilitator and in many cases would be beneficial to address in face to face group settings.

The face to face components

PowerPoint presentations have been provided as a tool for the facilitator to accompany most learning modules. While they have been developed as a valuable resource for the facilitator, and are highly recommended, the use of all presentations is not mandatory, they are an adjunctive tool. The use of the following presentations (as a minimum) to facilitate interactive learning has been identified as key to the CIN education:

- CIN Role
- Communication in the CIN role
- Waiting room management
- Pain Assessment and CIN Pharmacology
- Limb Assessment
- Caring for the patient with a Mental Health presentation in the waiting room and
- Documentation.

Use of the electronic resources

The CIN education program has been given approval to utilise several pre-existing electronic teaching resources. These include:

- ‘In Their Shoes’ developed by: Diversity Health, Prince of Wales Hospital.
- CIN rounding: Improving the Patient and Carer Experience Program, Health Services Performance Improvement Branch NSW Health
- Limb Examination: Developed by Sydney South West Area Health Service Centre for Education and Workforce Development.

Permission has been given for these DVD resources to be used exclusively for this program. They are not to be reproduced without permission. It is recommended that facilitators keep the Limb Assessment DVD in their library and loan it to participants for an agreed period.

An agreement has been made with WoundsWest to enable CINs to access this valuable on-line learning program. Users must comply with the ‘Terms of Use’ outlined in the Resource Manual and the modules cannot be imported onto local intranet systems.
Program Evaluation

The program will be evaluated in terms of key performance indicators, and by stakeholders, as outlined below:

**Key performance indicators**

- Percentage of eligible staff that have completed the course requirements
- Percentage of eligible staff that have obtained the relevant objectives/goals within an acceptable timeframe (to be determined locally – between 3-6 months)
- Percentage of staff that commenced program that have completed all clinical competencies.

It is expected that all facilities maintain the records of each participant’s progress to demonstrate achievement of KPIs.

**Stakeholder evaluation**

Participants will evaluate the CIN education program via an evaluation form.

The ED Nursing Clinical Leaders and Educators will be surveyed to evaluate the effectiveness of the educational program after 6 – 9 months.

**Key Points**

- The CIN education program provides the core material for the CIN role which is standardised state-wide in NSW.
- At most sites there will be some local supplementation of the education to align the training with local guidelines and protocols.

**Conclusion**

The following chapters align with the modules in the participant and Resource Manuals.

Listed under each of the headings are:

- Statement of Purpose
- Content Summary
- Activities and Discussion Points (answers or key discussion points for the facilitator are written in italics)
- Assessment Criteria.
Section 1

1.1 Introduction to the Clinical Initiatives Nurse Role

Statement of Purpose

The aim of this module is to define the Clinical Initiatives Nurse (CIN) role and detail the key elements that underpin the role. This will enable the CIN to develop an understanding of the objectives and accountabilities of the CIN.

Summary

This chapter explores the background and history of the CIN role since its inception in 2002.

It also gives a brief overview of the changes that were made following the review and standardisation of the role in 2010.

The key features include:
1. A detailed appreciation of the role description and the priorities to the waiting room patients and to do the ‘greatest good for the greatest number’ when the waiting area is busy.
2. The importance of the CIN as an ED team member and the key roles that it interacts with – as well as the purpose for those interactions. This will highlight the role boundaries.
3. Discussion of the accountabilities of the role and the importance of escalating issues to the appropriate position holders.
4. The outcome measures for the role.
5. The types of activities that will be undertaken in the CIN role.
6. The knowledge and experience for the role, including the assessment/accreditation criteria, and the local protocols that exist.

Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

Activity 1 Analyse and reflect on what constitutes care initiation

In 2006 a memo was issued by NSW Health which outlined the requirements for recording a ‘Nurse Seen’ time for the ED patient. The memo is located on page 5 of the Resource Manual.

Read and discuss the memo with your facilitator/manager to ensure you are aware of how the CIN contributes to commencing care.

The facilitator is required to provide clarity on what constitutes care initiation regarding nurse seen time in ED. It is expected this discussion will endorse the value of the CIN role in patient assessment and initial management and not lead to unnecessary testing or duplication of services.
Activity 2
Follow the link below on the NSW Health Intranet to the NSW Health Patient Survey Results for your Hospital; find the results for the Non-Admitted ED patients for the past 4 years. Discuss the results with your facilitator, and outline how the CIN may impact on these results.

http://www.plenari.com/doh/NSW_HEALT.php

If you are unsure how to use the survey check the user guide 'Tips for using the Report'.

The facilitator may be required to support the CIN participant to navigate this site. Discussion should focus on the role of the CIN in relation to the feedback, and how the CIN role may contribute to the patient & carers experience in the ED.

Resources

- The CIN Role Description

Assessment Criteria

There is no formal assessment process for this module.
1.2 CIN Communication and the Waiting Room

Statement of Purpose

The aim of this module is to emphasise the importance of the CINs understanding and management of patient and carer anxiety in the waiting room through effective communication. This will enable the CIN to display an understanding of the communication needs of the patients and carers in the waiting room and develop strategies to meet these needs.

Summary

This module discusses the communication needs of patients and carers in the waiting room and presents strategies that CINs can learn to meet those needs.

Feedback from the CIN role redesign in 2010 highlighted effective communication skills as a core CIN requirement to enable effective referral of patients to other clinicians (eg for escalation of care or to other services eg mental health, MAU, specialty CNCs or teams).

Facilitators can use the following resources to promote learning of this topic:
- Information provided in the ‘Clinical Initiatives Nurse Role in Emergency Departments’ booklet
- Supplied PowerPoint presentation
- Scenes provided from the ‘In Their Shoe’s DVD
- Referenced resources
- Clinical examples.

Suggested discussion points for the face to face session

Ask CINs to reflect on personal experiences they have had in ED or doctor’s waiting rooms, do they recognise elements from the psychology of waiting that contributed to their experience?

Discuss what elements from the psychology of waiting contribute to the experience for patients in their local ED waiting room as it is currently designed.

Discuss the A to E of communication and how using it may benefit the patient care and the CIN role.

Discuss the interaction of the CIN role with other key roles – Triage, Nurse In Charge & Senior Medical Officer.

Discuss the referral pathways that the CIN position may use in your ED. Explore the boundaries of the roles, and how they work together to promote effective patient care. Explore concerns or issues that may be raised by staff in regards to the role.

Re-iterate the use of a clinical handover tool such as ISBAR in the CIN role.
Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

**Activity 1  Case Scenario**

You return from a break to the CIN role and notice a 19 y/o male sitting in the waiting room supporting his shoulder looking pale and grimacing. You review the patient and believe he has a dislocated shoulder. When you mention this to the Triage Nurse they tell you they are aware, but all of the beds are full, no-one can move and he is ‘alright at the moment’. They state ‘he has had some Panadeine Forte, and ask you to keep an eye on him’. How, as the CIN, do you manage this situation?

**Discussion to focus on how as the CIN you would:**
- Communicate with the patient
- Escalate the care requirements – who do you contact/what options are available?
- Reconcile this situation with the triage nurse.

**Activity 2  Reflective exercise**

Review scenarios 1, 3, 4 and/or 5 on the ‘In their Shoes’ DVD and discuss how these situations could have been handled differently.

The reflective questions in the Participant Manual are:
- What features contributed to the escalation of the situation.
- What could have improved the situation?
- If you were the CIN reviewing the patient following this episode, how would you approach the patient/carer?

**Resources**


A full reference list for this module can be found in the Resource Manual.

**Assessment Criteria**

The CIN’s skills in communication with patients and carers in the waiting room will be evaluated during preceptored time in the role. The facilitator will base the assessment on the following:

- The CIN demonstrating an understanding of the needs of people in the waiting room (reassessment/reassurance/updated information etc.)
- The CIN effectively prioritising the need for regular communication with patients and carers in the waiting room (use of the A to E of communication is not mandatory to pass this module, however it does come highly recommended, other strategies may be used)
- The CIN communicating effectively with the team to escalate care (as required) or to present concerns using ISBAR (or alternate approved communication strategy).
1.3 Management of the Waiting Room

Statement of Purpose

The aim of this module is to emphasise the importance of maintaining a safe and efficiently functioning ED waiting room and provide the CIN with strategies to manage the waiting environment.

Summary

The facilitator can assist the CIN to become more confident with ‘working the waiting room’ using the content, resources and activities included in the module, as well as role modelling and mentoring the CIN in the role.

The waiting room may be a quiet or busy environment, at times the CIN may experience feelings of being overwhelmed by the numbers of people in the waiting room and the demands of the role. It is important to convey the priorities of the role to the CIN, which are listed clearly in the CIN booklet.

Priorities are:

- Patient safety – clinical and personal
- Communication and
- Care initiation.

The CIN Resource Manual discusses the efficiencies that can be gained by undertaking hourly rounds in the waiting room. The aim of these rounds, and the way they are conducted may vary at sites. Complete re-assessment of the patient should only be undertaken during these rounds when clinically indicated, otherwise the aim is a brief review and communication with the patient to ensure they remain safe and are updated about waiting times. Thus education should encourage CINs to use their experience and clinical knowledge to have the confidence and skill to achieve this objective.

In this module the facilitator can supplement the CIN Resource Manual in the following ways:

- Facilitating discussion about how to escalate care needs
- Outlining the method and expected documentation of waiting room care
- Exploring local guidelines for nurse initiated care and diagnostics
- Defining local referral practices for the CIN
- Discussing the maintenance of privacy and dignity and the use of the CIN area or suitable space by the CIN
- Management of patients who ‘Did not Wait’ or ‘Left treatment not complete’.
Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

**Activity 1 Case Scenario 1**

A 45 year old male and his wife are waiting quietly in the ED waiting room. You note from the triage record he has attended the ED due to nausea and vomiting. You are attending to a waiting room round (1500 hrs), make eye contact with the patient (male) and notice slight apprehension on his face and beads of sweat on his forehead. He denies being in pain, however does acknowledge he continues to have nausea and feels dry.

What would the CIN plan of action include?

**Activity 1 Case Scenario 2**

A 5 y/o male is brought to the ED by his mother, he has a 2 day history of vomiting, which is starting to settle, but she is concerned he is less active than usual. The triage nurse has assessed him as mildly dehydrated and has asked the CIN to commence a trial of fluids while he waits to be seen. He has a triage category 4. The ED and waiting room are quite busy. His mother has also brought her 3 other children along, a 7y/o girl, a 2 y/o male (who is running around the waiting room) and a 6mth old baby. She looks distracted when you are explaining the trial of fluids and she states the 7y/o will have to do this as she has got her hands full.

Consider some of the issues that this scenario raises. How would you manage this situation as the CIN?

**Issues of concern – a few are highlighted here, but more could be raised:** ability of a 7y/o to manage clinical care (is this a normal expectation?), the support systems in place for the mother (both immediate and at home), the possible escalation of frustration/anxiety in the waiting room with a young boy running around, the nature of the patient’s illness – is it infectious and the possible implications of this).

The expected answer needs to address the clinical needs of the patient as well as the family and wider waiting room issues, eg can another family members care for the well children?

**Activity 2 Resource finding and role play**

Search for your local policies and procedures in relation to the management of aggressive/violent incidents in your ED. Undertake a role play with your fellow colleagues and practice how you would manage an incident in your waiting room area.

_Work with the CIN participant to develop role plays of aggressive incidents._

_Use scenarios based on incidents that may have occurred or may be likely in your local ED._
Activity 3

Further activities are located in this guide for use in face to face teaching:

Film footage (in the PowerPoint presentation)

The CIN rounding DVD is not meant to be a perfect demonstration of rounding in the waiting room; rather it has been developed as a tool to facilitate learning and discussion.

The CIN activities displayed in the film/ DVD footage in the PowerPoint presentation can be used to discuss how rounds may be conducted and what the outcomes might be. Facilitated discussion may include the following points:

- Did the CIN use the A – E of communication?
- What verbal and non-verbal communication tools were displayed by the CIN? What effects did they have?
- What worked well?
- What changes could be made?
- Would the CIN be comfortable addressing the whole waiting room, what script (words) might be used?

Role play

1-2 persons are selected from the participants to act in the CIN role. Everyone else is given a condition on a piece of paper. The participants selected demonstrate how they would familiarise themselves with who is in the waiting room before approaching the ‘patients and carers’.

The objectives of the session should include:

- effective communicate with the whole waiting room
- identification and prioritisation of patients in the waiting room
- demonstration of escalating care due to patient deterioration
- discussion of the process to be followed for the patient who Left without Treatment/Left at Own Risk (after CIN intervention/diagnostic)

- The facilitator guides reflective review of the experience, difficulties & learning that arose.
  How could the CIN brochure assist the role?

Mentored/Preceptored shift

During the mentored CIN day, allocate 20-30 minutes (preferably when the waiting room is busy) for the CIN to sit in the waiting room and observe the experience.

Reflect on this experience:

- What did they observe?
- What made the experience better?
- What could have been better?
- How might this influence their CIN role?
Resources


A full reference list for this module can be found in the Resource Manual.

Assessment Criteria

There is not a formal competency for this assessment.

The CIN’s skills in managing the waiting room will be evaluated during preceptored time in the role.

Evaluation criteria are based on:

■ Demonstrated pro-active waiting room management that prioritises
  - Communication/updates and reassurance
  - Reassessment of patient acuity – escalation of care as required (using ISBAR or approved alternate)
  - Prioritisation and commencement of appropriate interventions (pain management, diagnostics and treatment)

■ Demonstrated ability to identify and manage the early signs of aggression (with an escalation plan as required).

.
1.4 Pain and Overview of CIN Pharmacology

Statement of Purpose

The aim of this module is to:
■ Provide an understanding of pain assessment and the physiological and behavioural indicators related to pain and pain assessment
■ Emphasise the importance of providing early assessment of pain and appropriate pain relief strategies
■ Provide the emergency nurse with an overview of pharmacological agents used in the treatment of pain and other common presenting problems
■ Discuss the medico-legal requirements for nurses using standing orders.

Summary

Pain is the most common symptom reported by patients who present to the ED, with evidence showing that more than 60% of patients report pain on arrival to the ED (Lord & Ramsden, 2007). Early assessment of pain and timely access to analgesia is one of the major objectives to good emergency care. A primary goal for the Clinical Initiatives Nurse (CIN) is the aim to reduce the time patients wait in pain through the provision of early analgesia and reassurance.

This module is divided into 4 sections:
Part 1: Pain Pathophysiology and Assessment
Part 2: Pharmacological Pain Management
Part 3: Other Pharmacological Drugs
Part 4: Medico-legal Considerations.

This module provides the core knowledge for CINs to assess and manage pain, and initiate several other medications commonly used in the CIN role. This module must be utilised in conjunction with locally approved CIN guidelines and pharmacological standing orders. It is highlighted in the Resource Manual and the Participant Manual that passing this module does not give CINs endorsement to initiate all mentioned medications. Facilitators will need to inform CIN participants of the following:
■ Which medication are approved as standing orders for their EDs
■ The Indications and Contraindications included in local standing orders
■ Any further accreditation requirements which are required by local Drug Committees or ED management.
■ Any other relevant information.
Part 1  Pain Pathophysiology and Assessment

Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

Learning Activity 1

Pain can be classified into somatic, visceral or neuropathic. Compare the clinical features associated with these 3 major types of pain.

- **Somatic** pain may be described as sharp, hot or stinging, is generally well localised and is associated with local and surrounding tenderness.
- **Visceral** pain may be described as dull, cramping, or colicky, is often poorly localised and may be associated with tenderness locally or in the area of referred pain, or with symptoms such as nausea, sweating and cardiovascular changes.
- **Neuropathic** pain may either acute or chronic and results from injuries or disease that directly affects the nervous system. Often it is associated with entrapment of nerves, causing a burning or tingling sensation.

Learning Activity 2

Pain assessment tools are essential when assessing patients pain severity. Identify which pain assessment tools are utilised in your facility, demonstrate how you will utilise these tools with your facilitator.

Demonstrate the Pain Assessment Tools and discuss the strengths and weaknesses of each

(Observational – clinicians tend to underscore pain, Self Report is usually best)

**Notes for Facilitators:** Whether due to a lack of confidence in the self report scales, or in how to administer them, research shows that insisting staff use self-report scales leads to fewer pain scores being recorded in EDs (Stewart et al. 2004). Knowing that using observational scoring scales usually means the patient gets a lower pain score than using a self report scale raises the question: is it better to use observational scales to record an assessment than to have no assessment? In part this answer depends on whether the score triggers an action to intervene with pain management, and whether re-assessment follows. There is evidence that the recording of a score does trigger the instigation of pain management, particularly when linked to protocols (Shavit et al. 2008, Stewart et al. 2004). Certainly, the majority of studies report that both observational and self-report tools have validity for detecting changes in pain level post intervention (Bailey et al. 2007). The most important point for staff to be aware of is the lack of significant agreement between types of scales.

Learning Activity 3.1

Identify the differences between these terms:

- **Addiction** is classed as a chronic disease characterised by impaired control over drug use, compulsive use, continued use despite harm and craving
- **Tolerance:** Decreasing effect of a drug at a constant dose or the need for a higher dose to maintain the effect. Opioid tolerance is a natural physiological response to long term therapy.
- **Physical Dependence:** A reliance on medication to control symptoms or disease. Withdrawal symptoms can occur from stopping the drug or reducing the dose.
Learning Activity 3.2
Consider your experience in managing pain.

1. Do you believe patient assessment tools work well? Why, Why Not?
2. Reflect on a pain management situation that you have experienced. What factors contributed to it going well? Or not going well? What did you learn from this experience that changed your practice?
3. What factors influence your beliefs about pain and how does that influence your approach to pain management? What situations do you find most difficult and why?

Answers will be individually based. The aim is to bring self-awareness to the CIN on what factors may influence their management of pain.

Part 2 Pharmacological Pain Management

Learning Activities and Discussions

Learning Activity 4 Paracetamol
Identify and discuss the inclusion and exclusion criteria and specified dosage for paracetamol in reference to your local standing orders, for patients presenting to ED with acute pain and/or fever:

Answers will be based on local standing orders.

Learning Activity 5 NSAIDs
Identify and discuss the inclusion and exclusion criteria and specified dosage of non steroidal anti-inflammatory (NSAID) medications in reference to your local standing orders, for patients presenting to ED with pain:

Answers will be based on local standing orders.

Learning Activity 6.1 Opioids
Identify and discuss some of the common adverse effects of opioid medications and how you would manage these for patients in your ED setting. What are the specific life-threatening adverse reactions you should be concerned about?

The most common adverse effects are constipation, light-headedness, dizziness, sedation, sweating, dysphoria, euphoria and urine retention. Discuss management of acute symptoms.
The most serious adverse reaction is Acute Opioid Toxicity that is manifested by a triad of symptoms:

- Coma
- Respiratory Depression
- Pinpoint Pupils.

Treatment requires:

- Immediate medical review
- Management of A, B, C, D,
- Administration of Naloxone.
Learning Activity 6.2  Opioids
Identify and discuss the inclusion and exclusion criteria and specified dosage for Opioids in reference to your local standing orders, for patients presenting to ED with pain:

*Answers will be based on local standing orders.*

Learning Activity 7  Inhalational Analgesics (as applicable)
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders for Inhaled analgesia, for patients presenting to ED with acute pain:

*Answers will be based on local standing orders.*

Learning Activity 8  Topical anaesthetics (as applicable)
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders for the application of local anaesthetics agents for patients presenting to ED with pain

*Answers will be based on local standing orders.*

Part 3  Other Drug Pharmacology

Learning Activity 9  Antiemetics
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders for antiemetics, for patients presenting to ED with vomiting and nausea.

*Answers will be based on local standing orders.*

Learning Activity 10  Immunisations (as applicable)
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders administration of immunisations, for patients presenting to ED with disrupted skin integrity.

*Answers will be based on local standing orders.*

Learning Activity 11  Intravenous fluids (as applicable)
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders for IV 0.9% Sodium Chloride infusion.

*Answers will be based on local standing orders.*

Learning Activity 12  Inhalational Bronchodilators (as applicable)
Identify and discuss the inclusion and exclusion criteria and specified dosage in reference to your local standing orders for the administration of Salbutamol and Ipratropium Bromide, for patients presenting to ED with asthma symptoms and wheeze:

*Answers will be based on local standing orders.*
Learning Activity 13  Case Scenarios

Case Scenario 1  Sebastian

18 year old Sebastian presents to the ED after a fall from his bike. He is pale and perspiring, holding his right forearm against his abdomen. He reports he wasn’t going too fast, and he was wearing his helmet. He states he has strong pain to his arm 7/10 (no visible deformity on initial glance by triage nurse), and you notice a graze to the right side of his face.

Discuss the pharmacological options available to treat Sebastian.

Answers will be based on local standing orders.

Identify which non-pharmacological options may be suitable in this situation
Rest, Ice, Compression, Elevation. Reassurance.

Further history reveals he isn’t sure if he had a LOC, as the fall was unwitnessed. He states he is feeling dizzy and faint and that he has had a poor appetite recently due to having gastroenteritis.

What further considerations to his treatment does this additional information make?
Consider dehydration, head Injury, c-spine injury (assess accordingly).

What is your plan for Sebastian as the CIN? Is there any other information that you would like from Sebastian?
Perform a head to toe assessment, including vital signs. Depending on finding, escalate care – does this patient meet trauma call criteria? Document findings. May require as a minimum neurological observations, c-collar, IV cannula, basic pathology and IV fluids.

Case Scenario 2  Lucy

3 year old Lucy presents with a 2 day history of wheeze and cough. The oxygen saturations are 96% on room air and she has slight intercostal recession. Expiratory wheeze is present on auscultation. She is tired looking and febrile on arrival at 38.2oC. She has no allergies and hasn’t had any medication today. Weight = 22kg.

Discuss the pharmacological options available to treat Lucy:
Answers will be based on local standing order. Discuss with the CIN what other information may be required to assist with decision making. May include bronchodilators and fever management depending on local protocols. Discuss whether locally this would be done by the CIN and in what location.

What dose of Salbutamol would be suitable for Lucy? How would you deliver it?
Answers will be based on local standing order – spacer is the ideal route.

Lucy has the Salbutamol in the waiting room and after 20 mins remains wheezy. What is your next action?
Re-assessment – Discuss what information is required to enable the CIN to decide to escalate care. How would this be done (ISBAR or approved alternate).

Calculate the dose of paracetamol for Lucy? Which route of administration would you select and why?
Answers will be based on local standing order (eg 15mgs/kg if not previously administered). Oral route. Discuss why ibuprofen would not be recommended in this case.
Learning Activity 14
Facilitator Discussion Points for Face to Face sessions.

- Taking a pain history is important in providing important diagnostic information about your patient’s clinical presentation. Use role-play scenarios to allow the participants to practice taking an accurate pain history utilising the mnemonic PQ rSt
- Facilitate participant discussion on the advantages and disadvantages of the pain assessment tools used in your ED
- Discuss strategies for pain assessment in patients who are unable to self-report pain. Discuss the importance of carer information in this assessment
- Discuss what other alternate options for pain relief are available for patients other than pharmacological therapies
- Discuss the differences between the terms addiction, tolerance and physical dependence and how this may impact on the provision of adequate analgesia for the patient.

Patient scenarios

- Develop scenarios based on local protocols and patient population.

Assessment Criteria

This module is designed to provide emergency nurses with the theory and practical components to progress towards initiating advanced standing orders.

In regards to this module the CIN participant must complete the following core educational components:

- Read the Resource Manual and complete all the required learning activities in the Participant Manual
- Complete the multiple choice exam and obtain an 80% pass mark (Assessment Document 1)#
- Achieve a level of competency, by the mastery in the performance of:
  * ______________________________

# Please note, this assessment is generic, and will assess the participant’s knowledge on pain assessment, pain pathophysiology, the paracetamol policy (PD 2006_004) and opioid toxicity. It does not assess knowledge of instigation of standing orders, due to variance at sites in:
  1. Where ED nurse standing orders are commenced in the career pathway
  2. The type and number of medication standing orders at different sites and
  3. The requirement by drug committees and ED management for local accreditation.

Several sample questions have been provided in Assessment Document 3 that may be used to assess the CINs knowledge of applying standing orders. These are not exhaustive, and do not cover all drugs addressed in the pharmacology module, and do not need to be used if local sites have suitable, pre-existing assessments.

- * As standing orders for CINs to initiate medications are developed and signed off at individual EDs or Local Health Networks there will be requirements for CINs to complete existing accreditation processes. (The facilitator should list these requirements in the CIN Participant Manual in the space marked * or in the space provided)
- As a minimum standard it is recommended that this should require:
  1. the supervised administration at least 4 pharmacological standing orders
  2. mastery of competency in administration (sample in Assessment Document 3)
  3. evidence of ongoing practice.
Resources

The following document brings together the best available evidence for the management of pain in a range of contexts. Specific sections are dedicated to the assessment and management of pain in ED’s and pain management in opioid-tolerant patients.


A full reference list for this module can be found in the Resource Manual.
1.5 Musculoskeletal Assessment of Limbs and Principles of Radiological Examination

Statement of Purpose

The aim of this module is to develop the Clinical Initiative Nurse’s musculoskeletal assessment skills, their decision making regarding imaging and enable documentation of clinical findings through increased anatomical awareness.

Summary

This module has been developed to provide CIN participants with the knowledge and skill set to competently assess patients with limb injuries and develop a plan of care for the patient with a limb injury, including decision making about radiological requirements.

Resources include the following:
- PowerPoint presentation
- Limb Assessment DVD
- Clinical competencies. And clinical scenarios with assessment findings to use for competency assessment purposes (Assessment Documents 4 & 5)

The competencies include the shoulder, elbow, wrist and hand in the upper limb, and the knee, foot and ankle in the lower limb. Copies of these documents are included in the Participants Manual.

The competencies may be undertaken in one or two sessions, or as individual assessments. This is to provide flexibility depending on workplace demands.

The CIN scope of practice in regards to Nurse Initiated X-ray must adhere to local guidelines which have been endorsed for use at local facilities.

Education must include the accountabilities for the CIN in relation to initiation and follow up of x-ray and the process to follow in the case of the patient who had investigations initiated but did not wait to be seen.
Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

The Activities in the CIN Participant Manual refer to learning from the Limb Assessment DVD.
Refer to ‘Use of Electronic Resources’ on page 5 regarding the terms of use of this resource.

Scenarios from the Participants Manual

Note: These are guides only. Further scenarios may be developed to enhance learning.

Case Scenario 1  Foot assessment
A 35 year old pastry chef drops a 5 kg weight onto her foot.
■ She is unable to weight bear
■ Her foot is swollen and bruising is evident
■ She has bony tenderness over her navicular bone on palpation.

What is your initial assessment and management plan?
Verify History and Examination – palpate for other areas of tenderness
Pain Assessment and Management (pharmacological and non pharmacological)
X-Ray foot (Ottawa Rules)
Importance of documenting the presence or absence of wounds.

Case Scenario 2  Ankle assessment
A 43yr old female presents to the ED for an x-ray. She was jogging on an uneven surface and ‘went over’ on her right ankle. She describes feeling a lot of pain and hobbled home to R.I.C.E. her ankle. As it was very swollen she decided to present to the ED for an x-ray.
■ Patient’s ankle is very swollen about the lateral malleolus
■ She can weight bear
■ There is no distal tip tenderness.

What is your initial assessment and management plan?
Verify History and Examination – palpate for other areas of tenderness
Pain Assessment and Management (pharmacological and non pharmacological)
Does not need an x-ray as there is no bony tenderness and the patient is weight bearing.
Describe the Ottawa Ankle and Foot Rules (managing patients expectations).
Importance of documenting the presence or absence of wounds.
Case Scenario 3  Lower leg assessment
A 23yr old male was kicked whilst playing soccer. He presents with swelling to the lower leg, he is in excruciating pain.

- He is unable to weight bear
- Swelling and deformity is obvious to the shaft of his tibia.

What is your initial assessment and management plan?

**Verify History and Examination – palpate for other areas of tenderness**

**Neurovascular examination**

**Pain Assessment and Management (pharmacological and non pharmacological) is a priority for this patient.**

He requires a trolley, splinting, elevation and IV analgesia.

**Importance of documenting the presence or absence of wounds**

**Importance of early signs of compartment syndrome.**

Case Scenario 4  Knee assessment
A 19 year old female was playing netball and was accidently kicked by an opponent on the side of the right knee. Patient describes falling over and rotating on her knee. There was a pop at the time of the injury

- There was immediate swelling and now the knee looks very swollen
- Patient is unable to weight bear and unable to flex her knee
- There is global knee tenderness present.

What is your initial assessment and management plan?

- **Verify History and Examination – palpate for other areas of tenderness**
- **Neurovascular examination**
- **Pain Assessment and Management (pharmacological and non pharmacological)**
- **Needs an x-ray because she meets 2 of the criteria of the Ottawa knee rules**
  - unable to weight bear
  - unable to flex to 90 degrees
- **Importance of documenting the presence or absence of wounds.**

Case Scenario 5  Wrist assessment
A 65 year old female slipped on a wet surface and fell onto her outstretched hand.

- Patient is complaining of a painful right wrist, which has a “dinner fork” deformity
- She has limited range of movement but is able to wiggle her fingers
- Bony tenderness is noted over the distal radius.

Describe your initial assessment and management plan

- **Verify History (simple trip and fall) and Examination – palpate for other areas of tenderness**
- **Neurovascular examination**
- **Pain Assessment and Management (pharmacological and non pharmacological) is a priority.**
  - She will require splinting, elevation in a sling, IV analgesia
- **Provisional diagnosis: possible Colles fracture**
- **X-ray - right wrist**
- **Clinical findings: ‘dinner fork’ deformity with tenderness over the distal radius.**
Case Scenario 6  Elbow assessment
A 5 yr old female presents after falling off the trampoline and landing on her right arm.

- She is complaining of pain and swelling to the right elbow
- She has bony tenderness and deformity felt over the supracondylar area of her right elbow.

What is your initial assessment and management plan?

- **Verify History and Examination**
- **Neurovascular examination – red flag for neurovascular compromise**
- **Pain Assessment and Management (pharmacological and non pharmacological – requires splinting and may require bed, and IV analgesia or intranasal Fentanyl for pain management)**
- **Provisional diagnosis: possible supracondylar fracture, requires x-ray.**

Case Scenario 7  Shoulder assessment
A 19 y/o male presents following a fall onto the tip of his left shoulder while being tackled at rugby today.

- He is complaining of pain to the left shoulder, splinting it closely to his body and reluctant to move the arm
- He is tender over the left clavicle.

What is your initial assessment to guide your plan of care?

- **Verify History and Examination – palpate for other areas of tenderness**
- **Neurovascular examination**
- **Pain Assessment and Management (pharmacological and non pharmacological)**
- **Importance of documenting the presence or absence of wound or ‘tenting’ of skin**
- **Provisional Diagnosis: Clavicle fracture**
- **X-ray Clavicle.**
1.6 Wound Care

Statement of Purpose

The aim of this module is to emphasise the importance of an accurate wound assessment and appropriate initial management of wounds in the Emergency Department. This is not only to ensure that no harm is done but also that we promote healing and better outcomes for the patient. Completion of the e-learning will enable the CIN to undertake a full wound assessment and plan initial wound care.

Summary

It is recognised that the CIN role requires the RN to be able to assess and apply appropriate first aid to wounds as a minimum. In some cases CINs may play a role in further management of particular wounds. This module does not recommend particular wound dressings, or discuss definitive wound management such as gluing and suturing.

On researching this topic, an excellent evidence based online learning package has been located. It has been developed by WoundsWest, and NSW Health has been given approval for CINs to utilise this training. CINs can apply to gain Continuing Nurse Education (CNE) points on completion of modules.

The core module provides excellent information on wound types and wound assessment and is to be completed as a minimum.

The skin tear and burns modules are recommended, to assist the CIN with wound assessment and first aid, however local or state guidelines are to be used in the management of these wounds.

The trauma wounds module (due for completion in 2011) is also expected to be of benefit for ED nurses. As the facilitator you will need to nominate the recommended modules for the CIN participant or other appropriate requirements as determined locally.

The link is:
http://woundswest.articulate-online.com/1656235026
Section 2

2.1 Care of the Patient with a Mental Health Presentation

Statement of Purpose

The aim of this module is to provide practical guidance for the CIN in the initial assessment and management of patient’s with mental health presentations in the waiting room.

Summary

The aim of this module is to provide knowledge and activities to increase CIN awareness and confidence in managing care for the patient with a mental health presentation in the waiting room. CINs need to be confident to approach and review patients without the fear of causing escalation of behaviours. Patients with mental health disorders and their carers may feel isolated in the waiting room due to lack of communication and interaction with clinical staff. This module has been written and reviewed by Mental Health Emergency Expert Nurses in Adult and Paediatric EDs, and they endorse the content as applicable to the needs of both populations.

This module is heavily based on the ‘Mental Health for Emergency Departments- A Reference Guide, NSW Health 2009’ which is an excellent resource.

Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

The PowerPoint includes an extensive section on medications and their side effects. Facilitators/Mental Health experts can make informed decisions regarding the learning needs of the CINs they are teaching.

Activity 1

Identify some of the main clinical features and initial management of patients with mental health presentations commonly seen in the ED. 
IE. schizophrenia, mania/manic episode, anxiety, depression, self-harm and suicide, eating disorders etc.

A CIAP reference for this has been supplied in the Participant Manual.
Patient Scenarios

The following scenarios have been developed by an ED Mental Health CNC. They are partially replicated in the CIN Participant Manual. However the part in italics has not been included in the participant’s manual. This allows the participant to make some initial assessment and management plans, before the facilitator gives them further clues as to the outcomes for the patient. They may be used in one on one discussion or in group sessions.

Case Scenario 1 Part 1

You are monitoring a number of patients in the ED waiting area including Ben, aged in his mid-30’s who presented with a two day history of a low grade fever, diarrhoea, and abdominal cramps. He was unable to get an appointment with his GP and feels he is getting worse. He is introduced to you by the ED triage nurse who gives you a brief description of his symptoms, and notes that he has a history of bipolar disorder for which he is taking Lithium Carbonate. He has also been taking some over-the-counter medication for ‘aches and fever’, including ibuprofen and herbal tea. He has been allocated triage Cat 5 and has been waiting for approximately 1hr to be seen by a doctor. You have noticed him sitting hunched in a chair holding his abdomen and note that he is frequently going to the toilet. He approaches you and asks how much longer the wait will be. His lips appear quite dry and it is a little difficult to hear what he is saying as his voice is somewhat hoarse. You also notice that he has a slight tremor in his hands, – when asked about this he comments that his hands often shake a little, especially when he has been feeling ill.

1. What nursing assessment are you going to do and what information do you want to obtain from Ben?
2. What red flags concern you as the CIN? Who would you convey your concerns to and what would you say?

Case Scenario 1 Part 2

You are asked to continue to observe the patient until the Mental Health team arrive or a bed is available.

Ben returns to you a number of times over the next hour and appears to be going to the toilet quite frequently. On one occasion you notice he began to enter the women’s toilets before being redirected by another person.

He returns to his seat and resumes sitting in the same manner as before. A short while later, he stands up and begins to walk toward a water fountain. You notice as he walks that he begins to lean to his right as he continues and holds on to the water fountain for support. He attempts to push the button to get a drink but his hand shakes violently and he misses. He tries a number of times but seems perplexed that he cannot get the fountain to work.

You approach him and offer to help. He turns as you speak to him and he seems to have trouble focussing his vision on you. In response to your offer to help he mumbles ‘I’m fine thanks’ and begins to walk back to the chairs. He leans alarmingly to his right and grabs the arm of the chair to lower himself in. Once seated he leans forward and begins picking at his shoelace – it is not clear to you whether he is trying to take his shoe off or re-tie the lace.

3. What action would you take at this stage?
4. Who would you convey your concerns to and what would you say?
Facilitators use: Guide for reflection/education

You raise your concerns with a senior medical officer.

What would you highlight?

- **Marked signs of increasing neurotoxicity:**
  - unfocussed gaze
  - markedly increased tremor
  - undirected activity (shoelaces)
  - ataxia
  - decreased problem solving ability (fountain)
  - decreased attention/increased confusion (women’s toilets)
  - signs of dehydration (dry throat, hoarse voice).

**Points to note:**

- Interaction between NSAID’s (such as ibuprofen), and Lithium Carbonate leads to increase risk of Lithium toxicity
- Recent history of diarrhoea and fever increase dehydration, raising serum level of lithium
- Herbal teas often contain substances that can have a strong diuretic effect
- Lithium toxicity is a medical emergency that needs immediate treatment!

**Case Scenario 2**

You are monitoring a number of patients in the ED waiting area including a young woman (in her late teens) accompanied by her mother who has been waiting for approximately 45 minutes. She was introduced to you as ‘Monica’ by the ED triage nurse who quickly told you she was presenting with ‘a history of depression, she stopped taking medication a few weeks ago, has very poor sleep and denies any suicide ideas this time but has had such ideas in the past’. Monica was given a triage category 4, – the ED is very busy and a number of category 4 and 5 patients have already been waiting over 1 hour. Monica is apparently known to Mental Health Services and the triage nurse is unsure of the wait time for a Mental Health worker to come and formally assess her or for her to be seen in ED.

You note that Monica stares at you intently as the introductions are made and that her mother seems very tired. Her mother asks ‘How long will it be before the psychiatrist can see us?’

You reply that you will contact the Mental Health team (or make enquiries as to the wait to be seen) and ask them and direct both Monica and her mother to take a seat. After they have sat down you call the Mental Health team to get an estimated time for their attendance and are told by the person who answers ‘The message has been given to the Crisis team, I don’t know when they will get there but they shouldn’t be too long’. (If no Mental Health team in your ED, – the scenario is you check with the ED and the wait is approximately another 30 minutes)

As you approach Monica to relay the message you note that she seems to be muttering quietly to herself but you cannot determine what she is saying. As you speak to her and her mother you note Monica again stares intently at you but does not say anything. Her mother responds by thanking you for the message and asks if she can get a cup of coffee. As she rises to leave, Monica arises with her and stands very close by, apparently not willing to be apart from her mother at all. Her mother sighs deeply stating resignedly ‘Come on then’ to Monica as they both walk to the coffee machine.

Shortly after they walk away a young boy is brought in by his father crying loudly. It appears he has suffered a minor but painful injury and is seen quickly by the triage nurse. Within 5 minutes Monica and her mother have returned and return to the seats they occupied previously. Monica seems to be whispering urgently to her mother and you overhear her mother say ‘ENOUGH!’ before sitting quietly once more.
As you re-enter the ED waiting area you notice the young boy has returned and is now crying loudly whilst his father tries to quieten him. A number of other people in the area are moving away from them and you approach Monica to tell her of the delay. As you explain the situation to her and her mother you find it hard to communicate at times due to the crying child. Monica’s mother rolls her eyes as she angrily snaps ‘Oh well, I don’t suppose there’s anything we can do about it’. Monica slumps into the chair whilst still staring intently at you. You leave them to tend to others in the waiting area.

Approximately 15 minutes later you hear a commotion in the area where Monica was sitting and see her stand up and start screaming at her mother ‘TAKE ME HOME, TAKE ME HOME’.

Her mother stands and tries to placate her by stating ‘Calm down, the doctors will see you soon’. As she says this Monica picks up a magazine and throws it at her mother, – it bounces off her and hits the child who escalates his crying even more.

The father loudly protests and Monica runs screaming from the ED waiting room and runs outside into the car park screaming ‘I HATE YOU, I HATE YOU, GO AWAY’. She sits down in the gutter with her hands over her ears crying loudly and her mother approaches you and pleads ‘do something, please! She’s been getting worse for weeks’.

1. What action would you take at this stage?
2. What red flags exist in this scenario?

Facilitators use: Guide for reflection/education

Response

- Maintain your safety at all times. Note where Monica is but do not approach on your own.
- Summon help (discuss local response procedures – security staff, wardsmen, nursing and medical staff etc)
- Approach her when support has arrived
  (see Mental Health for Emergency Departments – A Reference Guide, 2009, Chapter 12)
- Escalate triage category immediately and inform mental health services
  (or other as per local services) of the new situation
- Arrange care for others – other staff may have to assist/monitor people in the waiting area
  (those who may have been directly hurt, need reassurance etc)
- If Monica leaves the hospital grounds escalate response via senior staff in ED
  (contact police due to volatile presentation and psychiatric history).

Notes for the medical record

- Odd behaviour including:
  - staring, apparently mistrustful of you
  - odd affect (reportedly ‘depressed’ but not tearful)
  - volatile behaviour
  - lack of direct communication with you
  - heard to be muttering to herself
  - extreme reluctance to be separated from mother
  - circumstantial evidence that she may be enduring auditory hallucinations
    (hands over ears, unclear who she is telling to ‘Go away’)
- Tiredness of mother and her comment re Monica’s deterioration over a number of weeks
- Brief description of incident involving aggressive behaviour to mother etc.
Points to note

■ Do not assume past history is always accurate
■ Clarify what medications the patient has previously been on:
  – in this scenario staff may have presumed they were antidepressants when they could have been antipsychotics
  – negative symptoms of schizophrenia can mimic depressive illness
  – diagnoses such as schizophrenia may not be apparent on initial presentations
■ Consider the needs of the resource person:
  – in this scenario the mother was exhausted and becoming short tempered with her daughter
■ Consider the effect of the environment:
  – signs of distress already apparent in Monica and her mother being escalated by the volume increase in the waiting area from the distressed child
■ It is important that information from carers/relatives is sought from them and opportunities for this to be disclosed away from the patient
■ Escalate the triage category early, as soon as increased symptoms are apparent.

Resources


A full reference list for this module can be found in the Resource Manual.

Assessment Criteria

There is not a formal competency for this assessment. There is an expectation that the learning activities will be completed.
2.2 Care of the Patient with a Minor Trauma Presentation

Statement of Purpose

The aim of this module is to emphasise the importance of reassessing “minor” trauma patients that have been triaged into the waiting room and are waiting to be reviewed and treated. It is also to assist the CIN in developing skills to identify trauma patients that are considered ‘at risk’ or those more commonly referred to as having ‘red flags’.

Summary

This module focuses on the care of the patient who has sustained trauma, triaged as stable and is in the waiting room. Recent research has been referenced and clinical examples given to develop CIN knowledge and skill in assessing, observing and managing this patient group. The patient populations that present ‘red flags’, in relation to traumatic injuries, are highlighted.

Activities and Discussion Points

There is not a PowerPoint presentation developed to supplement the participant education on this topic.

Patient Scenarios

The following case studies have been provided. Case 1 is in the CIN participant guide. The others have been provided in the facilitator’s manual for use as appropriate to the setting. The focus of these studies is not meant to be on the triage of the patient, but the manner in which patient factors contribute to trauma outcomes. These can be used to promote reflection and discussion on the ‘at risk’ trauma groups in the waiting room, and the role of the CIN in facilitated discussion.

Further scenarios maybe developed by facilitators utilising de-identified case presentations from your ED.
**Case Scenario**

13.25 Arrival in ED via CDA. Report to triage from ambulance:

**I Identify**

Patient’s name Mrs Katrina Dean  
Age 65 years.

**S Situation**

Presenting problem – mechanical fall  
History of presentation – Mrs Dean is a 65 year old female who is normally fit and well, who fell over playing tennis and fell onto her knees.  
Symptoms – Painful and grazed knees.

**B Background**

Relevant past medical history – Atrial Fibrillation diagnosed 5 years ago; Transient Ischaemic Attack 1 year ago  
Prescribed medications – Warfarin 2mgs daily (prophylactic treatment for Atrial Fibrillation); Digoxin 0.025mgs daily.  
Allergies – nil.

**A Assessment & Action**

Physical findings – a rather shaky lady, c/o pain in both knees  
Examination – knees have a slight swelling with grazes to both knees, patient is able to straight leg raise, nil other long bone swelling or deformity. A small cut to right side of head is noted, it is not actively bleeding. Nil LOC. Nil other injuries noted. Not covered for tetanus.  
Pain scoring – pain in both knees = 3/10  
Vital signs: T = 36.2 GCS = 15 RR = 12 P = 60 BP = 125/70 SaO2 = 96% (RA)  
Last ate or drank at midday.

**R Response & Rationale**

Placement in the department – Off load from Ambulance to wheelchair  
Plan – ATS category 4 to “fast track or subacute area” (no further observations recorded as a policy of the “fast track/subacute area” patient classed as sustaining a bony injury).

**The CIN participant is requested to:**

- Outline their assessment  
- Outline their plan of care  
- List the risk factors for this patient.
Case progression
The patient receives the following:
Treatment – Ice pack to knees, Paracetamol 1G for pain relief
Investigations – x-ray bilateral knees
Pathology tests – nil
Notification of relevant staff – Nurse in charge of “fast track area.

13.55 – 14.30 Sent to X-ray = Nil bony injuries
14.50 returns to ED waiting room and is now complaining of painful right wrist and a headache and nausea.
15.00 Re-examined by nursing staff. Tenderness noted in the right “snuff box” and a laceration (oozing over the right temporal region). Dressing applied to head wound, patient sent back to x-ray for scaphoid views of right hand.
15.40 Return to x-ray
16.15 Returns to ED with a decreasing level of consciousness – GCS = 13, R pupil larger than the left with a sluggish reaction.
16.20 ISBAR communication to resuscitation doctor
17.05 Confirmed R subdural haematoma.

Facilitators use: Guide for reflection/education
This is a classic case of a seemingly minor injury evolving and an example of systematic errors that result in poor outcome

Risk factors
■ Elderly > 65 yrs
■ Medications – antihypertensives and anticoagulants
■ Mechanism of Injury – asking the right questions would have identified that this lady attempted to break her fall by putting her hands out as she fell over. This as a natural defence response; and would direct the nurse to examine for snuff box tenderness and or other arm injuries.

In her background physical assessment and medical history, it is noted that this lady is on warfarin. This is a red flag in the elderly. Warfarin does not cause a wound or blood vessels to immediately bleed (as does aspirin); therefore there is a delayed haemorrhaging after the initial impact. It had been noted that she had a small laceration to the right side of her head which requires further investigation when taking a history – does the patient remember hitting her head? There is cause for considering the worst case scenario. The most common cause of subdurals in the elderly is rupture of the bridging veins due to sheering forces. If the patient is on anticoagulants there is increased incidence of bleeding. It is also important to consider that in elderly patients the brain will have shrunken (atrophied) and be more likely to be subjected to contra-coup damage, and a consequent cerebral bleed. This lady’s pulse rate is not responding to her stress or blood loss as she is on beta blockade medication. Taking a blood sample and testing for clotting times is considered good investigative practice in falls in the elderly, who are taking anticoagulant therapy.

The following Case Scenarios have not been included in the participant’s manual, but have been developed for use. Alternate scenarios may be developed to suit the particular ED, eg paediatric facility.
Case Scenario 2

20.10 arrived in the ED, via car, accompanied by daughter:

I Identify
Patient’s name Doris Folley
Age 75 year old
Date of birth 17/03/1935.

S Situation
History of presentation – Mrs Folley is a 75 year old female who states that she fell over at home and hit her right side of chest on the coffee table. She is normally fit and well.
Symptoms – painful right lower ribs.

B Background
Relevant past medical history – Angina Dx two years ago, rectal prolapse 10 years ago, arthritis in R knee
Prescribed medications – Aspirin 150mgs daily, Metoprolol 100mgs BD glucosamine.
Allergies – nil.

A Assessment & Action
Physical findings – slight bruising over R lower ribs, nil other injuries and nil distress
Examination c/o pain on inspiration. Tetanus current (given for previous injuries).
Pain scoring 3/10
Vital signs – T = 36.2 GCS = 15 RR = 12 P = 60 B/ P = 125/70
Last ate or drank two hours ago.

R Response & Rationale
Treatment – Paracetamol 1G taken two hours ago, patient declines further analgesia.

The CIN participant is requested to:
- Outline their assessment
- Outline their plan of care
- List the risk factors for this patient.
**Case Progression**

The patient receives the following:

Investigations – Chest X-ray
Pathology tests – Nil

Notification of relevant staff – Nurse in charge of “fast track area”. Placement in the department – depending on results, ATS category 4 to “fast track/subacute area” (no further observations required as a policy of the “fast track/subacute area” patient classed as a bony injury).

Plan – depending on results
2035 To radiology for chest x-ray

21.10 On return from x-ray her daughter says her mother is c/o of increasing pain (7/10 in her lower ribs, she feels short of breath and is sweaty and feels sick. Mrs Folley is quite agitated and her daughter has taken to answering for her mother.

21.15 The CIN takes a set of vitals – T = 35.8 gCS = 14 RR = 22 P = 98 B/P = 100/55.

21.25 The CIN notifies the senior doctor utilising ISBAR. The triage category is adjusted to category 2.

21.40 Senior doctor examines the patient and notes decreased breath sounds in right lower lung and pain on palpation over bruised area. X-ray report = # ribs 9 – 11 + a right upper lobe pneumothorax (25%) and right lower lobe atelectasis. The heart is normal in size and left lung fields are also normal. As a precaution a FAST (Focused Abdominal Sonography in Trauma) scan was performed and revealed free fluids around the liver. She is transferred to the resuscitation rooms for trauma management. The old medical notes reveal multiple admissions for falls and stumbles. However, previous admissions reveal no known cause for the injuries.

**Lessons learned/reflective points**

Discussion of local application of trauma call criteria.

**Risk factors**

- elderly
- anticoagulant, aspirin. This, unlike warfarin, has an immediate effect on blood clotting times and is designed to stop the formation of the coagulation of platelets. Therefore she is likely to bleed very early following injury.
- beta blocker and is unable to sustain a circulatory response to loss of blood volume, and is likely to become profoundly hypotensive
- Establish if this was a mechanical fall or perhaps a syncopal episode
- Injuries to the right side of the chest, especially the lower region, have the likelihood to cause damage to the liver, as it lies in the right upper quadrant and is protected by the ribs (7 – 11) and the diaphragm. In this lady’s case, applying knowledge of the elderly and trauma risks may well have resulted in senior staff intervening at an earlier stage; or at least closer observations
- The old notes did reveal a long history of bruising and sprains and hand injuries. This matter was referred to the ASET (Aged-Care Emergency Services Team) to follow up regarding Elder Abuse.
**Case Scenario 3**

09.00 CDA presentation to the ED

**I Identify**

Patient’s name – Mr Matthew Wade  
Age – 25  
Date of birth – 02/11/85.

**S Situation**

History of presentation – 22 year old male was cycling downhill at “medium speed” and as his front wheel went over a “twig” he lost control of the bike and fell down the embankment. He was found by CDA sitting by the roadside, he had removed his own helmet.  
Symptoms – painful left clavicle.

**B Background**

Relevant past medical history – nil  
Prescribed medications – nil  
Allergies – nil.

**A Assessment & Action**

Physical findings – pain over midclavicular region  
Examination – pain and swelling over midclavicular region, shoulder is in a normal position, nil deformity or pain over the acromio-clavicular joint (ACJ), nil LOC or other injuries.  
Pain scoring pain 2/10 at rest.  
Vital signs – T = 36.7 GCS = 15 RR = 16 P = 60 B/ P = 110/65 SaO2 = 98% (RA).

**R Response & Rationale**

Treatment – sling, Paracetamol 1gm.

The CIN participant is requested to:

- Outline their assessment
- Outline their plan of care
- List the risk factors for this patient.
Case Progression

The patient receives the following:
Investigations – x-ray left clavicle
Pathology tests – nil
Notification of relevant staff – Nurse in charge of “fast track area” (or sub acute)
Placement in the department – Off load from Ambulance to wheel chair ATS category 4 to “fast track area”
(no further observations required as a policy of the “fast track/ subacute area” patient classed as a bony injury).
Plan – depending on results.

09.30  Sent to X-ray = # left Clavicle
10.10 returns from X-Ray = # left Clavicle and 1st left rib and pneumothorax.

The CIN notifies the doctor utilising ISBAR.
10.20 to resuscitation room for insertion of intrathoracic catheter and a full trauma assessment.
Mr Wade was admitted for observation for two days and discharged home.

Lessons Learned/Reflective Points

Risk factors

- Clinical Handover
- Mechanism of Injury
- The twig was later revealed by the patient to be a sizeable branch off a tree and he tumbled quite a way down the embankment and felt his bone crack on impact
- This mechanism of injury would be a “red flag” to consider more serious injuries
- In physical assessment listen to the lung fields to ascertain a baseline set of observations
- Trauma call criteria.

Resources

A full list of references can be found in the Resource Manual.

Assessment criteria

There is not a formal competency for this assessment. There is an expectation that the learning activities will be completed.
2.3 Care of the Patient with a Possible Sepsis Presentation

Statement of Purpose

The aim of this module is to emphasise the importance of early recognition and prompt treatment of undifferentiated emergency patients presenting with sepsis or developing sepsis. It is aimed at enabling the CIN to recognise the patient with suspected sepsis in the waiting room and anticipate and escalate care as required.

Summary

Sepsis and septic shock are life threatening conditions, which may be difficult to diagnose. This poses challenges for clinicians as the early recognition and management of sepsis is crucial because it has a significant impact on the long term outcomes for patients in terms of morbidity and mortality. A project titled ‘Improving the recognition and management of sepsis’ conducted by the NSW Agency for Clinical Innovation and the Clinical Excellence Commission identified many areas of improvement required in the management of sepsis and septic shock. Firstly it established that the average time to antibiotics in ED is too long at 4.45 hours. It also found that the sepsis was the number one reason for initiating a MET/PACE call in the deteriorating patient.

The Resource Manual highlights the steps in the recognition of sepsis. This includes an index of suspicion for at risk patient groups and outlines the importance of early warning signs as well as late warning signs of deterioration. These ‘WHEN TO WORRY’ signs are linked with the DETECT criteria. The role of the CIN in responding to, and escalating, clinical indicators of deterioration is also highlighted.

This topic is important to include in CIN education, as clinical incidents report the failure to recognise sepsis is a major contributor to adverse patient outcomes.

The Resource Manual discusses the recognition and management of sepsis. It is clearly stated that a patient with moderate to severe sepsis is not to be in the waiting room. The steps in the management of sepsis outline the initial management and septic work up. Emphasis is placed on re-assessment which is pivotal to the CIN role.
Key Points

- Sepsis and septic shock are life threatening conditions
- Early recognition and treatment of sepsis in the undifferentiated patient has a significant impact on patient outcome
- Signs of sepsis are subtle and non specific:
  - Patients may be hypothermic
  - Patients may have a normal or low white cell count.
- Know the high risk groups:
  - Aged over 70 years
  - Infants and young children
  - Immunosuppression
  - Chronic condition.
- Recognising sepsis involves the following
  - Identify possible source of infection
  - Look for signs of systemic inflammatory response syndrome (SIRS) which includes alteration in the following physiological parameters, respiratory rate, heart rate and temperature.
- Assess for hypoperfusion which is evidenced by hypotension or elevated serum lactate level (a late sign)
- Respond and escalate when there is an identified potential for deterioration in a patient
- Sepsis management is time sensitive with recommended time to first antibiotic 1 hour.

Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

Patient Scenario

A case review is presented which highlights the challenges involved in the care of the undifferentiated patient with possible sepsis who has an extended wait in the emergency department waiting room. It discusses concerns such as failure to recognise and respond to the deteriorating patient. This may be reflected in the ATGS Category allocated. It illustrates the important role ongoing monitoring and reassessment play in the waiting undifferentiated patient. The impact of the delay to treatment is also illustrated. Other issues that were highlighted in this case were the importance of ED processes, the impact of a busy department with stretched resources on patient outcome and the role of clinical handover.

Case Scenario

An 80 year old female, who had recently been diagnosed with renal failure, presented to ED at 2200 with 10 day history of a urinary frequency and dysuria. The patient had been commenced on antibiotics by her GP but was unable to finish the course due to GIT side-effects. Past medical history was hypertension. On arrival the patient’s observations were as follows:

- Blood pressure 104/37 mmHg  Heart rate 68/min
- Oxygen saturations 95%  Respirations 28/minute
- Temperature 35.4 Celsius.

She was given ATGS Category 4 and asked to wait with her relative in the waiting room as the ED was very busy that night. No further observations were taken until 0100 when the patient’s blood pressure was noted to be 82/60. The patient was still in the ED waiting room. Two further sets of observations (B/P & pulse rate only) were done by the busy triage nurse over the next four hours with blood pressure reading documented as 82/60mmHg and no change in heart rate.
The triage nurse documented the observations but was unable to report to ED Medical staff at the time as they were busy in resus. A bed became available at 0520 hrs. The patient was then seen by the ED senior doctor at 0620. An intravenous line was established and the patient was resuscitated with 3 litres of fluid. At 0825 an IDC was inserted as the patient had not passed any urine. IV antibiotics were prescribed at this time but because of busy work commitments of the agency nurse assigned to her care they were not given for a further 2 hours.

The patient was accepted by the renal team with a diagnosis of urosepsis. At 1100hrs a bed became available and patient was transferred to the ward. She required a MET call 20 minutes after transfer. She was found to be in acute pulmonary oedema and required transfer to ICU.

**Case Progression**

On review of this case the following issues were identified

- There are indications within this case review that there was failure and limited capacity to recognise and respond to the deteriorating patient
- The triage category was not appropriate as she was in a high risk group for sepsis, with a possible source of infection and early warning signs for deterioration. Thus ATS Category 2 would be appropriate
- Patient was in the high risk group for the development of sepsis due to her age and chronic condition. Her history suggests a urinary source of infection and her initial observations placed her in the Yellow Zone (DETECT), which indicates early warning signs for deterioration
- The responsiveness of the ED clinical staff to this patients presenting with non-specific signs of sepsis was not optimal
- Monitoring of the patient was inadequate (5 sets of observations in 9 hours despite hypotension)
- Treatment was delayed and inadequate particularly around time to antibiotics and appropriate fluid resuscitation
- Other issues that impacted on this case included ED processes and staffing. There was evidence that the staff were inexperienced in the management of sepsis. Clinical handover was also inadequate and the process to escalate the deterioration of a patient was suboptimal
- There were also issues with the resuscitation and reassessment of the patient’s response to therapy. This lead to the transfer of an unstable patient.

**Discussion Points in the CIN Participant Manual**

What protocols guide the management of sepsis in your ED?

_The facilitator is asked to ensure the CIN has working knowledge of departmental sepsis guidelines._

What role have CINs played in the recognition and escalation of care for patients with sepsis?

_The facilitator is asked to discuss the role of the CIN in the recognition of sepsis._

Further suggested discussion points for the facilitator to use:

- From the case review what aspects can you relate to your workplace?
- What do you think are the main points that the case review illustrates?
- Can you suggest how this case could have been managed more effectively?
- Outline the signs of systemic inflammatory response syndrome you would assess for and explain why they occur?
- Briefly outline the main stages of the body’s response to a reduction in blood pressure.
Resources

PowerPoint presentation titled ‘Sepsis’


Kumar, A et al Duration of hypotension before initiation of effective antimicrobial therapy is the critical determinant of survival in human septic shock, Critical Care Med 2006 Vol 34 No 6 1589-1596.

Hicks P Cooper, D (on behalf of the ANZICS Board and ANZICS Clinical Trials Committee) The Surviving Sepsis Campaign: International Guidelines for management of severe sepsis and septic shock: 2008 and the Australian and New Zealand Intensive Care Society, Critical Care and Resuscitation, Volume 10 Number 1 March 2008 6-8.

A full reference list for this module can be found in the Resource Manual.

Assessment Criteria

There is not a formal competency for this assessment.
There is an expectation that the learning activities will be completed.
2.4 Care of the Patient with a Drug and Alcohol Related Presentation

Statement of Purpose

The aim of this module is to emphasise the needs and issues of patients that may present with drug and/or alcohol related dependencies. This will enable the CIN to develop a plan for assessment and management of this patient population while they await definitive care, and escalate care as required.

Summary

This module provides guidelines on undertaking comprehensive history and assessment of the patient with a drug and alcohol related presentation. This knowledge will increase the confidence and knowledge for the CIN to manage patients with these presentations who may be triaged to the waiting area, or recognise deterioration or escalation that requires action. This patient group is a high risk group and have been associated with reportable incidents.

Key Points

- The CIN must be cognisant of the major risks for drug and alcohol affected patients presenting to the ED
- It is common for drug-dependent people to present in a state of intoxication (which can complicate assessment and management of withdrawal) or overdose (which can be life-threatening). Both intoxication and overdose may require acute medical care.
- Patients affected by drugs and/or alcohol need ongoing regular assessment to monitor their condition, detect deterioration, overdose, withdrawal.
- It is important to ask the person if they are using more than one drug at a time, as polydrug use can significantly increase the risk involved.

Activities and Discussion Points

The PowerPoint presentation is aimed at using the knowledge gained in the Resource Manual to relate to common issues that arise from common presentations. Facilitators are encouraged to promote discussion and reflection using the PowerPoint presentation.

Notes are provided for the facilitator to promote discussion, but discussion need not be restricted to these discussion/scenario points.
**Case Scenario 1**

A 56 year old man presents with abrasions to the right side of his face, right arm and right knee. He states he fell overnight but he is not sure when. He states he drinks half a cask of wine per day and he would like to stop. He has a history of a 'bit of blood pressure'. No current medications. Patient is alert on arrival, smells of ETOH, emaciated appearance with a wide gait. He has been allocated a triage category 4 and is seated in the waiting room.

1. What nursing assessment are you going to do and what information do you want to obtain?
   
   *This patient requires a more inclusive history, including drug and alcohol assessment, as well as a history of the events surrounding the fall and past medical history. It is also important to talk about having an index of suspicion for underlying trauma as the events surrounding the patient’s presentation are vague and unclear.*

2. What is your CIN plan for assessment and care/diagnostics initiation for this patient while he is in the waiting room?
   
   *As well as further history this patient requires a physical exam (in a private area), vital signs, alcohol withdrawal assessment and neurological assessment.*
   
   *Plan of care should include ongoing assessment while in the waiting room (esp. of this patient's red flags). Diagnostics may be related to specific protocols but should include Pathology, ECG, and BSL.*

3. What are the available referral options for ongoing management of his alcohol dependence?
   
   *Answers will depend on local arrangements.*

**Case Scenario 2**

15 y/o Sally has presented to the ED at 11pm with her boyfriend Jason who is 19. She has a laceration to her left hand which she states occurred when she fell out of a shopping trolley she was riding in at the park. She has been triaged to the waiting room and allocated a triage category 5. Over the first hour you notice the Sally seems quite agitated, unable to sit still. Her boyfriend is not paying much attention to this, sitting and watching television.

1. What concerns does this case raise?
   
   *Issues that could be discussed include: possible illicit drug use, concerns for child safety – what are the duty of care issues/mandatory reporting issues for this patient, contacting parents. Discuss strategies to approach this patient, and concerns CINs may have about escalating behaviours that may occur in this situation.*

2. What nursing assessment are you going to do and what information do you want to obtain?
   
   *This patient requires a more inclusive history, including drug and alcohol assessment, as well as a history of the events surrounding incident. The consideration of the use of amphetamines in this case is warranted.*

3. What is your CIN plan for assessment and care/diagnostics initiation for this patient?
   
   *As well as further history this patient requires a physical exam (in a private area) and vital signs.*
   
   *Duty of care issues need to be addressed.*

Develop scenarios based on cases that may have occurred in your ED or experience.
Resources


Assessment Criteria

There is not a formal competency for this assessment.
There is an expectation that the learning activities will be completed.
2.5 Care of the Paediatric Patient

Statement of Purpose

The aim of this module is to emphasise the role and responsibilities of the CIN in relation to infants, children, adolescents and their parents/carers in the ED waiting room. In this module child, children or paediatric patients refers to infants, children and adolescents unless otherwise specified and parents also includes carers.

Summary

This module is to be included in CIN program for nurses working in mixed or paediatric EDs. It aims to build on knowledge available in established resources for ED nurses such as: Paediatric Clinical Guidelines e-learning package http://doh.edmore.com.au/login.php or the Emergency Triage Education Kit (ETEK). It complements these resources with a focus on addressing the specific care of the paediatric patient and their carer in the waiting room.

There is some duplication of information as it is necessary to discuss red flags, however it is assumed that the CIN has completed the e-learning and has access to the ETEK as a reference guide.

The facilitator will need to address the specific local protocols for paediatric care initiation and analgesia provision to this patient group.

Activities and Discussion Points

There is a PowerPoint presentation developed to supplement the participant education on this topic.

Case Scenario

Tracy is a four year old child who is known to have infrequent, episodic asthma who is in the ED waiting room one hour post presentation to triage.

The triage nurse classified Tracy’s exacerbation of asthma as being mild, allocated a triage category 4 and asked the CIN to review Tracy after one hour.

The triage history and examination reveal that on presentation Tracy had no signs of increased work of breathing and had a variable wheeze. Tracy’s temperature was 36.8°C, heart rate 146 BPM, RR 32/min and her oxygen saturation was 96% in room air at triage. Tracy was last given Salbutamol via a puffer thirty minutes prior to arrival.

What nursing assessment are you going to do as the CIN and what information do you want to obtain from Tracy and her parents/carer?

Answers should note the red flags that were present at the time of triage. CIN approach should be to ABCD, further history and examination. Gaining valuable information from the child and the parent regarding past history, ongoing management and the course of this presentation will aid the CIN in planning care.
Case Progression

Whilst you are interviewing Tracy you notice she is quiet and pale and not able to speak more than a few words. Tracy is sitting upright and has a moderate tracheal tug with sub sternal recessions. On chest auscultation you find that Tracy has prolonged bilateral expiratory wheezes with decreased air entry in both bases. Tracy’s heart rate is 160 BPM, RR 40/min and oxygen saturation is now 92% in room air.

As the CIN, what are your actions now?

Escalation of care is required.

Tracy’s mother appears anxious and informs you that Tracy has started to cough more in the waiting room and asks why Tracy didn’t get taken in to see the doctor straight away.

What is your response to this questioning?

Answers should include principles of conflict management, addressing parental concerns and de-escalating a situation that has potential to worsen. CINs should also address feedback to triage regarding this situation.

Learning Activity 2 Discussion points

The following discussion questions are in the Participant Manual. There may be more that are useful for your ED.

What resources are available in your ED/waiting room to:
- Make the waiting room ‘paediatric friendly’?
- Allow the CIN to initiate care (what protocols are there?)
- Provide education to parents while they are waiting?

Develop scenarios based on local ED protocols and specific patient population needs.

Resources

The Children’s Hospital at Westmead (2005) Guidelines for the Role of the CHW ED CIN.
http://intranet.kids/ou/emergency/resources/triage/cin_role.pdf

A full reference list for this module can be found in the Resource Manual.

Assessment Criteria

There is not a formal competency for this assessment. There is an expectation that the learning activities will be completed.
2.6 Care of the Geriatric Patient

Statement of Purpose

The aim of this module is to emphasise the role of CIN in the assessment and management of the elderly patient within the emergency department waiting room. This will enable the CIN to develop an understanding of the specific needs of the elderly patient and their carers, as well as develop plans for their assessment and care initiation in the waiting room.

Summary

Emergency Departments are difficult and stressful places for vulnerable elderly patients. However, elderly patients regularly present to Emergency Departments with about one third of all hospital presentations in this age group. Elderly patients offer a challenge to emergency nurses as they are at significant risk of deterioration due to the following:

- Physiological changes of aging
- Polypharmacy
- Nutritional complications
- Age related disease.

Considering each of these factors and the way the ED service is structured, waiting undifferentiated elderly patients offer many challenges to CIN’s. Aging progressively changes all body systems and contributes to the elderly person’s capacity to respond and recover from illness or injury. Differentiating the normal physiological changes associated with aging from the symptoms of a new illness can be difficult but once this information is obtained early detection of risks to the patient’s health ensures ongoing assessments and plans of care are appropriate. The Resource Manual highlights these age-related changes and their significance to the clinical assessment and initial management.

Activities and Discussion Points

A PowerPoint presentation has been supplied to assist with face to face learning and to highlight the key points.

Activity 1

The referral to speciality geriatric teams is a valuable way of ensuring the unique needs of this population group are considered. A clinical example of using this strategy is included in the Participant Manual. It illustrates the positive impact on the elderly patient journey which can be made by the speciality team working closely with the ED clinical team.

Questions:

- From the clinical example what aspects can you relate to in your role as CIN?
- What do you think are the main points that the clinical example is trying to make?
■ What are some examples of poor outcomes when elderly patients are discharged from ED?
■ Can you suggest how these poor outcomes can be anticipated and addressed by the CIN, who is involved in the initial assessment of the waiting elderly patient?

**Case Scenario**

A PowerPoint presentation covering the physiological changes of aging has been developed and included in this education program. The Participant Manual guides the participant to relevant sections of this presentation to assist with completing the following learning activity.

**Activity 2**

The final teaching strategy in this module is a patient scenario, with the key learning outcomes from this structured learning activity being:

- early recognition of the deteriorating elderly patient
- patient focused assessment and interventions
- prioritisation and communicating relevant information
- seeking assistance and ensuring appropriate referral
- monitoring and documentation.

You commence your day in the CIN role and notice a 79 y/o female sitting in the waiting room supporting her right wrist. She is pale and guarding her right arm which is in a sling. You review the triage assessment which states she ‘fell onto her arm at 2am this morning. She is in no obvious distress and has a history of NIDDM and recent L shoulder dislocation.’

1. As the CIN outline your assessment of this waiting patient?

   **ABCD, history, examination – consider risk factors – age, NIDDM, nutritional status, explore the history surrounding the fall and recent shoulder dislocation. Limb and pain assessment. Consideration of relevant diagnostic tests including x-ray/pathology.**

2. What age related changes would you consider in your assessment? Discuss how these changes would influence your management of the patient?

   **Answer should include the physiological changes discussed in the Resource Manual/PowerPoint presentation and raise the index of suspicion for underlying injuries and medical conditions.**

3. This is a common scenario. Improving the recognition and management of the elderly patient who has the potential to deteriorate requires not one single “piece of information” but the bringing together of several pieces of a puzzle. What might suggest this patient is sicker and more complex than originally established at triage?

   **The discussion should focus on the following salient points:**

   - **Assess for potential Red Flags**
     - Potential cardiovascular problem
     - Potential metabolic problem eg low sugar
     - Potential for sepsis
     - Potential head injury/cerebral haemorrhage
     - Potential chest injury
     - Potential arm injury
     - Potential social issues.
Resources

A full reference list for this module can be found in the Resource Manual.

Assessment Criteria

There is not a formal competency for this assessment.
There is an expectation that the learning activities will be completed.
2.7 Care of the Pregnant Patient

Statement of Purpose

The aim of this module is to emphasise the importance of observation, review and effective communication with patients who have early pregnancy related presentations and are triaged to the waiting room. This will enable the CIN to recognise ‘red flags’ in this patient population and plan care for the patient while they are in the waiting room.

Summary

This module focuses on the care of the pregnant patient in the waiting room. As the most common presentation to ED in this patient group is bleeding in early pregnancy this is the main focus of the module. The module discusses the physical care of the patient as well as the emotional and educational needs that have been identified in reviews and research. CINs are encouraged to utilise the ‘Maternity Emergency Guidelines for Registered Nurses’ (2007), a resource which has been made available by NSW Health to all EDs.

This module is optional – as some sites do not see pregnancy related presentations. However it is to be used as a basis of CIN education in EDs that cater for this population.

Activities and Discussion Points

There is not a PowerPoint presentation developed to supplement the Resource Manual on this topic.

Activity 1 Familiarisation with local resources

The following questions are in the Participant Manual.

■ Is there an EPU or EPAS service in your facility? If so, what are the referral criteria for patients?
  What is the role of the CIN in the referral process?
■ What educational resources are available for pregnant patients with bleeding in early pregnancy?
  Where are they located?

Learning Activity 2 Case Scenario

A 36y/o female who is 13/40 pregnant has presented with mild PV bleeding and abdominal pain. She is seated in the waiting room with a triage category of 4. You note she is alone and awaiting clinical review. You introduce yourself as the CIN and take her to the CIN area for a review 1 hr after presentation.

1. Outline your CIN assessment priorities

   ABCD, History, including obstetric history and vital signs, pain assessment, bleeding assessment, social history assessment.
2. What is your nursing plan for this patient?

   *Answers will depend on local referral services. If no alternate referral service is available the plan should include regular review of physical status, blood loss, supplying the patient with information and instructions on the importance of contacting the CIN or Triage Nurse if concerned or they need to go to bathroom, and working with the patient to meet psychosocial needs (do they want to contact a support person, do they need social work support etc.)*

3. The patient begins to cry and asks you, am I going to lose my baby? What is your response/how would you manage this situation?

   *Answers should include the need to take the patient to a private area, allow the patient to express their concerns, being honest, arranging support.*

### Resources

A full reference list for this module can be found in the Resource Manual.

### Assessment Criteria

There is not a formal competency for this assessment.

There is an expectation that the learning activities will be completed.
Section 3

3.1 CIN Documentation

Statement of Purpose

The aim of this module is to emphasise the importance of nursing documentation whilst working in the CIN role and clarify the documentation requirements for the CIN.

Summary

The content provided for the participant in this module is listed under the following headings.

- Documentation mediums
- Medico-legal obligations regarding documentation
- Documentation of CIN assessment
- Formats used to document assessment
- Important aspects of relevant CIN documentation.

CINs need to be familiar with local requirements for documentation. Additionally NPs and Medical staff must be aware of the location of CIN notes to reduce the risk of duplication of assessment and interventions.

Key Points for the CINs

- Documentation should be consistent with NSW Health and Local Health Network standards
- The format for documentation will vary based on Local Health Network policy.

Activities and Discussion Points

There is a PowerPoint presentation developed to supplement the Resource Manual on this topic.

Activity 1  Familiarisation with local resources

What is the standard format for documenting your CIN assessment and the minimum documentation requirements for the CIN role in your ED?

Expectation of CIN documentation in local environment
Acceptable documentation format in local environment
CIN documentation in relation to local standing orders, policies and procedures
Escalation protocols in the emergency department for actioning/documenting abnormal findings.
Activity 2  Documentation activity

Mrs Bloggs is a 53-year-old female who presents with RUQ pain for 3 days. She has a background history of hypertension and asthma. Her pain is described as constant dull pain which she rates as 5/10. Vital signs are BP 153/98, pulse 68, RR 15, Temperature 35.9°C. On examination her abdomen is soft, tender in RUQ. Pt is nauseated. IV cannula inserted, bloods taken – FBC, EU/C’s, LFT’s and patient given IV Morphine and Maxalon with good effect as pain now settled. Awaiting medical review.

Document this presentation according to the method the CIN uses in your ED/LHN.

Examples of documentation guidelines are included in the PowerPoint presentation. Discuss the method used in your ED/LHN with the CIN participant/s and give feedback on their example.

Activity 3  Using examples of practice

- Find three examples of CIN documentation in your emergency department. Identify the reasons that you think the documentation meets or does not meet the appropriate standard. If it does not meet the standard highlight the reasons you feel the documentation could be improved. Discuss the enablers and barriers to CIN documentation.
- The facilitator is asked to review/critique the participant’s CIN documentation to ensure it meets required standards.

Resources

Local department policies on documentation, CIN role guidelines and standards.

NSW Health policies:


Care Records
- PD2007_077 Medication Handling in NSW Public Hospitals
- PD2005_268 Emergency Department Patients Awaiting Care.

Assessment Criteria

There is not a formal competency for this assessment.

The CIN’s skills in documentation will be evaluated during preceptored time in the role.

Evaluation criteria are based on:
- Demonstrated ability to record relevant information using a systematic approach, in the format endorsed by the ED.
Appendix 1

Respiratory Assessment

Statement of Purpose

The aim of this module is to emphasise the importance of an accurate respiratory assessment to inform appropriate management strategies. This will enable the CIN to re-assess the patient with a respiratory presentation and develop a plan of care for the patient while they are in the waiting room.

Summary

This module may be optional. It is expected that the ED nurse working in the CIN role can meet the competency level for a comprehensive respiratory assessment. Respiratory problems account for a significant proportion of emergency presentations. Symptoms may range from mild to immediately life threatening. It is imperative that the CIN has the ability to identify early signs of respiratory compromise as well as the patient in respiratory distress.

This skill is important in enabling the nurse to:

- Re-assess patients who have been waiting, to detect changes in acuity
- Determine if diagnostic tests or interventions are required and the suitable tests that may be indicated
- Articulate and document the assessment in a professional manner.

It is recognised that nurses who are commencing the CIN role may already have this skill.

A competency assessment has been provided. If the participant demonstrates mastery in this skill prior to commencing the program they will not be required to complete this module.

Activities and Discussion Points

There is a PowerPoint presentation developed to supplement the Resource Manual on this topic.

Activity 1  Case Scenario

You are asked to review and commence treatment on a 42 year old woman. She has presented to ED via ambulance with increased shortness of breath, and has been in the waiting room for an hour. Her family is concerned because she is becoming agitated and hyperventilating.
**CIN History and Examination**

Her partner reports she has a recent chest infection and worsening shortness of breath over the past 2 days. She has a past medical history of asthma. Physical exam reveals: the patient is leaning forward with hands on knees, she is speaking in short phrases, her respiratory rate is 38 breaths/minute. She is pursed lip breathing, pale, nails are dusky coloured. On palpation, the radial pulse is rapid and thready. The patient is alert and orientated.

1. As the CIN, where would you be advocating this patient be managed?
   a) waiting room
   b) sub acute
   c) acute
   d) **resuscitation bay**.

2. Which physical assessment findings would indicate acute deterioration in this patient?
   a) recent chest infection with increased shortness of breath
   b) **tripoding, short phrases, peripheral cyanosis, tachypnoea, pursed lip breathing**
   c) history of asthma
   d) elderly.

3. Relevant historical indicators of risk in an asthma presentation include:
   a) **past history of intubation and admission to HDU/ICU, or previous ED presentations for asthma**
   b) recent chest infection
   c) quiet inspiratory and expiratory wheeze
   d) ongoing possible exposure to known allergen.

4. You complete spirometry with your patient. What FEV1: FVC value would be indicative of obstructive respiratory disease?
   a) FEV1: FVC ratio of greater than 70%
   b) **FEV1: FVC ratio of less than 80%**
   c) FEV1: FVC ratio of greater than 80%
   d) FEV1: FVC ratio of less than 70%.

**Resources**

A full reference list for this module can be found in the Resource Manual.

**Assessment Criteria**

Accreditation requires mastery of the Respiratory Assessment Competency. (Assessment Document 6).
Appendix 2

Abdominal Assessment

Statement of Purpose

The aim of this module is to provide the clinician with the ability to perform a systematic approach to abdominal assessment and identify those patients that are at risk of an acute abdomen.

Summary

This module may be optional. It is expected that the ED nurse working in the CIN role can undertake a comprehensive abdominal assessment. Abdominal pain is one of the most common presenting problems for patients attending emergency departments. It can be the hallmark of diseases that are very minor through the spectrum to life threatening. The detection of changes in the patient’s symptoms can provide vital information as to the progression of the underlying disorder and the emergence of worsening disease states.

This skill is important in enabling the nurse to:
- Re-assess patients who have been waiting to detect changes in acuity
- Determine if diagnostic tests or interventions are required and the suitable tests that may be indicated
- Articulate and document the assessment in a professional manner.

It is recognised that nurses who are commencing the CIN role may already have this skill.

A competency assessment has been provided. If the participant demonstrates mastery in this skill prior to commencing the program they will not be required to complete this module.

Activities and Discussion Points

There is a PowerPoint presentation developed to supplement the Resource Manual on this topic.

Activity 1  Case Scenario

Mr Smith is a 20 year old male that presents to the emergency department on Sunday morning. He had been drinking on Friday night and since then has had a dull ache in his umbilical area which has now moved to the right lower quadrant. He had been vomiting since Friday but thought it was just because he had been drinking. In the waiting room he looks uncomfortable sitting in the chair and he is reluctant to move.

1. What other information would you like to know?  
   *Clinical history of current presentation, past history, medications (AMPLE), and pain assessment.*

2. How would you assess Mr Smith?  
   *Take him to a private area and use the systematic approach to abdominal assessment as outlined in the Resource Manual/competency.*
3. What diagnostic tests would you initiate?
   *Depending on findings (assuming RLQ tenderness) use local protocols to order pathology.*

4. Discuss analgesia options for Mr Smith.
   *Will be dependent on local standing orders and pain assessment – Opioids would be the drug of choice in this scenario.*

**Resources**

A full reference list for this module can be found in the Resource Manual.

**Assessment Criteria**

Accreditation requires mastery of the Abdominal Assessment Competency. (Assessment Document 7).
1.1 Exam Questions – short answer/multiple choice

Participants are required to achieve a minimum mark of 80%.

Part 1 Pain Pathophysiology & Assessment

1) Pain may be defined as: (1 mark)
   a) an unpleasant sensation
   b) a subjective and personal experience
   c) whatever the person says it is
   d) all of the above
   e) none of the above.

2) Pain is the 5th vital sign. Name two (2) pain assessment tools you can utilise to measure adult or paediatric patient’s pain? (2 marks)

3) When assessing your patient’s pain and pain score, the emergency nurse should take into account both subjective and objective data. (1 mark)
   a) TRUE
   b) FALSE.

4) The nursing pain assessment is a 3 step process. Name these steps: (3 marks)
   a) _______________________
   b) _______________________
   c) _______________________

5) Chronic pain is usually persistent or recurrent. (1 mark)
   a) TRUE
   b) FALSE.
6) Drug tolerance occurs for patients who have taken opioids for long periods and requires re-calculation of drug doses to effectively manage new, acute pain. (1 mark)
   a) TRUE
   b) FALSE.

7) Visceral pain may be described as dull, cramping or colicky and is often poorly localised. (1 mark)
   a) TRUE
   b) FALSE.

8) When assessing a person’s pain you should utilise the bio-psycho-social model which recognises that physiological, psychological and environmental factors influence the persons overall pain experience. (1 mark)
   a) TRUE
   b) FALSE.

9) You are administering standing order medications according to the 5 ‘Rs’. What are these? (5 marks)
   a) ______________________
   b) ______________________
   c) ______________________
   d) ______________________
   e) ______________________

10) The Faces Pain Scale – Revised (FPS-R) is intended to guide the patient to describe their pain, not for others to decide how their face looks. (1 mark)
    a) TRUE
    b) FALSE.

11) Somatic pain may be described as sharp, hot or stinging and is generally well localised. (1 mark)
    a) TRUE
    b) FALSE.

12) Acute pain can be associated with anxiety and hyperactivity of the sympathetic nervous system which results in the patient exhibiting symptoms such as tachycardia, hypertension and hyperventilation. If the patient does not exhibit these symptoms they do not have pain: (1 mark)
    a) TRUE
    b) FALSE.

13) List at least three (3) examples of non-pharmacological pain relief methods. (3 marks)
14) Acute pain is usually expected to last for a short period of time and is usually less than (1 mark).
   a) 12 months
   b) 6 months
   c) 3 months
   d) 1 month

15) When assessing a child’s pain the measuring tool must take into account a child’s age, cognitive level, type of pain and the situation in which it is occurring. (1 mark)
   a) TRUE
   b) FALSE.

Part 2 Medico-legal Considerations of using Standing Orders

16) How long after a NIA has been administered must the statim order be signed? Who is responsible for ensuring the order is signed? (2 marks)

17) What nursing assessment and documentation will you attend within the hour after administration of a standing order? (1 mark)

Part 3 Generic Questions about Paracetamol (Based on Policy PD2006_004)

18) NSW Health Policy Directive on Paracetamol Use recommends that rectal paracetamol is erratically absorbed and is not usually recommended. (1 mark)
   a) TRUE
   b) FALSE.

19) Which of the following products contain paracetamol? (circle all those that do) (1 mark).
   a) Tylenol
   b) Lemsip Lemon Powder
   c) Mersyndol
   d) Day and Night cold and flu capsules
   e) Diclofenac.
20) What is the recommended maximum daily dose of Paracetamol based on weight? For Paediatrics? For adults? (2 marks)

21) What precautions must be undertaken when calculating doses of paracetamol on persons who are underweight, overweight or obese? (1 mark)

22) When recording the dose of Paracetamol liquid administered must it be recorded in mLs or mgs? Why? (2 marks)

Part 4  Generic Questions about Opioids

23) Name at least five (5) possible adverse effects of morphine. (5 marks)

24) What is the reversal agent for opiate narcotic administration? (1 mark)
   a) Naloxone
   b) Amethocaine
   c) Methadone
   d) Anexate
   e) None of the above.
1.2 Exam Answers – short answer/multiple choice

Part 1 Pain Pathophysiology & Assessment

1) Pain may be defined as: (1 mark)
   a) an unpleasant sensation
   b) a subjective and personal experience
   c) whatever the person says it is
   d) all of the above
   e) none of the above.

2) Pain is the 5th vital sign. Name two (2) pain assessment tools you can utilise to measure adult or paediatric patient’s pain? (2 marks)

   Wong Baker, Faces – R, FLACC, Alder Hey Triage Pain Score VRNS, NRS, Abbey Pain Scale (others if used in your ED).

3) When assessing your patient’s pain and pain score, the emergency nurse should take into account both subjective and objective data. (1 mark)
   a) TRUE
   b) FALSE.

4) The nursing pain assessment is a 3 step process. Name these steps: (3 marks)
   a) History of presentation
   b) Physical Examination
   c) Pain History.

5) Chronic pain is usually persistent or recurrent. (1 mark)
   a) TRUE
   b) FALSE.

6) Drug tolerance occurs for patients who have taken opioids for long periods and requires re-calculation of drug doses to effectively manage new, acute pain. (1 mark)
   a) TRUE
   b) FALSE.
7) Visceral pain may be described as dull, cramping or colicky and is often poorly localised. (1 mark)
   a) TRUE
   b) FALSE.

8) When assessing a person’s pain you should utilise the bio-psycho-social model which recognises that physiological, psychological and environmental factors influence the person’s overall pain experience. (1 mark)
   a) TRUE
   b) FALSE.

9) You are administering standing order medications according to the 5 ‘Rs’. What are these? (5 marks)
   a) Right Patient
   b) Right Drug
   c) Right Dose
   d) Right Time
   e) Right Route.

10) The Faces Pain Scale – Revised (FPS-R) is intended to guide the patient to describe their pain, not for others to decide how their face looks. (1 mark)
    a) TRUE
    b) FALSE.

11) Somatic pain may be described as sharp, hot or stinging and is generally well localised. (1 mark)
    a) TRUE
    b) FALSE.

12) Acute pain can be associated with anxiety and hyperactivity of the sympathetic nervous system which results in the patient exhibiting symptoms such as tachycardia, hypertension and hyperventilation. If the patient does not exhibit these symptoms they do not have pain: (1 mark)
    a) TRUE
    b) FALSE.

13) List at least three (3) examples of non-pharmacological pain relief methods. (3 marks)
    Therapeutic touch, Heat or cold compresses, Acupressure, Play therapy/distraction therapy, Positioning, General comfort measures, Guided imagery, RICE – Rest, Ice, Compression, Elevation (splinting) Relaxation, Keeping patient informed and reassured.

14) Acute pain is usually expected to last for a short period of time and is usually less than (1 mark).
    a) 12 months
    b) 6 months
    c) 3 months
    d) 1 month.

15) When assessing a child’s pain the measuring tool must take into account a child’s age, cognitive level, type of pain and the situation in which it is occurring. (1 mark)
    a) TRUE
    b) FALSE.
Part 2  Medico-legal Considerations of using Standing Orders

16) How long after a NIA has been administered must the statim order be signed?
   Who is responsible for ensuring the order is signed? (2 marks)
   The drug order must be co-signed by a Medical officer (MO) within 4 to 24 hours from the time of administration (or as determined by your local policy). It is the responsibility of the nurse initiating treatment, to ensure that the MO co-signs this order as soon as possible.

17) What nursing assessment and documentation will you attend within the hour after administration of a standing order? (1 mark)
   Document the process of patient review and reassessment of pain score following the drug administration to establish the effectiveness of treatment.

Part 3  Generic Questions about Paracetamol (Based on Policy PD2006_004)

18) NSW Health Policy directive on Paracetamol use recommends that rectal paracetamol is erratically absorbed and is not usually recommended. (1 mark)
   a) TRUE
   b) FALSE.

19) Which of the following products contain paracetamol? (circle all those that do) (1 mark).
   a) Tylenol
   b) Lemsip Lemon Powder
   c) Mersyndol
   d) Day and Night cold and flu capsules
   e) Diclofenac.

20) What is the recommended maximum daily dose of Paracetamol based on weight? For Paediatrics? For adults? (2 marks)
   Paeds and adults: 60mg/kg/day
   Adult: 4gm/day.

21) What precautions must be undertaken when calculating doses of paracetamol on persons who are underweight, overweight or obese? (1 mark)
   For those with obesity, Paracetamol should be calculated according to lean body weight, not actual body weight. For those underweight, a lower dose may be required.

22) When recording the dose of Paracetamol liquid administered must it be recorded in mLs or mgs? Why? (2 marks)
   There are several different preparations of varying strengths, thus we must know what actual dose in mgs the patient has had. It is worked out on mgs/kg per dose, and as a daily amount.
**Part 4  Generic Questions about Opioids**

23) Name at least five (5) possible adverse effects of morphine. (5 marks)

- Constipation, light-headedness, dizziness, sedation, sweating, nausea and vomiting, dysphoria, euphoria and urine retention.
- Acute Opioid Toxicity that is manifested by a triad of symptoms
  - Coma
  - Respiratory Depression
  - Pinpoint Pupils.

24) What is the reversal agent for opiate narcotic administration? (1 mark)

  a) Naloxone
  b) Amethocaine
  c) Methadone
  d) Anexate
  e) None of the above.
Assessment Document 2

2.1 Sample Questions for application of commonly used Standing Orders for CINs – Adults & Paediatrics

These are sample questions only, they are not exhaustive, and do not cover all drugs addressed in the pharmacology module, and do not need to be used if local sites have suitable, pre-existing assessments.

Part 1 Application Questions – Adults

1) A 58 year old male presents with left loin pain that he rates as 10/10. He is too uncomfortable to sit down and is pacing, in obvious pain. There are 2 other patients waiting to be triaged and 8 more patients in the waiting room and the ED beds are full. He has been triaged category 2 and you have been asked to help him. What will you do for this patient? (2 marks)

2) Mrs Jones is a 65 year old lady with chronic renal failure who presents to triage with a fractured (L) radius & ulna which occurred yesterday. She complains that she was given ibuprofen to take home, but has not taken it as she remembers her GP told her not to take NSAID’s.
   a) Why is ibuprofen contraindicated in this patient? (1 mark)
   b) She is requesting further analgesia for moderate pain, what is your action? (1 mark)

3) An hour after administrating morphine to an elderly lady on reassessment her BP is 90/55, her GCS is 13 and she is acutely confused. What are your actions and why? (1 mark)
4) Mr Smith is a 40 year old man who presents pale and sweaty and complains of sudden onset of severe right-sided flank/loin pain. He has been given a triage score of 3 and pain score of 8/10. What nursing assessment of this patient is required prior to implementing a standing order of morphine? (If there is not a standing order in your dept – what needs to be assessed prior to administering Morphine as ordered?) (2 marks)

5) You have chosen to administer Morphine for this man, what dose will you choose? (1 mark)
   a) 5-10mg Morphine IM
   b) 2.5mg Morphine IV Stat
   c) 7.0mg Morphine IV every 5 mins
   d) 2.5mg Morphine IV increments until pain is resolved
   e) 2.5mg Morphine IV increments to a maximum of 10mg.

6) A 68 year old non-english speaking lady presents with cellulitis of her left calf. She appears distressed, calling out and unable to sit still. She is unable to specify how severe her pain is using the numerical or VAS pain score. Her daughter, who is translating for her, tells you she is stating her pain is “terrible”. She has not had any pain relief today, but did take panadeine yesterday which the daughter tells you did not help. Her past medical history includes insulin-requiring diabetes. She also takes a blood pressure tablet but can’t remember the name of it. How do you manage this patient’s pain and why? (3 marks)

7) What time frame is appropriate between administration of incremental morphine doses for someone with acute pain who is young fit and healthy? (1 mark)
   a) 3-5 minutes
   b) 7-10 minutes
   c) when time permits
   d) when the patient asks for more.
8) A 77 year old male presents with a dull frontal headache that he has had for 3 days. His BP is 210/100, HR 85 and has not taken any Panadeine Forte® for 4 hours. He presents requesting for some more Panadeine Forte®.
   a) What is your response to him (1 mark)

   b) How will you manage this patient and why? (1 mark)

Part 2  Application Questions – Paediatrics

1) Melanie is a 6 year old girl who presents with her mother after falling off her trampoline at home landing onto an outstretched hand. On examination she is complaining of a painful right wrist, with no obvious deformity.
   a) What pain scale will you utilise to assess her pain and why? (1 mark)

   b) She states her pain score is 6/10. What analgesia will you order and why? (1 mark)
2) Ben is a 12 year old boy who presents to triage in the morning following a sudden onset of generalised abdominal pain last night. His bowels have not been open for the past 5 days. His pain score is 5/10 and his mother gave him Panadeine at home and is asking for further analgesia. He has been assigned to the waiting room with a Triage Category of 3. (His weight is 60kgs) What nursing assessment and interventions will you do and why? (2 marks)

3) You are going to administer Paracetamol and Ibuprofen to 3 year old Claire who weighs 20kgs.
   a) Is it safe to administer these medications at the same time? What formula will you use to calculate the dose of these medications? (1mark)

   b) What dose(s) will you administer? (1 mark)

   c) An hour later you go to reassess Claire’s pain score and you find she is still in pain. Her father is demanding more analgesia. What is your action and why? (1 mark).

4) What is the Ibuprofen dose for a 10 year old child with a suspected sprained left wrist? (1mark)
   i) 20mg/kg
   ii) 15mg/kg
   iii) 10mg/kg
   iv) 5mg/kg
   v) None of the above.
2.2 Answers to the Questions for application of commonly used Standing Orders for CINs – Adults & Paediatrics

Part 1 Application Questions – Adults

1) A 58 year old male presents with left loin pain that he rates as 10/10. He is too uncomfortable to sit down and is pacing, in obvious pain. There are 2 other patients waiting to be triaged and 8 more patients in the waiting room and the ED beds are full. He has been triaged category 2 and you have been asked to help him. What will you do for this patient? (2 marks)

   a) Answers will be based on local arrangements. Ideally a place to assess and manage this patient’s pain with IV opioids should be found as a priority (liaising with the In Charge role).

2) Mrs Jones is a 65 year old lady with chronic renal failure who presents to triage with a fractured (L) radius & ulna which occurred yesterday. She complains that she was given Ibuprofen to take home, but has not taken it as she remembers her GP told her not to take NSAID’s.

   a) Why is Ibuprofen contraindicated in this patient? (1 mark)

   Ibuprofen reduces renal perfusion and can worsen renal failure.

   b) She is requesting further analgesia for moderate pain, what is your action? (1 mark)

   Undertake a patient assessment (history, physical examination and pain history). CIN interventions will be based on this history and local guidelines. The CIN may not prescribe ‘take home’ medications.

3) An hour after administrating morphine to an elderly lady on reassessment her BP is 90/55, her GCS is 13 and she is acutely confused. What are your actions and why? (1 mark)

   Stay with the patient, assess ABCD, administer oxygen, request urgent medical review and prepare for resuscitation and administration of Naloxone.

4) Mr Smith is a 40 year old man who presents pale and sweaty and complains of sudden onset of severe right-sided flank/loin pain. He has been given a triage score of 3 and pain score of 8/10. What nursing assessment of this patient is required prior to implementing a standing order of morphine? (If there is not a standing order in your dept – what needs to be assessed prior to administering Morphine as ordered?) (2 marks)

   Answers will be based on local standing orders, but should include as a minimum; set of vital signs, quick history to rule our contra-indications and previous allergies, somewhere to lay the patient down.
5) You have chosen to administer morphine for this man, what dose will you choose? (1 mark)
   a) 5-10mg morphine IM
   b) 2.5mg morphine IV Stat
   c) 7.0mg morphine IV every 5 mins
   d) 2.5mg morphine IV increments until pain is resolved
   e) 2.5mg morphine IV increments to a maximum of 10mg.

   **Answers will be based on local standing orders.**

6) A 68 year old non-English speaking lady presents with cellulitis of her left calf. She appears distressed, calling out and unable to sit still. She is unable to specify how severe her pain is using the numerical or VAS pain score. Her daughter, who is translating for her, tells you she is stating her pain is “terrible”. She has not had any pain relief today, but did take panadeine yesterday which the daughter tells you did not help. Her past medical history includes insulin-requiring diabetes. She also takes a blood pressure tablet but can’t remember the name of it.

   How do you manage this patient’s and why? (3 marks)

   **Answers will be based on local standing orders. Suggest that as this patient does not speak English and has severe pain, that there is an inability to obtain an accurate history at this stage, hence her care needs should be escalated, also a recommendation for health interpreter made.**

7) What time frame is appropriate between administration of incremental morphine doses for someone with acute pain who is young fit and healthy? (1 mark)
   a) 3-5 minutes
   b) 7-10 minutes
   c) when time permits
   d) when the patient asks for more

8) A 77 year old male presents with a dull frontal headache that he has had for 3 days. His BP is 210/100, HR 85 and has not taken any Panadeine Forte® for 4 hours. He presents requesting for some more Panadeine Forte®.

   a) What is your response to him (1 mark)

   **This patient requires a history and examination (including history of recent analgesia).**

   b) How will you manage this patient and why? (1 mark)

   **This patient requires escalation of care based on between the flags criteria – needs full history and head to toe assessment – not suitable for waiting room and CIN pain management.**
Part 2  Application Questions – Paediatrics

1)  Melanie is a 6 year old girl who presents with her mother after falling off her trampoline at home landing onto an outstretched hand. On examination she is complaining of a painful right wrist, with no obvious deformity.
   a)  What pain scale will you utilise to assess her pain and why? (1 mark)
       FACES or Wong Baker (self report scales, or other locally approved scale).
   b)  She states her pain score is 6/10. What analgesia will you order and why? (1 mark)
       Answers will be based on local standing orders.

2)  Ben is a 12 year old boy who presents to triage in the morning following a sudden onset of generalised abdominal pain last night. His bowels have not been open for the past 5 days. His pain score is 5/10 and his mother gave him Panadeine at home and is asking for further analgesia. He has been assigned to the waiting room with a Triage Category of 3. (His weight is 60kgs) What nursing assessment and interventions will you do and why? (2 marks)
       Undertake a patient assessment (history, physical examination and pain history). CIN interventions will be based on this history and local guidelines. Facilitators marking this question should look for evidence of critical thinking and the CIN utilising the options available to them.

3)  You are going to administer Paracetamol and Ibuprofen to 3 year old Claire who weighs 20kgs.
   a)  Is it safe to administer these medications at the same time? What formula will you use to calculate the dose of these medications? (1mark)
       Answers will be based on local standing orders. The CIN needs to ensure the patient is well hydrated, with no contra-indications.
   b)  What dose(s) will you administer? (1 mark)
       Answers will be based on local standing order, ensure the answers are given in mgs not mLs.
   c)  An hour later you go to reassess Claire’s pain score and you find she is still in pain. Her father is demanding more analgesia. What is your action and why? (1 mark).
       Answers will be based on local guidelines. At this point, if the end of CIN protocols have been reached, the CIN will be required to refer the child for further management.

4)  What is the Ibuprofen dose for a 10 year old child with a suspected sprained left wrist? (1mark)
   i)  20mg/kg
   ii) 15mg/kg
   iii) 10mg/kg
   iv) 5mg/kg
   v)  None of the above.
       Answers will be based on local standing orders.
## Assessment Document 3

### 3.1 Sample Competency for Mastery of Nurse Initiated Standing Orders

**NURSE INITIATED ANALGESIA (NIA)**

**Assumed Knowledge**
Participants are expected to demonstrate the following:
- Knowledge of the Anatomy and Physiology of Pain
- Knowledge of Pain Assessment and Pain Assessment Tools
- Knowledge of Local Inclusion and Exclusion Criteria
- Knowledge of Indications, Contraindications and adverse effects of specific drugs
- Knowledge of local policy and procedures in relation to ordering drugs based upon standing orders.

<table>
<thead>
<tr>
<th>Meets the Assumed Knowledge</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 1. UNDERTAKES PATIENT ASSESSMENT

#### 1.1 Adequately Assesses Patient

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>OBSERVABLE CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is able to rationalise the immediate need for adequate pain relief.</td>
<td>Obtains relevant medical history.</td>
</tr>
<tr>
<td>Can explain the different pain assessment tools and how to utilise them for specific age groups.</td>
<td>Obtains a pain history – PQRSST.</td>
</tr>
<tr>
<td></td>
<td>Is able to apply the appropriate pain assessment tool for scoring pain 0-10.</td>
</tr>
<tr>
<td></td>
<td>Obtains baseline vital signs relevant to presenting problem.</td>
</tr>
</tbody>
</table>

#### 1.2 Ensures a safe environment for patient

<table>
<thead>
<tr>
<th>KNOWLEDGE</th>
<th>OBSERVABLE CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can rationalise appropriate inclusion/exclusion criteria for specific patient groups.</td>
<td>Identifies any inclusion/exclusion criteria and those who are inappropriate for analgesia.</td>
</tr>
<tr>
<td>Is able to rationalise an appropriate plan of care for the patient based on local guidelines.</td>
<td>Asks patient about any allergies or contraindications to analgesia.</td>
</tr>
<tr>
<td></td>
<td>Identifies the appropriate pain relief for this patient and their presenting problem.</td>
</tr>
<tr>
<td></td>
<td>Identifies non-pharmacological alternatives to pain relief.</td>
</tr>
</tbody>
</table>
### 2. SAFELY AND EFFECTIVELY ADMINISTERS ANALGESIA ACCORDING TO STANDING ORDER

<table>
<thead>
<tr>
<th>2.1 Understands the effects of the medication on the patient’s physiology</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td><strong>OBSERVABLE CRITERIA</strong></td>
<td></td>
</tr>
</tbody>
</table>
| • Is able to identify indications and contraindications of specific analgesics:  
  – Morphine  
  – Ibuprofen  
  – Codeine  
  – Paracetamol. | • Initiates appropriate pain relief for presenting problem and pain score.  
• Administers nurse initiated analgesia according to the 5 R’s.  
• Educates patient on what side effects or any adverse reactions to observe for.  
• Attends pain score at least 1 hr after analgesia and/or according to local policy. |
| • Is able to describe the possible side effects and adverse reactions. | | |

### 3. SAFELY AND EFFECTIVELY MANAGES THE ONGOING CARE OF THE PATIENT

<table>
<thead>
<tr>
<th>3.1 Understands the medico legal responsibilities required for nurse initiated standing orders according to local guidelines</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| • Is able to discuss the medico legal requirements for NIA according to standing order policies. | • Correctly documents the drug name, dose and time administered on the statim medication chart.  
• Correctly records information in the S4 & S8 drug registers ie standing order & prescribing MO is Medical Director.  
• Records the effect of the drug on the patient and records pain score post analgesia.  
• Documents ongoing assessment of patient including any vital signs.  
• Escalates patients with any unresolved pain to the senior ED medical officer. |
Assessment Document 4

4.1 Competency Assessment – Upper Limb

Scenarios that may be used for assessment purposes:

Case Scenario  Injury to shoulder and clavicle

- 25 year old female playing basketball
- Her right arm was pulled when she was about to shoot a basket.
- She heard a clicking sound
- She is clutching her right arm and refusing to let anyone move it.

Clinical clues for scenario:

- Right shoulder looks deformed—not rounded like the left one
- Unable to move shoulder due to pain
- Bony tenderness noted over the head of humerus
- Axillary nerve involvement with loss of sensation over the deltoid muscle.

Scenario assessment findings:

- Verify History and Examination – palpate for other areas of tenderness
- Pain Assessment and Management (pharmacological and non pharmacological) is a priority for this patient. She requires a trolley, splinting/positioning, IV analgesia.
- Neurovascular examination: Loss of sensation over the deltoid muscle noted and documented prior to any intervention
- Advise patient to remain NBM
- Importance of documenting the presence or absence of wounds
- Provisional diagnosis: Possible dislocated shoulder/ possible fracture dislocation
- X-ray to order: X-ray of right shoulder.

Case Scenario  Elbow injury

- 24 year old male intoxicated the night before and fell down a stairs (2 steps) using right hand to break his fall
- Mechanism: fall onto an outstretched arm
- Now complaining of a painful right elbow.

Clinical clues for scenario:

- No obvious deformity
- Movement: Flexion and extension is very limited (not able to flex > 90 degrees)
- Pain on pronation/supination
- Bony tenderness over radial head.
Scenario assessment findings:
- Verify History and Examination – palpate for other areas of tenderness (mechanism of fall, height, HI, LOC, neck pain, alcohol, GSC)
- Pain Assessment and Management (pharmacological and non pharmacological)
- Neurovascular examination
- Provisional diagnosis: Possible radial head fracture
- X-ray to order: R elbow.

Case Scenario  Wrist injury
- 45 year old female presents with wrist tenderness after fall skiing 5 days ago.

Clinical clues for scenario:
- Patient is complaining of painful right wrist, no deformation
- Slight swelling around wrist, reduced flexion and extension
- Pain to the anatomical snuff box with associated swelling
- Reduced range of movement and loss of grip strength.

Scenario assessment findings:
- Verify History and Examination – palpate for other areas of tenderness
- Pain Assessment and Management (pharmacological and non pharmacological)
- Neurovascular examination
- Provisional diagnosis: possible Scaphoid fracture
- X-ray- right wrist with scaphoid views included.
### ASSESSMENT OF UPPER LIMB

The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accurate assessment of the patient presenting with minor trauma to the upper limb</strong></td>
<td>Accurate assessment of Mechanism of Injury Accurate Pain Assessment History incorporating: AMPLE A – Allergies M – Medications (including tetanus status and pain management as applicable) P – Past Medical/Surgical history L – Last ate E – Events (mechanism of injury, force/height/post injury movement &amp; sensation /management prior to arrival).</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>Identify the anatomy of the shoulder joint</strong></td>
<td>Bones • Scapula/Acromion/AC joint/Coracoid/Glenoid • Clavicle • Humerus: Head, greater tuberosity, shaft. Muscles • Biceps &amp; triceps.</td>
<td></td>
</tr>
<tr>
<td><strong>Systematic approach to assessment of the shoulder and clavicle</strong></td>
<td>Relevant additional history specific to shoulder/clavicle injury/pain • Trauma/traumatic • Previous dislocations • Previous surgery • Night pain • Systemic symptoms • Arthritis • Pain Assessment. Perform an assessment of the shoulder/clavicle Look • Swelling especially over AC joint/clavicle • Deformity • Colour and temperature • Scars &amp; skin integrity. Palpate/Feel • Scapula/Glenoid/ Acromion/AC joint/ Coracoid • Clavicle • Humerus: Head, greater tuberosity, shaft. Neurovascular assessment • Axillary nerve (over deltoid area) • Peripheral pulses • Sensation to limb and over the deltoid muscle. Move: (as pain permits) Assess degree of: • Flexion (90-170 degrees) • Extension (0-45 degrees) • Abduction (0-180 degrees) • Adduction • Internal rotation (90 degrees) • External rotation (70 degrees).</td>
<td></td>
</tr>
</tbody>
</table>
## ASSESSMENT OF UPPER LIMB

The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify the anatomy of the elbow joint</strong></td>
<td><strong>Bones</strong>&lt;br&gt;• Distal humerus&lt;br&gt;• Olecranon&lt;br&gt;• Trochlea &amp; Capitulum (not palpable)&lt;br&gt;• Radius&lt;br&gt;• Ulna.&lt;br&gt;<strong>Ligaments</strong>&lt;br&gt;• Medial and lateral collateral ligaments.</td>
<td></td>
</tr>
<tr>
<td><strong>Systematic approach to assessment of the elbow</strong></td>
<td><strong>Relevant history specific to the elbow</strong>&lt;br&gt;• History of throwing sports&lt;br&gt;• Pain assessment.&lt;br&gt;<strong>Look</strong>&lt;br&gt;• Deformity&lt;br&gt;• Swelling&lt;br&gt;• Colour and temperature&lt;br&gt;• Symmetry.&lt;br&gt;<strong>Feel</strong>: Bony landmarks&lt;br&gt;• Medial &amp; lateral epicondyles&lt;br&gt;• Olecranon&lt;br&gt;• Radial Head&lt;br&gt;• Radius and ulna&lt;br&gt;• Above and below the injury&lt;br&gt;• Feel for an effusion.&lt;br&gt;<strong>Neurovascular assessment</strong>&lt;br&gt;• Nerve sensation &amp; function (ulnar nerve)&lt;br&gt;• Pulses.&lt;br&gt;<strong>Move</strong>: (as pain permits)&lt;br&gt;Assess degree of:&lt;br&gt;• Supination/Pronation&lt;br&gt;• Flexion&lt;br&gt;• Extension.</td>
<td></td>
</tr>
</tbody>
</table>
## ASSESSMENT OF UPPER LIMB

The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the anatomy of the <strong>wrist joint</strong> and <strong>hand</strong></td>
<td><strong>Bones</strong>&lt;br&gt;• Distal radius and ulna&lt;br&gt;• Carpal bones (indertify scaphoid – anatomical snuff box)&lt;br&gt;• Metacarpals&lt;br&gt;• Phalanges.</td>
<td>Yes</td>
</tr>
<tr>
<td>Systematic approach to assessment of the wrist and hand</td>
<td><strong>Relevant history specific to the wrist and hand</strong>&lt;br&gt;<strong>Look</strong>&lt;br&gt;• Deformity ie dinner fork&lt;br&gt;• Swelling&lt;br&gt;• Colour and temperature&lt;br&gt;• Compare to other wrist &amp; hand&lt;br&gt;• Wounds.&lt;br&gt;<strong>Feel</strong>&lt;br&gt;• Distal radius &amp; ulna&lt;br&gt;• Carpal bones&lt;br&gt;• Scaphoid&lt;br&gt;• Metacarpals and digits.&lt;br&gt;<strong>Neurovascular assessment</strong>&lt;br&gt;• Radial nerve motor &amp; sensory function&lt;br&gt;• Median nerve motor &amp; sensory function&lt;br&gt;• Ulnar nerve motor &amp; sensory function&lt;br&gt;• Pulses (radial and ulnar).&lt;br&gt;<strong>Move (as pain permits)</strong>&lt;br&gt;Assess degree of&lt;br&gt;• Degree of flexion &amp; extension (wrist)&lt;br&gt;• Finger and digit movements (flexion and extension).</td>
<td></td>
</tr>
<tr>
<td>Document assessment findings and nursing management plan</td>
<td>Identify possible injuries based on mechanism of injury and clinical assessment findings.&lt;br&gt;Discuss the pain management as required.&lt;br&gt;Indicate if an x-ray is required and complete x-ray request.&lt;br&gt;Document assessment findings and nursing management plan.</td>
<td></td>
</tr>
</tbody>
</table>
Assessment Document 5

5.1 Competency Assessment – Lower Limb

Scenarios that may be used for assessment purposes:

Case Scenario Injury to Knee

- 45 year old male playing soccer and twisted his right knee medially.
- Patient describes falling over and rotating on his knee.
- There was a pop at the time of the injury.

Clinical clues for scenario:

- There was immediate swelling – the knee is now very swollen
- Patient is unable to weight bear and unable to flex his knee.
- No specific bony tenderness – “just hurts inside and feels tight”.

Scenario assessment findings:

- Verify History and Examination – palpate for other areas of tenderness
- Neurovascular examination
- Pain Assessment and Management (pharmacological and non pharmacological)
- Needs an x-ray because he meets 2 of the criteria of the Ottawa Knee rules
  - unable to weight bear
  - unable to flex to 90 degrees
- Importance of documenting the presence or absence of wounds
- Provisional Diagnosis: Cruciate ligament tear, Meniscus tear, Or MCL tear. Possible fracture (tibial plateau).
Case Scenario  Ankle injury

- A 17 yr old male fell off his bike and twisted his right ankle.
- He describes feeling a lot of pain and hobbled home to RICE his ankle.
- As it was very swollen and he decided to present to the ED for an x-ray.

Clinical clues for scenario:
- Patient’s ankle is very swollen below the lateral malleolus
- He can weight bear
- There is no distal tip tenderness to the lateral malleolus.

Scenario assessment findings:
Verify History (helmet, HI, speed, ?MVA, neck pain, alcohol) and Examination – palpate for other areas of tenderness – especially the calcaneum.
Pain Assessment and Management (pharmacological and non pharmacological).
Does not need an x-ray as there is no bony tenderness and the patient is weight bearing.
Describe the Ottawa Ankle and Foot Rules.
Importance of documenting the presence or absence of wounds.
Provisional Diagnosis: Ankle sprain – most probably calcano-fibular ligament (middle one).
### ASSESSMENT OF LOWER LIMB

The participant utilises knowledge and skills to assess and initiate management of an injury to the lower limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| **Accurate assessment of the patient presenting with minor trauma to the lower limb** | Accurate assessment of mechanism of injury  
Accurate Pain Assessment  
History incorporating: AMPLE  
A – Allergies  
M – Medications  
(including tetanus status and pain management as applicable)  
P – Past Medical/Surgical History  
L – Last Ate  
E – Events (mechanism of injury, force/height/post injury movement & sensation /management prior to arrival). | Yes | No |
| **Identify the anatomy of the knee joint** | **Bones**  
• Femur  
• Tibia & fibula (including head of fibula)  
• Patella.  
**Muscles**  
• Patellar tendon.  
**Ligaments**  
• Medial collateral ligament  
• Lateral collateral ligament. | | |
The participant utilises knowledge and skills to assess and initiate management of an injury to the lower limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| **Systematic approach to assessment of the knee** | **Relevant history specific to Knee Injury**  
- Primary complaint: Trauma/atraumatic  
- Ability to weight bear  
- Pop/click/snap at time of injury  
- Pain assessment.  

**Look**  
- Compare both sides  
- Swelling & effusions.  
- Deformity  
- Redness  
- Scars  
- Wounds.  

**Palpate:**  
- Zone of tenderness  
- Palpate proximal and distal areas  
- Palpate the fibula head and patella  
- Compare warmth of both knees.  

Neurovascular examination (altered sensation or altered vascular supply)  

**Move (as pain permits)**  
- Assess degree of flexion (0-140 degrees)  
- Assess degree of extension (0-140 degrees)  
- Straight Leg raise or Kick test.  

**Apply Ottawa knee rules:** Identify need for x-ray based on  
- Age 55 years or older  
- Isolated patella tenderness  
- Tenderness of head of fibula  
- Inability to flex to 90 degrees  
- Inability to weight bear immediately /in ED.
### ASSESSMENT OF LOWER LIMB

The participant utilises knowledge and skills to assess and initiate management of an injury to the lower limb.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| Identify the anatomy of the ankle and foot | **Bones**  
- Tibia and fibula  
- Talus  
- Navicular  
- Base of 5th Metatarsal  
- Calcaneum  
- Midfoot and forefoot bones  
- Toes.  
**Ligaments**  
- Deltoid ligament  
- Lateral ligaments.  
**Muscles and Tendons**  
- Achilles. | Yes  
No |
| Systematic approach to assessment of the ankle & foot | **Relevant history specific to the ankle and foot**  
- Inversion/ evasion/plantar or dorsiflexion  
- Fall (especially onto calcaneum)  
- Ability to weight bear immediately & in ED.  
**Look**  
- Deformity/Swelling/ bruising/redness  
- Scars  
- Wounds.  
**Feel**  
- Bony tenderness – Ottawa rules  
- Proximal fibula  
- Ligaments: lateral and medial  
- Achilles Tendon  
- Neurovascular exam  
- Calcaneum.  
**Move: (as pain permits)**  
State if it is normal or mild/mod/severely limited  
- Weight bearing  
- Dorsiflexion  
- Plantarflexion  
- Inversion  
- Eversion.  
**Apply Ottawa ankle and foot rules:** Identify need for x-ray based on  
- Posterior tenderness to either lateral or medial malleolus (6cm) (ankle)  
- Pain to the navicular or base 5th Metatarsal (foot)  
- Inability to weight bear immediately and in ED. | Yes  
No |
| Document assessment findings and nursing management plan | Identify possible injuries based on mechanism of injuries and clinical assessment findings.  
Discuss the indications for analgesia.  
Indicate if an x-ray is required and complete x-ray request.  
Document assessment findings and nursing management plan. | Yes  
No |
### RESPIRATORY ASSESSMENT

The participant uses knowledge and skills to perform a physical assessment on a patient presenting with exacerbation of asthma/shortness of breath.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| **Obtain a relevant history noting the following** | Presenting complaint  
Past history:  
• Allergies  
• Medications  
• Past medical history  
• Past admission history for this condition (ICU/Acute/previous presentations to ED)  
• Last ate/last menstrual period  
• Events leading to presentation.  
Current episode:  
• Duration of shortness of breath  
• Associated cough, sputum (colour, volume, presence of haemoptysis)  
• Associated fever, chills, rigors, pleuritic chest pain, URTI  
• What medications have you taken since the incident began? | Yes     | No      |
| **Inspect the chest** | • Assess work of breathing:  
  – recession  
  – level of consciousness  
  – diaphoresis  
  – tracheal tug  
  – accessory muscle use  
  – ability to speak in words, phrases.  
• Observe the chest wall for movement and symmetry  
• Notes the colour of the mucous membranes  
• Respiratory rate and pattern  
• Posture. | Yes     | No      |
| **Palpate the chest** | • Palpate the trachea (midline)  
• Feel for respiratory excursion  
• Palpate for subcutaneous emphysema. | Yes     | No      |
| **Percuss the chest** | • Note any abnormal resonance. | Yes     | No      |
## RESPIRATORY ASSESSMENT

The participant uses knowledge and skills to perform a physical assessment on a patient presenting with exacerbation of asthma/shortness of breath.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| **Auscultate the chest** | Listen to the chest in a systematic format for:  
- Air entry  
- Note normal breath sounds  
- Note adventitious sounds (wheeze, crackles)  
- Note reduced air entry. | Yes |
| **Record vital signs and perform objective tests and interpret results** |  
- Note blood pressure, heart rate, respiratory rate  
- SpO2, Temperature  
- Spirometry/ Peak Flow; FEV 1/ FVC  
- Establish a nursing diagnosis based on your assessment findings. | No |
| **Classify the exacerbation as mild, moderate or severe and document in patient notes** |  
- Refer all patients with severe asthma, dyspnoea or upper airway obstruction to SMO immediately  
- Initiate management as per Standing orders  
- Explain the role of the following drugs in asthma management  
- Salbutamol, Ipratropium Bromide, Steroids. | Yes |
## Assessment Document 7

### 7.1 Competency Assessment – Abdominal

#### ABDOMINAL ASSESSMENT

The participant uses knowledge and skills to perform a physical assessment on a patient presenting with abdominal pain.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| Obtain a relevant history noting the following: | **(a) Pain**  
- Location/change in location  
- Character or quality (dull, sharp)  
- Quantity or severity (pain score)  
- Timing (onset, frequency, duration)  
- Aggravating or alleviating factors  
- Associated symptoms  
- Heartburn, diarrhoea, bowel pattern  
- Patient’s thoughts on what precipitated the problem.  
**(b) Past medical history**  
- Previous, similar problem  
- Medical/Surgical history  
- Medications  
- Last ate  
- Allergies.  
Articulate the implications of the patient’s history for the potential physical assessment findings.  
Notes Red Flags. | Mastery |
| Prepare patient for physical assessment | - Stand on right side of bed.  
- Assess the general appearance of patient (lying without moving – moving all over bed -observe facial expression)  
- Place in supine position with head and knees supported  
- Expose the abdomen. | Mastery |
ABDOMINAL ASSESSMENT

The participant uses knowledge and skills to perform a physical assessment on a patient presenting with abdominal pain.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| Identify the quadrants of the abdomen and describe the major organs underlying each of these quadrants | **Right upper quadrant**  
- Right lobe of the liver  
- Gall bladder  
- Duodenum  
- Head of the pancreas  
- Parts of the ascending & transverse colon  
- Right kidney.  

**Right lower quadrant**  
- Caecum and appendix  
- Parts of the ascending colon.  

**Left upper quadrant**  
- Left lobe of the liver  
- Stomach  
- Body of the pancreas  
- Parts of the descending & transverse colon.  

**Left lower quadrant**  
- Sigmoid colon  
- Parts of the descending colon.  

**Pelvis**  
- Bladder  
- Uterus  
- Ovaries.  

**Inspect the abdominal contour** at the patient's level for:  
- Size  
- Shape  
- Symmetry  
- Masses or bulges  
- Colour, ecchymosis.  

**Auscultation**  
- Auscultate for bowel sounds  
  - RLQ (ileocaecal junction)  
  - All four quadrants.  

**Palpation**  
- Palpate the abdomen  
  - First palpate areas where you don’t expect problems  
    - Initial gentle palpation  
    - More firm palpation.  
  - Identify abnormal signs & implications  
    - Tenderness  
    - Rebound  
    - Guarding.  

+/- Percussion  
- Percuss the abdomen (not mandatory).  

**Investigations**  
- Initiate the appropriate investigations as per ED protocols/guidelines.
### ABDOMINAL ASSESSMENT

The participant uses knowledge and skills to perform a physical assessment on a patient presenting with abdominal pain.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
<th>Mastery</th>
</tr>
</thead>
</table>
| Identify the type of pain patient is describing and initiated appropriate pain management | **Discuss the indications for analgesia**  
  - Pain score  
  - Type of pain  
    - Visceral pain (dull, poorly localised, crampy)  
    - Somatic pain (well localised, intense)  
    - Referred pain (pain felt remote to organ)  
  - Nurse Initiated Analgesia (NIA) as per hospital protocol. | Yes     |
| Documentation                                                           | **Document the following in the medical records**  
  - Presenting problem  
  - History  
  - Assessment findings  
  - Pain assessment and re-assessment  
  - Interventions and investigations  
  - Nursing management plan. | No      |