

Clinical Initiatives Nurse in Emergency Departments

Educational Program



Participants Manual 2011



Health

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Introduction

The Clinical Initiatives Nurse (CIN) Education Program

The CIN Role builds on knowledge and experience gained as the Registered Nurse (RN) 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 RN 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 populations 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.

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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 Geriatric 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 participant and provides the following:

- The learning activities which relate to each module of the Resource Manual
- Space for notes
- A copy of the assessment outlines/a record of training/assessment.

What is not included in this Manual?

The 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 resources 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
- Eye Emergency Manual 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 preceptor 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 this manual provides evidence for Continuing Professional Development.

Participant's 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, power point 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 Resource Manual

Each module in the education module contains the following:

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

It is expected that the CIN participant will work through the CIN 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.

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 the program who have completed all competencies.

It is expected that all facilities maintain records of 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 Resource Manual.

Listed under each of the headings are:

- Learning Outcomes
- Activities and Discussion Points
- Assessment Criteria.

Section 1

1.1 Introduction to the Clinical Initiatives Nurse Role

Learning Outcomes

At the completion of this module the participant will be able to:

- Demonstrate knowledge of the following:
 - The purpose of the CIN Role
 - The CIN role as an ED team member
 - The accountabilities and role boundaries
 - The outcomes of the role
 - The experience and knowledge required for the role
- Analyse and reflect on what constitutes care initiation.

Activities and Discussion 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. Record key points below.

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_HEALTH.php

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

Lessons Learned/Notes

Assessment Criteria

There is no formal assessment process for this section.

The CIN Role	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

1.2 CIN Communication and the Waiting Room

Learning Outcomes

At the completion of this module the participant will be able to:

- Outline the key principles of the Psychology of Waiting
- Identify key learning from previous research on the ED waiting room experience
- Discuss strategies to effectively and efficiently manage communication in the waiting room
- Discuss challenging communication situations in the waiting room and the CIN role.
- Analyse and reflect on applying learning to 'real life scenarios'.

Activities and Discussion 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 and 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?

Activity 2 Reflective exercise

Review scenes 1, 5 and 6 of the 'In their Shoes' DVD and discuss how these situations could have been handled differently.

1. What features contributed to the escalation of the situation.

2. What could have improved the situation?

3. If you were the CIN reviewing the patient following this episode, how would you approach the patient/carer?

Lessons Learned/Notes

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).

CIN Communication and the Waiting Room	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

1.3 Management of the Waiting Room

Learning Outcomes

At the completion of this module the participant will be able to:

- Demonstrate effective communication aimed at minimising patient and carer anxiety
- Demonstrate effective assessment and prioritisation in managing clinical scenarios in the waiting room, through using appropriate clinical initiatives, communication, documentation and referral
- Demonstrate ability to prioritise CIN activities in a busy waiting room and escalate concerns regarding activity to promote patient safety as a key outcome
- Develop competency in aligning patient care and referral processes using local protocols and policies to promote patient flow in the ED
- Identify and manage the early signs of aggression
- Develop strategies to maintain privacy and dignity in the waiting room.

Activities and Discussion 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?

***Further information is given about this scenario in the facilitator's guide.
Discuss this with your facilitator.***

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?

Activity 2

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.

Activity 3

Further activities are located in the facilitator’s guide.
Discuss this with your facilitator preceptor.

Lessons Learned/Notes

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).

CIN Waiting Room Management	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

1.4 Pain and Overview of CIN Pharmacology

Learning Outcomes

At the completion of this module the participant will be able to:

- Describe current knowledge relating to the anatomy and physiology of pain
- Contrast the differences between acute, chronic, somatic, visceral and neuropathic pain
- Identify the essential components of a pain assessment and taking a pain history
- Analyse the application of commonly used and validated pain assessment tools available for scoring pain
- Identify the challenges to managing pain in specific population groups (ie children, elderly, and people from ethnic minority groups)
- Identify the differences between the terms addiction, tolerance and physical dependence
- Identify the appropriate pharmacological agents available and their indication according to the pain assessment
- Outline the vital role of re-assessment of patient's pain in the waiting room
- Discuss the role/options of non-pharmacological pain management in the ED
- Identify the medico legal responsibilities in relation to Nurse initiated analgesia (NIA) in the waiting patient
- For the listed medications identify key indications, contraindications and side effects
- Identify the barriers to effective pain management for the patient presenting with chronic pain.

Part 1 Pain Pathophysiology and Assessment

Activities and Discussion Points

Learning Activity 1

For learning Activities 1 and 3.1, consult a relevant text and answer the following questions. texts that may be useful include: Sheehy's Emergency Nursing, Rosen's Emergency Medicine and / or Core Curriculum for Pain Management Nursing. All of these resources are listed under online books in CIAP.

Pain can be classified into somatic, visceral or neuropathic.

Compare the clinical features associated with these 3 major types of pain.

Somatic

Visceral

Neuropathic

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.

Learning Activity 3.1

Consult a relevant text and answer the following. (suggested texts listed under learning activity 1).

Identify the differences between these terms:

Addiction

Tolerance

Physical Dependence

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?

Part 2 Pharmacological Pain Management

Activities and Discussion Points

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:

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:

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?

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:

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:

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:

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:

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:

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:

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:

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:

Identify which non-pharmacological options may be suitable in this situation:

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?

What is your plan for Sebastian as the CIN? Is there any other information that you would like from Sebastian?

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 to 38.2. She has no allergies and hasn't had any medication today. Weight = 22kg.

Discuss the pharmacological options available to treat Lucy:

What dose of Salbutamol would be suitable for Lucy?
How would you deliver it?

Lucy has the Salbutamol in the waiting room and after 20 mins remains wheezy.
What is your next action?

Calculate the dose of paracetamol for Lucy?
Which route of administration would you select and why?

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 #

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.

* 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 will list these requirements in the CIN Participant Manual in the space marked * above, or in the space provided below).*

Lessons Learned/Notes

Pain and Overview of CIN Pharmacology	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Written Test Completed with 80% pass mark			
Competency Completed			

1.5 Musculoskeletal Assessment of Limbs and Principles of Radiological Examination

Learning Outcomes

At the completion of this module the participant will be able to:

- Demonstrate a standardised approach to history taking and physical assessment for the patient with a limb injury.
- Recognise clinical or historical indicators of urgency (red flags) that require escalation in a patient with a limb injury
- Discuss appropriate first aid (including splinting), interventions, emergency treatment and pain management for the injury
- Identify radiology requirements according to assessment (using decision rules where available)
- Demonstrate competency in assessment of upper and lower limbs, including the specified joints
- Demonstrate competency in decision making regarding the ordering of radiological examination (dependent on local protocols)
- Demonstrate competency in documenting the assessment and any interventions that are commenced.

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-rays 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

Practicing these skills with relevant staff will assist in consolidating your learning.

It is suggested the participant;

- read the content in the Resource Manual
- review the anatomy using a text or online resource,
- watch the relevant assessment on the limb assessment DVD
- undertake the activity and
- practise the skill with the course facilitator.
- Complete clinical scenarios in partnership with a facilitator using the competency framework to gain experience in musculoskeletal assessment.
- Practice the skills in your role as CIN or ED nurse and gain feedback.

When you are ready complete the competency requirements for limb assessment.

Ankle and Foot Assessment

Activity 1

Watch the Foot and Ankle Examination of the Limb Assessment DVD.
Practice an examination with your facilitator after watching the DVD.

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?

Case Scenario 2 *Ankle assessment*

A 43yr female old 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?

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?

Activity 2

Watch the Knee Examination on the Limb Assessment DVD.

Practice an examination with your facilitator after watching the DVD.

Case Scenario 4 Knee assessment

A 19 year old female was playing netball and was accidentally 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?

Activity 3

Watch the Hand and Wrist Examination on the Limb Assessment DVD.

Practice an examination with your facilitator after watching the DVD.

Case Scenario 5 Wrist assessment

A 65 year old female slipped on a wet surface and fell onto her outstretched hand.

- The 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

Activity 4

Watch the Elbow Examination on the Limb Assessment DVD.

Practice an examination with your facilitator after watching the DVD.

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?

Activity 5

Watch the Shoulder Examination on the Limb Assessment DVD.

Practice an examination with your facilitator after watching the DVD.

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?

Assessment Criteria

The assessment requires mastery in the clinical competencies of musculoskeletal assessment of:

- Shoulder
- Elbow
- Wrist and Hand
- Knee
- Foot and Ankle.

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

There may be requirements at local sites for CINs to complete additional assessments to meet accreditation for Nurse Initiated X-ray.

(These may be listed in the space below)

Lessons Learned/Notes

MASTERY AWARDED – UPPER LIMB ASSESSMENT		Yes	No
Assessors Comments			
Name			
Signature			
Designation of Assessor			Date
Name			
Signature			
Designation of Participant			Date
Hospital			

MASTERY AWARDED – LOWER LIMB ASSESSMENT		Yes	No
Assessors Comments			
Name			
Signature			
Designation of Assessor			Date
Name			
Signature			
Designation of Participant			Date
Hospital			

Musculoskeletal Assessment of Limbs and Principles of Radiological Examination	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Upper Limb Competency Completed			
Lower Limb Competency Completed			

ASSESSMENT OF UPPER LIMB			
The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.			
Element	Performance Criteria	Mastery	
		Yes	No
<i>Accurate assessment of the patient presenting with minor trauma to the upper limb</i>	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).		
<i>Identify the anatomy of the shoulder joint</i>	Bones <ul style="list-style-type: none"> • Scapula/Acromion/ AC joint/ Coracoid/Glenoid • Clavicle • Humerus: Head, greater tuberosity, shaft Muscles <ul style="list-style-type: none"> • Biceps & triceps. 		
<i>Systematic approach to assessment of the shoulder and clavicle</i>	Relevant additional history specific to shoulder/clavicle injury/ pain <ul style="list-style-type: none"> • Trauma/atraumatic • Previous dislocations • Previous surgery • Night pain • Systemic symptoms • Arthritis • Pain Assessment. Perform an assessment of the shoulder/clavicle Look <ul style="list-style-type: none"> • Swelling especially over AC joint/clavicle • Deformity • Colour and temperature • Scars & skin integrity. Palpate/Feel <ul style="list-style-type: none"> • Scapula/Glenoid/ Acromion/AC joint/ Coracoid • Clavicle • Humerus: Head, greater tuberosity, shaft. Neurovascular assessment <ul style="list-style-type: none"> • Axillary nerve (over deltoid area) • Peripheral pulses • Sensation to limb and over the deltoid muscle. 		

ASSESSMENT OF UPPER LIMB			
The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.			
Element	Performance Criteria	Mastery	
		Yes	No
<p><i>Systematic approach to assessment of the shoulder and clavicle</i></p> <p><i>continued</i></p>	<p>Move (as pain permits) Assess degree of:</p> <ul style="list-style-type: none"> • Flexion (90-170 degrees) • Extension (0-45 degrees) • Abduction (0-180 degrees) • Adduction • Internal rotation (90 degrees) • External rotation (70 degrees). 		
<p><i>Identify the anatomy of the elbow joint</i></p>	<p>Bones</p> <ul style="list-style-type: none"> • Distal humerus • Olecranon • Trochlea & Capitulum (not palpable) • Radius • Ulna. <p>Ligaments</p> <ul style="list-style-type: none"> • Medial and lateral collateral ligaments. 		
<p><i>Systematic approach to assessment of the elbow</i></p>	<p>Relevant history specific to the elbow</p> <ul style="list-style-type: none"> • History of throwing sports • Pain assessment. <p>Look</p> <ul style="list-style-type: none"> • Deformity • Swelling • Colour and temperature • Symmetry. <p>Feel: Bony landmarks</p> <ul style="list-style-type: none"> • Medial & lateral epicondyles • Olecranon • Radial Head • Radius and ulna • Above and below the injury • Feel for an effusion. <p>Neurovascular assessment</p> <ul style="list-style-type: none"> • Nerve sensation & function (ulnar nerve) • Pulses. <p>Move (as pain permits) Assess degree of:</p> <ul style="list-style-type: none"> • Supination/Pronation • Flexion • Extension. 		

ASSESSMENT OF UPPER LIMB			
The participant utilises knowledge and skills to assess and initiate management of an injury to the upper limb.			
Element	Performance Criteria	Mastery	
		Yes	No
<i>Identify the anatomy of the wrist joint and hand</i>	Bones <ul style="list-style-type: none"> • Distal radius and ulna • Carpal bones (indentify scaphoid – anatomical snuff box) • Metacarpals • Phalanges. 		
<i>Systematic approach to assessment of the wrist and hand</i>	Relevant history specific to the wrist and hand <ul style="list-style-type: none"> • Pain assessment Look <ul style="list-style-type: none"> • Deformity eg dinner fork • Swelling • Colour and temperature • Compare to other wrist & hand • Wounds. Feel <ul style="list-style-type: none"> • Distal radius & ulna • Carpal bones • Scaphoid • Metacarpals and digits. Neurovascular assessment <ul style="list-style-type: none"> • Radial nerve motor & sensory function • Median nerve motor & sensory function • Ulnar nerve motor & sensory function • Pulses (radial and ulnar). Move (as pain permits) Assess degree of: <ul style="list-style-type: none"> • Degree of flexion & extension (wrist) • Finger and digit movements (flexion and extension). 		
<i>Document assessment findings and nursing management plan</i>	Identify possible injuries based on mechanism of injury and clinical assessment findings. Discuss the pain management as required. Indicate if an x-ray is required and complete x-ray request. Document assessment findings and nursing management plan.		

ASSESSMENT OF LOWER LIMB

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

Element	Performance Criteria	Mastery	
		Yes	No
<i>Accurate assessment of the patient presenting with minor trauma to the lower limb</i>	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).		
<i>Identify the anatomy of the knee joint</i>	Bones <ul style="list-style-type: none"> • Femur • Tibia & fibula (including head of fibula) • Patella. Muscles <ul style="list-style-type: none"> • Patellar tendon. Ligaments <ul style="list-style-type: none"> • Medial collateral ligament • Lateral collateral ligament. 		
<i>Systematic approach to assessment of the knee</i>	Relevant history specific to Knee Injury <ul style="list-style-type: none"> • Primary complaint: Trauma/atraumatic • Ability to weight bear • Pop/click/snap at time of injury • Pain assessment. Look <ul style="list-style-type: none"> • Compare both sides • Swelling & effusions. • Deformity • Redness • Scars • Wounds. Palpate <ul style="list-style-type: none"> • Zone of tenderness • Palpate proximal and distal areas • Palpate the fibula head and patella • Compare warmth of both knees. 		

ASSESSMENT OF LOWER LIMB

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

Element	Performance Criteria	Mastery	
		Yes	No
<p><i>Systematic approach to assessment of the knee</i></p> <p><i>continued</i></p>	<p>Neurovascular examination (altered sensation or altered vascular supply)</p> <p>Move (as pain permits)</p> <ul style="list-style-type: none"> Assess degree of flexion (0-140 degrees) Assess degree of extension (0-140 degrees) Straight Leg raise or Kick test. <p>Apply Ottawa knee rules: Identify need for x-ray based on</p> <ul style="list-style-type: none"> 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. 		
<p><i>Identify the anatomy of the ankle and foot</i></p>	<p>Bones</p> <ul style="list-style-type: none"> Tibia and fibula Talus Navicular Base of 5th Metatarsal Calcaneum Midfoot and forefoot bones Toes. <p>Ligaments</p> <ul style="list-style-type: none"> Deltoid ligament Lateral ligaments. <p>Muscles and Tendons</p> <ul style="list-style-type: none"> Achilles. 		
<p><i>Systematic approach to assessment of the ankle & foot</i></p>	<p>Relevant history specific to the ankle and foot</p> <ul style="list-style-type: none"> Inversion/ eversion/plantar or dorsiflexion Fall (especially onto calcaneum) Ability to weight bear immediately & in ED. <p>Look</p> <ul style="list-style-type: none"> Deformity/Swelling/ bruising/redness Scars Wounds. <p>Feel</p> <ul style="list-style-type: none"> Bony tenderness –Ottawa rules Proximal fibula Ligaments: lateral and medial Achilles Tendon Neurovascular exam Calcaneum. 		

ASSESSMENT OF LOWER LIMB			
The participant utilises knowledge and skills to assess and initiate management of an injury to the lower limb.			
Element	Performance Criteria	Mastery	
		Yes	No
<p><i>Systematic approach to assessment of the ankle & foot</i></p> <p><i>continued</i></p>	<p>Move (as pain permits) State if it is normal or mild/mod/severely limited</p> <ul style="list-style-type: none"> • Weight bearing • Dorsiflexion • Plantarflexion • Inversion • Eversion. <p>Apply Ottawa ankle and foot rules: Identify need for x-ray based on</p> <ul style="list-style-type: none"> • 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. 		
<p><i>Document assessment findings and nursing management plan</i></p>	<p>Identify possible injuries based on mechanism of injuries and clinical assessment findings.</p> <p>Discuss the indications for analgesia.</p> <p>Indicate if an x-ray is required and complete x-ray request.</p> <p>Document assessment findings and nursing management plan.</p>		

1.6 Wound Care

Learning Outcomes

At the completion of this module the participant will be able to:

- Demonstrate a wound assessment
- Discuss factors that may delay wound healing and compromise tissue viability
- Discuss strategies to promote wound healing
- Identify possible red flags that may signify greater risk to the patient and identify when referral to other health professionals is required
- Analyse and reflect on dressing categories for particular wound types
- Demonstrate the ability to make effective treatment decisions and initiate further investigation as required.

Activities and Discussion Points

Activity 1

Complete the Core Module 'Wound Assessment', the link is:
<http://woundswest.articulate-online.com/1656235026>

Activity 2 (to be listed by Facilitator)

Complete the modules below:

Lessons Learned/Notes

Wound Assessment	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

Section 2

2.1 Care of the Patient with a Mental Health Presentation

Learning Outcomes

At completion of this module the participant will be able to:

- Identify the essential elements of a mental health history and discuss the symptoms and management of various mental health presentations to the emergency department
- Discuss some of the risks to patient/carers and nursing staff when managing a patient with mental health issues in the waiting area
- Describe the management strategies for the acutely aggressive patient in the waiting room area
- Identify the main differences in the management of children, adolescents and elderly patients presenting with a mental health problem.

Activities and Discussion Points

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.

Refer to: Sadock, B.J., Sadock, V.A. & Ruiz P. (2009) Kaplan & Sadock's Comprehensive Textbook of Psychiatry 9th Edition, Available on CIAP.

Patient scenarios

The following scenarios have been developed by an ED Mental Health CNC.

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 these 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 becomes 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?

***Further information is given about this scenario in the facilitator's guide.
Discuss this with your facilitator/ preceptor.***

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 the 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 and ask them (or make enquiries as to the wait to be seen) and direct both Monica and her mother to take a seat. After they have sat down you call the Mental Health team (or other according to local arrangements) 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?

Assessment Criteria

There is not a formal competency for this assessment.

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

Care of the Patient with a Mental Health Presentation	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.2 Care of the Patient with a Minor Trauma Presentation

Learning Outcomes

At the completion of this module the participant will be able to:

- Identify at risk groups with minor trauma and escalate observation and treatment options
- Demonstrate a systemic approach to history taking and physical assessment for the patient with a traumatic injury
- Discuss the red flags that are specific to patients presenting with minor trauma and those that require escalation.

Activities and Discussion Points

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 wheel chair

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 possible bony injury).

You are the CIN and this patient is in the waiting room

1. Outline your assessment of this patient

2. Outline your plan of care

3. What are 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.

Further information is given about this scenario in the facilitator’s guide.

Discuss this with your facilitator/ preceptor.

Lessons Learned/Notes

Further scenarios may be presented by the program facilitator.

Assessment Criteria

There is not a formal competency for this assessment.

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

Care of the Patient with a Trauma Presentation	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.3 Care of the Patient with a Possible Sepsis Presentation

Learning Outcomes

At the completion of this module the participant will be able to:

- Discuss the importance of early recognition and management of sepsis to patient outcome
- Outline strategies to improve the recognition and management of sepsis
- Examine the treatment modalities, patient outcome measures and clinical indicators for sepsis
- Analyse the CIN role in detecting and responding to clinical deterioration of a patient with possible sepsis in the waiting room.

Activities and Discussion Points

Learning Activity 1 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 ATS 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 & Heart 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 an 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
- Her 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.

Discuss this scenario with the facilitator.

What protocols guide the management of sepsis in your ED?

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

Further discussion points are listed in the facilitator’s guide.

Lessons Learned/Notes

Assessment Criteria

There is not a formal competency for this assessment.
 There is an expectation that the learning activities will be completed.

Care of the Patient with a Possible Sepsis Presentation	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.4 Care of the Patient with a Drug and Alcohol Related Presentation

Learning Outcomes

At the completion of this module the participant will be able to:

- Identify common symptoms of drug and alcohol intoxication and withdrawal
- Identify the assessment criteria specific to the drug alcohol presentation
- List skills used to monitor the patient in the waiting room
- Outline the 'red flags' that require escalation for the patient with a drug and/or alcohol related presentation.

Activities and Discussion 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?

2. What is your CIN plan for assessment and care/diagnostic initiation for this patient while he is in the waiting room?

3. What are the available referral options for ongoing management of his alcohol dependence?

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?

2. What nursing assessment are you going to do and what information do you want to obtain?

3. What is your CIN plan for assessment and care/diagnostics initiation for this patient?

Further scenarios may be developed by the facilitator.

Lessons Learned/Notes

Assessment Criteria

There is not a formal competency for this assessment.
 There is an expectation that the learning activities will be completed.

Care of the Patient with Drug and Alcohol Related Presentation	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.5 Care of the Paediatric Patient

Learning Outcomes

At the completion of this module the participant will be able to:

- Discuss the role and responsibilities of the CIN to the paediatric population
- Recognise the signs of serious illness in children or 'paediatric red flags'
- Initiate treatments/investigations for waiting children
- Identify the common fears of children presenting to the ED
- Outline the concerns and anxieties of parents in the ED waiting room.

Activities and Discussion Points

Learning Activity 1

Prior to completion of this module the following learning activity is a prerequisite.

Recognition of a sick child online learning in the Paediatric Emergency Guidelines Training. Menu located at: <http://www.doh.edmore.com.au/login.php>

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 hr.

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.

1. 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?

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.

2. As the CIN, what are your actions now?

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.

3. What is your response to this questioning?

Learning Activity 2 Discussion points

What resources are available in your ED/waiting room to:

4. Make the waiting room `paediatric friendly?

5. Accredite the CIN to initiate care (what protocols are there?)

6. Provide education to parents while they are waiting?

Further scenarios may be developed by the facilitator.

Lessons Learned/Notes

Assessment Criteria

There is not a formal competency for this assessment.

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

Care of the Paediatric Patient	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.6 Care of the Geriatric Patient

Learning Outcomes

On completion of this section the participant will be able to:

- Describe the physiology of ageing
- Discuss the importance of early assessment of the elderly waiting patient
- Identify indicators of urgency for elderly patients
- Outline the importance of teams in caring for the elderly
- Identify the care needs of the elderly patient in the waiting room.

Activities and Discussion 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.

1. From the clinical example what aspects can you relate to in your role as CIN?

2. What do you think are the main points that the clinical example is trying to make?

3. What are some examples of poor outcomes when elderly patients are discharged from ED?

4. 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?

Activity 2 Case Scenario

Prior to completing this scenario, view the PowerPoint presentation titled 'Special Populations: Elderly (Slides 8-13)'. These slides outline the age related changes in the elderly. There is also reference to the clinical significance of these changes to the emergency environment. Alternately refer to a chapter on Elderly patients in an Emergency Text such as Curtis, K., Ramsden, C. & Friendship, J. (2007) 'Emergency and Trauma Nursing'.

Answer the following questions in relation to the following case scenario.

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?

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

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?

Further scenarios may be developed by the facilitator.

Lessons Learned/Notes

Assessment Criteria

There is not a formal competency for this assessment.

There is an expectation that the learning activities will be completed

Care of the Geriatric Patient	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

2.7 Care of the Pregnant Patient

Learning Outcomes

At the completion of this module the participant will be able to:

- Identify the major causes of pregnancy related presentations to ED
- Identify the red flags that require escalation in the patient with pregnancy related presentations
- Outline the psychological needs of the pregnant patient in the waiting room
- Analyse and reflect on the module content by applying learning to 'real life scenarios'.

Activities and Discussion Points

Activity 1

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 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.

Outline your CIN assessment priorities

What is your CIN plan for this patient?

Assessment Criteria

There is not a formal competency for this assessment.

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

Care of The Pregnant Patient	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

Section 3

3.1 CIN Documentation

Learning Outcomes

At the completion of this module the participant will be able to:

- Identify the reasons for documentation in the health care setting and CIN role
- Discuss the medico legal aspects surrounding documentation
- Discuss strategies and identify various methods of documenting a CIN assessment
- Analyse and reflect on CIN documentation requirements in their own health care institution.

Activities and Discussion Points

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?

- 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 enablers/barriers to CIN Documentation:

- When you undertake your CIN assessments, ask the facilitator to review/critique your CIN documentation. Request feedback from them on the following:
 - Does the documentation comply with policy and legislative requirements?
 - Is the content documented in a structured format?
 - Has all relevant information been documented?
 - Is there a clear plan of care documented?
 - Are there any suggested areas for improvement?

Lessons Learned/Notes

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.

CIN Documentation	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

Appendix 1

Respiratory Assessment

Learning Outcomes

At the completion of this module the participant will be able to:

- Outline the components of comprehensive respiratory assessment
- Identify a systematic approach to respiratory assessment and priorities
- Discuss the characteristics of respiratory distress and potential red flags
- Discuss diagnostics and monitoring to aid respiratory assessment
- Outline CIN interventions which may be initiated for the patient with respiratory problems
- Analyse and reflect on a respiratory management scenario
- Demonstrate competency in respiratory assessment.

Activities and Discussion Points

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) tripodding, 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%.

Lessons Learned/Notes

Assessment Criteria

Accreditation requires mastery of the Respiratory Assessment Competency.

MASTERY AWARDED – RESPIRATORY ASSESSMENT		Yes	No
Assessors Comments			
Name			
Signature			
Designation of Assessor		Date	
Name			
Signature			
Designation of Participant		Date	
Hospital			

Respiratory Assessment	Yes/No	Name/Signature And Designation	Date
Learning Activities Complete			
Assessment Completed			

RESPIRATORY ASSESSMENT			
The participant uses knowledge and skills to perform a physical assessment on a patient presenting with exacerbation of asthma/ shortness of breath.			
Element	Performance Criteria	Mastery	
		Yes	No
<i>Obtain a relevant history noting the following</i>	Presenting complaint Past history: <ul style="list-style-type: none"> • Allergies • Medications • Past medical history • Past admission history for this condition (ICU/Acute, previous ED presentations) • Last ate/last menstrual period • Events leading to presentation. Current episode: <ul style="list-style-type: none"> • 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? 		
<i>Inspect the chest</i>	<ul style="list-style-type: none"> • Assess work of breathing: <ul style="list-style-type: none"> – recession – level of consciousness – diaphoresis – tracheal tug – accessory muscle use – ability to speak in words, phrases. • Observe the chest wall for movement and symmetry • Note the colour of the mucous membranes • Respiratory rate and pattern • Posture. 		
<i>Palpate the chest</i>	<ul style="list-style-type: none"> • Palpate the trachea (midline) • Feel for respiratory excursion • Palpate for subcutaneous emphysema. 		
<i>Percuss the chest</i>	<ul style="list-style-type: none"> • Note any abnormal resonance. 		
<i>Auscultate the chest</i>	Listen to the chest in a systematic format for: <ul style="list-style-type: none"> • Air entry <ul style="list-style-type: none"> – Note normal breath sounds – Note adventitious sounds (wheeze, crackles) – Note reduced air entry. 		

RESPIRATORY ASSESSMENT

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

Element	Performance Criteria	Mastery	
		Yes	No
<i>Record vital signs and perform objective tests and interpret results</i>	<ul style="list-style-type: none"> • Note blood pressure, heart rate, respiratory rate • SpO₂, Temperature • Spirometry/ Peak Flow; FEV₁/ FVC • Establish a nursing diagnosis based on your assessment findings. 		
<i>Classify the exacerbation as mild, moderate or severe and document in the patient notes</i>	<ul style="list-style-type: none"> • Refer all patients with severe asthma, dyspnoea or upper airway obstruction to senior medical officer immediately • Initiate management as per Standing orders • Explain the role of the following drugs in asthma management – Salbutamol, Ipratropium Bromide, Steroids. 		

Appendix 2

Abdominal Assessment

Learning Outcomes

At the completion of this module the participant will be able to:

- Undertake a systematic approach to abdominal assessment
- Identify the signs and symptoms of specific abdominal pain
- Discuss the need for specific diagnostic studies related to the location/type of abdominal pain
- Demonstrate competency in abdominal assessment.

Activities and Discussion Points

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?

2. How would you assess Mr Smith?

3. What diagnostic tests would you initiate?

4. Discuss analgesia options for Mr Smith:

Assessment Criteria

Accreditation requires mastery of the Abdominal Assessment Competency.

MASTERY AWARDED – ABDOMINAL ASSESSMENT		Yes	No
Assessors Comments			
Name			
Signature			
Designation of Assessor			Date
Name			
Signature			
Designation of Participant			Date
Hospital			

Abdominal Assessment	Yes/No	Name/Signature and Designation	Date
Learning Activities Complete			
Assessment Completed			

ABDOMINAL ASSESSMENT			
The participant uses knowledge and skills to perform a physical assessment on a patient presenting with abdominal pain.			
Element	Performance Criteria	Mastery	
		Yes	No
<p><i>Identify the quadrants of the abdomen and describe the major organs underlying each of these quadrants.</i></p> <p><i>continued</i></p> <p><i>Inspection</i></p>	<p>Left lower quadrant</p> <ul style="list-style-type: none"> • Sigmoid colon • Parts of the descending colon. <p>Pelvis</p> <ul style="list-style-type: none"> • Bladder • Uterus • Ovaries. <p>Inspect the abdominal contour at the patient's level for:</p> <ul style="list-style-type: none"> • Size • Shape • Symmetry • Masses or bulges • Colour, ecchymosis. 		
<i>Auscultation</i>	<p>Auscultate for bowel sounds</p> <ul style="list-style-type: none"> • RLQ (ileocaecal junction) • All four quadrants. 		
<i>Palpation</i>	<p>Palpate the abdomen</p> <ul style="list-style-type: none"> • First palpate areas where you don't expect problems <ul style="list-style-type: none"> – Initial gentle palpation – More firm palpation • Identify abnormal signs & implications <ul style="list-style-type: none"> – Tenderness – Rebound – Guarding. 		
<i>+/- Percussion</i>	Percuss the abdomen (not mandatory).		
<i>Investigations</i>	<ul style="list-style-type: none"> • 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.

Element	Performance Criteria	Mastery	
		Yes	No
<i>Identify the type of pain patient is describing and initiated appropriate pain management</i>	Discuss the indications for analgesia: <ul style="list-style-type: none"> • 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 as per hospital protocol. 		
<i>Documentation</i>	Document the following in the medical records: <ul style="list-style-type: none"> • Presenting problem • History • Assessment findings • Pain assessment and re-assessment • Interventions and investigations • Nursing management plan. 		

